Standard Operating Procedural Guidelines for the Prevention and Management of MRSA

PROCEDURE SUMMARY
The purpose of this document is to ensure that all staff members, involved in direct patient care, are aware of their responsibility with regards to the prevention, and control of spread, of MRSA.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
The responsibility for monitoring and reviewing this Policy lies with the Director responsible for Infection Prevention and Control. Randomised care bundle audit of community services, submission of screening figures on a monthly basis and accessing electronic systems will monitor compliance and implementation.

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The Director responsible for monitoring and reviewing this procedure is Director of Infection Prevention and Control
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1.0 AIMS AND INTRODUCTION

1.1 The Department of Health is committed to reducing Health Care Associated Infections and has a MRSA zero tolerance ambition. It is considered unacceptable for a patient to acquire a MRSA blood stream infection (BSI) whilst receiving care in a health care setting.

1.2 Healthcare providers have been set the challenge of demonstrating zero tolerance of MRSA BSI through a combination of good hygienic practice, appropriate use of antimicrobials, improved techniques in the care and use of medical devices as well as adherence to best practice guidance.

1.3 The main aim of these guidelines is to reduce the risk of MRSA infection within high risk individuals.

The MRSA screening tool will be used to target only those patients who are deemed high risk of MRSA BSI e.g. those who have wounds and/or invasive devices, such as a catheter.

This will require all patients on admission to be risk assessed using the MRSA screening tool (Appendix 1) as part of the admission assessment to identify if they fall into the high risk category.

All patients whose screening results are MRSA positive will be offered decolonisation treatment.

2.0 WHAT IS MRSA?

2.1 Staphylococcus aureus is a bacterium that is found on the skin and in the nose of 1 in 3 members of the population. Staphylococcus aureus can cause boils, abscesses or impetigo.

2.2 MRSA is a strain of staphylococcus aureus which is resistant to some antibiotics normally used to treat staphylococcus aureus infection (penicillin, amoxicillin, flucloxacillin, erythromycin and cephalosporin). Therefore to effectively treat someone with MRSA infection the appropriate antibiotics must be prescribed following sensitivity testing (following the Trust antibiotic prescribing policy). MRSA and Methicillin Sensitive Staphylococcus Aureus (MSSA) cause the same range of infections, but due to antibiotic resistance, infections caused by MRSA are more difficult to treat.

2.3 Refusal to accept transfer of a patient known to be colonised with MRSA is only justifiable in exceptional circumstances on the basis of known risk posed to others. There is no reason to delay or refuse treatment, investigations or therapy because of MRSA.
2.4 Visitors should be assured that there is normally no risk to them. However if a relative is immuno-compromised or awaiting surgery and wants further advice they should discuss this with their GP or Practice Nurse.

### 3.0 COLONISATION AND INFECTION

3.1 **MRSA Colonisation**
The detection of MRSA in sites of the body usually nose, axilla and groin where there is no obvious evidence of infection.

3.2 **MRSA Infection**
Infection describes the presence of microbes on / in the body which are causing clinical signs of infection e.g. pain, pyrexia, dysuria, presence of pus, purulent sputum and require antibiotic treatment. A wound, such as a leg ulcer, may be colonised with MRSA where there is no obvious sign of infection or it may be infected with MRSA with symptoms including; redness, heat, inflammation, pain and there may be discharge. Clinical infection with MRSA occurs either through the haematogenous route, this is when a patient’s own bacteria causes infection, or by cross infection from another person, usually transferred by direct contact.

3.3 In most cases where infection is present, the infections are minor and remain localized to the area of broken skin and can be treated quickly and effectively. In some circumstances infection with MRSA may be problematic, particularly in the elderly and debilitated people and in those with a lowered resistance to infection. If MRSA is able to enter the bloodstream e.g. via a cut, abrasion, invasive device or from other medical interventions, it can cause serious infection such as septicaemia (MRSA bacteraemia). This potentially life threatening infection is more likely to affect people who already have a serious underlying condition that has weakened the body’s defense mechanism and urgent treatment is required.

3.4 **MRSA Decolonisation**
The purpose of decolonisation is to reduce the risk of the patient developing an MRSA infection with his or her own MRSA and transmission of MRSA to another patient.
4.0 SCREENING FOR MRSA

4.1 This is a method for detecting MRSA in people who may be carrying the organism. It involves taking bacteriological swabs, urine or sputum samples. These are then processed in the microbiology laboratory.

4.2 All Service areas EXCLUDING Podiatry:

Routine admission screening on all admissions to the Trust (service case load / inpatient) is not required; However, certain High Risk patients falling within a high risk category will require screening for MRSA, within 48 hours of admission to an inpatient unit or CHS case load. (See screening flow chart Appendix 1).

4.3 High Risk Patients
(Implementation of modified admission MRSA screening guidance for NHS (2014) DoH)
- All patients previously identified as colonised with or infected by MRSA
- All patients undergoing Podiatric surgery
- All patients with an invasive device – urinary catheter, central line, gastrostomy tube etc.
- All patients with a wound that:
  Has been present for longer than two weeks (excl leg ulcers)
  OR
  Is showing clinical signs of infection -as per wound swabbing flow Appendix 2 (incl leg ulcers)

4.4 Podiatry Services:

4.4.1 Patients with wounds on admission to the caseload to be assessed according to the wound swabbing pathway (Appendix 2) on admission. Swab for culture/screen for MRSA if indicated.

4.4.2 If swab returns positive, discuss further swabbing requirements and treatment regime with IPC team.

5.0 PODIATRIC SURGERY

5.1 Patients undergoing podiatric surgery in community hospitals meet the criteria of an ‘elective admission’ and therefore need to be screened. This will apply to all patients.

