# Meticillin Resistant Staphylococcus Aureus (MRSA) Policy

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<td>Infection Prevention and Control Team</td>
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Meticillin Resistant Staphylococcus Aureus (MRSA) Policy

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1. **INTRODUCTION**

*Staphylococcus aureus* is a strain of bacteria, which it is believed a third of the population carry harmlessly on different areas of the skin and in the nose. This is referred to as colonisation. In some circumstances *Staphylococcus aureus* may cause infections, for example boils, carbuncles and wound/skin infections and in some cases more severe infections such as blood or bone infections. However in the community setting clinical infection occurs less frequently.

Some strains of staphylococci have developed varying degrees of resistance. Meticillin Resistant *Staphylococcus aureus* (MRSA), of which there are many different strains, is identified as one, which is resistant to the antibiotic flucloxacillin, and can only be identified/confirmed through tests carried out in the Microbiology Laboratory.

Meticillin is also known or more commonly referred to as Methicillin. Meticillin is the British Adopted Name (BAN) and Methicillin is the United States Adopted Name (USAN) for the same thing. Developed in 1959 by Beecham, it was previously used to treat infections caused by susceptible Gram-positive bacteria such as *Staphylococcus aureus* that would otherwise be resistant to most penicillins. Methicillin has been replaced by flucloxacillin however MRSA continues to be used to describe all strains resistant to penicillins. Meticillin: [http://en.wikipedia.org/wiki/Meticillin](http://en.wikipedia.org/wiki/Meticillin)

MRSA is not a single organism to which there can be a universal treatment or management plan, each patient must be assessed and treated as an individual. Patients with MRSA are frequently cared for in both primary and secondary care settings without any problems. Effective and timely communication is paramount to the management of these patients.

All types of staphylococci are very hardy and are able to survive for long periods in dried pus/sputum, on clothing and in dust. Therefore high standards of environmental and hand hygiene are essential in reducing the spread of MRSA.

MRSA does not pose a problem to fit healthy individuals but may be harmful to patients cared for in communal settings, patients with surgical or open wounds, invasive devices and immuno-compromised patients.

Any situation not covered by this policy must be discussed with the Infection Control Team. To minimise the risk of selecting for MRSA, the trust antibiotic policy must be strictly adhered to.

2. **AIM OF THE POLICY**

The aim of the policy is to ensure the safe and appropriate clinical management of patients with MRSA and to control and prevent the spread of this organism to susceptible individuals or sites. The main areas of prevention are the use of appropriate protective clothing, strict hand hygiene before and after all direct patient contact or contact with the patient’s immediate environment, and compliant screening and treatment regimes.

In order to identify carriers of MRSA, the Infection Control Team will ensure that the patient’s Hospital case notes are labelled, the patient is flagged up on the Hospital patient administration system (PAS), and on SystmOne. It is the responsibility of each General Practitioner and/or healthcare worker to ensure that locally held patient records are flagged appropriately e.g. as a READ code.
3. **CONTACT DETAILS**

Advice on treatment and management of MRSA can be obtained from:

<table>
<thead>
<tr>
<th>Title</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>Consultant Medical Microbiologist/Infection Control Doctor</td>
<td>304742 304743</td>
</tr>
<tr>
<td>Secretary</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention and Control Nurse (RCHS)</td>
<td>307577 or 307720</td>
</tr>
<tr>
<td>Mobile</td>
<td>07818064753</td>
</tr>
<tr>
<td>Infection Control Nurse (RFT)</td>
<td>307211 or 304729</td>
</tr>
<tr>
<td>Internal pager</td>
<td>82774</td>
</tr>
<tr>
<td>Internal pager</td>
<td>82713</td>
</tr>
<tr>
<td>External pager</td>
<td>07659596170</td>
</tr>
<tr>
<td>Clinical Scientist (Microbiologist)</td>
<td>304741</td>
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4. **SCOPE**

This policy applies to all staff employed by or on behalf of Rotherham Community Health Services

5. **RESPONSIBILITIES**

**Managing Director of Rotherham Community Health Services**
- Has overall responsibility for infection, prevention and control and patient safety

**Director of Infection, Prevention and Control (DIPC)**
- Has the responsibility of ensuring the implementation of this policy and its adherence by staff
- Is responsible for monitoring of the policy as part of the Hygiene Code requirements

**Infection Prevention and Control Team (IPCT)**
- The Infection Prevention and Control Team will advise on the relevant screening and isolation/infection control precautions required in order to minimise the risks associated with MRSA.
- The Infection Prevention and Control Team will telephone and send written confirmation of a positive result to General Practitioners, Care Homes and District Nurse Teams so that the patients care record can be flagged to indicate MRSA.
• The infection Prevention and Control Team will ensure that screening and isolation/infection control precautions will be an integral part of the Mandatory and Statutory Training programme and delivered to all staff.

