MRSA (Meticillin Resistant Staphylococcus Aureus) Policy (Adults, Paediatrics & Neonates)

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Executive Summary

Meticillin Resistant Staphylococcus Aureus (MRSA) is a form of Staphylococcus aureus that has become resistant to antibiotics commonly used to treat Staphylococcus aureus. Although in most circumstances MRSA lives harmlessly on the skin or in the nose, vulnerable patients are at risk of developing an MRSA infection. The majority of patients who acquire MRSA are merely colonised, not ill and do not require antibiotic therapy. A proportion, possibly up to one third, depending on patient population, develop infection which may become invasive and in some cases contribute to, or result in death (Coia et al 2006).

Specific measures have been shown to be effective in preventing and controlling MRSA, necessary because MRSA can cause serious illness which is harder to treat due to limited therapeutic options and results in additional healthcare costs e.g. as a result of increased length of hospital stay and cost of antibiotics to treat the infection.

Identification, treatment and management of individuals carrying MRSA using interventions such as screening, MRSA suppression/decolonisation regimes, patient isolation and giving appropriate antimicrobial prophylactic regimes can reduce the risk of MRSA infection, including MRSA bloodstream infection, and MRSA transmission between patients.

This policy provides details on the standards required for the detection and management of MRSA in University Hospitals Southampton NHS Foundation Trust (UHS) in order to protect patients (adults, paediatrics and neonates) from infection or colonisation with MRSA, prevent the transmission of MRSA and to safely manage and treat patients who are colonised with MRSA.
1 Introduction

Staphylococcus aureus is a common bacterium that lives harmlessly on the skin and nose of about a third of the population. However it is the commonest cause of skin and soft tissue infection acquired in the community, or in the hospital following surgery or other procedures that cause a break in the skin. It has the potential to cause a range of invasive disease including post operative wound infection; bone and joint infections; endocarditis; urinary tract infection; septicaemia and bacteraemia.

Meticillin resistant Staphylococcus aureus (MRSA) is a form of Staphylococcus aureus that has become resistant to antibiotics commonly used to treat Staphylococcus aureus. Meticillin resistance indicates flucloxacillin resistance and resistance to beta-lactam antibiotics, (penicillins, cephalosporins, carbapenems). MRSA resistance was first reported in 1961 and MRSA continues to be endemic in many UK hospitals. Specific measures have been shown to be effective in preventing and controlling MRSA, necessary because MRSA can cause serious illness which is harder to treat due to limited therapeutic options and results in additional healthcare costs e.g. as a result of increased length of hospital stay and cost of antibiotics to treat the infection. The emergence of Vancomycin-intermediate and resistant S. aureus (VISA and VRSA) are further cause for concern.

Although in most circumstances MRSA lives harmlessly on the skin or in the nose, vulnerable patients are at risk of developing an MRSA infection. The majority of patients who acquire MRSA are merely colonised, not ill and do not require antibiotic therapy. A proportion, possibly up to one third, depending on patient population, develop infection which may become invasive and in some cases contribute to, or result in death.

Like other Staphylococci, MRSA strains can pass from one person to another by direct or indirect contact (e.g. via hands, equipment etc). Identification, treatment and management of individuals carrying MRSA using interventions such as screening, MRSA suppression/decolonisation regimes, patient isolation and giving appropriate antimicrobial prophylactic regimes can reduce the risk of MRSA infection, including MRSA bloodstream infection, and MRSA transmission between patients.

Patients and the public are increasingly aware of MRSA and regard it as an indicator of the quality of patient care. They require re-assurance that all healthcare professionals are taking reasonable precautions to minimise spread and it is their professional responsibility to do so.

This policy provides details on the standards required for the detection and management of MRSA in University Hospitals Southampton NHS Foundation Trust (UHS) in order to protect adult, paediatric and neonatal patients from infection or colonisation with MRSA, prevent the transmission of MRSA and to safely manage and treat patients who are colonised with MRSA.

The policy is supported where necessary by agreed Unit or Care Group specific guidance developed by clinical teams in collaboration with medical and nursing members of the Infection Prevention Team.
1.2 Scope

This Policy applies to all staff employed or contracted by UHS and also to all visiting staff including tutors, students and agency/locum staff and volunteers. Every member of staff has personal responsibility to ensure they comply with this document.

This Policy includes:
- The detection of MRSA by screening patients
- Actions to be taken when admitting patients who have or may have MRSA.
- 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 that should be taken to ensure safe, appropriate treatment of MRSA infection
- Risk reduction measures required to reduce the risk of MRSA acquisition and infection in patients not known to be MRSA positive.
- Communication and patient/relative information.

1.3 Purpose

The objectives of this Policy are:
- To prevent the transmission of MRSA within UHS
- To protect patients from infection or colonisation with MRSA
- To ensure patients who are confirmed to have MRSA are managed safely and appropriately, and receive adequate information about their condition

1.4 Definitions

**MRSA Infection:** There are signs and symptoms of infection caused by MRSA. Infection occurs when MRSA enters a body site and multiplies in tissue causing clinical manifestation of disease. This is usually evident by fever, a rise in the white blood cell count / CRP or purulent drainage from a wound or body cavity.

**MRSA Colonisation:** MRSA is found on the skin or mucous membranes but there are no signs or symptoms of infection. Colonisation occurs when a patient has MRSA in or on a body site but has no clinical signs or symptoms of disease. A person colonised with MRSA may be a temporary or long term carrier of the organism.

**MRSA Screening:** process of obtaining microbiological swabs to identify presence of MRSA

2 Related Trust Policies

- Standard infection control precautions policy
- Infection Prevention Personal protective equipment (PPE) policy
- Hand hygiene policy
- Isolation of adult patients with infectious conditions policy
- Paediatric Isolation Policy
- Policies and guidelines for management of invasive devices (peripheral and central venous devices, including tunnelled lines, indwelling urinary catheters)
- Blood culture policy (adults)
- Aseptic non-touch technique (ANTT), including wound care, Policy.
- Appearance policy
- Trust Infection Prevention plans and the Trust Infection Prevention Strategy
- MRSA antimicrobial management guidelines (including decolonisation)
- UHS Antimicrobial Prescribing Policy & Guidelines.
- Paediatric Antimicrobial Prescribing Policy & Guidelines
- MRSA screening, risk reduction and decolonisation within Maternity services
- Surveillance of Infection Policy
- Decontamination of Medical devices Policy
- Play equipment, maintenance and decontamination policy.

3 Roles and Responsibilities

The Chief Executive As accountable officer, is responsible for the overall leadership and management of the Trust and its performance in terms of service provision, financial and corporate viability, ensuring that the Trust meets all its quality and safety, statutory and service obligations and for working closely with other partner organisations. The CEO delegates aspects of this responsibility to relevant Executive Directors according to their organisational portfolios. The CEO directly manages communications, information services and corporate affairs.

Director of Nursing holds delegated Executive responsibility for the management and control of healthcare associated infection.

Director of Infection Prevention and Control is responsible for the management and control of healthcare associated infection, including implementation of this policy.

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

Ward and Department Managers are responsible for ensuring that all possible measures are taken to reduce the spread of infection to patients, visitors and staff. All managers are responsible for ensuring this policy is implemented in their areas and for ensuring all staff who work within the area adhere to the principles and standards at all times. All managers are responsible for ensuring that staff have access to up to date training to enable them to adopt safe working practices at all times and are appropriately trained to minimise risks to themselves and others.

Consultant Medical and Surgical staff are responsible for ensuring that all possible measures are taken to reduce the spread of infection to patients, visitors and staff. They are responsible for ensuring this policy is implemented in their areas and for ensuring all staff who work within the area adhere to the principles and standards at all times. They are responsible for ensuring their junior staff read and understand this policy and adhere to the principles contained in it at all times.
Site Co-ordination Team and Bed 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 Prevention 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 the development and dissemination of the policy and for ensuring the policy remains consistent with the evidence-base for safe practice, and for reviewing the policy on a three-yearly basis unless new guidance is published before this time.

