Methicillin Resistant *Staphylococcus aureus* (MRSA) Policy

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1. INTRODUCTION

Infections can be a serious event during a patient's hospital stay and can be a life-threatening experience. The Health and Social Care Act 2008, Code of practice for health and adult social care on the prevention and control of infections and related guidance, sets out compliance criterion that all registered providers will be judged on how it complies with the registration requirement for cleanliness and infection control. Act is now 2015

MRSA infections can be difficult to treat and therefore it is important to manage patients who are at greatest risk if they acquire it and to treat patients who are colonised/infected appropriately.

Each Hospital is responsible and accountable for delivering microbiological screening of admissions; also where appropriate suppression treatment and isolation.

Strains of *Staphylococcus aureus* resistant to many antibiotics including Methicillin (flucloxacillin) pose an increasing problem in hospitals and other healthcare settings. *Staphylococcus aureus* which is Methicillin resistant (MRSA) is usually also resistant to most other commonly used antibiotics and treatment of infection is difficult and expensive. MRSA is equally as pathogenic as Methicillin sensitive strains and is of particular concern in intensive treatment units and surgical wards. It has a considerable capacity to spread and colonise other patients and sometimes members of staff.

There are strains of MRSA, which have reduced sensitivity to Vancomycin and Teicoplanin therefore reducing treatment options. There is also increasing resistance to Bactroban, which has been a useful topical treatment for colonisation and superficial wound infection.

This policy has been written with reference to the 2005 Revised Methicillin Resistant *Staphylococcus aureus* Infection Control Guidelines for Hospitals, Report of a combined Working Party of the British Society for Antimicrobial Chemotherapy, the Hospital Infection Society and the Infection Control Nurses Association. The key points from this report follow:

- The significant increase in the incidence of MRSA in many countries, major changes in health care delivery over the last decade and additional demands on infection control teams have prompted a re-assessment of previous guidelines.
- The occurrence of invasive infection, especially in vulnerable patients, and limited options for therapy justify continued efforts to limit spread of MRSA.
- Control programmes to prevent spread of endemic MRSA and to minimise the number of patients affected during epidemics have been shown to be effective and to contribute to patient care.
- Assessing the financial impact of MRSA and measures to prevent spread is difficult but the evidence strongly suggests that control strategies are cost effective.
- Hospital-wide infection control programmes, antibiotic policies and good practice are key measures in minimising hospital-acquired infection, including MRSA. Hand washing, adequate cleaning and patient isolation or cohorting are particularly important.
- In those hospitals which do not have MRSA, every effort should be made to preserve this situation without compromising overall patient care.
- Where MRSA is endemic, a risk assessment should be carried out and resources utilised in those areas where the impact of spread is likely to be greatest, i.e. in high-

risk areas such as the Intensive Care Unit (ICU). The extent of measures in moderate (e.g. a general surgery ward) and low risk areas (e.g. a medical ward) will be less.

- The requirement for urgent specialist care should not be compromised by control measures and the patient's overall needs should take precedence.
- The extent of patient screening is determined by the clinical area and the number of patients affected; screening staff is usually only indicated in high-risk areas or where spread of MRSA continues despite on-going control measures.
- Recommended sampling sites for initial patient screening are the nose and groin.
- Prolonged (>5 days) or repeated (more than twice during one admission) courses of Mupirocin nasal ointment should be avoided to prevent resistance emerging.
- Ward closure should only be recommended following risk assessment and after full consultation with relevant clinicians and hospital management.

2. PURPOSE AND SCOPE

The purpose of this policy is to ensure prompt recognition of those patients at greatest risk and reduce the risk of infection with MRSA to a minimum. This document applies to all staff either employed or contracted by East Coast Community Healthcare CIC (ECCH).

3. RESPONSIBILITIES

It is the responsibility of all staff to ensure that they adhere to best practice.

4. POLICY STATEMENT

This policy will be implemented to ensure adherence to safe practice, and to ensure compliance with the latest DoH publications:- 2008 Gateway 11123. 2010 Gateway 13482

5. PROCEDURE

Transmission of MRSA

MRSA colonises the same regions of the body as other strains of *Staphylococcus aureus* that is nose, throat, ears, axillae, groin, perineum and gastrointestinal tract. The most practical approach to screening for colonisation is to take nose and groin swabs and to check any skin puncture sites, catheters and wounds. Transmission is by direct or indirect contact or may be air borne on dust particles and skin scales.

