Northern Lincolnshire and Goole NHS Foundation Trust

CHIEF NURSE DIRECTORATE

POLICY FOR THE CONTROL OF METICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS

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Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity and good race relations.

The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including their religion, beliefs, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin.

These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of this document.

1.0 Purpose

1.1 Summary

This is an over-arching Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) Policy on the detection and management of MRSA.

1.2 Objectives/success factors

The objectives of this policy are:

- To ensure patients who are confirmed to have MRSA are managed safely and appropriately, and receive adequate information about their condition.
- To ensure the spread of MRSA within NLAG is minimised.
- To protect patients from infection or colonisation with MRSA.

This policy includes:

- Detection of MRSA by screening certain categories of patients.
- Actions to be taken when patients who have or may have MRSA are admitted.
- Appropriate placement of patients with MRSA.
- Decolonisation treatment for patients with MRSA.
- Actions required to reduce the risk of infection in patients who are already colonised with MRSA.
- Actions that should be taken to ensure safe, appropriate treatment of MRSA infection.
- Communication of infection status on transfer or discharge using the Inter Healthcare Infection Control Notification Form or discharge information leaflet as relevant to circumstances.

2.0 Area

This policy will apply to all relevant patients and all disciplines of healthcare staff and allied professionals employed within Northern Lincolnshire & Goole NHS Foundation Trust (NLAG).

3.0 Duties

All staff working on Trust premises, including Trust employed staff, contractor's staff, agency and locum staff are responsible for adhering to this policy, and for reporting breaches of this policy 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 that they and their junior staff read and understand this policy and adhere to the principles contained in it at all times.

Divisonal Management Teams are responsible for monitoring implementation of this policy, and for ensuring action is taken when staff fail to comply with the policy.

Site Co-ordinators and Bed Managers are responsible for ensuring patients are placed in accordance with this policy, and for escalating any situations where safe placement cannot be achieved.

On-call Managers and Directors are responsible for providing senior and executive leadership to ensure implementation of this policy, 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 policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required. They are also responsible for ensuring this policy remains consistent with the evidence-base for safe practice, and for reviewing the policy on a regular basis. On identification of a new case of MRSA the Infection Control Team will inform ward staff, arrange for the patient's electronic records to be flagged and advise that decolonisation be initiated. All subsequent follow-up - including initiation of the MRSA Care Pathway - is the responsibility of the clinical team, with support from the Infection Control Team.

Infection Prevention & Control Committee (IPCC) will receive reports from the IPCT and monitor compliance with and the effectiveness of this policy.

4.0 Actions

Standards to be followed:

4.1 **Antimicrobial Prescribing**

Adhere to Antibiotic Policy.

4.2 **Surveillance of MRSA**

The IPCT will perform surveillance for MRSA isolates routinely as part of alert organism surveillance. Clinical areas will be informed of all identified MRSA-positive patients by the laboratory/Infection Control Team.

The IPCT will perform enhanced surveillance of MRSA Bacteraemia in line with the Department of Health requirements. The results of this surveillance will be fed back to Clinical and Management Teams for action.

Clinical and Management Teams are responsible for ensuring review/Root Cause Analysis of each clinical case of MRSA Bacteraemia and implementation of local action plans to improve practice.

MRSA surveillance data will be reported and reviewed via local Governance arrangements/IPCC.

4.3 **MRSA Screening**

Patients will be screened for MRSA in accordance with Department of Health guidance, for the following reasons:

- Patients found to be positive can be managed to minimise the spread of MRSA infection during their treatment. This may require different antimicrobial prescribing, topical decolonisation prior to a procedure or other measures eg isolation.

- To protect other patients from the risk of colonisation or infection with MRSA during their treatment.

- Follow up screening is confined to:

  - Inpatients. It is only necessary in the management of isolation facilities and does not directly influence patient management.

  - Pre assessment cases who are due to undergo implant surgery (orthopaedic, vascular and breast implant) and who are found to be MRSA positive at pre assessment screening.

  - Staff who may need to undergo a risk assessment before returning to work.

- Patients that decline to be screened should be considered to be positive and isolated accordingly.

- NB: If a patient has ever been MRSA positive, a subsequent negative result may not indicate eradication but merely suppression to below detectable levels. In this event, the use of antibiotics NOT effective against MRSA, including for surgical prophylaxis, may encourage the regrowth of MRSA and lead to infection.

4.4 MRSA Decolonisation

All inpatients found to be MRSA positive will require topical decolonisation in an attempt to eradicate MRSA, and reduce the subsequent risk of infection. This is in addition to the Trust Antibacterial Body Wash for All Policy.

4.5 Isolation

All patients found to be MRSA positive will have an alert flag placed on the electronic record systems. Responsibility for checking for alerts rests with the medical and nursing staff that admit the patient.

All patients with MRSA will be managed with standard infection control precautions

Single room isolation will be implemented for all patients in accordance with facilities available. A risk assessment may need to be undertaken to prioritise single room use. Patients that have declined screening should be isolated subject to the need for risk assessment.

Where single room isolation cannot be achieved the Infection Control Team and Site Co-Ordinator must be informed so an appropriate risk assessment can be undertaken. An incident form must be completed where isolation cannot be implemented.

4.6 Documentation

The MRSA status of all patients must be accurately recorded in medical and nursing notes, including information on topical decolonisation therapy and specimen results. An alert should be posted on the A&E Symphony system. IPCNs will inform A&E staff of new positive cases. Good communication of patients' MRSA status between wards and departments is vital.

4.7 Communication and Patient Information

Patients and visitors must be provided with accurate information on MRSA. This is the responsibility of the medical and nursing team admitting or providing care for the patient.

This includes information for all patients on the risk of infection during procedures, and information for those found to be positive on their management. Information leaflets are available on the public website of the Trust as well as the Infection Control hub site.

Accurate information on MRSA status must be recorded and communicated to other wards and departments within NLAG 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 using either the Inter Healthcare Infection Control Notification Form or the Discharge Instruction Leaflet for Patients and Carers.

The team caring for the patient should inform them of the implications of their current MRSA positive status in relation to their management during future admissions.

A patient with a previous history of MRSA colonisation who has achieved a minimum of 5 negative screens collected on consecutive dates will be told they no longer require source isolation as a routine on re admission as they are deemed to be low risk.

5.0 Actions/Procedures

Controlling MRSA by Risk Areas and Susceptibility of Patients

5.1 Each ward/department can be categorised into a clinical risk area.

When patients from different categories are mixed on a ward/unit, the higher category applies to ALL patients.