All staff working on Trust premises, including agency and locum staff are responsible for adhering to this policy and for reporting breaches of this policy to the person in charge and to their line manager.

Non-compliance with a Trust Policy, Procedure, Guideline, PGD, protocol or patient information standard may result in disciplinary action.

4 Principles

Safe, effective and prompt detection and management of patients with MRSA requires adherence to the following principles:

4.1 Antimicrobial Prescribing

- Avoid unnecessary antibiotic prescribing to reduce selection pressure for resistant organisms including MRSA.
- Avoid prescribing antibiotics known to be associated with increased MRSA incidence in hospitals including: fluoroquinolones, third-generation cephalosporins, macrolides and co-amoxiclav (Aldeyab MA et al 2008).
- Reduce the use of broad spectrum antibiotics to reduce emergence of multiply resistant organisms
- Consider the risk of MRSA as a potential pathogen and prescribe appropriate antimicrobial therapy or surgical prophylaxis when indicated
- Limit the indiscriminate use of glycopeptide antibiotics to reduce development of resistant organisms
- Refer to Trust Antimicrobial Prescribing Policy and Guidelines for appropriate antibiotic choice (Adult & Paediatric)

4.2 Surveillance of MRSA

- Local surveillance will be performed in order to monitor trends in MRSA and facilitate prevention and control measures.
- UHS will participate in mandatory surveillance schemes relating to MRSA as required by the Department of Health.
4.3 MRSA Screening
- Screen patients by taking specimens from the correct sites, and labelling them correctly.
- All patients admitted to UHS will be screened for MRSA, as part of pre-assessment procedures or on admission, except for those in the identified exception categories as defined in this policy.

4.4 MRSA Decolonisation
- Prescribe and administer MRSA topical decolonisation therapy correctly in line with policy.
- Ensure patients who are MRSA positive receive appropriate decolonisation either to eradicate MRSA or to reduce the bioburden and risk of infection.

4.5 Isolation Care
- Ensure all patients are cared for as required in this policy: for most areas this will require isolation in a single room. This must be supported by an isolation risk assessment, which must be documented in the clinical records.

4.6 MRSA risk reduction measures
- Ensure routine risk reduction measures are implemented for all adult patients, except for those in identified exception categories as defined in this policy.
- Adult patients will receive routine washes containing a skin disinfectant on admission.
- Ensure routine risk reduction measures of Octenisan washes are implemented on admission for specific paediatric patients.
- Additional risk reduction measures will be implemented for patients admitted with chronic wounds or indwelling devices.
- Additional risk reduction measures will be implemented for adult inpatients that subsequently require surgical or interventional procedures during their hospital stay.
- Additional risk reduction measures will be considered for paediatric inpatients that subsequently require surgical or interventional procedures during their hospital stay.

4.7 Documentation
- Ensure the MRSA status of all patients is accurately recorded, including information on topical decolonisation and specimen results.
- Ensure risk reduction measures are accurately documented and recorded.

4.8 Communication and Patient information
- Provide patients and relatives/visitors with accurate information on MRSA, including the risk of infection, risk reduction measures and management of those who are MRSA positive. Every patient who has MRSA, or their family when they are not well enough to receive it, must be given a Trust MRSA information leaflet.
- Ensure accurate information on MRSA status is recorded and communicated to other wards and departments within UHS in order to facilitate safe care.
- Ensure accurate information on MRSA status including information on topical decolonisation and specimen results, is recorded and communicated to staff in primary and community care and receiving/referring hospitals upon transfer to another organisation or discharge home.
5.0 Standards to be followed

5.1 Antimicrobial Prescribing

- All Divisions must put into place guidelines for effective antimicrobial prescribing and these guidelines must be agreed with the relevant Consultant Medical Microbiologist.
- Adherence to antimicrobial prescribing guidelines will be monitored by ward pharmacists and non-adherence referred to microbiology/infectious disease ward rounds or more urgently to a medical microbiologist if required.
- Guidelines for surgical prophylaxis must include recommended choice of agents and regimens for patients at high-risk of MRSA colonisation or infection, or known to be colonised or infected with MRSA.
- The guidelines must be audited annually to demonstrate effective prescribing patterns are maintained. Responsibility for this rests with the Divisional Clinical Director.
- All consultant medical staff are responsible for ensuring appropriate antimicrobial prescribing by their junior staff. This includes ensuring courses of antimicrobial agents are prescribed for the correct duration and dosage and this includes topical decolonisation agents.
- Nursing staff are responsible for ensuring prescribed antimicrobial agents are given at the correct time and the correct dosage. This includes topical decolonisation agents – see Appendix F (adults) and Appendix P (paediatrics).
- Refer to Trust Antimicrobial Prescribing Policy and Guidelines for appropriate antibiotic choice (Adult & Paediatric).

5.2 Surveillance of MRSA

- The Infection Prevention Team will perform surveillance for new MRSA isolates routinely as part of alert organism surveillance; this will include enhanced surveillance to monitor compliance against aspects of this policy.
- Clinical areas will be informed of all newly-identified MRSA-positive patients by the laboratory/Infection Prevention Team.
- Enhanced surveillance of MRSA Bacteraemia will be undertaken in line with the Department of Health requirements. The results of this surveillance will be fed back to Clinical and Management Teams for learning and action.
- MRSA surveillance data will be reported and reviewed by the Infection Prevention Committee and via Divisional Governance arrangements.

5.3 MRSA Screening

Patients will be screened for MRSA in order to improve patient safety, for the following reasons:
- Patients found to be positive can be managed to minimise the risk of MRSA infection during their treatment. This may require different antimicrobial prescribing, topical decolonisation prior to a procedure, or other measures.
- To protect other patients from the risk of colonisation or infection with MRSA during their treatment.

**ADULTS:**
- All adult patients admitted as emergency admissions to UHS (elective and emergency admissions) except for agreed exceptions, are to be screened for MRSA on admission. See Appendix A
- All adult elective patients, except for agreed exclusions, admitted to UHS are to be screened for MRSA as part of pre-assessment procedures or on admission.
Additional MRSA screening of adult patients following admission to UHS will be undertaken as detailed in Appendix B.

Agreed exclusions for MRSA screening of elective and day case admissions within UHS are listed in Appendix D. These are based on initial guidance from the Department of Health (2008 - 2010) and a further review of the UHS MRSA screening programme undertaken in 2016 based on 2014 DH recommendations resulting in further extension to the day case exclusion list.

Adult Day case patients undergoing surgical procedures will be screened for MRSA as part of pre-assessment procedures or on admission if:

- Patient is known to be MRSA positive/has an MRSA alert on e-camis
- Planned overnight stay or >5% chance of overnight stay
- Antibiotic prophylaxis is required

(See appendix E).

Refer to Appendix C for MRSA screening specimen requirements.

PAEDIATRICS & NEONATES:

- All paediatric (children aged 17 and younger) and neonatal patients admitted to UHS (elective and emergency admissions) except for agreed exceptions, are to be screened for MRSA on admission or as part of pre-assessment procedures prior to admission. Children attending Burseldon House will only be screened for clinical reasons. See Appendix P.
- Additional MRSA screening of paediatric patients following admission to UHS will be undertaken as detailed in Appendix P
- Agreed exclusions for MRSA screening of elective and day case admissions within UHS are listed in Appendix D.

Refer to Appendix C for MRSA screening specimen requirements.

5.4 MRSA Topical Decolonisation

- All patients (adult, paediatric and neonatal) known or found to be MRSA positive will receive a 5-day course of topical decolonisation in an attempt to eradicate MRSA, and reduce the subsequent risk of infection, unless this is contra-indicated or there are clinical reasons why this is not appropriate. In these circumstances the reason for not decolonising the patient must be documented.

For details of topical decolonisation – See Appendix F (adults) and Appendix P (paediatric and neonates).

