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<td>Nursing, Quality &amp; Patient Experience</td>
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<td>Infection control Team</td>
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<td>Pre-assessment team management</td>
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1. Equality Impact Assessment (EIA) Disclosure Statement

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<td>This policy was assessed on the 25th day of September 2018 for its impact on equality. The assessment determined that the policy will <strong>not</strong> have a <strong>significant</strong> negative impact on equality in relation to each of the protected staff/patient groups below:</td>
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<td>i.) Age; ii.) Sex (Male and Female); iii.) Disability (Learning Difficulties/Physical or Sensory Disability); iv.) Race or Ethnicity; v.) Religion and Belief; vi) Sexual Orientation (gay, lesbian or heterosexual); vii) Pregnancy and Maternity; vii) Gender Reassignment (The process of transitioning from one gender to another); viii) Marriage and Civil Partnership.</td>
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1. Privacy Impact Assessment (PIA) Disclosure Statement

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<td>This policy was assessed on the 25th day of September 2018 for its impact on privacy. The assessment determined that the policy will not have a significant negative impact on privacy of members of staff/patients.</td>
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2. Summary

This policy has been developed by the Royal National Orthopaedic Hospital to provide guidance to staff on screening, treatment and ongoing management of the patient with MRSA and to reduce transmission, acquisition, colonisation and infection with MRSA.

The Policy includes:

- Detection of MRSA carriage by screening patients; elective and emergency admissions / transfers.
- Actions to be taken when patients either known to have; or to be at risk of MRSA colonisation or infection are admitted to the RNOH.
- Appropriate placement of suspected / MRSA positive patients to comply with the Trust isolation policy.
- Suppression therapy for patients with MRSA.
- Actions to ensure prompt and appropriate treatment of MRSA infection.
- Communication of MRSA status during the patient’s stay at RNOH.
- Communication of MRSA status on transfer or discharge.
3. Introduction and aims

Staphylococcus aureus (*Aureus*) is a bacterium that usually colonises the nose of approximately 30% of healthy people. *S. aureus* acquires resistance genes to many antibiotics, but acquiring the gene encoding resistance to Methicillin (and Flucloxacillin, a type of antibiotic) leads to *S. aureus* called *Methicillin Resistant Staphylococcus aureus* (MRSA). MRSA can breach host defences and cause a range of infections including superficial skin infections, or more rarely life threatening infection such as a bacteraemia. The control of MRSA is therefore an important factor in the provision of patient care.

This policy details the clinical significance of the organism and highlights the importance of admission screening to prevent cross-infection throughout the Trust, together with the management of patients and/or staff colonised/infected with MRSA. The Policy aims is to provide guidance on how to protect patients, staff and the general public from exposure to MRSA by preventing cross-infection and also preventing contamination of the environment. Also to ensure that patients who are colonised or infected with MRSA are managed appropriately, and receive adequate information about their condition.
4. Definitions

**Eradication/decolonisation** - This is the term given to the treatment process for MRSA patients; it includes a 5day protocol of hibiscrub body wash and bactroban nasal ointment.

**Contact Precaution/Isolation** - This is the term for isolation protocol applicable to patients colonised/infected with bacteria's that are transmissible through contact from person, surfaces or equipment's.

**Transient carriage**: This occurs when MRSA is present on the hands, arms, face or inside the nose for a short period of time, i.e. a few hours. Staff often becomes transient carriers when caring for patients with MRSA.

**MRSA Colonisation/carriage**: Occurs when it is present on, or in, the body for a significant period of time but causes no ill effects. Patients may be colonised with MRSA, sometimes for several months or years, without it being a problem to them. However, if a colonised patient requires surgery or other invasive procedures, MRSA may be introduced inside the body where it may cause infection.

**MRSA Infection**: This occurs when the presence of MRSA causes clinical consequences, e.g. inflammation, swelling and pus formation. MRSA infection can occur in the skin and soft tissues, lungs, bones and joints or in the blood stream i.e. MRSA bacteraemia.
5. Duties and Responsibilities

As an employee of the Royal National Orthopaedic Hospital, all staff are expected to practice at all times in accordance with infection control standards specified in this policy in response to the Health Care Act (2006) Code of Practice for the prevention and control of health care associated infections. Also to act in a way that minimises infection risk to the patients and colleagues.

1. **The Chief Executive** has overall accountability for ensuring that the RNOH Trust fulfils its statutory and non-statutory commitments in relation to patient safety and maintaining appropriate standards of clinical care in relation to infection prevention and control.

