

GUIDELINES FOR THE CONTROL OF METICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

The following guidance is based on 'Guidelines on the Control & Prevention of MRSA in Hospitals' (BSAC/HIS/ICNA Working Party) 2005 and MRSA Screening Operational Guidance (DOH 2008). The Working Party believes that control of MRSA is still an important component to the provision of patient care and that strenuous efforts to ascertain possible sources and prevent spread are worthwhile. Isolation of infected or colonised patients in a single room, preferably in an isolation unit with designated staff, is considered to be one of the main measures for preventing the spread of staphylococcal infection. Together with **hand hygiene** that is recognised to be one of the most effective methods of preventing organism transmission (see Hand Hygiene Policy 1.5). Review of antibiotic therapy is also an important measure with respect to control, as antibiotic therapy has been identified as a risk factor for acquiring MRSA however, reduction in antibiotic prescribing both in terms of the number of prescriptions and the length of courses needs the co-operation of all medical prescribers.

STAPHYLOCOCCUS AUREUS

Staphylococcus aureus is a bacterium which is widely distributed in the air, in dust, on clothing and bedding, and can be carried on the fur of animals. It can be found in the noses of about 40% of healthy adults and 5-10% of people carry it in their throats, faeces and on their skin.

Staphylococcus aureus is the commonest cause of pus forming infection in mankind, the majority of which will be of skin sites.

RESISTANCE

Resistance is a method of adaptation by bacteria to ensure their survival. Potentially resistant organisms are in the environment and use of antibiotics selects them out to flourish to the detriment of sensitive normal flora.

EPIDEMIC METICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS

Epidemic strains were first recognised in the early 1980's. They appear to be more infectious and are resistant to more antibiotics making them a potential problem in hospitals.

MRSA was first diagnosed in London and various types have now spread to most major centres. The most frequently occurring sub types of MRSA being isolated in the country at present are MRSA 15, and 16.

COLONISATION

Where MRSA has been isolated and the response from the patient is slight or absent.

INFECTION

When the organism has caused the person to produce an inflammatory response with certain signs and/or symptoms.

COURSE OF ACTION WHEN INFECTED OR COLONISED PATIENTS ARE DETECTED

The action taken depends on a variety of factors including:-

- the virulence and potential transmissibility of the organism, e.g. MRSA resistant to gentamicin is of high risk
- type of ward, patient susceptibility, invasive interventions and devices and antibiotic use
 - intensive care or other high risk unit
 - acute
 - non-acute
- single room availability for patient isolation
- experience of MRSA in the hospital
 - first identification of MRSA in the ward/unit
 - MRSA is endemic in the hospital
- whether the patient is likely to be a heavy disperser eg. with infected eczema, psoriasis, etc.
- consider appropriate antimicrobial prophylaxis if patient having surgery.

MRSA PREVENTION AND CONTROL STRATEGIES

As previously stated, the risk from MRSA, in terms of morbidity and mortality is considered to be different in different clinical areas. The Trust provides a variety of health services from a variety of settings, therefore the strategy adopted for preventing and controlling MRSA will vary. The following guidance outlines the approach that will normally be taken within wards and departments in each of the main risk categories. **It is not possible to be prescriptive for all circumstances as decisions need to be based on the local situation.**

SCREENING

In accordance with MRSA Screening Operational Guidance (Department of Health July 08) all elective and emergency admissions in addition to attendees will be screened for MRSA at pre-admission or entry to the hospital. Any patients who are colonised must be actively de-colonised.

Within elective admissions and attendances, the following patient groups SHOULD NOT be routinely screened:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures eg warts or other liquid nitrogen applications
- Children/paediatrics unless already in a high risk group
- Maternity/obstetrics except for elective caesareans and any high risk cases, ie high risk of complications in the mother and/or potential complications in the baby, (eg likely to need SCBU, NICU because of size or known complications or risk factors).

ICU patients should be screened on admission and decolonisation commenced immediately whilst awaiting results. The MRSA decolonisation regime should be discontinued if the screening test is negative. All patients in ICU should be screened at weekly intervals thereafter.

Orthopaedic patients must be screened on admission and at weekly intervals thereafter.