- Successful decolonisation is unlikely in patients with chronic wounds, permanent tracheostomy, and long-term indwelling devices. Where these risk-factors for long-term carriage are present the patient should be managed as listed immediately below.
- If it is impossible to clear a patient of MRSA prior to the admission for surgery, if they have already had multiple (three) decolonisation attempts previously, or if they have other factors which make successful decolonisation unlikely, bioburden reduction should be commenced 48 hours pre-operatively in order to reduce the level of MRSA at the time of the procedure, see Appendix F (adults) and Appendix P (paediatrics and neonates). Additional measures for management of chronic wounds etc. should also be taken if applicable (see Appendix G). These patients must be admitted and managed as MRSA positive.
5.5 MRSA Clearance

- Clearance of MRSA will be considered by the UHS Infection Control Doctor (ICD) on a case by case basis. This is a subjective assessment of risk and will be determined on an individual patient basis. Refer to Appendix N for clearance criteria.
- Clearance is unlikely in patients with risk factors for long term carriage e.g. chronic wounds, permanent tracheostomy, long-term indwelling devices and skin shedders.
- Patient’s should continue to be treated as MRSA positive until you have confirmation from the Infection Prevention Team that the patient has been cleared and the MRSA alert removed from e-camis.

5.6 MRSA Risk reduction for patients not known to be MRSA positive.

ADULTS:

- To reduce the risk of MRSA colonisation and infection, all adult patients not known to be MRSA positive, except for those in identified exception categories as defined in this policy, will receive routine washes containing a skin disinfectant on admission (see Appendix H & I).
- Additional risk reduction measures will be implemented for patients admitted with chronic wounds or indwelling devices (see Appendix G and J).
- Inpatients who subsequently require surgical or interventional procedures during their hospital stay will receive a risk reduction washes containing a skin disinfectant prior to the procedure/intervention (see Appendix J).

See Flow Chart in Appendix M for MRSA Screening and risk reduction measures for adult patients not known to be MRSA positive.

PAEDIATRICS:

- To reduce the risk of MRSA colonisation and infection, all patients specified within the policy not known to be MRSA positive, will receive routine washes for 5 days containing a skin disinfectant on admission (see Appendix P).
- Ensure routine risk reduction measures of Octenisan washes are implemented on admission for specific patients including:
  - All admissions to PICU, PHDU and E1 HDU
  - All transfers from other hospitals
  - Any patient alerted as being MRSA positive
  - Patients having spinal or cardiac surgery and those having specialist surgery as requested by consultant team on a case by case basis.
  - Some oncology patients as requested by consultant team on a case by case basis.
- Additional risk reduction measures will be considered for patients admitted with chronic wounds or indwelling devices (see Appendix P)
- In-patients who subsequently require surgical or interventional procedures during their hospital stay will be considered for risk reduction washes containing a skin disinfectant prior to the procedure/intervention (see Appendix P)

See Flow Chart in Appendix P for MRSA Screening and risk reduction measures for paediatric patients not known to be MRSA positive.
5.7 Isolation Care

Mode of Transmission of MRSA

- **Contact transmission** is the most important and frequent mode of transmission and involves either direct person-to-person contact or indirect contact via a contaminated intermediate object.
- **Droplet transmission** occurs rarely with MRSA. If a patient has MRSA colonisation of their sputum and has a productive cough, droplets are generated mainly during coughing, sneezing or open suction procedures. These droplets are propelled a short distance only; hence special ventilation is not required to prevent transmission. If these patients are nursed in close proximity to other patients, transmission of MRSA may occur.

Isolation precautions

- All patients with MRSA will be managed with standard infection control precautions. In addition; contact precautions will be implemented in all wards and departments, as defined in UHS Isolation of Adult Patients with Infectious Conditions Policy and Paediatric Isolation Policy, unless stated otherwise in local policy and approved by the Infection Prevention Team.
- Hand hygiene is essential before and after contact with the patient or their environment. Refer to UHS Hand hygiene policy and UHS Isolation of Adult Patients with Infectious Conditions Policy and Paediatric Isolation Policy.
- All isolation rooms/bedspaces, where there are patients with confirmed/suspected infectious conditions, including MRSA, must be cleaned daily using Actichlor Plus, a chlorine based solution of 1,000 parts per million available chlorine and terminal cleaning, using Actichlor Plus must be undertaken following the discharge/transfer of a patient with MRSA (Refer to UHS Isolation of Adult Patients with Infectious Conditions Policy and Paediatric Isolation Policy)
- Equipment should be kept to a minimum and any unnecessary furniture removed.
  - Dedicated equipment should be used where possible and kept in the room.
  - Use disposable equipment where possible. e.g. hoist slings.
  - Reusable equipment must be thoroughly decontaminated before use on another patient (see Decontamination of Medical Devices policy).
- An isolation risk assessment must be performed for all MRSA positive patients, as per the UHS Isolation of Adult Patients with Infectious Conditions Policy and this must be recorded in the clinical notes. The score must be reviewed at least weekly.
- Single room isolation will be implemented for all patients in accordance with the isolation risk score, unless stated otherwise in local policy and approved by the Infection Prevention Team. Approved exceptions include Countess Mountbatten House (CMH), Emergency Medicine/Specialist medicine/Medicine for Older People Care Groups, the Stroke Unit (Appendix O), Day units (see below) and Burseldon House (See Appendix P).
- Where single room isolation cannot be achieved, the escalation process must be followed as defined in the UHS Isolation of Adult Patients with Infectious Conditions Policy and Paediatric Isolation Policy.

See Appendix O for isolation precautions for patients in Countess Mountbatten House (CMH), Emergency Medicine/Specialist medicine/Medicine for Older People Care Group and the Stroke Unit.
See Appendix P for additional guidance for paediatric patients.

Management of MRSA Positive day cases on day case units

- Patients known to be MRSA positive who are admitted as day cases to day case units do not require isolation unless they are skin shedders or sputum colonised with a productive cough, providing that standard precautions are implemented and any equipment that has been in contact with the patient is cleaned after use. Any patient who subsequently requires overnight hospital stay must be isolated as per the isolation policies.
- Patients known to be MRSA positive that are skin shedders or sputum colonised with a productive cough should be isolated in single rooms as per the adult and paediatric isolation policies.

5.8 Diagnostic Investigations and Treatment in other Departments

- All patients with MRSA may visit other departments for investigations or treatment provided the department is informed of the patient’s MRSA status in advance. This information will allow staff in these departments to make appropriate arrangements, call the patient in a timely manner, to take appropriate infection control precautions during the procedure and reduce the risk of cross infection to others.
- Porters transferring the patient must be instructed on precautions required when entering the isolation room, e.g. wearing of protective clothing. Protective clothing should be removed once the patient has been transferred into the chair/trolley and hands decontaminated before leaving the room.
- PPE, including aprons and gloves, MUST NOT be worn to transfer patients through the hospital. Hand hygiene using alcohol gel is sufficient in this situation. Where there is a risk of splashing with body fluids or if it is likely that procedures/interventions will be required during transfer e.g. suctioning, clinical staff should wear PPE as appropriate.
- The patient should be seen as soon as possible in the receiving area/department - where possible the patient should not wait in a communal area close to other patients and should be returned to the ward as soon as possible after the procedure.
- The patient can be seen at any time during the working session provided contact precautions are implemented by staff who have hands-on contact with the patient. Staff should wear protective clothing when having contact with the patient. Hands should be decontaminated after contact with the patient.
- All equipment that has been in contact with the patient should be cleaned after the patient has left the department. The trolley/chair should be cleaned after use with universal sanitising wipes (see Decontamination of Medical Devices Policy)
- When moving patients through the hospital, movement through public areas (e.g. C-level Centre block) should be avoided.