2. **The Director for Infection Prevention and Control** (who is also the Director of Nursing) is responsible for ensuring that there are adequate resources and management structure for infection prevention and control within the Trust.

3. **The IPC Team:** Reports to the Director of Infection Prevention and Control and has responsibility for the development and supporting implementation of the Trust Infection Prevention and Control, policies and Programme.

4. **Role of the Divisional Managers/ Matrons:** Divisional Managers must ensure that resources are available for health care workers to implement infection control measures within their unit in relation to this policy.

5. **Role of Ward Sister/Charge Nurses:** Ward Sisters/Charge Nurses and departmental managers are responsible for ensuring that staffs are aware of this policy and professionally support the implementation of this policy in practice.
6. **Role of Medical Staff:** Medical Staff are responsible for medical management of patients with infection in line with trust Antibiotic guide/policy and seeking appropriate support from the trust microbiologist.

7. **Role of the Infection Control Committee:** The Infection Control Committee (ICC) is responsible for approving this policy, monitoring the implementation and compliance with this policy.

8. **Occupational Health Service:** The Occupational Health Service is responsible for; screening staff for MRSA carriage when this is indicated by the IPCT, i.e. in the event of an outbreak where staff may be considered a source of MRSA to patients, advising managers on restrictions to work activities if a member of staff is found to be colonised or infected with MRSA, Prescribing topical decolonisation products for members of staff and providing follow up screening on completion of decolonisation treatment.
6. Body of Policy

6.1 MRSA Transmission/Screening
The most common mode of spread of MRSA in hospitals is direct person to person contact usually by contaminated hands of healthcare workers.

When any type of infection is suspected it is normal practice to obtain a relevant specimen for microscopy, culture and sensitivity. This may identify MRSA as the infecting organism. Subsequent screening of common carriage sites on the same patient may subsequently identify skin or nasal colonisation.

MRSA colonisation can be identified by screening patients prior to or on admission. The rationale for screening is to identify MRSA carriers at the earliest opportunity. Identification will trigger the prescription and administration of topical MRSA decolonisation/suppression protocol, inform the selection of appropriate systemic antimicrobial prophylaxis for surgical procedures, inform the selection of appropriate empirical antimicrobial treatment in the event of subsequent sepsis, and inform decision making regarding appropriate patient placement in hospital. The following outlines the different groups of patients who require screening for MRSA in RNOH:

- All patients admitted as elective admissions, including day cases.
- All emergency admissions or transfers into the Trust.
- All patient attending Pre-Assessment for elective procedures
- Screen patients prior to transfer to other Healthcare providers if required
- MRSA weekly screening for all ITU in-patients in order to monitor acquisition.
Patients should be screened for MRSA by taking swab specimens from the applicable correct sites listed and labelling them correctly with patient details, type of specimen and site.

- Nose and groin (Routine sites for pooled result)
- Vascular and other health care devices e.g. Picc lines, central line, cannulae, tracheostomy port
- Sputum, if productive
- Wounds, abrasions, skin lesion, exfoliating skin and urine sample if catheterised.

Note:

- Urgent red swabs for MRSA rapid testing can ordered for emergency admission / where required.
- Admissions and bed management teams have a responsibility to ascertain the patients’ MRSA status before admission. This will help with isolation room prioritisation and management.
- Staff Screening for MRSA is not routinely performed, and must only be undertaken at the request of the IPCT or Occupational Health. The case management of any staff member found to be MRSA positive as part of staff screening will be undertaken by Occupational Health. If appropriate they will liaise with relevant parties following consent of the staff member.

6.2 Treatment and Management protocol for patient with MRSA

All patient screened as MRSA positive will have their Electronic Patient Record on (ICS) flagged with a red MRSA flag on the top left hand corner of the screen. It is the ward staff’s responsibility to inform the patient and provide them with a patient information leaflet on MRSA. The Infection control Nurse can be contacted if further advice is required. The suppression/decolonisation protocol must be commenced immediately
In-patients with MRSA will need to be placed in a single room with ‘Contact Precautions’ in place followed by decolonisation regime. Patient found to be MRSA positive from Pre-Assessment screening will need to be prescribed MRSA decolonisation protocol to be completed as outpatient followed by 3set of negative swabs via the GP. The 3 sets of negative is required from 48hours, 1 week apart post decolonisation protocol for patients who have had MRSA suppression protocol and is undergoing orthopaedic surgery in RNOH

The 5 day course of treatment can be repeated for a further 5 days if the patient remains positive. (Only two courses of 5 days is recommended). One negative set of MRSA screening result is considered valid for a period of 16 weeks for patients tested MRSA Negative whilst 3 sets of negative is required for patients who have had successful MRSA decolonisation protocol to be flagged as MRSA Clear (MRSAC). For in patients, once the patient has 3 clear complete sets of screens, each set 1 week apart, isolation may be discontinued in liaison with the IPC team.