5.2 Screening should be carried out prior to admission and steps must be taken to decolonise the patient if results are MRSA positive, to reduce the risk of infection post-operatively.
5.3 **Practice:**

- When patients are sent their pre-operative assessment appointment they will also receive a letter explaining the need for MRSA screening (Appendix 12).

- The pre-operative assessment appointment will take place a maximum of 4 weeks prior to the planned surgery.

- During the pre-operative assessment, the patient will have a nasal swab taken by the podiatry staff and will be asked to take their own groin swab. Verbal and written instructions on how to do this must be given to the patient (Appendix 13).

- The groin swab is taken to increase the chance of finding MRSA colonised patients as it is known that occasionally carriers are found who have negative nasal swabs.

- However, if the patient is unwilling or unable to take their own groin swab, the nasal swab alone will be sent for MRSA testing.

- The swabs will be sent to the local acute hospital pathology lab for microbiological testing, results should be available within one week (typically 2-4 days).

5.4 **Screening results:**

- Results will be reported to the relevant Podiatry/Podiatric Surgery Department. If this is not the local process swabs should be followed up by the responsible Podiatrist.

- For patients whose swab results are negative, no further action is required and their planned surgical intervention can proceed.

- If a patient’s swabs are positive, they will be informed by letter (Appendix 14) advising them to make an appointment to see their General Practitioner (GP).

- At the same time, a letter will be sent to their GP advising them of their patient’s result and the need to decolonise them before surgery (Appendix 15).

- Instructions for the use of the body wash and nasal ointment (Appendix 7) should be sent to both the patient and their GP.

- The patient will not be required to have a negative screen prior to their podiatric appointment. However, in order to maximise the chance of ensuring that the patient is not heavily colonised with MRSA at the time of their surgery, the GP will be asked to instruct the patient to commence treatment just 5 days prior to their planned surgery, so that
the last day of treatment coincides with their podiatric clinic appointment.

5.5 Podiatric patients who refuse to be screened

The patient will have received a letter explaining the rationale for screening. Therefore, this should be carefully explained at pre-operative assessment, emphasising that it is for the patient’s benefit and that if they are found to be positive the treatment will reduce their risk of post-operative infection. If the patient still refuses, the clinician must decide the risk of post-operative infection and whether the surgery can be undertaken in the community.

6.0 HOW TO SCREEN FOR MRSA COLONISATION

6.1 Inform patient and gain and record consent.

6.2 When carrying out a Full Body MRSA Screen the following sites must be swabbed.

See Appendix 3

- **Nose** – Tip patient’s head back and swab both nostrils with same swab.
- **Groin** – swab both groins with same swab.
- **Wounds:** If your patient has wounds which meet swabbing criteria (Appendix 2), sites of suprapubic catheter, PICC and Hickman line, and Percutaneous Endoscopic Gastrostomy (PEG) tube, these will also need to be swabbed (a separate swab for each wound)
- **Urine:** If a urinary catheter is in situ, a urine specimen to be obtained. Samples should be taken from the needle-free access sample port after cleansing the area with a device cleaning swab – a sterile syringe must be used.
- **Sputum:** if patient has a productive cough, please obtain a sputum sample

6.3 What swabs to use

Cotton tipped bacteriology swabs. The swab should be dampened in the culture medium from the swab container prior to the swab being taken to ensure that any bacteria present adhere to the swab and then rubbed over the skin at the appropriate site. Swabs are obtainable from local microbiology laboratories/ NHS supply chain.

6.4 Once the swab is taken

It should be placed into the transport medium and then placed in a specimen bag. A Microbiology form should be completed listing the sites sampled. This form should be sent in the same specimen bag as all the screening specimens from the same patient but use an additional bag/form if there are more than 3 swabs. The screen and form should be sent to the microbiology laboratory.
6.5 **Record the MRSA Screening**
Details of the date, time and site of swabs/samples taken should be recorded in the patient’s notes.

6.6 **Results**
Swab/sample results must be noted and filed in the patient’s records, paper and electronic. The MRSA Care Pathway form should be used to record this (Appendix 4). For Remedy users (North Mental Health services) use Appendix 6 – MRSA Screening Form. Patients and responsible clinician should be informed of the results.

6.7 NB: Screens will not be processed over the weekend or bank holidays

### 7.0 DECOLONISATION / TREATMENT

7.1 In inpatient units, where possible, patients who have been assessed as high risk and require screening should be isolated/barrier nursed until results are returned, and then during decolonisation, if required. In mental health services, discuss with the Infection Prevention and Control (IPC) team if isolation is not going to be achievable.

7.2 Patients discharged from an acute hospital who have started decolonisation treatment should complete the course.

7.3 Standard decolonisation is as follows:
1. *Octenisan body wash* to be used once daily for five days. Using a disposable washcloth (or freshly laundered flannel/cloth),
2. Wet skin
3. Apply undiluted *Octenisan* to the washcloth.
4. Wash whole body ensuring you observe a contact time of one minute.
5. Rinse off thoroughly
6. Dry with freshly laundered towel
7. Hair should be washed with *Octenisan* on day two and four (See Appendix 9)

7.4 As with any topical treatment there is a risk of skin irritation. If this occurs, stop treatment and contact the IPC team. Specialist dermatology advice must be sought for patients with skin disorders who require decolonisation.

7.5 For bed-bound / decreased-mobility patients, *Octenisan wash mitts* can be used in place of the body wash. No rinsing off is required. Hair can be washed on day 2 and 4 using the *Octenisan wash cap*.

7.6 2% Mupirocin (Bactroban) nasal ointment is only to be prescribed if it has been confirmed that the patient is nasally colonised with MRSA. Apply to the anterior nares (inner surface of the nostrils) 3 times daily for five days. Gently pinch the sides of the nose together after application to ensure an even distribution of the ointment.
If a Mupirocin resistance or allergy exists, use Naseptin or Octenisan nasal gel.

