Aneurin Bevan Health Board

Infection Prevention Policy

Control & Management of Methicillin Resistant Staphylococcus Aureus MRSA

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.
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1 Executive Summary

1.1 Purpose of Policy

This Policy specifies the approach of the Organisation to control Methicillin Resistant Staphylococcus aureus (MRSA) through;

- Surveillance
- Risk Assessment
- Contact Precautions
- Source Isolation
- Cohort Isolation
- MRSA Screening
- Decolonisation Regimes
- Treatment of MRSA Infection
- Appropriate MRSA Prophylaxis

Note: For specific advice on the control and management of MRSA in members of staff, please refer to separate policy.

1.2 Target Audience

Any member of staff having contact with patients, and those who have responsibility for providing healthcare at all levels of management.

1.3 Implementation

All divisions must ensure that;

- Staff have access to this policy
- Staff have the required resources to comply with this policy in terms of equipment, staffing levels and training.

2 Introduction

The control and management of MRSA within today’s healthcare system presents challenges to everyone involved in patient care.

MRSA remains a significant pathogen and it is vital that robust systems are in place to identify those at risk of MRSA acquisition, and those already affected, in order to reduce the incidence of MRSA infection and transmission to others within the healthcare setting.

3 Policy Statement

The Aneurin Bevan Health Board is committed to the prevention and control of MRSA Organisation wide through implementation of this policy.
4 Aim

➢ Provide information and advice for members of the public, staff, patients and their visitors in relation to MRSA

➢ To understand MRSA and why control of this organism is so important

➢ To set out the necessary steps to control the spread of MRSA within our Organisation and how to appropriately manage our patients and staff who are found to have the organism.

➢ To demonstrate controls based on risk assessment that provides a balanced and practical approach in the management of MRSA within the Aneurin Bevan Health Board.

5 Objectives

➢ Explain MRSA and why control of this organism is important

➢ State requirements for managing patients with MRSA

➢ Identify those who require screening

➢ Provide information on how to take an MRSA Screen

➢ Provide suggested regimens for eradicating MRSA carriage

➢ Clarify roles and responsibilities in the control & management of this organism

➢ Ensure patients with a history of MRSA that are admitted to the Organisation are promptly identified and managed appropriately

6 Responsibilities

The Infection Prevention Committee endorses and communicates the MRSA policy Organisation wide and provides advice and support on its implementation.

The Infection Prevention Team (IPT) are responsible for the production of an evidence-based policy to control MRSA and will audit compliance as part of a planned audit programme. The IPT will monitor and collect data on the incidence of MRSA and respond to increases with interventions to control further spread.

The Infection Prevention Team has primary responsibility for providing training on the policy where needed. Managers have responsibility to support the IPT by ensuring that staff are able to attend training sessions in response to identified needs.
All Organisation Employees from Board to Ward have responsibility for implementing this policy.

All wards and departments must have a copy of this policy accessible to staff.

7 What is MRSA?

MRSA is a resistant type of a very common micro-organism or bacteria called Staphylococcus aureus.

Staphylococcus aureus can be carried on the skin, or in the nose or throat of approximately 30% of people. Up to half of these may be the MRSA type.

Commonly used antibiotics cannot treat infections caused by MRSA. Some strains produce toxins that can cause severe skin and chest infections.

MRSA is short for Methicillin or Multi Resistant Staphylococcus Aureus.

In healthy individuals the presence of MRSA on the skin, in the nose and throat causes no harm and there are no symptoms that would show that any MRSA bacteria are present. This is called colonisation.

There is no evidence that MRSA poses a risk to healthy people, including healthcare workers and their families. There is no special risk to a healthy mother or baby prior to, during or after pregnancy in normal circumstances.

To cause harm, the MRSA needs to invade the tissues of the body and cause infection. Infection may occur when skin is broken, for example, at the time of an operation and post-operatively before the wound has healed. The bacteria can also be introduced into the body through invasive procedures such as venepuncture & cannulation, insertion of catheters and any other procedure that breaches the body’s natural defences. Individuals with chronic wounds or broken skin from skin disorders such as eczema are also at risk of acquiring MRSA that might lead to clinical infection in some patients.

Patients most susceptible are those in critical care wards and those undergoing surgery, particularly implant surgery such as vascular and orthopaedics.

MRSA infection can range from trivial skin infections to life-threatening conditions such as bacteraemia, endocarditis, osteomyelitis and pneumonia.

It is vital that patients presenting with MRSA infection are treated with appropriate antimicrobials following prompt diagnosis.
8 How is MRSA Spread?

These bacteria are mainly spread by direct contact with affected individuals and indirectly from items (e.g. equipment, soiled dressings, bedding etc.) contaminated with MRSA.

Airborne transmission can occur but is not the main method of spread provided good housekeeping arrangements are in place, and basic rules are followed to prevent the raising of any dust in the Healthcare setting. For example the use of static mops for cleaning, careful removal and bagging of linen from beds, and care when removing bandages and dressings to avoid dispersal of micro-organisms into the air.

In healthcare settings the main method of spread is via the hands of healthcare workers.

9 Management of MRSA

Effective management and control of MRSA is dependent upon the following:

- Accurate surveillance and the timely feedback of acquisitions to relevant health care workers and senior management
- Risk Assessment
- The identification of MRSA carriers through appropriate screening
- Contact Precautions
- Source Isolation
- Treatment
- Rigorous hand hygiene practice

9.1 Surveillance

Surveillance is undertaken routinely as part of the hospital’s infection control programme by the Infection Prevention Team and the data must be a recognized element of the clinical governance process. The purpose is to determine whether the MRSA is probably Healthcare-associated or Community-acquired and enable the IPT to rapidly identify MRSA clusters or outbreaks.

Increased rates of MRSA infection or colonisation acquired on particular wards can show poor infection control compliance. Conversely wards that do not have increasing rates of MRSA acquisition despite high numbers of known or community-acquired MRSA patients on the ward demonstrate good standards of infection control practice.

Surveillance data should be fed back to hospital staff routinely and considered regularly at hospital senior management committees.
MRSA surveillance data will be fed back in the form of Statistical Process Charts as follows:

- To Organisation Board via a quarterly report
- To the Formal Executive Team and Non-Executive Director Lead for Infection Control on monthly basis
- To divisions via the designated divisional infection control lead
- To Ward Managers
- Annual data will be fed back by the Infection Prevention Annual Report via the Quality and Governance Committee.