AREA: CRITICAL CARE CLINICAL RISK AREA	**ITU, CCU, HDU, Oncology and Haematology (Inpatients)**
ROUTINE ADMISSION SCREENING (WITHIN 24 HOURS)	All patients screened on admission to the above areas (nose, perineum, lesions, manipulated sites and any previously MRSA positive sites) and also, weekly whilst on the unit. In addition, wounds should be screened at the first dressing change. **ITU** – Screen before transferring out of unit.
ANTIBACTERIAL BODY WASH PROPHYLAXIS FOR ALL PATIENTS	Commence washing with antibacterial body wash on admission and continue for length of stay.
TREATMENT FOR MRSA POSITIVE PATIENTS	❑ Follow MRSA Pathway. ❑ Continue with daily antibacterial body wash for length of stay. ❑ Use Mupirocin nasal ointment (paraffin based) three times per day for 5 days. ❑ If patient on oxygen use Mupirocin ointment (water based), three times a day for 5 days ❑ If patient Mupirocin resistant use Prontoderm nasal gel, three times per day for 5 days ❑ ❑ If patient has a nut or chlorhexidine allergy, use Prontoderm nasal gel, three times per day for 5 days ❑ If patient on facial oxygen and has a Mupirocin resistant strain of MRSA use Naseptin or Prontoderm nasal gel as above ❑ Use other antimicrobials if indicated ie MRSA infections.
FOLLOW-UP SCREEN OF MRSA POSITIVE PATIENTS	❑ Following completion of the 5-day nasal decolonisation regimen, wait for 48 hours and then screen nose, perineum, lesions/wounds and manipulated sites and previous positive eg sputum on 3 consecutive days. ❑ Do not discontinue antibacterial body wash.
ISOLATION OF PREVIOUSLY POSITIVE PATIENTS	❑ Isolate all known positive patients and previous positive patients with less than 5 consecutive negative screens since last positive specimen. ❑ Isolate higher* risk patients whilst awaiting admission screening results.
LENGTH OF ISOLATION FOR PATIENTS POSITIVE THIS ADMISSION	For patients positive this admission: ❑ Isolate until 3 full sets of negative post-treatment swabs obtained. ❑ Continue with daily antibacterial body wash for duration of admission.
SCREENING FOLLOWING DISCONTINUATION OF ISOLATION	❑ All patients weekly screen while remaining on unit.

* Higher risk patients (ie those most likely to be positive) include those transferred from Non-NLAG hospitals including transfers from hospitals abroad or transferred from any non-NLAG hospital, residential/nursing homes and previously positive patients.

AREA: **HIGH CLINICAL RISK AREA**	**Inpatients - Orthopaedic, Breast Implants (Laurel Ward)**
ROUTINE ADMISSION SCREENING (WITHIN 24 HOURS)	All patients on admission. For all elective cases: ❑ Patients should have been screened at pre-assessment clinic. ❑ Repeat screen on admission (nose, perineum, lesions/wounds, manipulated sites and any previously MRSA positive sites). ❑ For emergency cases: screen on admission (nose, perineum, lesions/wounds & manipulated sites).
ANTIBACTERIAL BODY WASH PROPHYLAXIS FOR ALL PATIENTS	Commence antibacterial body appication as advised before admission where applicable (Orthopaedic, Vascular & Breast Implants). Commence/continue daily antiseptic body application for the duration of hospitalisation.
TREATMENT FOR MRSA POSITIVE PATIENTS	❑ Follow MRSA Pathway. ❑ Continue with daily antibacterial application for length of stay. ❑ Use Mupirocin nasal ointment (paraffin based) three times per day for 5 days. If patient on oxygen use Mupirocin ointment (water based). ❑ If patient Mupirocin resistant use Prontoderm nasal gel, three times per day for 5 days ❑ If patient has a nut or chlorhexidine allergy, use Prontoderm nasal gel, three times per day for 5 days ❑ If patient on facial oxygen and has a Mupirocin resistant strain of MRSA use Prontoderm nasal gel as above ❑ Use other antimicrobials if indicated ie MRSA infections.
FOLLOW-UP SCREEN OF MRSA POSITIVE PATIENTS	❑ Following completion of the 5-day nasal decolonisation regimen, wait for 48 hours and then screen nose, perineum, lesions/wounds and manipulated sites and previous positive sites eg sputum on 3 consecutive days. ❑ Do not discontinue antibacterial body wash.
ISOLATION OF PREVIOUSLY POSITIVE PATIENTS	❑ Isolate all known and previous positive patients with less than 5 consecutive negative screens since last positive specimen. ❑ Consider cohort nursing**.
LENGTH OF ISOLATION FOR PATIENTS POSITIVE THIS ADMISSION	For patients positive this admission: ❑ Isolate until 3 full sets of negative post-treatment swabs obtained. ❑ Continue with daily antibacterial body wash for duration of admission.
SCREENING FOLLOWING DISCONTINUATION OF ISOLATION	For patients positive this admission: ❑ Weekly screen while remaining in hospital as advised by IPC

** If side room availability is limited, undertake a risk assessment to determine which patient has priority for isolation. Patients with skin conditions, wounds, an intravascular or urinary device should be given priority over patients with intact skin.

AREA: MEDIUM CLINICAL RISK AREAS	**General Medical, Stroke Units, General Surgery, Urology, Gynaecology (Ward 19), HOBS**
ROUTINE ADMISSION SCREENING (WITHIN 24 HOURS)	**Screen:** Previously positive cases with less than 5 consecutive negative screens since last positive specimen, patients transferred from Non-NLAG hospitals including hospitals abroad, and patients admitted from residential / nursing homes. **Screening sites**: Nose, lesions/wounds, manipulated sites and any previously MRSA positive sites.
ANTIBACTERIAL BODY WASH PROPHYLAXIS FOR ALL PATIENTS	Prophylactic antibacterial body application not necessary.
TREATMENT FOR MRSA POSITIVE PATIENTS	❑ Follow MRSA Pathway. ❑ Continue with daily antibacterial body wash for length of stay. ❑ Use Mupirocin nasal ointment (paraffin based) three times per day for 5 days. If patient on oxygen use Mupirocin ointment (water based). ❑ If patient Mupirocin resistant use Prontoderm nasal gel three times per day for 5 days. ❑ If patient has a nut or chlorhexidine allergy, use Prontoderm nasal gel three times per day for 5 days. ❑ If patient on facial oxygen and has a Mupirocin resistant strain of MRSA use Prontoderm nasal gel as above for 5 days. ❑ Use other antimicrobials if indicated ie MRSA infections.
FOLLOW-UP SCREEN OF MRSA POSITIVE PATIENTS	❑ Following completion of the 5-day nasal decolonisation regimen, wait for 48 hours and then screen nose, perineum, lesions/wounds and manipulated sites and previous positive sites eg sputum on 3 consecutive days.
ISOLATION OF PREVIOUSLY POSITIVE PATIENTS	❑ Isolate all known and previous positive patients with less than 5 consecutive negative screens since last positive specimen. ❑ Consider cohort nursing**.
LENGTH OF ISOLATION FOR PATIENTS POSITIVE THIS ADMISSION	For patients positive this admission: ❑ Isolate until 3 full sets of negative post-treatment swabs obtained

** If side room availability is limited, undertake a risk assessment to determine which patient has priority for isolation. Patients with skin conditions, wounds, an intravascular or urinary device should be given priority over patients with intact skin.

