UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

TRUSTWIDE POLICY FOR

SCREENING, PREVENTION OF AND MANAGEMENT OF PATIENTS WITH METICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

TW/ICO/GU/4/014

Author: Infection Prevention and Control Team
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Contents

1. Introduction

Meticillin Resistant *Staphylococcus aureus* (MRSA) - previously called Methicillin - is a feature of modern day health care across the world. MRSA, like Meticillin Sensitive *Staphylococcus aureus* (MSSA) can cause a spectrum of illness ranging from asymptomatic colonisation through to life threatening infections e.g. bacteraemia and septicaemia.

Present guidelines indicate the need for the continued control of MRSA and its importance in the provision of patient care. Patients and the public are increasingly seeing MRSA and MRSA infection rates as indicators of the quality of patient care.

This policy is based on the recommendations made in 1999 from a National Joint Working Party of the British Society for Antimicrobial Chemotherapy, Hospital Infection Society , Infection Control Nurses Association and the recently issued draft guidelines (July 2005) from a reconvened group of this same Working Party.

2. Purpose of this Policy

2.1 Summary

This policy reiterates the general principles of infection control that all staff must adhere to at all times. It outlines the importance of risk assessment, the appropriate actions that need to be taken with all MRSA patients and the responsibilities of staff. Implementation of this policy aims to facilitate the detection and management of patients with MRSA, prevent the acquisition of MRSA and to prevent cross infection between patients and staff.

2.2 Objectives/success factors

The objectives of this policy are:

- To ensure that the spread of MRSA within UHCW is minimised
- To protect patients from infection or colonisation of MRSA
- To ensure patients who are confirmed to have MRSA are managed safely and appropriately and receive adequate information about their condition.

3. Scope of this policy

This policy includes:

- Detection of MRSA by screening patients
- Actions to be taken when patients have or may have MRSA are admitted to UHCW.
- Appropriate placement of patients with MRSA
- Decolonisation of patients with MRSA
- Actions required to reduce the risk of infection in patients who are already colonised with MRSA.

- Actions taken that should be taken to ensure safe and appropriate treatment of MRSA infection
- Communication of infection status on transfer or discharge

4. Links to other key strategies and policies/guidelines

- Universal Standard Precautions Guidelines
- Hand decontamination Policy
- Isolation Policy
- Glove Policy
- Antibiotic policy
- Transfer and receiving of infected patients guidelines
- Cleaning and Disinfection of Non-invasive equipment and the environment
- Equipment decontamination prior to service and repair
- Bed cleaning Guidelines
- Guidelines principles of asepsis and clean technique
- Guidelines and scope of professional practice documents for management of intravenous devices (i.e. peripheral and central – including tunnelled lines)
- Catheter Care Guidelines
- Trust infection plans and the Trust infection prevention and control strategy
- Uniform policy
- Patient Transfer Policy
- Trust Outbreak and Incident Plan
- Staff information leaflet (appendix 1).
- Patient Information leaflet (appendix 2)

5. Breach of this Policy and responsibilities of all staff

All staff working on Trust premises, including Trust employed staff, contractors staff, temporary staff –are responsible for ensure that a high standard of infection control practice is achieved in all clinical areas by adhering to infection control policies and reporting breaches of this policy to the person in charge or their line manager.

Additional Responsibilities of specific staff groups

Ward and Department Managers – are responsible for ensuring implementation within their areas, and for ensuring all staff who work within the area adhere to the principles contained in it at times.

Consultant Medical Staff – are responsible for ensuring their junior staff read and understand this policy and adhere to the principles contained in it at all times.

Divisional Management Teams – are responsible for monitoring implementation and compliance of this policy and for ensuring action is taken when staff fail to comply with this policy.

Site –Co-ordination Team, Bed managers and Capacity Managers – are responsible for ensuring patients are placed in accordance with this policy and for escalating any

situations where safe placement cannot be achieved.

On-call Managers and the On-Call Executive – are responsible for providing senior and executive leadership to ensure implementation of this policy and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

The Infection Control Team – is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation and assisting with risk assessment where complex decisions are required. They are also responsible for ensuring that this policy remains consistent with the evidence-base for safe practice and for reviewing the policy on a two yearly basis.

Non-compliance with the policy **may result in disciplinary action.**

6. General principles

The general principles of infection control are applicable to the control of MRSA and apply to all wards and departments. These are detailed in the Universal Infection Precautions Guidelines and staff information leaflet (appendix 1) which outlines what MRSA is and how it may be transmitted. In addition the safe, effective and prompt detection and management of patients with MRSA requires adherence to the following principles:

6.1 Good Hand Hygiene

- Correct handwashing/decontamination technique using soap and water and additional use of gel as per Hand Decontamination Policy.
- Use of surgical scrubs prior to sterile/operative procedures.

6.2 High Standards of Clinical Care

- Following good practice guidelines, where they have been developed for care of wounds, vascular lines, urinary catheters and other clinical procedures.
- Follow policy and guidelines for safe cleaning, disinfectant and sterilisation of equipment.
- Use of personal protective clothing and equipment (gloves, aprons, masks, goggles/visors) when appropriate.
- Safe disposal of sharps and clinical waste.

6.3 Antimicrobial Prescribing

- Avoid unnecessary antibiotic prescribing to reduce selection pressure for resistant organisms including MRSA.
- There must be rational use of antibiotics and adherence to the Trust's Antibiotic Policy- available through the Trust's Intranet Site.
- All consultant medical staff are responsible for ensuring appropriate antibiotic prescribing by their junior staff, this includes ensuring courses are prescribed for the correct duration and dosage.

- Nursing staff are responsible for ensuring prescribed antibiotics are given at the correct time and the correct dosage. This includes topical decolonisation agents.

6.4 Surveillance of MRSA

- Surveillance will be performed in order to monitor trends in MRSA and facilitate prevention and control measures.
- The Infection Control Team will undertake surveillance for new MRSA isolates routinely as part of alert organism surveillance. Clinical areas will be informed of all newly-identified MRSA-positive patients from the laboratory via the Infection Control Team.
- The Infection Control Team will undertake enhanced surveillance of MRSA Bacteraemia in line with the Department of Health Mandatory Reporting Scheme. The results of this surveillance will be fed back to Clinical and Management Teams for action.
- Clinical Teams are responsible for undertaking a root cause analysis of each clinical case of MRSA Bacteraemia within 1 week of diagnosis and implementation of local action plans to improve practice.
- MRSA surveillance data will be reported and reviewed by the Strategic Infection Prevention and Control Group and through Divisional Governance meetings action plans will be monitored and updated.
- Divisional teams will report their MRSA data monthly to the Operational Infection Control and Prevention Group and at their Quarterly Performance review as one of their Infection Control Key Performance Indicators.
- All new MRSA positive patients will be alerted on the CRRS system by the Infection Control Team.