7.7 Patients must be re-screened after decolonisation on Day 8. (See Appendix 9)

7.8 **LOW RISK screened** patients (i.e. no wounds or invasive devices) who remain **positive** after the first course of treatment, should receive no further courses of treatment. A risk assessment should be undertaken and management guidance sought from the IPC Team. This must be recorded in their healthcare records. For Low risk patients who test negative after re-screening, treatment and isolation can be discontinued immediately.

7.9 **HIGH RISK screened** patients (with invasive devices and/or wounds) who test positive – please discuss with the IPC Team. It is likely they will suggest that the patient should receive one further course of decolonisation. Should they remain positive after the second round, the patient will continue to use Octenisan body wash as part of their daily hygiene regime for the duration of their inpatient stay / as long as the risk (wound or invasive device) exists.

7.10 A risk assessment should be undertaken and management guidance sought from the IPC Team - this must be recorded in their healthcare records.

### 8.0 WOUND CARE

8.1 Treatment of patients with MRSA colonised or infected wounds should ideally be at the end of a working session to minimise the risk of cross infection.

8.2 Patients with infected and colonised wounds need an assessment to see what further management is required, by a staff member with knowledge of wound management.

8.3 Clinically infected wounds may require treatment advice from the microbiologist although sensitivities should be identified on microbiology results. Additionally topical/ treatment/dressing advice may be sought from the Tissue Viability Nurse (TVN).

8.4 MRSA wound colonisation does not usually require aggressive antimicrobial intervention. Silver based or iodine dressings should be considered (if in doubt liaise with the TVN).

8.5 Care must be taken to provide the optimum conditions for healing and wounds should be covered with an impermeable dressing.

8.6 Wounds should not be re-swabbed unless there are clinical signs of infection. (See Wound Swabbing guidelines - Appendix 2)
8.7 Skin and nasal decolonisation is not required if, after a full body screen, only the wound is found to be positively colonised. Manage the wound as per Community & Inpatient MRSA Treatment Regime (Appendix 11)

9.0 TRANSFER FROM THE WARD TO ANOTHER WARD/ HOSPITAL OR HOME

9.1 Please complete the Trust Infection Risk on Admission/Transfer form (Appendix 5) if a patient is to be transferred to another healthcare organisation with MRSA infection/colonisation all relevant clinical details must be included in the Transfer Form.

9.2 Patient discharges/transfers should not be delayed due to their MRSA status decolonisation regimes can be continued within the new care setting.

END
Does the new patient fall into the high risk categories?
**COMPLETE AND RECORD WITHIN 48HRS OF ADMISSION**

1) All patients previously identified as colonised with or infected by MRSA
2) All patients undergoing Podiatric surgery
3) All patients with an invasive device – urinary catheter, central line, gastrostomy tube etc.
4) All patients with a wound that:
   - Has been present for longer than two weeks (excl leg ulcers) OR
   - Is showing clinical signs of infection -as per wound swabbing flow chart - Appendix 2 (incl. leg ulcers)

NO

Admission screening not required, however patient should be monitored closely during admission and if they fall into high risk category at any time patient should be screened and treated accordingly.

NEGATIVE result

No action required

YES

Screen patient
Swabs to be taken from:
- Groin
- Nose
- Chronic/infected wounds
- Urine, if patient catheterised
- Sites of invasive devices e.g. PEG
- Sputum if patient has productive cough.

POSITIVE result

- Inform Infection Prevention & Control Team (IPCT)
- Commence Treatment Checklist
- Inform Doctor/GP to decolonisation treatment as required.
- Discuss implications with patient e.g. hand hygiene etc.
- Inform Support Services of need for extra cleaning
- Commence decolonisation in accordance with Appendix 9, 10 & 11
- Implement MRSA care plan see Appendix 4 or 6

Post-decolonisation screening results received.

NO

- HIGH RISK PATIENT - Inform Infection Prevention & Control Team
- Repeat decolonisation regime x1 more, including post-decolonisation screening.
- Remains Positive – use Octenisan body wash as part of daily hygiene.

POSITIVE

- LOW RISK PATIENT - Inform Infection Prevention & Control Team
- No further action. Monitor condition.

NO

- No further action required

YES

- HIGH RISK PATIENT - Inform Infection Prevention & Control Team
- Repeat decolonisation regime x1 more, including post-decolonisation screening.
- Remains Positive – use Octenisan body wash as part of daily hygiene.

- LOW RISK PATIENT - Inform Infection Prevention & Control Team
- No further action. Monitor condition.
Appendix 2.

Infection Prevention and Tissue Viability Wound Swabbing and Antimicrobial Dressing Pathway

**STATIC OR DETERIORATING WOUND**

Consider, and where possible, address underlying aetiology:
- **Pressure ulcers** complete SSKIN Bundle
- **Leg ulcers** complete holistic assessment including Doppler assessment.
- **Diabetic foot ulcers** – follow diabetic foot ulcer pathway

**SIGNIFICANT INFECTION**

- Signs of local infection (previously referred to as critical colonisation)
  - Malodour
  - Abnormal/absence of viable tissue
  - Excessive or increased exudate
  - Possible increase in wound size
  - No fever but localized heat and pain (change from normal

**SWAB WOUND** (based on clinical assessment by a registered nurse, and collection times for swabs): It is important to identify whether MRSA is present.

- Clean wound with Octenilin wound irrigation solution as per manufacturer’s directions.
- Dress wound with antimicrobial dressing as per wound formulary guidelines and reassess after two weeks

- **If MRSA +ve**
  - Send nose and groin swabs then, follow MRSA Standard Operating Procedure (ICPG1, section 5) for your area if body decolonisation is required
  - If patient shows signs of systemic infection (e.g., pyrexia) contact GP/Ward Dr to request oral antibiotics (refer to sepsis pathway)

- **Two week review**
  - Have clinical signs of infection resolved?

