Policy on screening and precautions to be observed when caring for patients colonised or infected with Meticillin Resistant *Staphylococcus Aureus* (MRSA)

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Approvals

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1. Introduction

Infections can be a serious event during a patients 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 judged on how it complies with the registration requirement for cleanliness and infection control.

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 decolonisation and isolation.

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 within in-patient areas in East Coast Community Healthcare CIC (ECCH).

3. 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

4. Responsibilities

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

5. Policy monitoring

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

6. Review

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

7. Introduction to MRSA

Strains of *Staphylococcus aureus* resistant to many antibiotics including Meticillin (flucloxacillin) pose an increasing problem in hospitals and other healthcare settings. *Staphlycoccus aureus* which is Meticillin 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 Meticillin 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 Meticillin 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 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 Bactroban 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.

8. 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 wound. 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

9. Management and control of MRSA

9.1 Screening of patients

- All admissions including day cases must be screened (Effective since April 2008 in inpatient areas in ECCH) DoH Gateway 13482

History of the above
All elective patients must be screened pre admission by 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 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 rescreened.**

9.2 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 nurses 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.

9.3 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). 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 be 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.
- Patient notes should be labelled with an MRSA sticker. They should be signed and dated. The stickers are available from the infection prevention and control team.
- The patient should be given an explanation regarding MRSA and a leaflet. 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).
- Under the Health and Social Care Act (2008) 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.

9.4 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 with a detergent solution and 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 Actichlor plus is used a single clean only is required
- The curtains must be changed around the bed space when the patient is discharged or moved.

9.5 Laundry

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

9.6 Waste

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

10. MRSA checklist for clinical staff

Once MRSA positive results are **confirmed**:

- 2 x yellow MRSA stickers out/inside cover of patients' notes with date confirmed and legible signature of the nurse informed. (stickers are available from the infection prevention and control team)
- The infection prevention and control team will advise which decontamination 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.

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

11. References

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Department of Health (2009) The Health and Social Care Act 2008. DoH London_ 13072
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Duckworth G et al (2005). Revised Methicillin Resistant *Staphylococcus Aureus* Infection Control Guidelines for Hospitals.
Royal College of Nursing (2005) MRSA guidance for nursing staff. RCN London
Chief Medical Officer. (2003) *Winning Ways*: working together to reduce healthcare associated infection in England. London. DoH

<u>Obtaining routine MRSA swabs from nose and groin</u>

As <u>soon after admission</u>* 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.

- Ensure media bottle is in date. NB 'broth' has a short expiry date.

- Ensure all documentation / clinical details are correct.

- Decontaminate hands and wear gloves and an apron.

- Moisten swab prior to obtaining sample from nose and groin (sterile water). If 'broth' is being used nose and groin specimens may be placed in the same bottle.

- Obtain sample and place in bottle

- Ensure media lid is secure.

- Discard gloves and apron into clinical waste bag and decontaminate hands.

*swabs must be taken as part of the emergency admission procedure it is poor practice to delay this process.

Appendix 2

Decolonisation regime

A 5 day course prescribed on patients 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 Apply to both nostrils for 5 days
Or

  ❖ Chlorhexidine hydrochloride 0.1% neomycin sulphate 0.5% 15g TDS apply to both nostrils 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 wound the IPCT will advise treatment with discussion with ECCH infection control doctor.

5 days of treatment – body wash and nasal ointment

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

If further treatment is required the IPCT will advise.