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Meticillin Resistant Staphylococcus Aureus (MRSA) Policy

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Type of document	Policy
Target audience	All CWP staff
Document purpose	<i>Meticillin resistant staphylococcus aureus (MRSA) and its control within the healthcare and community environment is a challenge for all healthcare professionals in the hospital and community setting. Preventing the transmission of MRSA will assist in the prevention of many other healthcare associated infections via universal precautions and effective treatment. This policy sets out how all healthcare staff can help prevent the spread of MRSA and reduce MRSA infection and/or colonisation in all service users within CWP. This is a key IPC policy of which all CWP staff should be familiar with.</i>

Approving meeting	<i>Infection Prevention and Control Sub-Committee</i>	Date 23-Oct-19
Implementation date	23-10-2019	

CWP documents to be read in conjunction with	
IC1	Trust-wide infection prevention control operational policy
IC2	Hand decontamination policy
IC3	Standard (universal) infection control precautions policy
IC10	Prevention and management of exposure to health care associated infections and inoculation incidents
SOP23	Policy for handling of linen and clothing
GR30	Decontamination policy and disinfection policy
MP1	Medicines management policy
IC8	Policy for the procedure for aseptic non touch technique (ANTT)
GR1	Incident reporting and management policy

Document change history	
What is different?	No changes made, guidance remains the same
Appendices / electronic forms	Remain the same as previous version
What is the impact of change?	None - guidance remains the same

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.
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Document consultation	
Clinical Services	Who within this service have you spoken to
Corporate services	Who within this service have you spoken to

External agencies	Who within this service have you spoken to
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Financial resource implications	None
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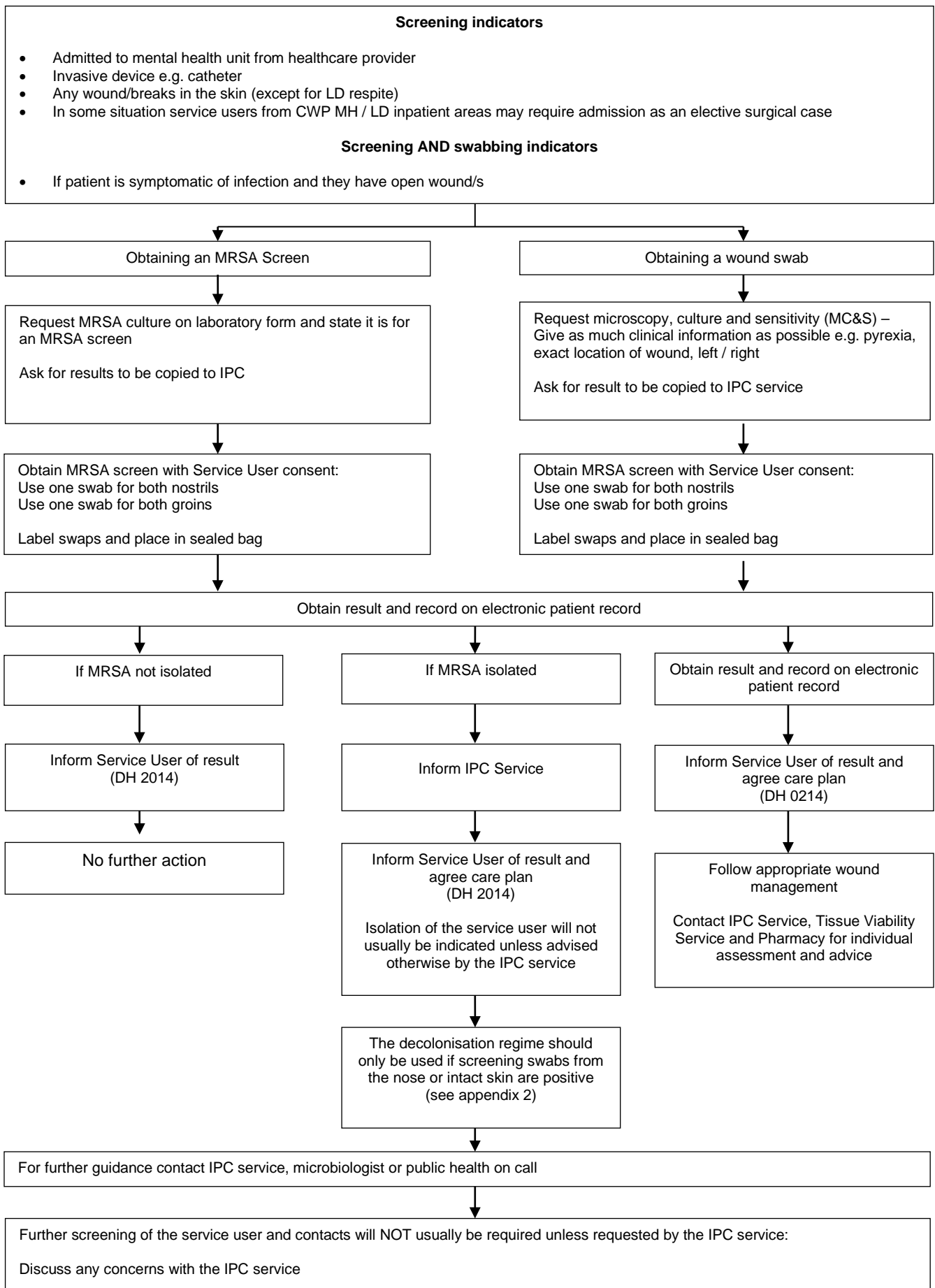
External references
1. Nathwani D, Morgan M, Masterton RG, et al (2008) Guidelines for UK practice for the diagnosis and management of methicillin-resistant Staphylococcus aureus (MRSA) infections presenting in the community, Journal of Antimicrobial Chemotherapy. Oxford University Press.
2. Coia J.E. et al (2006) Guidelines for the control and prevention of methicillin resistant staphylococcal aureus (MRSA) in healthcare facilities by the joint BSAC/HIS/ICNA working party on MRSA. Journal of Hospital Infection 63S, S1-S44. London
3. Department of Health (2008).Screening elective patients for MRSA – FAQs. http://www.clean-safe-care.nhs.uk/Documents/Screening%20FAQsv4%20Final.pdf . Retrieved from the World Wide Web 23/11/2010.
4. WHO (2009), 5 moments for Hand Hygiene.
5. Department of Health. Implementation of modified admission of MRSA screening guidance for the NHS (2014). Dept. of Health expert advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
6. NHS Commissioning Board. Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2013.
7. Loveday, H.P. et al. EPIC 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection. 86S1 (2014) S1-S70.