A system of identifying previously positive patients should be maintained by marking the patient's notes with a yellow MRSA sticker, which should be placed in the left bottom inside cover of the notes and on the patient 'alert' sheet. This is particularly helpful in identifying previous carriers and preventing the re-introduction of MRSA into clinical areas. **Ward staff must routinely inform the Infection Control Nurse when patients known to have been previously positive are re-admitted or transferred, in order that appropriate screening and MRSA surveillance is monitored and patient management agreed.**

MICROBIOLOGICAL SAMPLING

Decontaminate hands prior to the procedure. Swabs with culture/transport medium should be used – remove swab from wrapper, rub gently over the site and re-sheath in transwab immediately. If sampling a dry site moisten the swab with the sterile normal saline prior to sampling. If no saline is available the transport medium may be used to moisten the swab.

Sample sites:

Nasal – one swab for right and left nostrils

Groin – one swab for right and left groin

In addition, if applicable: wounds, urine if catheterised, IV sites, sputum if productive cough

a) Label samples clearly using correct patient details.

b) For each person, send one microbiology request card listing all sites sampled.

RESULTS OF SCREENING

Negative:

Discontinue isolation precautions – undertake terminal clean of isolation room, see Section 1.6 Infection Control Standard Isolation Policy.

Positive MRSA

- a. Ward will be informed by the laboratory or infection control team. If the patient may have acquired the organism whilst an in-patient, the microbiologist will write to the patient's consultant, ward sister and lead nurse as applicable.
- b. A 'MRSA' label must be dated and attached to the inside bottom left hand corner of the patient's medical notes and additionally on the 'alert' sheet. Supplies of the labels are available in ward infection control files alongside the MRSA policy guidance.
- c. Single room isolation or cohort patients as necessary in bay. (Appendix 2 provides guidance on risk assessing MRSA patients in the absence of isolation facilities – if in doubt contact the infection control nurses.
- d. Commence standard isolation in single room or bay if patients are cohorted. If single room facilities are not available then the patient should be nursed adjacent to hand wash basin in bay area. Where possible the patient should not be nursed next to patients with wounds/IV lines. Cohort nursing of MRSA colonised/infected patients should be undertaken when isolation room facilities are not available.
- e. Attach yellow isolation alert to door and return bottom attachment of slip to the infection control nurses.
- f. Start MRSA Care Pathway (Appendix 1) and follow guidance. This document acts as an aide memoir and should be placed in the patients' notes, following patient discharge.

DECOLONISATION TREATMENT

Patient Group Directions are available for prescribing topical treatment ie 2% Mupirocin nasal ointment and antimicrobial wash.

For 5 days:

- a. Mupirocin 2% (Nasal Ointment) cream should be applied to both nostrils three times daily. Using a gloved finger or a swab, rub the cream thoroughly into the entire nostril going as high up as possible and also into the bulb of the nose. (NOTE – this should not be used for more than 10 days or when large open wounds, tracheostomy, intravenous cannulae, urinary catheters are present).
- b. The patient must have a daily total body wash/shower/bath using an antimicrobial wash. Hair should be washed twice weekly. **NB:** If patient has a skin condition, it may be necessary to consider an alternative agent for decontaminating the skin. Advice can be obtained from a Consultant Dermatologist.

- c. Colonised wounds should be treated with inadine twice daily and repeated 24 hours later. This should then be discontinued. The wound should be kept covered.
- d. If the wound appears infected seek the advice of the tissue viability nurse or microbiologist.
- e. All potentially contaminated areas of broken skin should be occluded with sterile dressings.
- f. Particular care should be given to sites of vascular access and urinary catheters in order to minimise the risk of infection occurring.

RE-SCREENING FOLLOWING TREATMENT

Two days after the decolonisation process ends, i.e. 8th day after commencement of treatment, the patient must be re-screened.

Three sequential negative screens at weekly intervals are required before isolation of the patient can cease.

If 3 consecutive screens have been taken this may place the patient in a lower risk group for subsequent carriage.

ACTION FOLLOWING TREATMENT

MRSA Negative

- a. Bath/wash/shower the patient and redress in clean clothes.
- b. Relocate the patient in a clean area, in a fresh bed.
- c. Ensure the vacated room is cleaned in accordance with 1.7 Hospital isolation & infection control related precautions.

Unsuccessful Decolonisation - Patient still MRSA Positive

After one unsuccessful treatment the treatment regime may be repeated once only. NASAL MUPIROCIN SHOULD NOT EXCEED 10 DAYS IN TOTAL.