It is suggested that a Root Cause Analysis is conducted on any patient who has acquired an MRSA bacteraemia by the appropriate directorate.

### 9.2 New admissions

Patients admitted to any healthcare setting must be assessed as to their MRSA status as part of the admission assessment.

If an alert for MRSA appears on the Clinical Workstation, staff must inform the clinician responsible for the patient’s care, as the management of the patient with an MRSA alert will need to be reviewed. *(Please see section 9.3 on known positive patients).*

### 9.3 Known MRSA Patients

The clinical risk will vary depending on the patient, and the “speciality” where the patient is located.

In the case of patients undergoing invasive or surgical procedures, MRSA prophylaxis and current MRSA status will need to be considered and steps taken to reduce potential post operative MRSA infection. Advice can be obtained from the Consultant Microbiologist.

If possible, patients with a history of MRSA should have three negative MRSA screens prior to surgery. Please see section on screening pre-operatively for further information.

All healthcare workers in direct contact with patients known or suspected of having MRSA must maintain strict contact precautions whether or not the patients are source isolated.

Contact precautions consist of wearing disposable gloves and an apron. Eye and mouth protection must also be worn if splashing of blood or body fluids is anticipated in line with universal blood and body fluid precautions. Hands must be washed when the protective clothing is removed. Protective clothing must be disposed of as clinical waste.
Patients admitted with a history of MRSA require a full body screen on admission to check their current MRSA status. See **N.B.** below.

It is essential that the MRSA status of patients is communicated via healthcare staff on admission, transfer of care and discharge. As a safety precaution to this communication, the IPT alerts MRSA patients on the Clinical Work Station. Each time the patient is admitted or transferred within the Organisation this alert will remind staff that the patient has a history of MRSA.

**N.B.** — not all patients with a history of MRSA will have an MRSA alert on the system. For example:

- **Patients who do not have previous medical records in this Organisation.**
- **Patients whose MRSA result was processed in a laboratory outside of this Organisation.**
- **Patients who were MRSA positive prior to September 2001.**

Therefore the patient must be asked if they have a history of MRSA as part of the admission assessment.

### 9.4 New MRSA Patients

The IPT will telephone new MRSA results on in-patients to the ward or dept. and advise the nurse responsible for the patient’s care to place the patient into source isolation — **See Appendix 6.** In the acute setting an Infection Prevention Nurse (IPN) will visit the ward and document the result in the medical notes.

The nurse responsible for the patients care is required to provide the patient or their relative with an MRSA Patient Information Leaflet available from the intranet.

The Infection Prevention Nurses will provide advice and support to the multidisciplinary team in management of the patient and also visit the patient to discuss the MRSA result if required.

In the community setting the Infection Prevention Nurses telephone all new MRSA positive results for patients in the Community hospitals. If the patient has been discharged prior to the positive result being received, the positive result is communicated to the patient’s consultant via their secretary.

The Infection Prevention Nurses do not telephone results from GP initiated swabs. The results are sent from the laboratory to the surgery as for all other results. However the Infection Prevention Nurses are available to provide advice on MRSA to patients and the primary care team if needed.
9.5 **Contact Precautions**

Contact precautions must be maintained with all patients who are known or suspected of having MRSA. All staff handling the patient or having contact with the patient’s immediate environment must use disposable gloves, and aprons or gowns. Hands must be washed following removal of protective clothing. Protective clothing must be disposed of as clinical waste into an ‘infected clinical waste’ bag.

All waste generated during patient care must be disposed of as infected waste as per current Organisation Waste policy and regulations.

Masks are rarely necessary other than perhaps for procedures that may generate staphylococcal aerosols, such as sputum suction, chest physiotherapy etc. Other than this, the use of masks and visors are only required if there is a risk of blood or body fluid splashing as for universal blood and body fluid precautions which must be followed for all patients regardless of the patient’s MRSA status.

For advice in relation to visitors see section 13 of this policy.

9.6 **Source Isolation**

All MRSA positive patients are required to be source isolated in a side room in the acute setting – See Appendix 6.

However, patients in minimal-risk areas of hospital where MRSA is endemic do not require isolation. These areas include long-stay care of the elderly; Psychiatry; EMI. Rehabilitation units may not be minimal risk if post-operative patients are present. In high-risk areas where MRSA is endemic, isolation is recommended.

Standard source isolation procedures must be instigated for affected patients in areas assessed as other than minimal risk. The patients’ medical and psychological welfare should not be compromised by unnecessarily restrictive infection control practices. The IPT must be contacted in case of doubt.

- **The side room used for isolation purposes must contain a clinical hand washbasin. Ensuite facilities are preferred especially for patients who are ambulant and able to use the facilities provided.**

- **Equipment in the room must be kept to a minimum as a cluttered environment cannot be cleaned easily and does not convey a message of quality care.**

- **The patient must be provided with their own equipment i.e. stethoscope, sphygmomanometer, lifting sling (single patient use), commode etc. If this is not possible, such items must be effectively decontaminated following use. Please refer to the Infection Control Sterilisation and Disinfection**
Policy, Section 23 in the Infection Control Manual or the IPT or Organisation decontamination Manager if advice on decontamination is required.

- Disposable cutlery and crockery are not required.

- The patient’s notes, observation charts and nursing care plan etc must not be taken into the isolation room.

- Personal protective equipment must be kept just outside the room to aid compliance with contact precautions.

- Alcohol foam should be present at the point of care.

- A clinical waste sack must line the bin in the room and the bin must be a pedal operated type in working order.

- The door to the room should be kept closed to minimise spread to nearby areas. However if this affects patient safety in any way, a risk assessment must be made as to whether the door may be kept open.

- The door to the side-room must be closed during any procedures that may generate staphylococcal aerosols, i.e. chest physiotherapy, wound dressings or bed-making.

- A source isolation sign is to be downloaded from the intranet, printed on yellow paper, laminated and displayed on the door for staff and visitors to contact the nurse in charge before entering the room. This applies to all visitors including staff from other wards and departments e.g. phlebotomists, radiographers, medical teams, hotel services staff, must only enter the room once permission and instructions have been given by the nurse in charge of the patient or the ward. (See appendix 7).

It is important to ensure that patients are informed about source isolation. Please see section 13 and also appendix 8 for further information.

9.7 Deceased patients

The Infection control precautions are the same for handling deceased patients with MRSA as those used in life.