• Will initiate a Root Cause Analysis (RCA) investigation into each case of a confirmed MRSA Bacteraemia (blood borne).

**Heads of Service-Managers**

• Will ensure the policy is available and adhered to by all staff within their service provision. This includes identifying and training and/or development needs of the staff or service, and the provision of equipment/supplies in order to facilitate and support this policy.

• Will identify and address any non adherence with this policy.

**All Staff have a responsibility to**

• Ensure that this policy is adhered to, issues that fall outside of this policy must be reported and discussed with the Infection Prevention and Control Team

• Identify and report training/developmental needs and changes in their practice to their line manager

• Raise and report any issues for concern via the Infection Prevention and Control Team and Rotherham Community Health Services Incident Reporting System [http://websrv.rotherhampct.nhs.uk/?FileID=14062](http://websrv.rotherhampct.nhs.uk/?FileID=14062)

• Take part in any required audit acting in relation to the policy
SECTION ONE

ISOLATION PRECAUTIONS

As people affected by MRSA present minimal risk to the general community, they should continue their normal lives without restriction. If there are specific concerns, advice should be sought from the Infection Prevention and Control Team.

Whilst patients in the community (living in their own homes/care homes/communal settings) do not require isolation, good general infection control practices must be adhered to at all times (see later sections). The prevention of the spread of MRSA within Care Homes/communal settings is dependent upon a correct understanding and practice of standard infection control practices. Strict isolation is not generally recommended as this may adversely affect the resident’s rehabilitation.

Patients admitted to inpatient areas known to have currently, or in the past, carried MRSA must be admitted directly into a side room and a full screen obtained (see Section 2). Skin and wound precautions should be instigated immediately. The door must be kept closed, unless this compromises the patient’s physical or mental well being.

All visitors must report to the Nurse in Charge before entering the room.

Along with the aforementioned patients, those who are admitted from high risk areas such as:

- Transfers from a neighbouring hospital/unit
- Admissions from a nursing or residential home
- Any other area which increases the patients risk or carriage e.g. abroad

should also have a full screen obtained (see section 2). These patients do not require single room isolation, however, contact precautions should be instigated within the bay, in an end bed, to minimise the risk of transmission.

The highest priority for side rooms should be for those patients with clinical infection, those patients who are sputum productive and those with widespread carriage, as this may increase dispersal of the organism.

Hand Washing/Hand Hygiene

Strict hand hygiene is proven to be the most effective control measure to prevent the spread of MRSA and must therefore be carried out before and after patient contact, prior to any clean/aseptic procedure, after any body fluid exposure risk, after contact with the patient or the patient’s immediate environment. Hands should be washed/decontaminated thoroughly following the recommended six-step technique, ensuring all aspects of the hands are covered. Hand hygiene may be achieved using soap and water or Alcohol hand rubs (as long as hands are physically clean) - see RCHS Hand Hygiene Policy (IPC 5) [http://websrv.rotherhampct.nhs.uk/?FileID=11589](http://websrv.rotherhampct.nhs.uk/?FileID=11589)

Where soap and water are used, hands must be thoroughly dried using disposable paper towels.

If hand-washing facilities are not available – Alcohol hand rub must be used.

Within care homes and inpatient areas, strict hand hygiene must be observed amongst staff, patients and visitors on entering and leaving the room.
**Gloves**

Disposable powder-free latex gloves must be worn for any direct patient contact or prolonged contact with patients’ environment and when handling any contaminated items such as dressings, blood/body fluid or waste.

Latex-free products are available for staff/patients with latex sensitisation. Patients with suspected sensitisation must be investigated by the clinician responsible for their care. Staff should be referred to the Occupational Health Department for assessment/investigation.

For general purposes, vinyl gloves may be worn; however these do not provide adequate protection for prolonged contact with or excessive exposure to blood/body fluids.

Hand hygiene, either with soap and water or with alcohol hand rub must be carried out after removal of gloves, (which must be discarded as clinical waste), and prior to leaving the patient’s room/area/house.

Gloves must be changed in between clean and dirty tasks carried out on the same patient, and must not be washed or alcohol gelled.

**Aprons**

Disposable plastic aprons must be worn for direct patient contact or contact with the patient’s immediate environment.

If extensive contact is necessary, or the patient is very heavily colonised, then disposable long sleeved gowns are available.