5.9 Management of MRSA Positive Patients in Theatres

Theatres must be informed of the patients’ diagnosis/condition to allow them to make appropriate arrangements e.g. appropriate placement on operating list, call the patient in a timely manner, take appropriate precautions during the procedure and recovery and reduce the risk of cross infection to others.
- MRSA positive patients can be placed anywhere on the operating theatre list provided all surfaces and equipment are cleaned between the MRSA positive patient and the next patient.
• Routine cleaning measures, with Actichlor Plus, should be adequate provided 15 minutes elapses between the MRSA positive 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 between cases unnecessary, though thorough cleaning with Actichlor Plus is still required.
• MRSA positive patients, with a small number of exceptions, may be recovered in recovery units, providing contact precautions are adhered to, and equipment in contact with the patient is cleaned after use as per Decontamination of Medical Devices Policy.
• MRSA positive patients who are skin sheddars, sputum positive and productive and PVL producers should be recovered in theatre. Patients should be assessed prior to surgery occurring to determine placement for recovery.

5.10 Prevention and Management of MRSA in very high-risk units.
• Identified very-high risk units within UHS include, but are not limited to, all adult and paediatric, critical care units and high dependency units.
• All patients will be screened for MRSA on admission to these identified very-high risk units and weekly surveillance screening will be performed on all patients not already known to be MRSA positive.
• Additional routine measures in very high-risk units will be implemented including administration of topical agents for bioburden reduction regardless of MRSA status.

Further detail is provided in Appendix K (adults) and P (paediatrics)

5.11 Documentation
• The MRSA status of all patients must be accurately recorded in medical and nursing notes, including information on risk reduction measures, topical decolonisation therapy and specimen results. This is the responsibility of the medical and nursing teams caring for the patient, and is essential to ensure safe, effective care.
• All patients found to be MRSA positive will be alerted on the e-camis system (also visible on e-quest) by the Infection Prevention Team, and the notes flagged via use of a sticker. This will allow staff to identify patients known to be MRSA positive. Responsibility for checking this rests with medical and nursing staff who admit the patient. Areas who decant medical/nursing notes into dedicated folders for the current admission must ensure that an alert sticker is also placed with the decanted notes.

5.12 Communication and Patient/Carer Information
• Patients, carers and visitors must be provided with accurate information on MRSA. This is the responsibility of the medical and nursing team admitting or providing care for the patient, and includes giving the patient, or their relatives/carers, a copy of the relevant Trust information leaflet – adult or paediatric.
• This includes information for all patients on the risk of infection during procedures, risk reduction measures, and information for those found to be positive on their management. Information leaflets are available on the public website of the Trust.
• Carers, relatives & visitors must be advised of the precautions required when visiting a patient with MRSA, e.g. hand hygiene and wearing of personal protective equipment if contributing to patient care.
- Accurate information on MRSA status must be recorded and communicated to other wards and departments within UHS in order to facilitate safe care.
- Accurate information on MRSA status including information on topical decolonisation and specimen results, must be recorded and communicated to staff in primary and community care upon transfer to another organisation or discharge home. Information must be recorded on the patient’s discharge summary and other transfer of care documents.

See Appendix P for additional guidance for paediatrics.

5.13 Action to take if a patient refuses MRSA Screening, Decolonisation or risk reduction Measures.

If a patient refuses to be screened for MRSA or refuses decolonisation/risk reduction measures the following action should be taken:

- A clear explanation must be provided to the patient and/or parent/carer explaining the rationale for the screening/decolonisation/risk reduction measures.
- The potential risks of not undertaking these measures must be explained to the patient and/or parent/carer so that the patient understands the potential consequences of not undertaking these actions.
- This should extend to explanation of the need for specific measures when a patient is MRSA positive, for example a patient with MRSA who refuses to have a beard clipped off to facilitate effective skin disinfection for internal central venous catheter insertion should have the increased risk of infection explained to him, and this must be documented.
- The patient’s and/or parent/carer refusal and discussions related to the above must be clearly documented in the medical notes.
- The patient’s Medical Consultant must be informed of the patient’s and/or parent/carer decisions.

5.14 Staff and MRSA

Where there are concerns about MRSA in staff, these will be handled by the Occupational Health Department, in strict confidence. Further detail can be found in Appendix Q.

6. Implementation

Communication and Dissemination Plan

- This policy will be placed on Staffnet and on the extranet and public websites in order that the information contained within it is available to primary and community care providers, patients and the public.
- This revised policy will be launched with communication via the Staffnet news pages, infection prevention newsletter and an email alert.
- The Infection Prevention Team will also issue a briefing paper, highlighting the main changes in the revised policy, and this will be circulated to all care groups.
**Education and Support Plan**

- An education and support plan will be developed and implemented by the Infection Prevention Team in collaboration with Divisions and Care groups.
- Infection Prevention link staff will be provided with education sessions about the policy at their meetings.

**7. Process for Monitoring Compliance/Effectiveness**

Compliance with the policy will be monitored via:

<table>
<thead>
<tr>
<th>What aspects of compliance with the document will be monitored</th>
<th>What will be reviewed to evidence this</th>
<th>How and how often will this be done</th>
<th>Who will coordinate and report findings</th>
<th>Which group or report will receive findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>All elements</td>
<td>Enhanced MRSA surveillance of new MRSA acquisition against MRSA policy standards.</td>
<td>As they occur</td>
<td>IPT</td>
<td>Compliance with care bundle reported to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Delivery Group</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>- Infection Prevention Committee</td>
</tr>
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<td></td>
<td></td>
<td>- TEC/Trust board</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Divisional Governance</td>
</tr>
<tr>
<td>All elements</td>
<td>Post Infection Review (PIR) of MRSA bacteraemia cases</td>
<td>As they occur</td>
<td>IPT</td>
<td>PIRs reviewed at Chief Executive Review Meeting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reported to:</td>
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<td>- Delivery Group</td>
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<td></td>
<td>- Infection Prevention Committee</td>
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<td></td>
<td>- TEC/Trust board</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Divisional Governance</td>
</tr>
<tr>
<td>Screening compliance</td>
<td>Review at delivery group.</td>
<td>Quarterly</td>
<td>IPT</td>
<td>Trust Delivery Group</td>
</tr>
<tr>
<td>Isolation, Infection control standards</td>
<td>Audits of Practice</td>
<td>Infection Prevention Audits – Isolation, PPE, Saving Lives etc. As per annual audit programme</td>
<td>IPT</td>
<td>Infection Prevention Committee, Divisional Governance</td>
</tr>
</tbody>
</table>
8. **Arrangements for Review of the Policy**

This document will be reviewed by the Infection Prevention Team in the following circumstances:
- When new national or international guidance is issued
- When newly published evidence demonstrates need for a change to current practice
- Every 3 years routinely

9. **References**


Dept of Health (2010). [Screening Emergency Admissions for MRSA- FAQs](#): April 2010

Dept of Health (2009) [Screening Elective patients for MRSA- FAQs](#): May 2009


APPENDIX A  MRSA Screening of ADULT Emergency & Planned (Elective) Admissions

All adult patients will be screened for MRSA on admission, or as part of routine pre-assessment procedures prior to admission, with the exception of some day cases and some obstetric cases as detailed in this appendix.

Screening of Emergency admissions

All adult patients admitted as emergencies to UHS must be screened on admission to hospital. These patients require one screen for MRSA on admission (see Appendix C for screening specimen requirements).

Appropriate risk reduction/decolonisation measures must be implemented following completion of admission screening as detailed in Appendices F- J.

Exclusions:
- Accident & Emergency - Excluded as patients not ‘admitted’
- Patients admitted for less than 12 hours - All patients admitted on e-camis for less than 12 hours currently excluded.

