Policy for the Management of Meticillin Resistant Staphylococcus Aureus (MRSA)

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Purpose of Agreement	To provide Solent NHS Trust staff with clear infection prevention and control guidance on the management and control of MRSA
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Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
1	06.03.12	8	6.5 clarification of process if unable to screen client	Immediate
2	13.06.14	18	Mupirocin 2% dosage changed from TDS to BD for 5 days	Immediate
3	08.04.16	17	Mupirocin 2% changed back from BD to TDS for 5 days to reflect change in prescribing guidelines	Immediate
4	20.09.17	20	MRSA and MSSA Suppression Regime added as appendix 4	Immediate
5	06.12.17	17	Octenisan added to treatment regime	Immediate
6	15.01.20	8	Inpatient management of MRSA updated	

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Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
4	November 2019	N. Mounter	IPCG	Standard Review

SUMMARY OF POLICY

Meticillin Resistant Staphylococcus Aureus (MRSA) is a strain of Staphylococcus aureus that has over time developed resistance to Flucloxacillin and related antibiotics. MRSA infection can result in additional morbidity and mortality as well as contributing to healthcare costs.

By its very nature MRSA is opportunistic and will thrive and flourish easily, particularly within the healthcare environment where it has become endemic over the years.

The control of MRSA is an important factor in the provision of safe patient care and this policy outlines measures needed to prevent the acquisition and spread of MRSA. It aims to provide all staff working in Solent NHS Trust with evidence-based information about MRSA transmission and the potential risks to patients, healthcare workers and visitors. It will aim to identify strategies to manage these risks effectively.

It is important to note that each case of MRSA within the organisation will differ in relation to needs of the patient. Therefore discussion with the Infection Prevention Team (IPT) regarding risk assessments is encouraged.

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1. INTRODUCTION & PURPOSE

1.1 "Good infection prevention and control are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be consistently applied by everyone" (Health and Social Care Act, 2008). Meticillin Resistant Staphylococcus Aureus (MRSA) is a significant Healthcare Associated Infection (HCAI) resulting in additional morbidity and mortality as well as contributing to healthcare costs. If basic principles of infection control are followed, the risks of a patient acquiring MRSA or indeed any other HCAI will be effectively minimised in all types of community settings.

2. SCOPE & DEFINITIONS

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

2.3 **Aerosol:** A suspension of fine solid particles or liquid droplets released as a spray into the atmosphere.

2.4 **Community Associated MRSA (CA-MRSA):** Newer strains of MRSA that have emerged over time that cause infections in people within the community that have had no previous history of direct or indirect contact with healthcare. These strains have been designated CA-MRSA as they are genetically and phenotypically distinct from HA-MRSA (Nathwani et al 2008).

2.5 **Endemic**: When infection is constantly maintained at a baseline level within certain areas.

2.6 **Healthcare Associated MRSA (HA-MRSA):** Strains of MRSA that are transmitted to and circulate between individuals who are or have been in contact with healthcare facilities. HA-MRSA is endemic in hospital and healthcare facilities.

2.7 **High risk groups:** National and local evidence shows that certain people will be at increased risk of acquiring MRSA, specifically those who:

- Have been MRSA positive in the past (irrelevant of how long ago)
- Have had an admission to a healthcare facility in the last six months

- Live in residential settings i.e. nursing or residential homes
- Presence of any in-dwelling medical device i.e. urinary catheter, intravenous line or device, feeding tubes or tracheostomy tube
- Presence of a chronic wound or chronic skin condition i.e. eczema or psoriasis
- People who inject drugs (PWID)
- People whose immune system is compromised by existing disease
- Healthcare workers

2.8 **Meticillin Sensitive Staphylococcus Aureus (MSSA):** Generally a skin infection that is NOT resistant to certain antibiotics but has the ability to cause boils, abscesses, wound infections and more seriously pneumonia and blood stream infections with outbreaks of MSSA being well documented.

2.9 **MRSA:** A variant of Staphylococcus aureus that has developed resistance to commonly used antibiotics and is now endemic in hospitals, residential care homes and community healthcare settings.

2.10 **MRSA bacteraemia:** The presence of MRSA in the blood stream. This type of MRSA infection can lead to septicaemia very quickly and has a high mortality rate.

2.11 **MRSA colonisation:** The asymptomatic carriage of MRSA on an individual. Whilst most of the time this does not cause a problem to the individual it has the potential to act as a reservoir of the bacteria in a healthcare setting, hence the importance of all staff adhering to good infection prevention practice at all times. Colonisation also increases the risk for the person of going on to develop infection or bacteraemia from MRSA if the right circumstances prevail.