Aprons must be removed after patient contact and disposed of as clinical waste before leaving the patients room/area/house. **Strict hand hygiene**, either with soap and water or alcohol hand rub, should then be undertaken.

**Masks**

If MRSA is present in the patient’s sputum, masks should only be worn for procedures that may generate aerosols or droplets which may contain the organism, e.g. chest physio, where the patient is sputum productive, or is receiving nebulizer therapy. Masks may also be required where patients have wide spread skin carriage and are heavy skin shedders. Advice must be sought from the Infection Prevention and Control Team.

**Purchase of Personal Protective Equipment (PPE)**

Staff employed by or on behalf of RCHS should be able to obtain supplies of PPE such as masks, gloves and aprons via RDC/NHS logistics.

Home Care staff should obtain supplies from home care services.

Independent contractors/practitioners should purchase direct from supplier.

**Visitors**

Visitors to care homes and inpatient areas are not required to wear protective clothing unless they are directly involved in delivering patient care, in which case the above recommendations apply. However, all visitors to MRSA positive patients must exercise good hand hygiene, using soap and running water or alcohol hand rub.
Linen and Clothing

Appropriate protective equipment must be provided and used for handling all infected linen.

Within care homes and inpatient areas all patient clothing and bed linen should be changed daily after carrying out personal hygiene needs.

Linen must be placed inside the laundry bag whilst inside the patient's room or at the bedside avoiding the creation of dust. Linen must never be sorted in the residential/communal areas.

Linen used in clinical areas such as treatment rooms, should be treated as infected and placed in a red alginate bag inside a red plastic laundry bag.

Any independent contractors should ensure appropriate arrangements are in place to deal with contaminated/infected linen.

If a home linen collection service is required for patients with MRSA living within their own homes, this should be arranged by the healthcare professional/carer contacting Social Services. Water soluble alginate bags and instructions for collection will be provided.

Patient's own clothing/bed linen should be washed separately if possible on as hot a cycle as the material will allow. Following this, if desired, the machine can be run empty on a hot cycle.

Care must be taken not to overfill laundry bags, as this poses a manual handling risk to staff transporting the bags and increases the likelihood of the bag bursting open and the spillage of infected linen.

Hand hygiene must be carried out after handling any contaminated/infected linen.

Toilets

Where patients with MRSA are inpatients within the community, wherever possible they should be provided with en-suite toilet facilities. Where this is not possible, a toilet may be allocated for the patient’s sole use. If necessary a commode may be placed in the patient’s room.

Toilet areas must be decontaminated daily using hypolchlorite e.g. sanitiser, and must be terminally cleaned when the patient leaves using 1000ppm solution of hypochlorite e.g. Haz Tabs or Chlor-Clean.

Waste

Waste resulting from patient care should be placed into an orange “Hazardous Waste for Incineration only” bag. Medium duty/gauge bags will be sufficient for most patients; however where waste is particularly heavily contaminated with significant quantities of blood or body fluid, thus carrying an increased risk of leakage, then heavy duty/gauge bags should be used. There is no need to double bag waste created by MRSA patients.

Hazardous waste from patients' homes should be collected by prior arrangement, using the Metropolitan Borough Council/Environmental Health collection service.

This can be arranged by contacting the Environmental Health Department, Rotherham (01709) 823130, stating the following information:

- Patient’s name
- Address
- Frequency of collection required
Environmental Health Department deliver ‘offensive waste’ bags by default; therefore they need to be informed that ‘HAZARDOUS WASTE’ bags are required.

Within inpatient areas and care homes the orange ‘hazardous waste’ bag must be placed in a rigid foot operated, lidded bin. All waste should be disposed of and kept inside the patient’s room until it is ¾ full then it should be sealed securely by swan-necking and taping with designated ID tape.

The bag must then be dated using a permanent marker pen and placed in the sluice/collection area for collection by designated staff/contractors.

**NB:** Healthcare waste must not be transported in the back of community staff cars, in accordance with the safe disposal of clinical waste guidelines, issued by the Health and Safety Commission.

**Crockery and Cutlery**

It is not necessary to use disposable items.

Crockery, cutlery and water jugs etc from isolation rooms within inpatient areas and care homes should be placed in the facility dishwasher, with a minimum wash temperature of 60°C and a final rinse temperature of 80°C for one minute or other appropriate time/temperature ratio such as 71°C for three minutes. This will achieve satisfactory decontamination of the used items.

If these facilities are not available in inpatient areas, please contact the Infection Prevention and Control Nurses on extension 7720 or 7577 or mobile 07818 064753.

Within patients’ own homes these items produce very little risk of transmitting MRSA. If a dishwasher is not available, hot soapy water is adequate.