Wounds must be covered with an impermeable dressing.

The risk to relatives, mortuary staff or undertakers is negligible provided basic infection control precautions are followed.
9.8 Cleaning, Disinfection & Terminal Cleaning

The room should be cleaned daily using Actichlor plus at 2000 ppm. Nurses and domestics must be aware of their cleaning responsibilities – please refer to cleaning responsibilities chart.

Following discharge of the patient the isolation room requires thorough cleaning. This terminal cleaning requires input from Hotel Services and Nursing staff. As soon as the room is vacated the nursing staff must inform the Hotel Services supervisor who will arrange terminal cleaning and obtain replacement curtains.

- The nursing staff must remove all clinical equipment and either decontaminate or dispose of the items.
- Staff from Hotel Services must remove the curtains around the bed or at the window prior to any room cleaning and send them to the laundry as for infected linen (placed into an alginate bag, then into a red plastic bag and secured at the neck with yellow hazard tape).
- The room requires cleaning with hot water and detergent. Particular attention must be paid to the cleaning of all horizontal surfaces.
- After cleaning the surfaces must be disinfected with Chlorine releasing solution 2000ppm (0.2% solution). It is essential that the correct strength solution is used.
- Cleaning with detergent can be omitted if using a dual purpose chlorine solution such as Actichlor plus.
- Once cleaning and disinfection has been carried out, clean curtains can be put in place. The room does not require “airing” and provided all surfaces are dry another patient can use the room.

9.9 Cohort Isolation

Occasionally there are insufficient side rooms to isolate patients individually. A group of MRSA patients can be nursed together in a defined area of the ward e.g. a bay. Advice must be sought from the IPT. Ideally, patients without MRSA should not be cohort nursed with affected patients.

9.10 Theatre and Procedure (endoscopy, arteriogram, etc.) Departments

Known or suspected MRSA patients requiring invasive procedures within the theatre and Procedure departments must be treated as for infected cases. Please refer to Infection Control – Operational Guidelines for Theatres.
10 Transfer and Discharge of Colonised or Infected Patients

10.1 Transfer within the Organisation

Where possible transfers must be kept to a minimum. However this should not compromise their care in any way.

When transferring patients to other wards the receiving ward must be informed of the patient’s MRSA status before transfer so that arrangements can be made regarding contact precautions and a side-room if isolation is required.

When patients are ready for transfer i.e. from Critical Care to a General Ward, if a side room is required, but not available, please contact the Infection Prevention Team for advice. Critical Care beds should not be blocked.

As an added control measure the receiving ward must check for an MRSA alert on all transferred patients as part of the admission procedure. If an MRSA alert is seen on a patient transferred with no prior communication regarding MRSA, please contact the transferring ward and the IPT who will be able to advice.

Staff who are involved in the transportation of the patient must wear gloves and apron when preparing the patient for transfer. Gloves and aprons can be removed on transfer to the receiving ward.

Portering staffs do not need to know the MRSA status of a patient. However they must be advised and instructed on the need for contact precautions.

Any lesions/ wounds on the patient should be covered with an impermeable dressing, if possible.

Following transfer and before use on another patient the trolley or chair must be cleaned. Alcohol 70% (alcohol wipe) can be used unless the surfaces are soiled with blood or body fluids. If such soiling has occurred, a Chlorine releasing solution such as Actichlor 10,000ppm (1% solution) must be used as per spillage policy and then cleaned with detergent and water.

Staff must wash their hands and dry thoroughly after dealing with the patient and cleaning the trolley or chair. An antiseptic detergent such as Chlorhexidine must be used or ordinary soap followed by disinfection of dried hands with alcohol.

10.2 Transfer to another Hospital

When a patient is transferred to a hospital in another Organisation, the receiving ward/dept must be informed of the patient’s MRSA status prior to transfer. This communication is vital as the receiving Organisation will not have access to our MRSA alert system.
10.3 Ambulance Transportation

The Ambulance service must be notified in advance by the responsible clinician or delegated ward staff of the patient’s MRSA status.

Ambulance staff must use an alcohol hand rub after contact with the MRSA patient.

Most patients can be transported with others in the same ambulance without any special precautions, other than changing the bedding used by the patient. However, if a patient is being transported with a heavily discharging wound that cannot be contained in an impermeable dressing or the patient has widespread skin lesions advice should be obtained from the IPT who will carry out a risk assessment. It may be necessary to transport this patient alone and to instruct ambulance personnel in contact with the patient to wear disposable gloves and an apron. The IPT can advise the ambulance service in these special circumstances.

Patients at particular risk from MRSA acquisition must not be transported in the same ambulance as a known MRSA patient.

10.4 Discharge of Patients

MRSA patients should be discharged promptly from hospital when their clinical condition allows.

The patient’s General Practitioner must be informed and any other healthcare agencies involved in providing care to the patient. This should take place as part of the discharge planning.

If the patient is discharged to a nursing or residential home, the medical and nursing staff must be informed in advance. MRSA colonisation should not prevent discharge to a Nursing or residential home.

Patients should not be routinely screened for MRSA prior to discharge into the community.

The patients and their relatives should be provided with appropriate advice in relation to the risk posed by MRSA in the home setting. (Please refer to section 13 Advice to Patients and Relatives).

11 Purpose of MRSA Screening

- Identify MRSA in those patients most at risk of carrying MRSA to reduce potential spread of MRSA within the Organisation.

- Identify MRSA in those patients undergoing a procedure that puts them at increased risk of MRSA infection. A decolonisation regime can be
commenced to reduce or eradicate carriage of MRSA to minimise the risk of infection.

- Check for MRSA clearance following decolonisation treatment.
- Outbreak control. Screening may include patients and staff to ascertain the extent of the problem.

11.1 Screening protocol

Please refer to Appendices 1, 2, 3 and 4 for screening protocol and management for each clinical area according to risk, i.e. High-risk, Medium-risk, Low-risk and Minimal-risk respectively. Appendix 5 provides recommended screening protocol for antenatal patients.

The nasal and skin swabs should be moistened with sterile normal saline. Use a fresh sachet or vial of saline/sterile water for each patient.

It is important to allow three working days for the result.

**N.B. MRSA screening is only a guide to the MRSA status of the patient. A patient with a negative result may have MRSA, but in insufficient numbers to detect on the screen at that time.**

Compliance with MRSA screening will be monitored by the Infection Control Committee.