2.12 **MRSA infection:** Occurs when the bacteria invades the skin or deep tissue in sufficient numbers to cause a localised or systemic response.

2.13 **PVL-associated Staphylococcus Aureus:** Panton-Valentine Leukocidin (PVL) is a toxic substance produced by some strains of Staphylococcus Aureus and has been associated with an increased ability to produce disease.

2.14 **Screening:** The process of testing to identify the presence of MRSA on a person by taking swabs/samples from various sites and sending them to a microbiology laboratory for analysis.

2.15 **Staphylococcus aureus (SA):** A gram positive bacterium that commonly colonises human skin and mucosa without causing harm. However it has the ability to cause infection if it enters the body through broken skin or during a medical procedure for instance. It can cause skin and soft tissue infections, wound infections, infected eczema, abscesses, joint infections, endocarditis, pneumonia and bacteraemia, blood stream infection and sepsis.

2.16 **Suppression Therapy (previously known as decolonisation therapy):** The method by which an attempt is made to eradicate or reduce the amount of MRSA being carried on a person. Please see Appendix A and B for guidance on how to administer MRSA suppression therapy.

2.17 **Terminal or deep clean:** A high level clean of the environment and equipment which is required once a patient with a known infection has vacated a room or bed space. This level of cleaning will involve the use of approved disinfectants. Please refer to the decontamination policy for further guidance.

2.18 **Transient:** Describes the short term carriage of MRSA that can easily be removed by good practice such as hand washing.

3. PROCESS/REQUIREMENTS

3.1 TRANSMISSION OF MRSA

3.1.1 **Direct contact** is the main route of transmission. The hands of healthcare workers have the potential to transfer MRSA from one person to another or from one body site to another if correct hand hygiene and adherence to basic infection control standard precautions are not followed.

3.1.2 **Indirect Contact** can occur through the environment and equipment. Therefore it is important to maintain high standards of environmental cleaning to keep dust levels at a minimum. All equipment needs to be routinely and effectively decontaminated.

3.1.3 **Endogenous spread** is when a person transfers organisms from one part of the body to another. This can be done by the patient themselves or by a member of staff who fails to carry out correct hand hygiene between different episodes of care on the same person.

3.2.1 MRSA SCREENING

3.2.1 All patients admitted to Solent NHS Trust in-patient areas must be screened for MRSA. This will enable the identification of MRSA carriage, implementation of treatment if appropriate and the application of necessary precautions in order to reduce the risk to the patient and others within the vicinity (Appendix C: How to Screen for MRSA).

3.2.2 Screening should be carried out within 24 hours of admission, however the following exceptions can be considered:

- Screening should not delay any urgent treatment
- For patients admitted on a Friday or Saturday, the screening should take place on the Sunday night or Monday morning so that the samples are not left in the collection fridge over the weekend
- When a wound is to be screened for MRSA then the swab should be taken when the next dressing change is due; the dressing should not be taken down for the sole purpose of taking an MRSA swab. However, best practice indicates that wound dressing should be taken down and the wound assessed in a timely manner after admission.

3.2.3 Routine admission screening includes the **nose** and the **groin**. In addition to this swabs/samples will need to be taken from the following if present:

- Wound and skin lesions (except new trauma wounds)
- Invasive devices i.e. intravenous/central lines, tracheotomy or feeding tube sites

- If a urinary catheter is in situ a catheter sample of urine (CSU) needs to be obtained using an aseptic technique (please state this is part of an MRSA screen).

3.2.4 Swabs need to be labelled correctly with three points of identification and placed with the microbiology request form in the appropriate collection area.

3.2.5 If any wound or site appears to be infected you must also request Microscopy, Culture and Sensitivity (MC&S) in addition to MRSA.

3.2.6 Results of screens MUST be checked for by the person, ward or department that sent the screen and a robust system needs to be in place in every in-patient area to ensure this happens.

3.2.7 Compliance with admission screening for MRSA will be monitored every quarter and form part of the infection prevention report. Any non-compliance will be escalated as appropriate.

3.2.8 If on admission a patient is already undergoing a course of suppression therapy the screen will not be required at that time. This is because a positive result has recently been identified and the treatment will provide a false result. This will need to be clearly documented in the admission information and IPT must be informed.

3.2.9 If a patient has been MRSA positive in the past, or who is currently known to be positive but is not undergoing suppression therapy, a new admission screen is still required.