**Personal Hygiene**

Topical treatments with anti-bacterial agents of skin and nasal carriage are not usually indicated in the general community settings, or within communal care homes. However, if this is deemed necessary following clinical and risk assessment, it will be advised by the Infection Control Team on an individual patient basis. If treatment of skin carriage is required, following the risk assessment or if the patient is in an inpatient area, then the skin and, where possible, hair should be washed/bathed daily by using a Octenisan body wash. The procedure should be carried out using clean cloths, which should be laundered after use.

In the absence of skin carriage, patients should be washed/bathed daily using soap and water.

Normal social contact should be maintained.

**Deceased Patients**

In the event of death, the precautions required for the Last Offices of an MRSA positive patient are the same as those taken in life. Any lesions should be covered with an occlusive dressing.

**High-risk cadaver bags are not routinely required. There is no special notification to the undertaker required.**

**STAFF**

Any staff member with chronic skin conditions, e.g. open or weeping eczema, open wounds etc should, wherever possible, NOT care directly for known MRSA positive patients.
SECTION TWO

SCREENING

INTRODUCTION

As per Department of Health, ‘MRSA Screening Operational Guidance’ (2008), Rotherham Community Health Services will introduce MRSA screening for all elective patients by 31st March 2009.

Elective admission is defined as one that has been arranged in advance. It is not an emergency admission, or transfer from a bed in another provider.

It is therefore agreed that all patients for elective/emergency admission to RCHS in-patient areas (including The Hospice, Breathing Space and Learning Disabilities) and pre-assessment for a specific procedure (including podiatric surgery and vasectomy) will be screened for MRSA prior to admission (screening can be performed up to 8 weeks prior to admission).

If results are needed in less than 24 hours, then rapid testing is available – this would need to be in conjunction with advice from the Infection Prevention and Control Team.

Results and any follow up/pre-admission treatment will be performed in consultation with the Infection Prevention and Control Team, the requesting practitioner and the patient.

It is not the intention that any patient admission, investigation or treatment should be cancelled or delayed as a result of this screening strategy.

Higher risk or patients with complex needs may be discussed with the Medical Microbiologist and/or the Infection Prevention and Control Team prior to admission so that suitable arrangements and appropriate plans of care can be agreed.

RCHS intends to screen all elective day case surgery patients in accordance with the guidance as above.

RCHS will provide screening data as required by NHS Rotherham.

Screening is carried out essentially to establish whether a patient is colonised with MRSA and to what extent. Screening is the microbiological testing of a sample taken from the potential carriage sites of a patient on or before admission.

Colonised patients are at an increased risk of developing infection and are a possible source of transmission to other patients and/or health care workers.

Wherever possible, patients in whom MRSA is isolated must be admitted into a single room. Where this is not possible for any reason, the infection prevention and control team must be contacted for advice.

SCREENING PROCEDURE

Please refer to the theatre recovery flow chart (Appendix 1) and the MRSA screening flow chart (Appendix 2)

Screening will be performed on all patients prior to admission/day of elective procedures; if this is not possible patients will be screened immediately on admission/day of procedure. Staff must explain the procedure and the reason for screening clearly to patients and/or their carers and must
issue a patient information leaflet on MRSA screening. These leaflets can be downloaded via the intranet.

**Screening Sites**

Nasal and perineum

Broken areas or skin discontinuity sites e.g:

- Wounds, including pressure sores
- Skin lesions such as eczema
- Cannula or other line sites
- PEG site, Suprapubic Catheter site, Tracheostomy site etc

CSU if the patient is catheterised

Sputum sample if the patient has a productive cough

**NB**: if there is evidence of urethral discharge the catheter entry site must also be swabbed.

**SCREENING TECHNIQUES**

**Bacteriology (Charcoal) swabs must be rubbed firmly and thoroughly over the area several times to ensure a good pick-up of organisms present.**

**Nose**

One swab only should be used to swab **both** nostrils. It should be passed firmly over the membrane lining the fleshy part of the nose, three or four times for each nostril.

**Perineum and Skin Areas**

The perineum is swabbed as this area is the main carriage site on skin. Swabs used for dry skin areas should be moistened in sterile saline and rubbed firmly over the area several times to ensure good pick up of the organism.

A good screening technique is vital, to ensure a good pick up of bacteria, therefore patients must not be permitted to take their own swabs.

Once the swabs have been taken, the results will remain valid for up to 8 weeks. If patients are not admitted within 8 weeks, the process must be restarted.