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? Select		
Is the impact of the document likely to be negative?	No	
- If so can the impact be avoided?	N/A	
- What alternatives are there to achieving the document without the impact?	N/A	
- Can we reduce the impact by taking different action?	N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.		
If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

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Quick reference flowchart - MRSA screening and treatment



1. Introduction

Meticillin Resistant Staphylococcus Aureus (MRSA) and its control within the healthcare and community environment is a challenge for all healthcare professionals. Preventing the spread of MRSA will assist in the prevention of many other healthcare associated infections. This policy sets out how all healthcare staff can help prevent the spread of MRSA and reduce MRSA infection and colonisation within CWP.

The aim of this policy is for all CWP staff to understand the key principles within this policy and be able to apply those principles in clinical practice. Reducing the incidence of any infection within healthcare is of paramount importance to the Infection Prevention and Control Team (IPC) Service. All incidents of infections are considered by the IPC Service and this is included in the work programme and assurance framework.

2. What is MRSA?

MRSA stands for Meticillin Resistant Staphylococcus Aureus. It is a type of bacteria called Staphylococcus aureus that is resistant to some of the standard antibiotics that are used to treat staphylococcal infections including penicillin's and cephalosporin's.

Staphylococcus aureus is a bacterium which may cause a range of infections affecting all age groups. These infections can be mild e.g. wound infections, boils or impetigo or may be more severe e.g. Septicaemia or Pneumonia.

MRSA is more commonly found in community settings and whilst MRSA is not commonly identified in the mental health setting it is essential that CWP has robust procedures in place to minimise the spread of MRSA, where any vulnerable service users may be present either as inpatients or patients visiting community healthcare settings. Certain strains of MRSA have the capacity to establish themselves easily within the healthcare setting and some strains are known as epidemic (E) strains or (E)MRSA and currently EMRSA 15 and 16 are a problem throughout the United Kingdom. MRSA continues to be encountered within the healthcare environment and therefore all CWP staff must observe a high standard of personal and environmental hygiene to limit the spread of potential pathogens, including MRSA between service users and others.

MRSA can affect service users / patients in two ways:

- **Colonisation** is when an individual carries MRSA in the nose, groin, on the skin or in superficial wounds without showing signs or symptoms of infection;
- **Infection** is when an individual has signs or symptoms of infection that are caused by MRSA such as abscesses, wound infections, pneumonia, blood or urinary tract infections.

A Post Infection Review (PIR) is required for any incidence of MRSA bacteraemia (blood stream infections) (NHS 2013) and Datix reporting (Incident recording and management policy) should be completed in all instances where provider input has been involved in the care of any patient diagnosed with the same.