6.2.1 MRSA Decolonisation regime

Systemic Antimicrobial Therapy: If the patient is clinically infected and not simply colonised, the duty medical microbiologist can be consulted for advice on appropriate systemic antibiotic therapy. Patients will also require topical treatment.

Topical Treatment of Adults and Children: Whether colonised or infected, the 5-day decolonisation/ suppression protocol topical treatment should be provided to patients with positive MRSA screening test result. The protocol consists of;

I. Chlorhexidine 4% body wash – shower / bath once a day for 5 days

II. Mupirocin 2% Nasal Ointment – apply to the anterior nares 3 times a day for 5 days.
Eradication of MRSA is often not achieved particularly for the types of patients listed below but topical treatment is still useful to suppress the growth of MRSA, reduce the risk of endogenous infection and the risk of cross infection to others in hospital care settings.

- Patients with long term indwelling devices e.g. urinary catheters and gastrostomy feeding tubes.
- Patients with throat carriage, sputum positive and still expectorating
- Patients with chronic wounds e.g. pressure sores, leg ulcers, large or deep unhealed wounds
- MRSA colonized patient’s residents in nursing /care homes.

6.3 MRSA Chronic Carrier:
Patients who cannot be successfully decolonised after 2 attempts are referred to as ‘chronic carriers’ of MRSA and they can be admitted for surgery with infection control precautions unless the consultant responsible for the patient assesses that this is clinically risky for the patient and further treatment plan can be agreed with the microbiologist. Chronic MRSA carrier patients must be isolated from admission and be treated with the usual decolonisation regime for 4 days prior to surgery and then undergoing surgery on day 5 under Teicoplanin prophylaxis (see Antimicrobial policy/ consult with microbiologist). These patients must be placed last on the theatre list if possible. Where there are no side rooms available the patient may be admitted to a bay with strict contact precautions in place. The curtains should remain closed and a sign placed clearly on the curtains. Such patient must be managed as MRSA positive for their whole length of stay at RNOH.

For MRSA infected chronic wound, consider use of wound dressings that have good anti-staphylococcal activity: options .Seek Tissue Viability/pharmacy/ microbiology advice for situations where the wound does not improve within 2 weeks of commencing treatment.
Insertion sites for indwelling devices such as PEG tubes and supra-pubic catheters can provide a focus for infection, and provide a route for MRSA to track along and potentially cause deep infection. Where sites are well-healed they can be treated as 'normal' skin during topical decolonisation for MRSA, and washed using decolonisation solutions. If the insertion site is infected with MRSA and medical advice should be sought as antibiotics may be required.

Use of an appropriate dressing with anti-staphylococcal activity on the site/around the device should also be considered. Advice must be taken from TV and Pharmacy on the compatibility of the dressing to be used and the material the device is made from, due to the possibility that some chemical agents may damage indwelling devices and cause them to rupture.

For Infected IV Insertion sites in patients known to have MRSA; Remove line and re-site if access is still required, Swab the site for culture and sensitivity, Dress the site using an appropriate dressing; if the patient has MRSA a dressing with anti-staphylococcal activity should be selected if possible, Document the VIP score of the site, and actions taken including choice of dressing
## MRSA DECOLONISATION REGIMEN