**Labelling of Form and Specimen**

All specimens and accompanying forms should be legible and **clearly** labelled with the following information as per the RCHS Management of Diagnostic Testing Policy (RCHS8)

http://websrv.rotherhampct.nhs.uk/?FileID=19134

- The individual’s name, hospital number and/or NHS number and date of birth
- The date the specimen was obtained
- Site specimen obtained from (if wound please state area of wound)
- A short clinical summary indication that the specimen has been obtained as part of an MRSA elective screening programme
- Destination of report
- Antibiotic history must be included
No more than FOUR swabs must be included on one microbiology request form.

**Transportation of Specimens**

Wherever possible the specimens should be transported to the laboratory on the same day, if this is not possible, they should be kept at room temperature.

**Contact Screening**

The course of action taken when a patient is newly found to be colonised or infected with MRSA will be determined by the Infection Control Team using risk assessment. This will be based on the index case and the clinical area involved. If contact screens are involved, specimens should be taken from the ‘screening sites’ mentioned earlier and the same procedure followed. The clinical summary must state that the specimen has been obtained due to contact screening.

**Staff Screening**

Staff will only be screened on the advice of the Infection Prevention and Control Team following a risk assessment.

All staff screening should be co-ordinated by the Nurse in Charge of the area in conjunction with the Occupational Health Department.

Staff must be screened at the start of a shift (prior to patient contact) and **not** during or after the shift, as this increases the risk of transient carriage. Any problems or difficulties with this must be discussed with Occupational Health Department.

Specimens from members of staff should include the department/area in which the staff member works in the clinical details. The requesting clinician must be the Consultant in Occupational Health and **NOT** a clinician/practitioner in the employee's place of work.

MRSA is not generally considered to be a risk to pregnant staff.
SECTION THREE

TREATMENT OF MRSA POSITIVE PATIENTS

Routine treatment of skin and/or nasal colonisation is not required in the community. If, following risk assessment, treatment is indicated or the swabbing was part of the elective screening programme the following regime should be followed:

Nasal Carriage

The most effective treatment of nasal carriage is 2% Mupirocin (Bactroban nasal). This should be applied three times daily to the anterior nares. Treatment should continue for 5 days.

Once the 5 days of treatment is completed there should be 2 days free from treatment, and then a further swab taken, treatment should recommence until the result of the swab is available. A maximum of two courses of treatment are allowed.

Where colonisation is persistent or if the strain identified is resistant to Mupirocin, the Consultant Microbiologist will advise on alternative treatments.

Once a negative nasal swab has been obtained, Bactroban nasal should be discontinued.

Carriage At Other Sites

If MRSA is present on other skin sites the patient should be washed daily for 5 days using an antiseptic wash, Octenisan. The solution should be applied to the skin in place of soap using disposable wipes.

Hair should be washed twice weekly using this solution. Normal shampoo may be used after the antiseptic detergent.

If patients are known to suffer with eczema or develop any skin irritation, the Infection Prevention and Control Team should be notified to discuss alternative preparations.

Once the 5 days of treatment is completed there should be 2 days free from treatment, and then a further swab taken.

Wounds/Broken Areas

Wounds will be assessed on an individual basis in consultation with the Infection Prevention and Control Nurse, Tissue Viability Nurse and relevant community care team. The treatment of wounds will be determined by the condition/type of wound and the patient's clinical symptoms. If the wound appears clinically infected, systemic treatments will usually be required; this should be discussed with the Consultant Microbiologist. If this is no evidence of clinical infection, topical antimicrobial treatments/dressings are usually adequate

If strike through of exudate is evident on the dressing, this should be dealt with immediately wherever possible.

When is a patient considered clear?

All MRSA positive inpatients should continue to be screened at weekly intervals, obtaining specimens from all sites listed above. A patient is considered to be clear of carriage once three consecutive negative screens have been recorded. This is for the current episode of care only and each subsequent episode will require screening due to the high recolonisation rate.

This weekly screening is not required of patients within their own homes or within care homes.
SECTION FOUR

DOMESTIC ISSUES

Patients and their carers should be instructed on the importance of maintaining good standards of housekeeping/cleanliness at all times.

It is important to note that when patients are being treated in non RCHS sites/buildings that cleaning services should be negotiated and monitored appropriately.

Toileting

Within care homes and inpatient areas, toilet areas or commodes must be cleaned after use/daily and on discharge using detergent and water which is then followed by cleaning with hypochlorite solution (1000ppm).

Daily Cleaning

In patient areas and care homes occupied by MRSA positive patients must be damp dusted daily using detergent and water and designated cleaning materials, if prolonged use is required these materials should be laundered/changed regularly.

Areas used by colonised/infected patients should be cleaned after all other areas have been completed.