- **Yes**
  - Continue antimicrobial dressing
  - Consider alternative antimicrobial formulary dressing
  - Discuss with/refer to Tissue Viability team or Leg Ulcer team
  - Refer to Vascular Team SGH if required
  - Maintain regular reviews

- **No**
  - Discontinue antimicrobial dressing – continue with appropriate standard formulary dressing

- **Wound continues to improve**
  - Consider re-commencing antimicrobial dressing

- **Continue with standard treatment**
Appendix 3

Hands must be decontaminated prior to and after the swabbing procedure.

Each swab should be dampered in the culture medium from the swab container prior to the swab being taken to ensure that any bacteria present adhere to the swab.

When carrying out an MRSA screen the following sites must be swabbed:

- **Nose**: Tilt patient’s head back. Swab both nostrils with same swab.
- **Groin**: Swab both groins with same swab.
- **Wounds**: Ensure site of wound is clearly labelled on the swab
- **Drains / drain**: Identify the drain site
- **Pressure ulcer / leg ulcer**: Ensure site of ulcer is clearly marked. If more than one ulcer, ensure each one is individually swabbed and swab is clearly labelled with site.
- **Catheter**: Send sterile Catheter Sample of Urine – samples must be taken from the needle-free sample port after cleansing the area with a device cleaning swab – a sterile syringe must be used.
- **Sputum**: If patient has a productive cough or is intubated
- **Percutaneous Endoscopic Gastrostomy (PEG) site**
## MRSA Care Pathway

This Pathway is for patients with MRSA colonisation or infection in Mental Health and Community inpatient units

### Patient: NHS Number: Screenings of Patients

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- Has initial screening been completed and results documented?
- Date positive MRSA result received
- Infection Prevention & Control Team informed?
- Ward doctor responsible for patient management informed of positive MRSA status?

### Isolation of Patients

Complete isolation is not always necessary or possible – discuss with IPC team if any challenges exist.

- The following patients should have their own room if this will not adversely affect their treatment/rehabilitation:
  - Those with clinical signs of infection
  - Those who have high levels of skin shedding
  - Those with high exudate wounds
  - Those who are MRSA positive in their sputum and have a productive cough
  - Those who are MRSA positive in their urine and are incontinent (urine is not contained in a pad/catheter bag)

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- Does the patient fulfill any of the above criteria?
- If yes, is the patient isolated in a side room?
- If a side room is unavailable or isolation would compromise patient safety, has the management of the patient been discussed with the Infection Control Team?

### Infection Control Precautions

- Is relevant equipment available i.e. gloves, aprons?

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<tr>
<td>Clinician responsible for patient management informed of positive MRSA status?</td>
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<td>Have the patient/relatives been informed of the infection control measures and the reasons why? e.g. hand hygiene before and after visiting</td>
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<td>Has the patient/relatives been given an information leaflet to support this explanation? Appendix 17</td>
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<td>When care pathway discontinued – this is discussed with the patient</td>
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<tr>
<td>On discharge or transfer to another organisation – GP or organisation informed of MRSA status and current management via Infection Risk on Admission/Transfer Form - Appendix 5</td>
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### Cleaning

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<td>Has Facilities been informed of the isolation and the need to undertake daily barrier precaution clean?</td>
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<td>Once isolation discontinued, has Facilities been informed of need for terminal clean of area?</td>
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### Treatment, where relevant

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<th>If no, recorded in patient notes? YES/NO</th>
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<td>Medications have been prescribed via: Patient Group Directive □ Clinician □</td>
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<tr>
<td>Has Decolonisation Therapy been commenced as per Appendix 9, 10 and 11?</td>
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<tr>
<td>If Mupirocin nasal ointment has been prescribed is this for 5 days only?</td>
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<td>If not, has the relevant prescriber addressed this?</td>
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<td>Has the patient had more than two courses of Mupirocin?</td>
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<tr>
<td>If yes, Mupirocin should be stopped immediately and management should be discussed with the clinician responsible for the patient’s care</td>
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<tr>
<td>Date of Decolonisation regime completion</td>
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### This pathway is discontinued when:

- the patient is discharged from inpatient setting
- the patient has had a negative screen result or the ICT advises it's no longer required.
- clinical signs of infection are no longer present (where applicable) and
- the wound has healed completely (where applicable)

Pathway discontinued
### Infection risk (on admission/transfer) form

*(On Admission - TO BE COMPLETED WITHIN TWO HOURS OF ADMISSION) (on Transfer – Original to accompany patient to receiving facility / Ward)*

| Time of Admission: |

<table>
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<tr>
<th>Patient’s name</th>
<th>NHS Number</th>
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<tbody>
<tr>
<td>Consultant:</td>
<td>Transferring facility – hospital, ward, care home, other</td>
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<tr>
<td>GP:</td>
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<tr>
<td>Current Location:</td>
<td>Is the IC Nurse /Ambulance aware of transfer?</td>
</tr>
</tbody>
</table>

**Does the patient have any wounds?**

- Yes
- No

Describe site and condition:

**Is there an indwelling catheter?**

- Yes
- No

Confirmed risk - Organism

If Yes – complete Catheter Notification form and forward to IPC team

**Are there other indwelling devices?**

- Yes
- No

Confirmed risk - Organism

Describe:

- No known risk, Patient exposed to others with infection e.g. D&V
- Yes
- No

**Are there any infestations i.e. headlice, scabies?**

- Yes
- No

If patient has diarrhoeal illness, please indicate bowel history for last week (based on Bristol stool form scale)

If Yes – describe last treatment type

**Known HIV positive**

<table>
<thead>
<tr>
<th>Known Hep B positive</th>
<th>Known Hep C positive</th>
</tr>
</thead>
</table>

Is the diarrhoea thought to be of an infectious nature?