ISOLATION ROOM

- a. Remove unnecessary equipment, furniture etc, from the room before admitting the patient. Single room door must be kept closed.
- b. Limit unnecessary movement in patient's room.
- c. Visitors must decontaminate hands prior to entering the room, protective clothing must be used if there is risk of close contact with the patient environment and/or risk from exposure with bodily fluids.

- d. Keep the patient's room clean and tidy.

EQUIPMENT

All equipment used in the room must be decontaminated prior to removal. See 2.3 Sterilisation, Disinfection and Cleaning Guidelines.

LAUNDRY

- a. Soiled linen will carry skin scales and must be handled with care. Place gently into red alginate bags in room then red infected linen bag outside room.
- b. Advise relatives to take home patient's clothing for washing and reinforce importance of hand hygiene.
- c. Do not use fabrics in room which cannot be hot washed.

HOUSEKEEPING

Daily and as necessary

- a. All isolation rooms **MUST** be cleaned daily.
- b. Plastic aprons and disposable gloves must be worn when carrying out cleaning duties. Gloves must be disposed of and hands washed before leaving the room.
- c. Disposable cloths must be used and the mop head hot washed after each use. Each isolation room should have a designated set of cleaning tools (mops and cloths) in accordance with the NHS Estates National Specifications for Cleanliness (2004) and National Colour coding scheme for hospital cleaning materials and equipment (NHS – NPSA 2007).

NB: Mattresses must be cleaned regularly if the patient has a prolonged stay in hospital.

On discharge of patient a terminal clean should be undertaken

- a. Remove all linen and curtains and send to laundry.
- b. The room should be vacuum cleaned and/or mopped. Hard surfaces should be cleaned with disposable cloths using detergent/hypochlorite (e.g. Chlorclean).
- c. All equipment should be cleaned prior to removal.
- d. Any partially used products, i.e. boxes of tissues, should be discarded.

NB: Clean room and furniture with great care with special attention to cracked wall areas, radiator grills and mattresses.

MOVEMENT OF MRSA PATIENTS TO OTHER DEPARTMENTS

Movement of MRSA Patients to Theatres

- a. Liaise with the Infection Control Team and Theatre Manager regarding the date and time of the operation.
- b. Ideally, the patient must be last on the operation list, but in adverse situations a risk assessment may be necessary
- c. Continue isolation, decolonisation and swabbing as normal. Every effort should be made to eliminate MRSA prior to surgery. Surgical prophylaxis to be discussed with Consultant Microbiologist. Teicoplanin/Vancomycin may be required in place of usual regime and should also be considered for patients in a high risk group for colonisation from whom screening results are not available.
- d. All wounds/open lesions must be covered with occlusive dressings.
- e. Patients may be cared for in recovery, preferably near hand decontamination units.
- f. The theatre should be thoroughly cleaned with an emphasis placed on operating table and surfaces where there has been patient contact or where dispersal of skin scales may have occurred.

(See Operating Theatres – Guidance for the Management of Infection Control Part 3.3 page 14)

Diagnostic Departments, Audiology, Dental etc

If possible the clinician should visit the patient.

- a. Move only if considered necessary.
- b. Department must be informed in advance and warned of risk and necessary precautions.
- c. Ideally appointments should be made for the end of the day. Patients must be seen promptly.
- d. In the patient's notes, record details of the department visited with the name of the doctor who ordered it.
- e. Terminal clean of room/cubicle.

VISITORS

- a. Visitors must be advised by the nurse in charge about risk and safe practice before entering isolation rooms.
- b. Advice must be sought from nurse in charge of ward before allowing children to visit a patient in an isolation room.

- c. Protective clothing is not necessary, unless it is likely that there will be close contact with the patient environment or direct patient care is to be undertaken, then disposable gloves and aprons should be worn. Hand decontamination must be carried out prior to entering and before leaving room.
- d. Visitors should not visit other patients and must be discouraged from taking unnecessary effects into the room.
- e. Should visitors fail to comply with the advice given to them the nurse should record this as an 'untoward incident' and documented in patient's notes.

STAFF

Protection

- a. To avoid unnecessary staff contact the number of staff entering rooms of colonised patients must be limited where possible.
- b. Disposable plastic aprons must be worn if direct patient contact is anticipated. Gloves should be worn when handling the patient or their body fluids.
- c. Wounds or broken skin must be covered.
- d. Strict hand hygiene must be observed.
- e. Staff with eczema or other skin conditions must not care for these patients. Occupational Health advice should be sought.

Screening of staff for MRSA

Outbreak Screening

Screening of staff during an outbreak of MRSA will be undertaken at the request of the Infection Control Team.