Staff cleaning an affected area should wear disposable gloves and aprons which must be removed before leaving the room and disposed of in a clinical waste bag.

Hands must be thoroughly washed/decontaminated using soap and water and alcohol hand rub. After washing with soap and water hands must be thoroughly dried.

Terminal Cleaning on Discharge or Death

When the room is no longer required for isolation purposes, all equipment must be cleaned with soap and water and decontaminated by wiping with hypochlorite (1000ppm e.g. Haz Tabs) or alcohol wipes, if hypochlorite is inappropriate, and then removed from the room.

The bed should be stripped of all bedding and then handled/treated as infected linen.

The curtains should be removed for laundering and then handled/treated as infected linen.

All surfaces and patient equipment e.g. commodes must be cleaned with detergent/soap and water to remove any organic matter or dust, followed by hypochlorite 1000ppm. Particular attention must be paid to flat surfaces and dust collection areas.

The floor area must be thoroughly cleaned as appropriate.

Once all surfaces are thoroughly dry, clean curtains should then be hung and the bed made up with clean linen.
SECTION FIVE

DECONTAMINATION OF EQUIPMENT

As MRSA poses no threat to healthy individuals, there is no need for high level decontamination of equipment.

Most equipment will be adequately decontaminated by wiping down the surfaces as follows:

- Detergent and water or detergent wipes, which when dry should be followed with:
- Hypochlorite (1000 ppm) or alcohol wipes

(Hypochlorite is corrosive to metal, therefore once thoroughly dry any residue should be removed using a clean cloth).

Additional advice may be sought from:

The Infection Prevention and Control Team
Sterile Services Manager or Deputy.
SECTION SIX

PATIENT MOVEMENT
The clinical team/service looking after the patient should notify all relevant personnel in the community, care home, in patient area, hospital of the patient's status using the Inter Healthcare Infection, Prevention and Control Transfer Form. MRSA is not a reason to keep a patient in hospital, if they are otherwise medically fit.

All staff must notify any other team or service taking over the patient’s care. This should be done using the Inter-Healthcare Infection Prevention and Control Transfer form. If a patient is known to carry, or suspected of carrying MRSA, requires hospital admission, investigations, attendance to day care facilities or transfer to any other healthcare team/service/ department the form should be completed and sent with the patient, this should also be discussed with the accepting team/service/department and if necessary the Infection Prevention and Control Team.

Outpatients/X-Ray Department

When MRSA positive patients need to visit any department, staff in the receiving area should be notified to ensure appropriate arrangements are made.

Such patients should be booked or treated at the end of the working session and should spend the minimum length of time in the department.

THE INFECTION RISK MUST BE CLEARLY STATED ON THE REQUEST FORM.

Ambulance Transportation

The risk of cross- infection from an MRSA colonised or infected patient to other patients in an ambulance is minimal. Good infection control practices and routine cleaning should suffice. The ambulance service does however require notification in advance of a patient's MRSA status, known or suspected, in advance of booking transport (if possible). This should be done by the healthcare worker organising the transport. Patients will be divided into 2 main categories which should be decided on an individual patient basis:

- **Category 1 (multiple patient transportation) – LOW RISK**

  Patients with MRSA in a site that is covered by a dressing or normal clothing - It is not necessary to transport these patients separately or to take any specific precautions. Medicars may be used. It is not necessary to disinfect the vehicle after use. Most patients will fall into this category. Normal hand hygiene should be followed.

- **Category 2 (single patient transportation) – HIGH RISK**

  Those patients with MRSA on open skin lesions, e.g. external fixators or have widespread skin carriage of MRSA. In these cases the following procedure should be followed:
  - Patients should be transported on their own
  - Ambulance staff should wear recommended appropriate clothing
  - Minimise patient contact where possible
  - Hands must be washed or an alcohol hand rub used after patient contact.
  - The chair or stretcher which the patient has used should be wiped down with a 70% alcohol hard surface wipe or hypochlorite (1000ppm) solution. If any surface or equipment is visibly soiled, this should be firstly cleaned with soap and water.

PATIENTS WHO ARE NASAL CARRIERS ALONE MAY BE TRANSPORTED AS Category 1, ONCE THEY HAVE COMPLETED AT LEAST 48 hours of NASAL BACTROBAN.

MRSA is not a risk to healthy people and normal social activity should continue.
SECTION SEVEN

MANAGEMENT OF MRSA POSITIVE STAFF

Effective and continuous lines of communication will be maintained between the Occupational Health Department and Infection Control Team in order to ensure effective management of staff who become colonised or infected with MRSA.