AREA	ROUTINE MATERNITY/OBSTETRICS
ROUTINE ADMISSION SCREENING (WITHIN 24 HOURS)	**Department of Health Guidance 2009 (Gateway 10234) states:** *"Routine Maternity/Obstetric patients do not need to be routinely screened except for elective Caesareans and high risk cases ie high risk of complication in mother and/or potential complication in the baby eg likely to need SCBU/NICU for reasons of size or known complications or risk factors" eg emergency Caesarean sections.* *Patients undergoing elective Caesarean sections should be screened in antenatal clinic and again on admission if more than two weeks have elapsed."* Patients transferred from Non-NLAG hospitals including hospitals abroad, and patients admitted from residential / care homes should undergo screening as well as previous positive patients with less than 5 consecutive negative screens since the last positive specimen. Screening sites: Nose, lesions/wounds, manipulated sites and any previously MRSA positive sites.
ANTIBACTERIAL BODY WASH PROPHYLAXIS FOR ALL PATIENTS	Prophylactic body wash not necessary.
TREATMENT FOR MRSA POSITIVE PATIENTS	❑ Follow MRSA Pathway. ❑ Commence with daily antibacterial body application for length of stay. ❑ Use Mupirocin nasal ointment (paraffin based) three times per day for 5 days. ❑ If patient on oxygen use Mupirocin ointment (water based)/ three times per day for 5 days. ❑ If patient Mupirocin resistant use Prontoderm nasal gel three times per day for 5 days. ❑ If patient has a nut or chlorhexidine allergy, use Prontoderm nasal gel three times per day for 5 days. ❑ If patient on facial oxygen and has a Mupirocin resistant strain of MRSA use Prontoderm nasal gel as above for 5 days. ❑ Other antimicrobials if indicated ie MRSA infections.
FOLLOW-UP SCREEN OF MRSA POSITIVE PATIENTS	**For MRSA positive inpatients:** ❑ Following completion of the 5-day nasal decolonisation regimen, wait for 48 hours and then screen nose, perineum, lesions/wounds and manipulated sites and previous positive sites eg sputum on 3 consecutive days.
ISOLATION OF PREVIOUSLY POSITIVE PATIENTS	**For inpatients:** ❑ Isolate all known positive patients and previous positive patients with less than 5 consecutive negative screens since last positive specimen**.
LENGTH OF ISOLATION FOR PATIENTS POSITIVE THIS ADMISSION	For patients positive this admission: ❑ Isolate until 3 full sets of negative post-treatment swabs obtained.

** If side room availability is limited, undertake a risk assessment to determine which patient has priority for isolation. Patients with skin conditions, wounds, an intravascular or urinary device should be given priority over patients with intact skin.

AREA	SCBU/NICU
ROUTINE ADMISSION SCREENING (WITHIN 24 HOURS)	Screen all babies on admission to unit (cord, nose, manipulated sites, lesions and wounds and any previously MRSA positive sites). It is important to establish a family history of MRSA.
ANTIBACTERIAL BODY WASH PROPHYLAXIS FOR ALL PATIENTS	Prophylactic body wash not necessary.
TREATMENT FOR MRSA POSITIVE PATIENTS	❑ Follow MRSA Pathway/Policy. ❑ Continue with daily antibacterial body wash until MRSA clear. **Note instructions for use of specific antibacterial body wash for children under 1 year of age.** ❑ Use Mupirocin nasal ointment (paraffin based) three times per day for 5 days. ❑ If patient on oxygen use Mupirocin ointment (water based) three times per day for 5 days. ❑ If patient Mupirocin resistant use Prontoderm nasal gel three times per day for 5 days. ❑ If patient has a nut or chlorhexidine allergy, use Prontoderm nasal gel three times per day for 5 days. ❑ If patient on facial oxygen and has a Mupirocin resistant strain of MRSA use Prontoderm nasal gel as above for 5 days. ❑ Other antimicrobials if indicated ie MRSA infections.
FOLLOW-UP SCREEN OF MRSA POSITIVE PATIENTS	❑ Following completion of the 5-day nasal decolonisation regimen, wait for 48 hours and then screen nose, perineum, cord, lesions/wounds and manipulated sites and previous positive sites eg sputum on 3 consecutive days. ❑ Do not discontinue antibacterial body wash.
ISOLATION OF PREVIOUSLY POSITIVE PATIENTS	❑ Isolate all positive patients. ❑ Isolate higher risk patients* whilst awaiting admission screening results.
LENGTH OF ISOLATION FOR PATIENTS POSITIVE THIS ADMISSION	❑ Isolate until 3 full sets of negative post-treatment swabs obtained.
SCREENING FOLLOWING DISCONTINUATION OF ISOLATION	❑ All patients weekly screen while remaining in unit.

* Higher risk patients (ie those most likely to be positive) include those transferred from Non-NLAG hospitals including hospitals abroad, frequent admissions to any hospital, previously positive patients and patients admitted from the community.

AREA	CHILDREN'S WARDS
ROUTINE ADMISSION SCREENING (WITHIN 24 HOURS)	No admission screen required unless a child in an inpatient area is in a high risk* group or previously MRSA positive with less than 5 consecutive negative screens since last positive specimen. **Screen**: nose, lesions/wounds, manipulated sites and any previously MRSA positive sites. It is important to establish a family history of MRSA.
ANTIBACTERIAL BODY WASH PROPHYLAXIS FOR ALL PATIENTS	Prophylactic antibacterial body wash not necessary.
TREATMENT FOR MRSA POSITIVE PATIENTS	❑ Follow MRSA Pathway/Policy. ❑ Continue with daily antibacterial body agent application until MRSA clear. **Note instructions for use of specific antibacterial body wash for children under 1 year of age.** ❑ Use Mupirocin nasal ointment (paraffin based) three times a day for 5 days. ❑ If patient on oxygen use Mupirocin ointment (water based) three times a day for 5 days. ❑ If patient Mupirocin resistant, Prontoderm nasal gel three times per day for 5 days. If patient has a nut or chlorhexidine allergy, use Prontoderm nasal gel three times a day for 5 days. ❑ If patient on facial oxygen and has a Mupirocin resistant strain of MRSA use Prontoderm nasal gel as above for 5 days. ❑ Other antimicrobials if indicated ie MRSA infections.
FOLLOW-UP SCREEN OF MRSA POSITIVE PATIENTS	❑ Following completion of the 5-day nasal decolonisation regime, wait for 48 hours and then screen nose, perineum, lesions/wounds and manipulated sites and previous positive sites eg sputum on 3 consecutive days.
ISOLATION OF PREVIOUSLY POSITIVE PATIENTS	**For inpatients:** Isolate all known and previous positive patients with less than 5 consecutive negative screens since last positive specimen.
LENGTH OF ISOLATION FOR PATIENTS POSITIVE THIS ADMISSION	**For patients positive this admission**: Isolate until 3 full sets of negative post-treatment swabs obtained.