Screening of planned/elective admissions

- All patients who are planned/elective admissions, including most day cases, require 1 screen for MRSA, either prior to an elective admission (see below), or on admission to UHS. More detailed guidance for specific specialities and exceptions is detailed within this Appendix D & Appendix E.
- Pre-Admission Elective Screening: All adult patients requiring elective admission should be routinely screened for MRSA, unless they meet the exclusion criteria (see below for screening requirements relating to day cases).
- Screening should take place in pre-assessment clinics whenever possible and should be included as part of routine pre-assessment procedures.
- Pre-assessment clinics must ensure there are clear arrangements for checking, documenting and acting upon the results of screening. This is the responsibility of Divisional Management Teams.
- Laboratory request forms should be completed and clinical details should clearly state ‘Pre-Admission Screen prior to X’ (X = the type of surgery).
- If a patient is found to be MRSA positive at pre-assessment the following actions must be performed:
  - Patient and GP should be notified by the pre-assessment clinic following review of the results by clinic staff.
  - The notes should be marked and the e-camis alerted. The patient must also be informed by the department who sent the screen to the laboratory and a patient information leaflet provided.
  - An attempt should be made to decolonise the patient (see Appendix F).

Elective admissions, who do not attend pre-assessment, should be screened on admission to hospital.
<table>
<thead>
<tr>
<th><strong>Screening of Day cases</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Within elective admissions and attendances (surgical and medical) day cases / attendees must be screened unless they meet the exclusions criteria detailed in Appendix D and E. Screening should be undertaken at pre-assessment where possible or on admission if the patient does not attend pre-assessment.</td>
</tr>
<tr>
<td>Adult Day case patients undergoing surgical procedures will be screened for MRSA as part of pre-assessment procedures or on admission if:</td>
</tr>
<tr>
<td>- Patient is known to be MRSA positive/has an MRSA alert on e-camis</td>
</tr>
<tr>
<td>- Planned overnight stay or &gt;5% chance of overnight stay</td>
</tr>
<tr>
<td>- Antibiotic prophylaxis is required</td>
</tr>
<tr>
<td>(See Appendix E).</td>
</tr>
<tr>
<td>If a patient is found to be MRSA positive at pre-assessment the actions must be taken as detailed above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Screening of patients who are Regular Attenders as Day Cases/attendees</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Those patients attending hospital as regular attenders to undergo a course of treatment over a period of time should be screened at the beginning of their treatment and then at monthly intervals (or at the next attendance if this is more than four weeks from the previous attendance) whilst they are undergoing their treatment, unless otherwise defined in local guidance and agreed with the Infection Prevention Team/Infection Control Doctor.</td>
</tr>
<tr>
<td>Examples include but are not exclusive to, oncology patients attending for chemotherapy, patients in the Specialist Medicine Care group under the managed care service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Screening of Obstetrics</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to MRSA screening, risk reduction and decolonisation within Maternity services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Screening of Pre-Admission Urgent Transfers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Patients requiring urgent transfer to UHS from other centres should be screened as soon as the decision to transfer is made, and risk reduction measures commenced. Results of the screen should be communicated to the receiving unit at UHS prior to transfer. This will allow the appropriate prioritisation of single rooms within that unit and priority can be given to patients already known to be MRSA positive on transfer.</td>
</tr>
<tr>
<td>- Receiving units within UHS should ask for this information prior to transfer. Transfer must not be delayed if the results of this screening are unavailable. It should be noted that the purpose of this screening is to assist with identification of positive patients rather than to identify those who are negative.</td>
</tr>
<tr>
<td>- Patients who are urgent transfers should still be screened on admission to UHS even if they have been screened prior to transfer, and risk reduction / decolonisation measures should be continued/ implemented according to this policy.</td>
</tr>
<tr>
<td>- Patients transferred from other hospitals should be isolated in single rooms until screening results are available. If this is not possible they must be nursed in a bay with contact precautions until screening results are known. Once results are available the patients will either be managed as MRSA positive or negative, as per this policy</td>
</tr>
</tbody>
</table>
to UHS

1. Screening on transfer between units/Care Groups within UHS:

Admissions to Very High Risk Units

All patients admitted to identified **very high-risk units** within UHS will be screened for MRSA. This includes, but is not limited to, all adult critical care units and high dependency units. See Appendix K Prevention and Management of MRSA in very high-risk units.

Transfers between different care groups within UHS.

Patients known to be MRSA positive who are transferred between different care groups within UHS must be managed in accordance with the UHS isolation of adults with infectious conditions policy.

Where patients, who are not known to be MRSA positive, are transferred between different care groups within UHS, the following measures must be taken:

- Screen on arrival
- Re-commence MRSA risk reduction measures for 5 days - 4% chlorhexidine washes (unless within 5 days of admission and original risk reduction measures are still ongoing)
- Implement contact precautions until results of the screen are known

Once results are available the patients will either be managed as MRSA positive or negative, as per this policy

If the patient has been screened within the previous 48 hours, a screen on transfer is not required.

2. Routine monitoring for MRSA throughout admission.

Routine screening in identified very high-risk areas.

- All patients **not known** to be MRSA positive in identified very high-risk units will be screened weekly for MRSA acquisition. This includes, but is not limited to; all critical care units and high dependency units. Each of these patients will have a weekly screen, to include nose, groin, line sites (note: wounds, sputum, and CSU to be sent if clinically indicated for M, C&S). These swabs to be labelled ‘MRSA weekly screening’.

See Appendix K: Prevention and Management of MRSA in very high-risk units.

Routine screening of inpatients

1. **Vascular Surgery, Bone Marrow Transplant, Intestinal Failure Unit** – all patients not known to be MRSA positive must be screened **weekly** until discharge.

2. **All other areas** - those patients who remain inpatients for over 14 days should be screened **every two weeks** until discharged.

3. Contact Screening

- A single contact screen for patients exposed to someone found to have MRSA will be performed in all areas of the hospital, except Countess Mountbatten House.
- Contact screening will also not be performed in very high risk areas who are sending weekly screens already, unless advised by the Infection Prevention Team (i.e. during an outbreak)
- Results must be recorded in the notes, and the patient informed if the result is positive.
4. Routine Screening of Patients known to be MRSA Positive

Routine screening of known MRSA positive patients following admission is not required except:

- For clearance screening (refer to Appendix N)
- Prior to specific events such as surgery or interventional procedures.

Any patient found to be MRSA positive should commence topical decolonisation (Appendix F)
APPENDIX B  Additional MRSA Screening of ADULT Patients following admission to UHS

1. Screening on transfer between units/Care Groups within UHS:

Admissions to Very High Risk Units
All patients admitted to identified very high-risk units within UHS will be screened for MRSA. This includes, but is not limited to, all adult critical care units and high dependency units. See Appendix K Prevention and Management of MRSA in very high-risk units.

Transfers between different care groups within UHS.
Patients known to be MRSA positive who are transferred between different care groups within UHS must be managed in accordance with the UHS isolation of adults with infectious conditions policy.

Where patients, who are not known to be MRSA positive, are transferred between different care groups within UHS, the following measures must be taken:

- Screen on arrival
- Re-commence MRSA risk reduction measures for 5 days - 4% chlorhexidine washes (unless within 5 days of admission and original risk reduction measures are still ongoing)
- Implement contact precautions until results of the screen are known

Once results are available the patients will either be managed as MRSA positive or negative, as per this policy

If the patient has been screened within the previous 48 hours, a screen on transfer is not required.

2. Routine monitoring for MRSA throughout admission.

Routine screening in identified very high-risk areas.

- All patients not known to be MRSA positive in identified very high-risk units will be screened weekly for MRSA acquisition. This includes, but is not limited to; all critical care units and high dependency units. Each of these patients will have a weekly screen, to include nose, groin, line sites (note: wounds, sputum, and CSU to be sent if clinically indicated for M, C&S). These swabs to be labelled ‘MRSA weekly screening’.

See Appendix K: Prevention and Management of MRSA in very high-risk units.

Routine screening of inpatients

5. Vascular Surgery, Bone Marrow Transplant, Intestinal Failure Unit – all patients not known to be MRSA positive must be screened weekly until discharge.

6. All other areas - those patients who remain inpatients for over 14 days should be screened every two weeks until discharged.