- Yes
- No
Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant enterococcus SPP (GRE and VRE), Clostridium difficile, multi-resistant Acinetobacter SPP and Carbapenemase producing Enterobacteriaceae and treatment information, including antimicrobial therapy.

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

**Treatment Information**

**Other Information**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient aware of their diagnosis/risk of infection?</td>
<td></td>
</tr>
<tr>
<td>Does the patient require isolation?</td>
<td></td>
</tr>
<tr>
<td>Does the patient require MRSA Screening on admission If no, please state the reason why:</td>
<td></td>
</tr>
</tbody>
</table>

Swabs sent

Form completed by___________________________________________________________

Date ________________________________
Appendix 6

MRSA SCREENING TOOL – REMEDY USERS (MH North Services)

Screening tool for MRSA must be completed for all patients on admission. Swabbing must take place within 48 hours of time of admission - (found under Assessments on Remedy)

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
</tr>
<tr>
<td>Ward</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date screening tool completed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date swabbed</td>
<td></td>
</tr>
<tr>
<td>Sites swabbed</td>
<td></td>
</tr>
<tr>
<td>Samples obtained</td>
<td></td>
</tr>
</tbody>
</table>

Is there a long term invasive device in place— e.g. urinary catheter?

Are there any skin breaks including wounds, pressure sores and self-harm injuries?

If any patient has an open wound or a catheter please notify [Name] – Nurse Consultant Physical Health on [Number]

- Please complete this form under Assessments on Remedy for every patient on admission.
- If any box is ticked please swab the patient as guided in the MRSA Protocol
- IPCT will monitor completed forms monthly against ward admissions.
Appendix 7
How to use Octenisan Body Wash and Bactroban Nasal Ointment for Decolonisation of MRSA

1. Ensure that your hair and body are wet
2. Put the lotion onto a damp clean washcloth
3. Apply all over hair and body paying special attention to the areas indicated in red
   Leave the lotion on your skin for 1 minute before rinsing off
4. Rinse off thoroughly
5. Dry with a clean, dry towel
6. Put on clean underclothes/nightwear every day and change bedding after daily use of Octenisan

Octenisan 5 day Antimicrobial Wash Protocol.

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body</td>
<td>Body &amp; Hair</td>
<td>Body</td>
<td>Body &amp; Hair</td>
<td>Body</td>
</tr>
</tbody>
</table>

Do not forget about these areas
As with any topical treatment there is a risk of skin irritation. If this occurs, stop treatment and contact the Infection Prevention and Control Team or microbiologist. Specialist dermatology advice must be sought for patients with skin disorders who require decolonisation.

**BACTROBAN NASAL OINTMENT (Mupirocin 2%)**

If MRSA is found in your nose you need to use Bactroban Nasal Ointment (Mupirocin 2%). Use it three times each day for 5 days.

A small amount of ointment, about the size of a match head, should be placed on your finger and applied to the inside of each nostril (apply to the front part of the nostril). The nostrils should be closed by pressing the sides of the nose together; this will spread the ointment through the nostrils.
Appendix 8

octenisan® wash mitts

Antimicrobial wash mitts for convenient body washing

in NHS Supply Chain

Our Plus

- excellent skin and mucous membrane compatibility
- broad antimicrobial efficacy
- contains allantoin for gentle and soothing skin cleansing
- colour and perfume free
- ready to use, no rinsing required
- improved health and safety as no water required
- easy and convenient to use, saves time

Areas of application

- for bedside washing of whole body – please follow instructions on packaging as to use of these mitts.
- 1 new packet to be used each day.
- suitable for use by patients with limited mobility or for washing bedridden patients
- for antimicrobial washing including decolonisation and prophylactic washing.
# COMMUNITY & INPATIENT MRSA TREATMENT REGIME

**Name:**
**GP name and address:**
**DOB:**
**Date regime commenced:**

<table>
<thead>
<tr>
<th>Recommended Treatment</th>
<th>Day</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td><em>NB THIS IS NOT A PRESCRIPTION</em></td>
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<td><strong>OCTENISAN Body Wash daily</strong></td>
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<tr>
<td><strong>NASAL MUPIROCIN 2% (BACTROBAN)</strong> TDS for 5 days (if nasally colonised)**</td>
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<tr>
<td><strong>Day</strong></td>
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<tr>
<td><strong>WASH HAIR AND BODY</strong></td>
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<tr>
<td><strong>WASH BODY</strong></td>
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<tr>
<td><strong>WASH BODY</strong></td>
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<tr>
<td><strong>NORMAL SOAP WASH</strong> (Stop nasal Bactroban)</td>
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<td><strong>NORMAL SOAP WASH</strong></td>
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<tr>
<td><strong>DAY 8 - SWAB NOSE, GROIN AND DEVICE ETC. BEFORE RECOMMENCING OCTENISAN WASH ONLY</strong></td>
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</tbody>
</table>

Ensure there is skin contact time of at least 60 seconds, rinse thoroughly. Hair should be washed on day 2 and day 4 where possible. Nasal Bactroban should only be used if nasally colonised. Await screen results and seek Infection Control advice before commencing a second course of Bactroban.

**Note:** Bed linen, nightclothes/clothes should be changed daily.
**For further advice contact the Infection Control Team –**
# Appendix 10  
## Treatment of Patients who require Decolonisation or have MRSA Infection

This guidance only applies to those individuals who have MRSA isolated and fulfill the criteria for treatment outlined in the screening flowchart.