Swabs will be taken at the beginning of working shift from the following anatomical locations:

- Nose
- Any skin lesions
- Other sites clinically or epidemiologically indicated

Treatment of Staff Carriers

- Nasal carriers will be treated with mupirocin or alternative agents applied on a cotton wool bud to the inner aspect of both nares.
- Skin lesions will be treated with topical mupirocin or alternative agents.

- If skin lesions are present the staff member will be relocated from working in a high or moderate risk area. If nasal carrier only, can recommence work in high risk area after 48 hours decolonisation. If commencing or continuing to work in a low or minimal risk area the lesions should be covered with an impermeable dressing.
- Staff members who are multi-site carriers of MRSA will be suspended from clinical activities whilst appropriate decolonisation treatment is given. A return to clinical activities will be advised once clear evidence of decolonisation is available ie. when 3 negative swab results from the appropriate body sites have been obtained on at least three sequential samples dates.
- In most ward areas staff who are only nasal carriers can continue working once appropriate treatment has been commenced.
- If failure to eradicate MRSA carriage from a member of staff after two courses of treatment occurs their clinical management and placement will be reviewed.
- An assessment by an Ear Nose and Throat specialist if there is persistent throat carriage or by a dermatologist if there is a persistent skin condition may be required.

Follow up of treated Staff Carriers

- At least three negative swabs from positive sites should be examined, preferably at weekly intervals, before accepting that MRSA has been cleared.
- Depending on circumstances the Infection Control Team may decide to reduce this interval period between sampling.

Previously positive staff should be considered as potential MRSA carriers and will be re-sampled during any subsequent outbreaks.

Colonised Staff

- a. Any member of staff found to be colonised with MRSA must attend the Occupational Health Department.
- b. Occupational Health will liaise with the Infection Control Team re further management.

FURTHER WARD/DEPARTMENT SCREENING/WARD CLOSURE

- Screening of a wider group of patients may be advised, following a risk assessment by the infection control team.
- Such a step should only be taken after a risk assessment has been carried out by the outbreak control group, with full consideration of all the facts by relevant parties. Factors which should be considered include:

- MRSA strain e.g. known to be virulent and/or transmissible
 - number of cases
 - clinical activity and availability of alternative facilities locally
 - staffing levels, skill mix, dependence on agency staff
 - whether risk of transmission outweighs benefit of admission
- Staff education on MRSA, aetiology, mechanisms of spread, and procedures for minimising cross infection should be undertaken at staff induction and mandatory updates. Infection Control Link Nurses/professionals should undertake training within their areas. All wards/departments should undertake 'Saving Lives' High Impact Interventions:
- **No1: Central venous catheter care bundle**
 - **No2: Peripheral intravenous cannula care bundle**
 - **No3: Renal dialysis catheter care bundle**
 - **No4: Care bundle to prevent surgical site infection**
 - **No5: Care bundle for ventilated patients (or tracheostomy where appropriate)**
 - **No6: Urinary catheter care bundle**
 - **No7: Care bundle to reduce the risk from *Clostridium difficile***

Compliance scores should be monitored by staff and training intervention undertaken as necessary.

- A thorough clean of the ward should be carried out after it has been closed, together with thorough daily cleaning of all bay areas and twice daily cleaning of isolation rooms.

DEATH OF PATIENT COLONISED WITH MRSA

- a. The infection control precautions for handling deceased patients are the same as those used in life.
- b. A body bag is not necessary for MRSA colonisation/infection.

PATIENT DISCHARGE FROM HOSPITAL

To another NHS hospital

- a. Inform receiving hospital in advance of:
 - positive/negative MRSA status of patient,
 - dates and sites of screening,
 - decolonisation method for nose, body and wounds.
- b. Prior to transfer ensure daily treatment regime has been undertaken with patient changing into clean attire.
- c. Further screening of patient may be requested by receiving hospital prior to discharge.

d. Complete documentation as per Discharge Policy.

To the patient's home

- a. Forward recommendation for continued decolonisation to GP as per Appendix..
- b. If for district nurse referral, liaise in advance.
- c. If patient is in the process of decolonisation and this is to be continued, send supply of treatment with patient.
- d. It may be necessary for patient to be rescreened after treatment dependant upon whether readmission is planned.