3. Prevention of the spread of MRSA

This policy outlines the measures required to minimise the spread of MRSA if it is encountered within a clinical area. This policy must be considered along with other CWP IPC policies e.g. Trust-wide infection prevention control operational policy, [hand decontamination policy and procedure](#), [standard \(universal\) precautions](#) and [prevention and management of exposure to healthcare associated infections and inoculation incidents policy](#), which aims to prevent the spread of all types of infection.

It is well documented that the hands of healthcare staff are the commonest vehicle by which infection is spread; therefore it is imperative that all CWP staff adhere to the highest standards of hand hygiene (EPIC 3). Hands must be washed with liquid soap and water before and after physical contact with the service user, their environment, used equipment and before Aseptic Non Touch Technique (ANTT),

(WHO 2009). Staff must have access to alcohol hand gel and this can be used as an alternative to liquid soap and water when hands are physically clean.

4. MRSA Decolonisation regime

The decolonisation regime should only be used if screening swabs from the nose or intact skin are positive. ([See Appendix 2](#))

4.1 MRSA decolonisation assessment tool

The decolonisation Risk assessment for MRSA colonised Service Users admitted to CWP from Secondary care units.

4.2 Patients with infected or colonised ulcers or wounds following a positive result

In addition to the regimen given above, those patients with broken skin should have a suitable anti-staphylococcal dressing applied e.g. iodine or silver based dressings during the decolonisation programme, refer to Tissue Viability Services for advice. Mupirocin is **NOT** to be applied topically to wounds unless discussed and agreed with the IPCT.

If the service user requires treatment in another department / healthcare environment, staff must ensure that the appropriate staff are informed of the service user's MRSA status.

Where appropriate any infected wounds must be covered by an occlusive dressing; clean clothing is recommended to prevent the dispersal by skin scales and the service user should be encouraged to wash their hands before leaving the ward / unit to reduce potential contamination by hand contact.

For wound care advice it may be necessary to inform the Physical Health Lead, Matron or Tissue Viability Team if specialist advice is needed.

4.3 Factors which may affect long term success of topical decolonisation

- Non-compliance with the topical decolonisation regime; refusal to undertake treatment;
- Attempts to decolonise whilst still shedding *S. aureus* from an infected lesion, e.g. healing abscess, or break in the skin e.g. chronic ulcer;
- Re-colonisation from a close contact;
- Re-colonisation from the service users own flora e.g. gut, vagina;
- Re-colonisation from the environment;
- Presence of a urinary catheter.

These factors need to be taken into account when considering a topical decolonisation regimen.

4.4 Groups where decolonisation may not be appropriate

It is not possible to be prescriptive for all circumstances as decisions need to be based on an assessment of the individual service user. It is the prescribing clinician's responsibility to assess whether decolonisation therapy is required or is appropriate. In some instances it may be inappropriate to attempt decolonisation due to the patient's condition as it will not improve the patient's outcome and may be unsafe to attempt:

- Service user's on final days of life pathway;
- Where treatment may have a detrimental effect on the patients mental wellbeing;
- Very frail patients;
- Allergy to any of the products used.

5. Advice on discharge home

If the service user is to be discharged home without the need for further medical intervention then no further action is required. The General Practitioner (GP) needs to be informed in the discharge letter of their MRSA status. If the service user requires care at home from e.g. community nurses, then they should be advised accordingly of the infection / colonisation and the current treatment / dressings in

use. If the service user is to be discharged to another care facility it is important to liaise at an early stage with the staff concerned. MRSA infection or colonisation should not be a barrier to discharge to the patient's own home. Please contact the IPC Service at the earliest opportunity if any assistance is required in facilitating discharge.

6. Cleaning of the environment

In an Inpatient setting terminal cleaning should be thorough cleaning with general purpose detergent and hot water. Curtains will also require changing.

In an Inpatient setting communal equipment must be thoroughly cleaned as per the CWP [decontamination and disinfection policy](#) e.g. commodes, walking frames, fans etc. daily and prior to returning to storage.

7. Information for visitors and service users

Visitors need not be discouraged from visiting healthcare facilities. Good hand hygiene should be encouraged on entering and leaving the ward. Personal protective clothing is not necessary unless assisting with personal care/ cleaning the environment. If the service user's family / friends have any concerns regarding MRSA then these should be answered by the nursing staff and / or the clinician. If there remain questions that cannot be answered by these staff then advice should then be sought from the IPC Service. Information including leaflets are available from the IPC Service and on the CWP IPC pages on the website.

8. Clothing

Service users clothing may be washed using domestic washing machines and tumble driers, following the CWP [policy for handling linen and clothing](#)

Action required following an MRSA positive result

If MRSA is identified in a service user following screening, the IPCT must be contacted. They will advise staff with regards to the necessary interventions that may be required.

