METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (M.R.S.A.) POLICY

First Issued by/date | Issue Version | Purpose of Issue/Description of Change | Planned Review Date
---|---|---|---
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Named Responsible Officer:- | Approved by | Date
---|---|---
Infection Prevention and Control Lead | Infection Control Committee | 18th June 2008

Policy File:-
Infection Control Policy No 10 | Impact Assessment Screening Complete-May 2008 | Full Impact assessment Required - No

Key Performance Indicator

1. Community MRSA Bacteraemia rates
2. Attendance levels at infection control training
3. Compliance with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection

UNLESS THIS VERSION HAS BEEN TAKEN DIRECTLY FROM THE PCT WEB SITE THERE IS NO ASSURANCE THIS IS THE CORRECT VERSION
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Meticillin Resistant Staphylococcus Aureus (M.R.S.A) Policy
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Wirral PCT

Meticillin Resistant Staphylococcus aureus (MRSA) Policy

Introduction

Meticillin Resistant Staphylococcus aureus (MRSA) is a variety Staphylococcus aureus (S.aureus) that has developed resistance to a type of penicillin called meticillin and other antibiotics that are used to treat infections. It is commonly associated with healthcare and can cause a healthcare associated infection.

Meticillin has been used in place of the established ‘methicillin’ in accordance with the new International Pharmacopoeia guidelines.

Policy Aim

The purpose of this policy is to provide guidance on the control and prevention of the spread of MRSA in primary care settings in line with the duties identified in the Health Act (2006) Code of Practice for the Prevention and Control of Health Care Associated Infections. The principles contained within this policy reflect best practice and are in line with the Department of Health Essential Steps to safe, clean care, Managing MRSA in a non acute setting.

It is the responsibility of each Independent Contractor to reduce Healthcare Associated Infection (HCAI) and ensure the Health and Safety of staff. The PCT recommends that contractors apply the principles of this policy as minimum standards within their practices to ensure their professional and contractual duties are discharged.

Policy outcome

- Care will be given in line with accepted best practice
- Staff will be aware of the precautions that need to be taken to prevent the spread of MRSA
- Patient care will not be compromised due to their infection
- Cross infection with MRSA should be minimised
- Staff will be aware of the governance processes to ensure best practice and ‘learning from experience’
- Staff will be aware of the appropriate use of screening and eradication therapy
Target group

- PCT salaried staff.
- Shared as best practice with Independent General Practice staff and General Dental Practice staff and where appropriate, Independent Pharmacists and Optometrists.

Specific responsibilities

Chief Executive

The Chief Executive has overall responsibility for ensuring infection prevention and control is a core part of the Trust's governance and patient safety programmes.

Board

The Board has collective responsibility for ensuring assurance that appropriate and effective policies are in place to minimise the risks of health care associated infections.

Director of Infection Prevention and Control

It is the responsibility of the Director of Infection Prevention and Control to oversee the development and implementation of infection prevention and control policies.

Infection Prevention and Control Team

It is the responsibility of the Infection Prevention and Control Team to ensure this policy is reviewed and amended at the review date or prior to this following new developments in the management of MRSA.

Service Managers

It is the responsibility of managers to ensure that staff have read the MRSA policy and participate in the Root Cause Analysis process for MRSA bacteraemia.

Staff

It is the responsibility of staff to ensure they follow the advice on the management and control of MRSA as detailed in this policy.
Cross reference related PCT policies

- Risk Assessment Policy
- Serious and Untoward Incident Policy
- Policy and Procedure for the Administration of Sub Cutaneous Fluids
- Procedure for Cannulation for Wirral Intermediary Care Service.
- Procedures for Aseptic and Clean Techniques
- Procedure following Expected Death of an Adult in Community Nursing
- Male Catheterisation
- Catheter Care
- Female Catheterisation
- Procedure for taking a Wound Swab
- Hand Decontamination Policy
- Personal Protective Equipment (Standard Precautions)
- Healthcare Waste
- Decontamination of re-usable medical devices
- Meticillin Resistant Staphylococcus Aureus (MRSA) Decolonisation Guidance
- Dress Code Guidance

Evidence to support policy

National Resource for Infection Control. Clinical Practice. MRSA
www.nric.org.uk

Health Protection Agency. MRSA
www.hpa.org.uk

Background

M.R.S.A. stands for Meticillin-Resistant Staphylococcus Aureus.