To nursing/residential home

- a. Liaise in advance with Nurse Manager.
- b. Inform GP.
- c. If patient is in the process of decolonisation and this is to be continued, send supply of treatment with patient with details of completion date and date for re-screening. (See GP letter – part of the MRSA Care Pathway).
- d. Carriage of MRSA is not a contraindication to the transfer of a patient to a nursing or residential home.

AMBULANCE SERVICE - MRSA PATIENTS

- The ambulance service should be notified in advance by the responsible clinician or by their delegated ward staff.
- Ambulance staff should use an alcohol hand rub after contact with all patients (handwashing where practicable should take place if contamination with bodily fluids is present) in addition to good basic infection control practice.
- Most MRSA carriers may be transported with others in the same ambulance without any special precautions, other than changing the bedding used by a carrier.
- However, if transport of a potentially heavy disperser is necessary (e.g. patient with a discharging lesion which cannot be enclosed by an impermeable dressing or a widespread colonised skin lesion and co-existing skin conditions), advice should be obtained from a member of the Infection Control Team. It may then be necessary to transport this patient alone and for ambulance staff handling the patient to wear a plastic apron and to use an alcoholic hand rub and wipe down surfaces in contact with the patient with an alcohol wipe afterwards.
- Routine cleaning of the ambulance should be undertaken after transporting an MRSA positive patient.

COMMUNITY CARE - GENERAL ADVICE

Carriage of MRSA is primarily of concern in areas of the hospital where there are immuno-compromised, post-operative patients, and antibiotic use is high.

RESUME INFECTION CONTROL PROCEDURES

- a. Good hand hygiene practice must be observed by all people. See Section 1.5 Hand Hygiene Policy.
- b. Disposable aprons and gloves should be worn when undertaking procedures where close contact with the patient environment is envisaged, e.g. contact with patient bedding and contact with bodily fluids.
- c. Broken skin must be covered with occlusive dressings.
- d. Sharps and clinical waste must be correctly disposed of.
- e. Soiled linen from infected patients must be handled with care and be hot washed. Use of woollen and some synthetic items which are damaged by heat should be avoided.
- f. Crockery and cutlery should be washed in hot soapy water, rinsed and dried in the normal way.
- g. Equipment such as commodes, should be cleaned after use using detergent and hot water and dried.
- h. Environmental cleaning should be undertaken in accordance with Section 1.6.
- i. Details of where to get further advice if needed must be known, eg: Consultant in Communicable Disease Control (CCDC) or Community Infection Prevention & Control Nurse at NHS Lincolnshire.

MRSA CARRIER ATTENDING OUTPATIENTS DEPARTMENT/ACCIDENT & EMERGENCY DEPARTMENT FROM THE COMMUNITY

- a. All wounds must be covered with occlusive dressings.

On Arrival

- b. The receptionist must report the patient's arrival to the nurse in charge.
- c. Prior arrangements should be made, where possible, for the patients to be seen last in the clinic.
- d. Staff must wear protective clothing for dressings/invasive procedures.
- e. Linen, dressing gown, etc must be bagged as per 'Infected Laundry'.

- f. Equipment must be decontaminated as per Infection control guidelines Part 2.3 – Cleaning, disinfection & sterilization guidelines for re-usable medical devices.
- g. Room must be cleaned after use.

SURVEILLANCE

Trust staff participate in the Department of Health scheme for reporting all cases of MRSA bacteraemia. After each such case relevant Trust and Primary Care Trust are involved in a root cause analysis of the case so that necessary changes to practice can be identified and acted upon.

MRSA RISK ASSESSMENT TOOL FOR PLACEMENT OF PATIENTS WITHIN THE WARD AREA

(All patients identified as being colonised/infected with MRSA should be nursed in a single room, however in the event of unavailability of single room accommodation please risk assess using the following guidance)

HIGH RISK

MRSA identified at the following sites:-

- Deep leaking wounds
- Gentamicin/Mupirocin Resistant MRSA
- Multiple wounds/pressure sores
- Dermatitis/other skin conditions
- Sputum
- Multiple body sites on screening
- Urine + urinary catheter in situ

IF POSSIBLE PATIENTS MEETING WITH ANY OF THE ABOVE CRITERIA SHOULD BE NURSED IN A SINGLE ROOM WITH FULL STANDARD ISOLATION PRECAUTIONS

MODERATE RISK

MRSA identified at the following sites:-

- Nasal only
- One or two superficial wounds, healing and covered with dressings
- One or two body sites ie groin/nasal
- One full site of negative screening swabs
- Patient able to be confined to bed area

IN THE ABSENCE OF SINGLE ROOM ACCOMMODATION, PATIENTS MEETING ANY OF THE ABOVE CRITERIA SHOULD BE NURSED IN A BAY AREA OF THE WARD NEXT TO A HANDWASH BASIN – AVOID WHERE POSSIBLE PLACING NEXT TO PATIENTS WITH WOUNDS, IVI'S, URINARY CATHETERS.

References

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Addressograph

Patient NHS No:
Patient Name:

Clinical Area: Consultant:

MRSA Integrated Care Pathway

Inclusion Criteria – This ICP is for use with known and newly diagnosed MRSA adult patients.

Exclusion Criteria – This ICP is not for use with patients 16 years or younger. Contact Infection Prevention & Control Team for risk assessment.

1. **At Risk**
Does the patient meet any of the following At Risk criteria? Yes No
- From another hospital. From healthcare facility. Transfer from abroad.
 Previous MRSA carrier. Nursing Home / Rest Home.

2. **Date the patient was identified as being diagnosed with MRSA Bacteraemia:**
- Date Datix completed: Date RCA completed:

3. **Screening**
Was the full MRSA screen taken within 24 hours of being admitted? Yes No
- If no, please state reason why:

Results of Screening

	Site of swab	Date swab taken	Date positive result obtained	Initials
1	Pooled screen of nose and groin.			
2	Urine (if urinary catheter in situ)			
3	Wound (state site)			
4	IVI / CVC site			
5	Peg Site			
6	Other (state site)			

References

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- Joint BSAC-HIS-ICNA Working Party on MRSA, May 2006, Journal of Hospital Infection , Vol 63, Supplement 1, Guidelines for control and prevention of Methicillin-Resistant Staphylococcus aureus (MRSA).
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MRSA ICP v16 October 08

Addressograph

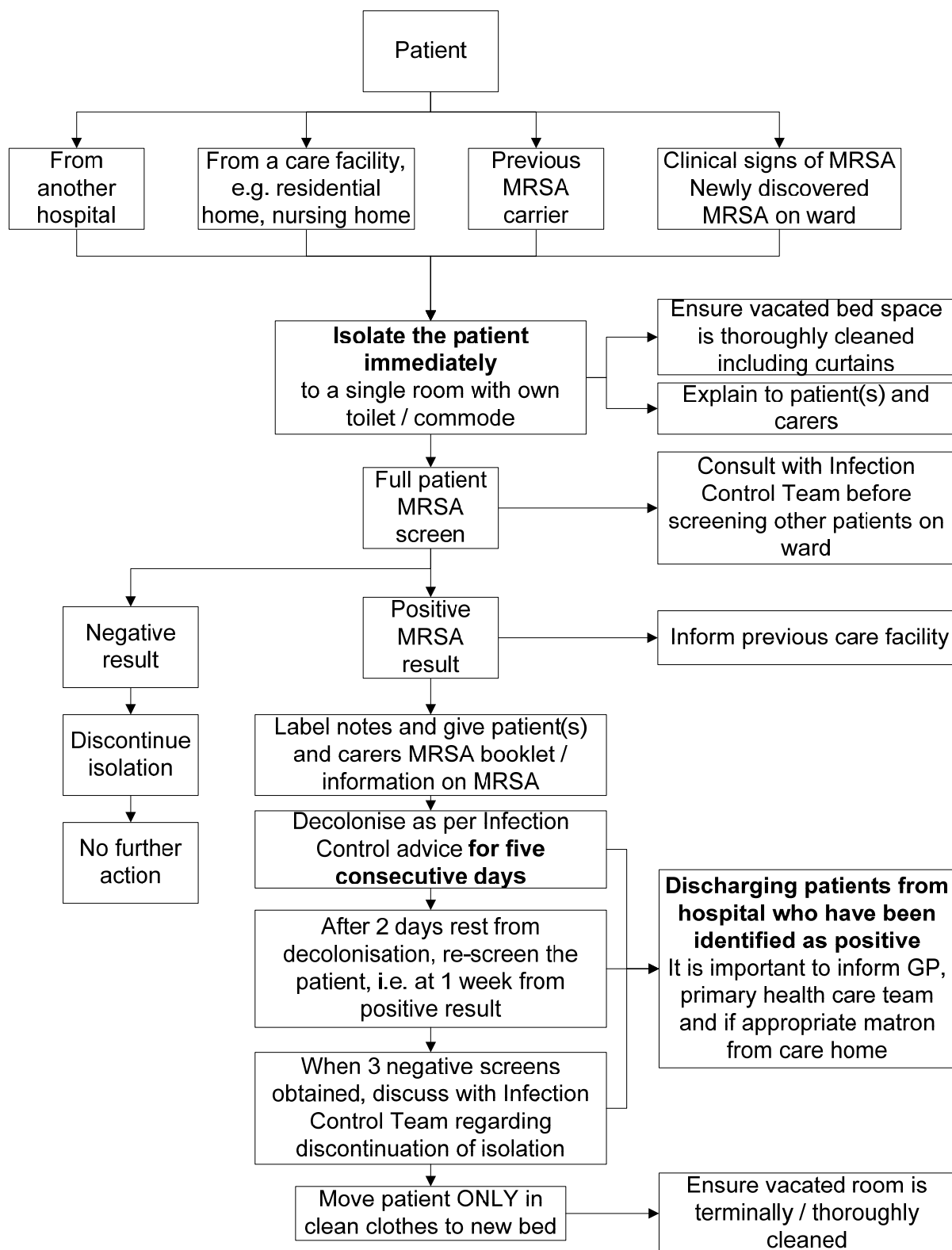
Patient NHS No:
Patient Name:

		Intervention	Yes Initials	No Initials	Date	Time	Variance and action taken
7	Isolation	Has the patient been isolated in a single room and Barrier Nursing commenced? If yes, state date:	Room No:				If no, why not? <input type="checkbox"/> No single room available. Nurse as if in isolation & involve Infection Prevention & Management Nurses / Link Nurses. <input type="checkbox"/> Psychological reasons. <input type="checkbox"/> Other, state.
		Ensure universal precautions are available i.e. gloves, aprons, hand hygiene solutions / personal hand decontamination gel.					
		Have the patient / relatives been informed on the isolation measures and the rationale e.g. hand hygiene before and after visiting, and has the patient / relatives been given the leaflets to support this explanation e.g. pictorial pathway, MRSA and isolation leaflet?					
8	Treatment	Medications are prescribed. <input type="checkbox"/> Patient Group Direction <input type="checkbox"/> Doctor					If no, state reason:
		Has the treatment started within 24 hours of a positive result?					
		Being received? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'No', specify why:					
		Skin and nasal decolonisation treatment to be given for 5 days NB nasal mupirocin 2% should not be used for more than 10 days in total and should not be used for patients with large or open wounds, tracheostomy, intravenous cannula or urinary catheter in place. Seek further advice from Infection Prevention as required. Superficial wound treatment to be given for 2 consecutive days					

Treatment / Decolonisation checklist					
	Start date	Specific sites (tick)	Completion date	Rest Days	Next screen All sites ✓ date
9		<input type="checkbox"/> Nose & Groin <input type="checkbox"/> Urine <input type="checkbox"/> Wound (State site _____) <input type="checkbox"/> IVI <input type="checkbox"/> Peg <input type="checkbox"/> Other _____			
10		<input type="checkbox"/> Nose & Groin <input type="checkbox"/> Urine <input type="checkbox"/> Wound (State site _____) <input type="checkbox"/> IVI <input type="checkbox"/> Peg <input type="checkbox"/> Other _____			
11		<input type="checkbox"/> Nose & Groin <input type="checkbox"/> Urine <input type="checkbox"/> Wound (State site _____) <input type="checkbox"/> IVI <input type="checkbox"/> Peg <input type="checkbox"/> Other _____			

If patient continues to be positive, seek the advice of the Infection Prevention & Control Team.

Algorithm for the management of MRSA



United Lincolnshire Hospitals

NHS Trust

<p>Lincoln County Hospital Greetwell Road, Lincoln, LN2 5QY</p> <p>Tel: 01522 512512 Infection Prevention & Control Team: Ext: 3152/8627/3606</p>	<p>Pilgrim Hospital Sibsey Road, Boston, PE21 9QS</p> <p>Tel: 01205 364801 Infection Prevention & Control Team Ext: 6336</p>
<p>Grantham & District Hospital Manthorpe Road, Grantham NG31 8DG</p> <p>Tel: 01476 565232 Infection Prevention & Control Team Ext: 4535</p>	<p>County Hospital High Holme Road, Louth LN11 0EU</p> <p>Tel: 01507 600100 Infection Prevention & Control Team Ext:1242</p>

Date:

Dear Dr

RE: Name:.....DOB.....

NHS number.....

The above patient has been identified as an MRSA carrier following screening swabs taken from the nose and skin at Hospital on (date)..... and topical treatment is recommended/ has been commenced (delete as applicable).

Treatment should be maintained as per the enclosed regime. If the MRSA has not been eradicated following the first course of treatment then one further treatment may be administered.

For further advice please contact a member of the Infection Prevention & Control Team as above.

Thank you.

INSTRUCTIONS FOR THE USE OF ANTIMICROBIAL WASH AND NASAL MUPIROCIN

- ❖ Patients should bathe (bed bath / bath/ shower/wash) **for five consecutive days** with antimicrobial wash
- ❖ Wash hair **twice** weekly with the same solution
- ❖ Use as a liquid soap
- ❖ Apply about 30mls directly onto the skin using a wet disposable cloth
- ❖ Pay particular attention to the **hair, around the nostrils, axillae, groin and feet**
- ❖ Rinse – head to toe
- ❖ Dry using a towel – launder towel daily
- ❖ Clean bed linen should be used where possible after treatment

Applying nasal Mupirocin 2%

- ❖ A small amount of nasal ointment (about the size of a match head) should be placed on a cotton bud or on the little finger and applied to the inner surface of each nostril.
- ❖ Apply three times daily for five days
- ❖ The nostrils should be closed by pinching the sides of the nose together at each application (spreads the ointment throughout the nares)
- ❖ Your Doctor may wish to take swabs from the nose and the skin following treatment.

The above treatment should be discontinued after five days. Then a period of 48 hours allowed before screening of patient i.e, on the 8th day following commencement of treatment.

If patient screens positive for MRSA then one further course of treatment may be prescribed.

Screening for clearance

- ❖ Nose (swab both anterior nares with the same swab)
- ❖ Groin
- ❖ Any other wound

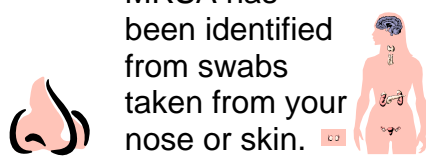
Please request MRSA screen on the laboratory request form.

Treatment / Decolonisation checklist				
Start date	Specific sites (tick)	Completion date	Rest Days	Next screen All sites ✓ date
	<input type="checkbox"/> Nose & Groin <input type="checkbox"/> Urine <input type="checkbox"/> Wound (State site _____) <input type="checkbox"/> IVI <input type="checkbox"/> Peg <input type="checkbox"/> Other _____			
	<input type="checkbox"/> Nose & Groin <input type="checkbox"/> Urine <input type="checkbox"/> Wound (State site _____) <input type="checkbox"/> IVI <input type="checkbox"/> Peg <input type="checkbox"/> Other _____			

Care pathway for people with MRSA

This pathway has been developed to guide you on what to expect during treatment.
There may be differences depending on your individual needs.

IDENTIFYING MRSA

MRSA has been identified from swabs taken from your nose or skin. 

Source Isolation / Blood Precautions
Visitors must report to the Nurses' Station BEFORE entering a patient's room

You may be moved into a single room and a yellow sticker put on the door. This is to advise people of the need to comply with Isolation precautions.

Further swabs will be taken during your stay to establish if the MRSA has gone.



TREATING



If you are a skin carrier you will be advised to bathe or shower for 5 days using an antiseptic wash. Hair should be washed twice in this period with the same solution.

To treat MRSA in your nose, a nasal ointment may be applied 3 times a day for 5 days.



You may be given antibiotics either orally or through a drip.

REDUCING THE SPREAD OF GERMS



Clean hands can reduce the spread of germs. Use the hand rub solution at your bedside. Rub into hands as you would when normal hand washing. There is no need to rinse off with water.

The doctors and nurses will be available to answer questions. A leaflet about MRSA is also available.



VISITORS



Visitors should wash their hands or use the available hand rub on entering your room and before leaving.



Please ask visitors not to sit on your bed.



Keep your belongings to a minimum. Ask visitors to take home extra items as well as flowers from your room.

DISCHARGE HOME

UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
INFECTION CONTROL MANUAL (DECEMBER 2008) FOR REVIEW DECEMBER 2010

Disclaimer: It is your responsibility to check against the intranet that this printout is the most recent issue of this document.

You may be asked to continue with treatment at home.