11.2 Pre-operative Screening

Patients who require elective implant surgery such as Orthopaedics and Vascular are at increased risk of MRSA infection. Infection post-operatively in these patients may have serious consequences. Therefore these patients are screened for MRSA before admission in the pre-admission clinic. Anyone found to have MRSA must be considered for treatment to eradicate the MRSA before surgery.

This screening may extend if Consultants within other surgical specialities decide to request pre-operative MRSA screening for their elective patients.

The success of this pre-operative screening depends upon effective communication between hospital staff, primary care staff and the patient.

Attempts should be made to eradicate MRSA carriage in patients found to have MRSA pre-operatively. This will take time. Therefore the Surgeon must risk assess the patient as to whether surgery is urgent or can wait until a decolonisation regime and post-treatment screening has been carried out.
In any event the patient with a history of MRSA, even if clear at the time of operation should be given antimicrobial prophylaxis specific for MRSA, for other than the most minor procedures.

Wherever pre-operative screening is carried out, it is essential that roles and responsibilities within the ward or dept are understood, and staff time is allocated to ensure the process is effective.

Staff roles and responsibilities must be designated to ensure the following:

- The patient is informed of the rationale for screening pre-operatively and implications of positive result.

- Patient is checked for any MRSA alert that would indicate previous history of MRSA before a screen is taken. If an MRSA alert is present the patient’s Consultant must be informed. The patient’s history for previous MRSA must also be checked through questioning the patient because some patients may have had MRSA at another Organisation. A history of MRSA will indicate the need for more than one negative pre-operative screen. Please see Appendix 9.

- Follow up of pre-admission screening results to ensure results are known prior to admission.

- The patient’s Consultant is informed of any positive result or history of MRSA, so that a prompt decision can be made on postponement or continuance of planned surgery.

- The patient is informed of a positive result, and given advice regarding treatment and further screening. The patient must also be informed of any delays expected with their planned surgery as a result of the MRSA results. If decolonisation fails the patient must be seen by their Consultant so that a decision can be made with the patient regarding future management.

- Inform the patient’s GP of the result, recommended decolonisation regime, and post treatment screening requirements. Suggested Pre-operative Action Plan for carriers of MRSA is available from the IPT and includes advice on decolonisation regimes and treatment. (See appendix 10)

- If a new date for surgery is given because the patient required MRSA clearance, ensure that the required three consecutive negative screening results are available before admission, and this is verified with the IPT.

- The negative screens remain valid for at least one month, provided the patient has not been in contact with a healthcare environment e.g. in-patient or resident of a nursing home etc. – See Appendix 6. In this
event, the IPT would suggest repeating the “third screen” in the week prior to surgery/admission.

- Patients who are at continuing high risk of acquiring MRSA between the time of preadmission screening and that of admission (e.g. they reside in a residential care facility which is known to have a high prevalence of MRSA) must be rescreened on admission, and should be isolated or cohorted according to policies in place on the admitting unit until both sets of screening results are known. This includes healthcare workers who continue to work following their preadmission screen.

The IPT can support staff by checking results of screens on request, advising on the policy, and talking to the patient and/or relatives who have specific concerns or anxieties in relation to MRSA.

The IPT recommends that a Care Pathway is followed for patients who require MRSA screening prior to elective surgery. This will ensure that patients receive optimum care through appropriate management.

### 11.3 Post-Treatment Screening

Screening is required on completion of treatment for infection or colonisation to check for clearance.

Negative full body screens are required as per screening protocol risk (Appendix 1-4). The National Guidelines recommend that clearance screens should be taken at weekly intervals. However, if time does not permit this, screens can be taken no less than 48 hours apart. A reduction in the period of time between each screen will affect the overall reliability of the negative results.

If clearance of colonisation is not achieved, a second course of topical treatment for decolonisation can be tried. However more than two courses of Mupirocin is not advised as resistance can develop. Advice must be sought from the IPT.

It is important that the patient is kept informed of the results and any anxieties due to continued presence of MRSA discussed in a sensitive manner.

### 11.4 Staff Screening

The screening of staff to check for MRSA carriage is sometimes necessary. Please refer to the separate Staff Screening Policy.

### 11.5 Decolonisation Regimes

Please see *appendix 11* for recommended regimes.
12 Treatment of MRSA Infection

The prompt commencement of appropriate antimicrobial treatment for those identified with MRSA infection will reduce the mortality and morbidity associated with this organism.

It is essential that clinicians are able to assess patients effectively to ascertain whether MRSA is causing an infection as opposed to colonisation. Where there is doubt the Infection Control Doctor or Consultant Microbiologist can advise.

Vancomycin or Teicoplanin, possibly combined with Rifampicin are the usual agents of choice for severe infections. Rifampicin must never be given on its own to treat MRSA as resistance will rapidly emerge. There are newer antimicrobials available that can be used to treat MRSA. It is recommended that discussion with a Consultant Microbiologist takes place before prescribing these.

For continuing treatment for less severe infections other agents may be considered if the MRSA is sensitive to these. To prevent further resistance advice must be sought from the Consultant Microbiologist.

The source of the Infection should be identified in patients presenting with MRSA bacteraemia and where possible removed, e.g. an intravenous cannula.

12.1 Antimicrobial Prophylaxis for MRSA

Patients with MRSA or a history of MRSA who require invasive procedures or surgical interventions should be considered for MRSA prophylaxis as many commonly used prophylactic antibiotic regimes do not cover MRSA. Vancomycin or Teicoplanin should be administered in the hour before commencing the operation, as close as possible to induction. Further doses may be needed if the operation is prolonged or there is a large volume of blood loss.

12.2 Urinary Catheters

If a urinary catheter needs to be changed when the urine is infected with MRSA (or any other potential pathogen), it is wise to administer a single dose of an antibiotic to which the organism is susceptible if the patient is particularly vulnerable to infection, e.g. if immunosuppressed.

If the antibiotic sensitivity test results are not yet available from the laboratory, blind treatment can be given based on the expected results for local common strains.

A single dose of gentamicin is generally suitable, but further advice can be sought from the medical microbiologist.
Advice to Patients, Visitors and Relatives

MRSA does not pose a risk to healthy relatives or visitors. However, if any visitors or relatives are healthcare workers with patient contact they should contact their Occupational Health Department as they may pose a risk to other patients in their care.

If any relatives or visitors are immunocompromised, or suffer from skin conditions such as eczema or psoriasis they are at increased risk of MRSA acquisition that may lead to infection. Please contact the IPaC for advice.

Relatives or visitors who have been in contact with MRSA should inform their GP or Consultant if they are due for any invasive or hospital treatment. Young babies should not visit.

Visitors who assist with the patient’s bodily care should be encouraged to wear disposable gloves and apron. Visitors who only have social contact with the patient such as shaking hands, do not need to wear protective clothing, but do need to wash hands on leaving the room.

Visitors and relatives should be advised to cover any cuts or broken areas with an impermeable dressing.

The IPT have produced patient information leaflets on MRSA for patients in the healthcare and community setting. They are available from the IPT or the Infection Control website on the Intranet. There is also a leaflet for patients’ soiled linen.

Visitors or relatives who are washing the patients’ soiled/used clothing must be provided with an information leaflet on this.

An Infection Prevention Nurse can visit patients and/or relatives to discuss MRSA in detail and any related anxieties they may have. Please contact us if this is required.

Organisation staffs have a duty of care to inform relatives of the required infection control precautions. However, we must not inform visitors of the patient’s MRSA status unless the patient has agreed to this. Please see appendix 8 for best practice points on informing patients and next of kin about MRSA.

Training

The IPT will provide training on all aspects of infection control and specific training on the MRSA policy as required.

Through MRSA surveillance and audit the IPT may highlight areas of non-compliance with the MRSA Policy. This will be fed back to the staff...
concerned and their manager. If lack of understanding of the MRSA policy is identified, specific training on the policy will be made available to the staff.

It is important that the ward manager or delegated member of staff makes this policy known to any new staff member.

If staff training is arranged to address non-compliance or identified training needs staff must be allocated time to attend. The IPT will develop a training session(s) to meet individual ward/divisional requirements.

15 Outbreak Identification and Management

The IPT monitors MRSA acquisition within the Organisation as part of a rigorous surveillance programme. Increases in MRSA acquisition are readily identified and action taken.

Action taken is dependent upon the numbers involved, the speciality, and background level of MRSA etc. Control measures include

- Identifying staff with skin lesions
- Deep cleaning of affected ward(s)
- Audit of infection control practice, particularly compliance with the MRSA screening policy;
- Staff screening
- Possibly wider screening of patients.

The MRSA isolates can be sent to the reference laboratory for typing and other tests to establish source or link.

Typing of MRSA can be of limited help, as the majority of MRSA are currently the same type.

The ward staff, clinicians and senior management are informed of the cluster or outbreak.

Occasionally a decision to close the ward to further admissions is made, particularly where control measures have not resolved the outbreak or because of a lack of resources to effectively manage the increased numbers of affected patients, i.e. staffing levels or number of side rooms etc.

16 Vancomycin – resistant Staphylococcus aureus (VRSA & VISA)

There has been a small but increasing number of clinical isolates with reduced glycopeptide susceptibility such as Vancomycin – resistant Staph aureus (VRSA). It is essential that microbiological and infection control advice is sought if a patient isolates VRSA or Vancomycin – intermediately susceptible Staph aureus (VISA).
17 Further Information

This policy is based on available guidance. Please see section 18, References.

The policy has also been influenced by the IPT members’ experience of day-to-day management of MRSA in a large Organisation.

Further information is available from the Isolation policy; Sterilisation & Disinfection policy, Staff Screening Policy, and Major Outbreak policy available in the Infection Control Manual on the intranet.

If further advice is required please contact the Infection Prevention and Control Team.

18 References


Appendix 1 - Management & Screening Protocol – High Risk

### CLINICAL RISK AREA

The following areas are to be considered High-Risk for management of MRSA.

<table>
<thead>
<tr>
<th>CRITICAL CARE</th>
<th>HAEMATOLOGY</th>
<th>TRAUMA &amp; ORTHOPAEDICS</th>
<th>DERMATOLOGY</th>
<th>NEONATES</th>
<th>BREAST SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CRITICAL CARE</strong></td>
<td><strong>HAEMATOLOGY</strong></td>
<td><strong>TRAUMA &amp; ORTHOPAEDICS</strong></td>
<td><strong>DERMATOLOGY</strong></td>
<td><strong>NEONATES</strong></td>
<td><strong>BREAST SURGERY</strong></td>
</tr>
</tbody>
</table>

### SCREENING REQUIREMENTS

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Screening Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>Nose, throat, groin/perineum</td>
</tr>
<tr>
<td>Haematology/Dermatology</td>
<td>Nose, throat, groin/perineum</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>Nose, throat, axilla and groin/perineum</td>
</tr>
<tr>
<td>Neonates *See Appendix 13 for suggested decolonisation for Neonates with MRSA</td>
<td>Nose, throat, groin/perineum and umbilicus</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td>Nose, throat and axilla</td>
</tr>
</tbody>
</table>

**In addition** to these sites,
- CSU must be sent if the patient has a urinary catheter
- Wound swab if any wounds present (state site)
- Abnormal areas of skin e.g. eczema
- Skin lesions e.g. tracheostomy sites
- If the patient has a productive cough, sputum sample should be sent separately with the appropriate request form

**ALL** patients to be screened. (Those patients not screened prior to admission via a managed pre-admission screening process must be screened **on admission**)

- Patients who are for **elective** orthopaedic or vascular operations should be screened pre-operatively in pre-admission clinic, and results known prior to admission.
Where possible, isolate transfers from other hospitals until results are known.

Screens will be taken weekly in Adult and Neonatal ICU.

**MANAGEMENT OF MRSA PATIENTS**

Patients known or suspected of having MRSA should be source isolated until the patient has had three consecutive negative full body screens as per policy. However, please see note below regarding elective orthopaedic and elective vascular patients.

In the critical care areas isolation of the patient is recommended, however this will depend on availability of side-rooms and the requirements of the critically ill patient. Discussion with the Infection Prevention Team is advised.

On Neonatal Units where babies are “isolated” in incubators, babies may potentially be kept in the main area with strict contact precautions; however this should be discussed with the Infection Prevention Team.

Strict contact precautions must be taken with all patients.

**N.B.** Patients with a history of MRSA and who are considered clear as per screening policy must be accommodated in a side-room and source isolated for the duration of their stay on elective vascular and elective orthopaedics, or as directed by the patient’s Consultant.

**COMMENTS**

If a patient is admitted please check Clinical Workstation for an MRSA alert. If an MRSA alert is seen please take strict contact precautions and inform the patients’ clinician.