Staphylococcus aureus is a bacterium that is often found in the nose and throat of approximately one quarter of healthy people, it is commonly found on intact skin where it is carried asymptomatically. Infections are commonly endogenous in nature, being caused by the person's own strain. Staphylococcus aureus is the commonest cause of localised wound and skin infections. Some strains of Staphylococcus aureus have developed resistance to commonly used antibiotics like flucloxacillin and including penicillin called meticillin. This situation has arisen through over use and misuse of antibiotics over the years and is usually acquired during exposure to hospitals or other healthcare facilities; these are often termed healthcare-associated or hospital associated MRSA (HA-MRSA). MRSA is no more virulent than an antibiotic sensitive staphylococcus aureus but the options for treatment of an infection are more limited.
MRSA, like any other pathogenic bacteria can cause infection if it has an opportunity to enter the body, this may be through cuts or grazes, surgical or chronic wounds, invasive devices i.e. catheters, intravenous devices. If bacteria enter the bloodstream it can cause serious infections such as bacteraemia.

**Community- associated MRSA (CA-MRSA)**

New strains of MRSA have recently emerged which cause infections in community patients who have had no previous history of direct or indirect contact with healthcare, these strains have been termed community MRSA (CA-MRSA). Prevalence is low, currently estimated at less than 0.5% of all MRSA. These strains are still susceptible to a wide range of antibiotics.

**Risk groups for CA-MRSA:**

- Children under 2 years of age
- Athletes (mainly contact-sport participants)
- Injecting drug users
- Men who have sex with men
- Military Personnel
- Inmates of correctional facilities, residential homes or shelters
- Vets and pet owners
- Patients with post flu-like illnesses and/or severe pneumonia
- Patients with concurrent soft skin tissue infections
- History of colonisation or recent infection with CA-MRSA
- History of antibiotic consumption in the previous year, particularly quinolones or macrolides.

**Differences between CA-MRSA and HA-MRSA:**

<table>
<thead>
<tr>
<th>Hospital associated-MRSA</th>
<th>Community associated-MRSA</th>
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<tbody>
<tr>
<td><strong>Typical patient</strong></td>
<td></td>
</tr>
<tr>
<td>Elderly, debilitated and/or critically or chronically ill</td>
<td>Young, healthy people; students, athletes and military service personnel</td>
</tr>
<tr>
<td><strong>Infection site</strong></td>
<td></td>
</tr>
<tr>
<td>Often bacteraemia with no obvious infection focus. Also surgical wounds, open ulcers, IV lines and catheter urines. May cause ventilator associated pneumonia</td>
<td>Often spontaneous. Skin infections: cellulitis and abscesses. May cause necrotising community acquired pneumonia, septic shock or bone and joint infections</td>
</tr>
<tr>
<td><strong>Transmission</strong></td>
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<tr>
<td>Within healthcare, little spread among household contacts</td>
<td>Community acquired. May spread in close community settings e.g. families</td>
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In an inpatient setting

In an outpatient or community setting

History of MRSA colonisation/infection, recent surgery; admission to a hospital or nursing homes, antibiotics; renal dialysis; permanent indwelling catheter; skin ulcers; diabetes

No significant medical history or health care contact

Community spread is limited, PVL genes usually absent

Community spread occurs easily, PVL genes often present, predisposing to necrotising soft tissue or lung infections

Choice of agents is often more limited

Currently more susceptible to antibiotics

**Panton-Valentine Leukocidin (PVL) toxin**

Infections caused by PVL-SA are currently uncommon in England and Wales. Less than 2% of all Staphylococcus aureus strains, both meticillin sensitive and resistant, have been found to have the potential to produce a toxin called Panton-Valentine Leukocidin (PVL) which destroys white blood cells and is associated with an increased ability to cause disease. However it is still sensitive to many antibiotics.

In common with Staphylococcus aureus infections in general, PVL Staphylococcal aureus (PVL-SA) predominantly causes skin and soft tissue infections but it can also cause invasive infections, the most serious of which is a necrotising Haemorrhagic pneumonia.

**Risk factors for PVL-SA**

**“5 C's”** of risk factors:
1. Contaminated items
2. Close contact
3. Crowding
4. **Cleanliness**
5. **Cuts and other compromised skin integrity**

e.g. households, close contact sports such as wrestling, American football, rugby, judo, military training camps, gyms, prisons.

Management of PVL-SA is in ICP12 Panton-Valentine Leukocidin Staphylococcus aureus (PVL-SA) Guidance.

