East and North Hertfordshire NHS
NHS Trust

Trust-wide Policy

For

Meticillin resistant Staphylococcus aureus

A document recommended for use

In: All Clinical settings

By: Staff who are caring for patients in clinical settings

For: All patients

Key Words: MRSA, Mupirocin, Isolation, Hand washing, Protocol

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Chairman

May 2016

Trust Ratification: J.A. Evans

J. Evans

10th June 2016

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To be reviewed by: Lead Nurse, Infection Prevention & Control

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5	December 2007	Scheduled review
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10	February 2012	Scheduled review
11	September 2013	Change DH to perform PIR, development of discharge lounge and protocol for chlorhexidine sensitive patients
12	December 2014	ARHAI National guidance on implementation of modified MRSA screening for NHS 2014
13	October 2015	Local modification of the National Guidance and alignment with the SSI Policy
14	June 2016	Minor update to include reference to Neo 049 Neonatal Unit Protocol for MRSA Decolonisation. Review date unchanged from previous version
14.1	March 2018	Extended for 6 months

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

Dissemination and Access
This document can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre. If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation

- CSEC 011 - Hand Hygiene Policy
- CSEC 032 - Isolation Policy
- CSEC 033 - Standard Precautions Policy
- CSEC 027 - Decontamination Policy
- 39- Uniform & Dress Code Policy
- ENHT ewp 06 - Waste Policy
- CSEC 070- Linen Policy
- CP 110 - Management of Outbreaks Policy
- CP 133 - Prevention of Surgical Site Infections
- Neo 049 – Neonatal Unit Protocol for MRSA Decolonisation

Review
This document will be reviewed within two years of issue, or sooner in light of new evidence.

SECTION 1 – MANAGEMENT OF THE PATIENT WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

1. INTRODUCTION

Staphylococcus aureus is a bacterium that can be carried, asymptomatically, in the nasopharynx, perineum and skin. It can cause a spectrum of illness, ranging from skin infections to bacteraemia, endocarditis and pneumonia. A proportion of *Staphylococcus aureus* is resistant to meticillin. Meticillin is an antimicrobial agent used in the laboratory to determine sensitivity to flucloxacillin. Hence, Meticillin Resistant *Staphylococcus aureus* (MRSA) is a strain of the bacterium that has developed resistance to flucloxacillin.

MRSA is spread from person to person either by direct or indirect contact. In the healthcare environment MRSA can be spread by the hands of health care workers, or by contaminated objects or environment.

2. AIM

The aim of this policy is to prevent the spread of MRSA in the Trust by:

- The early identification of patients carrying MRSA to ensure:
    - timely isolation of patients
    - commencement of the appropriate treatment

3. RISK APPROACH

This policy incorporates the guidance issued by the Department of Health expert advisory committee on antimicrobial resistance and healthcare associated infection (ARHAI) and a local risk assessment streamlining MRSA screening to:

- Patients admitted to high risk units
- Patients previously identified as colonised with or infected by MRSA

The policy applies a risk approach recommended by the Working Party for Screening.

4. SCREENING FOR MRSA

4.1 Screen all patients admitted to the following high risk units:

- Vascular
- Renal / dialysis
- Orthopaedics / trauma
- Haematology / Oncology
- Critical Care / High Dependency
- Coronary Care / Cardiac Unit
- Neonatal intensive Care Unit (NICU)
- Stroke Unit (Pirton and Barley wards)

4.2 For the following high risk patient categories, screen and place in isolation:

- Patients with a previous history of MRSA carriage
- Residents of residential or nursing homes
- Transfers from other hospitals (UK and abroad)
- A history of an inpatient stay in the previous 12 months.

4.3 Additional Screening

- Screen patients who are a contact of a known MRSA positive patient.

4.4 Re-screening

The following patients will require rescreening:

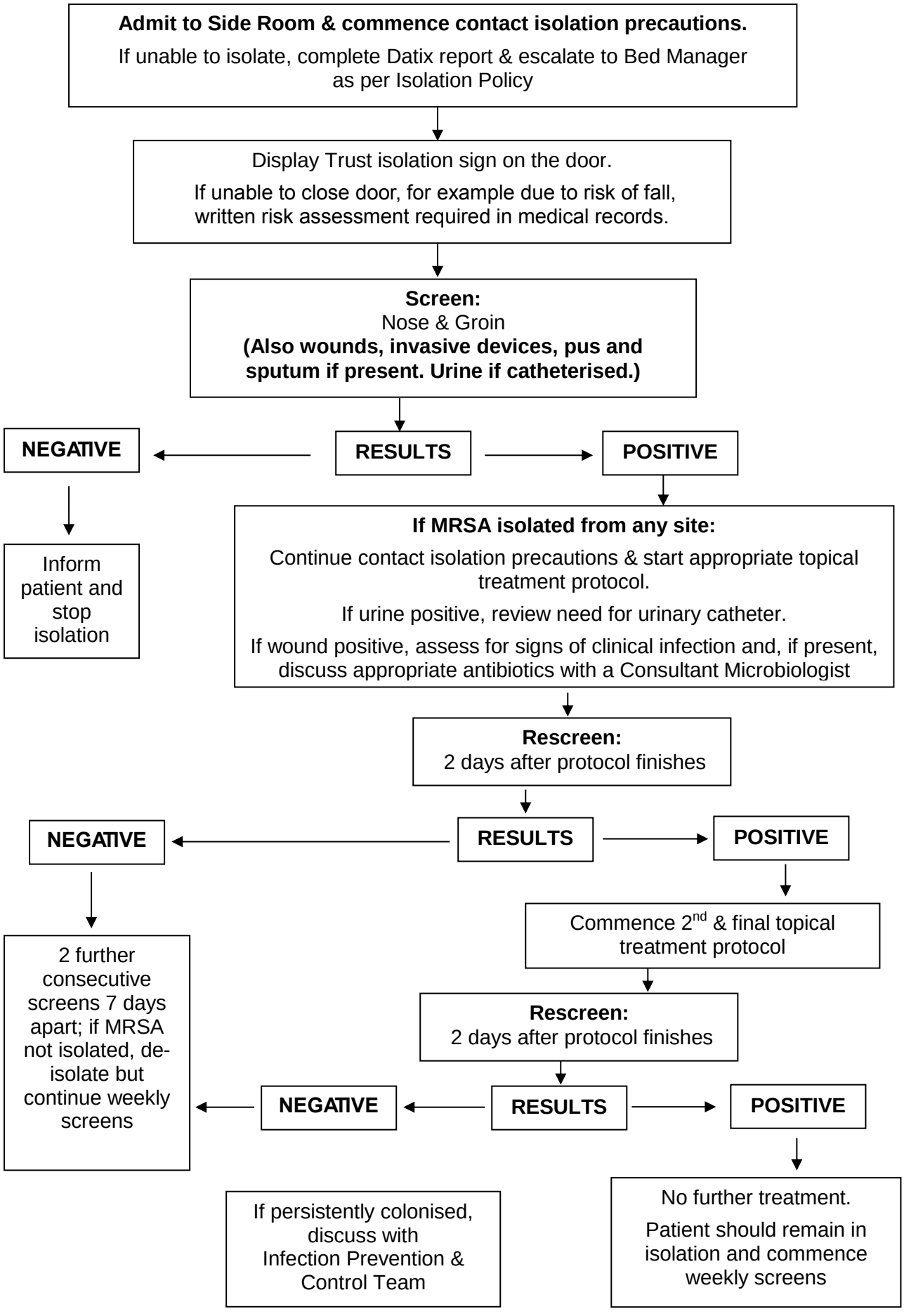
- Patients receiving a course of chemotherapy are to be screened at the commencement of the course.
- Patients receiving renal dialysis are to be screened every three months.
- Patients on the high risk areas are to be screened weekly following admission
- Any patient who is for elective orthopaedic joint replacement and has received decolonisation still requires rescreening **prior to** admission. Three negative screens should be obtained to confirm the patient has been successfully decolonised. If three negative screens cannot be obtained or the patient remains positive a risk assessment should be conducted by the surgeon with advice from the Consultant Microbiologist.
- Patients undergoing other major surgery (e.g. vascular) may require screening to determine their MRSA status. A decision should be made by the surgeon in consultation with the Consultant Microbiologist.

Other procedures do not routinely require a rescreen for MRSA.

5. HOW AND WHERE TO TAKE SCREENING SWABS

- Pre-moisten all swabs with either normal saline or transport medium.
- Nose swab (anterior nares); one swab can be used for both nostrils. Gently rotate the swab in both nostrils and place in transport medium.
- Groin swab each side of the groin
- Swab any surgical wounds, leg ulcers, breaks in skin or other lesions.
- Swabs from manipulated sites lines, cannulas, tracheostomy, Percutaneous Endoscopic Gastrostomy (PEG) and drain sites.
- Sputum if productive.
- Umbilical swabs of neonates.
- Urine sample in catheterised patients only.

6. PROCEDURE FOR HIGH RISK PATIENTS



All patients must be risk assessed for isolation priority by ward/department staff & if required, with the advice from the Infection Prevention & Control Team (IP&C Team).

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

If the patient has already been discharged from hospital, the IP&C Team will write to the patient and the patient's G.P (and care home where applicable) to inform them of the positive result.

Staff performing the screening should advise the patient that they will only be informed if the result is positive.

7. MRSA ALERT SYSTEM ON PAS

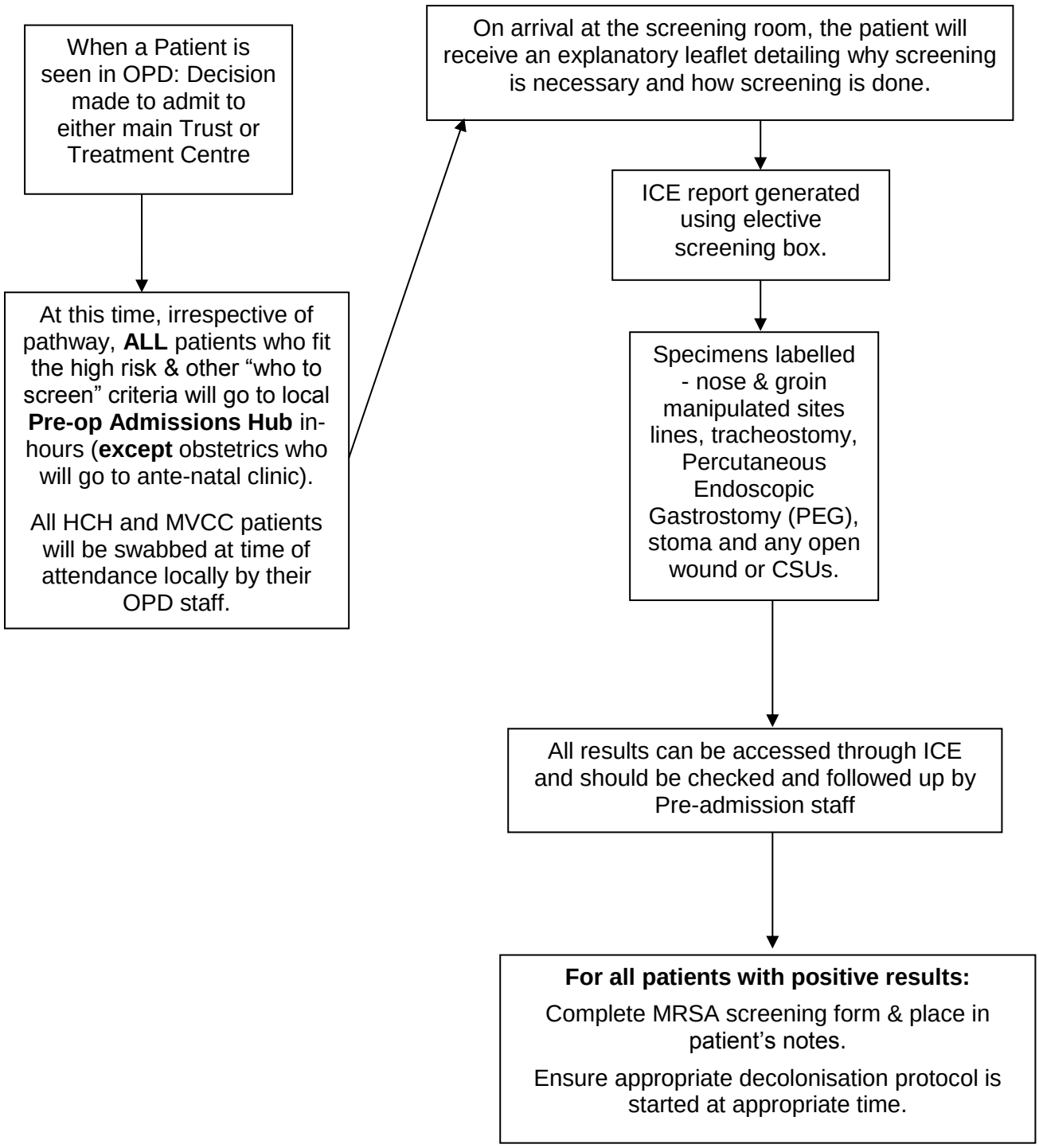
All patients found to be MRSA positive from screening will have an **'MRSA Alert'** placed on their PAS records. This alert will remain on the patient's records even after they have had 3 or more negative MRSA screens and therefore indicates that the patient is an 'MRSA risk' and not necessarily 'MRSA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

Upon receipt of a positive result on ICNet, the IP&C Team will:

- Add PAS and ICE alerts to patient records
- Add MRSA alert sticker to the inside cover & body of the medical records & the nursing notes
- Advise the ward staff of the result and the need to commence protocol as per MRSA Policy

It is the responsibility of clinical staff to check for an alert on PAS when the patient is admitted so that the patient is managed appropriately

8. PRACTICE FOR MRSA ELECTIVE (ADULT) SCREENING IN OUTPATIENT (OPD) SETTING FOR HIGH RISK PATIENTS



9. MANAGING OUTPATIENTS WHO FALL INTO THE 'WHO TO SCREEN CRITERIA' - ELECTIVE SCREENING RESULTS

- It is the responsibility of the designated person or area to check the results daily and contact the patients.
- The person receiving the result will contact the patient, inform them of the result and arrange for the patient to attend a clinic where they will be given information and a decolonisation pack. The patient will be instructed to use the pack for 5 or 10 days in accordance with the prescribed protocol, starting five or 10 days prior to admission, as appropriate.
- Patients from HCH will attend QEII Pre op admissions hub (POA) Hub. Lister patients will go to the Pre- Operative Assessment Unit.
- Obstetric patients will follow the pathway for all general patients being followed up at antenatal clinic and decolonisation arranged 2 weeks prior to booked admission time
- Medical patients will follow respective OPD pathways.

Cancellations or delayed elective admissions who required screening

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

10. INFECTION CONTROL PRECAUTIONS IN THE CLINICAL ENVIRONMENT

Mode of Transmission

- Hands are the main method for the transmission of most bacteria, including MRSA.

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

Patient Isolation

Standard isolation precautions in side room

- Always inform the bed manager of any side room used for isolation and, if a side room is required, escalate using the Trust Isolation Policy criteria (see escalation process appendix 1 in the Trust Isolation Policy
- Patients with eczema/psoriasis (skin shedders) should have priority for side rooms.
- The door must be kept closed (if closed door poses risk to patient, document the risk assessment in medical & nursing notes regarding the need for the door to remain open despite isolation)
- Complete Adverse Incident Form for patients that you are not able to isolate due to lack of facilities.

Protective Clothing

- All staff entering the isolation room or cohort bay must be 'bare below the elbows' i.e. must have short sleeves, no bracelets, watches, false nails or nail varnish.
- All staff must comply with Uniform & Dress Code for Clinical Staff.
- Disposable plastic aprons and gloves must be put on before entering the isolation area.
- Gloves may need to be changed between procedures and hands decontaminated prior to donning a new set of gloves.
- In the case of cohort patients, gloves and aprons must be changed and hands decontaminated between contact with each patient and patient environment.
- Eye protection must be worn when performing any aerosolising procedure, e.g., chest physiotherapy and suctioning.

- Protective clothing must be removed directly after each episode of patient care, and be disposed of appropriately in a clinical waste bin. Hands must then be decontaminated.

Clinical Waste and Linen

- Disposal of waste must conform to the **Trust Waste Policy.**
- Used linen must conform as per **Trust Management of Linen Policy**
- Towels and bed linen should be changed **daily.**
- Do not sit on beds as clothing is likely to become contaminated.

Cleaning

- All isolation rooms should be cleaned as per **Trust Isolation Policy**

Visitors

- Visitors do not need to wear protective clothing for social contact.
- Visitors should be advised to decontaminate their hands using the alcohol based hand sanitizer or soap and water on entering and leaving the isolation room.

Access to information

- All patients should be given an MRSA information leaflet, available from the Knowledge Centre under Infection Prevention & Control.

Screening of contacts of new cases

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

11. PATIENT SAFETY/PSYCHOLOGICAL ASPECTS OF ISOLATION

- All patients should be assessed for their suitability for isolation.
- If due to an identified risk (e.g. mental health needs or high risk of falls) the patient cannot be placed in isolation or is in an isolation room but cannot have the door kept closed, there must be a clearly documented risk assessment in the clinical notes.
- Regular re-assessment and timely screening of patients should occur in order that patients may be de-isolated as soon as possible.

12. CLINICAL MANAGEMENT OF THE MRSA POSITIVE PATIENT

Medical Treatment of Patients

- For neonates, see Neo 049: Neonatal Unit Protocol for MRSA Decolonisation
- The advice of the Consultant Microbiologist should be sought in ALL instances where an MRSA positive patient may require antibiotics.
- Topical treatment protocol is designed for patients who are colonised or infected with MRSA in any site, and is recommended for all such patients.
- If the first indication of MRSA in a patient is from either urine, a wound swab or blood, the complete protocol is still required (as well as appropriate antibiotic) irrespective of subsequent surface site results.
- The topical treatment protocol can be given a maximum of twice per admission (2 x five or 10 day courses, as appropriate)
- If skin irritation occurs, discontinue the use of Hibiscrub (Chlorhexidine gluconate 4% w/v) and/or Mupirocin (Bactroban). A Consultant Microbiologist will advise on alternative treatment.

- There is little data available regarding the safety or efficacy of using Mupirocin around PEG tubes, tracheostomy tubes, catheters and similar devices. A single course of Mupirocin (5 day Mupirocin-sensitive protocol) may be considered on an individual patient basis by the Infection Prevention & Control Team. For patients requiring the 10 day (Mupirocin-resistant) protocol, the IP&C Team or Consultant Microbiologist should be contacted for advice on alternative products.
- Commence MRSA Care Pathway. The prescription for the protocol below is part of the Pathway document.
- All Patients must be risk assessed for sensitivities/allergies to chlorhexidine. Those patients identified as at risk should be prescribed Octenisan.as an alternative to chlorhexidine.
- The prescription chart in the MRSA Care Pathway document *must be signed* when each protocol is given. Failure to do so is a drug error.

Topical Treatment Protocol – Mupirocin Sensitive (5 day programme)

Formulation	**Frequency**	**Duration**
Nasal Mupirocin (Bactroban) **2% nasal ointment**	Three Times Daily	5 days
Mupirocin **2% cream** for secondarily infected traumatic lesions (not greater than 10cm² in area or10cm in length)	Up to 3 Times Daily	May be given up to 10 days, but re-evaluate after 3-5 days
Body Wash- Hibiscrub (Chlorhexidine gluconate 4% w/v) or Octenisan (for Chlorhexidine sensitive)	Daily, apply to skin before entering bath or shower	5 Days
Shampooing Hibiscrub (Chlorhexidine gluconate 4% w/v) or Octenisan (for Chlorhexidine sensitive)	Twice per protocol	2 times over 5 days

Topical Treatment Protocol – Mupirocin Resistant (10 day programme)

Formulation	**Frequency**	**Duration**
Naseptin nasal ointment* *[Contains peanut oil]*	Four Times Daily	10 days
Seek advice from The IP&C Team (01438 285383) or Consultant Microbiologist via switchboard for secondarily infected traumatic lesions (not greater than 10cm² in area or10cm in length)	As advised by IP&C Team or Consultant Microbiologist	As advised by IP&C Team or Consultant Microbiologist
Body Wash- Hibiscrub (Chlorhexidine gluconate 4% w/v) or Octenisan (for Chlorhexidine sensitive)	Daily, apply to skin before entering bath or shower	10 Days
Shampooing Hibiscrub (Chlorhexidine gluconate 4% w/v) or Octenisan (for Chlorhexidine sensitive)	Four times per protocol	4 times over 10 days

Instructions for use of Octenisan for patients sensitive to Chlorhexidine

schülke

What is octenisan®?

octenisan® is an antimicrobial hair and body wash effective against a broad range of micro organisms whilst caring for the skin.

How to use octenisan®

octenisan® 5 day antimicrobial wash protocol.

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
Body ☐	Body ☐ Hair ☐	Body ☐	Body ☐ Hair ☐	Body ☐

Step 1 Wet skin and/or hair

Step 2 Apply an adequate amount of octenisan® undiluted onto a damp wash cloth

Step 3 Apply octenisan® evenly all over the body & hair (recommended skin contact time 1 minute*)

Do not forget:



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Paying particular attention to:

a) Armpits

b) Groin

c) Perineum (area of skin around bottom)

Step 4 Rinse off

Step 5 Dry with a clean towel

Step 6 Put on clean clothing and clean bedding

Important: Bath or shower **daily** using octenisan® and following this procedure.

Ensure that you are the **sole user** of the washcloth and towel or that these are disposable.

Use a **clean and dry** washcloth and towel for each shower or bath and ensure that these are properly cleaned and dried before using again.

If you experience any difficulty in following this procedure, please seek help from a carer or healthcare professional.

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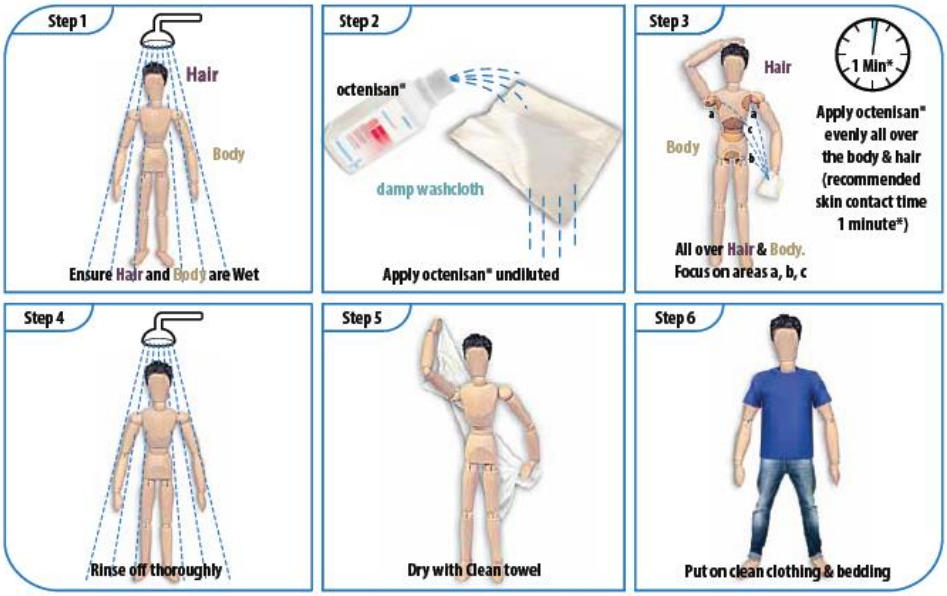
octenisan®
5 day antimicrobial wash protocol

Instructions for use

- Apply octenisan® undiluted onto a clean, damp washcloth
- Rub onto the areas of the body to be cleansed and wash off
- For showering or hair washing, simply use octenisan® in the same manner as other hair and skin washing preparations
- Always observe the recommended contact time of 1 minute*

*tested according to EN 12054



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

After protocol, apply clean clothing, bedding and supply clean towels.

- Disposable flannels should be used for washing patients.
- Disposable washbowls must be used for MRSA positive patients.
- For high level Mupirocin resistance, Naseptin may be advised nasally 4 times a day for 10 days per protocol in place of Mupirocin (NB: Naseptin contains peanut oil).

Topical treatment for patients with High Shedding skin conditions for example: eczema, dermatitis & psoriasis.

- Seek advice from Consultant Dermatologist with view to use of Oilatum bath additive or Oilatum plus (with added benzalkonium chloride 6% & Triclosan).
- This should only be prescribed by a Consultant Dermatologist.
- Treat underlying skin condition.

Protocol for neonates and breast-feeding mothers

- For neonates, see Neo 049: Neonatal Unit Protocol for MRSA Decolonisation
- The management of breast milk expressed from MRSA colonised mothers will be advised on an individual basis by the Infection Prevention & Control Doctor/Consultant Microbiologist.

Post Treatment Screens

Screening should commence 48 hours after protocol has finished, and repeated weekly (7 days apart) thereafter. After 3 consecutive negative screens the patient can be de-isolated but must continue with weekly screens.

Patients with Wounds

- Patients with MRSA colonisation of wounds can have daily baths as outlined above if the condition of their wounds permits.
- Seek advice from the Tissue Viability Nurse. Mupirocin 2% cream may be used on secondarily infected traumatic lesions not greater than 10cm² in area or 10cm in length.
- If signs of infection are present, discuss appropriate treatment with a Consultant Microbiologist.
- All wound dressings should be performed using aseptic non touch technique.

Urine/Sputum

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

Pre-operative preparation for known MRSA positive patients

- Every effort should be made to decolonise patients pre-operatively and/or suppress infection with MRSA before surgery (see Surgical Site Infection High Impact Intervention located on the Knowledge Centre for further information).
- The night before surgery, bathe/shower the patient with Hibiscrub (Chlorhexidine gluconate 4% w/v) applying it directly to the skin and then rinse off. Do not pour in to the bath or bowl. Patients who cannot tolerate Chlorhexidine Gluconate should be bathed in Octenisan. Cover affected lesions with an impermeable dressing.
- Apply Mupirocin 2% nasal ointment to nose pre-operatively (if nasal carrier) or Naseptin if Mupirocin-resistant.
- If prophylactic antibiotic cover is indicated for a surgical procedure this must be discussed with a Consultant Microbiologist.
- Place patient last on the list to enable recovery in the operating theatre.
- Theatre surfaces in close contact or near the patient, such as operating table or instrument trolley, need to be cleaned with a general purpose detergent and hot water or a detergent wipe (as per Trust Decontamination Policy).

- Recover in the operating theatre after surgery, or area not occupied by other patients to avoid possible contamination.
- Porter staff must wear personal protective equipment (gloves if only touching the bed and aprons and gloves if they need to assist the patient manually into a chair) whilst transporting the patient to and from theatre; to remove PPE and decontaminate hands once patient delivered to a department and before going to another department.

13. VISITS TO OTHER DEPARTMENTS

- The clinical needs of a patient take priority over their infectious status.
- When an MRSA positive patient requires an investigation in another department, it is the responsibility of the requesting Doctor to ensure that the request form includes the MRSA status of the patient (e.g. X-ray, Theatres Endoscopy, Outpatients, Physiotherapy and Occupational Therapy). In addition to this, the department must be informed in advance by the ward staff.
- Patients must not be left in a corridor waiting to enter the respective departments.
- Wearing of protective clothing should conform to Trust Standard Precautions Policy located on the Knowledge Centre.
- Staff coming into physical contact with either the patient or their equipment must wear disposable gloves and aprons.
- Hands must be decontaminated between all patients with liquid soap and water or alcohol foam (socially clean hands).
- All equipment with which the patient has had direct contact e.g. examination couch, wheelchair, trolley etc. must be cleaned by personnel in that department with an all-purpose detergent and hot water or a detergent wipe (as per Trust Decontamination Policy).
- Linen, contaminated instruments and waste must be processed in accordance with relevant policies.
- Extra floor cleaning is only required for blood and body fluid spillage. (Follow the procedure for spillage of blood and body fluids in the Standard Precautions Policy located on the Knowledge Centre.)

14. TRANSFER OR DISCHARGE TO OTHER HOSPITALS

- Identification of infected or colonised patients depends primarily on the transferring hospital. The clinician responsible for the patient should contact the Medical Team at the receiving hospital to inform them of the patient's MRSA status. Additionally, the nursing staff should inform the ward staff of the receiving hospital. Transfer form should be completed.
- Any patient received from another hospital must be considered to be a high risk patient; request the patient’s MRSA status and inform Bed Manager that they will require a side room.
- Inform the ambulance crew if an MRSA positive patient has a desquamating skin condition, e.g. eczema. These patients should not be transported in the same vehicle with other patients. If the MRSA positive patient does not have a skin condition, then they may travel along with other patients. Wounds must be covered. If a patient has open skin lesions that are unable to be covered with an impermeable dressing, the advice of the Infection Control Team should be sought. This may result in the patient travelling alone in the ambulance. (National Guidance and Procedures for Infection Prevention and Control by Ambulance Association 2004).
- Unless there is blood/body fluid spillages no extra decontamination of the ambulance is usually required after transporting an MRSA positive patient.

15. DISCHARGE OF PATIENTS INTO THE COMMUNITY SETTING

- All patients discharged into the community should have their MRSA status included in their discharge summary. State the number of protocols administered. Inform if currently on a protocol which requires completion and request any further screening required.
- Most patients who have MRSA are generally not followed up in the community. MRSA Treatment Protocol and swabs for MRSA should only be arranged if clinically required e.g. patient is to be re-admitted for surgery.

- Inform and involve Community Liaison Nurse, Primary Care Trust (PCT) IPCN, General Practitioner, District Nurse and Home Care Team where appropriate, so that they can take appropriate precautions. This is important in case clinical infection develops when MRSA can then be considered and appropriate antibiotics given. The IP&C Team inform the patient, GP and, where applicable, the care home.
- Inform Nursing/Residential Home. Carriage of MRSA should NOT prevent transfer of a patient to a nursing, residential or convalescent home. In the event of any difficulties with placement of a patient, contact the Health Protection Unit (HPU) Infection Prevention & Control Nurse or the Consultant in Communicable Disease Control, telephone 0300 303 8537 and or the CCG Lead IPCN on 0750 095 2019
- Patients should be advised that if they are readmitted to hospital at any time they should inform staff to ensure they are appropriately managed.

16. TRANSFER TO DISCHARGE LOUNGE

- Inform staff in discharge lounge of patient's MRSA status.
- Comply with MRSA policy.
- On discharge of the patient, decontaminate equipment which has come into contact with the patient, using an all-purpose detergent and hot water or a detergent wipe.

17. LAST OFFICES

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

18. CLINICAL GOVERNANCE - POST INFECTION REVIEW

- A Post Infection Review (PIR) is required following any MRSA bacteraemia. All MRSA bacteraemias are considered an internal 'Never-Event'. A 72-hour report will be required and a PIR meeting will need to be held within ten days of the result. The purpose of this is to identify the most probable root cause and implement any learning strategies resulting from such analysis.
- All MRSA bacteraemias are reported as Serious Incidences.
- Should it be identified that the patient was admitted with the MRSA bacteraemia, the PIR report, once complete, should be passed on to the CCG Infection Prevention & Control Nurse.
- An Adverse Incident Form must be completed by the clinical team for every hospital acquired MRSA bacteraemia.

19. AN OUTBREAK OF MRSA

Definition

- An outbreak is defined as two or more related cases of MRSA (with the same sensitivity/typing pattern) in one clinical area.
- In the event of an outbreak, the Trust Policy for the Management of Outbreaks will be adopted.

Immediate management

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

Major Outbreak

- Should an outbreak spread beyond the confines of a cohort, a **major outbreak** may be declared.
- The IP&C Team will state when a major outbreak has occurred and the Trust Policy for the Management of Outbreaks will be implemented (see Knowledge Centre)**.**

20. TRUST STAFF SCREENING

- Healthcare staff may be screened during outbreaks of MRSA.
- Staff screening will be carried out at the discretion of the IP&C Team/Occupational Health Department and in compliance with Infection Control Issues for Staff Health Policy located on the Knowledge Centre.
- Staff must **not** screen themselves without prior arrangement with the Occupational Health Department.
- Treatment of MRSA colonised staff will be in accordance with the **Topical Treatment Protocol.**
- The Occupational Health Department will advise staff who are MRSA positive on an individual basis whether they need to be excluded from work.

For any queries contact the IP&C Team on Lister ext.: 5383 or bleep 5383

SECTION 2 – MANAGEMENT OF VISA / GISA AND VRSA

1. INTRODUCTION

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

Therefore risk factors are:

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

2. INFECTION PREVENTION & CONTROL PRECAUTIONS IN THE CLINICAL ENVIRONMENT

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

Healthcare workers

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

Isolation precautions

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

- Contact precautions must be used by EVERYONE ENTERING the room.
- Disposable masks and eye protection should be worn by carers for procedures likely to generate aerosols/splashing.
- Hand hygiene must be performed using alcohol gel before and after each patient contact. Visibly soiled hands should be washed with soap and water.
- All non-disposable items that cannot be easily decontaminated must be kept for the sole use of the patient.
- All patient charts must be kept outside the room.
- All linen must be treated as infected and conform to the Trusts linen policy.
- All waste should be treated as described in the Trust waste policy..
- Transfers of colonised/infected patients within/between departments/hospitals should be avoided unless essential. The receiving departments/hospitals must be made aware of the patient's infection/colonisation status.
- After discharge of the patient the room should be terminally cleaned with special attention to the horizontal surfaces (see Trust Decontamination Policy).

Screening of patients

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

Screening of staff

- Agreement with staff on the need for screening should be sought.
- Nose, perineum and any skin lesions of healthcare workers and others with close physical contact with the case should be screened for carriage of VISA/GISA and VRSA.
- Healthcare workers who maintain contact with the patient will require weekly screening.
- Colonised staff should be excluded from work until eradication of carriage is achieved.

SECTION 3 - REFERENCES AND BIBLIOGRAPHY

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SECTION 4 - APPENDICES
APPENDIX 1: EMERGENCY ADMISSIONS MRSA & CRE SCREENING RECORD

East and North Hertfordshire NHS Trust

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

Hosp No: ..... DoB: .....
Surname: .....
Forename(s): .....
Male ☐ Female ☐ (Or use Pt label)

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

Site: Lister ☐ MVCC ☐ QEII ☐ **Ward:**

Date of Admission: ..... / ..... / .....

MRSA

1. **Has the Pt been an In-patient in *any* hospital (UK or abroad) within the past 12 mths?** Yes* ☐ No ☐
2. **Does the patient live in a Residential/Nursing Home?** Yes* ☐ No ☐
3. **Has the patient previously been informed that they were positive (check for MRSA Alert on PAS)?** Yes* ☐ No ☐
4. **Is the patient being admitted to the specialities below:**
   Vascular Patients ☐ Orthopaedic/Trauma ☐ Renal/Dialysis ☐ Haematology/Oncology ☐
   Critical Care/HDU ☐ Neonatal ICU ☐ Cardiac Unit Patients ☐ Stroke Unit Patients ☐

***If the answer to any of the above is 'Yes', this Pt is at High Risk of MRSA and the Bed Manager must be informed that an isolation room is required & isolation precautions must commence.**
If results subsequently show Pt is + ve for MRSA, decolonisation must be attempted immediately and Infection Prevention & Control Team informed about this patient.

Does the patient have any of the following: (Pse ✓ all that apply)
Wound/lesion ☐ Urinary catheter ☐ Productive cough ☐ Tracheostomy/Stoma ☐

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

Swab/s or sample/s taken from: (Pse ✓ all that apply)
Nose ☐ Perineum/Groin ☐ Wound/lesion (including MC&S) ☐ Catheter urine ☐ Sputum ☐
Tracheostomy/Stoma site ☐ Other ☐ Specify: .....

Carbapenem-Resistant Enterobacteriaceae (CRE)

1. **Has the Pt been an In-patient or had renal dialysis in *any* hospital abroad, London, Manchester or the North West, within the past 12 mths?** Yes* ☐ No ☐
2. **Has the Pt ever been told they were positive for CRE?** Yes* ☐ No ☐
3. **Has the Pt been in close contact with anyone known to be positive for CRE?** Yes* ☐ No ☐

***If the answer to any of the above is 'Yes', this Pt is at High Risk of CRE and the Bed Manager must be informed that an isolation room is required & isolation precautions must commence.**
2 stool samples are required, at least 2 days apart
If results subsequently show Pt is + ve for Carbapenem-Resistant Enterobacteriaceae, screening of contacts and effective treatment (in case of infection) must be commenced immediately.
The Consultant Microbiologists and the Infection Prevention & Control Team must be informed about this patient.

Infection Prevention & Control Team
Revised: August 2015 Review due: August 2017

Order Code:

Stool specimen taken for CRE? Yes* ☐ No ☐ *If Yes **Date of sample** ……/……/…….
or
Rectal swab with visible faeces taken for CRE? Yes* ☐ No ☐ *If Yes **Date of swab/s:** …… / ….. / ……..

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

CHECKLIST COMPLETED BY: NAME:……**GRADE**……

SIGNATURE:……

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

SCREENING CARRIED OUT BY: NAME:……**GRADE**……

SIGNATURE:……

SCREENING RESULTS:

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

RESULTS COMPLETED BY: NAME: …… **GRADE:** ……

SIGNATURE: ……

CRE POSITIVE [2] ☐ **CRE NEGATIVE [2]** ☐ If positive discuss with Microbiologist

RESULTS COMPLETED BY: NAME: …… **GRADE:** ……

SIGNATURE: ……

Recommended Sampling Sites for use in MRSA / CRE Screening

MRSA

Sampling sites for initial screening for all patients are:

- Nose
- Perineum or Groin
- Any wounds or lesions

CRE

Sampling sites for initial screening for all **High Risk** patients

- Rectal swab (must have visible faecal matter) **or** Stool specimen
- Any wounds or lesions (if possible)
- Any medical device insertion sites (if possible)

Additional sampling/testing for both MRSA and CRE screening should also be carried out as follows:

- If the patient has a urinary catheter, a sample of the catheter urine should be collected and sent for testing
- If the patient has a productive cough, a sample of the sputum should be collected and sent for testing
- If the patient has a tracheostomy, the tracheostomy site should be swabbed
- If the patient has any stoma, the stoma site should be swabbed

APPENDIX 2: OBSTETRICS & GYNAECOLOGY MRSA & CRE SCREENING RECORD

East and North Hertfordshire NHS Trust

OBSTETRICS & GYNAECOLOGY

Pre-Admission

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

MRSA & CRE SCREENING RECORD

Hosp No: .....
DoB: .....
Surname: .....
Forename(s): .....

Male ☐ Female ☐ (Or use Pt label)

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

MRSA

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

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

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

Site	Swabbed	Negative	Positive
Nose			
Perinium/Groin			
CSU			
Sputum			
Wound/Stoma 1:			
Wound/Stoma 1:			
Wound/Stoma 1:			

MRSA sticker put on inside cover of patient's notes: Yes ❑ No ❑

Consultant informed of +ve result? : Yes ❑ No ❑. If yes: **DATE**: ..../...../.....

Patient informed of +ve result? : Yes ❑ No ❑. If yes: **DATE**: ..../...../.....

Date agreed for decolonisation treatment to start: ...../...../.....

MRSA Pack

Written information given to patient: MRSA leaflet? : Yes ❑ No ❑ User protocol? Yes ❑ No ❑

Date MRSA Pack given to patient: ..../...../.....

Hibiscrub (Chlorhexidine gluconate 4% w/v) Batch number..... **Expiry Date:** ...../.....

Mupirocin batch number ..... **Expiry Date:** ...../.....

Patient's identity confirmed? Yes ❑ No ❑.

Qualified Nurse/Midwife: Signature..... Printed name: .....

Re-screening date: On admission

Any other comments/information: .....

.....

Order code:

Infection Prevention & Control Team
Reviewed: August 2015 Review due: August 2017

Carbapenem-Resistant Enterobacteriaceae (CRE) Risk Assessment Form

For all Obstetric & Gynaecology Patients requiring admission

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

Ask **all Obstetric & Gynaecology Patients** requiring admission:

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

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

* YES = HIGH RISK		If the patient answers 'Yes' to ANY of these questions, see action plan below.	NO	

Action plan for patients identified as being 'at high risk' of CRE

Two stool specimens are required, at least 48 hours apart

- **Give patient 2 stool specimen pots and information/instruction leaflet**

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

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

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

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

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

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

SCREENING RESULTS [1]:

CRE POSITIVE** ☐ **CRE NEGATIVE** ☐

Results [1] completed by: NAME: ..... **GRADE:** .....

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

**If positive, inform: Patient's Consultant ☐ Consultant Microbiologist ☐ Bed Management Team ☐

Contact Waiting List: ☐ Theatres ☐

SCREENING RESULTS [2]:

CRE POSITIVE** ☐ **CRE NEGATIVE** ☐

**If positive, discuss with Microbiologist

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

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

**If positive, inform: Patient's Consultant ☐ Consultant Microbiologist ☐ Bed Management Team ☐

Contact Waiting List: ☐ Theatres ☐

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

Order Code:

Infection Prevention & Control Team
Reviewed: August 2015 Review due: August 2017

APPENDIX 3: PRE-OPERATIVE ASSESSMENT SCREENING RECORD FOR MRSA, CRE & CJD/vCJD

East and North Hertfordshire NHS Trust

Pre-operative assessment screening record
for MRSA, CRE & CJD/vCJD for all patients having elective surgery or endoscopy procedure

Consultant:……TCI Date:…… Operation / procedure:……

Screening completed by: *(print name)……(Grade)……(signature)……(Date)……*

Results checked by: *(print name)……(Grade)……(signature)……(Date)……*

Hosp No: ……
DoB: ……
Surname: ……
Forename(s): ……

Male ☐ Female ☐ (Or use Pt label)

Please tick and sign all relevant boxes and give further information as requires for all risk assessments undertaken – Pt=Patient/ RA=Risk assessment

Ask ALL questions below and tick the relevant outcome then proceeding to the action plan(s) as directed	YES	NO	Unknown	Action
1. **Have you been an inpatient or had renal dialysis in any overseas hospital, London, Manchester or the North West of England in the last 12 months?**				Complete **ALL** RA sections 1,2,& 3 if Pt answers Yes or Unknown
2. **Has the patient ever been told they were positive for CRE?**				Complete RA section 2 in all cases
3. **Has the patient been in close contact with an individual known to be CRE positive?**				Complete RA section 2 in all cases
4. **Has the patient been notified that they are at increased risk of CJD/vCJD for public health purposes?**				Complete RA section 3 in all cases
5. **Has the patient ever been MRSA positive before?**				Complete **ALL** RA sections 1,2,& 3 if Pt answers Yes or Unknown
6. **Is the patient intended to go to critical care post operatively?**				Complete **ALL** RA sections 1,2,& 3 if answer Yes or Unknown
7. **Is the patient under the care of the Orthopaedic / Vascular / Renal / Haematology team?**				Complete **ALL** RA sections 1,2,& 3 if answer Yes or Unknown
8. **Is the patient on an oncology pathway?**				Complete **ALL** RA sections 1,2 & 3 if answer Yes or Unknown
9. **Is the patient from a Nursing or residential home?**				Complete **ALL** RA sections 1,2,& 3 if answer Yes
Free text notes related to ALL RA pathways				

This form must be filed in the "Nursing / other" section of the patients medical records once risk assessment and any appropriate actions completed.