Results must be recorded in the notes, and the patient informed if the result is positive

Screening of inpatients prior to Surgery/Interventional Procedures

In-patients who subsequently require surgical or interventional procedures during their hospital stay should be screened 48 hrs prior to the procedure where possible and undergo a risk reduction wash (see Appendix J)
3. Contact Screening

- A single contact screen for patients exposed to someone found to have MRSA will be performed in all areas of the hospital, except Countess Mountbatten House.
- Contact screening will also not be performed in very high risk areas who are sending weekly screens already, unless advised by the Infection Prevention Team (i.e. during an outbreak)
- Results must be recorded in the notes, and the patient informed if the result is positive.

4. Routine Screening of Patients known to be MRSA Positive

Routine screening of known MRSA positive patients following admission is not required except:
- For clearance screening (refer to Appendix N)
- Prior to specific events such as surgery or interventional procedures.

Any patient found to be MRSA positive should commence topical decolonisation (Appendix F)
APPENDIX C

MRSA Screening Specimens

Staff must ensure correct specimens are requested for MRSA screening, as listed below.

Specimens to be taken:

- **Nose**: All patients as listed in policy: one swab used inside both anterior nares (fleshy part of the nose)

- **Groin**: All patients as listed in policy: one swab used for both sides

- **Skin Lesions and/or Wounds**: one swab from each site; clearly identifying sites

- **Umbilical swab**: in neonates 1 month or younger.

- **Insertion sites for devices in-situ at time of screening**: PEG sites, tracheostomy, IV devices

- **CSU**: A CSU from patients who have catheters in situ at the time of screening. This must be taken using correct technique, not from the bag.

- **Any other site that has been previously positive** if the patient has had MRSA previously, i.e. stoma, sputum (or throat if not sputum productive).

- Specimens must be correctly labelled with patient details. The laboratory will reject unlabelled specimens.
- Clinical details must include current antibiotic therapy.
- Specimen requests must clearly identify the reason for the screening request. Specimens requested without an indication for screening may be rejected by the laboratory.

**It is the responsibility of the person sending the specimen to check the result and ensure this is clearly documented in the clinical records.**
Within elective admissions and attendances the following patient groups do not need to be routinely screened for MRSA:

| Day case and outpatient dermatology | All |
| Day case ophthalmology, | All |
| Day case dental | Patients attending for dental procedures or for biopsy of lesions on the face or in the buccal cavity. |
| Day case Oral Surgery | All |
| Day case Endoscopy | All |
| Day case Hepatology | Patients attending for supervised self-administration of antiviral agents. Patients attending for venesection only as an outpatient to Hepatology (Haemachromatosis). |
| Day case Respiratory medicine | Patients attending respiratory centre for admission avoidance. Patients attending the sleep labs overnight. |
| Day case Neurology: | Patients attending for assessment only. No invasive intervention. |
| Day case Urology | Cystoscopy |
| Day case Gynaecology | Hysteroscopy cases. Terminations of pregnancy. |
| Day Case Rheumatology | Patients undergoing minimally invasive procedures e.g. joint injections, intramuscular injections. |
| Day Case Nutritional/Gastrointestinal | Patients attending for written or verbal advice or occasionalsubcut fluids. Patients attending for a range of Sub cutaneous or IM injections (e.g. methotrexate/HUMIRA) |
| Day case haematology/General Medical Patients | Patients attending for one off single transfusions of blood products or at ad hoc irregular periods of time. |
| Day Case Clinical Oncology | Patients attending for low risk non-invasive / minimally invasive procedures as defined in the Day Case cancer care MRSA screening risk assessment e.g. Pentamadine Nebulisers, IM/Sub-cut injections, venesection. |
| Day Case Medical Oncology | |
| Day Case Clinical Haematology | |
| Interventional Radiology | Refer to agreed local guidance |
| Children attending Burseldon House | Screen only if clinically indicated |

Refer to Appendix E for screening requirements of Adult Day case patients undergoing surgical procedures

Refer to Specific Screening guidance for Cancer Care & Specialist Medicine Care Groups and Interventional Radiology
APPENDIX E

Flow chart for assessing MRSA screening requirements for Adult Surgical Day Cases

1. Patient comes to pre-assessment clinic
   - Current MRSA alert on the system
     - Planned overnight stay or >5% chance of overnight stay
       - Surgical prophylaxis regimen contains MRSA-active drug (e.g. gentamicin, vancomycin or teicoplanin) for all patients [or no antibiotic prophylaxis required]
     - Planned day case surgery with <5% chance of overnight stay
       - Surgical prophylaxis guideline offers choice of regimens for MRSA +ve and MRSA –ve patients
   - No current MRSA alert on system
     - Planned day case surgery with <5% chance of overnight stay
     - No screen

2. Patient arrives day of surgery, no pre-assessment
   - Current MRSA alert on the system
     - Planned overnight stay
       - No screen pre-op, but if they stay overnight, send screen.
     - >5% chance of overnight stay
   - No current MRSA alert on system
     - Planned day case surgery with <5% chance of overnight stay
     - No screen
APPENDIX F  MRSA Topical decolonisation for ADULT Patients

All adult patients found to be MRSA positive should receive topical decolonisation as an attempt to eradicate MRSA, and reduce the subsequent risk of infection, unless there are contraindications or clinical reasons why this is not appropriate. In these circumstances the reason for not decolonising the patient must be documented.

Pre-Admission Elective Patients

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

- Patient and GP should be notified by the pre-assessment clinic following review of the results by clinic staff.
- The notes should be marked and the e-camis system alerted. The patient must also be informed by the department who sent the screen to the laboratory and a patient information leaflet provided.
- An attempt should be made to decolonise the patient.
- Repeat screening should be performed a minimum of 48 hours after treatment has stopped.
- If repeat screening is negative, a minimum of 2 further screens are required before clearance can be considered (see Appendix N for clearance requirements). 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 these risk-factors for long-term carriage are present the patient should be managed as listed immediately below.

If it is impossible to clear a patient of MRSA prior to the admission for surgery, if they have already had multiple (three) decolonisation attempts previously, or if they have other factors which make successful decolonisation unlikely, bioburden reduction should be commenced 48 hours pre-operatively in order to reduce the level of MRSA at the time of the procedure, see below. Additional measures for management of chronic wounds etc. should also be taken if applicable (see Appendix G). These patients must be admitted and managed as MRSA positive.

All other admissions

Patient’s known to be MRSA positive on admission.
An MRSA Decolonisation Regime should be prescribed on admission and commenced within 12 hours of arrival within the unit. Additional measures for management of chronic wounds etc. should also be taken if applicable (see Appendix G).

Patients Found to be MRSA Positive during admission
An MRSA Decolonisation Regime should be prescribed following confirmation of the positive result). Additional measures for management of chronic wounds etc. should also be taken if applicable (see Appendix G).

Prescribing of Topical decolonisation for MRSA positive patients
When topical MRSA decolonisation is performed in an attempt to eradicate MRSA, the nose, skin and hair must all be treated using the following regime:

### MRSA DECOLONISATION REGIMEN

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily shower / bath / blanket bath</td>
<td>Chlorhexidine Gluconate 4% (hibiscrub®)</td>
<td>Apply product directly to wetted skin using a disposable cloth. (Consider using a chlorhexidine compatible skin cream if skin becomes dry, e.g. Diprobase®).</td>
<td>For 5 days (longer courses are not more effective)</td>
</tr>
<tr>
<td>Washing hair twice during period</td>
<td>Chlorhexidine Gluconate 4% (hibiscrub®)</td>
<td>Wash hair with product in place of shampoo</td>
<td></td>
</tr>
<tr>
<td>Nasal clearance</td>
<td>Mupirocin ointment 2% (Bactroban®)</td>
<td>Applied to nostrils 2 times a day</td>
<td>For 5 days</td>
</tr>
</tbody>
</table>

**Action to take if MRSA eradication cannot be achieved prior to procedures - BIOMBURDEN REDUCTION.**

When eradication of MRSA cannot be achieved, the following regime should be used for 48 hours prior to planned interventional procedures or surgery, and continued for 3 days after the procedure (total 5 days) in order to reduce the bioburden and the risk of infection.