**Healthcare-Associated MRSA (HA-MRSA)**

HA-MRSA is the commonest strain of MRSA identified in primary care. The bulk of this policy will be directed to the identification and management of HA-MRSA.

HA-MRSA can be found as either a colonising or infecting organism.

**Colonisation:** This is where MRSA is identified through a microbiological culture to be present on the body or on a chronic wound but the person has no signs of infection. Colonisation with MRSA may be long term. Colonisation with MRSA does not usually pose a risk to other healthy individuals.

Treatment with antibiotics has no benefit in most cases of colonisation and may increase bacterial resistance.

**Infection:** This is where a pathogen is identified on a microbiological sample and the person is showing clinical signs associated with infection indicating the pathogen has invaded the tissues and multiplied i.e.

- Systemic temperature
- Pain at wound site
- Inflammation at wound site
- Redness surrounding wound site
- Wound deterioration
- Discharge/pus

Infections can usually occur in particularly vulnerable patients. A clinical infection can be from either the patients own resident MRSA where a colonisation exists, or by cross infection from a transient carrier or contaminated equipment.

**Bacteraemia:** This is where an infection spreads further into the body and is found to be present in the blood., bacteria are not normally present in blood, if the bacteria multiply a septicemia can occur, this is severe and life threatening, symptoms include:

- High fever
- High white cell count
- Rigors (shivers)
• Disturbance in blood clotting causing abnormal bleeding
• Organ failure

Transmission within a healthcare environment

MRSA does not have the ability to move under its own volition, commonest transmission routes are:
• Person to person spread by hands of healthcare professionals which have been transiently contaminated.
• Indirect spread by contact with insufficiently decontaminated equipment
• Shed contaminated skin scales carried in environmental dust, contaminating clothing or the environment.
• Droplets from aerosol spray (sneezing or coughing) from a patient with respiratory colonisation or infection.

Management of Patients within Primary Care

Staff must follow the same high standards of hand hygiene and standard infection control precautions for infection prevention for all patients regardless of MRSA infection or colonisation status.

Patients who are colonised with MRSA should continue to live a normal life in the community without restriction.

MRSA does not pose any extra risk to staff that are pregnant; staff should follow standard infection control practice.

Colonisation or infection with MRSA should not prevent a patient being transferred to a care setting in the community or intermediate care facility if their general condition allows. If in doubt contact the PCT Infection Prevention & Control Team.

Patient information leaflets on MRSA can be found on the Wirral PCT intranet site – Services the PCT Provides - Infection Prevention and Control

Standard (Standard) Infection Prevention and Control Practice

Hand Hygiene: The PCT Hand Decontamination Policy must be followed. Healthcare grade liquid soap used with a robust hand washing technique will remove any transient MRSA contamination. It is essential to thoroughly dry hands using disposable paper towels. MRSA is sensitive to healthcare grade alcohol gel; this may be used on uncontaminated hands, and following washing with liquid soap. Hands must always be decontaminated before and after every episode of direct care for an individual patient where multiple treatments are being performed in one care session to reduce the potential of cross infection between multiple individual wounds or wounds and invasive devices.
**Gloves:** Gloves must be worn where a risk assessment has identified that contact with body fluids or excretions are possible. Gloves are single use and protect the patient as well as the carer so therefore must be changed between each episode of care for an individual patient. Gloves must always be removed before handling notes, holding pens, answering the telephone, opening doors to prevent cross contamination.

**Plastic Aprons:** Uniforms are not protective clothing; where close personal care is performed plastic aprons protect the health carer’s uniform from transient contamination which could cause cross infection between patients in a home or clinic setting.

**Masks/Visors/Safety spectacles:** These should only be worn if a procedure risk assessment indicates facial contamination is possible. As these are not commonly used in primary care it is essential that healthcare staff communicate the need for face protection to the patient and/or relatives prior to use.

**Waste:** Waste produced as part of health care for a patient with MRSA is not automatically to be disposed of as ‘hazardous waste’. Healthcare waste contaminated with body fluids must be risk assessed for the appropriate waste disposal route.

**Uniforms:** Staff should change their uniforms daily. Uniforms may be machine washed at the temperature indicated for the fabric. Do not wash in an overloaded washing machine. Tumble drying or ironing following line drying is advised. Uniforms are not protective clothing; disposable plastic aprons must always be used when contamination of the uniform is possible.