3.2.10 If it is not possible to obtain an MRSA screen due to clinical reasons or patient refusal this must be clearly documented in the admission documents. Further attempts to obtain an MRSA screen should be made as the clients condition stabilises. For the purposes of auditing compliance– a valid reason for a screen not having taken place and accurately documented will be considered to be fully compliant.

3.2.11 Staff carriage of MRSA can be transient and easily removed with good hand hygiene and adherence to standard precautions. Therefore routine screening of staff is not recommended practice and will only be instigated in exceptional circumstances on the advice of a consultant microbiologist. This may be necessary as part of an MRSA outbreak management plan for instance, especially if epidemiological factors indicate that staff members may be the source of an increased rise in cases of MRSA among a particular group of patients. If staff screening is required it will be coordinated and carried jointly between the IPT and Occupational Health and Wellbeing (OHWB) to ensure staff confidentiality is maintained.

3.3 IN-PATIENT MANAGEMENT OF MRSA

3.3.1 Once a positive MRSA status is known, a risk assessment is required in conjunction with the IPT. This will ensure the best placement in a ward environment. Consideration will be given to where the MRSA is isolated and the risk of onward transmission.

3.3.2 All patients who are positive for MRSA must be barrier nursed, whether they are in an open bay or in a single room. Please see the Isolation Policy for further guidance on barrier nursing.

3.3.3 Single room isolation would be considered appropriate when MRSA has been isolated from:

- An exuding wound
- A person who has a skin shedding condition such as eczema or psoriasis
- Sputum, where the individual has an expectorating cough
- Urine when a person is likely to be incontinent

3.3.4 If a person is isolated for one of the reasons above it is important to close the door to the room if this does not compromise patient safety. The door must be closed however when staff are present and undertaking activities such as chest physiotherapy, wound dressings or bed making as these activities generate dust and aerosols. For further guidance on isolation precautions please refer to the isolation policy.

3.3.5 It is recognised that full isolation is rarely possible within Adult or Older Persons Mental Health so a management plan must be agreed in conjunction with the IPT.

3.3.6 Rehabilitation is the main aim of the majority of in-patients within Solent NHS Trust so it is important for all staff working with these patients to understand how rehabilitation can be maintained whilst upholding safe practice.

3.3.7 If the MRSA is identified as nose and groin carriage only and no other risk factors have been noted the patient can be barrier nursed within a shared bay with full barrier nursing precautions, minus the isolation sign. It is important to note that there will be a process to follow for the duration of the patient's stay, even when any suppression treatment is completed, so that the risk of onward transmission is kept to a minimum. These include:

- Placing the patient near to the hand wash basin
- Placing a small stock of Personal Protective Equipment (PPE) kept for that patient on a trolley at the end of the bed
- The positive MRSA status of the person needs to be communicated between clinical staff for the duration of the stay at each handover
- Regular cleaning of horizontal surfaces will be effective using detergent wipes followed by drying with a paper towel
- The entire bed space will require a terminal clean when the patient has been discharged and this needs to include a change of privacy curtains.
- Shared toilets, baths and showers need to be cleaned after use. This does not refer to a terminal clean but a standard clean with a solution of Actichlor Plus at a ratio of 1000ppm.
- Waste generated needs to be placed within the infectious waste stream.

3.3.8 Barrier nursing and any isolation precautions should continue for the duration of the inpatient stay, unless otherwise advised by IPT or Microbiology.

3.3.9 IPT must be informed of any MRSA positive results. Suppression therapy may need to be commenced following discussion with the IPT when a positive MRSA result is obtained.

3.3.10 A patient with a known or suspected MRSA infection will need careful monitoring so that any deterioration or signs of sepsis are quickly identified and medical help obtained.

3.3.11 If infection is suspected general observations using NEWS2 need to be increased to four times a day. Wounds/IV lines sites will need regular review and careful and comprehensive description. Any deterioration must be reported to the medical team caring for the patient.

3.3.12 MRSA infection should be considered, even if the admission screen is negative, if the patient has any factors that place them at increased risk of acquiring MRSA. These factors include:

- Have been MRSA positive in the past (irrelevant of how long ago)
- Have had an admission to a healthcare facility in the last six months
- Live in residential settings i.e. nursing or residential homes
- Presence of in-dwelling medical device i.e. urinary catheter, intra venous line, feeding tubes etc.
- Presence of a chronic wound or chronic skin condition i.e. eczema or psoriasis
- People who inject drugs (PWID)
- People whose immune system is compromised by existing disease or medication
- Healthcare workers

It should also be considered when any infection fails to respond to first line antimicrobial treatment.

3.3.13 If MRSA is identified as causing an infection it is essential to ensure any antibiotics are prescribed in accordance with the sensitivity results.