NB: HANDS OF CARERS ARE THE MOST COMMON ROUTE OF TRANSMISSION

Management and control of MRSA

Screening of patients

- Community cases are individual assessed and must be discussed with a member of the IPCT.
- All admissions including day cases must be screened (Effective since April 2008 in inpatient areas in ECCH) DoH Gateway 13482
- This is audited on a monthly basis by the IPCT, any lapses will be reported on QUEST

  History of the above
  All elective patients must be screened preadmission since March 2009. DoH Gateway 11123

- If a patient is admitted on treatment for MRSA this treatment should be continued until discussed with the infection prevention and control team. The IPCT will assist the ward in the risk assessment as to when to stop treatment for 48 hours so the patient may be re-swabbed. It is not recommended to swab a patient whilst on treatment.
- Any patient who has previously been known to have MRSA must be rapidly swabbed on admission and commenced on body wash, until results are known.
- Any patient that has been an inpatient for longer than 4 weeks must be risk assessed for rescreen (individual case basis).
- Planned day case admissions must be screened prior to admission.
- MRSA PII management in clinic setting (Appendix 3)

Single room

A patient known to be infected or colonised with MRSA should be admitted into a single room where available. If admitted to a ward, which already has patients with MRSA, it may be appropriate to care for these patients together in a larger room (cohort nursing).

If an MRSA patient is not isolated a risk assessment must be completed.

The infection Prevention and control team must be informed of any patient admitted who is known to have been MRSA positive in the past.

It will be usual for the Infection Prevention and Control Team (IPCT) to notify the clinical area of a positive MRSA result. However, it is the responsibility of all clinical staff to check microbiology results.

Care of patients colonised or infected with MRSA

- Single room where available, (see above)
- Adherence to strict Standard (Universal) Precautions by all disciplines.
- All clinical personnel attending the patient should wear gloves and apron. (Gloves and apron are **not** necessary for visitors unless assisting with personal care). All visitors must decontaminate their hands before and after leaving the patient area.
- Clutter must be kept to a minimum to aid effective cleaning.
- Assess the patients' clinical condition. If infection is suspected, it is advisable the clinician caring for the patient discusses antibiotic treatment with the microbiologist. Topical treatment may also be recommended; this will be assessed on an individual patient basis.
- Shared equipment such as toilets, commodes must be decontaminated as per ECCH policy after each use.
- A high priority reminder should be placed on the patients notes on SystmOne.
- The patient should be given an explanation regarding MRSA and a patient information leaflet, (Appendix 4).The ward staff should contact the Infection Prevention and Control team if a patient has any particular queries they cannot answer.
- If the patient is discharged to a nursing/residential home or another hospital/healthcare facility, they must be informed of the patients' status before their discharge (consent to pass this information on must be obtained from the patient). Hospital Transport must also be advised when booking transport for discharge or outpatient appointments.
- Under the Health and Social Care Act (2008) 2015 An NHS body must ensure that it provides suitable and sufficient information on a patient's infection status whenever it arranges for that patient to be moved from the care of one organisation to another, so that any risks to the patient and others from infection may be minimised.

- Patients under the care of other ECCH specialities (podiatry District Nursing (D/N) etc) who are known to have MRSA should be notified to the IPCT.

Cleaning

It is essential to keep the patients bed space/room clean at all times.

- Cleaning must occur on a daily basis; this should include damp dusting all horizontal surfaces These areas must be decontaminated using Actichlor Plus, floors should be kept free of dust and dirt.
- It is important to keep the room/bed space clutter free, with only essential items in the room.
- When the patient is discharged, the room/area previously occupied must be thoroughly cleaned with a detergent solution and dried, followed by a 0.1% Sodium Hypochlorite solution (this must include bed, locker, bedside table and chair). If Sochlor is used a single clean only is required.
- The curtains must be changed around the bed space when the patient is discharged or moved.

Laundry

All laundry generated from patients known to have MRSA should be considered as infected and placed into a water-soluble red bag inside a normal linen bag for dispatch to the laundry.
Advice on washing must be given to relatives if they are taking washing home.

Waste

Waste must be appropriately segregated and disposed of according to ECCH policy.