**Home**

- If possible visit the patient at the end of the morning or afternoon. If this is not possible risks assess those patients to be visited and visit any high risk susceptible patients before patients with MRSA.
- Plastic aprons must never be reused in a home setting; these are single use items and may contaminate staffs uniform or clothes.
- Never shake bedding or clothing as this can cause airborne dispersal of skin scales.
- Equipment required for healthcare within the home should remain in the home for the duration of treatment. Following use it must be appropriately decontaminated before future use. Single use equipment should be considered if decontamination cannot be guaranteed e.g. blood pressure cuffs.
- Home collection of healthcare waste is only required for waste which fits the criteria for hazardous healthcare waste, regardless of an MRSA colonisation diagnosis.
- Patients own laundry can be washed in a domestic washing machine using the temperature appropriate for the fabric. Most bacteria are destroyed by temperatures over 60 degrees however lower washing temperatures will remove MRSA contamination by the washing and
rinsing process and so it is important the washing machine is not overloaded. Additionally the heat of tumble drying and ironing will also kill bacteria.

- Relatives both young and old who are physically well are not generally at risk from MRSA and should not be discouraged from visiting. Visitors should be advised to wash their hands before leaving. They do not need to wear gloves or aprons when visiting. If a relative has a pre-existing serious illness further advice may be required from their G.P. or the PCT Infection Prevention and Control Team.
- Crockery and cutlery can be washed as normal in a sink or dishwasher.

**Clinics/Treatment rooms**

Patients with MRSA infection or colonisation should not be precluded from visiting a clinic or surgery for treatment if fit to do so. Risk of transmission is minimal if good infection prevention is practiced.

- Assign the patient a treatment slot at the end of a morning or afternoon session if possible.
- If the patient has had a procedure carried out which may have contaminated equipment through direct contact i.e. treatment couch, footstool, clean following treatment with hot water and healthcare grade general purpose detergent using disposable cloths or healthcare grade detergent wipes.
- If exudates/s from a contaminated wound cannot be contained by the dressing/s it would be advisable to treat the patient in a home setting until the exudates/s is under control. Seek advice from the PCT Infection Prevention and Control Team.
- Linen sheet and blankets must not be used in a clinic or treatment room unless they are changed between each patient and laundered at a temperature of 60 degrees centigrade or above. Laundry must not be washed in a domestic washing machine.

**Bathing Centre**

Patients colonised with MRSA may visit the bathing centre if fit to do so. Risk of transmission is minimal if good infection prevention is practiced.

- Adherence to standard infection control practice.
- Patients may attend if any wounds present can be covered with a waterproof dressing.
- Assign the patient a bathing slot at the end of a morning or afternoon session if possible.
- Clean the bath with detergent and hot water following use.
**Transport of patients**

If transport is required for a person who is known to have MRSA or has previously been MRSA positive, this carries little risk of cross infection providing wounds are covered.

**MRSA Screening and Decolonisation Therapy**

The Department of Health have introduced national screening and decolonisation recommendations for inpatient treatment in hospitals, however there is no evidence that this is of benefit to patients receiving treatment in primary care. The purpose of decolonisation therapy for patients accessing acute care is to reduce the risk of a patient infecting themselves or transmitting MRSA to another patient. Treatment is commenced 7 days prior to admission for planned treatment or started immediately on admission. As soon as therapy is implemented the presence and shedding of MRSA are reduced significantly in the short term.

A small number of patients may require assistance with the application of decolonisation therapy prior to admission. Alternative arrangements are in place for these individuals. Please contact the PCT Infection Prevention & Control Team for advice.

**Within primary care:**

Routine swabbing of patients with MRSA in the community is not indicated unless:

- The patient is showing clinical signs of infection.
- A hospital has requested specific screening swabs as part of elective pre-admission assessment.

Guidance on when decolonisation is required in primary care can be found in ICP11 Meticillin Resistant Staphylococcus Aureus (MRSA) Decolonisation Guidance.

**Screening of staff within Primary Care and Provider Services:**

- Screening of new or current staff for MRSA is not routinely recommended in the primary care setting.
- If a member of staff has a colonisation identified through secondary care screening the community infection control team and Occupational Health Service must be consulted to risk assess work practices.

**Within secondary care:**

- **Elective pre-admission MRSA screening:** Patients undergoing elective medicine or surgery in an acute hospital will be routinely
screened pre admission for MRSA. The General Practitioner of patients
with a positive swab will be contacted by letter to prescribe eradication
therapy prior to their 7 days prior to their admission to hospital - Appendix A.