Author(s): Pre-Operative Assessment/Infection Prevention & Control Team
Version No.1

Date of issue: August 2015
Valid until: August 2017

Order code:

APPENDIX 4: MRSA SCREENING PATIENT INFORMATION LEAFLET

East and North Hertfordshire NHS Trust

MRSA Screening

Patient Information Leaflet

What is MRSA?

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

Why do I need to be screened for MRSA?

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

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

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

What will happen if MRSA is found?

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

Will I be checked to see if it has gone?

You may have another swab taken. Your doctor or nurse will advise.

Will my operation be cancelled?

Your operation may be postponed if further checks or treatment is advised.

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

If you have any questions, please speak to your doctor or nurse.

APPENDIX 5: MRSA MULTI-DISCIPLINARY INTEGRATED CARE PATHWAY (ICP)

Ward……

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

PATIENT DETAILS (affix label)
Name Hospital No D.O.B Address

Standard:
Previously known or newly diagnosed MRSA positive patients will be placed appropriately, receive timely and effective information, treatment and undergo follow up screening.
Inclusion criteria
All in-patients with a positive MRSA result
All previously known positive renal patients
Exclusion Criteria
Decolonisation protocol should not be used for children under 1 year (inc. neonates) seek advice from Infection Prevention & Control Team (IPCT)

INSTRUCTIONS FOR USING THIS ICP

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

ALL PERSONS COMPLETING THIS ICP MUST SIGN BELOW				
NAME	**SIGNATURE**	**INITIALS**	**DESIGNATION**	**Bleep//Ext**

CARE PATHWAY FOR MRSA				
Initial Details & Actions		**Date**	**Time**	**Initials**
MRSA colonisation/infection (including bacteraemia) identified: From admission screening ❑ From clinical specimen during inpatient admission ❑ From ward/bay screening ❑				
A full MRSA screen is obtained Yes ❑ No ❑ Full screen must be obtained prior to starting protocol (with exception of Renal)				
Sites of initial screening (from full screen)	**Positive/ negative result or NA**	**Date**	**Time**	**Initials**
Nose				
Groin				
Wound (state site)				
Wound (state site)				
Catheter Specimen Urine				
Sputum				
Invasive device (state site e.g., PVC, suprapubic catheter, Percutaneous Endoscopic Gastrostomy (PEG) site, etc.)				
Other				

Date	Variance and actions	Initials

Communication at time of positive result If not met document reasons in the variance section	**Yes/No Initials**	**Date**	**Time**
Infection Prevention & Control Team			
MRSA alert placed on PAS & ICE by IPCT?			
A record of the result is recorded by the IPCT in the current nursing and medical notes & ICNet?			
Ward Staff			
Has the patient been informed and have they fully understood the explanation given?			
The patient is informed of the isolation measures to be taken and the rationale?			
MRSA leaflet given to patient, and relatives if patient consents to reinforce the above?			
Are there any concerns that the patient may not be compliant with the isolation measures (record in variance and actions).			
Does the patient have any questions? If yes specify in patient's own words in variance and actions section.			
Is 'Stop and Think' card is displayed on the room door?			
Have the domestic staff been informed of the isolation cleaning requirements using the request form in Appendix 11 of the Isolation Policy?			

Ward Staff	Yes/No Initials	Date	Time
Has the consultant and his/her medical team been informed of the patient's MRSA positive status?			
Has the patient's nursing team been alerted to the positive MRSA result?			
Medical Staff			
Has the MRSA positive result been discussed with the patient?			
Does the patient have any questions? If yes specify in patient's own words in 'Variance section'			

Date	Variance and actions	Initials

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

* **Document as variance at bottom of page**

**** A full decolonisation protocol is required irrespective of site positive**

Date	Variance and actions	Initials

Isolation Care Reminders:

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

Topical Five Day Decolonisation Checklist: 1st Treatment Cycle						
Drug hypersensitivity: Please state if none						
Start date: **Stop date:**						
Prescribers Signature **(This is a prescription therefore lack of signature is a drug error)**		**Day 1** Day & Initial	**Day 2** Day & Initial	**Day 3** Day & Initial	**Day 4** Day & Initial	**Day 5** Day & Initial
Hair washed using Hibiscrub (Chlorhexidine gluconate 4% w/v) or Octenisan for sensitive patients, as shampoo (twice only) – Initial date performed.						
Patient has a shower / bath using Hibiscrub (Chlorhexidine gluconate 4% w/v) as shower gel (use disposable wipes and clean towel)						
Topical Mupirocin 2% ointment to nose as per prescription TDS (Must commence 9am Day 1)	0900					
	1400					
	2200					
Patient's nightclothes and bedding changed each day following bath / shower						
Authorisation to administer/supply on discharge: Signature Date:						
				Day 1	**Day 2**	**Day 3**
Patient has a two day rest period from topical treatment						**Re-Swab**

Post 1st Treatment Screening Schedule

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

Screen	Date taken & Initial	Nose	Groin	CSU	Wound (state site)	Wound (state site)	Invasive device (state site)	PEG site	Other
1		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
2		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
3		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -

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

	Initial	Date
Is the patient to be discharged with protocol to finish the course Yes ❑ No ❑		

Topical Five Day Decolonisation Checklist: 2nd Treatment Cycle (to be given if screening sites are +ve post 1st protocol.						
Start date: **Stop date:**						
Prescribers signature **(This is a prescription therefore lack of signature is a drug error)**		**Day 1** Day & Initial	**Day 2** Day & Initial	**Day 3** Day & Initial	**Day 4** Day & Initial	**Day 5** Day & Initial
Hair washed using Hibiscrub (Chlorhexidine gluconate 4% w/v), or Octenisan for Chlorhexidine sensitive patients, as shampoo (Twice only) - Initial date performed						
Patient has a shower / bath using Hibiscrub (Chlorhexidine gluconate 4% w/v) as shower gel (use disposable wipes and clean towel)						
Topical Mupirocin 2% ointment to nose as per prescription TDS (Must commence 9am Day 1)	0900					
	1400					
	2200					
Patient's nightclothes and bedding changed each day following bath / shower						
Authorisation to administer/supply on discharge: Signature Date:						

	Day 1	**Day 2**	**Day 3**
Patient has a two day rest period from topical treatment			**Re-Swab**

Post 2nd Treatment Screening Schedule

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

Screen	**Date taken & Initial**	**Nose**	**Groin**	**CSU**	**Wound** (state site)	**Wound** (state site)	**Invasive device** (state site)	**PEG site**	**Other**
1		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
2		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
3		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -

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

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

	Initial	Date
Is the patient to be discharged with protocol to finish the course ***Yes*** ☐ ***No*** ☐		

Date	**Variance and actions**	**Initials**

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

Date	Variance and actions	Initials

Discharge/Transfer to another hospital	Date	Initials
1. GP/Transfer letter outlines MRSA status and all associated treatment		
2. District nurses/community team (including IPCN), if applicable, are informed of the MRSA status and any treatments given		
3. Patient and carers/family are fully informed and written information has been given		
4. Unused disposable equipment from isolation room is discarded		
5. All reusable patient equipment has been decontaminated as per Trust Decontamination Policy		
6. The Infection Prevention & Control Team are aware of the patient's discharge/ transfer		

Weekly Screening - whilst in-patient
If any sites are found to be positive on weekly screening – recommence isolation precautions

Week	Date taken & Initial	Nose	Groin	CSU	Wound (state site)	Wound (state site)	Invasive device (state site)	PEG site	Other
1		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
2		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
3		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
4		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
5		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
6		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
7		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
8		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
9		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
10		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
11		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
12		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
13		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
14		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
15		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
16		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
17		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
18		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
19		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -
20		+ -	+ -	+ -	+ -	+ -	+ -	+ -	+ -

APPENDIX 6 – MRSA: INFORMATION FOR PATIENTS IN HOSPITAL

MRSA

Information for patients in hospital

This leaflet contains information about patients in hospital and the people around them

What is MRSA?

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

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

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

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

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

How do people get MRSA?

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

How can you tell if someone has MRSA?

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

What happens when a patient gets MRSA?

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

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

- Everyone should clean their hands before and after touching patients
- Hands can be cleaned with soap and water, or an alcohol gel, or hand rubs
- Staff will wear gloves and aprons when they care for a patient who has

- MRSA
- A patient who has MRSA may be moved to a room on their own or into a separate area for people who have MRSA or other infections. It is very important that the doors to the single room or area remain closed at all times. This is to reduce the risk of MRSA spreading into the general environment.

How is MRSA treated?

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

Can MRSA harm family and friends?

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

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

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

Simple hygiene measures reduce the risk of

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

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

How is MRSA monitored?

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

APPENDIX 7 – INSTRUCTION SHEET FOR MRSA PACK

Instruction Sheet for MRSA Decolonisation

MRSA treatment consists of 'Hibiscrub' (Chlorhexidine gluconate 4% w/v) or 'Octenisan' Body Wash **and** 'Mupirocin Bactroban' or 'Naseptin' Nasal Ointment.

Instructions for use are given below - Please use them exactly as directed.

How to use your MRSA Body Wash and Nasal Ointment

Body Wash:

- Use the Body Wash **once a day, for 5 consecutive days** (Mupirocin Sensitive) or **10 consecutive days** (Mupirocin Resistant)
- Apply the Body Wash **directly** on to your body, and then wash off using water
- Apply the Body Wash **all over** your body – including your back
- **Do not pour** the Body Wash into the water in your bath or sink/basin as this will dilute it and make it less effective
- **Do not use** bubble bath or shower gel with the Body Wash
- You may use a **flannel**, but this must be **changed each day** for a clean one
- You should also use a **clean towel** every day
- Use the Body Wash **as a shampoo** twice in the 5 days – e.g., on day 1 & day 5 or four times in the 10 days **if you have been told to follow a 10 day programme** (days 1, 4, 7 & 10)

  (You may put conditioner on your hair afterwards if you wish.)

Nasal Ointment:

- Put a small amount of the Nasal Ointment inside <u>each</u> nostril **three times a day** (Bactroban) or **four times a day** (Naseptin)
- **Wash your hands** after each application

After 5 days:

- **Stop** the use of the Body Wash and Nasal Ointment **unless you have been told to follow the 10 day programme**

<u>See overleaf for 5 day and 10 day programme 'At a Glance'</u>

MRSA Decolonisation

5 Day Programme 'At a Glance'

(Patients using 'Hibiscrub' or 'Octenisan' Body Wash and 'Bactroban' Nasal Ointment)

Day 1	Day 2	Day 3	Day 4	Day 5
▪ Use Body Wash ▪ Apply Bactroban Nasal Ointment to both nostrils 3 times during the ▪ Shampoo hair with Body Wash	▪ Use Body Wash ▪ Apply Bactroban Nasal Ointment to both nostrils 3 times during the day	▪ Use Body Wash ▪ Apply Bactroban Nasal Ointment to both nostrils 3 times during the day	▪ Use Body Wash ▪ Apply Bactroban Nasal Ointment to both nostrils 3 times during the day	▪ Use Body Wash ▪ Apply Bactroban Nasal Ointment to both nostrils 3 times during the day ▪ Shampoo hair with Body Wash

Stop the programme after 5 days

10 Day Programme 'At a Glance'

ONLY FOR PATIENTS WHO HAVE BEEN TOLD TO FOLLOW A 10 DAY PROGRAMME

(Patients using 'Hibiscrub' or 'Octenisan' Body Wash and Naseptin Nasal Ointment)

Day 1	Day 2	Day 3	Day 4	Day 5
▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day ▪ Shampoo hair with Body Wash	▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day	▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day	▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day ▪ Shampoo hair with Body Wash	▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day

Day 6	Day 7	Day 8	Day 9	Day 10
▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day	▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day ▪ Shampoo hair with Body Wash	▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day	▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day	▪ Use Body Wash ▪ Apply Naseptin Nasal Ointment to both nostrils 4 times during the day ▪ Shampoo hair with Body Wash

APPENDIX 8 - IMPLEMENTATION AND MONITORING EFFECTIVENESS OF THE MRSA POLICY

1. The policy can be accessed via the Trust Knowledge Centre
2. Policy review occurs every two years unless national guidance changes.
3. Compliance with the MRSA Policy is an integral component of the Infection Prevention & Control programme and Annual Report.
4. Training in compliance with the MRSA Policy is embedded into all infection prevention & control training sessions for all staff as identified in the infection prevention & control Training Needs Analysis (TNA). This includes core-training sessions, such as mandatory update and induction. The content of these sessions is normally reviewed annually.
5. The Nurse Education and Training department follows up mandatory update and induction non-attendees.
6. Clinical Governance:

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

7. The process for monitoring the effectiveness of compliance with MRSA policy occurs by the following methods:

    - Link Person Update
    - Nurses & Midwives Mandatory Update
    - Nursing Executive Committee
    - Sisters Meetings
    - Senior Management Team Meetings

APPENDIX 9 - NATIONAL HEALTH SERVICE LITIGATION AUTHORITY (NHSLA) RISK MANAGEMENT STANDARDS FOR ACUTE TRUSTS

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

Chief Executive	• Ensure that functioning Infection Prevention & Control Team is in place • Ensure that a Director of Infection Prevention & Control (DIPC) has been appointed • Ensure that an Infection Control Doctor (ICD) has been appointed
Infection Prevention & Control Team (IPCT)	• Staff training • Policy formulation • Provide specialist advice to clinical areas covered in this policy • Dissemination of Infection Prevention & Control audit results
All Trust Employees	• Attend training • Comply with Trust policies