Staff will be screened at the discretion of the Infection Prevention and Control Team and Occupational Health Department (OHD). Screening must be carried out prior to commencement of the shift. Where this poses problems, please discuss with Occupational Health Department to make alternative arrangements.

If a member of staff has been identified as carrying or infected with MRSA, the staff member will be referred to OHD where a full screen will be obtained. This is to assess the extent of carriage.

Screening swabs should be taken from the anterior nares and any areas of abnormal or broken skin and perineum (or groin). Treatment with Mupirocin (nasal Bactroban) and antiseptic skinwash will be commenced immediately. The staff member will be excluded from work for 24-48 hours (depending on the area/ type of work) of Mupirocin treatment, pending the results of the skin swabs. Any prolonged exclusion will be based on a risk assessment carried out by the Infection Prevention Control Team and OHD.

Any screening done by Occupational Health Department and the nature of the results will be STRICTLY CONFIDENTIAL. However where identified as MRSA carriers, staff with patient records will be flagged in the same way as any patient i.e. PAS and Protechnic databases, locally held and hospital records/notes.

Nasal Carriage Only

If carriage is confined to the nose, the staff member may return to work after the agreed 24-48 hours, but must continue using the Mupirocin for a full 5 days.

After a break of 48 hours following completion of the treatment, the staff member will be requested to attend OHD for weekly swabbing.

Repeat swabbing will continue until three consecutive negative screens have been obtained.

Widespread Skin Carriage

If the staff member is positive in any skin sites, Octenisan skin wash will be prescribed for 5 days.

The Octenisan should be applied daily using a clean washing cloth/flannel, which should be laundered after each use. Clean clothing should be worn after washing to prevent recolonisation with the organism.

Hair should be washed twice weekly using the Octenisan. Normal shampoo may be used afterwards.

Bed linen should be changed twice weekly to reduce the possibility of recolonisation.

After a break of 48 hours following completion of the treatment the staff member will be asked to attend the OHD for repeat screening.

Any staff member with widespread skin carriage will be excluded from work until three consecutive negative screens have been obtained.
IF SKIN IRRITATION DEVELOPS, DISCONTINUE USE OF THE ANTISEPTIC AND NOTIFY A MEMBER OF THE OCCUPATIONAL HEALTH DEPARTMENT OR INFECTION PREVENTION AND CONTROL TEAM.

FAILRE TO ERADICATE CARRIAGE FROM STAFF MEMBERS

Every effort will be made to eradicate MRSA carriage from staff. Failure to achieve this will be assessed on an individual basis by the Occupational Health Department and Infection Prevention and Control Team.

Staff who are working in clinical areas and experiencing difficulty in eradicating MRSA carriage, will be assessed by the Occupational Health Consultant. Redeployment to non-clinical work may need to be considered, although this would be assessed on an individual basis.

Failure to eradicate carriage from staff members will require individual consideration by the Facilities Manager employed within care homes.

Related Policies
RCHS8 - Policy for the Management of Diagnostic Testing

IPC8 - Decontamination Policy

MRSA screening – Operational Guidance, July 2009. Department of Health

Source Material.
Impact Assessment of screening elective patients for MRSA. http://www.tinyurl.com/59nwuu

MRSA Screening – Operational Guidance 3, Gateway Reference number 13482, March 2010 Department of Health
**EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL**

**Document Name:** Meticillin Resistant Staphylococcus Aureus (MRSA) Policy  
**Date/Period of Document:** June 2010

**Lead Officer:** Helen Levers  
**Directorate:** RCHS  
**Reviewing Officers:** Angela Shaw

<table>
<thead>
<tr>
<th>Function</th>
<th>x Policy</th>
<th>Procedure</th>
<th>Strategy</th>
<th>Joint Document, with who?</th>
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</table>

Describe the main aim, objectives and intended outcomes of the policy: (Also consider Qa)

The following will help you to check if this policy is sensitive to people of different age, ethnicity, gender, disability, religious belief, sexual orientation and carers. It will help you to identify any strengths and/or highlight improvements required to ensure that the policy is compliant with equality legislation.

1. **Assessment of possible adverse impact against any minority group**

   **Does your policy contain any statements, conditions or requirements which may exclude people from using the services who would otherwise meet the criteria under the grounds of:** (Also consider Q's b, c and d on the guidance page)

<table>
<thead>
<tr>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
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<td>Yes</td>
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   1. Age?  
   2. Gender (Male, Female and Transsexual)?  
   3. Disability (Learning Difficulties/Physical or Sensory Disability)?  
   4. Race or Ethnicity?  
   5. Religious, Spiritual Belief?  
   6. Sexual Orientation?  
   7. Carers?