- If any swabs could not be obtained the General Practitioner will be
  requested to complete the remaining screening swabs - Appendix B.

**Acute admission screening:** Patients admitted to hospital as an
emergency will be screened on admission for MRSA. If positive
decolonisation therapy will be commenced.

- If the patient is discharged before treatment has been completed
treatment will need to be completed in the home environment. On
  completion of the 5 days Octenisan antimicrobial wash lotion and 7
days nasal bactroban treatment (Patient leaflet Appendix C) it is not
  necessary to screen or repeat the treatment. Continued use of this
treatment may lead to reduced effectiveness and resistance to the
  products.

- If a patient is discharged before the MRSA results are reported a
  positive result will be reported to the patients General Practitioner.
  Current Department of Health Advice is that patients do not routinely
  require decolonisation therapy unless requested by the Hospital
  Infection Control Team for short term clearance. If you are unclear
  whether decolonisation therapy is required please refer to ICP ICP11
  Meticillin Resistant Staphylococcus Aureus (MRSA) Decolonisation
  Guidance. Advice can be obtained from the PCT Infection Prevention
  and Control Team.

**Root Cause Analysis – Pre-48-hour MRSA bacteraemias**

A pre-48-hour MRSA bacteraemia is defined as an MRSA bacteraemia
(MRSA identified in a blood culture) of a patient who has been in hospital for
less than 48 hours. These bacteraemias are considered to possibly have
occurred before hospital admission.

- Initial investigation of all MRSA Bacteraemias are conducted by the
  Infection Control Team of the Acute unit.
- The Infection Control Team within the acute unit will notify the PCT
  Infection, Prevention and Control Team of any pre-48-hour MRSA
  bacteraemias within 48 hours by telephone. This will be followed by a
  copy of the Initial Investigation form.
- Following initial assessment by the PCT Infection, Prevention and
  Control Team if there has been recent involvement with any community
  healthcare provider an anonymised Incident form is generated and the
  Root Cause Analysis process is activated. Flow chart - Appendix D.
- The Infection Prevention and Control Team will notify the Director of
  Infection Prevention and Control who will brief the Chief Executive.
- The Director of Infection Prevention and Control is responsible for
  briefing the Board.
- Pre-48-hour bacteraemias associated with a PCT service will be
  reported through the PCT incident reporting system by the Infection
Prevention and Control Team and also as an untoward incident to the Patient Safety and Learning from Experience Group by the PCT Infection Prevention and Control Team.

- Action required will be monitored by the Patient Safety and Learning from Experience Group.
- Findings of Root Cause Analysis will be regularly reviewed by Wirral PCT Infection Prevention and Control Team together with the Wirral University Teaching Hospital (WUTH) Infection Prevention and Control Team.

Appendix D – MRSA Bacteraemia flowchart

Care given by PCT salaried services, General Practice and General Dental Providers

The root cause analysis will be conducted together with the staff associated with the care of the patient using the National Patient Safety (NPSA) Learning through Action Toolkit. The aim of this process is to identify any areas of practice where learning from experience may be applied. The steps are:

1. REACT – What where the critical problems?
2. RECORD – What where the main contributory factors/root causes?
3. RESPOND – What needs to be done?

The Team Leader/Manager of the staff involved will be responsible for agreeing the recommendations, action and steps, agreeing the person responsible for the change and the timescale for action.

The PCT Infection Prevention and Control Team will be responsible for completing the Pre 48 hour MRSA bacteraemia Untoward Incident Form. This form must be signed off by the Director of Infection Prevention and Control.

The PCT Infection Prevention and Control Team will be responsible for reporting to the Infection Control Committee.

The Patient Safety and Learning from Experience Group will be responsible for monitoring the progress and completion of actions identified for PCT salaried services. The Dental Directorate Board will be responsible for General Dental Services and Primary Care Management Board for General Practice.