Patients undergoing invasive or surgical procedures who have a history of MRSA must be considered for antibiotic prophylaxis specific for MRSA.

Advice can be obtained from the Microbiologist. Where possible, clearance of MRSA should be attempted prior to any elective procedure to reduce the risk of post-operative MRSA infection.
Appendix 2 - Management & Screening Protocol – Medium Risk

CLINICAL RISK AREA

The following areas are to be considered Medium-Risk for management of MRSA.

OBSTETRICS – See Appendix 5
GYNAECOLOGY
GENERAL SURGERY

SCREENING REQUIREMENTS

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Screening Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics</td>
<td>Nose, throat, groin/perineum</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Nose, throat, groin/perineum</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Nose and throat</td>
</tr>
</tbody>
</table>

In addition to these sites,
- CSU must be sent if the patient has a urinary catheter
- Wound swab if any wounds present (state site)
- Abnormal areas of skin e.g. eczema
- Skin lesions e.g. tracheostomy sites
- If the patient has a productive cough, sputum sample should be sent separately with the appropriate request form

MANAGEMENT OF MRSA PATIENTS

Patients known or suspected of having MRSA should be source isolated with strict contact precautions until patient has had 3 consecutive negative full body screens as per policy.

COMMENTS

Patients undergoing invasive or surgical procedures who have a history of MRSA must be considered for antibiotic prophylaxis specific for MRSA. Advice can be obtained from the Microbiologist. Where possible, clearance of MRSA must be attempted prior to any elective procedure to reduce the risk of post-operative MRSA infection.

If a patient is admitted please check Clinical Workstation for an MRSA alert. If an MRSA alert is seen please take strict contact precautions and inform the patients’ clinician.
Appendix 3 - Management & Screening Protocol – Low Risk

<table>
<thead>
<tr>
<th>CLINICAL RISK AREA</th>
<th>LOW RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following areas are in the Low-Risk category in relation to MRSA.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICINE (Unscheduled Care)</th>
<th>PAEDIATRICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCREENING REQUIREMENT</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Screening Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>Nose and Throat</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Nose and Throat</td>
</tr>
</tbody>
</table>

In addition to these sites,
- CSU must be sent if the patient has a urinary catheter
- Wound swab if any wounds present (state site)
- Abnormal areas of skin e.g. eczema
- Skin lesions e.g. tracheostomy sites
- If the patient has a productive cough, sputum sample should be sent separately with the appropriate request form.

In Paediatrics where the incidence of MRSA is low, screening on admission can be limited to children with a history of MRSA and those transferred from another hospital.

A full body screen* is required for all paediatric patients who will be having a surgical intervention that will require a surgical implant (e.g. orthopaedics)

*Nose, throat, axilla, groin/perineum (plus additional sites above).

MANAGEMENT OF MRSA PATIENTS

Patients known or suspected of having MRSA should be source isolated with contact precautions until the patient has had 3 consecutive negative full body screens as per policy.

COMMENTS

If a patient is admitted please check Clinical Workstation for an MRSA alert. If an MRSA alert is seen please take strict contact precautions and inform the patients’ clinician.

Patients undergoing invasive or surgical procedures who have a history of MRSA must be considered for antibiotic prophylaxis specific for MRSA.
Advice can be obtained from the Microbiologist. Where possible, clearance of MRSA should be attempted prior to any elective procedure to reduce the risk of post-operative MRSA infection.
Appendix 4 - Management & Screening Protocol – Minimal Risk

CLINICAL RISK AREA | MINIMAL
--- | ---
The following areas are to be considered minimal-risk for management of MRSA.

LONG STAY | MENTAL HEALTH
LEARNING | DAY HOSPITALS
DISABILITIES | REHABILITATION

SCREENING REQUIREMENTS
Screening is only required;

- If a patient is due to undergo an elective invasive procedure in an acute site within the organisation (please contact the IPT for advice about screening requirements).
- If requested by Infection Prevention Team.

Please contact Infection Prevention Team for advice about patients with a history of MRSA.

MANAGEMENT OF MRSA PATIENTS
Contact precautions to be taken if patient is known or suspected of having MRSA.

In some circumstances, patient may require their own room. Please refer to Risk Assessment for Isolation tool and contact Infection Prevention for advice.

COMMENTS
If a patient is admitted please check the Clinical Workstation for an MRSA alert. If an MRSA alert is seen please take contact precautions and inform the patients’ clinician.

Patients undergoing invasive or surgical procedures who have a history of MRSA must be considered for antibiotic prophylaxis specific for MRSA. Advice can be obtained from the Microbiologist. Where possible, clearance of MRSA must be attempted prior to any elective procedure to reduce the risk of post-operative MRSA infection.

Patients may require treatment in these areas prior to transfer to the acute setting for elective surgery. Please contact Infection Prevention for advice.

Depending on the type of patients on the ward/unit, this may be classified as medium risk.
Appendix 5 - MRSA Screening Protocol during Antenatal Period

(APROVED BY OBSTETRIC GUIDELINE GROUP)

A MRSA SCREEN IS REQUIRED AT 30-36 WEEKS of PREGNANCY FOR ANY WOMAN WHO:

- Is booked for an elective Caesarean. If a decision is made after week 36 weeks that the woman will have an elective Caesarean please screen when decision made.
- Has been a hospital inpatient within the last 12 months including any admission to the gynaecology ward (Antenatal admissions to the obstetric ward are excluded).
- Has ever had MRSA isolated or diagnosed in the past. (Please contact Infection Prevention Nurse for advice regarding screening.)
- Is a healthcare worker (If the lady works after 36 weeks they will need to be re-screened when they stop work)
- Any skin conditions such as eczema or psoriasis

Swabs will need to be taken from the Nose, Throat, Groin/Perineum

In addition to these sites,

- CSU must be sent if the patient has a urinary catheter
- Wound swab if any wounds present (state site)
- Abnormal areas of skin e.g. eczema
- Skin lesions e.g. tracheostomy sites
- If the patient has a productive cough, sputum sample should be sent separately with the appropriate request form

Swabs should be moistened with sterile saline or water if sample site is dry (e.g. nose and groin).

The midwife undertaking the screen is responsible for accessing the results. Contact Infection Prevention for further advice following a positive screen.