The interventions may include:

- Further screening of the service user and contacts will NOT usually be required unless requested by the IPCT;
- Isolation of the service user will not usually be indicated unless advised otherwise by the IPCT;
- Decolonisation treatment is available as per [section 7](#) - but should only be prescribed and used under guidance of the IPCT, microbiologist or public health on call;
- In some situations service users from CWP MH / LD inpatient areas may require admission as an elective surgical case. If the service user is found to be colonised with MRSA prior to admission then inpatient staff should support the decolonisation regime prescribed by the admitting trust.
- Antibiotics must be prescribed in accordance with the CWP antimicrobial guidelines and [medicines management policy](#);
- Used linen should be treated as per the CWP [policy for handling of linen and clothing](#). Personal Protective Equipment (PPE) e.g. gloves and aprons must always be worn when dealing with used clothing / linen and hands washed on removal of the PPE;
- All visitors should be advised on the need for good hand hygiene and advised to wash their hands or use the alcohol hand gel provided on entering and leaving the ward / unit / clinic area;

Appendix 1 - Decolonisation regime

The decolonisation regime should only be used if screening swabs from the nose or intact skin are positive. ([See Appendix 2](#))

- Mupirocin 2% nasal ointment applied to both anterior nares three times daily for same five days as below (apply a match head size amount each time);
- Daily washes with antiseptic body-wash (Octenisan) for same five days as below. If excessive skin drying occurs consider Oilatum Plus as an emollient;
- Hair washed with antiseptic body-wash twice within the five-day treatment period, ideally day 2 & 4;
- Encourage daily change of flannel, towel and personal clothing and if possible, bedding.

	Day 1	Day 2	Day 3	Day 4	Day 5
Body wash	✓	✓	✓	✓	✓
Hair wash		✓		✓	
Mupirocin	✓	✓	✓	✓	✓
TDS	✓	✓	✓	✓	✓

Appendix 2 - Risk assessment for MRSA colonised Service Users admitted to CWP from Secondary care units.

HIGH RISK	
Service User (SU)	Treatment advice
<p>All MRSA skin and / or nasal colonised SU identified from secondary care units, who have been discharged with surgical or chronic wounds or invasive devices (Peripheral, central or tunnelled IV lines, PEG, urinary catheter, tracheotomy)</p> <ul style="list-style-type: none"> – Cardiothoracic surgery; – Vascular surgery; – Orthopaedic surgery; – Neurological surgery; – Implant surgery; – Renal medicine; – Oncology. 	<p>SU discharged from secondary care on decolonisation therapy:</p> <ul style="list-style-type: none"> – Complete current course of decolonisation therapy. <p>SU discharged before decolonisation therapy could be started*:</p> <ul style="list-style-type: none"> – Complete 5 day course of decolonisation therapy. <p>Clinical signs of infection:</p> <ul style="list-style-type: none"> – Discuss with microbiologist.
INTERMEDIATE RISK	
Service User (SU)	Treatment advice
<p>MRSA colonised SU's not included above with the following (primary or secondary care):</p> <ul style="list-style-type: none"> – Extensive or deep surgical or traumatic wounds or pressure sore or leg ulcer with MRSA colonisation / infection; – Invasive devices i.e. PEGs, urinary catheters, tracheotomies; – Eczema or psoriasis with MRSA colonisation of the skin; – Immunocompromised patient; – SU's with wounds on immune suppressant drugs e.g. TNF drugs; – Extensive venous / arterial ulcers with or without diabetes; – Severe uncontrolled exudating oedema. 	<p>SU discharged from secondary care on decolonisation therapy:</p> <ul style="list-style-type: none"> – Complete current course of decolonisation therapy. <p>SU discharged before decolonisation therapy could be started*:</p> <ul style="list-style-type: none"> – Complete 5 day course of decolonisation therapy. <p>Primary care microbiology culture positive for MRSA:</p> <ul style="list-style-type: none"> – Complete 5 day course of decolonisation therapy if considered appropriate by IPC Service.
LOW RISK	
Service User (SU)	Treatment advice
<p>All other MRSA colonised SU's with no wounds or invasive devices regardless of age or living accommodation.</p>	<p>SU discharged on decolonisation therapy:</p> <ul style="list-style-type: none"> – Complete current course of decolonisation therapy. <p>SU discharged before eradication therapy started or diagnosed after discharge:</p> <ul style="list-style-type: none"> – Complete 5 day course of decolonisation therapy if considered appropriate by IPC Service.

* Results of inpatient screening swabs not available at the time of discharge.