3.3.14 For severe wound infections the advice of a microbiologist should be obtained as often these patients may need transfer to secondary care for intravenous antibiotics.

3.3.15 If MRSA blood stream infection (BSI) is suspected the patient will need urgent transfer to secondary care for rapid treatment. If using NEWS2, this will flag for sepsis to allow for rapid transfer.

3.3.16 On confirmation of an MRSA BSI the IPT will lead on a Post Infection Review (PIR) in line with current Public Health England (PHE) guidance.

3.3.17 A Serious Incident (SI) will be raised if MRSA features on part one of a death certificate. In addition to this a SI can and should be raised if there are organisational lapses in care noted that may have contributed to the event.

3.3.18 Any person with MRSA must not be refused treatment, investigations or therapy. They must be treated like any other patient with dignity, respect and in confidence.

3.3.19 An MRSA diagnosis like any other diagnosis must be confidential. Therefore non-medical staff such as facilities, housekeeping or voluntary staff only need to made aware of any precautions required but not the actual diagnosis.

3.3.20 Visitors are not required to wear Personal Protective Equipment (PPE) unless they are providing personal care. They are advised to carry out hand hygiene on entering and leaving the area.

3.3.21 Any spillages of body fluids will need to be cleaned as soon as possible in accordance with the decontamination and standard precautions policy.

3.3.22 Bedding and laundry must be treated as infectious. An alginate water soluble bag needs to be taken to the point of care, filled and sealed prior to taking to the appropriate laundry stream.

3.3.23 Personal clothing needs to be washed separately on the highest temperature recommended by the manufacturer, tumble dried, and ironed if possible.

3.3.24 Maintain a dust and clutter free environment, paying particular attention to horizontal surfaces where dust will settle.

3.4 DISCHARGE OR TRANSFER OF MRSA POSITIVE PATIENTS

3.4.1 The receiving ward, department, residential home or GP must be informed of the MRSA status prior to transfer. This will allow that area to make the appropriate plans.

3.4.2 The MRSA status of the patient needs to be clearly documented on any transfer documentation including discharge summary accompanying the patient or being sent to the GP.

3.4.3 If the patient requires on-going care from community nursing, podiatry or primary care ensure those teams are provided with information regarding MRSA status.

3.4.4 If the patient is still on a course of suppression therapy this must be sent with the patient with clear instructions on how to complete the treatment.

3.4.5 Terminal cleaning of the room or bed space will need to be requested via the facilities team with as much notice as possible.

3.4.6 It is the responsibility of the clinical staff to clean and inspect the mattress and medical equipment prior to the terminal clean.

3.5 CARE OF THE DECEASED PATIENT WITH MRSA

3.5.1 The same standard precautions should be applied for a deceased patient as with a living patient.

3.5.2 Black body bags must NOT be used for MRSA alone unless there is evidence that the patient also had a notifiable disease (MRSA is not a notifiable disease).

3.5.3 There is negligible risk to mortuary staff as long as they adhere to standard infection prevention precautions.

3.6 OUTBREAKS OF MRSA

3.6.1 An outbreak may be declared if there is an exponential rise in the number of cases in one area.

3.6.2 Assessment and management of the outbreak will be led by the IPT in consultation with a consultant microbiologist and the Director of Infection Prevention and Control (DIPC).

3.6.3 Screening of staff will only be carried out following the decision of a Microbiologist/IPT. If screening of staff is required it will be coordinated in conjunction with OHWB.

3.6.4 If an outbreak has been declared the ward will need to be closed to admissions and transfers for a period of time and a SIRI instigated to ensure all learning is captured.

3.6.5 Portable fans are not recommended for use during outbreaks of infection or when a person has a known or suspected infection that can be dispersed through the airborne route.

3.7 **MRSA AND COMMUNITY NURSING TEAMS (including Paediatric Nursing Teams)**

3.7.1 It needs to be recognised that many clients being cared for in their own homes will have long standing complex health conditions that place them at higher risk of MRSA acquisition. Some clients will have chronic MRSA colonisation which in turn suggests that the home itself will be colonised. It is therefore important for staff to adhere to strict infection control precautions to prevent onward transmission of MRSA to other clients.

3.7.2 Hand hygiene needs to be carried out on entering and leaving the patient's home as well as prior to any episodes of care. Staff need to be 'bare below the elbow' for any episodes of clinical care

3.7.3 If it is not possible to use the hand washing facilities within a patient's home following risk assessment then individual hand wipes should be used prior to using the alcohol hand gel.