Infection Prevention Team

Royal Gwent: 01633 238101/4921
Nevill Hall: 01873 732048/2613
Community: 07903 324603/07903 324597
Appendix 6

Risk Assessment for need for Isolation for MRSA

Due to the limited number of cubicles in some acute areas of the organisation, risk assessments are required to ensure patients with high risk pathogens are prioritised for isolation.

In the first instance, patients with C difficile, diarrhoea and vomiting, respiratory borne infections, chicken pox and shingles should be prioritised.

Does the patient have a positive MRSA result?

YES

Has the patient had 3 negative full body screens including any positive sites not included in the FBS? The last screen must have been taken in the last month*.

NO

YES

Isolate until 3 negative full body screens obtained 1 week apart. Include any positive sites not included in the FBS

No need to isolate

NO

Has the patient had 3 negative full body screens obtained 1 week apart. Include any positive sites not included in the FBS

* Please seek advice from Infection Prevention in relation to patients admitted for surgery

* Please seek advice from Infection Prevention in relation to patients admitted for surgery

Approved by: Infection Control Committee

Status: Issue 2

Issue date: 12 November 2012

Review by date: 12 November 2015
Appendix 7 – Source Isolation Sign
PRINT ON YELLOW PAPER

Aneurin Bevan Health Board

Would all staff & visitors please contact the Nurse in Charge before entering this room.

THANK YOU
Appendix 8 - Informing Patients & Next of Kin about MRSA

The Healthcare Team’s responsibilities

It is essential that all competent patients be told about their MRSA status as soon as possible after the Nurse or Doctor has received the result. If the patient is not competent, establish who their nominated next of kin is and share this information with them.

This information should be given in a discrete manner, remembering to preserve the patient’s confidentiality as much as possible. It is important to appreciate that staff who come into contact with MRSA on a regular basis can underestimate the negative impact it may have on the patient or their family.

By ensuring the following approach is taken you can help to minimise this impact:

Try to be alert for responses that may indicate that the patient/next of kin is afraid or misinformed and use your skills to support and reassure them.

Use uncomplicated language to explain what the problem is.

Inform the patient/next of kin about what will be happening to help them following the MRSA result.

If the patient/visitors need to take precautions tell them exactly what needs to be done and tell them what precautions staff will be taking.

Ask the patient/next of kin to tell you briefly what you have explained to them (in this way you can rectify misunderstandings early on).

Support verbal information by providing written information as well. Wherever printed patient information is available relating to the patient’s specific infection, use this as your framework: in this way you can reassure yourself that the information you are giving is correct and knowledgeable. Always give the patient/next of kin a copy to keep.

If you are unable to use printed information, write down the relevant information in bullet point form, keep a copy in the patients’ notes & give a copy to the patient/next of kin. Document in the nursing or medical notes that the patient and/or family have been informed.

The Infection Control nurses are available to see patients or next of kin on a discretionary basis. For example, if the patient/next of kin asks to see them or, if the nurse or doctor believes that more detailed information is required from the Infection Control Team, after the healthcare team have spoken to the patient/next of kin.

Remind the patient/next of kin that if, at any time, they have any questions or worries in relation to the MRSA they should discuss it with a member of the healthcare team.
Appendix 9 - Protocol for Patients with a History of MRSA awaiting Surgery

1. All patients attending pre-admission clinic must be checked as to whether they have a history of MRSA by:
   - Looking for an MRSA alert on the Clinical Workstation or PAS*.
   - Asking if they have a history of MRSA.
   * Patients with MRSA prior to September 2001, may not have an alert on the system. However, it may be recorded in their notes.

2. Patients with a history of MRSA will require a full body screen at pre-admission clinic.

   An MRSA screen consists of nose, throat, axillae (orthopaedic, breast and permanent pace maker operations) perineum, CSU if a urinary catheter is present and also includes a swab(s) of any wound(s), abnormal or damaged skin. A groin swab is an acceptable alternative to the perineum if the patient objects or physical disability precludes it. Swabs should be moistened with sterile saline or water if sample site is dry.

3. The Infection Control Team must be contacted who will check if the patient has had any recent screens, as three consecutive negative screens will be required. One negative pre-admission screen will not meet these requirements.

4. The consultant responsible for the patient must be informed if any patient due for surgery has a history of MRSA. The infection control team advises that positive patients should be decolonised if appropriate. Three consecutive negative screens obtained a week apart prior to surgery are recommended if time permits.

   Surgery can go ahead as planned if urgent, however an appropriate decolonisation regime should be commenced, and the patient must be considered for antibiotic prophylaxis specifically for the MRSA. The decision for surgery, as always, rests with the Consultant responsible for the patient. Please refer to MRSA policy and Consultant medical microbiologist for further advice.

5. The pre-admission nurse or designated member of staff will need to check the pre-admission screening results for the patient. Any patient who re-isolates MRSA should be considered for decolonisation treatment. This can be managed via their GP with their agreement. A suggested decolonisation regime (and letter informing the GP of the screen result) can be faxed to the surgery by the designated member of staff if required.

   The pre-admission nurse or designated member of staff will need to follow up the patient to check that three screens have been taken post treatment. Once three consecutive negative screens have been obtained the consultant's
secretary must be informed so that the patient can be given a date for surgery. It is important that the date for surgery is within two to three months of the negative screen results. Where possible a surgery date close to the results is preferred. We would recommend a maximum time interval of two weeks. The rationale for this is that the patient may recolonise in the interval between screening and surgery. The risk would be greater if the patient was in a Nursing or Residential Home or having contact with healthcare providers etc. If in doubt please contact the Infection Control Team.

**Important note:**

A patient who has not had three consecutive negative screens will need isolation and barrier nursing and must be placed last on the theatre list regardless of whether a negative MRSA screen has been obtained. MRSA prophylaxis must also be considered.

Surgical patients who have had three consecutive negative screens at the recommended time intervals will not require isolation and barrier nursing* but MRSA prophylaxis must still be considered.

*Please note* Orthopaedic patients with a history of MRSA who have had three consecutive negative screens must still be isolated and barrier nursed on the elective orthopaedic and elective vascular wards unless directed by the Consultant in Charge.

Microbiological advice is available 24 hours, 7 days a week. Out of hours please contact the Consultant Microbiologist via the main switchboard.
Appendix 10 - Suggested Preoperative Action Plan for Carriers of MRSA

(METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS)

Decolonisation regime for Carriers of MRSA.

Patients must be checked by prescribing physician regarding any allergies or contraindications. Advice on alternative decolonisation regimes is available from the Consultant Microbiologist via hospital switchboard.