* Higher risk patients (ie those most likely to be positive) include those transferred from Non-NLAG hospitals including hospitals abroad, patients admitted from residential / nursing homes and previously positive patients.

** If side room availability is limited, undertake a risk assessment to determine which patient has priority for isolation. Patients with skin conditions, wounds, an intravascular or urinary device should be given priority over patients with intact skin.

AREA	HAEMATOLOGY/ONCOLOGY DAY CASE UNITS
ROUTINE ATTENDANCE SCREENING	Frequent attenders to be screened at 3-monthly intervals (eg Haematology/Oncology patients). Previous positive patients to be screened on each attendance (nose, lesions/wound, manipulated sites and any previously MRSA positive sites). Pathology request forms must be appropriately annotated so that a copy of the results is sent to the patient's GP.
ANTIBACTERIAL BODY WASH PROPHYLAXIS FOR ALL PATIENTS	N/A
TREATMENT FOR MRSA POSITIVE PATIENTS	Follow up treatment will be decided by the patient's GP and Community IPCT following a risk assessment for infection. It is the responsibility of the clinical team submitting the swab to ensure positive results are communicated to the patient's GP and the community IPCT
FOLLOW-UP SCREEN OF MRSA POSITIVE PATIENTS	No routine follow up unless deemed necessary by GP.
ISOLATION OF PREVIOUSLY POSITIVE PATIENTS	Where possible, isolate previously positive patients during their attendance if they do not have 5 consecutive negative MRSA screens
LENGTH OF ISOLATION FOR PATIENTS POSITIVE THIS ADMISSION	For the duration of patient's attendance.

AREA	PRE ASSESSMENT CLINIC: (FOR PATIENTS DUE TO BE ADMITTED TO AN INPATIENT WARD
ROUTINE SCREENING	For all patients intended as elective inpatient admissions to: ❑ Orthopaedic Wards, Laurel Ward, Critical Care Areas (ITU, CCU, HOBS, HDU): screen nose, perineum, lesions/wounds, manipulated sites and any previously MRSA positive sites ❑ General Surgical Wards: only screen patients with a history of MRSA with less than 5 consecutive negative screens since last positive specimen, or is a patient from a Nursing and Residential care home. **Screen:** nose, lesions/wound, manipulated sites and any previously MRSA positive sites. Lab request forms should clearly state “Pre-admission screen prior to X” (X = type of surgery/procedure). Path lab requests must be appropriately annotated so that a copy of the results is sent to the GP.
ANTIBACTERIAL BODY WASH PROPHYLAXIS	Prophylactic body wash will be given at pre-assessment for all patients undergoing hip, knee, breast and other implant surgery and patients with a previous history of MRSA and should be used before coming into hospital. Date of commencement to be advised by the Pre-Assessment Team.
TREATMENT FOR MRSA POSITIVE PATIENTS	The Pre-assessment Team must ensure there are clear arrangements for checking results and communicating positive results in order that action and follow up screening can be taken prior to the procedure by : ❑ The patient’s GP. ❑ The Pre-assessment Team. ❑ North Lincs Decolonisation Clinic if available. The decision to admit the patient is the responsibility of the Clinician in Charge. Advice can be sought from the Consultant Microbiologist.
ISOLATION	The Pre-assessment Nurse should inform the ward of any positive results in order that isolation facilities are made available and correct placement on the theatre list.
ADDITIONAL ACTIONS	The electronic patient record systems (eg Symphony system, Web V) should have an alert flag applied. Staff members requiring pre-assessment and who are identified as MRSA positive should be referred to the Occupational Health Department for advice, exclusion from work and re-screening.

AREA	PRE-ASSESSMENT FOR DAY SURGERY
ROUTINE SCREENING	❑ ALL patients undergoing Orthopaedic procedures screen: nose, perineum, lesions/wounds, manipulated sites and any previously MRSA positive sites ❑ All previous positive MRSA cases with less than 5 consecutive negative screens since the last positive specimen identified via electronic alert systems and patients from Nursing and Residential care homes. **Screen**: nose, lesions/wounds, manipulated sites and any previously MRSA positive sites.
ANTIBACTERIAL BODY WASH PROPHYLAXIS	❑ For patients who have a previous history of MRSA as identified as above, commence treatment with antibacterial wash before surgical procedure
TREATMENT FOR MRSA POSITIVE PATIENTS	For MRSA positive patients The Pre-assessment Team must ensure there are clear arrangements for checking results and communicating positive results in order that action and follow up screening can be taken prior to the procedure by : ❑ The patient's GP. ❑ The Pre-assessment Team. ❑ North Lincs decolonisation clinic if available. The decision to progress with the patient's surgery is the responsibility of the Clinician in Charge. Advice can be sought from the Consultant Microbiologist.
ISOLATION	The Pre-assessment Nurse should inform the relevant unit of any positive results in order that isolation facilities are made available and correct placement on the theatre/procedure list.

AREA MEDIUM CLINICAL RISK AREA	**Neuro Rehabilitation Centre (Ward 4)**
ROUTINE ADMISSION SCREENING (WITHIN 24 HOURS)	**Screen**: Previously positive cases with less than 5 consecutive negative screens since last positive specimen, patients transferred from all non- NLAG hospitals including hospitals abroad. **Screening sites**: Nose, lesions/wounds, manipulated sites and any previously MRSA positive sites.
TOPICAL ANTIBACTERIAL PROPHYLAXIS	Consider for those patients who meet the high risk criteria for the unit.
TREATMENT FOR MRSA POSITIVE PATIENTS	❑ Follow MRSA Pathway. ❑ Use Mupirocin nasal ointment (paraffin based) three times per day for 5 days. **If patient on oxygen use Mupirocin ointment (water based).** ❑ If patient Mupirocin resistant, use Prontoderm nasal gel three times per day for 5 days. ❑ If patient has a nut or chlorhexidine allergy, use Prontoderm nasal gel three times per day for 5 days. ❑ If patient on facial oxygen and has a Mupirocin resistant strain of MRSA use Prontoderm nasal gel as above or Octenisan nasal gel twice per day for 5 days. ❑ Use other antimicrobials if indicated ie MRSA infections. Consider consulting with the Microbiologist for an appropriate management plan
FOLLOW-UP SCREEN OF MRSA POSITIVE PATIENTS	❑ Following completion of the 5-day nasal decolonisation regimen, wait for 48 hours and then screen nose, perineum, lesions/wounds and manipulated sites and previous positive sites eg sputum on 3 consecutive days. ❑ **Do not** discontinue antibacterial topical treatment whilst waiting for results.
ISOLATION	❑ Isolate all known and previous positive patients with less than 5 consecutive negative screens since last positive specimen.
LENGTH OF ISOLATION	For patients positive this admission: ❑ Isolate until 3 full sets of negative post-treatment swabs obtained.
SCREENING FOLLOWING DISCONTINUATION OF ISOLATION	For patients positive this admission: ❑ Monthly screening, on risk assessment/review with the Infection Prevention & Control team while remaining in hospital.

5.2 Colonisation vs Infection

Definitions:

Colonisation: When bacteria which are able to cause infection are isolated from non-infected sites, eg *Staphylococcus aureus* in the nose.

Infection: The reaction to microbes lodging and multiplying in the tissues, for example abscesses, wound infections or chest infections.

A list of signs and symptoms that may or may not be present in varying degrees is detailed below:

	Colonisation	**Infection**
Erythema	No	Yes
Pyrexia	No	Yes
Cellulitis	No	Yes
Odour	Yes	Yes
Positive swab results	Yes	Yes
Purulent discharge	No	Yes
Excess exudate	Yes	Yes
Local pain	No	Yes
Local oedema	No	Yes

5.3 How To Screen

Swabs should be rubbed firmly over the area with 10 - 20 strokes, rotating the swab through 360^0C to ensure full coverage, and sent immediately to the laboratory. There is no need to moisten the swabs with sterile saline or water.

5.4 MRSA Screening Method

Specimens to be taken:

1. Nose: One swab used inside both anterior nares (fleshy part of the nose).
2. Skin Lesions and/or Wounds: one swab from each site; clearly identifying sites. Label wound swabs “For culture and sensitivity (C & S)” rather than “MRSA screen”.
3. Any other site (except blood cultures) that has been previously positive eg sputum.

- Indications for MRSA screening to be documented on the request form
- Specimens must be correctly labelled with patient details. The laboratory will reject unlabelled or incorrectly labelled specimens.

5.5 Follow Up Screening of Specimens

It is the responsibility of the person sending the specimen to check the results and ensure this is clearly documented in the clinical records.

5.6 Communication of MRSA positive results

Patients should be informed about the need for screening and explanations provided about the implications of a positive result.

Patients who are colonised or infected with MRSA should be informed of their condition by their clinical team.

Electronic patient record systems (including the A & E system) should be appropriately labelled to enable rapid recognition on subsequent admission.

Day case patients who have been discharged prior to the result will be informed by the GP.

No special precautions are necessary for visitors. Hand washing should be carried out on leaving the room.

5.7 Staff Screening

Staff must not undertake self-screening.

- **Routine staff screening for MRSA**

  Screening of staff is not currently undertaken as a matter of routine in line with National guidance, although if there is evidence of sustained healthcare transmission, groups of staff may be required to be screened. This is confidential screening undertaken through Occupational Health. Staff found to be positive under this process will be managed by Occupational Health.

- **Staff positive at Pre assessment screening**

  Staff that screened positive as a result of pre assessment screening will be managed by the process already in place within the pre assessment pathway. This usually means decolonisation and subsequent post decolonisation screening will be undertaken via the GP/ pre assessment clinic. Results of post decolonisation screening will be followed up by the pre assessment team in order for surgery to be rearranged.

- **Staff screened during an admission but discharged post result**

  In the above instance the Community Infection Control Nurse will arrange for the patient to be notified of their positive result and advise to visit their GP for decolonisation treatment. As it is not customary for post decolonisation screening to be undertaken in this group of patients, Staff should also be advised to contact Occupational Health to advise them of their positive result in order for post decolonisation screening to be undertaken along with specific advice on suitability for return to work. This will be based on a risk assessment.

- **Risk assessment criteria for positive staff**

  Any risk assessment should take account of the following:

- Any break in the skin surface including minor/recently healed wounds, eczema or psoriasis. This is particularly relevant for hands and arms. Staff members with colonised or infected hand lesions should be deployed to a non-clinical area or excluded from work while they are

receiving decolonisation treatment. Where hands are colonised there is greater risk of transmission than with nasal colonisation.

- Staff with MRSA in lesions other than on hands may continue working, even in high risk areas, provided the lesion is covered and they maintain good hand hygiene
- Staff who are ONLY nasal carriers should commence decolonisation and may continue to work in all clinical areas of the Trust.

  Failure to eradicate MRSA after 2 courses of treatment should be reviewed by the Infection Control Doctor. Persistent colonisation may require antibiotic therapy.

6.0 BASIC INFECTION PREVENTION & CONTROL MEASURES

6.1 General Principles

The general principles of Infection Prevention & Control apply to all wards and departments and are applicable to the control of MRSA:

- Correctly performed hand washing and disinfection.
- Wearing of gloves and disposable aprons for contact with body fluids, lesions and contaminated materials. Change between each episode of care.
- Appropriate isolation of patients with, or suspected of having, a communicable infection.
- Rational use of antibiotics and an antibiotic policy.
- High standards of aseptic techniques.
- High standards of ward cleaning.
- Careful handling of used linen and its transport in sealed bags of appropriate colour.
- Segregation of all waste, careful handling of clinical waste and its transport in a sealed bag of appropriate strength and colour.
- Avoiding overcrowding of patients.
- Reviewing the need for and minimising intra and inter ward transfers of patients.
- Maintaining adequate and appropriately skilled nursing and other staff levels.
- Regular monitoring or compliance with Infection Control policies through effective audits.
- The requirement for urgent specialist care should not be compromised by control measures and the patient's overall needs should take precedence.
- Ward closure should only be recommended after risk assessment and after full consultation with relevant clinicians, hospital management and the Infection Control Team.
- On discontinuation of isolation the following procedures must be carried out: patient is to be bathed and clean attire put on, all equipment to be decontaminated or replaced and a terminal clean of the room with curtain change.

6.2 Hand Decontamination

Hand decontamination remains the primary strategy for reducing the spread of MRSA. Soap and water with a good technique will remove MRSA from the hands. Alcohol hand rub can be used on visibly clean hands as a substitute for soap and water and will destroy MRSA rapidly. (See Hand Decontamination Policy.)

6.3 Isolation

Isolation in a single room, ideally with the door closed and en suite toilet facilities, will limit spread by promoting hand decontamination and limiting environmental dispersal of the organism on skin scales. (See Isolation Policy.)

Where isolation is not achievable due to limited side room availability or concerns regarding patient safety the placement of the patient should be such that risks of transmission are minimised. Discuss with Bed Management and Infection Control.

Priority for isolation should be given to MRSA positive patients with the following factors:

- Eczema or psoriasis (skin shedder)
- Sputum where patient is coughing
- More than 1 site colonised with MRSA
- Uncovered wound
- Invasive devices including urinary catheter

Where isolation facilities cannot be identified, complete an incident form and consider placing patient:

- In a bay with other patients colonised with MRSA (cohort nursing).
- In a bed adjacent to a sink.
- In a bay with patients who do not have devices/wounds/chronic skin conditions.
- In a bay with patients who require minimal assistance with care activities.

Bays with doors and en-suite facilities are preferable for cohort nursing.