3.7.4 Uniforms must be protected by a plastic apron when close contact with the client or environment is anticipated. Gloves need to be worn when any contact with body fluid is anticipated. Other PPE should be used following a risk assessment.

3.7.5 Equipment utilised by staff should be kept in good condition and cleaned regularly.

3.7.6 Community staff are encouraged to discuss any concerns regarding care of MRSA colonised/infected clients with the IPT. It may be necessary to formulate an individual plan for that service user.

3.7.7 Previous history of MRSA should always be considered as relevant.

3.7.8 Wound care needs to be carried out using the principles of asepsis in accordance with the Policy for Aseptic Technique and Aseptic Non Touch Technique. This will help prevent the introduction of pathogens to the site.

3.7.9 Chronic wounds are a potential cause of skin and soft tissue infections as there is an increase in bacterial burden often including MRSA. It is therefore necessary to adhere to the principles of asepsis for wound care.

3.7.10 Wound swabs should be taken if there are signs of infection i.e. redness, inflammation, discharge, non-healing persists or a wound has not improved following a course of first line antibiotics.

3.7.11 Any waste generated by a healthcare worker as a result of wound care in a domestic setting that is considered to be infected by MRSA will need to be disposed of following the correct infected waste collection service. If in doubt staff must contact the waste management team for advice.

3.7.12 When taking a swab the wound should be cleaned first to remove surface contaminants and any slough.

3.7.13 A brief history of the patient and current or recent antibiotic treatment should be included on the laboratory request form.

3.7.14 Results of wound swabs should be obtained as soon possible so that there is no delay in the correct treatment being prescribed if needed. Contact IPT to obtain results if necessary.

3.7.15 All patients with known MRSA infection in a wound or indwelling device should be monitored for potential development of MRSA bacteraemia (MRSA in the blood stream). These patients should:

- Have a full set of baseline observations taken if not already on record
- Have observations taken if they complain of feeling unwell (a minimum of temperature, heart rate , respirations and blood pressure)
- Have observations taken if they display signs of infection (a minimum of temperature, heart rate , respirations and blood pressure)
- Be highlighted to senior staff if MRSA bacteraemia is suspected

3.8 PODIATRY SERVICES AND MRSA

3.8.1 Podiatry services provide care for many patients with increased risk of developing infection in chronic wounds. Many of these patients have diabetes and this will be of significance as raised blood glucose levels increase risk of ulceration and infection. Diabetes can also cause suppression to normal inflammatory responses that may mask signs of infection so this needs to be taken into account when assessing a wound.

3.8.2 When high risk podiatry interventions are being considered it is recommended that the MRSA status of the patient is reviewed. If positive or previously positive for MRSA then suppression therapy and antibiotic prophylaxis may be considered on an individual basis and for further advice contact IPT or Microbiology.

3.8.3 Wound care needs to be carried out using the principles of asepsis in accordance with Policy for Aseptic Technique and Aseptic Non Touch Technique. This will prevent the introduction of pathogens to the site.

3.8.4 Every attempt needs to be made to ensure that requests for swabs or antibiotic treatment are prompt so that treatment when necessary can commence at the earliest opportunity.

3.8.5 Due to the invasive nature of some podiatry procedures there is a risk of contamination of inanimate objects such as couches with body fluids. Therefore the correct cleaning/disinfection materials need to be at hand and used correctly following risk assessment. Please refer to Decontamination policy for more information.

3.8.6 Wound swabs should be taken if there are signs and symptoms of infection i.e. redness, inflammation, discharge, non-healing persists or a wound has not improved following a course of first line antibiotics.

3.8.7 When taking a swab the wound should be cleaned first to remove surface contaminants and any slough.

3.8.8 A brief history of the patient and current or recent antibiotic treatment should be included on the laboratory request form to aid a more comprehensive laboratory report.

3.8.9 Results of wound swabs should be obtained as soon as possible so that there is no delay in the correct treatment being prescribed if needed. Contact IPT to obtain results if necessary.

3.8.10 All patients with known MRSA infection in a wound or indwelling device should be monitored for potential development of MRSA bacteraemia (MRSA in the blood stream). These patients should:

- Have a full set of baseline observations taken if not already on record
- Have observations taken if they complain of feeling unwell (a minimum of temperature, heart rate , respirations and blood pressure)
- Have observations taken if they display signs of infection (a minimum of temperature, heart rate , respirations and blood pressure)
- Be highlighted to senior staff if MRSA bacteraemia is suspected

4. ROLES & RESPONSIBILITIES

4.1 **The Director of Infection Prevention and Control (DIPC)**
Is responsible for ensuring that this policy is implemented and adhered to across the organisation. In Solent NHS Trust this role is held by the Chief Nurse.