Nasal Carriage/Colonisation
- Apply mupirocin 2% in paraffin base (Bactroban nasal) to each nostril three times daily for 5 days.
- The patient should use antiseptic detergents for washing e.g. Chlorhexidine gluconate 4% (Hibiscrub)
- Wash hair twice weekly with prescribed antiseptic.
- If skin irritation is experienced the patient must inform the GP immediately. An alternative agent may be suggested.

Skin Carriage/Colonisation (positive axilla, groin or perineum)
- Treat with Chlorhexidine Gluconate 0.2% (Corsodyl) mouthwash 3 times a day or spray twice a day for 5 days.
- Daily antiseptic bathing for 5 days e.g. with Chlorhexidine 4% (Hibiscrub)
- Wash hair twice weekly with prescribed antiseptic.
- Seek dermatological advice for patients with skin disorders or fragile skin.

Throat Carriage/Colonisation
- Treat with Chlorhexidine Gluconate 0.2% (Corsodyl) mouthwash 3 times a day or spray twice a day for 5 days.
- The patient should use antiseptic detergents for washing e.g. Chlorhexidine gluconate 4% (Hibiscrub)
- Wash hair twice weekly with prescribed antiseptic.
- May be difficult to eradicate and oral antibiotic may be needed.

Small Skin Lesions
- For small lesions apply Mupirocin 2% in polyethylene glycol base (Bactroban Cream) up to 3 times daily for no more than 5 days. **Important Cream and Ointment are not interchangeable.**
- *(NB Advice from Consultant Microbiologist must be obtained for large lesions or wounds that appear infected).*

Patients with Eczema, Dermatitis or other Skin Conditions

Attempts should be made to treat the underlying skin condition. Advice on suitable eradication protocols for these individuals should be sought from a consultant dermatologist. Oilatum bath additive or Oilatum plus (with added benzalkonium chloride 6% and triclosan 2%) may be used with these patients; these should only be prescribed on the advice of a dermatologist.
Post-treatment screening.

TO BE COMMENCED 48-HOURS AFTER COMPLETION OF DECOLONISATION.

- 3 full body screens* should be taken 1 week apart.
- If any screening swabs are positive, a second attempt to decolonise should be considered. However, avoid prolonged or repeated courses, which encourage selection of mupirocin resistance in Staphylococcus aureus.
- If advice is required, please contact the Infection Control Team or Microbiologist via hospital switchboard.

When screening is completed please ensure that the pre-assessment clinic is aware of the results to allow the patient to be booked in for their surgery.

*A full body screen consists of nose, throat, axilla (orthopaedic, breast and permanent pace maker surgery only), perineum or groin, wounds / broken skin, (if catheterised) CSU.
Appendix 11 - Suggested Decolonisation Regime for Carriers of MRSA

Patients must be checked by prescribing physician regarding any allergies or contraindications. Advice on alternative decolonisation regimes is available from the Consultant Microbiologist via hospital switchboard.

**Nasal Carriage/Colonisation**
- Apply mupirocin 2% in paraffin base (Bactroban nasal) to each nostril three times daily for 5 days.
- The patient should use antiseptic detergents for washing e.g. Triclosan 2% (Aquasept) or Chlorhexidine gluconate 4% (Hibiscrub)
- If skin irritation is experienced the patient must inform the GP immediately. An alternative agent may be suggested.

**Skin carriage/colonisation (i.e. Positive axilla, groin, or perineum)**
- Daily antiseptic bathing for 5 days e.g. with Triclosan 2% (Aquasept) or Chlorhexidine 4% (Hibiscrub)
- Wash hair twice weekly with prescribed antiseptic.
- Seek dermatological advice for patients with skin disorders or fragile skin.

**Throat Carriage/Colonisation**
- Treat with mouthwash or spray, e.g. Chlorhexidine gluconate 0.2% (Corsodyl) for 5 days.
- May be difficult to eradicate and oral antibiotic may be needed.

**Small skin lesions**
- For small lesions apply Mupirocin 2% in polyethylene glycol base (Bactroban Cream) up to 3 times daily for no more than 5 days. **Important Cream and Ointment are not interchangeable.**

*(N.B. Advice from Consultant Microbiologist must be obtained for large lesions or wounds that appear infected)*.
Infection Prevention Team

Appendix 13 - Standard Operating Procedure
Treatment of Neonates with MRSA Colonisation

Methicillin-resistant Staphylococcus aureus (MRSA) colonisation continues to be of concern for neonatal intensive care units. Although MRSA septicaemia is rare, babies admitted to neonatal units are susceptible to infections and should be considered at risk.

The following standard operating procedure standardises the action taken if a neonate is found to be colonised with MRSA.

- A risk assessment & decision should be undertaken by the Neonatal Consultant regarding the decolonisation of the baby, in consultation with advice from the Consultant Microbiologist if required.

Suggested MRSA Decolonisation Regime:

Skin Decolonisation

Octenisan wash lotion should be applied once a day for five days.

Octenisan is an antimicrobial cleansing solution intended to be used for the decontamination of MRSA colonised skin in patients and healthcare workers.

Due to the absence of percutaneous absorption and its good skin compatibility there are not normally any objections against the safe intended use of Octenisan in babies or preterm infants. However, as there is limited information on systemic absorption caution must be exercised in preterm babies especially those with immature broken skin. Octenisan should be discontinued if local irritation occurs.

How to use Octenisan - Neonatal washing procedure:

**Step 1** - Wet the baby's skin by immersing in a bath or by wiping over the body with gauze/cotton wool & water.

**Step 2** - Apply Octenisan to the baby using a single use gauze/cotton wool paying particular attention to the creases e.g. armpits, umbilicus, groin.

**Step 3** - Ideally the contact time with Octenisan should be 3 minutes.
If the baby is likely to become cold a minimum of 1 minute is acceptable. **THE BABIES NORMOTHERMIA MUST BE MAINTAINED.**

**Step 4** - The Octenisan should then be rinsed off using either fresh clean water or with gauze/cotton wool & water

**Nasal Decolonisation**

Mupirocin (Bactroban Nasal) 2% in a paraffin base x 3 daily for 5 days.

Apply to inner surface of each nostril with a cotton bud.

**Post Treatment Screening**

Screen 48 hours after completing topical treatment. Three negative screens at least a week apart are required before declaring the babies MRSA status as negative.