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
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<tbody>
<tr>
<td>Daily shower / bath / bed bath</td>
<td>Chlorhexidine Gluconate 4%</td>
<td>Apply product directly to wetted skin using a disposable cloth. (consider using a chlorhexidine compatible skin cream if skin becomes dry)</td>
<td>For 5 days (longer courses are not more effective)</td>
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<tr>
<td>Wash hair twice during 5 day period</td>
<td>Chlorhexidine Gluconate 4%</td>
<td>Wash hair with product in place of shampoo.</td>
<td></td>
</tr>
<tr>
<td>Nasal clearance</td>
<td>2% Mupirocin cream</td>
<td>Applied to nostrils 3 times a day</td>
<td>For 5 days</td>
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**MRSA bioburden reduction regimen** for Chronic MRSA Patient is the same as above applicable for the whole length of patients stay in the hospital, also consider advice from microbiologist and pharmacist. Where the MRSA strain is resistant to Mupirocin, Chlorhexidine 0.1% and neomycin sulphate 0.5% cream may be used as an alternative.
6.4 **Patient Information:**
It is vital that patients/service users are provided with accurate information verbal and written (RNOH patient guide to MRSA leaflet) about MRSA and what it means for them and their family. Many will have heard about MRSA through the media and may be very worried. Patients/service users should also be given an explanation of how MRSA is transmitted, the rationale for isolation (if applicable) and why there are variations in the control measures required depending on the associated risk setting and level of contact.

6.5 **Prevention and Control of the spread of MRSA:**
Safe, effective, prompts detection and management of patients with MRSA requires strict adherence to standard infection control precautions and aseptic procedures necessary to reduce the risk of transmission of MRSA to other patients and to vulnerable body sites on the same patient. It is important to note that control measures should not compromise usual standards of care, discharge or delay for urgent specialist care or clinical investigations. Some of the prevention and control measures include;

- **Effective hand hygiene**- adherence to the ‘5 moments’ for hand hygiene Hands must be decontaminated by either washing with liquid soap and water and then applying an alcohol rub or washing with a hand disinfectant in theatres (refer to Trust hand hygiene policy)

- **Appropriate use of personal protective equipment (PPE)** e.g. gloves and aprons. Gloves must be worn for contact with colonised/infected body sites e.g. wounds, gastrostomy sites. Aprons must be worn to protect clothing when bed making and providing direct patient care to infected/colonised patients. After contact with the patient or patient
environment, gloves and apron must be removed whilst in the room, disposed of in the clinical waste bin and hands decontaminated before leaving the room.

- **Environmental cleaning** - Maintaining a clean environment to minimise dust accumulation. Through frequent and thorough cleaning, whether the patient is nursed in a single room or in an open ward area. Frequency of routine cleaning may need to be increased, particularly if the patient has an exfoliating skin condition. Isolation rooms and bed spaces in bays must be terminally cleaned on discharge in accordance with the terminal cleaning procedure.

- **Decontamination of shared equipment between patient uses.**

- **Careful handling of used linen to reduce dispersal of skin squames** (red alginate bag required for disposal of linen from infectious patients)

- **Source isolation with contact precautions applicable to in-patient depending on care facility, patient’s condition (e.g. psychological and rehabilitation needs) and risk assessment of contact with vulnerable or immunocompromised patients.** Where source isolation in a single room cannot be provided either because a single room is not available or a higher risk condition is needed for isolation or multiple patients MRSA, then the patient can be barrier cohort nursed in a corner bed of multi-bed space neared to hand hygiene facilities, PPE with curtain kept closed and contact isolation poster in place.

- **Antimicrobial Prescribing/stewardship – Compliance with the Trust’s Antimicrobial policy /Prescribing Guidelines is essential for effective prevention and control of MRSA.** Key factors include avoidance of unnecessary antibiotic prescription to reduce selection pressure for resistant organisms, prescription of appropriate antimicrobial therapy or surgical prophylaxis when indicated. Nursing staff are responsible for ensuring prescribed antimicrobial agents are given to the right patient at the correct time, correct dosage and duration, this includes topical decolonisation agents. Antimicrobial prescribing will be audited in accordance with the Antimicrobial Policy and reported via the agreed governance structure.
6.6 Surveillance:
Surveillance will be performed by the IPCT in order to monitor MRSA screening compliance, trends in MRSA and to optimise prevention and control measures. Cases of MRSA colonisation and infection will be monitored and investigated.

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

The bi-annual Audit compliance with MRSA screening of elective and emergency admissions will be done by the IPCT, monitored and feedbacks to Divisional leads/ ward Management through the infection control Committee and other governance arrangements.

6.7 Post Infection Review Tool (previously Root Cause Analysis)

- MRSA bacteraemia will be investigated via the Post Infection Review Tool /Root Cause Analysis.

- The IPCT will report any MRSA bacteraemia to the Public Health England (PHE) via the HCAI data capture system within the specified deadline.

- Clinical and Management Teams are responsible for ensuring review of each clinical case of MRSA Bacteraemia and implementation of local action plans to improve practice.
6.8 Urgent Transfers

- Patients requiring urgent transfer to RNOH from other centres should be screened as soon as the decision to transfer is made. Results of this screen should be communicated to the receiving ward/department at RNOH prior to transfer or as soon as the result is known. If the patient requires transfer prior to the result being available the patient should be transferred to a single room where possible and the IPCT informed. This will allow the appropriate prioritisation of single rooms within that area and priority can be given to patients already known to be MRSA positive on transfer.

- Transfers to RNOH from other providers with at least two sets of valid (the first set taken no more than 12 weeks ago and the second 3 days before transfer) negative MRSA swabs and one set of negative MRSA swabs taken on admission to RNOH - can be admitted into an open bay. All admissions and transfers without evidence of MRSA screening prior to admission into RNOH must be admitted into a side room or barrier nursed in the bay with contact isolation precaution if side room is not available. If the admission is urgent/ agreed with medical team, patients in this category must all be screened for MRSA immediately on admission using the urgent red swabs.

- The bed manager /receiving areas within RNOH should ask for this information prior to transfer. Transfers must not be unnecessary delayed if the results of this screening are unavailable. Instead, if a result is unknown, these patients must be isolated immediately upon admission until results are known.

- If any patient’s clinical condition is deemed such that isolation would mentally or physically compromise their safety consultation must be made with the IPCT to ensure a full risk assessment is made with infection control advice. Actions/decisions must be documented.
in patient medical notes. The patient must be isolated at the earliest opportunity at RNOH as at when the multidisciplinary team deemed fit and safe to do so.

6.9 Inter-hospital Transfers:
**MRSA** positive patients and patients with unknown MRSA status must be kept in isolation and should not be transferred to another ward or department. If a transfer is unavoidable, the IPCT must be contacted so both the transferring and receiving ward/department can be advised accordingly.

If a patient with MRSA must be transferred within the hospital to another ward or to Theatre, the transferring ward must make the receiving area fully aware of the patient’s MRSA status prior to transfer and this should be documented. In order to facilitate safe care, notification must be given by the referring ward to other departments prior to the patient being transferred (e.g.: X-ray / Theatres/ HDU/Therapies).

If an MRSA positive patient is transferred without the full knowledge of the receiving ward this is an untoward incident and an incident report must be completed in accordance with the Trusts Incident Reporting Policy. The IPCT should also be informed.

6.10 Infection control precautions for MRSA Patients
- When attending to a cohort of MRSA positive patients, hands must be decontaminated and gloves and yellow aprons changed between each patient.
- Careful handling of clinical waste and linen.
- Minimise of inter- and intra- ward transfer of patients.
- Maintaining adequate and appropriately skilled nursing mix and other staff levels.
• Adherence to Bare below the elbow policy: Sleeves must be rolled up. Wrist watches and jewellery (except one band ring) removed.

• Only essential staff should enter MRSA patient’s rooms.

• Medical rounds/Therapists / Phlebotomists and Cannulation staff: All should attend non-isolated patients on each ward before isolated patients. Use of dedicated toilet and bathroom to MRSA infected patients or adequate cleaning after infected patients where an ensuite facility is not available.

• It is not necessary for visitors to wear gloves and aprons whilst they are not visiting other patients or giving close direct care but they should be advised to decontaminate their hands before entering and leaving the room.

• Doors of isolation rooms must be kept closed at all times. If the patient is being barrier nursed in a bay curtains must be drawn at all times and the sign clearly displayed so that all staff entering the patients bed space are aware that contact precautions are in place.

• As far as possible, equipment must be dedicated to the MRSA positive patient or cohorted patients in the bay. If equipment is shared between patients it must be decontaminated after each patient use with Clinell Universal wipes (green), in accordance with the manufacturer’s instruction.

• Personal medical equipment, i.e. stethoscopes MUST also be cleaned between patients using Clinell Universal wipes (green). The patient must be given clean sheets, towels and pyjamas at least daily.

• Used linen/laundry must be treated as contaminated and placed in a red bag (alginate bags).
- **MRSA contact screening:** All patients who are contacts of known MRSA patients must be screened. ONE complete set of swabs is needed. This may be by the routine black/blue swabs or PCR (red top swabs) where requested by IPCT.