6.5 MRSA Screening

Specific groups of patients will be screened for MRSA in order to improve patient safety, for the following reasons:

- Patients found to be positive and are colonised can be managed to minimise the risk of MRSA infection during their treatment. This may require different antibiotic prescribing, decolonisation prior to a procedure or other measures.
- To protect other patients from the risk of acquisition of MRSA during their hospitalisation.

(see guideline 1 for details of screening requirement for different patient groups and guideline 2 for swabs to be taken)

6.5.1 Action to be taken once a patient is found to be positive on screening

- All patients found to be MRSA positive will have an alert placed on CRRS
- Patients must be commenced on MRSA Quick Action Guide (Guideline 3)
- Patients should be placed in isolation
- Decolonisation protocol to be commenced
- After the initial screen, swabs should only be taken when topical treatments have been stopped for two days in line with the decolonisation protocol. Screening whilst on treatment e.g IV antibiotics may give false results.
- Screening should continue until three negative swabs have been obtained from all

previously positive sites- this will usually take 3 weeks..

6.6 MRSA Decolonisation

- All patients found to be MRSA positive will be commenced on the Infection Control MRSA Washing Regime (topical decolonisation therapy) in an attempt to eradicate MRSA and reduce the subsequent risk of infection.
- Advice should be sought from Dermatologist prior to commencing patients with chronic skin conditions on the regime
- If there is a failure to decolonise a patient after three weeks of consecutive treatment – please seek advice of Infection Control Team.

(see guidelines 4, 5 & 6 for details of decolonisation)

6.7 Isolation Care

(see guidelines 3 & 8 for general guidance regarding isolation and quick Action Guide for Management of Positive Cases)

6.7.1 Risk Assessment in Practice.

The course of action taken when a patient is colonised or infected with MRSA depends on a variety of factors including:

- The type of ward the patient is being nursed on.
- The facilities available for patient isolation – risk assessment may apply.
- Whether affected patients are likely to be heavy dispersers of skin scales e.g. have infected eczema, psoriasis, large open wounds or burns
- The virulence and strain of the organism, which may be detected on phage typing. Occasionally isolates of MRSA are identified in the laboratory, which are resistant to one or more of the agents usually used to treat MRSA. This would often warrant the classification being changed from low risk to high risk.

It is important to note that these guidelines cannot always be prescriptive and decisions need to be based on the local situation. It is recognised that some patients may not be suitable for a side room due to their increased risk of falls, confusion etc. Advice can be sought from the Infection Control Team who will undertake a risk assessment.

6.7.2 Isolation Precautions

- All patients found to be MRSA positive will have an 'ALERT' placed on the CRRS System. The medical and nursing staff admitting the patient are responsible for checking the system.
- All patients with MRSA will be managed with Standard Universal Infection Control Precautions.
- In addition contact precautions will be implemented in all wards and departments (see guidance notes 8).

6.5.3 Transfer of patients to other wards/units or departments

- Transfer of MRSA patients to other wards in the hospital should be minimised to reduce the risk of cross infection, but this should not compromise care, such as rehabilitation. When transferring patient to another ward/unit the patient transfer sheet must be completed.
- If visits to other departments are necessary i.e. for investigation or treatment, the receiving department should be informed in advance so that they can implement the appropriate measures i.e. environmental cleaning.
- When attending other departments, if the patients clinical condition permits they should attend at the end of the working session.
- The patient should spend the minimum time in the department i.e. should be sent for when the department is ready and not left in the waiting area with other patients.
- All bed linen must be changed before transporting the patient.
- When transporting infected/colonised MRSA patients to other departments all lesions should be covered with an impermeable dressing
- Staff are **not required to wear aprons and or gloves** whilst physically transporting patients between departments/wards, i.e. pushing beds, trolleys or wheelchairs. Hand hygiene using alcohol gel is sufficient in this situation
- Aprons should be worn if handling and moving the patient from bed to wheelchair/trolley etc. These must be removed once the patient is settled and before leaving the isolation room or department and hands washed.
- Aprons must be disposed of as clinical waste and hands must be washed after removal. Gloves are only required if it is anticipated that there may be contact with the patients blood or body fluids. When gloves removed hands must be washed after removal.
- The trolley or chair must be decontaminated, using a detergent wipe, after use by the patient and before being used for another patient.
- Staff must decontaminate their hands thoroughly after dealing with a patient and/or cleaning the trolley or chair or other equipment used.
- All staff in the receiving department must ensure that basic infection control measures as outlined in the MRSA Quick Action Guide (guideline 4) are implemented.
- Equipment and the number of staff attending should be kept to a minimum.
- All surfaces that the patient has had direct contact with should be decontaminated using 'chlor-clean'.

STRICT HAND DECONTAMINATION MUST BE EXERCISED AT ALL TIMES

6.5.4 Theatres

- Theatres must be informed in advance if a patient is MRSA positive so that they can implement the appropriate measures i.e. environmental cleaning.
- Ideally as with all infected patients, MRSA positive patients should be placed last on the operating theatre list, to ensure all surfaces and equipment are cleaned between the MRSA positive patient and the next patient.
- Routine cleaning measures should be adequate provided 15 minutes elapses between the MRSA patient leaving the theatre and the next patient entering in conventionally ventilated theatres. This allows sufficient time for adequate air change between patients (Coia et al 2006).
- Airflows in ultra-clean theatres make a minimum time unnecessary.

- MRSA patients may be recovered in recovery units, providing contact precautions are adhered to and equipment in contact with the patient is cleaned after use using chlor clean.