4.2 **Clinical & Operational Directors & Clinical Governance Leads**
Have the responsibility for the co-ordination of Health and Safety activities within the service lines or care groups and for ensuring that decisions are implemented in accordance with this policy.

4.3 **Infection Prevention and Control Group (IPCG)**
Has a responsibility to ensure that this Policy complies with advice and guidance from the Department of Health and other bodies.

4.4 **The Infection Prevention Team (IPT)**

Are responsible for developing and updating the policy to ensure it complies with Department of Health, Health and Safety Legislation and other national guidance. The IPT will support the provision of training and education both mandatory and bespoke.

4.5 **Service Line Managers and Matrons**

Responsible for ensuring that staff are aware of their responsibilities under this Policy. They are also responsible for ensuring that staff have the appropriate resources available for use and education and clinical skills in order to comply with the policy.

4.6 **Employees**

All employees have a responsibility to abide by this Policy. This Policy is enforceable through Health and Safety Legislation and Solent NHS Trust disciplinary procedures. If employees are aware that the Policy or associated guidance is not being complied with they must first take the issue to their line manager and if the problem is not resolved they must inform the Infection Prevention Team.

4.7 **Infection Prevention Link Advisors (IPLA)**

IPLA's are healthcare staff selected by their managers to receive additional training in infection prevention and control. The key role of link staff is to develop best practice within their clinical area. The additional training for the IPLA role is provided by the IPT in the form of a two day course.

4.8 **Ward / Departments**

Ward/clinical areas are responsible for:

- Informing the Infection Prevention Team when an MRSA positive result is identified
- Discussing and planning with IPT individual risk assessments for any patient colonised and/or infected with MRSA
- In-patient areas must ensure there is a robust process in place to ensure all new admissions are screened for MRSA. Any deviance from this must be clearly documented
- Upholding strict infection prevention precautions

5. TRAINING

5.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis on the intranet.

5.2 All training undertaken must be recorded on the Organisational Learning Module (OLM) of the Electronic Staff Record (ESR) taken from signing in sheets. Monitoring of the training attendance will be carried out Learning and Development.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 The Equality and Diversity and Mental Capacity Impact Assessment (IA) were conducted and no negative impact was highlighted. A copy of the IA is attached as Appendix D.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 The IPCT will monitor the effectiveness of this policy by:

7.2 Compliance with MRSA screening will be monitored quarterly. This will be undertaken by the IPT using Point Prevalence Surveillance (PPS). Results will be shared with service line managers and recorded within infection prevention reports. Results are also published on Trust Score Cards and discussed at IPCG.

7.3 On-going surveillance of infections will highlight any trends or hotspots and assurance will be required that the patient received an MRSA admission screen.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 HR53 Equality, Diversity and Human Rights Policy
IPC01 Infection prevention and control policy
IPC10 Policy for Aseptic Technique and Aseptic Non Touch Technique
IPC02 Isolation Policy
IPC05 Hand Hygiene Policy
IPC07 Infection Prevention and Control Standard Precautions Policy
IPC12 Decontamination Policy

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NHS England (2013). Everyone Counts: Planning for Patients 2014/15 - 2018/19. NHS England: Leeds.

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10. GLOSSARY

DIPC – Director of Infection Prevention and Control
SI – Serious Incident
NEWS2 – National Early Warning Score 2
IPT – Infection Prevention Team
MRSA - Meticillin Resistant Staphylococcus Aureus
SA - Staphylococcus Aureus
HCAI – Healthcare Associated Infection
CA - MRSA – Community Associated MRSA
HA - MRSA - Healthcare Associated MRSA
PWID – People who inject drugs
MSSA – Meticillin Sensitive Staphylococcus Aureus
CSU – Catheter Sample of Urine
MCRS – Microscopy Culture & Sensitivity
IPCG – Infection Prevention & Control Group
OHWB – Occupational Health & Wellbeing
PPE – Personal Protective Equipment
BSI – Blood Stream Infection
PIR – Post Infection Review
PHE – Public Health England
PVL – Panton-Valentine Leukocidin

Appendix A

MRSA SUPPRESSION THERAPY REGIMEN

Procedure – daily shower / bath / blanket bath

Duration – 5 days

First line treatment - Hibiscrub® (Chlorhexidine 4%) or Octenisan® wash

- Apply once daily directly to wet skin. Do not dilute in large amounts of water. In hospital settings disposable wipes should be used by staff
- If flannels or wash cloths are used these need to be laundered after each use
- Wash body, neck and face paying particular attention to axillae, groin, perineum, buttocks and other skin folds
- Rinse off thoroughly
- In the hospital setting clean bedding and clothes should be supplied daily during the treatment
- Within the patient's own home this may not be possible and may affect the success of the treatment
- Hair should be washed if possible during this 5 day period using the treatment
- Minor skin dryness or irritation can be controlled by a simple emollient such as E45 cream
- As with any medication if the patient experiences signs of allergic reaction or severe skin irritation the treatment should be immediately discontinued

For patients with a documented chlorhexidine allergy or the patient has dry skin or a known skin condition the following options should be considered after seeking medical advice

Second line treatment where Chlorhexidine or Octenisan are not suitable **– Dermol 500®**

For contraindications, special warnings and other interactions, please refer to the latest British National Formulary medical compendium for manufacturer's advice.

NOSE

Procedure – apply to both nostrils three times per day

Duration – 5 days to coincide with topical washing

Appendix A

First line treatment - Mupirocin 2% (Bactroban®) –Three times daily for 5 days

- Using a clean finger the patient should apply a pea-sized amount of the ointment around the inside of each nostril and squeeze their nose for few seconds
- As with any medication if the patient experiences signs of allergic reaction or severe irritation the treatment should be immediately discontinued

Repeated or prolonged courses of Mupirocin 2% must be avoided due to the possible development of resistance

For patients with a Mupirocin resistance or allergy the following option should be considered after seeking medical advice

Second line treatment – Chlorhexidine hydrochloride 0.1%, neomycin sulphate 0.5% (Naseptin®)

For contraindications, special warnings and other interactions, please refer to the latest British National Formulary medical compendium for manufacturer's advice.

Please note that for in-patients the MRSA Suppression Therapy needs to be prescribed correctly and clearly on the patient's prescription chart.

Appendix B

MRSA and MSSA Suppression Regime

Information for patients, staff and carers.

MRSA is short for (Meticillin-Resistant *Staphylococcus aureus)*
MSSA is short for (Meticillin-Sensitive *Staphylococcus aureus)*

You are being given this treatment because you either carry or are at increased chance of carrying MRSA or MSSA on your skin or up your nose. It is not always necessary to treat this however there will be times when your clinician feels it would be beneficial for you to use this treatment to reduce the risk of complications.

Please read this sheet carefully and follow all of the instructions. If you need help to do this, please ask a nurse / carer / relative to assist you.

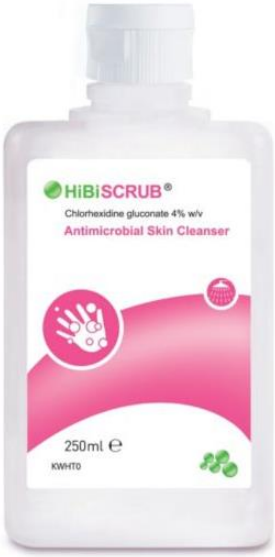
What does the treatment involve?

You will be given a treatment soap to wash with and some nasal cream to put up your nose. You should use both for 5 days.

- Wash all over with the treatment soap once a day for 5 days
- Put the cream up your nose 3 times a day for 5 days

What is the treatment soap?

The soap is called Hibiscrub. It is a pink, lightly perfumed liquid soap containing chlorhexidine. You should not use it if you have an allergy to chlorhexidine (alternatives are available). Hibiscrub should not be used on children.



How often should I use the special soap?

You should wash your whole body using this treatment soap ***once a day for 5 days.***

How do I use this treatment soap?

- You can use the treatment soap in the bath or shower
- Do not dilute the treatment soap in water.
- Wet your face and body first.
- Pour undiluted soap onto a clean washcloth then wash **all over, leaving the soap on your skin for at least 1 minute.**
- Pay special attention to your face, armpits and groin but do not use inside the body.
- Wash your hair with the treatment soap on days 1 and 3 of treatment. You can use your normal shampoo/conditioner in between.
- Use the treatment soap generously the bottle provided is the correct amount for the entire treatment

- To increase effectiveness of the treatment clean towels and fresh clothes should be used after washing. Bed sheets, pillows and nightclothes should be changed daily.

What is the ointment that I put up my nose?

The ointment is called Mupirocin (Bactroban®). It is an antibiotic ointment. It does not contain penicillin. You should not use the ointment if you are allergic to Mupirocin or paraffin cream (alternatives are available).

How do I use this ointment?