<table>
<thead>
<tr>
<th>Nose</th>
<th>Skin Carriage e.g. Groin, PEG site</th>
<th>Open Wounds, Leg Ulcers, Pressure Ulcers</th>
<th>Urine or Sputum</th>
<th>Eye</th>
<th>Systemic Infections</th>
</tr>
</thead>
</table>
| **Day 1-5** – apply 2% Mupirocin (Bactroban) ointment as far up nostrils as possible twice daily.  
**Day 6-7** – no treatment  
**Day 8** – rescreen all sites and recommence washes  
**Do not recommence Mupirocin until results from screen available.**  
If positive a further course of treatment can be prescribed. NB No more than 2 three to five day treatments should be prescribed to prevent resistance - management should be discussed with microbiologist or infection control team.  
If Mupirocin resistant or unavailable Naseptin (10 day course) or Octenisan nasal gel can be used. The patient should be encouraged to wash their hands after handling their nose and dispose of tissues correctly. | **Day 1-5** – daily wash, shower or bath with Octenisan (body wash or mitts)  
**Day 2+4** – hair wash with Octenisan  
**Day 6-7** – no treatment  
**Day 8** – rescreen all sites  
**Low risk patients:** If negative: discontinue treatment  
If positive – consult the infection control team to discuss future management.  
**High risk patients:** follow guidance in the flowchart (appendix 1). Discuss with infection control team.  
Wash hands following the administration of the treatment.  
**NB if PEG site is clinically infected it should be treated as for ‘open wounds etc.’** | Commence decolonisation.  
In addition: Wound to be irrigated with appropriate solution e.g. Octenilin wound irrigation solution.  
The appropriate dressing should be used that will encourage wound healing.  
If the wound is clinically infected the relevant antibiotic therapy should be commenced, based on sensitivities or microbiologist advice.  
The wound should be kept covered until healed to reduce the risk of cross infection.  
Gloves and aprons should be worn, aseptic technique maintained for wound dressings.  
If the patient has clinical signs of infection or requires decolonisation, the relevant antibiotic therapy should be commenced, based on sensitivities or microbiologist advice.  
If the patient has a urinary catheter, this should be reviewed. Where possible the catheter should be removed or changed to reduce the amount of MRSA colonisation and increase effectiveness of antibiotics where used.  
Octenilin catheter solution to be used during catheter change.  
Gloves and aprons should be worn when handling urine or sputum.  
Patient and staff should be encouraged to wash their hands following contact with urine or sputum. | If the patient has signs of MRSA bacteraemia (blood stream infection) i.e. pyrexia, hypotension, tachycardia, an urgent medical review should be sought.  
The patient should be admitted to an acute hospital as soon as possible (as appropriate).  
The relevant intravenous antibiotic therapy should be commenced as soon as possible, based on sensitivities or microbiologist advice (**Acute setting**).  
The patient should be closely monitored for changes in condition i.e. blood pressure, pulse, temperature (**Acute setting**).  
The infection prevention & control team are informed of the MRSA bacteraemia and patient management decisions. Teams will be contacted as appropriate and an investigation carried out. |  
If exudate present bathe the eye externally with warm water as required.  
The relevant eye drops/ointment should be prescribed according to sensitivities or microbiological advice.  
When administering eye drops/ointment ensure good hand hygiene and infection prevention precautions are maintained to reduce the risk of cross infection.  
Encourage the patient to wash their hands whenever they have had contact with their eyes. | |
The following guide aims to help staff manage high risk patients with MRSA effectively in the community setting. High risk patients i.e. with an invasive device, history of MRSA or chronic wound, have a greater risk of developing a bacteraemia caused by MRSA. In order to minimise the risk, the following flow chart should be followed if your patient meets any of these at risk categories, and is infected or colonised with MRSA.

**COMMUNITY & INPATIENT MRSA TREATMENT REGIME**

**Low risk** contact IPC team for advice.

- MRSA status alert must be flagged on patient notes.
- Inter-healthcare transfer form to be completed if patient is accessing further healthcare (e.g. hospital admission).
- Re-screen after treatment.

**Positive result**

- Stop treatment, stop isolation.
- Monitor patient’s condition for deterioration/signs of infection – swab/screen as appropriate.

**Negative result:**

- Stop treatment, stop isolation.
- Monitor patient’s condition for deterioration/signs of infection – swab/screen as appropriate.

**De-colonisation treatment: Octenisan Body Wash**

- Wet skin, apply to damp disposable wash cloth and wash all over body, ensure there is skin contact time of at least 1 minute, rinse thoroughly. Octenisan Mitts can be used for bed-bound patients.
- Hair should be washed with Octenisan on day 2 and day 4 if possible.

**Nasal Bactroban**

- Only to be used for 3-5 days if nasally colonised, await screen results - seek Infection Control advice before starting 2nd course of Bactroban.

*If patient shows / develops clinical signs of infection or possible sepsis contact the Hospital Microbiologist for clinical advice. For further advice contact the Infection Control Team.*

- **High risk:** continue with decolonisation and re-screening. If **Positive** after 2 courses maintain continuous Octenisan washes as part of daily hygiene. Monitor condition for signs of infection/deterioration

- **Low risk:** contact IPC team for advice.

- **MRSA screen**
  - Swab: nose, groin, any lesions and CSU (if catheter present). Patient should receive 5 days of treatment then be re-screened 48 hours after treatment discontinued. Octenisan body wash can be recommenced immediately after screening is undertaken.

- **MRSA isolated from specimen**
  - *Patient considered to be infected*
  - Inform Infection Control Team and Medical team.
  - Discuss antibiotic sensitivities with Microbiologist with regard to treatment on [patient's notes].
  - Commence topical de-colonisation treatment and follow instructions for colonised patients.

- **Patient considered to be colonised**

- If invasive device present - Document the reason for the invasive device and record in patient’s notes. Complete relevant care bundle.

- **MRSA status alert** must be flagged on patient notes.

- **Inter-healthcare transfer form to be completed if patient is accessing further healthcare (e.g. hospital admission)**

- **Re-screen after treatment**
Appendix 12

Patient information to go with podiatry appointment letter

Screening for MRSA

As part of the pre-assessment process, we are applying Department of Health recommendations and now screen all patients for carriers of Methicillin Resistant Staphylococcus Aureus (MRSA) prior to all podiatric surgery.

Why do you need to be screened?

MRSA can live quite harmlessly on the skin and in the nose, but it is known that when carriers of MRSA have surgery it can sometimes get into the wound and cause infection.

The idea of screening you is so that, if we find you have got it on your skin / in your nose you can be given some simple treatment to get rid of it so it is not there when you have your surgery.

While, in our experience, the risk of having an infection caused by MRSA after podiatric surgery appears to be extremely low, screening will make that risk even smaller.

What does screening involve?

The majority of people who carry (are colonised with) MRSA will have the germ in their nose.

One of the appropriately trained staff in the Podiatry Department will swab both of your nostrils with a moistened swab (like a large cotton bud). This may tickle a little but will not hurt.

MRSA can also colonise the groin area - we will therefore ask you to take a clean swab to the toilet during your appointment and swab your groin (an instruction leaflet will be provided). The staff in the department will provide further explanation at the time of your pre-assessment.

If you have any concerns about doing this or feel you will be unable to do it, please tell the podiatry staff at the time of your appointment. In many cases a nose swab will be sufficient.

When will the results be available?

We expect to receive the results within a week following the swabs being taken. We will not contact you if the results are negative and will proceed with the surgery as planned.

What if the test is positive for MRSA?

If your swabs are positive (meaning you are carrying/colonised with MRSA), we will write to you to inform you and ask you to make an appointment to see your doctor. At the same time, your doctor will be informed and they will prescribe a body wash
and some nasal cream that you must use for 5 days. You will be given instructions on how to use these.

So that your surgery is not delayed, you need to commence treatment at the correct time. You will need to start using the treatment 5 days before your surgery so that you have your last dose on the day of your surgery. Your doctor will be advised what day you should start.

Having the treatment immediately leading up to your surgery will dramatically reduce the risk of you developing an MRSA wound infection afterwards. It is therefore important that you do not start your treatment too early – even though you may be tempted to do so.

*Remember that if we do find you are positive for MRSA it doesn’t mean that you will suddenly be a risk to others. Many healthy people carry it on their skin and it doesn’t cause a problem. Our concern is for you because you are going to have foot surgery and if you are carrying MRSA it may result in you developing an infection.*

**What happens after your surgery if you have been found to be a carrier of MRSA?**

Once you have had your surgery you will not need to be checked again for MRSA unless you have to have further surgery (in which case the process of screening will begin again).

If you have any concerns or questions about the MRSA screening prior to your pre-assessment appointment, please contact:

The Podiatric Surgery department.
Appendix 13

**Patient instructions for taking a groin swab**

Before you have your surgery we need you to take a groin swab to check whether you are carrying MRSA on your skin. You will be asked to:

- Take the swab to the toilet - to afford you the privacy to expose your groin area.

- You may find sitting on the toilet makes the procedure easier for you.

- Open the swab packet. The packet contains the swab and the container to put it in after the swab has been taken.

- Take the swab (which looks like a large cotton bud) and moisten the cotton wool end of the swab in the solution in the swab container (tube).

- Wipe the swab over the skin on both sides of your groin areas.

- Remove the blue top off of the swab container and put the swab in (making sure it is secure).

- When you have finished, give the swab to the podiatry staff – they will ensure your details are written on the label.
Dear …………………………….,

Following your recent Pre-operative Assessment for podiatric surgery, your MRSA screening results have come back as **positive**.

Please try not to be concerned, many people carry this on their skin unknowingly and are not harmed by it.

However, as you are due to undergo foot surgery in the near future we would like you to have some treatment to remove the MRSA from your skin and nose before your planned procedure. This is to minimise the risk of you developing a wound infection after surgery.

Please make an appointment with your doctor (GP) - he/she will prescribe a body wash and if necessary a nasal ointment which you should use for the five days immediately before your surgery. It is very important that you **start** the treatment on ........................ and have your **last dose the day of your planned surgery**.

Your doctor has also been sent a letter advising of the need for you to be treated; however we would recommend that you take this letter with you to your appointment.

Attached are instructions for use of the body wash and nasal ointment. Your doctor may choose to prescribe a different body wash to Octenisan – if this is the case instructions for use will be supplied with the treatment.

If you have any queries or concerns please contact the Podiatry Department on the telephone number above.
Appendix 15

Example of letter to be sent to GPs of MRSA positive patients

Dear Dr (GP name)

Your patient ……………………………………………… DOB……………………

of ……………………………………………………………………………………………

Recently attended the pre-operative assessment unit at Herts and Essex Hospital prior to their podiatric surgery which is due to be carried out on …………

In line with Department of Health recommendations, he/she was screened for MRSA at this appointment and results have shown that he/she has tested positive.

In order to reduce the risk of post-operative infection, the patient needs to be decolonised in the week preceding their planned surgery.

We would therefore ask that you prescribe the following:

- 2 % Mupirocin (Bactroban) nasal ointment – twice daily for 5 days
- Octenisan body wash – daily for 5 days

The patient needs to start the treatment on …………………which is 5 days before surgery.

Instructions for use of the nasal ointment and body wash are included. Please ensure that the patient receives a copy with their prescription.

Yours sincerely,

The Podiatric Surgery department
Appendix 16

Podiatry patient information – using Bactroban (2% Mupirocin) ointment

Start your treatment on …………………… and continue for 5 days finishing on the day of your surgery.

- Use in conjunction with your daily body wash which your doctor has prescribed.
- Always use Bactroban exactly as instructed by your doctor – you should check with your doctor, nurse or pharmacist if you are not sure.
- Do not mix Bactroban with any other external cream or ointment as this may reduce the effectiveness of it.

To apply:

- Wash your hands before using the ointment
- Blow your nose if necessary before applying the treatment
- Apply a match head size amount of the ointment to your little finger
- Apply Bactroban into the inner surface of the right and left nostrils (as far up as you safely can)
- Squeeze the nostrils together several times to disperse the ointment
- Try not to wipe or blow your nose immediately afterwards
- You should apply the ointment twice daily for 5 days only
- Replace the cap on the tube and wash your hands again
INFECTION PREVENTION & CONTROL ADVICE SHEET FOR PATIENTS, CARERS AND CARE STAFF

Management of patients/clients known or previously known to have: Methicillin Resistant \textit{Staphylococcus aureus} (MRSA)

There are a number of different types (families) of germs found on the human body and in the environment around us. One of these families of germs is called \textit{Staphylococcus aureus}. MRSA belongs to this family.

\textbf{Staphylococcus aureus}

\textit{Staphylococcus aureus} (\textit{S. aureus}) is found on about a third of the population. It usually lives in the moist areas such as armpits, groin and nose, although it can be found on other parts of the body such as the hands. Mostly, it causes no problems, though like any other germ, it can cause infections. In particular, \textit{S. aureus} can cause skin-related problems such as pimples and boils. These germs can cause more serious infections if they get into sites where they would not normally be found, for example through cuts or surgical wounds.

This family of germs is treatable with a wide range of antibiotics and is known sometimes as Methicillin sensitive \textit{Staphylococcus aureus} or MSSA. (Methicillin is a type of antibiotic).

\textbf{MRSA}

MRSA (Methicillin resistant \textit{Staphylococcus aureus}) is the name given to \textit{S. aureus} when it becomes resistant to Methicillin. This means there is a reduced choice of antibiotics available to treat it, although it is still treatable with other antibiotics.

MRSA is not a risk to normal healthy people in the community. The main risk is to hospital patients, especially those who are severely ill or those who are undergoing major surgical operations, as their immune systems are lowered, this makes them vulnerable to picking up infections.
What is the difference between colonisation and infection with MRSA?

**MRSA colonisation**
People colonised with (or carrying) MRSA on their skin and/or nose ARE NOT ILL. Some of us carry it for a few hours, or days, while others carry it for weeks or for their whole lives. Most people will be unaware that they are carrying MRSA, because it does not harm them and they have no symptoms.

**MRSA infection**
MRSA (like other germs) can cause harm when it gets an opportunity to enter the body, for example through a cut or wound. It can cause pimples and boils, or more serious problems such as wound infections and chest infections. In more serious cases it can cause bloodstream infections (referred to as MRSA bacteraemia).

Patient/clients with an invasive device (e.g. urinary catheter, feeding tube, central/Hickman line etc.), chronic wounds/fragile broken skin, on steroids or immuno-suppressants are at a higher risk of developing a blood stream infection. Please consult with Community Nursing Service or Infection Prevention and Control Nurse to ensure your patient/client is on the correct treatment.

**Care of a Patient with MRSA**
MRSA is transmitted mainly by direct skin to skin contact.

- If appropriate your patient/client may have been prescribed eradication therapy. Treatment consists of an antimicrobial body wash and if nasal colonisation has been identified nasal ointment may be prescribed. Apply as directed by the GP, Infection Control Team or Community Nursing Service. If your patient has an invasive device your they may be on a screening regime or continuous decolonisation therapy, you must liaise with the Community Nursing Service or GP responsible for your patients’ prescription for further advice or contact the community Infection Control Team for further information.
Use disposable wipes only, or a clean flannel for washing patient/clients. Towels and flannels (if used), should be laundered daily and not be shared between household members.

Apply Standard Infection Control Precautions - outlined as follows:

- **Hand Hygiene** - Hand washing is the single most important measure for preventing cross infection. Carers should ensure they wash their hands before and after patient contact. Hands should be washed with soap and water and dried with disposable towels (e.g. kitchen roll). Alcohol hand gel should be used if there is no access to soap and water and hands are physically clean. (Detergent wipes can be used if physical soiling is present on your hands followed by alcohol hand gel). Alcohol hand gel can also be used for rapid decontamination of physically clean hands.

- **Gloves** - Disposable gloves must be worn whenever there might be contact with blood or body fluids and removed after each episode of care. Followed by effective hand washing Gloves should be disposed of immediately after each episode of care. (Can be disposed of with normal household waste).

- **Disposable plastic aprons** - Should be worn whenever there is direct hands-on care and when there is a risk of contaminating clothing with body fluids. Plastic aprons must be removed after each episode of care and disposed of. (Can be disposed of with normal household waste).

- **Linen** - Clothes, bedding and linen can be washed as normal using washing powder or liquid detergent at the hottest temperature suitable for the fabric. Clothes can be incorporated into the family wash as usual, taking care not to overload the machine. All linen can then be tumbled or line dried and ironed as normal. Ideally bedding should be changed daily.

- **Waste management** – Waste can be double bagged and disposed of in the non-recyclable household waste stream. However if the waste is heavily soiled, (e.g. large blood stained dressings) it should be treated as
infectious and a special clinical waste collection arranged. (Please contact the Infection Control Team for further advice)

- **Environmental Cleaning** - While special cleaning measures are not required, good hygiene and cleaning procedures will lower the risk of potential spread of MRSA.

Surfaces should be kept dust-free (damp dusting is preferable) and carpets vacuum regularly. Baths, showers basins and toilets should be cleaned regularly with usual household cleaning products.

Hard surfaces upon which clinical practice takes place must be cleaned thoroughly before and after use with detergent and hot water.

- **Decontamination** - All shared equipment which has direct patient/client contact must be cleaned after use, with detergent and hot water.

**References:**

Advice for those affected by MRSA outside of hospital (Department of Health 2008)

A Simple guide to MRSA; (Department of Health 2004)

**For further advice please contact:**

The Infection Prevention and Control Team on:

[redacted] or [redacted]