MRSA CHECKLIST FOR CLINICAL STAFF

Once MRSA positive results are **confirmed**:

- A high priority reminder alert must be placed on the patients notes on SystmOne.
- The infection prevention and control team will advise which Suppression products are to be used following discussion with the infection control doctor.
  See Appendix 2
- Source Isolation
- All disciplines to use strict Standard (Universal) Precautions (refer to policies on: Hand Hygiene & Disposal of Waste)
- Explain MRSA details to patient and relatives.
- Give patients an MRSA information leaflet and record in the patient's notes that this has been explained and given.

Contact Infection Prevention and Control on 01502 445361 for any further advice on any further action.

6. MONITORING AND REVIEW

It is the responsibility of all department heads/professional leads to ensure that the staff they manage adhere to this policy.

The IPCT will monitor inpatient screening compliance on a monthly basis; the results will be fed back to IPACC. Non-compliance will be reported via QUEST.

This policy will be reviewed by the Infection Prevention and Control Team.

7. REFERENCES

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Chief Medical Officer. (2003) *Winning Ways*: working together to reduce healthcare associated infection in England. London. DoH
National Institute for Health and Care Excellence (2018 Revised January 2024) *Management of MRSA in Primary Care* https://cks.nice.org.uk/topics/mrsa-in-primary-care/management/management/ (Accessed 26/03/2026)

8. AUTHOR

Infection Prevention and Control team June 2026

9. APPENDICIES

Appendix 1

Obtaining routine MRSA swabs from nose and groin

As soon after admission* as practicable swabs should routinely be taken from nose & groin, if patient has a wound and/or catheter then a sample must be taken from those areas as well.

- Explain the procedure to the patient and obtain consent.
- Ensure the charcoal swabs are in date.
- Ensure all documentation / clinical details are correct.
- Decontaminate hands and apply gloves and an apron.
- Moisten swab prior to obtaining sample from nose and groin (sterile water).
- Obtain sample and place in the tube containing a transport medium infused with activated charcoal
- Ensure media lid is secure.
- Discard gloves and apron into clinical waste bag and decontaminate hands.
- Record consent gained and swabs taken in the patients notes.

*swabs must be taken as part of the admission procedure it is poor practice to delay this process. Out of hours swabs will be required to be placed in a dedicated refrigerator; it is not acceptable to place specimens in a drug or food refrigerator

Appendix 2

Suppression Treatment regime

A 5 day course of body wash prescribed on patient's drug chart and on the individuals care plan

- **Octenisan body wash** (use for 5 days once a day) 500ml bottle

- Do **NOT** apply to dry skin.
- Use as liquid soap in the bath or shower daily and as a shampoo on day 1, day 3 and day 5 (hair must be washed at least twice during the treatment where possible).
- Pay particular attention to armpits, groins, under breasts, hands and buttocks
- Do **NOT** dilute it beforehand in water as this will reduce its efficacy – apply direct to wet skin on a dampened wash cloth / shower scrunch.
- It should remain in contact with the skin for **one** minute.
- Rinse off thoroughly.
- Towels must be for individual use and changed daily as must the bed linen and any underwear worn.
- It is important to ensure that the product is rinsed off the skin and the skin is dried properly, especially for people with skin conditions.

PLUS

- Mupirocin 2% nasal ointment 3g TDS.(This is often unavailable, check if available) Apply to both nostrils for 5 days

Or

- Naseptin (Chlorhexidine hydrochloride 0.1% neomycin sulphate 0.5%) 15g TDS apply to both nostrils for 10 days (Do not use if patient has a nut or soya allergy)

OR if the patient is resistant to Mupirocin, allergic to nuts, soya or using oxygen Octenisan nasal gel 6ml can be applied to both nostrils BD for 5 days

- Wash hands before applying
- Apply a pea-sized amount to the inner surface of each nostril and massage gently upwards, use a finger or cotton bud. Close the nostrils by pressing the sides of the nose together for a moment; this will spread the ointment inside each nostril.
- Wash your hands.

If the patient has a static wound and is positive for MRSA on the admission nose and groin screening, the IPCT must be informed. They will then risk assess and advise if the wound requires a screening swab.

5 days of treatment – body wash

5 days treatment –Mupirocin or Octenisan

Or

10 days treatment-Naseptin.

Followed by at least 2 days without treatment then patient to have repeat swabs.

If further treatment is required, the IPCT will advise.

Appendix 3

Management of MRSA PII (Period of increased incidence) in a clinic setting

Potential Outbreak Identification and Notification

Any suspected outbreak must be reported immediately to:

- Clinic Manager
- IPCT (IPC team to notify ICB)
- Local Health Protection Team (UKHSA) 0300 3038537
- An IMT will be convened.