Using a clean finger, you should wipe a pea-sized amount of ointment around the inside of each nostril and squeeze your nose. You should be able to taste the ointment in the back of your throat when you have finished. If you cannot, you should apply a small amount of extra cream. **You must wash your hands after this.**

How often should I put the ointment up my nose?

You should put the ointment up your nose ***three times a day for 5 days***.

Are there any risks to me?

The ointment sometimes causes irritation to the skin in your nose. If this happens, stop using the ointment and talk to a member of staff.

After 5 days, your treatment is complete. Please do not continue with the ointment or soap beyond 5 days.

You will not routinely be re-swabbed for the presence of MRSA or MSSA after completing the treatment.

Further Information:

Infection Prevention Team Solent NHS Trust
Enablement Services Building
St Mary's Community Health Campus
Milton Road, Portsmouth, PO3 6AD
Telephone: 0300 123 6636 Team email: snhs.infectionteam@nhs.net

Appendix C

HOW TO SCREEN FOR MRSA

All emergency or elective patients admitted to hospital require a full MRSA screen according to organisational policy.

All clinicians in both hospital and community settings should consider taking an MRSA screen if, in their professional judgement, it is considered prudent to do so.

Verbal consent needs to be obtained from the patient before obtaining any swab/sample.

The swabs used need to be used dry in accordance with manufacturer's instructions.

Assess the level of contact needed with the patient and/or their environment to carry out the screen and use the appropriate PPE.

Anterior Nares (nostrils)

1. Perform hand hygiene and use appropriate PPE
2. The same swab should be used for both nostrils
3. Check expiry date of the swab
4. Insert the swab into the anterior nare (nostril). Sweep round and gently upwards
5. Repeat process with same swab in the other nostril
6. Without contaminating the swab place back into the culture medium within the container
7. Remove any PPE and dispose of according to organisational policy
8. Perform hand hygiene
9. Label swabs accurately before moving onto next part of screen

Groin Swabs

Ensure groin swabs are carried out in a private area and that the patient's dignity is maintained at all times. The patient may be able to carry this out themselves under supervision.

1. Perform hand hygiene and use appropriate PPE
2. The same swab should be used for both sides of the groin
3. Check expiry date of the swab
4. Insert the swab to the left of the inner thigh and groin area using a gentle sweeping motion
5. Repeat process with same swab in the right hand side of the groin
6. Without contaminating the swab, place it back into the culture medium within the container
7. Remove any PPE and dispose of according to organisational policy

8. Perform hand hygiene
9. Label swabs accurately before moving onto next part of screen

Wound/ Device/ Skin Lesion Swabs

A full screen will need to include the above if present but may have to be carried out at a different time to the basic nose and groin screen.

All of the above principles apply. Wounds (with the exception of new trauma wounds) should be cleaned prior to swabbing.

Catheter Specimen of Urine

If the patient has an indwelling catheter at the time of admission, a Catheter Specimen of Urine (CSU) must be obtained.

It must be obtained using a sterile technique from the correct sampling port.

Ensure all the patient details are correct on the microbiological request form.

The swabs/specimens can be placed together with the one form.

Appendix D

Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	**Answer**		
1. What are the main aims and objectives of the document?	To limit the spread of MRSA in the clinical and community setting and to ensure a better outcome for patients and service users who are MRSA positive		
2. Who will be affected by it?	Service users and all staff who have access to clinical areas		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Compliance with MRSA screening will be monitored quarterly. This will be undertaken by the IPT using Point Prevalence Surveillance (PPS).		
4. What information do you already have on the equality impact of this document?	There is no adverse impact		
5. Are there demographic changes or trends locally to be considered?	No		
6. What other information do you need?	None		
Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully discriminate against any group?		x	
2. Can any group benefit or be excluded?	x		The policy benefits staff and patients
3. Can any group be denied fair & equal access to or treatment as a result of this document?		x	This policy aims to actively encourage fair individual treatment of those with confirmed or suspected MRSA. However, patients with suspected or confirmed MRSA may be treated differently to other patients, in accordance with this policy.

Appendix D

4. Can this actively promote good relations with and between different groups?	x		This policy aims to ensure those with confirmed or suspected MRSA infection are treated fairly
5. Have you carried out any consultation internally/externally with relevant individual groups?	x		IPT, Ward Managers and Matrons, IPCG, Policy Steering Group
6. Have you used a variety of different methods of consultation/involvement	x		Email, face-to-face group meetings, meetings with specific individuals, and IPT discussions
<u>Mental Capacity Act implications</u>			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)		x	
<u>External considerations</u>			
8. What external factors have been considered in the development of this policy?		x	
9. Are there any external implications in relation to this policy?		x	
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?		x	None