### MRSA BIOBURDEN REDUCTION PRIOR TO PROCEDURES

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily shower / bath / blanket bath</td>
<td>Chlorhexidine gluconate 4% (Hibiscrub®)</td>
<td>Apply product directly to wetted skin using a disposable cloth. (Consider using a chlorhexidine compatible skin cream if skin becomes dry, e.g. Diprobase®)</td>
<td>For 5 days (longer courses are not more effective)</td>
</tr>
<tr>
<td>Wash hair twice during period</td>
<td>Chlorhexidine gluconate (Hibiscrub®)</td>
<td>Wash hair with product in place of shampoo</td>
<td></td>
</tr>
<tr>
<td>Nasal clearance</td>
<td>Mupirocin ointment (Bactroban®)</td>
<td>Applied to nostrils 2 times a day</td>
<td>For 5 days</td>
</tr>
</tbody>
</table>

Prophylactic antimicrobial therapy should also be administered in accordance with Trust antimicrobial guidelines.

In addition, Radiology guidelines relating to specific interventional procedures should also be followed, as advised by Radiology.

**Chlorhexidine allergy:** For patients with a documented chlorhexidine allergy (diagnosis by allergy team or dermatology), Octenisan® should be used as an alternative to 4% Chlorhexidine gluconate, for skin and hair washing.

**Decolonisation of MRSA positive patients with active skin disease (e.g. eczema, psoriasis)**
- Decolonisation with topical agents alone is likely to be unsuccessful in patients with open skin lesions. Therefore a risk assessment for MRSA bacteraemia or other invasive MRSA infection should be carried out.
- If full decolonisation is advisable (e.g. for those patients at high risk of MRSA bacteraemia/invasive MRSA infection) a combination of topical and systemic treatment is indicated. Medical teams are advised to discuss MRSA sensitivities and systemic antimicrobial treatment with microbiology.
- For low-risk patients, biodurden reduction with topical agents alone may be appropriate.

### MRSA DECOLONISATION /BIOBURDEN REDUCTION REGIMEN FOR PATIENTS WITH ACT SKIN DISEASE

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily shower / bath / blanket bath</td>
<td>1. Cautious trial Chlorhexidine gluconate 4% (Hibiscrub®)</td>
<td>Apply product directly to wetted skin using a disposable cloth. (Consider using a chlorhexidine compatible skin cream if skin becomes dry).</td>
<td>For 5 days (longer courses not more effective)</td>
</tr>
<tr>
<td>2. If reaction to 4% chlorhexidine, try Dermol 500®.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. If reaction to Dermol 500®, try Octenisan®.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wash hair twice during period</td>
<td>As above</td>
<td>Wash hair with product in place of shampoo</td>
<td>For 5 days</td>
</tr>
<tr>
<td>Nasal clearance</td>
<td>Mupirocin ointment (Bactroban®)</td>
<td>Applied to nostrils 2 times a day</td>
<td>For 5 days</td>
</tr>
</tbody>
</table>

**Note:**

**Naseptin** (chlorhexidine 0.1% with neomycin 0.5%) nasal ointment is the recommended alternative to Bactroban

- Naseptin is a prescription-only medicine licensed for the eradication of nasal infection with, and carriage of, staphylococci.
- Naseptin is applied **four times** daily for **10 days** to eliminate organisms from the nostrils.
- Naseptin is contra-indicated in patients who have allergy to **peanuts, soya or chlorhexidine**. Contact microbiology on 6408 to discuss alternatives to Naseptin if contra-indicated
APPENDIX G    Management of Wounds and Invasive Device Insertion Sites

All patients admitted with a wound (chronic or otherwise) should have the wound reviewed within six (6) hours of admission (NICE guidance) and an appropriate dressing selected.
Priority must always be given to the use of the most appropriate treatment for the type of wound involved.
**ALWAYS** seek advice from Tissue Viability and Microbiology for the management of infected wounds.

The suggested products in the following table are for guidance only:

<table>
<thead>
<tr>
<th>Type of Wound/Site</th>
<th>Considerations</th>
<th>Non-infected</th>
<th>Infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leg Ulcer</td>
<td>All patients admitted with a leg ulcer, should have the wound reviewed and an appropriate dressing selected. Priority must <strong>always</strong> be given to use of the most appropriate treatment for the type of wound. Check with GP/Community Nurse for previous treatment strategies to avoid repeating treatments that have already failed. Tissue Viability advice should be sought if an appropriate dressing cannot be identified.</td>
<td>All leg ulcers, pressure ulcers and cavity wounds not known to be colonised or infected with MRSA <strong>MUST</strong> be dressed with an appropriate dressing – refer to the Trust Wound Formulary Poster for guidance.</td>
<td>All leg ulcers, pressure ulcers or wounds colonised or infected with MRSA <strong>MUST</strong> be referred to Tissue Viability for advice.</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>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 cellulitis, further wound breakdown or delayed healing, advice should be sought from medical staff as antibiotics may be required.</td>
<td>If there is a reason why a wound cannot be dressed, advice should be sought from the Infection Prevention Team or Tissue Viability.</td>
<td></td>
</tr>
<tr>
<td>Surgical Wound Site</td>
<td>On admission, insertion sites should be checked for signs of infection and to ensure that they are fully healed. If there are signs of infection (redness, pain, inflammation, pus, spreading cellulitis) the site should be swabbed and sent for culture and sensitivity.</td>
<td>Where sites are well healed they can be treated as ‘normal’ skin during topical decolonisation for MRSA, or during risk reduction measures. <strong>No dressing required.</strong></td>
<td>Sites that appear to be infected or are not healed should be reviewed and an appropriate barrier dressing applied. In addition if there are signs of infection a medical review should be sought, and antimicrobial treatment commenced if appropriate. <strong>Kendall™ AMD Antimicrobial Foam Dressing</strong></td>
</tr>
<tr>
<td>PEG Site</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


**Suprapubic Catheter Site**

On admission, insertion sites should be checked for signs of infection and to ensure that they are fully healed.

Where sites are well healed they can be treated as ‘normal’ skin during topical decolonisation for MRSA, or during risk reduction measures. **No dressing required.**

If the insertion site is infected with MRSA medical advice should be sought as antibiotics may be required. Use of an appropriate dressing with good barrier properties or anti-staphylococcal activity on the site/around the device should also be considered.

*Kendall™ AMD Antimicrobial Foam Dressing*

<table>
<thead>
<tr>
<th>Type of Wound/site</th>
<th>Considerations</th>
<th>Non-infected</th>
<th>Infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral IV Device Site</td>
<td></td>
<td>Trust approved IV dressing</td>
<td>Management of Infected Insertion sites in patients known to have MRSA</td>
</tr>
</tbody>
</table>

- Remove line and re-site if access is still required
- Swab the site for culture and sensitivity
- Dress the site using an appropriate dressing; (see below)
- Document the Visual Infusion Phlebitis (VIP) score of the site, and actions taken including choice of dressing.
- The infected site should continue to be monitored after removal of the device using the VIPS scoring system in order to provide objective monitoring of improvement or deterioration. Any deterioration must be reported to medical staff
- Systemic antibiotics should be considered as per the Trust Antimicrobial Guidelines (adult & Paediatric). Topical antibiotics must not be used unless advised by a Medical Microbiologist.