6.4 Use of Protective Clothing

The use of protective clothing is an important principle of isolation care to prevent transmission of MRSA. Standard Universal Precautions should be implemented for patients in source isolation. The choice and use of protective clothing should be based on how pathogens are spread in order to minimise that spread to both other patients and the healthcare worker. The following is required for MRSA source isolation:

MRSA	Gloves	Apron/Gown	Mask and Eye Protection
Contact precautions required.	If there is potential contact/exposure to blood/ body fluids/chemicals. Effective hand washing is necessary even when gloves are worn.	If contact with the patient or their environment is anticipated.	Only required as part of standard precautions: during procedures likely to cause contamination/ aerosols of blood or body fluids

If in doubt, contact a member of the Infection Prevention & Control Team.

6.5 Cleaning and Disinfection

Instruments or equipment (eg sphygmomanometers and cuffs, stethoscopes, lifting slings, physiotherapy exercise machines) should be designated solely for the use of the MRSA patient. It is preferable to use disposable or single use items. If this is not possible, re-usable items should be disinfected before use on another patient.

Daily cleaning of the room with approved Trust cleaning agent will avoid accumulation of dust (skin scales) and is an important element of MRSA control.

The side room in which an MRSA patient has been cared for must undergo a terminal clean (see Infection Control Guidelines for Domestic Services) after the patient's discharge or on confirmation of effective decolonisation if the patient is to remain in the room. Special attention should be given to horizontal surfaces and dust-collecting areas. Therapy beds need special cleaning and curtains must be changed if material (disposable curtains with biocide agent can remain insitu)

If an MRSA patient is known to be a heavy shedder of skin scales (eg psoriasis, eczema), then the IPC team may suggest additional cleaning requirements such as UVC and clean curtains.

The IPCN should document that the above is required and should also communicate this to the Ward Manager. Where appropriate, the IPCN should inform the Deep Clean Team.

There should be planned, periodic, thorough cleaning of the whole ward, including bedding and curtains.

Where a patient has been found to be positive in a bay, the bed space should be cleaned and curtains changed prior to admitting the next patient.

7.0 TREATMENT: INPATIENTS

7.1 *Treatment of Patients who are Colonised*

When a patient is identified as carrying MRSA on any site, decolonisation should be commenced as soon as possible and, ideally, on the same day that the patient is identified as being colonised with MRSA.

The MRSA pathway should be implemented to facilitate compliance with treatment and screening regimens. It is preferable that treatment is performed using a shower. However a bath, bed bath or bowl is acceptable.

Patients colonised with MRSA who need to use wash areas outside of their isolation room should do so after all other patients have used them. The area should not be used by other patients until thoroughly cleaned by Domestic staff. The Infection Prevention & Control Nursing Team should be consulted where facilities outside the isolation room are to be used.

A Patient Information Sheet should be given to the patient to help to explain what the positive result means to them.

7.2 *Procedure*

Application of body wash

Patients should bathe (shower/bed bath/bath) every day with their usual wash products and shampoo hair at least twice weekly, drying themselves and their hair with a clean towel. For patients with skin sensitivities, Dermol cream/lotion should be prescribed.

- Apply Skinsan Scrub N Foam to the whole body and face. Apply undiluted onto a dry wash cloth.
- Pay particular attention to armpits, groin, nostrils and feet.
- Do not wash lotion off. Leave to dry before dressing.
- Continue to apply even if not able to have a full wash.
- Wash hair with foam as would be done with a normal shampoo ad rinse. Ordinary shampoo and conditioner can be used afterwards if desired.
- Where a patient has mobility or incapacity issues, assistance may be required to facilitate treatment.
- Clean bed linen and clean clothing should be provided daily after treatment
- Hands of staff and carers should be decontaminated after this procedure

In patients who cannot tolerate an approved body wash, consider Dermol ointment or lotion as an alternative. Use instead of using the usual soap or shower gel. Dermol 500 lotion will not foam or lather like ordinary cosmetic products. After washing, pat skin dry with soft towel. Do not rub as this could worsen the skin condition. Patients using Dermol lotion should wash their hair using Dermol shower gel twice a week in place of their regular shampoo.

Antiseptics should be used with care in patients with eczema, dermatitis or other skin conditions. A dermatologist should be consulted for advice on such patients. If MRSA not eradicated after 2 courses of treatment please contact the Consultant Microbiologist for advice

7.3 *Confused Non-Compliant Patients*

For patients who are not compliant with the body wash decolonisation due to confusion, Skinsan N foam may be attempted in place of the usual antibacterial body wash. This product can be applied without rinsing off so may aid compliance with decolonisation in these patients.

7.4 *Application of nasal ointment*

- Apply a small amount of nasal ointment (Mupirocin 2%, Bactroban) using a cotton wool swab or bud to the inner surface of each nostril.
- Apply 3 times a day for five consecutive days.
- The nostrils should be closed by pinching the nose together at each application (because this spreads the ointment throughout the nares).
- Hands should be decontaminated after this procedure

If the strain is Mupirocin-resistant, use Prontoderm nasal gel for 5 days. If patient has a nut or chlorhexidine allergy, use Prontoderm nasal gel three times per day for 5 days. Application is the same as that described above.

Antibiotics that may be required for systemic use should not be used topically (eg Fusidic Acid, Gentamicin and Vancomycin)

NB: An alternative to Mupirocin nasal ointment must be considered when the patient is receiving oxygen therapy. Mupirocin skin ointment, which is water-based, is a suitable alternative.

7.5 Treatment of MRSA Positive Neonates, Premature Babies and Babies up to 1 Year Old

For MRSA positive babies, topical decolonisation of the skin will be with Octenisan.

Prior to commencing full body washes in **premature babies** a skin patch test should be performed as below:

- Wet area (arm or leg)
- Apply a small amount of Octenisan to identified area
- Leave in contact with the skin for 3 minutes
- Rinse off and dry thoroughly
- Document limb and site (upper, lower, left, right) in Nursing records.
- Check site 24 hours later for any reaction
- If no reaction observed, commence the 5-day whole body treatment
- If redness is detected, inform Microbiologist for further advice.

Treatment: The approved antibacterial body wash should be prescribed as a soap substitute for bathing babies to prevent cross infection. Octenisan should be applied as follows:

- Apply directly onto skin moistened with water using a dampened cotton wool/balls/gauze
- Pay particular attention to hair, axillae and groin areas
- Cord care is extra important in theses cases. Consider topical cord care.
- Ensure between 1 and 3-minute contact time is achieved
- Rinse off thoroughly and dry using a clean towel
- Clean bed linen and clothing should be provided daily after treatment
- Apply a small amount of mupirocin 2% nasal ointment as prescribed to each nostril three times per day. Decolonisation should be continued for five days.
- NB: An alternative to Mupirocin must be considered when the patient is receiving oxygen therapy or has a mupirocin resistant strain of MRSA.