Infection Control Measures

IPC Team to audit and risk assess PII affected clinical area

***Standard Precautions*:**

- Rigorous hand hygiene with soap and water or alcohol-based rub.
- Personal Protective Equipment (PPE): gloves and aprons for all wound care.
- Aseptic non-touch technique (ANTT) for dressings.

Patient Management

- Cohort or isolate MRSA-positive patients.
- Schedule these patients at the end of clinic sessions or use home visits if possible.

Equipment and Environment

- Review multi- patient equipment cleaning process and schedules.
- Use single-use or dedicated equipment.
- Clean shared equipment between patients with chlorine-based disinfectants.
- Review clinic cleaning procedures, including cleaning schedules.
- Increase frequency of cleaning in treatment and waiting areas.

Screening and Surveillance

- Patients: Liaise with UKHSA regarding need to screen clinic patients. (wound, nose, groin).
- Staff: Only screen if part of outbreak investigation (UKHSA to advise).
- Maintain a log of positive results and review trends weekly.

Treatment and Decolonisation

- Colonisation
- Offer decolonisation:
- Mupirocin 2% nasal ointment TDS for 5 days
- Chlorhexidine 4% body wash daily for 5 days
- If Mupirocin resistant, then prescribe Naseptin (10 days)

Infection

- Prescribe antibiotics based on sensitivities

Communication

- Inform patients and families of the outbreak and the control measures.
- Provide MRSA information leaflets.
- Maintain open communication with GPs and other involved services
- IMT to discuss communication of Duty of Candor

Post-Outbreak Actions

- IMT to declare outbreak over after:
- No new MRSA cases for 6 months.
- All control measures reviewed and effective.
- Conduct a Post-Incident Review:
- Identify possible causes and learning points.
- Update policies and procedures as required.

Monitoring and Audit

- Perform monthly audits of:
- Hand hygiene compliance
- Cleaning standards
- Dressing technique
- Report audit outcomes to clinic leadership and IPCT

Training

- All staff to receive annual infection control training.
- Additional training provided during or after an outbreak.

Appendix 3

4_MRSA Leaflet NEW 2026

MRSA

Methicillin Resistant Staphylococcus aureus

Patient information leaflet

Produced by East Coast Community Healthcare Infection, Prevention and Control Team
First issued: July 2014 reviewed June 2026

10. EQUALITY & DIVERSITY IMPACT ASSESSMENT

In reviewing this policy, the HR Policy Group considered, as a minimum, the following questions:
- Are the aims of this policy clear?
- Are responsibilities clearly identified?
- Has the policy been reviewed to ascertain any potential discrimination?
- Are there any specific groups impacted upon?
- Is this impact positive or negative?
- Could any impact constitute unlawful discrimination?
- Are communication proposals adequate?
- Does training need to be given? If so is this planned?

Adverse impact has been considered for age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

Blank version of the full Equality & Diversity Impact assessment can be found here:

http://eccho/Home/FormsGuidance.aspx?udt_575_param_index=E&udt_575_param_page=2

11. DOCUMENT CONTROL

Version Date	Version No.	Author/ Reviewer	Comments
Feb 2012	5	IPC	Logo changed
Feb 2014	6	ADIPC	Clarity around specimen storage
Feb 2016	7	ADIPC	
Feb 2018	8	IPC	Minor changes
Feb 2020	9	IPC	Added nasal treatment
June 2022	10	IPC	
June 2024	11	IPC	Minor changes

DOCUMENT CONTROL SHEET

Name of Document:	Policy on screening and precautions to be observed when caring for patients colonised or infected with Meticillin Resistant Staphylococcus Aureus (MRSA)
Version:	12
File Location / Document Name:	ECCHO
Date Of This Version:	June 2026
Produced By (Designation):	Infection Prevention & Control Team

Reviewed By:	IPACT
Synopsis And Outcomes Of Consultation Undertaken:	Changes relating to relevant committees/groups involved in ratification processes.
Synopsis And Outcomes Of Equality and Diversity Impact Assessment:	Reference to key guidance documents
Ratified By (Committee):-	IPACC
Date Ratified:	June 2026
Distribute To:	Clinical staff
Date Due For Review:	June 2028
Enquiries To:	Infectionprevention@ecchcic.nhs.uk
Approved by Appropriate Group/Committee **Approved by Policy Group** **Presented to IGC for information**	☐ Date: ☐ Date: ☐ Date: