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## MRSA Policy (including MRSA Screening Policy)

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1. Introductions and aims of policy

Policy Statement

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.

Scope

This document applies to all staff employed by or contracted to the Royal National Orthopaedic Hospital.

This 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 that should be taken 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.

Purpose of this Policy

Summary

This is an over-arching RNOH Trust Policy on the detection and management of MRSA infection and colonisation.

The responsibility for this Trust Policy rests with the Infection Prevention & Control Lead Nurse, and the Director of Infection Prevention and Control.

Objectives / success factors

The objectives of this policy are:

To protect patients, staff and the general public from exposure to Meticillin-Resistant Staphylococcus aureus (MRSA) by preventing cross-infection and also preventing contamination of the environment.
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.

- To minimise the transmission of MRSA within RNOH.
- To protect patients from infection or colonisation with MRSA.
- To ensure that patients who are colonised or infected with MRSA are managed appropriately, and receive adequate information about their condition.

Purpose

To ensure all staff employed by or contracted to RNOH provide a high quality service towards diagnosis, treatment and care for patients with MRSA, and to additionally comply with Department of Health requirements in relation to MRSA management.

INTRODUCTION

*Staphylococcus aureus* (*S. 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. All elective patients will be screened for MRSA pre-operatively and all emergency admissions will be screened on admission to RNOH.

2. Breach of Policy and Responsibilities of staff

- **All staff working on Trust premises, including Trust employed staff, contractors’ staff, agency and locum staff** are responsible for adhering to this policy, and for reporting breaches of this policy to the person in charge and to their line manager.

- **Ward and Department Managers** are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles at all times.
- **Consultant Medical Staff** are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles contained in it at all times.

- **Clinical Service Managers** are responsible for monitoring implementation of this policy, and for ensuring action is taken when staff fail to comply with the policy.

- **Bed Managers / Bleep Holders** are responsible for ensuring patients are placed in accordance with this policy, and for escalating any situations where safe placement cannot be achieved.

- **On-call Managers and the On-call Executives** are responsible for providing senior and executive leadership to ensure implementation of this policy, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

- **The Infection Prevention and Control Team (IPCT)** is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required. They are also responsible for ensuring this policy remains consistent with the evidence base for safe practice, and for reviewing the policy on a regular basis.

### 3. Success Indicators

Success indicators are a list of the key performance indicators that can be measured and monitored to ensure a policy is being complied with. These success indicators should be audited regularly and feedback reports provided to the local group responsible for approving the policy.

The Infection Control Committee will be responsible for monitoring the effectiveness of this policy and associated policies and procedures for reducing healthcare associated infection (HCAI). Auditing of this policy will be used as evidence of NHSLA and CQC requirements.

They will do this in a variety of ways including:
4. Principles and Standards

Safe, effective and prompt detection and management of patients with MRSA requires adherence to the following principles and standards.

**Limiting Mode of Transmission through effective hand hygiene**

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

**Antimicrobial Prescribing**

Avoid unnecessary antibiotic prescribing to reduce selection pressure for resistant organisms including MRSA.

- Reduce the use of broad spectrum antibiotics to reduce emergence of multiply resistant organisms.
Consider the risk of MRSA as a potential pathogen and prescribe appropriate antimicrobial therapy or surgical prophylaxis when indicated.

Limit the use of glycopeptide antibiotics to reduce development of resistant organisms.

Compliance with the Trust’s Antimicrobial Prescribing Guidelines.

Adherence to antimicrobial prescribing guidelines will be monitored by ward pharmacists and Antimicrobial pharmacist and non-adherence referred to IPCT and Medical Director or more urgently to a medical microbiologist if required.

Guidelines for surgical prophylaxis must include recommended choice of agents and regimens for patients at high-risk of MRSA colonisation or infection or known to be colonised or infected with MRSA (see Antibiotic prescribing guidelines).

The guidelines must be audited twice annually by pharmacy to demonstrate effective prescribing patterns. Responsibility for this rests with the Antimicrobial pharmacist.

All consultant medical staff are responsible for ensuring appropriate antimicrobial prescribing by their junior staff. This includes ensuring courses of antimicrobial agents are prescribed for the correct duration and dosage and this includes topical decolonisation agents.

Nursing staff are responsible for ensuring prescribed antimicrobial agents are given at the correct time and the correct dosage. This includes topical decolonisation agents.

5. Surveillance of MRSA

Surveillance will be performed by the IPCT in order to monitor 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.

Post Infection Review Tool (previously Root Cause Analysis)

MRSA bacteraemia will be investigated via the Post Infection Review Tool (previously known as Root Cause Analysis).
The IPCT will report any MRSA bacteraemia to the HPA 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.

MRSA surveillance data will be reported to and reviewed by the Infection Control Committee via Governance arrangements.

6. MRSA Screening

The following outlines the different groups of patients who require screening for MRSA:

- All patients admitted as elective admissions, including day cases.
- All emergency admissions or transfers into the Trust.

See Appendix 1 for screening protocol, Appendix 2 for actions following screening.

- Screening is valid for a period of 12 weeks.
- Screen patients by taking specimens from the correct sites (i.e. nose, groin, sputum if productive, wounds, abrasions, exfoliating skin, urine if catheterised), and labelling them correctly. See Appendix 3 for detailed list of sites for MRSA screening.
- Screen patients prior to transfer to other Healthcare providers if required.
- ITU patients should be screened for MRSA weekly in order to monitor acquisition.
- See Appendix 4 for management of patients with MRSA in wounds and invasive devices.
- Patients with MRSA will need to be placed in a single room with Contact Precautions in place. See Appendix 5 for Source Isolation and Contact Precautions
- If a patient is found to be MRSA positive at pre-assessment unit and is undergoing orthopaedic surgery then the points below should be actioned:
  1. An attempt should be made to suppress/ decolonise the patient prior to their operation (See Appendix 6 for decolonisation regimen)
2. The patient, GP and consultant should be informed of the result by the IPCT as soon as the result is available (See Appendix 7 for MRSA letters to patient, GP consultant.)

3. The GP should be asked to prescribe the skin suppression/decolonisation regimen (See Appendix 7 for letter to GP) and thereafter send three clear MRSA swabs to the IPCT following treatment.

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.

7. 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 area 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 if side room is not available and admission is urgent/agreed with medical team. Patients in this category must all be screened immediately on admission.

- Receiving areas within RNOH should ask for this information prior to transfer.

- Transfers must not be 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.

- Patients who are urgent transfers must be admitted into a side room and be screened on admission to RNOH. If there are no side rooms available and the admission is urgent, the patient should be admitted to a bay for barrier nursing with strict contact precautions in place and transferred to a side room as soon as one becomes available.

- Action to take if patient’s medical condition is compromised
• 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 deemed fit and safe to do so by the multidisciplinary team.

Inter-hospital Transfers (also see appendix 1-3 – MRSA screening)

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.

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.

Inpatients (also applies to patients known to be MRSA colonised on admission)

Patients with MRSA should be nursed in a single room or cohorted with other patients colonised with MRSA on the ward. A Contact Precautions sign must be placed outside the single room/cubicle door.

When MRSA is isolated in an in-patient for the first time, the ward will be contacted by either the Royal Free Hospital Microbiologist or an Infection Prevention and Control Nurse (IPCN).

The patient’s Electronic Patient Record (ICS) will be labelled 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 ICN can be contacted if further advice is required. The suppression/decolonisation protocol must be commenced immediately (see appendix 6).

Side room priority must be given to patients more likely to disseminate MRSA e.g. patients with wounds or with central lines in situ. A contact precautions sign must be displayed on the door of the side room or bay.

Gloves and yellow plastic aprons must be worn by all staff for any patient contact.

Hands must be decontaminated prior to donning gloves and disposable plastic apron.
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.

When attending to a cohort of MRSA positive patients, hands must be decontaminated and gloves and yellow aprons changed between each patient.

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).

8. MRSA Decolonisation

Prescribe and administer MRSA topical suppression/decolonisation therapy correctly in line with policy. See Appendix 6

Ensure all patients who are identified as MRSA positive prior to procedures receive appropriate suppression/decolonisation; either to eradicate MRSA or to reduce the bioburden and therefore risk of infection across the healthcare community.

Patients who cannot be decolonised after 2 attempts and chronic carriers of MRSA may be admitted for surgery if their consultant is happy to proceed. They 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 and 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.
All patients found to be MRSA positive will be prescribed topical decolonisation in an attempt to eradicate MRSA, and reduce the subsequent risk of infection.

Following suppression/decolonisation a set of MRSA, screening swabs should be taken 48 hours after completion of the suppression regimen and then a further two screens should be taken a week apart. 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).

Once a patient has 3 clear **complete sets** of screens, each set 1 week apart, isolation may be discontinued in liaison with the IPC team.

Successful decolonisation is unlikely in patients with chronic wounds, permanent tracheostomy, and long-term indwelling devices. Where these risk-factors for long term carriage are present the patient should be managed immediately as listed below:

If it is impossible to clear a patient of MRSA prior to admission for surgery, if they have already had multiple decolonisation attempts previously, or if they have other factors which make successful decolonisation unlikely i.e. they are a permanent resident in a care home, bioburden suppression / decolonisation should be commenced precisely 4 days prior to their date of surgery. (See Appendix 8 for patient information for decolonisation therapy) The patient should undergo surgery on the 5th day (under Teicoplanin prophylaxis). Further advice regarding safe use of antimicrobials must be sought from the consultant Microbiologists via switch board.

**The patient must be managed as MRSA positive for their whole length of stay at RNOH.**

A Red MRSC flag will appear adjacent to the MRSA flag for all patients with recent clear swabs for a period of 12 weeks

**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 PCR (red top swabs) where requested by IPCT.

9. **Isolation Care**

**Isolation Care** (See Appendix 5)

All MRSA positive patients and those whose status is unknown (emergency admissions/ transfers) will require isolation in a single room.

The IPCN must also be made aware and if isolation facilities are limited, the IPCN will make a decision regarding the patient’s placement. If there are no isolation rooms available the patient may be nursed in a bay with strict contact precautions in place.
The curtains will need to be drawn and a sign placed on the outside of the curtains that is clearly visible.

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 the Contact Precautions sign is placed on the door outside the room and keep the door closed.

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.

Where single room isolation cannot be achieved and there is more than 1 patient with confirmed MRSA an MRSA cohort bay may be established. This will only take place under the strict guidance of the Infection Prevention and Control Team.

**10. 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 (appendix 10)

Notification must be given by the referring ward to other departments prior to the patient being transferred (e.g.: X-ray / Theatres/ HDU/Therapies).

**11. Communication and Patient Information**

Provide patients and visitors with accurate information on MRSA, including the risk of infection and management of those who are positive. Every patient who is screened positive for MRSA should be given a patient MRSA leaflet.

Ensure accurate information on MRSA status is recorded and communicated to other wards and departments within RNOH in order to facilitate safe care.

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.
Ensure the patients’ MRSA status is communicated clearly for inter-departmental transfer.

The patients’ MRSA status must be well documented within the admission/discharge documentation book.

12. 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.
- Though standard precautions are adequate in most departments for most investigations, it is important to inform other departments that they will need to use contact precautions in addition. This information will allow staff in these departments to call the patient in a timely manner and to take appropriate additional contact precautions and clean the area appropriately after the procedure.
- 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.
- Patients undergoing invasive procedures in X-ray or Scanning department must be treated as indicated in 7.8.

13. Control Measures for MRSA

Basic infection Control Measures

- Strict compliance with hand washing procedures.
• Wearing of appropriate personal protective equipment e.g. yellow aprons and gloves
• Rational use of antibiotics (see RNOH Antimicrobial Policy)
• High standard of aseptic technique
• High standard of ward cleaning.
• Careful handling of clinical waste and linen.
• Minimise of inter- and intra- ward transfer of patients.
• Maintaining adequate and appropriately skilled nursing 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.
• Doors to isolation rooms should remain closed, with contact isolation information card displayed clearly on the door.
• 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.

Hand washing

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).

Hand washing should be performed:
- Before entering an isolation room
- Before and after contact with the patient
- Before clean/aseptic procedure
- After contact with potentially infected materials

If gloves have been worn, hand washing must be performed following removal of the gloves.

Disposal of waste

All infected waste should be disposed of into a clinical waste bin.

Linen

All linen should be placed in the appropriate bag for infected linen and returned to the laundry. Curtains adjacent to MRSA positive patients and visibly contaminated curtains should be sent to the laundry.

Instruments or equipment

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.
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.

Cleaning 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.

14. Theatres and Recovery Area (Urgent Deep Cleans in Theatres)

**MRSA positive patients should be placed last on the operating theatre list wherever possible.**

- 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).

**Theatre staff responsibilities prior to deep clean**

- Prior to infected or colonised patient’s surgery, 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).

**Domestic staff deep clean responsibilities**

- Report to the nurse in charge before entering the theatre/area and ensure all the removable disposable equipment has been removed.
- Domestic staff will not carry out a deep clean unless the area has been prepared by the theatre staff.
- Wear appropriate protective clothing e.g. clean disposable gloves & apron and theatre boots.
- Clean all flat areas with a 0.1% sodium hypochlorite (1000ppm available chlorine) for example Actichlor Plus ® working from highest point to lowest point using disposable paper towels and dry well.
- Clean all areas according to the Deep Clean programme.
- On completion of a deep clean, remove protective clothing and place in a yellow clinical waste bag and wash and dry hands thoroughly.

**15. Communication and Patient Information**

This is the responsibility of the medical and nursing team admitting or providing care for the patient. Please contact the Infection Prevention and Control Nurse if information is required.

- MRSA Information leaflets are available in each ward.
- See Appendix 8 for information leaflet regarding decolonisation therapy.
16. MRSA positive patients on ICS

All MRSA positive patients will be flagged as red on ICS by Infection Control. The flag will not be removed if patients happen to be MRSA negative following decolonisation treatment but they can be removed from isolation following three sets of negative MRSA swabs, each set taken one week apart.

**A Red MRSC flag will appear adjacent to the MRSA flag for all patients with recent clear swabs for a period of 12 weeks**

Patients who have never had MRSA and who have had clear swabs prior to admission will show as MRSN on ICS.

17. Staff and MRSA

Where there are concerns about MRSA in staff, these will be handled by the Occupational Health Department, in strict confidence.

**Routine Staff Screening for MRSA**

Screening of staff is not currently undertaken as a matter of routine in line with national guidance, although following advice from the consultant microbiologist groups of staff may be required to be screened based on clinical evidence and risk. This confidential screening is undertaken through occupational health.

18. Communication and Education Plan for this document

**Communication and Dissemination Plan**

This policy will be placed in the Policies and Procedures under the Infection Prevention and Control section of the RNOH Intranet, and public websites in order that the information contained within it is available to primary and community care providers, patients and the public.

This policy will be launched with communication via the Intranet, and an email alert.

19. Education and Support Plan

Education sessions will be provided by the Infection Prevention and Control Team via the Mandatory training process, and these will be available for all Trust staff.

Infection control link staff will be provided with education sessions about the policy at their meetings.
20. Review plan for this document

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.
- Every 3 years routinely.

21. Key References


www.clean-safe-care.nhs.uk/emergency admissions_MRSA screening pathway
Appendix 1: 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

**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**
- Admit to side room.
- If surgery is urgent surgical prophylaxis should be used.
- Last on theatre list.

**Negative Result**
- Can be moved to open ward.

**Positive Result or not available**
- 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

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.
Appendix 2:  Actions to be taken following MRSA Screening

**Patient Screened**

- **Negative result**
  - Inform patient by letter
  - Inform Consultant by letter
  - Add alert to ICS

- **Positive result**
  - Microbiology sends result to IPCT

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

  - 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 12 weeks ns to MMMMRSA after 12 weeks.
Appendix 3: MRSA Screening sites

Staff must ensure correct specimens are requested for MRSA screening, as listed below.

A negative result is considered active for a period of no more than 12 weeks

Specimens to be taken:

1. **Nose:** All patients as listed in policy: one swab used in both anterior nares (fleshy part of the nose).
2. **Groin:** All patients as listed in policy: one swab used
3. **Skin Lesions and/or Wounds:** one swab from each site; clearly identifying sites.
4. **Insertion sites for devices in-situ at time of screening** ie. PEG sites, tracheostomy.
5. **CSU:** A catheter specimen of urine should be taken from patients who have catheters in situ at the time of screening. This must be taken using correct technique, not from the bag.
6. **Any other site that has been previously positive** if the patient has had MRSA previously, i.e. stoma / wound.

Laboratory request forms should be completed and clinical details should clearly state ‘Pre-Admission Screen.’ Specimens must be correctly labelled with patient details. The laboratory will reject unlabelled specimens. Clinical details must include current antibiotic therapy

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

**Routine monitoring for MRSA throughout admission**

All patients **not known** to be MRSA positive in ITU/HDU will be screened weekly for MRSA acquisition, in line with national guidance (DH Saving Lives 2006). Each of these patients will have a weekly screen, to include nose, groin, lines sites (note: wounds, sputum, and CSU to be sent if clinically indicated for M, C&S). These swabs to be labelled ‘MRSA weekly screening’.

**Contact Screening**

A single contact screen for patients exposed to someone found to have MRSA will be performed in all areas of the hospital. Contact screening will also not be performed in very high risk area who are sending weekly screen already, unless advised by the IPCT (i.e. during an outbreak). Results must be recorded in the notes, and the patient informed if the result is positive.
Appendix 4: Management of MRSA in wounds and invasive device insertion sites

The Following options should be reviewed for each of the specific issues listed:

1. **Chronic Wounds, such as leg ulcers**

Consider use of wound dressings that have good anti-staphylococcal activity: options include:

Follow advice by Tissue Viability /Pharmacy

The wound and product should be reviewed weekly to ensure wound healing is taking place.

Tissue Viability advice should be sought in situations where the wound does not improve within 2 weeks of commencing treatment.

2. **Wounds healing by Primary Intention, but infected with MRSA**

In general there should be no need to select a specific dressing to tackle MRSA in wounds healing by primary intention although honey dressings should be used as first line if they can be tolerated.

The wound should be monitored regularly, and if there is evidence of cellulitis, further wound breakdown, or delayed healing advice should be sought from TVN

Written advice on treatment is available within the Antimicrobial Policy

3. **PEG sites, Suprapubic catheter sites**

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, 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.
4. **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.

5. **Tracheostomy sites**

Once the exposed edges of a permanent/long tracheostomy site is ‘healed’ it should be carefully cleaned daily as part of normal hygiene of the stoma.

There is nil else that can be specifically done to reduce MRSA colonisation from this site which is a well described potential complication of tracheostomy sites.
Appendix 5: Source Isolation and Contact Precautions

Rationale for source isolation

Source isolation refers to the physical isolation of patients with infections, or colonisation with some resistant micro-organisms including MRSA. It indicates the patient is the “source” of infection. It is designed to prevent the transmission of pathogens from an infected/colonized patient to other patients, hospital personnel and visitors. Patients with MRSA need to have contact precautions in place as MRSA is transmitted through contact.

Mode of Transmission of MRSA

Contact transmission is the most important and frequent mode of transmission and involves either direct person-to-person contact or indirect contact via a contaminated intermediate object.

Droplet transmission occurs rarely with MRSA. If patient has MRSA colonisation of their sputum and has a productive cough, droplets are generated mainly during coughing, sneezing or open suction procedures. These droplets are propelled a short distance only; hence special ventilation is not required to prevent transmission. However, if these patients are nursed in close proximity to other patients, transmission of MRSA may occur and under these circumstances patients should be isolated where possible.

Isolation Facilities

Source isolation can be achieved by placing patients in:

- **Single rooms** on general wards, preferably with ensuite facilities.
- **Isolation Units** with negative pressure isolation rooms
- **COHORT**: When single rooms/isolation rooms are not available and where several patients with the same confirmed organism have been identified, these patients may be placed together in a bay/ward: this includes patients with MRSA.

Isolation precaution signage must be clearly displayed on the isolation room door.

The door must be kept shut.

Hand Hygiene

Hand hygiene is essential before an aseptic procedure; after any potential or actual contact with bodily fluids and after clinical contact with the patient or their environment, and before and after wearing gloves and other protective clothing. This complies with the World Health Organisation Guidelines (5 moments of hand hygiene and the NPSA Clean your Hands Campaign.)
Use of Protective Clothing

The use of protective clothing is an important principle of isolation care to prevent transmission of MRSA (yellow aprons and gloves for confirmed cases and those patients whose status is unknown). Hand gel must be available at the patients bed space at all times.

Transmission-based contact precautions, in addition to standard precautions, should be implemented for patients in source isolation. The choice and use of protective clothing should be based on how pathogens are spread in order to minimise that spread to both other patients and the healthcare worker, the following is required for MRSA source isolation.

<table>
<thead>
<tr>
<th>MRSA</th>
<th>Gloves</th>
<th>Apron/Gown</th>
<th>Mask Eye Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard and Contact precautions required</td>
<td>By staff on entering the room if contact with the patient or their environment is anticipated</td>
<td>By staff on entering the room if contact with the patient or their environment is anticipated. Not by visitors.</td>
<td>Only required as part of standard precautions: during procedures likely to cause contamination/aerosols of body fluids.</td>
</tr>
</tbody>
</table>
Appendix 6: Prescribing of topical decolonisation for eradication or suppression of MRSA

**MRSA DECOLONISATION REGIMEN**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
</tr>
</thead>
<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>
</tr>
<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>Mupirocin cream 2%</td>
<td>Applied to nostrils 3 times a day</td>
<td>For 5 days or stop sooner if found to be MRSA negative</td>
</tr>
</tbody>
</table>

**Prescribing of topical agents to reduce the level of MRSA during procedures (bioburden reduction).**

When eradication of MRSA cannot be achieved, the following regime should be commenced precisely 4 days prior to their date of surgery. The patient should undergo surgery on the 5th day (under Teicoplanin prophylaxis). The patient must continue to use the Chlorhexidine wash for the entire length of their stay but the Mupirocin topical treatment is not required.

**MRSA BIOBURDEN REDUCTION REGIMEN**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily shower / bath / blanket 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 length of stay</td>
</tr>
<tr>
<td>Wash hair twice during 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>Mupirocin cream 2%</td>
<td>Applied to nostrils 3 times a day</td>
<td>For 5 days</td>
</tr>
</tbody>
</table>

Where the MRSA strain is resistant to Mupirocin, Chlorhexidine 0.1% and neomycin sulphate 0.5% cream may be used as an alternative.
Appendix 7: MRSA letter to Patient’s GP

MRSA letter to Patient’s GP

Date:
PRIVATE AND CONFIDENTIAL

Dr. A

Dear Dr A

A patient from your practice, Ms C, ------DOB : attended the Royal National Orthopaedic Hospital for an outpatient appointment.

This patient was screened for MRSA, in line with the Department of Health guidelines. This patient was found to have MRSA isolated from a nose and groin 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, 1 week apart ; these must be received by the Infection Control Office. Failure to forward these results may affect the patients' future treatment/operation date.

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

Yours sincerely

Lead Infection Control Nurse
Infection Control Department
(Tel) 0208 909 5625
(Fax) 0208 909 5369
MRSA Letter to Patient

Date:

Private and Confidential

Ms N.

Dear Ms N

You recently attended the RNOH, where you were routinely swabbed for MRSA and unfortunately had a positive result isolated from a nose and groin 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 using below contact to ensure your treatment /operation date is not affected.

We have also advised your Consultant, Mr C.

Yours sincerely

Lead Infection Control Nurse
Infection Control Department
(Tel) 0208 909 5625
(Fax) 0208 909 5369
MRSA Letter to Patient’s Consultant

PRIVATE & CONFIDENTIAL

DATE
Mr
RNOHT
Stanmore

Dear Mr

Re: NG (hospital number)

The above patient was screened for MRSA whilst at the RNOH on DATE. This patient is identified as having MRSA isolated from a nose and groin 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 following treatment otherwise they may have to be admitted as an Infected patient and receive treatment accordingly.

Yours sincerely

Lead Infection Control Nurse
Infection Control Department
(Tel) 0208 909 5625
(Fax) 0208 909 5369
Appendix 8: Pre-operative assessment clinic protocol for decolonisation

Treatment of MRSA colonisation - Information

**Nasal carriage:**
The most effective topical treatment for the eradication of nasal carriage is Mupirocin which should be applied as described below to the anterior nares three times daily for 5 days

**Wash hands thoroughly** then remove the cap

- With gloved fingers or a cotton wool bud apply a ‘match head’ size of ointment to the inner side of both nostrils
- Press the nostrils together and gently massage for approximately one minute to distribute the ointment evenly throughout the inside of the nostrils
- Wash hands and replace the cap back on the tube

**Intact Skin:**
Skin adjacent to carriage sites is frequently contaminated with *S. aureus*, which may be spread into the environment on skin scales. Washing the skin and hair with an antiseptic detergent may reduce the Staphylococcal load.

**Instructions for use:**
- The skin should be **wet** first which will reduce the risk of sensitivity reactions
- Whilst the patient is bathing or showering the Chlorhexidine (Hydrex) should be applied **neat and directly to the skin without diluting**. If the patient is bathing, Chlorhexidine should **not** be applied to the bath water alone. Equally, if the patient is being bed-bathed by the nursing staff, the Chlorhexidine should be applied neat onto a disposable washing cloth – not into a bowl of water as this is less effective at removing the Staphylococci
• Pay particular attention to moist areas of skin such as the perineum, axilla, groin and any other original positive sites
• Rinse off the Chlorhexidine thoroughly
• Wash hair twice (during the five days) with Chlorhexidine. Ordinary shampoo and conditioner can be used afterwards

After 5 days, stop the treatment, wait for 2 days and arrange to have your swabs taken on the 7th day.

The patient should be made aware to report skin sensitivity reactions to their GP / Practice Nurse / District Nurse.
Appendix 9: Intensive therapy unit / critical care

Admissions

All patients with a known infectious or transmissible organism will have effective infection control measures put in place. A risk assessment may also be needed to prioritise the use of isolation facilities for patients with the most virulent or transmissible organisms first. It is understood that there are limited isolation facilities and sometimes clinical need means that isolation of patients with infectious/transmissible organisms may not occur. A risk assessment should be performed and documented by the critical care unit in these cases.

All MRSA positive patients leaving the unit transfer to isolation side rooms.

ITU MRSA Screening and topical decolonization programme - This protocol applies to ITU only

Screen all patients on admission to ITU for MRSA. (Nose, perineum, CSU, wounds, and IV cannula sites and sputum / endotracheal aspirate.)
Isolate known positive MRSA patients. Initiate decolonization regimen for MRSA positive patients

Mupirocin in paraffin base t.d.s. to both nostrils. (Chlorhexidine 0.1% and neomycin sulphate 0.5% cream used if isolate is resistant to Mupirocin or if it is unavailable)

Chlorhexidine mouthwash 0.2% q.d.s applied as mouth care using pink sponges from oral care pack

Chlorhexidine 4% skin cleanser. Apply to wash cloth and use daily directly as skin wash / bed bath. Do not dilute.

Chlorhexidine 4% skin cleanser used as shampoo every 2-3 days.

Continue protocol for 2 weeks or until patient leaves ITU, whichever is sooner. Following completion of protocol discuss with the Infection Prevention and Control Nurse.

Document reasons for not using protocol.
Appendix 10: MRSA Care Plan

Infection Control Care Plan

Patient Demographic / label

RNOH
Ward:

**Infection Control Care Plan for a patient with MRSA**

Statement: This Care Plan should be used with patients who are suspected of or are known to have MRSA. This Care Plan should be followed to reduce the risk of transmitting MRSA to other patients, staff, carers and visitors. If it is not possible to follow this policy, please notify a member of the IPCT who will carry out a risk assessment on how best to care for this patient.

<table>
<thead>
<tr>
<th>Date</th>
<th>No</th>
<th>Issue/Problem</th>
<th>Action to be taken</th>
<th>Signature</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Accommodation</td>
<td>• Isolate the patient in a single room with <em>en-suite</em> facilities.</td>
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<td></td>
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<td>• Place a contact precautions sign on the door – this will maintain confidentiality but also communicates to staff that contact precautions are necessary</td>
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<td>• If <em>en-suite</em> is not available ensure access to own commode.</td>
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<td></td>
<td>• If there are no single rooms available, the patient may be nursed in a bay with contact precautions in place</td>
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<td>• Explain diagnosis to the patient and provide them with a patient information leaflet on MRSA</td>
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<td>2</td>
<td></td>
<td>Hand Hygiene</td>
<td>• Hand hygiene must be performed before and after contact with the patient, their environment or equipment, and on leaving the isolation room.</td>
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<td></td>
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<td></td>
<td>• Soap and water or alcohol gel (if hands are visibly clean) can be used for hand decontamination.</td>
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<td></td>
<td><strong>Gloves should be used. After glove removal hands must be decontaminated.</strong></td>
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<td></td>
<td><strong>Ensure hand washing facilities are offered to the patient regularly, especially before eating and after using the toilet.</strong></td>
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<tr>
<td>3</td>
<td><strong>Personal Protective Equipment (PPE)</strong></td>
<td><strong>Wear plastic aprons and gloves for contact with the patient, the immediate patient environment and equipment.</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Visitors are NOT required to wear gloves and aprons if they are not visiting other patients.</strong></td>
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<tr>
<td>4</td>
<td><strong>Specimens</strong></td>
<td><strong>Following first isolate, a full screen is required. Nose and groin, and any other vulnerable site, i.e. wound, catheter, central line, if signs of infection are present etc. See screen chart on page 4.</strong></td>
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<tr>
<td>5</td>
<td><strong>Decontamination of Patient Equipment</strong></td>
<td><strong>Equipment where possible should be designated for the patient’s own use and kept in their room.</strong></td>
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<td></td>
<td></td>
<td><strong>Equipment removed from the room must be cleaned with chlorine based detergent, eg Actichlor Plus.</strong></td>
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<td></td>
<td><strong>Patient crockery/cutlery should be removed from the room and washed in the normal way.</strong></td>
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<td></td>
<td></td>
<td><strong>Keep items/equipment to a minimum within the room.</strong></td>
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<td></td>
<td></td>
<td><strong>Equipment should be cleaned between and after use.</strong></td>
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<tr>
<td>6</td>
<td><strong>Laundry</strong></td>
<td><strong>All patient linen should be changed on a daily basis.</strong></td>
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<td><strong>Place used linen in alginate bag, then clear polythene bag, then into a white laundry bag.</strong></td>
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<td></td>
<td></td>
<td><strong>Clean linen to be taken into the room only when required.</strong></td>
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<td></td>
<td></td>
<td><strong>Do not store clean linen in room.</strong></td>
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<tr>
<td>7</td>
<td><strong>Waste</strong></td>
<td><strong>Dispose of all waste into clinical waste pedal bin inside room. When sack ¾ full fasten securely and label with ward ID where required</strong></td>
<td></td>
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<tr>
<td>8</td>
<td><strong>Environmental cleaning</strong></td>
<td><strong>Floor, surfaces, sink, toilet etc. must be cleaned twice daily by domestic staff using chlorine based detergent, e.g. Actichlor Plus.</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Nursing staff are responsible for the cleaning of patient related equipment twice daily using chlorine based detergent, e.g. Actichlor Plus or Clinell green wipes</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>When room vacated nursing staff should clean patient related equipment with chlorine based detergent, e.g. Actichlor Plus and remove it from the room.</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Domestic staff should then carry out a thorough terminal clean of the room. When dry the room can be used.</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9</td>
<td><strong>Visitor restrictions</strong></td>
<td><strong>Visitors do not have to wear PPE but must ensure they decontaminate their hands before and after leaving the room.</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>Visitors should be discouraged from sitting on the patient’s bed.</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Visitors report to nurse in charge before entering.</strong></td>
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<tr>
<td>10</td>
<td>Personal clothing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Transfer to another department or hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Suppression/decolonisation therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Isolation of Patient</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- Visitors are NOT required to wear gloves and aprons, but should wash their hands when leaving the room.

- There are no special washing instructions. Relatives should wash their hands after handling used linen. Personal laundry contaminated with blood or body fluids should be placed in a patient clothing bag before being given to the carer or relative for home laundering.

- Prior to transfer the receiving area/department, e.g. radiology, they must be informed of the patients MRSA status. Ward staff should inform the IPCT of planned transfer to allow risk assessment of the patient and receiving area to ensure the most appropriate patient placement. Patient should be placed last on the list so area/department can conduct a deep clean after they have left. Patients with open wounds or faecal incontinence must not attend hydrotherapy.

- Ensure all patients who are identified as MRSA positive prior to procedures receive appropriate suppression/decolonisation; either to eradicate MRSA or to reduce the bioburden and therefore risk of infection across the healthcare community. Follow the suppression/decolonisation protocol in the MRSA policy. If it is impossible to clear a patient of MRSA prior to surgery, if they have already had multiple decolonisation attempts previously, or if they have other factors which make successful decolonisation unlikely i.e. they are a permanent resident in a care home, bioburden suppression/decolonisation should be commenced precisely 4 days prior to their date of surgery. The patient should undergo surgery on the 5th day (under Teicoplanin prophylaxis). They must continue to use the Chlorhexidine wash for the entire length of their stay but the Mupirocin topical treatment is not required.

- Patients can be removed from isolation when 3 full sets of consecutive negative screens have been obtained at intervals of no less than one week apart AND 48 hours after suppression/decolonisation therapy has finished. Patients should only be removed from side room after consulting the ICT.
Infection Control Care Plan for a patient with MRSA: 1 set of screening swabs from all appropriate sites (nose, groin, lesions or wounds, insertion site of indwelling devices, CSU if catheter insitu)

### Screening results

<table>
<thead>
<tr>
<th>Date</th>
<th>Nose</th>
<th>Groin</th>
<th>Wound 1</th>
<th>Wound 2</th>
<th>CSU</th>
</tr>
</thead>
</table>

#### MRSA DECOLONISATION REGIMEN

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
</tr>
</thead>
<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>
</tr>
<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>Mupirocin cream 2%</td>
<td>Applied to nostrils 3 times a day</td>
<td>For 5 days or stop sooner if found to be MRSA negative</td>
</tr>
</tbody>
</table>

#### MRSA BIUBURDEN REDUCTION REGIMEN

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily shower / bath / blanket 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 length of stay</td>
</tr>
<tr>
<td>Wash hair twice during 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>Mupirocin cream 2%</td>
<td>Applied to nostrils 3 times a day</td>
<td>For 5 days</td>
</tr>
</tbody>
</table>
Appendix 11: Minimally invasive procedures exempt from MRSA screening

Some patients who are undergoing minimally invasive or non-invasive procedures at RNOH and are not admitted may be exempt from MRSA screening. Where patients are undergoing such procedures but are admitted to RNOH they will still require screening.

**Patients having any of the following minimally invasive procedures are exempt from MRSA screening unless they are admitted to RNOH.**

**Rehabilitation ward**
- biologic infusions

**Rehabilitation Patients**
- Patients who are undergoing rehabilitation and are admitted will require screening.
- Patients who are undergoing rehabilitation at hotel facilities will not require screening.
- If patients do need to stay overnight and have not been screened they will need to be treated as though they have MRSA until clearance swabs have been taken.

**Metabolic Unit**
- intravenous bisphosphonate infusions
- intramuscular injections of vitamin D
- subcutaneous injections of denosumab.

If patients are stable and do not require admission to RNOH but do require to stay overnight for other reasons it may be preferable to accommodate the patient in hotel facilities.

**Imaging**

**Ultra sound injection**
- elbow
- foot
- shoulder
- ankle
- Plasma rich protein (prp)

**Fluoro injection**
- ankle
- shoulder
- hip
- foot
- spine (nerve root, facet joint, vertebroplasty)

**CT spine** (nerve root, facet joint, vertebroplasty)

**CT RF ablations**

**Chronic Pain Team (Plaster theatre):**
- Lumbar epidural
- Caudal/Thoracic/Cervical epidural
- Lumbar/Thoracic/Cervical medial branch blocks
- Prognostic spinal injection
- Prognostic epidural
- Epidurogram with epidural injection
- Pulsed Radiofrequency injections Lumbar/Cervical/Thoracic
- Cervical/Thoracic/Lumbar nerve root injection
- Pulsed Radiofrequency Suprascapular/Intercostal Nerve
- Suprascapular/Intercostal nerve block
- Stellate Ganglion block
- Lumbar Sympathetic block
- Dorsal Ramus block
- Dorsal Ramus denervation
- Radiofrequency denervation Lumbar/Thoracic/Cervical facet joints
- Facet joint injection Lumbar/Thoracic/Cervical
- Sacroiliac Joint Injection
- Sacroiliac Joint denervation
- Trigger point and scar injection
- Intravenous infusions Lidocaine/Ketamine/Phentolamine
- Rehab infusion suite intrathecal pump refills + Minor injections such as Suprascapular nerve block.

Patients undergoing any of the following procedures will require MRSA screening

Peripheral Nerve Injury Procedures
- exploration of nerve
- exploration and repair of nerve injury
- nerve transfer
- neurotisation
- exploration of neuroma
- exploration of brachial plexus
- exploration and repair of brachial plexus (if under 6hrs)
- tendon transfer

Peripheral Nerve Injury Procedure
- any operation on a patient with Diabetes mellitus, immunocompromised- (on steroids, HIV etc.)
- revision surgery of any kind
- Free functioning muscle transfer (never less than 9hrs long sometime 14 hs long)

Urology Patients
- endoscopic cases – i.e. botulinum toxin injections to the bladder,
- cystoscopy and bladder biopsies
- insertion of suprapubic catheters.
Appendix 12: Other linked trust policies and guidelines

- Hand Hygiene policy
- Communicable diseases and Isolation policy
- Admissions Policy
- Polices and guidelines for management of IV devices (peripheral and central, including tunnelled lines)
- Uniform policy
- Antimicrobial Prescribing Guidelines
- Guideline for Inter-departmental Transfer of Infected Patients
- Decontamination Policy
- Cleaning Policy

The DH strategy for NHS trusts regarding screening for MRSA colonisation identifies the need to screen all elective admissions either before or on admission, unless the patient falls into groups who should not be routinely screened. The recommended groups who should not be screened includes children/paediatrics unless they are already in a high risk group. There is no additional guidance on children.

Radiological patients should not be routinely screened, but there is a case for some other regular attenders, e.g. chemotherapy, to be screened at the beginning, but not at every attendance. The frequency of screening should be determined by local practice.
Appendix 13: Privacy Impact Assessment and Equality Analysis

**Name of Policy:** MRSA Policy

**Date Form Completed:**

**Name of Policy Facilitator / Policy Sponsor:** Annesha Archyangelio: Lead Nurse Infection Prevention and Control
Paul Fish: Director of Nursing / Director of Infection prevention and Control

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do the stakeholders of the policy include different and minority groups of people, for example, disabled individuals, different ethnic backgrounds or different religions (Y/N)</td>
<td>Y</td>
</tr>
<tr>
<td>Have any of the above groups of individuals been involved in the consultation process (Y/N)</td>
<td>Y</td>
</tr>
<tr>
<td>Who are the intended recipients of the policy - staff and / or service users (Please Provide Details)</td>
<td>All Staff / service users</td>
</tr>
<tr>
<td>Who are the actual staff or service users who will be affected and / or benefit by the policy (Please Provide Details)</td>
<td>All Staff / potentially all patients</td>
</tr>
<tr>
<td>Have specific benefits / implications of the policy on minority groups been considered as part of the policy development process (Y/N)</td>
<td>Y</td>
</tr>
<tr>
<td>Have any literature searches been carried to ensure the policy specifically encompasses the requirements of minority groups (Y/N)</td>
<td>Y</td>
</tr>
<tr>
<td>Is there or could there be any disadvantage or adverse impact experienced by any group of people or individuals based on the content or requirements of this policy (Y/N)</td>
<td>N</td>
</tr>
<tr>
<td>Are there any aspects of the policy that could be changed or removed to reduce any disadvantage caused (Y/N)</td>
<td>N</td>
</tr>
<tr>
<td>Have any specific modifications to the policy already been made to reduce the risk of disadvantage, discrimination or potential adverse impact upon any group of people (Please Provide Details)</td>
<td>N</td>
</tr>
<tr>
<td>Could the contents or requirements of this policy potentially lead to any direct or indirect unlawful discrimination (Y/N)</td>
<td>N</td>
</tr>
<tr>
<td>Is the proposed policy specifically intended to increase equality of opportunity by some groups (Y/N)</td>
<td>N</td>
</tr>
<tr>
<td>Do any steps need to be taken to counter any potential resentment this policy may cause (Y/N)</td>
<td>N</td>
</tr>
</tbody>
</table>

**Conclusions:**

Can this policy be considered to support and promote equality and Diversity within the Trust (Y/N) | Y
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:

6. Fraud and Bribery
7. Standard Financial Instructions
8. Declaration of Interests
9. Gifts and Hospitality
10. Whistleblowing
11. Disciplinary
12. IT
13. Anti-Money Laundering
14. Managing Sickness Absence
15. Secondary Employment
16. Expenses
17. Overpayment
18. Financial Redress
19. TOIL (Time off in Lieu)
20. Code of Conduct/Standards of Business Conduct
21. Data Protection
22. Lone Worker
23. Patient Transport
24. Commercial Sponsorship
25. Overseas Visitors
26. Disclosure