7.6 *Follow Up*

- After completing the course of decolonisation, nasal treatment should be discontinued for 48 hours. Screen then follow the MRSA pathway.
- Post-treatment screening swabs of the nose, perineum, wounds, manipulated sites and source of initial positive result (if different from those indicated) should be taken on 3 consecutive days. If the patient is receiving antibiotic treatment for the MRSA, then postpone taking the re-screen swabs until 48 hours after cessation of the antibiotic treatment.
- Nasal decolonisation and body lotion treatment should be recommenced whilst awaiting results.
- If MRSA is eradicated the decolonisation treatment is discontinued.
- If MRSA is not eradicated treatment needs to be continued for a further cycle.

7.7 *Treatment of Patients who are Throat Carriers*

These are difficult to treat and their role in the transmission of infection is uncertain. Systemic treatment is usually required. This should be considered only in exceptional circumstances, eg evidence of transmission from a throat carrier, or when it is contributing to a continuing outbreak. This must be clearly explained to the patient or member of staff.

If treatment is required, a course of appropriate antibiotics should be given for a period of 5 days, according to the susceptibility of the strain.

Courses should usually not be repeated since side effects are common and increase with the length of treatment. The risk of emergence of resistance is also increased.

The value of local treatment such as antiseptic gargles or sprays is uncertain, but it may reduce Staphylococcal load.

- ***Sputum***

  Sputum carriage need not necessarily be actively treated as it often represents upper respiratory tract colonisation. Topical decolonisation should be adequate. The Consultant Microbiologist should be contacted for advice.

7.8 *Treatment of Patients with Infected or Colonised Skin Lesions*

Mupirocin (2%) cream may be applied to small lesions but not to large raw areas such as burns or to indwelling plastic devices.

Treatment should not extend beyond 7 - 10 days and a repeat course should preferably be avoided since resistance may emerge.

Dressings containing Chlorhexidine or Povidone-iodine or silver may be applied to infected or colonised wounds. These are unlikely to eradicate the organisms but may help to reduce numbers of organisms and thus dissemination. There are other products available that may be appropriate for the treatment of wounds or for patients with allergies to the above.

Liaison with the Tissue Viability Nurse Specialist, where available, is advocated in wound care management.

7.9 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.
- Liaison with the Tissue Viability Nurse may also be appropriate if the PEG site is infected.

7.10 Infected Peripheral IV Insertion sites in patients known to have MRSA

- Remove cannula 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 VIP score of the site, and actions taken including choice of dressing

7.11 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 nothing else that can be specifically done to reduce MRSA colonisation from this site

7.12 Treatment of Infections in Patients

Consult with the Consultant Microbiologist who will advise on the most appropriate treatment/antibiotics. This is of course dependent upon the antibiotic sensitivity pattern of the infecting organism.

7.13 Wounds

Antibacterial wash must not be used on wounds. Liaison with the Tissue Viability Nurse is advised for the management of MRSA positive wounds.

8.0 TRANSFER & DISCHARGE OF PATIENTS COLONISED OR INFECTED WITH MRSA

8.1 Within the Hospital

Transfer of MRSA affected patients to other wards should be minimised to reduce the risk of spread but this should not compromise other aspects of care such as rehabilitation. (See also Bed Management policy.)

The patient should have clean clothing before transfer.

The patient should be transferred to a bed with clean linen. The patient's original bed linen should be left behind on the ward and disposed of as infected linen.

Transport of the patient should be carefully supervised:

Lesions should be occluded whenever possible with an impermeable dressing.

Attendants who may be in contact with the patient should wear aprons when contact is likely. This is unnecessary if contact is unlikely. Aprons should be removed when contact with the patient has finished and disposed of as clinical waste.

Gloves should only be worn where risk assessment has indicated they are necessary.

The trolley or chair should be cleaned with Actichlor plus and dried thoroughly after use by the patient and before being used for another patient. All linen should be dealt with according to the Safe Management of Linen Policy.

Staff should decontaminate hands thoroughly with soap and water or alcohol hand rub after dealing with the patient and cleaning the trolley or chair.

8.2 Visits to Outpatients and Specialist Departments

Visits by MRSA positive patients to other departments should be kept to a minimum. If this is necessary, either for investigation or treatment, prior arrangements should be made with senior staff of the receiving department, so that control of infection measures for that department can be implemented. These should include:

Deal with these patients at the end of the working session if at all possible.

The patient should spend the minimum time in the department being sent for when the department is ready and not left in a waiting area with other patients.

Staff coming into direct hands on contact with the patient should wear disposable aprons. Disposable gloves must be worn for contact with infected dressings, secretions, excretions etc. The importance of hand washing should be emphasised. Staff should avoid direct contact with other patients whilst dealing with an MRSA patient.

Equipment and the number of staff attending should be kept to a minimum.

Surfaces with which the patient has direct contact should be wiped clean using approved biocide wipes and left to dry thoroughly.

Linen should be treated as infected linen according to the Safe Management of Linen Policy.

Staff should decontaminate hands thoroughly with soap and water or alcohol hand rub after dealing with the patient.

Transport measures should be indicated as above.

8.3 Surgical Operations/Special Procedures

MRSA is not an absolute contraindication for patients undergoing surgery or special procedures. A risk assessment must be undertaken in conjunction with the Infection Prevention & Control Team. However, every effort should be made to eliminate MRSA before surgery. If not possible the following should be performed prior to surgery:

Bathe the patient with the approved antibacterial body wash.

Cover any affected lesion with an impermeable dressing.

Apply Mupirocin (or alternative) to the nose before the operation if the patient is a nasal carrier.

Prophylaxis as per the Trust Antimicrobial guidance should be considered in place of routine prophylaxis for patients undergoing surgery, particularly if high risk such as implant surgery, who may have been exposed to risk of acquisition of the strain during an outbreak on their ward. Advice can be obtained from the Consultant Microbiologist where required.

Patients should be allowed to recover after surgery in the Operating Theatre or an area not occupied by other patients to avoid possible contamination of the usual recovery area.

Theatre surfaces in close contact or near the patient, such as the operating table or instrument trolley, should be disinfected with Actichlor Plus before being used for the next patient.

8.4 Ambulance Transportation

When ordering transport the Ambulance Liaison Officer (ALO) must be informed that the patient is colonised/infected with MRSA. It is helpful if staff assist the ALO to make a risk assessment according to the Ambulance Policy (see below).

The vast majority of patients fall into the following category:

- Patients that are able to keep their colonised/infected areas of skin enclosed by dressings or normal clothing. These patients may travel with other patients and no protective action is necessary.
- Patients should have received their decolonisation treatment and wear clean clothing before travel.

A small minority of patients have MRSA with additional complications eg:

- Exposed areas of skin or where a heavy colonisation on multiple body sites is identified.
- Co-existent with extensive eczema or psoriasis.
- Coughs with sputum colonisation.

In these cases, it is recommended that the patient is transported on their own.

8.5 Transfer to Another Hospital

MRSA colonisation or infection should not be a barrier to good clinical care. Consequently, inter-hospital transfers for good clinical reasons should not be prevented. However, unnecessary movement should be avoided.

Identification of infected or colonised patients is the responsibility of the transferring hospital. Before transfer, the clinician responsible for the patient at the transferring hospital should inform the Clinicians and/or Infection Control Team at the receiving hospital.

Nursing staff should complete the inter-healthcare Infection Control Notification Form.

9.0 Discharge of Patients

MRSA patients should be discharged promptly from hospital when their clinical condition allows. MRSA carriage should not delay discharge.

The General Practitioner and other health care agencies involved in the patient's care should be informed by ward staff. Positive results received by the Infection Prevention & Control Nurses after the patient's discharge are to be communicated to the Community IPCN via telephone.

MRSA carriers will not normally require special treatment after discharge from hospital. However, primary treatment courses should be completed. MRSA positive staff may require additional screening depending on risk assessment.

If the patient is discharged to a nursing or convalescent home, the care home should be informed in advance by the ward discharging the patient and the Inter-healthcare Infection Control Notification Form completed. Carriage of MRSA is not a contraindication to the transfer of a patient to a nursing or convalescent home.

Patients should be informed that there is no risk to healthy relatives or others outside the hospital.

There is no indication for routine screening before hospital discharge to the community.

As a prophylactic measure, all patients being discharged home with an invasive device should have a 28-day supply of antibacterial body wash prescribed as a TTO.

Any routine screening follow up should be done based on a risk assessment.

10.0 Deceased Patients

The Infection Control precautions for handling deceased patients are the same as those used in life. Any lesion should be covered with impermeable dressings. Plastic body bags are not necessary. There is negligible risk to relatives, Mortuary staff or undertakers, as long as basic Infection Control precautions are followed. See Last Offices Policy.

11.0 Community Services

11.1 Routine Screening

Routine screening of MRSA is not normally indicated in community settings. However a number of exceptions exist and these include instances where:

- A patient is found to be positive to MRSA on pre-assessment screening and following a course of decolonisation requires a further 3 negative screens prior to treatment/ surgery. Repeat screening can be facilitated by either the GP, DN or via the Decolonisation Clinic. Advice on repeat screening and interpretation of screen results can be sought by contacting the Community Infection Prevention & Control Team.

- If a patient is previously found to be MRSA positive in a wound swab but following a course of decolonisation and/or antibiotics no improvement is noted and there is evidence of ongoing infection, a further swab/screen for MRSA would be indicated.

If community services staff are doubtful as to when to take a swab/screen advice can be sought by contacting the Community Infection Prevention & Control Team.

11.2 MRSA Positive Patients

Patients who are found to be MRSA positive in hospital are prescribed decolonisation treatment and advised to complete the treatment course following discharge irrespective of where they reside.

Patients who are screened positive for MRSA but are discharged before the result is known will require decolonisation treatment prescribing. A positive result will be phoned through to the Community Infection Prevention & Control Team (CIPCT) who will record details of the case and arrange decolonisation. Decolonisation is not prescribed by the patient's GP but organised by the CIPCT following liaison with the Chronic Wound Team who provide a decolonisation service for patients in North Lincolnshire. The Decolonisation Clinic is based at the Ironstone Centre and facilitated by the Chronic Wound Team.

The CIPCT also stock a small supply of decolonisation treatment for those patients who are unable to attend the clinic.

For advice on decolonisation treatment Community Services staff are advised to contact the CIPCT in the first instance rather than the Chronic Wound Team.

11.3 Risk Areas

Risk areas within the community differ to those present in a hospital. Patients in their own homes should be informed that there is no risk to healthy relatives or others within the community. Patients will be provided with information regarding MRSA and advice on infection control within the home setting.

For management of patients in other community settings such as care homes and/or hospices Community Services staff should refer to the NHS North Lincolnshire policy on the Control of Meticillin- Resistant Staphylococcus Aureus in Community Settings and the North Yorkshire and Humber Health Protection Unit Management of MRSA in Care Homes Policy.

11.4 **Treatment**

For patients in North Lincolnshire who access care outside of North Lincolnshire boundaries but who require pre-assessment screening, screening should be provided by the admitting NHS Trust hospital but a screening service is provided by the CIPCT and delivered by the Chronic Wound Team who provide both a screening & decolonisation service for MRSA/MSSA. Patients can also be screened via their GP if the GP practice provides this service.

12.0 Monitoring Compliance and Effectiveness

Group Management Teams/Site specific Infection Control Groups will be responsible for monitoring compliance with and assessing the effectiveness of this policy using specific Infection Control Audit Tools.

13.0 Associated Documents

Infection Prevention and Control - Overview of Trust Approach and Arrangements

NLAG Decontamination Policy

NLAG Glove Usage Policy

NLAG Hand Decontamination Policy

NLAG Isolation Policy

NLAG Safe Management of Linen Policy

NLAG Last Offices Policy

NLAG Infection Control Guidelines for the Wearing of Personal Protective Equipment

NLAG MRSA Care Pathway

NLAG MRSA/HCAI Action Plan

NLAG Inter-healthcare Infection Control Notification Form

NLAG Infection Control Discharge Advice for Patients and Carers.

NLAG Infection Control Information Leaflets for Patients and Staff

NLAG Community Services MRSA Bacteraemia Risk Assessment Tool

14.0 References

Coia 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; Vol 63, Supplement 1.

Dept of Health (2006). Going further faster: Implementing the Saving Lives delivery programme. Sustainable change for cleaner, safer care.

Dept of Health (2007). Clean, safe care: reducing MRSA and other healthcare-associated infections - a national update.

Dept of Health (2007). Screening for Meticillin-resistant Staphylococcus aureus (MRSA) colonisation: a strategy for NHS Trusts - a summary of best practice.

Dept of Health (July 2008). MRSA Screening – Operational Guidance. Gateway reference number 10324.

Dept of Health (December 2008). MRSA Screening – Operational Guidance 2. Gateway reference number 11123.

Epic 2. National Evidence-based Guidelines for Preventing Healthcare-associated Infections in NHS Hospitals in England. Journal of Hospital Infection (2007).

http://www.clean-safe-care.nhs.uk/

Department of Health (2014) Implementation of modified admission MRSA screening guidance for NHS Department of Health expert advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Prepared by ARHAI MRSA Screening Implementation Group
https://www.gov.uk/government/publications/how-to-approach-mrsa-screening

15.0 Definitions

N/A

16.0 Consultation

Infection Prevention & Control Team

Infection Prevention & Control Committee

17.0 Dissemination

This policy will be placed on the Infection Prevention and Control section of the NLAG hub

The Infection Prevention & Control Team will also issue a briefing paper, highlighting the main changes in the revised policy, and this will be circulated to all divisions.

Education and Support Plan

Education sessions will be provided by the Infection Prevention & Control Team, and these will be available for all Trust staff. Infection Control link staff will be provided with education sessions about the policy at their meetings.

18.0 Implementation

It is the responsibility of each Division to identify relevant members of staff involved in patient care and to ensure that they are fully informed and competent in the practices outlined in this policy.

19.0 Document History

This iteration of the policy incorporates minor changes to sections 4.3, 5.7, 7.1, 8.3, 9.0.