To promote collaborative working between WUTH and Wirral PCT Root Cause Analysis be shared with Infection Control and the Risk Management/Clinical Governance Structure.
Procedure Guidance

Wound related infection/colonisation

- Routine swabbing of a wound colonised with MRSA is not required unless there are signs of infection as wounds are unlikely to become negative until healing has taken place. A single negative swab does not guarantee that the patient remains MRSA negative.
- Treatment should follow Tissue Viability Wound Care Guidelines for optimum wound healing practice.
- If a clinical infection is suspected and exudate is heavy, a collection of the exudates may be sent to the Microbiology laboratory for examination.
- If sending a swab from a suspected infection ensure that adequate information is given on the laboratory form i.e. MRSA status, description of infection symptoms, underlying medical conditions i.e. diabetes, current medication including recent antibiotics both orally and topically.
- Always change gloves between multiple dressings to prevent spreading colonisation between wounds.
- Always keep the wound covered with a dressing, adjust dressing frequency to prevent leakage of wound exudates and potential reinfection.
- Do not use Otenisan antimicrobial wash lotion directly onto wounds. If required Chorhexidine Gluconate 0.05% is available in single use sachets is a suitable wound antiseptic/wound cleansing agent.
- There is some evidence to show that dressings containing chlorhexidine, povidone-iodine or silver may help to control bacterial numbers on a wound. Refer to wound care formulary or seek advice from the Tissue Viability Service.
- Mupiricin (0.5%) in a polyethylene glycol base (‘Bactroban’) may be applied to small lesions, but not to large raw areas i.e. burns, large pressure sores, leg ulcers or to indwelling catheters. Mupiricin in a paraffin base (‘Bactroban Nasal’) may be considered in this situation. This treatment should not last for more than ten days. Repeating the course should be avoided as this may induce resistance. Use must be discussed with the Infection Prevention and Control Team first.

Urinary catheter related infection/colonisation

- Follow aseptic principles for insertion and management of urinary catheters as outlined in Nice Clinical Guidelines 2. (June 2003).
- Standard precautions must be followed.
- Antibiotics are unlikely to clear MRSA in the presence of a urinary catheter.
- There is no good evidence that catheter changes need to be covered with prophylaxis to prevent catheter related urinary tract infections.
• MRSA urinary tract infection with systemic symptoms and white cells in the urine is likely to require systemic antibiotic treatment.
• There is some evidence to suggest that silver/hydrogel coated catheters might be effective in reducing catheter associated urinary tract infections (CAUTI) in short term catheterisation. The Continence service must be contacted for advice regarding the use of continence devices.

Symptoms of a urinary tract infection may have abdominal pain, temperature and the urine may become cloudy and smell.

PEG sites and supra-pubic catheter related infection/colonisation

Insertion sites for indwelling devices such as PEG tubes and supra-pubic catheters can provide a focus for infection or colonisation and provide a route for MRSA to track along and potentially cause deep infection.

• Where sites are well-healed they can be treated as ‘normal’ skin.
• If the insertion site is infected with MRSA systemic antibiotic treatment may be required.
• If the insertion site is colonised with MRSA use of a dressing around the device with anti-staphylococcal activity should be considered. Before use check compatibility with the device material.

Venous catheter related infection

MRSA may infect the entry site of an invasive device causing signs of a localised inflammation, pus may be present. MRSA then has the potential to enter the blood stream and cause a bacteraemia (see page 8 and 13)

• An aseptic technique must be used for catheter site care and for accessing the system
• If insertion site shows clinical signs of infection remove device and re-site a new cannulae if access is still required. Dress infected site with an appropriate dressing.

Respiratory management of sputum positive patients

Lung infections with MRSA are rare. Patients with a tracheostomy or on a ventilator are at higher risk.

• Patients known sputum positive should be encouraged to expectorate into a tissue, dispose of tissue immediately and wash hands.
• Nebulising equipment must be decontaminated between use following manufacturers recommendations.
• Once the edges of a permanent or long term tracheostomy are ‘healed’ it should be cleaned as part of the normal hygiene of the stoma.
• Masks are rarely necessary other than procedures which may generate aerosols e.g. chest physiotherapy, sputum suction. Follow standard precautions.

**Equipment**

Ongoing decontamination of equipment is essential to prevent the transfer of MRSA and other transient organisms regardless of the care setting.

• As for all patients any equipment identified as single use, equipment must be disposed of appropriately after use.
• Staff attending to multiple dressings/treatments must use new or decontaminated equipment for each dressing/treatment to prevent transfer of micro organisms between wounds e.g. leg ulcer buckets, gallipots.
• Reusable equipment used within a clinic or treatment room setting must be decontaminated according to manufacturer’s instructions following use.
• Reusable equipment used within the home setting must remain with the patient for the duration of treatment. Single patient use equipment may be more appropriate in this situation e.g. blood pressure cuffs.
• Any Community Equipment Service loaned equipment must be single patient use until no longer required.

**Communication**

**Hospital to Community:** The General Practitioner will be informed in the Discharge letter. Community Care Staff or Care Home Manager will be informed on the nursing referral form.

**Community to new care setting:** Patients previously identified with MRSA at WUTH will be identified via the PCIS system other hospitals, care homes and transfers out of Wirral PCT care must be informed of the Patients MRSA status prior to their transfer if possible.

**Information leaflets:** Information leaflets on MRSA are available for staff and patients/relatives on the PCT Intranet and Internet site.

**Death of a patient with MRSA**

The same precautions (Standard Precautions) must be applied to the patient as were applied during life.

All wounds and open sites must be covered with an impermeable dressing.

The use of body bags is not necessary for patients who were infected or colonised with MRSA.
Training

Training in standard infection control precautions will be provided by the Infection Prevention Team through Essential Training.

Audit

Standard Infection Control Practice will be audited through the Infection Control Rolling Programme, Community Clean Your hands programme and Essential Steps to Safe Clean Care.

Archiving

Hard and/or electronic copies of previous versions of this document will be held by the Infection Prevention & Control Team for the retention period required under current NHS guidance.

Risk Assessment

Included in service risk assessment, clinic and procedure risk assessment.

References


Glossary of terms

RCA  Root Cause Analysis (RCA) is a retrospective review of an incident undertaken in order to identify what, how, and why it happened. The analysis is then used to identify areas for change, recommendations and sustainable solutions, to help minimise the re-occurrence of the incident type in the future.

Pathogen  A micro-organism which has the capacity to cause an infection

Bacteraemia  Presence of micro-organisms in the bloodstream

Resident  Micro-organisms that colonise the deeper crevices of the skin and hair follicles. Not readily transferred to other people or objects, or removed by the mechanical action of soap and water. They can be reduced in number by the use of antiseptic soap.

Transient  Micro-organisms acquired on the skin through contact with surfaces. They can usually only survive for a short period of time, but they are readily transferred to other surfaces touched. Can be removed by washing with soap and water.

Septicaemia  A severe illness caused by bacteria in the blood stream.

Endogenous  An infection originating from a person's own micro-organisms

Necrotising  Causing death in a specific area of tissue.
List of those consulted in drafting process

Infection Control Committee
PRE-OPERATIVE ASSESSMENT & ADVICE SERVICE

When telephoning or calling please ask for: ......................... on Ext. No. 4325

Dear Doctor,

With reference to your patient:

Name ........................................................................................................

Address ....................................................................................................

DOB ...........................................................................................................

C/S No ......................................................................................................

The above patient was reviewed prior to admission for the following procedure:

..................................................................................................................on .............................

He/She has been found to have MRSA in Nose ☐, Groin ☐, Wound ☐, Catheter ☐,
Other ☐ (please specify)........................................ Date of positive result .................

Please prescribe a course of Octenisan skin antiseptic whole body wash to be
applied daily for 5 days and Bactroban nasal ointment to be administered QDS to
both nostrils for 7 days. This eradication therapy should be commenced 7 days prior
to surgery.

I have advised the patient to make arrangements to pick up the prescription and to
make an appointment at your surgery for further advice if required.

This fax includes a leaflet with the common questions asked by patients newly
diagnosed with MRSA. If you require any further advice on MRSA or any other
infection control issue, please contact the Community Infection Control Nurses on
0151 488 7777.

Yours sincerely

Pre Op Assessment Service
Appendix B

Pre operative Assessment
Clatterbridge Hospital
Clatterbridge Road
Bebington
Wirral
CH63 4JY

Tel: 0151 334 4000 Ext 4325

Date ……./……./……..

Re: 

Name …………………………..
Address…………………………
Case sheet no ……………………

Dear ……………………………..

As you are probably aware, Wirral University Teaching Hospital have introduced routine MRSA screening of all patients who are being admitted for elective surgery. This screening takes place at the pre-operative assessment clinic or at outpatient clinic and includes swabs of the nose, perineum or groin and any lesions the patient may have.

Unfortunately we were unable to obtain all of the required swabs and would appreciate it if you could perform the following:

…………………………………………………….
…………………………………………………….
…………………………………………………….

Please complete the laboratory form requesting an 'Infection Control Screen' and return with the swab to: Wirral Medical Microbiology, Clatterbridge Hospital, Bebington, Wirral, CH63 4JY.

If you require any further advice on MRSA or any other infection control issue, please contact the community Infection Control Nurses on 0151 488 7777.

Yours Sincerely

Pre Op Assessment Service
# Daily Check List

<table>
<thead>
<tr>
<th>Operation date</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: 7 days before operation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Bactroban nasal ointment 4 times per day for 7 days</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Octenisan Body wash</td>
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</tbody>
</table>

**Comments:**

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**Appendix C**

**Body wash / Nasal Ointment**

**Daily Check List**

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**Wirral University Teaching Hospital**

**NHS Foundation Trust**

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**Patient Information Leaflet**

**MRSA Positive Screening Result**

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*Produced by Infection Control and the Surgical Division*

*Wirral University Teaching Hospital*

*January 2008*

*Review date: January 2009*
What do we mean by “MRSA Positive”?

This means that the laboratory has identified the MRSA germ in the swab(s) you had taken recently.

Please do not panic about the positive result. Now that we are aware, you will be given treatment to reduce the risk of you developing a wound infection after your operation.

What will happen now?

To try and reduce the number of MRSA germs on your body, you will need to have antiseptic treatment, starting 7 days before your operation is due. You need to contact your General Practitioner (GP) to get a prescription, so that you can begin your treatment seven days before you come into hospital for your operation.

Why?

MRSA lives in or on many people without causing harm, however when someone is having an operation, this germ may cause an infection after an operation. Therefore you will need to start the treatment near the time of your operation.

If you need any specific advice, please contact your GP practice or if you have general questions, here are some useful websites:

www.hpa.org.uk
www.nhsdirect.nhs.uk

What is the treatment?

Skin Antiseptic: You will shower every day with the antiseptic for 5 days before your operation. You should wet your skin, apply the antiseptic using your hands or a clean flannel (cloth) massage it in for about 3 minutes and then rinse it off. Dry yourself with a clean towel. You should wash your hair with it at least twice during the 5 days.

If you haven’t got a shower, and you have a bath, wet all your skin in the bath water, stand or kneel up, apply the lotion with your hands or a clean face cloth (flannel). Massage your body for 3 minutes and then immerse yourself in the bath water and rinse it off. Dry yourself with a clean towel.

If you can’t bathe or shower, have a strip wash every day and apply the lotion, massaging it for 3 minutes all over your body with a clean face cloth (flannel) or your hands, rinse and dry.

Nasal Ointment: You should apply this to the inside of both your nostrils 4 times a day for 7 days. You can rub your nostrils together afterwards. You should be able to taste it in the back of your throat as it gets absorbed.

If you are unable to undertake the treatment, please ask a carer to help you or tell you GP.

If your treatment has not been completed before you are admitted to hospital, tell the nurse who admits you when you are admitted to the ward.
Appendix D - Pathway for investigating pre-48-hour MRSA Bacteraemia

Serious Untoward Incident

COMMISSIONERS

ACUTE PRIMARY AND COMMUNITY CARE

Acute Trust to inform PCT Director of Infection Prevention and Control

Confirmation of MRSA bacteraemia in blood culture identified in 1st 48 hours of admission

RCA commenced within 12 hours

Complete review and action plan within 10 days

Report via own pathway

Acute and PCT Infection Control Teams meet to review findings and agree learning points

RCA sent to PCT Director of Infection Prevention and Control for sign off and review of avoidable infections by 10th of each month

RCA sent to SHA Lead Director on 15th of each month to:
- Record and review monthly
- Review avoidable infections

Chief Executive informed by Director of Infection Prevention and Control by monthly report

Acute Trust informs PCT Infection Control Team within 12 hours

Implementation of the RCA within non-acute setting within 5 working days

- Investigate patient care interventions
- Review Primary Care interventions
- Work with non NHS healthcare and Social Care providers to review care interventions
- Forward to specialist services where required

- Inform Director of Infection Prevention and Control or Deputy
- Inform Risk Manager
- Inform Head of Service/Locality as appropriate
- Report as a serious and untoward incident

- Outcome within 10 days of commencement of investigation
- Report to Director of Infection Prevention and Control
- Liaise with Acute Trust Infection Control Lead
- Commence appropriate actions

Infection Control Team to present anonymised report and action plan to:
- Infection Control Committee
- Patient Safety and Learning from Experience Group
- Patient Safety group WUTH

RCA sent to PCT Director of Infection Prevention and Control for sign off and review of avoidable infections by 10th of each month

Infection Control Policy No 10 Version 3

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