6.5.5 Patient transferred to other hospitals

When patients are transferred to other hospitals, the nurse in charge of the ward should inform:

- The receiving hospital of the patient's MRSA status prior to transfer.
- The ambulance service prior to the patient transfer.
- Complete Patient Transfer Sheet (see Trust Patient Transfer Policy)

6.5.6 Discharge from Hospital

- Patients with MRSA should be discharged promptly from hospital when their clinical condition allows.
- The General Practitioner, and other community services must be informed of a patients current positive status as part of the discharge information process prior to the patients discharge.
- Discharging medical staff are responsible for including details about a patients MRSA status in the discharge letter.
- Staff at nursing, convalescent or residential home should be informed in advance of discharge but carriage of MRSA is not a contraindication to admissions to these establishments. The spread of MRSA can be controlled with good infection control practices.
- If staff at the residential or nursing homes have any queries relating to patients being discharged to them who are MRSA positive, they should discuss it with the Infection Control Nurse that provides their Infection Control Service.
- Patients should be advised that if at a future time they are hospitalised they should advise admitting staff that they have previously been identified as carriers of MRSA, to ensure that they are appropriately managed.
- There are no special precautions that families need to undertake at home providing family members are all fit and well. Family members may have contact with the MRSA patient but should remember good hygiene practices i.e. hand washing, environmental cleanliness etc. If a family member is unwell or is a health care worker please speak to the Infection Control Team for further advice.

6.5.7 <u>Ward closures as a consequence of an outbreak of MRSA</u>

Ward closure to new admissions may be necessary if:

- Existing isolation or cohort nursing measures fail to control the spread of MRSA
- The Infection Control Team perceives a serious risk to new patients being admitted to the ward/unit.
- The Infection Control Team would usually only recommend such a step after full discussion and consultation with:
    - Infection Control Outbreak Committee Members
    - Clinicians
    - Trust Management

- Health Protection Agency representative
- Before reopening to new admissions terminal cleaning will need to have been undertaken.

6.6 Documentation

- The MRSA status of all patients must be accurately recorded in the medical and nursing notes.
- All patients who are previous positive case of MRSA must be commenced on the UHCW Quick Action Guide for Management of Patients with MRSA. (Guideline 3 on admission to hospital. This includes the Infection Control MRSA Washing Regime.(Guideline 6)
- All patients who are new case of MRSA must be commenced on UHCW Quick Action Guide for Management of Patients with MRSA (Guideline 3) as soon as informed that patient positive. This includes the Infection Control MRSA Washing Regime.(Guideline 6)
- All MRSA positive patients will be alerted on the CRRS system by the Infection Control team. This will allow staff to identify patients previously known to be MRSA positive.

6.7 Communication and Patient Information

- Patients and visitors must be provided with accurate information on MRSA, this is the responsibility of the medical and nursing teams admitting and providing care to the patient.
- This includes information on the risk of infection and information for those found to be MRSA positive on their management. Patient information leaflets are available on the Infection Control web site on the intranet, hard copies in the Patient Library and all clinical areas.
- Accurate information on MRSA Status must be recorded and communicated to other wards and departments to facilitate safe care.
- The patient transfer sheet in the Patient Transfer Policy must be completed when patients are transferred to other wards, units and hospitals.
- Accurate information on MRSA status including information on topical decolonisation and specimen results, must be recorded and communicated to staff in primary care on transfer to another organisation or discharge home.

6.8 Staff and MRSA

Staff screening should only be carried out after consultation with the Infection Control Team and Occupational Health Department and will be Influenced by the specialty in which they work or as part of investigation to an incident or outbreak. Staff will be treated confidentially by the Occupational Health Department.

(**See Guideline 7, for further information re staff screening and treatment)**

7. Communication and Dissemination Plan

- This policy will be placed on the Trust Document Management System (elibary).

- The revised policy will be launched with communication via the all user message and Team Brief.
- The Infection Control Team will issue a briefing paper, highlighting the main changes in the policy and this will be circulated to all staff groups.

8. Education and Training

- Education sessions will be provided by the Infection Control Team and these will be available for all Trust staff. A rolling programme of these sessions will continue throughout 2007-2008.
- Infection control link staff will be provided with education sessions about the policy at their meetings.

9. A review plan for this policy

- This document will be reviewed by the Infection Control Team in the following circumstances:
    - When new national or international guidance is issued
    - When newly published evidence demonstrates a need for a change to current practice.
    - Routinely every two years.

10. Audit of Compliance

An audit of compliance against this policy will be undertaken by the Modern Matrons and or the Infection Control Team every quarter and the results and action plans will be feedback to the Infection Control Operational Group and the Strategic Health Authority.

11. References/bibliography

Coia JE, Duckworth GJ, Edwards DI et al (2006). Guidelines for the control and prevention of meticillin-resistant *staphylococcus aureus (*MRSA) in healthcare facilities by the Joint Working Party of the British Society of Antimicrobial Chemotherapy, the Hospital Infection Society and the Infection Control Nurses Association. *Journal of Hospital Infection.* 635 S1 – S44.

Department of Health (2006). Screening for Meticillin-resistant *staphylococcus aureus* (MRSA) colonisation. A strategy for NHS trusts: a summary of best practice. London:Department of Health.

Appendix 1- Staff Information Leaflet
What is MRSA?

- *Staphylococcus aureus* is an organism that is commonly found on the skin, the anterior nares, perineum and umbilicus. MRSA is a more antibiotic resistant variant of *Staphylococcus aureus*

- MRSA also commonly survives in the same body sites as *Staphylococcus aureus without causing infection – a state known as colonisation.*

- A patient becomes clinically infected if the organism invades the skin or deeper tissues and multiplies to cause a localised or systemic response, for example in septicaemia.

- Methicillin resistance means the same fllucloxacillin resistance.

- When there is resistance to methicillin, the bacterium is labelled MRSA. Some strains of MRSA – known as epidemic strains or EMRSA – are more likely to spread.

- To date, 17 epidemic strains have been identified in the UK. The most common strain seen in the Midlands is EMRSA-15 with occasional EMRSA-16.

- Individuals may acquire MRSA as a result of exposure to antibiotics, or from exposure to the organism, for example from previous contact with health care.

- The consequences of developing a serious infection with MRSA can be severe because the range of effective antibiotics is limited, costly and potentially toxic. Therefore it is important to take precautions to prevent transmission, especially in patient groups that are susceptible to infection.

How is MRSA transmitted?

- As well as occurring in the colonized sites described above, MRSA may also colonise chronic wounds, for example in eczema, varicose and decubitus ulcers.
- MRSA may spread in the same ways as sensitive strains of staphylococcus either by endogenous or exogenous spread.

Endogenous spread

- This occurs when a person with staphylococci spreads the bacteria from one part of their body to another.
- Endogenous spread can be prevented by both encouraging patients to wash their hands and discouraging them from touching wounds or damaged skin.