- **The IPCN must also be made aware and if isolation facilities are limited, the IPCN will make a decision regarding the patient’s placement.**

- **All patients found to be MRSA positive will have this recorded in their Medical and Nursing notes and will also be flagged on ICS. Responsibility for checking for this rests with medical and nursing staff who admit the patient.**

- **All patients will be managed with standard precautions (i.e. handle their blood and body fluids as infected); regardless of patients’ MRSA status. In addition to standard precautions, the patient with MRSA will be managed with contact precautions.**

- **Ensure appropriate personal protective clothing is available outside the room; this must be put on before entering the room if direct patient contact is required.**

- **Documentation:** Ensure the MRSA status of all patients is accurately recorded in the medical and nursing notes, including information on topical decolonisation and specimen results.

- **An MRSA care plan must be implemented from admission for all MRSA patients or once diagnosis is confirmed.**

- **Ensure accurate information on MRSA status including information on topical decolonisation and specimen results, is recorded and communicated to staff in primary and community care upon transfer to another organisation or discharge home.**

- **Daily cleaning if the patient is in a single room, the nurse in charge must ensure that the appropriate cleaning is carried out. The isolation room floor, fixtures and furniture**
must be deep cleaned twice a day by ISS cleaners using 0.1% sodium hypochlorite (1000ppm available chlorine) for example Actichlor Plus ®.

- If the patient is being nursed with barrier precautions in an open bay, the ward area where the patient is present should be cleaned to the highest standard twice daily.

- On discharge nursing staff should advise cleaners when a patient with MRSA has been discharged. The patient’s room must be given a thorough Terminal clean by ISS cleaners with detergent and water and then decontaminated with 0.1% sodium hypochlorite (1000ppm available chlorine) for example Actichlor Plus ®.

- Walls and ceilings must be cleaned where necessary. All hospital furniture (e.g. bedframe, tables) and any dust collecting ledges should be wiped with Actichlor Plus ®. The room should be allowed to dry thoroughly before a new patient is admitted.

- Theatres and Recovery Area (Urgent Deep Cleans in Theatres)

6.11 Diagnostic Investigations and Treatment in other Departments
All patients with MRSA may visit other departments for investigations or treatment provided the department is informed of the patient’s MRSA status in advance.

- MRSA infected patients must be placed last on the list whenever possible.

- It is good practice for therapies department to send for MRSA patients last on their activities list for the day so the area can be deep cleaned at the end of the day.

- Equipment used on the patient including the examination table must be cleaned after use with Clinell universal wipes (green) and allowed to dry completely before further use.
• Personal protective clothing can be used to transfer the patient but hand hygiene must be performed before and after patient contact. Hand hygiene using alcohol gel is sufficient in this situation.

• Seeing an infected patient last on the list in X-ray, scanning or physio room will make it easier for the affected area to be deep cleaned thereafter, in readiness for the following day.

• Instruments and equipment such as writing materials, sphygmomanometers and stethoscopes should be designated for MRSA patients. If this is not possible, such items should be cleaned and disinfected before use on another patient using Clinell universal green wipes.

• In the event of surgery being carried out on a patient who is known to be infected or colonised with MRSA, or on a patient who has come from a closed ward area deemed to be at high risk by the IPCT, all theatre areas with which the patient has had contact must be deep cleaned by theatre staff cleaners with 0.1% sodium hypochlorite (1000ppm available chlorine) for example Actichlor Plus® prior to any further patients being admitted to the area. All equipment in contact with the patient must be cleaned after use with Clinell Universal wipes (green) and allowed to dry completely before further use.

• Restrict the movement of theatre staff between theatres. Theatre clothes (Blues) including hats and masks must be changed after the MRSA positive case has left the theatre and before the next case is started.

• MRSA positive patients may be recovered in recovery units provided contact precautions are adhered to, and all equipment in contact with the patient is cleaned after use with Clinell Universal wipes (green) and allowed to dry completely before further use. Floors, furniture and fixtures must be cleaned with 0.1% sodium
hypochlorite (1000ppm available chlorine) for example Actichlor Plus ® by theatre staff cleaners as per protocol.

- The area can be reused as soon as it is dry, if it is required again within a short time frame, provided 15 minutes elapses between the MRSA patient leaving the theatre and the next patient entering, in conventionally ventilated theatres. This allows sufficient time for adequate air change between patients (Coia et al 2006).

Prior to deep cleaning following an infected MRSA or other infected case, theatre staff should remove all exposed extra items from work top surfaces and shelves and de-clutter the room as much as possible to prevent potential contamination and also to lessen the burden of having to decontaminate extra items.