   If you answered yes to any of the above items the policy may be considered discriminatory and require review / further work to ensure compliance with legislation.

2. **Assessment of possible positive impact against any minority group**:

   **Does the policy, or could it with minor amendments, have a positive impact or promote equal opportunities on the grounds of:** (Also consider Qe on the guidance page)

<table>
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   1. Age?  
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   4. Race or Ethnicity?  
   5. Religious, Spiritual Belief?  
   6. Sexual Orientation?  
   7. Carers?

3. **Summary**

   On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?

   Please rate, by circling, the level of impact:
   - Positive: HIGH, MEDIUM, LOW, NIL
   - Negative: LOW, MEDIUM, HIGH

   **Date assessment completed:** July 2010

   **Is a full equality impact assessment required?**
   - Yes (documentation on the intranet)
   - No

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WE ARE REQUIRED TO PUBLICISE THE RESULTS OF ALL IMPACT ASSESSMENTS, COULD YOU PLEASE FORWARD A COPY OF YOUR COMPLETED SCREENING TOOL AND WEBSITE SUMMARY FORM TO BIANCA YOUNG (bianca.young@rotherhampt.nhs.uk) FOR UPLOADING TO THE INTERNET/INTRANET.
APPENDIX 1

Theatre Flowchart for Management of MRSA Patients

*All Patients planned for elective admissions must be screened up to 8 weeks prior.*

- **Is this screening negative?**
  - **Yes** → Recover patient in recovery area
  - **No**
    - **Is this nasal colonisation only in a patient having naso-pharyngeal surgery?**
      - **Yes** → Recover patient in theatre
      - **No** → Recover patient in recovery area
    - **Is this nasal colonisation only in a patient having any surgery other than a naso-pharyngeal procedure?**
      - **Yes** → Recover patient in recovery area
      - **No**
        - **Is this skin colonisation that is identified as ‘scanty’ growth on culture? Recorded as +/-**
          - **Yes** → Recover patient in theatre
          - **No** → Recover patient in recovery area
        - **Is this skin colonisation identified as ‘moderate to heavy’ growth? Recorded as ++ or +++**
          - **Yes** → Recover patient in theatre
          - **No** → Recover patient in recovery area
    - **Was the MRSA in the wound pre-operatively and the wound is leaky/likely to be so?**
      - **Yes** → Recover patient in recovery area
      - **No**
        - **Was the MRSA in the wound pre-operatively, but the wound is likely to remain dry?**
          - **Yes** → Recover patient in recovery area
          - **No**
All patients planned for elective admissions, must be screened prior to admission (screens can be done up to 8 weeks prior). If results are needed in less than 24 hours, then a rapid test is available – this needs to be discussed with the Infection Prevention and Control Nurse. If the patient has frequent admissions, screening should be done on each separate admission. Request forms for initial and follow-up screens up to the time of admission must be labelled ‘Elective Screen’.

**Patients with a previous history of MRSA**

Staff undertaking screening of patients with a previous history of MRSA must inform Infection Prevention and Control Nurses, via Fax (7221) that the patient has been swabbed. This must include patient’s name, NHS number and hospital ID number.

Staff should obtain swabs from:
- Perineum
- Nose
- Any break in skin integrity
- CSU (indwelling catheter patients)
- Axillae for Breast patients

**Results of new positives and results from previous positives will be confirmed to the requesting Practitioner by Infection Prevention and Control Nurses – The requesting practitioner also has a duty of care to ensure any results are followed up and appropriate action taken.**

**Positive Results**

Infection Control team will inform:
- Requesting Practitioner
- Relevant in-patient facility
- New isolates will have letter sent to GP by Infection Prevention and Control Team

**Management of Positives**

- Treat as advised by IPCT
- Re-screen as per MRSA policy and/or advised by IPCT

If patients are not admitted within 8 weeks, restart the screening process.
- Follow up screening and treatments can be done in conjunction with GPs & Community Health Services Staff.

It is not the intention that any patient’s admission, investigation or treatment should be cancelled as a result of this screening strategy. Higher risk or complex patients may be discussed with the Medical Microbiologist and/or the Infection Prevention and Control Team, prior to admission, so that suitable arrangements and an appropriate plan of care can be agreed.

**Positive at time of admission**

- Single room
- Isolation precautions required
- Continue active decolonisation
- MRSA Prophylaxis if indicated – if unsure contact Microbiologist (304742)
- Re-screen and continue active decolonisation in line with MRSA policy

**MRSA not isolated at time of admission**

- Place next to low risk patient if multi-bedded bay used
- MRSA Prophylaxis if undergoing any invasive procedure – if unsure contact Microbiologist (304742)