Exogenous spread

- This occurs when the organism is spread from person to person by direct contact with the skin. In health care, this is usually via the hands of healthcare workers.
- MRSA can also be spread by a contaminated environment or equipment.
- Skin scales may contaminate the environment if they become airborne, for example during activities such as bed making, or if the affected person is heavily colonised, or has a condition such as eczema which causes shedding of high numbers of organisms.
    - Staphylococci that are shed into the environment may survive for long periods in dust.
    - Some of the ways exogenous spread can be prevented are:
        - Effective hand decontamination and cleanliness of patient equipment
        - Applying topical treatment to reduce skin carriage
        - Keeping the environment as clean and dry as possible
        - Ensuring that doors are kept closed during airborne generating procedures

Appendix 2 – Patient Information

Infection Control

M.R.S.A. – Information for Patients and Relatives

You may have been told you have MRSA. This leaflet has been produced to help you understand what is meant by this and to answer some of your questions.

What is MRSA?

MRSA stands for Meticillin (M) Resistant (R) Staphylococcus (S) Aureus (A). It is a germ that may harmlessly carried on the skin and in the nose of about a third of the population. People who have MRSA on their bodies or in their noses, but who are unharmed by it, are described as being colonised.

What problems can MRSA cause?

MRSA can cause problems if it gets the opportunity to enter the body. This more likely to happen to people who are already unwell, have wounds, a drip or a drain. MRSA can cause abscesses, boils or can infect wounds. These are called local infections.

Sometimes local infections may spread into the body and cause serious infections such as Blood Poisoning. In hospital the main concern is that the germ is resistant to some of the most commonly used antibiotics, although alternative antibiotics are available to treat MRSA, but in most cases are not needed.

How did I get MRSA?

It is difficult to say where you acquired MRSA as this germ is found in the community as well as hospitals.

How did you find the germ?

Sometimes your doctor or nurse purposely look for the germ: for example before certain major operations or if you have carried this germ before. Sometimes it is found during the routine investigations we perform as part of your care.

What happens now?

Swabs will be taken to find out exactly where the germ is living on your body.

Can I get rid of the germ?

Whilst in hospital you may be given an antiseptic wash to use daily along with a special cream for your nose. If the germ has entered your body and is causing an infection, your doctor may need to prescribe antibiotics.

How does this germ spread?

Like most germs MRSA spreads easily on unwashed hands. We therefore encourage staff, visitors and patients to wash their hands. Staff may wear gloves or protective aprons whilst caring for you depending on the care they are giving you.

Will the germ make me feel unwell?

Usually people do not feel unwell, but like any germ it can cause an infection. Most people suffer no ill effects from this germ and are totally unaware of its presence.

Can I stay on the same ward?

Yes, but you may be nursed in a single room whilst germ is present. If a single room is not available you may be asked to move to a single room on another ward. This will be avoided if possible. If there are several patients with the same germ, you may by nursed in a shared same sex cubicle.

Can I have visitors?

Your friends and family may continue to visit you. They do not need to wear gloves or plastic aprons whilst visiting. Encourage your visitors to wash their hands when they arrive and before they go home.

Advice for safe laundering of clothing and soiled items should be sought from your ward.

What happens when I am ready to leave hospital?

Having MRSA should not delay your discharge. If you need a district nurse he/she will be informed. You do not need to take any special precautions when you get home.

What if I need to come into hospital again?

If you are admitted to any hospital in the future, you should always tell your nurses nad doctors that you have had MRSA germ.

If you wish to speak to the Infection Control Nurses about any issues relating to MRSA please ask the nurse looking after you.

The Infection Control Nurses are available, Monday to Friday between 9am and 5pm to speak to you and your family. Contact us on Telephone number 02476 964791

Other leaflets produced by the Infection Control Team include:

- Isolation and Barrier Nursing
- ESBL
- *Clostridium difficile*

The Trust has access to interpreting and translation services. If you need this information in another language or format, please contact 02476 964791 and we will do our best to meet your needs.

The Trust operates a smoke free policy

Document History (Patient Information Leaflet)

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Guideline 1. - MRSA Screening

The transmission of MRSA and the risk of MRSA infection (including MRSA bacteraemia) can only be addressed if measures are taken to identify MRSA carriers as potential sources and treat them to reduce the risk of transmission. This requires screening of patient populations either before or on admission to identify carriers and commence treatment (DOH 2007).

1 Screening of High Risk Admissions/High Risk Areas

The following patients that must be screened:-

- All patients who are know to have MRSA
- All patients who have previously been MRSA positive
- All patients who have had frequent/numerous admissions to hospital or other healthcare facility
- All patients transfers to UHCW from other hospitals.
- All patients transferred/admitted to high risk units i.e General Critical Care, Cardiac CCU, Neonatal Intensive Care Unit and high dependency units.
- Patients admitted to the Orthopaedic Wards i.e wards 52, 52A, 53 and Cedar Ward
- All Trauma patients
- All renal transplant patients
- All new renal patients undergoing dialysis
- All admissions or transfers from nursing/ residential care facilities
- All patients undergoing Cardio-thoracic surgery
- All clean vascular patients
- All elective neurosurgical patients
- All Healthcare workers who are patients

Patients in any of the above categories require screening for MRSA either prior to an elective admission (see point 3) or on admission to UHCW.

2 Identification of known MRSA positive patients.

- It is essential that known MRSA patients are identified as soon as they enter the hospital setting in order that they receive the correct infection control management to minimise the risk to themselves and others.
- This information is also vitally important in selecting the correct antibiotic(s) if the patient has an infection.
- In order to aid recognition of known MRSA positive patients there is a field on the CRRS system termed '**Alert'** which will flag red if a patient has a number of infection risks including MRSA.
- It is the responsibility of the admitting nurse and doctor to check for an '**Alert'** on CRRS and document any positive findings in the patients notes and inform any receiving teams of the patients status.
- It is the responsibility of the admitting nurse to take routine swabs (**see guidelines 3 for swabbing procedure).**

3 Pre-admission Elective Screening

- Patients requiring elective admission for the following will be screened for MRSA prior to their admission in line with national guidance (DH Saving Lives 2007):
  - All patients undergoing elective orthopaedic surgery
  - All patients prior to cardiothoracic surgery
  - All patients prior to neurosurgery
  - All patients undergoing arterial surgery
  - All patients admitted to the clean vascular ward (33A)
  - All transplant patients
  - All patients admitted to the renal ward
  - All patients undergoing new renal dialysis
  - All healthcare workers who are patients

- Screening should take place in pre-assessment clinics whenever possible and should be as close to the operation date as possible. This should be included as part of the routine pre-assessment procedures.
- Specialist Pre-assessment clinics must ensure there are clear arrangements for screening, checking, documenting and acting upon the results of screening. This is the responsibility of Divisional Management Teams of these specialities.
- Laboratory result forms should be completed and clinical details should clearly state 'Pre Admission Screen prior to X (X= the type of surgery or procedure)
- Adherence to the MRSA screening guideline must be monitored quarterly. Results should be fed back to Divisional Teams and to the Operational Infection Control and Prevention Group and at Quarterly Performance Reviews.