- Wear protective clothing e.g. disposable gloves and apron.
- Clean patient designated equipment and dry well e.g. anaesthetic machines, diathermy/suction machines, drip stands, monitors, infusion pumps oxygen etc. with Clinell Universal wipes (green).
- Clinical equipment including gratnell trolleys, instrument trolleys, operating tables and attachments must be thoroughly cleaned with Clinell Universal wipes (green).
7. Monitoring and the effectiveness of this policy

This document will be reviewed by the IPCT in the following circumstances; when new national or international guidance is issued, when newly published evidence demonstrates need for a change to current practice.

Infection control link staff will be provided with education sessions about the policy at their meetings.

Compliance to this policy and its effectiveness will be monitored by the infection control team through daily operational activities; incidents reported via safeguard and follow up to laboratory investigation results. Overall reporting of compliance will be via the Infection Control Committee (ICC) and Clinical Quality Commissioning Group (CQCG).
Appendix 1:  Glossary of Terms

IPCC – Infection Prevention and Control Committee

IPCT - Infection Prevention and Control Team

ICLP – Infection Control Link Professional

MRSA - Meticillin- Resistant *Staphylococcus aureus*

MSSA - Meticillin-Sensitive *Staphylococcus aureus*

DH – Department of Health

HCAI – Healthcare Associated Infection

PIR – Post-Infection Review
Appendix 2: Other linked trust policies and guidelines

Hand Hygiene policy

Decontamination policy

Outbreak Management Policy

Infection control Isolation prioritisation Scoring and Transfer policy.

Key References

- *Journal of Hospital Infection*, 63 (supplement 1)
Appendix 3:  MRSA Screening Process

**MRSA Screening Process**

**Elective Admission**
- Must all be screened and status checked. Results must be within last 12 weeks

**Emergency Admission**
- Must have a Red (PCR) set of swabs with request form* plus normal black MRSA set of swabs taken
- Must be admitted into a side room until results are available

**Transfer from other Healthcare provider**
- Must have 1 set of swabs in last 3 weeks
- 1 set taken within 24hrs of transfer (PCR)*
- 1 set taken immediately on admission

- Negative Result
  - Can be moved to open ward
  - If result is unavailable – swab patient and await results whilst:
    - Treat as positive
    - Admit to side room
    - If surgery is urgent surgical prophylaxis should be used
    - Last on theatre list

- Results available
  - Patient can be moved to open ward if negative
  - Surgical prophylaxis should cover MRSA (i.e. teicoplanin) see MRSA policy
  - Place last on theatre list
  - Ensure cleaning protocol followed
  - Treat as positive

- Results unavailable but surgery is urgent
  - Surgical prophylaxis should cover MRSA (i.e. teicoplanin) see MRSA policy
  - Place last on theatre list
  - Ensure cleaning protocol followed
  - Treat as positive

**Positive patients**
- Must be admitted to a side room with contact precautions in place
- Must have suppression/decolonisation treatment (see MRSA policy)
- Must have 3 sets of clear swabs, the first one taken 48 hrs after decolonisation treatment. Each set 1 week apart.
- If surgery is deemed urgent, consultant can treat the patient with the appropriate antibiotics (see MRSA policy)
- Patients will need to be last on the theatre list and cleaning protocol followed

**Negative patients**
- Admit patient as usual.
- Document results

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1 set of swabs =
- Nose
- Groin
- Sputum if productive
- Wounds
- Abrasions
- Exfoliating skin
- Urine if catheterised

* All red pcr swabs must have an accompanying request form with reasons for rapid pcr request and clinical details.
Patient Screened for MRSA

Negative result

- IPCT: Inform patient by letter
- IPCT: Inform Consultant by letter
- IPCT: Add alert to ICS

Positive result

Microbiology sends result to IPCT

Result picked up by IPCT

IPCT:
- Inform GP by letter and send instructions for decolonisation regime
- Recommend patient be re-swabbed 48 hours after decolonisation
- Decolonisation treatment can be repeated twice
- Explain how to communicate with RNOH when patient has 3 clear swabs or needs to be treated despite positive status.

Patient remains MRSA positive

- GP informs IPCT
- IPCT Communicate with Consultant
  If surgeon is happy to proceed; patient rescheduled for surgery.