4 Pre- admission Urgent Transfers

- Patients requiring urgent transfer to UHCW from other centres should be screened as soon as a decision to transfer is made. Results of this screen should be communicated to the receiving ward/unit at UHCW prior to transfer. This will allow the appropriate prioritisation of single rooms within the ward/dept and priority can be given to patients already known to be MRSA positive on transfer.
- Receiving wards/units should ask for this information prior to transfer.
- Patient transfer **must not be delayed** if the results of this screen are unavailable. It should be noted that the purpose of this screen is to assist with identification of positive patients rather than to identify those who are negative.
- Patients who are urgent transfers should be screened on admission to UHCW even if they have been screened before.

5 Routine monitoring for MRSA

- All patients not known to be MRSA positive in identified very high risk units will be screened weekly for MRSA acquisition, in line with national guidance (DH Saving Lives 2007). This includes all adult and paediatric/neonatal critical care units and high dependency units.
- Each of these patients will have a weekly screen, to include nose, groin (umbilicus and perineum of babies – neonatal unit), line sites (note: wounds, sputum and CSU to be sent if clinically indicated for M,C&S). These swabs will be labelled 'MRSA weekly screening'.

6 Screening of staff - (see guideline 9, regarding screening and treatment of staff)

Overview of MRSA Screening and where patients should be screened

Patient Group	**WHERE TO BE SCREENED**		
Known to have MRSA	**Emergency Department**	**or**	**On admission to ward**
Previously MRSA positive	**Emergency Department**	**or**	**On admission to ward**
Frequent/numerous admissions to hospital or other healthcare facility	**Emergency Department**	**or**	**On admission to ward**
Admissions transfers nursing/residential homes	**Emergency Department**	**or**	**On admission to ward**
Trauma patients	**Emergency Department**	**or**	**On admission to ward**
Transfer from other hospitals	**Emergency Department**	**or**	**On admission to ward**
Transfer/admission to Critical Care Unit/HDU or Neonatal Unit or Paediatric critical care/HDU	**Emergency Department or prior to transfer**		
New Renal dialysis patients	**Pre-admission**		
Renal transplant patients	**Pre-admission**		
Elective orthopaedic surgery	**Pre-admission clinics**		
Cardiothoracic surgery	**Pre-admission clinics**		
Neurosurgery	**Pre-admission clinics**		
Arterial Surgery	**Pre-admission**		
Patients admitted clean Vascular Ward (33A)	**Pre-admission**	**or**	**On admission to the ward**
Admissions to renal ward	**Pre-admission**	**or**	**On admission to the ward**
Admissions Orthopaedic wards 52, 52A, 53 Cedar.	**Pre-admission clinics Emergency Department**	**or**	**On admission to the ward**
Healthcare workers who are patients	**Pre-admission clinics/ Emergency Department**	**or**	**On admission to the ward**

Guidelines 2 - MRSA Swabbing procedure

1. Routine screening

Routine screening for MRSA should include one swab from:

- Nose (one swab for both nostrils)
- Perineum or Groin (one swab for both sides left and right)

Swabs should also be taken from other sites if present i.e:

- Skin lesions/abrasions
- Eczema
- Pressure sores
- Burns
- Catheter sample urine, if indwelling/subra-pubic catheter is present
- Sputum specimen, if cough is evident
- Tracheostomy sites
- Percutaneous Endoscopic Gastrostomy sites (PEG)
- Venflons
- Central lines
- Arterial lines
- Drain sites
- Surgical wounds
- Ventilated patients or patients with a productive cough, a sputum specimen is required

2. How to take swabs for MRSA

- From all dry sites, swabs should be moistened with sterile water or sterile saline prior to swabbing (Blue or Charcoal swabs may be used).
- One swab should be used for both nostrils and one swab for both sides of the groin/perineum.
- Separate swabs should then be taken for each skin lesion, etc.
- All swabs should be labelled accurately
- All separate swabs can be placed together in the same specimen bag.
- Full clinical details must then be entered on the microbiology request form; including information about any treatments e.g. antibiotic treatment and details on which site the swab relates.
- The request form should be labelled MRSA screen

For positive patients – decolonisation treatment must continue until three negative sets of swabs are obtained.

GUIDELINE 3 QUICK ACTION GUIDE FOR MANAGEMENT OF NEW CASES OF MRSA & PREVIOUSLY POSITIVE CASES ON ADMISSION

Date Name Hospital number

Ward New case ☐ Previously positive case ☐

Nursing staff	**Date completed/signature**
Provide patient/carer with information leaflet	.../...../...../.....
Isolate patient inside room instructing the patient to stay in their room. (If side room not available contact infection control immediately or out of hours duty microbiologist	.../...../...../.....
Place isolation door label on entrance to room and enforce universal precautions.	.../...../...../.....
Send full MRSA screen (see cover)	.../...../...../.....
Inform medical staff and ask to prescribe decolonisation regimen protocol (see over)	.../...../...../.....
Follow and complete decolonisation schedule and repeat screening guidance (see overleaf)	.../...../...../.....
If essential to send patient to another department/ward/hospital inform receiving area in advance. Patients should only go to other areas when they are ready to receive them. For departments patients should be seen at the end of a session or theatre list.	.../...../...../.....
Inform infection control of transfers.	.../...../...../.....

Medical staff	**Date completed/signature**
Prescribe decolonisation protocol as per schedule	.../...../...../.....
Review patient for any clinical evidence of infection requiring systemic antibiotics.	.../...../...../.....
If patient undergoes a procedure requiring antibiotic prophylaxis include in addition cover against MRSA where indicated.	.../...../...../.....
Inform general practitioner of MRSA status on day of discharge.	.../...../...../.....

Good line management is essential as this is a common portal for MRSA infections.

For the septic patient broad antibiotic cover includes cover against MRSA should be initiated pending identification of the definitive pathogen.

Guideline 4- Prescribing of topical decolonisation for eradication of MRSA

1. Treating MRSA infection/colonisation depends upon:

- The individual's own risk factors - for example, the presence of invasive devices
- Whether the patient is infected or colonised.
- Treatments must be prescribed for five days, stopped for two days followed by patient re-screening
- If repeat screening is negative a further two screens are required before clearance can be considered

1.1 Patients clinically Infected

- Patients with a clinical infection will usually require a course of systemic antibiotics.
- The choice of antibiotic depends upon the site of infection and on the particular strain of MRSA.
- Advice can be sought from the duty Microbiologist (available via switchboard.)

1.2 Skin Colonisation

- The use of an antiseptic solution for the washing of all colonised patients is necessary to limit the amount of skin colonisation and should be applied thoroughly to all areas of **pre-moistened** skin.
- The washing regime must be carried out for a period of five days (See Guideline 7/8)
- Treatment must then be withheld for two days and the patient washed in ordinary soap.
- The patients must be re-screened on the eighth day and treatment recommenced before results of the screen are obtained. This will avoid delays in treatment whilst waiting for the laboratory results.
- Disposable cloths must be used to wash the patient and particular attention should be paid to the axilla and groin areas.
- Clean clothes and bed linen must then be used.
- Hair should be washed twice weekly in an antiseptic solution, which may be followed by the use of ordinary shampoo.
- If skin irritation is noted with any antiseptic solution used the Infection Control Team or dermatologist should be informed immediately. An alternative agent may then be suggested.
- All lotions, solution or creams must be used for single patient use only.
- Antiseptics should be used with care in patients with eczema, dermatitis or on more delicate aging skin.

(For neonatal regime see Guideline 7)

1.2.1 Nasal Carriage

- **Mupirocin Sensitive Strain**

  - Where there is **nasal carriage**, Mupirocin nasal 2% should be prescribed and applied to the inner surfaces of each nostril three times a day for five days using a gloved finger or appropriate instruction given to patient if they wish to apply the cream themselves.
  - The treatment should then be discontinued for two days and re-screening should be carried out on the eighth day.

- **Mupirocin Resistant Strain**

  - Repeated and prolonged courses of Mupriocin treatment are not recommended as it may result in the emergence of resistance to the organism.

Therefore no more than two repeated treatments are recommended, any further treatments should be discussed with Infection Control

  - If the strain is **Mupirocin resistant** or the MRSA is still present after two courses of treatment then an alternative agent i.e. the use of Naseptin or Polyfax may be used following discussion with Microbiology or Pharmacy.

1.2.2 Treatment of skin lesions

- Topical treatment of small skin lesions with Mupirocin is appropriate. Care must be exercised when used in patients with renal impairment (check with pharmacy) Further advice may be sought from the Tissue Viability Team.

1.2.3 Invasive Devices

- Invasive devices, such as urinary catheters, often extend the period of colonisation.
- Aseptic techniques must be used when handling the device
- The device must be removed as soon as clinically possible.

(**see Guideline 5: for more information regarding management of devices and wounds)**

2. Decolonisation of Pre-admission Elective Patients

- If a patient is found to be MRSA positive at pre-assessment the following actions will be performed:-

  - Patients GP to be notified by specialist preadmission teams following review of the results.
  - The CRRS system should be updated and Alert added. The patient must also be informed and commenced on decolonisation treatment.
  - Repeat screening should be performed a minimum of 48 hours after treatment has stopped.
  - If repeat screening is negative a further two screens are required before clearance can be considered. If the repeat screen is positive the patient should be managed as MRSA positive on admission.
  - Successful decolonisation is unlikely in patients with chronic wounds, permanent tracheostomy and long term indwelling devices. Where risk factors for long term carriage are present the patient should be managed as below. For these patients the decision to treat will be made by the consultant who may wish to discuss the management of the patient and prophylactic antibiotics with the duty microbiologist. These patients must be admitted and managed as MRSA positive.

- Clearance of MRSA carriage should be attempted prior to surgery wherever possible. However if this is not possible or when the status of the patient is unknown;

  - The patient should be washed in Aquasept or Hibiscrub pre operatively.
  - Wounds/ lesions to be covered with an impermeable dressing
  - Mupirocin to be applied to the nose of nasal carrier during the peri-operative stage
  - Prophylactic antibiotics, which include cover for MRSA, may be indicated and clinicians may wish to consult the Microbiologist for advice.
  - Where possible patients should be placed at the end of the list, and recovered separately from other patients.
  - Theatre surfaces to be appropriately decontaminated according to the Trust Decontamination of the Environment and Non Invasive Equipment Guidelines (2006) before the next case.

3. All other admissions

An MRSA decolonisation regime and quick action guide must be implemented on admission and treatment commenced within 12 hours of arrival within the ward/unit.

Guideline 5: Management of MRSA in wounds and invasive device insertion sites

The following options should be reviewed for each of the specific issues listed:

1. Chronic Wounds, such as leg ulcers

- Consider use of wound dressings that have good anti-staphylococcal activity: options include:
  - Cadexomer iodine products (e.g iodoflex); see current UHCW Wound Formulary
  - Other products as advised by Tissue Viability
- The wound and product should be reviewed weekly to ensure wound healing is taking place
- Tissue viability advice should be sought in situations where the wound does not improve within 2 weeks of commencing treatment.

2. Wounds healing by primary intention, but infected with MRSA

- In general there should be no need to select a specific dressing to tackle MRSA in wounds healing by primary intention.
- The wound should be monitored regularly, and if there is evidence of cellulites, further wound breakdown, or delayed healing advice should be sought from medical staff as antibiotics may be required.

3. PEG sites, Suprapubic catheter sites

- Insertion sites for indwelling devices such as PEG tubes and suprapubic catheters can provide a focus for infection, 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 during topical decolonisation for MRSA, and washed using decolonization solutions.
- If the insertion site is infected with MRSA medical advice should be sought as antibiotics may be required.
- Use of an appropriate dressing with anti-staphylococcal activity on the site/around the device should also be considered. Advice must be taken from Tissue Viability/Pharmacy on the compatibility of the dressing to be used and the material the device is made from, due to the possibility that some chemical agents may damage indwelling device and cause them to rupture.

4. Infected IV insertion site sin patients known to have MRSA

- Remove line and re-site if access is still required.
- Swab the site for culture and sensitivity.
- Dress the site using an appropriate dressing; if the patients has MRSA a dressing with anti-staphylococcal activity should be selected if possible.
- Document the VIP score of the site, and actions taken including choice of dressing

5. Tracheostomy sites

- Once the exposed edge of a permanent/long term tracheostomy site is “healed” it should be carefully cleaned daily as part of normal hygiene of the stoma.
- There is nil else that can be specifically done to reduce MRSA colonisation from this site.

GUIDELINE 6

INFECTION CONTROL MRSA SWAB AND WASHING REGIME FOR ADULT PATIENTS

Patient's name: _____ **Hospital no:_____**

MRSA SCREENING SWAB PROTOCOL Take swabs/specimens from following sites: 1. **NOSE, GROIN/PERINEUM** 2. **ABNORMAL AREAS OF SKIN – E.G** DERMATITIS, BURNS, ULCERS, PRESSURE SORES, WOUNDS 3. **AROUND LINES –** PERIPHERAL AND CENTRAL LINES 4. **AROUND PEG/DRAIN SITES/TRACHEOSTOMY** 5. **SPUTUM IF WITH COUGH** 6. **URINE IF CATHETERISED**	○ From all dry sites, swabs should be pre moistened with sterile water or saline prior to swabbing (Blue or Charcoal swabs may be used) ○ One swab should be used for both nostrils and one swab for both sides of the groin/perineum. ○ Separate swabs should be taken for each skin lesions, etc. **Full clinical details should then be entered on the microbiology request form, including information about from which site the swab has been taken.**

	Day 1 Aquasept or Hibiscrub & Nasal Mupiricin	**Day 2 Aquasept or Hibiscrub & nasal Mupiricin**	**Day 3 Aquasept or Hibiscrub & nasal Mupiricin**	**Day 4 Aquasept or Hibiscrub & nasal Mupiricin**	**Day 5 Aquasept or Hibiscrub & nasal Mupiricin**	**Day 6 Stop Aquasept or Hibiscrub & use soap – STOP nasal Mupiricin**	**Day 7 Stop Aquasept or Hibiscrub & use soap – STOP nasal Mupiricin**
Week One	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature
Week Two	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature
Week Three	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature

- Patients with chronic skin conditions, please check with the dermatologist prior to the commencement of treatment.
- Ensure that all skin is pre-moistened before the application of Aquasept or Hibiscrub solution and use solution neat as a liquid soap.
- Whenever possible patients should bath or shower daily using Aquasept or Hibiscrub as a liquid soap applied directly to the skin and not diluted in the bath water. Pay particular attention to the groin area, axilla and skin folds.
- Disposable cloths must be used rather than flannels and hospital towels, which is then discarded as infected linen.
- Apply clean clothes (including underwear, Pyjamas/Clothes) and change bed linen DAILY
- Wash hair twice- weekly using Aquasept or Hibiscrub as a shampoo followed by ordinary shampoo.

INFECTION CONTROL MRSA WASHING REGIME FOR PRE-TERM, NEONATES & PAEDIATRICS

Baby's name: _____ **Hospital no:_____**

MRSA SCREENING AND SWAB PROTOCOL

Take swabs/specimens from following sites:

1. **Umbilical swab**
2. **Nose**
3. **Perinieum**
4. **any invasive device**
5. **areas of broken skin**

- From all dry sites, swabs should be pre moistened with sterile water or saline prior to swabbing (Blue or Charcoal swabs may be used)
- One swab should be used for both nostrils and one swab for both sides of the groin/perineum.
- Separate swabs should be taken for each skin lesions, etc.

Full clinical details should then be entered on the microbiology request form, including information about from which site the swab has been taken.

	Day 1 Octenisan & apply Nasal Mupiricin	**Day 2 Octenisan & apply nasal Mupiricin**	**Day 3 Octenisan & apply nasal Mupiricin**	**Day 4 Octenisan & apply nasal Mupiricin**	**Day 5 Octenisan & apply nasal Mupiricin**	**Day 6 Stop Octenisan**		
Week One	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature		
Week Two	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature	Date/signature		

- Apply to wet skin using dampened cotton wool balls
- Use as a liquid soap paying particular attention to axilla, groins and perineum.
- Rinse thoroughly from the skin before drying.
- Observe skin carefully for dryness or signs of irritation; stop treatment immediately
- Contact Infection Control for further advice

Guidelines 7 - Staff screening and decolonisation

1. Screening

- Research (Working Party guidelines 1998) has shown that the carriage of MRSA by healthcare workers rarely cause infection to either themselves or their families.

- However it is possible for colonised staff to introduce MRSA to unaffected areas and therefore screening of staff may be indicated when:
    - There is an outbreak of MRSA on a particular ward or specialised unit.
    - Where there is an increasing incidence over a short period of time.
    - Where the spread of MRSA is continuing despite the introduction of control measures.
    - Staff are epidemiologically implicated

- Staff screening should only be carried out after consultation with the Infection Control Team and Occupational Health Department and will be influenced by the speciality they work in.

- Care should be taken when screening staff, as transient carriers (carriers of MRSA for the duration of a shift only), may be deemed persistent carriers and therefore given unnecessary treatment. Staff screening should therefore take place prior to the commencement of duty.

- Swabs must be taken from the nose and any skin lesions. **This must be carried out by the Occupational Health Department.**

- Staff will be treated confidentially by the Occupational Health Department. Staff and managers are reminded that they must not access the laboratory results for themselves or other staff via the trust laboratory report system.

- Staff must not undertake any self-screening. Staff must not undertake any self-screening. Swabs not undertaken via occupational health will not be processed.

2. Specimens to be taken

- **Nose:** One swab used inside both anterior nares (fleshy part of the nose)
- **Skin Lesions and/or Wounds**: one swab from each site; clearly identifying sites
- **Any other site that has been previously positive** if the staff member has had MRSA previously, i. e. wound site

    - Indications for MRSA screening to be documented on the request form
    - Specimens must be correctly labelled with staff details. The laboratory will reject unlabelled specimens and those without Occupational Health number.
    - Clinical details must include current antibiotic therapy.

3. Decolonisation/Treatment of staff

- Where possible an attempt should be made to eradicate colonisation. However treatment of colonisation may vary according to where the healthcare worker is employed.

- Staff will be treated with empathy, respect and in confidence and will commence a topical decolonisation regime

- Healthcare workers should be reminded to report infected skin lesions/eczma/dermatitis to Occupational Health Department.

- Managers should confirm that exclusion from duty for infection control purposes should not be deemed as sick leave.