Patient has 3 clear swabs

- GP informs IPCT
- IPCT informs, Bed Manager & Consultant
- Patient scheduled for surgery
- Patient remains flagged on ICS as MRSC for 16 weeks and requires rescreening after 16 weeks in which the MRSAC flag would have expired.
20th September 2018
PRIVATE & CONFIDENTIAL

Mr ............
Consultant
Speciality
RNOHT
Stanmore

Dear Mr ...............,

Re: Patient Name (7xxxxx5)

The above patient was screened for Methicillin Resistant Staphylococcus Aureus (MRSA) whilst at the RNOH. This patient is identified as having MRSA isolated from a routine swab.

I have informed their GP via letter asking them to contact the patient. The GP was asked to prescribe a topical eradication protocol consisting of:
Chlorhexidine 4% body wash – shower / bath once a day for 5 days
Mupirocin 2% Nasal Ointment – apply to the anterior nares 3 times a day for 5 days.

The patient will need three sets of clear swabs from the nose and groin, 7 days apart following treatment otherwise they may have to be admitted as an Infected patient and receive treatment accordingly.

Yours sincerely,

Lead Infection Control Nurse
(Tel) 0208 909 5625
(Fax) 0208 909 5369
MRSA Letter to Patients GP

Date ………
PRIVATE AND CONFIDENTIAL

Dr. ………………..
Grove House Surgery
Albert
St. Werburgh Med. Practice
Bells Lane

Dear Dr ……………..

A patient from your practice, ………………… with date of birth xx/xx/xxxx attended the Royal National Orthopaedic Hospital for an outpatient appointment.

This patient was screened for Methicillin Resistant Staphylococcus Aureus (MRSA), in line with the Department of Health guidelines. This patient was found to have MRSA isolated from a screening swab.

The patient requires a topical eradication protocol for five days. The protocol comprises of:

1. Chlorhexidine 4% Body wash – shower / bath daily for 5 days.
2. Mupirocin 2% Nasal Ointment to be applied to each nostril, 3 times a day for 5 days.

Thereafter, please arrange to re-swab this patient 2 days after the protocol has ended. We will require three sets of clear swabs from the nose and groin, 7 days apart; and, these results must be received by the Infection Control Office. Failure to forward these results may affect the patients’ treatment date.

This patient’s consultant at the RNOH is aware of this result.

Yours sincerely,

Lead Infection Control Nurse
(Tel) 0208 909 5625
(Fax) 0208 909 5369
Date ……..

Private and Confidential

Parent /Guardian of:
Miss…………………………
Flat 10, ………………….
…………………………
London
N1 ……………………..

Dear Parent/Guardian,

……..patient Name) recently attended the RNOH, where she was routinely swabbed for Methicillin Resistant Staphylococcus Aureus (MRSA) and unfortunately had a positive result isolated from a routine swab.

We have notified your GP who will be contacting you in order to commence antibiotic treatment. If you do not hear from your GP please contact the Practice to arrange an appointment and discuss any concerns you may have.

Following your treatment please advise me of the results on the number below.

Please can you ensure your GP forwards copies of your MRSA result following treatment to the Infection Control Team at the above address to ensure your operation date is not affected.

We have also advised your Consultant, ……..Consultants Name.

Yours sincerely,

Lead Infection Control Nurse
(Tel) 0208 909 5625
(Fax) 0208 909 5369
Date ………
PRIVATE AND CONFIDENTIAL

Ms …….Patient name
86 ………. Road
London
E1…………..

Dear Ms …………,

You recently attended the RNOH, where you were routinely swabbed for Methicillin Resistant Staphylococcus Aureus (MRSA) and unfortunately had a positive result isolated from a routine swab.

We have notified your GP who will be contacting you in order to prescribe a topical eradication protocol. If you do not hear from your GP please contact the Practice to arrange an appointment and discuss any concerns you may have.

We have also advised your Consultant, …….Consultants Name.

Yours sincerely,

Lead Infection Control Nurse
(Tel) 0208 909 5625
(Fax) 0208 909 5369
This policy is available on request in large print and alternative languages. It is a manager’s responsibility to ensure employees are aware of these options.

* The following policies must be sent for review to the Local Counter Fraud Specialist:

- Fraud and Bribery
- Standard Financial Instructions
- Declaration of Interests
- Gifts and Hospitality
- Whistleblowing
- Disciplinary
- IT
- Anti-Money Laundering
- Managing Sickness Absence
- Secondary Employment
- Expenses
- Overpayment
- Financial Redress
- TOIL (Time off in Lieu)
- Code of Conduct/Standards of Business Conduct
- Data Protection
- Lone Worker
- Patient Transport
- Commercial Sponsorship
- Overseas Visitors
- Disclosure