4. MRSA Staff Decontamination Regime

Staff will receive topical decolonisation therapy for 5 days. When topical decolonisation is performed in an attempt to eradicate MRSA, the nose, skin and hair must all be treated using the following regime:-

MRSA DECONTAMINATION REGIMEN			
Procedure	Product	Directions	Duration
Daily shower/bath	Chlorhexidine gluconate 4% (e.g. Hibiscrub) or Aquasept	Apply product directly to wetted skin using a disposable cloth (Consider using a chlorhexidine compatible skin cream if skin becomes dry). Change underclothes daily	For 5 days (longer courses are not more effective)
Wash hair twice during period	Chlorhexidine gluconate 4% (e.g. Hibiscrub) or Aquasept	Wash hair with product in place or shampoo	
Nasal clearance	Mupirocin cream 2% (Bactroban)	Applied to nostril 3 times a day using gloved finger	For 5 days

- 48 hours after completion of treatment repeat MRSA screening (i.e. day 7). Include details of treatment on the laboratory forms.

- If these swabs are negative, a further repeat of swabs will be required after a further 7 days. If the second set of swabs is positive advice must be sought from consultant microbiologist.

- Staff members found to be persistently colonised/infected will be managed on an individual basis in confidence by the Occupational Health Department, will advice from a Consultant Microbiologist.

4.1 Nasal Carriage

Mupirocin Sensitive strain

- Mupirocin nasal should be applied three times daily to the anterior nares using a gloved finger for five days.
- Treatment should then stop for two days and then screening can be completed on the eighth day.
- In most ward areas staff who are nasal carriers can continue to work whilst on Mupirocin treatment.
- In high risk areas staff should be excluded from work for 48hrs, from the start of Mupirocin treatment (see guidance note for risk areas).

Mupirocin Resistant strain

- Contact Consultant Microbiologist for advice.

4.3 Skin lesions

- Mupirocin ointment can be used as an effective anti-staphylococcal agent applied to skin lesions such as superficial eczema.
- All skin lesions to be reported to Occupational Health.
- Staff with MRSA positive skin lesions in a high to moderate risk area should be excluded from duty, however they may continue to work in a low risk area providing the lesions are covered with an impermeable dressing.

Please contact Occupational Health for further advice

Out of hours contact occupational health on 24543 and an answer machine will take a message.

GUIDELINE 8 - Isolation Procedures

Standard isolation should be implemented (Refer to Trust Isolation Policy (UHCW 2006) for further details). Specific universal precaustions are as follows:-

- Patients should be nursed in a single room preferably a negative pressure room or where this is not possible an ordinary side room. Where neither these two options are available and after discussion with Infection Control Nurses patients may be cohort nursed (nursed together in a bay) if there are not enough side rooms available.

- Patients should be given both a full explanation of the reasons for isolation and written information relating to MRSA by the nurse looking after the patient. The Infection Control Nurse is available to speak to any patient who may have any further concerns.

- Where possible, the door should be kept closed to avoid dispersal to adjacent areas.

  (If the patient's safety or psychological status may be compromised a risk assessment must be made and documented in the nursing profile, as to whether the door may be kept open). However, the door should be closed during periods of activity i.e. bed making.

- Identification of isolation is required outside the isolation room i.e. door label.

- Staff having direct contact with the patient should wear disposable gloves and aprons.

- Hand decontamination in accordance with the Trust's Hand Decontamination Policy must be performed after removal of protective clothing and on leaving the room. Alcohol hand rub must be readily available and used on leaving the isolation room.

- Masks and eye protection are only required as part of standard precautions: during procedures likely to cause contamination/aerosols of blood or body fluids e.g. suctioning/chest physiotherapy, which may generate staphylococcal aerosols.

Visitors who have **only** social contact with the patient in isolation i.e. shaking hands talking etc. need not wear protective clothing **but** must be instructed to wash their hands on leaving the room

Other Specific Standard Universal Precautions

Clinical Waste

- All waste generated in an Isolation area must be disposed of in a yellow bag for incineration according to the Trust's Waste Management Policy – (UHCW 2007)

Linen

- To be disposed of as infected linen i.e. in a red alginate liner, then sealedand put into a red linen bag for collection. The red alginate liner should not be stored in the isolation room but removed when contaminated items are placed in it regardless of whether the bag is full or not.

Equipment

- Equipment for patients in isolation should be kept to a minimum. All equipment from an isolation room must be thoroughly cleaned and decontaminated after use according to the Trust's Decontamination of Non Invasive Equipment Policy (UHCW 2006).

Terminal cleaning of Isolation room

- An isolation room used for a patient who has had MRSA should be cleaned after their discharge in accordance with the Trust Decontamination of the Environment and Non Invasive Equipment Guidelines (UHCW 2006)

- Chlor -Clean solution must be used for all terminal cleans.

GUIDELINE 9 - Actions to be taken when MRSA has been identified from laboratory samples. (in-patients)

The following actions must be taken after every positive new "in-patient" MRSA isolate regardless of location:

Action	Rationale
The Infection Control team will telephone the result to the ward	To ensure adequate precautions are taken when patients is admitted and patient is screened in line with current protocol
The nurse in charge of the patient will: • Document the result in the patient's records. • Inform the medical team that MRSA has been isolated and appropriate treatments started. • Inform the patient and explain to them about MRSA and give them a MRSA patient information leaflet Ensure that patient is commenced on MRSA quick action guide and appropriately completed (Guideline 3)	To ensure accurate documentation To ensure decolonisation protocol started and any other appropriate treatment (i.e. systemic antibiotics) if clinically indicated To gain consent and co-operation from the patient and ensure the patient is adequately informed of reasons for isolation and proposed treatment To ensure appropriate treatment and care for patient with MRSA
Isolate the patient in a side room if available dependent on risk factors and individual patient risk assessment	To minimise the risk of cross infection
Isolation sign is placed on the side room door (see Isolation Policy (TW/ICO/PL/2/04-2007)	To ensure isolation precautions are taken by all staff
Ensure that gloves, aprons and alcohol hand rub are available outside side room either on trolley / 'danicentre'	To minimise the risk of cross infection an maintain universal Infection control precautions
Staff from other wards and departments e.g. physiotherapists, radiographers, other medical team etc. must speak to the nurse in charge before approaching the isolated patient	To minimise the risk of cross infection and ensure the appropriate use of Personal Protective Equipment and the appropriate decontamination of any equipment used

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