If an IV device has been removed and the site appears to be infected (redness, pain, inflammation, pus and/or spreading cellulitis)

- Swab the site for culture and sensitivity
<table>
<thead>
<tr>
<th>Central Line Device Site</th>
<th>Biopatch®, or equivalent, should be considered for all Central Venous Catheter insertion sites in patients who are MRSA positive.</th>
<th>Management of Infected CVC Insertion sites in patients known to have MRSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- Remove line and re-site if access is still required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Swab the site for culture and sensitivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Dress the site using an appropriate dressing (see below)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Document the Central Access Device Infection (CADI) score of the site, and actions taken including choice of dressing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Systemic antibiotics should be considered as per the Trust Antimicrobial Guidelines (adult and paediatric). Topical antibiotics must not be used unless advised by a Medical Microbiologist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Kendall™ AMD Antimicrobial Foam Dressing</strong> if exudate present <strong>Inadine</strong> if no exudate</td>
</tr>
<tr>
<td>Tracheostomy Site</td>
<td>Once the exposed edges of a permanent/long term tracheostomy site are ‘healed’ it should be carefully cleaned daily as part of normal hygiene of the stoma.</td>
<td><strong>Prontosan Soaks</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>15 minutes, twice daily around stoma.</td>
</tr>
</tbody>
</table>

Aseptic non-touch technique (ANTT) must be adhered to when undertaking wound or invasive device site care. Refer to Aseptic Technique (ANTT), including wound care, Policy.
APPENDIX H  MRSA Risk Reduction Measures for ADULT patients not known to be MRSA Positive

All adult patients admitted to UHS, who are not known to be MRSA positive, (except those listed in identified exception categories within this appendix), should receive once-daily washes using 4% chlorhexidine wash solution (Hibiscrub®). This should be used as a liquid soap and should be applied directly to wetted skin. This should also be used as a shampoo during showers or bathing.

This must be commenced within 12 hours of admission, following MRSA screen, and continue daily for 5 days, or until the patient is discharged (if they are an inpatient for less than 5 days).

NOTE: Nasal Mupirocin is NOT required for risk reduction measures.

Guidance for patients with active skin disease /chlorhexidine allergy:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1. Patients with active skin disease (e.g. eczema, psoriasis) | 1. Cautious trial with Chlorhexidine gluconate (Hibiscrub®)  
2. If reaction to 4% chlorhexidine, try Dermol 500®  
3. If reaction to Dermol 500, try Octenisan®.  
Seek dermatology advice if further reaction/problems. |
| 2. Patients with a documented chlorhexidine allergy (diagnosis by allergy team or dermatology) | Use Octenisan as an alternative to 4% chlorhexidine wash solution (Hibiscrub®). |

Additional risk reduction measures should also be implemented for patients admitted with chronic wounds or indwelling devices etc (see Appendix G and J).

Information to Patients

If patients are performing their own personal hygiene, they should be asked to use the product like shower gel or liquid soap and an information leaflet provided (Appendix L). They should apply it to wet skin, ensure all parts of their body are covered and rinse thoroughly. They should also use the product to wash their hair if possible. They should be informed to report any skin dryness or irritation to nursing staff.

Action if Skin Dryness or Irritation Occurs

If significant skin dryness develops during use of 4% chlorhexidine (Hibiscrub®), consider the use of a moisturising cream compatible with chlorhexidine such as Diprobase®. If significant skin irritation develops during use of 4% chlorhexidine, the product should be stopped and Octenisan® used instead. If irritation is severe all products should be stopped, and medical staff should be asked to discuss with the dermatology/allergy teams and possible use of topical steroid agents should be discussed with the clinical pharmacist, who will advise on the most appropriate agent to use.
Action to take following receipt of MRSA admission screening result after admission.

**Patients found to be newly MRSA positive** should commence a topical decolonisation regime for MRSA eradication using Chlorhexidine 4% body washes (Hibiscrub®) for a further 5 days and nasal mupirocin (see Appendix F).

In addition, patients who are newly confirmed to be MRSA positive in the following sites will need additional specific measures:

- Chronic wounds including leg ulcers
- Peg sites
- Tracheostomy sites
- Other long term device insertion sites

Specific measures to reduce colonisation of these risk sites should be considered, as detailed in Appendix G.

**Patients found to be MRSA negative** should continue with the routine risk reduction washes using Chlorhexidine 4% wash solution (Hibiscrub®) until the 5 day course is complete, or until the patient is discharged (if they are an inpatient for less than 5 days).
APPENDIX  I  Risk Reduction Measures for ADULT patients, not known to be MRSA positive, being admitted for Planned Surgery or Interventional procedures

Patients attending pre-assessment:
All pre-assessed patients will be instructed to have 3 days of 4% chlorhexidine pre-operative washes (one of which will be on the day of surgery and will include a hair wash) and 2 days of post-operative washes. If they are discharged before this time they can stop the washes.

Patients who do not attend pre-assessment
- Patients who do not attend pre-assessment should be advised to have a shower or a bath at home either the night before, or on the day of, surgery, preferably with an anti-microbial wash solution. This advice should be incorporated into their routine admission information and a wash solution provided at their outpatient appointment where possible.
- MRSA risk reduction measures, using 4% chlorhexidine wash solution, should be commenced on admission, following MRSA screen, and continue for 5 days or until discharged (if inpatient for less that 5 days).
- If found to be newly MRSA positive action must be taken as detailed above.

In addition, Radiology guidelines relating to specific interventional procedures should also be followed, as advised by Radiology.

Exclusions include all groups listed in the exclusion criteria for MRSA Screening in Appendix D & E.

Patients who are Regular Attenders as Day Cases/attendees
- Routine MRSA risk reduction measures do not routinely have to be implemented for those patients attending hospital as regular day attenders to undergo a course of treatment over a period of time. However, measures to reduce the risk of cross-infection in patients with chronic wounds and invasive device insertion sites should be considered if appropriate, as detailed in Appendix G.
- Patients should be educated regarding the importance of good daily personal hygiene, including hand hygiene, and staff caring for them must maintain a high level of standard precautions.

Risk reduction measures in Obstetrics
Refer to guidelines for MRSA screening, risk reduction and decolonisation within Maternity services
Management of Wounds & Invasive Device Insertion Sites.

Wounds and insertion sites for invasive devices such as PEG tubes and Suprapubic catheters can provide a focus for infection.

Additional risk reduction measures should also be implemented for patients admitted with chronic wounds or indwelling devices etc (see Appendix G).

Measures to reduce the risk of cross-infection in patients with wounds and invasive device insertion sites should be considered for any patient admitted to UHS.

Additional Risk reduction measures for inpatients that require Surgical or Interventional procedures.

In-patients who subsequently require surgical or interventional procedures during their hospital stay should have a wash/shower on the day of, surgery with 4% chlorhexidine.

In addition, Radiology guidelines relating to specific interventional procedures should also be followed, as advised by Radiology.
APPENDIX K  Prevention and Management of MRSA in very high-risk units:

Additional requirements

Units that fall into the category ‘very high risk’ category are:

<table>
<thead>
<tr>
<th>Adults:</th>
<th>Paediatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>General ICU</td>
<td>PICU</td>
</tr>
<tr>
<td>Cardiothoracic ICU</td>
<td>PHDU</td>
</tr>
<tr>
<td>Neuro ICU/HDU</td>
<td>E1 HDU</td>
</tr>
<tr>
<td>Medical /Respiratory HDU</td>
<td></td>
</tr>
<tr>
<td>Surgical HDU</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic HDU</td>
<td></td>
</tr>
<tr>
<td>Vascular surgery</td>
<td></td>
</tr>
</tbody>
</table>

In very high-risk units caring for adult and paediatric patients the following routine measures will apply:

- All patients will be screened for MRSA on admission to the unit
- For the first 5 days of admission all patients will receive topical agents to reduce the bioburden regardless of MRSA status: see Appendix F (Adults) and Appendix P (Paediatrics). This must be prescribed on the drug chart.
- If the patient is discharged to a ward, or transferred to another very high-risk unit within the first 5 days, the course of topical therapy must be completed in the receiving area.
- When a patient transfers from one very high-risk unit to another, the 5-day course should continue, rather than being restarted from day 1. If a 5-day course has already been completed, the receiving unit should NOT commence a second course.
- Weekly surveillance screening will be performed on all patients not already known to be MRSA positive
- Bio-patch, or equivalent, should be considered for use on all CVC device insertion sites in patients who are MRSA positive

Strict implementation of Standard Infection Control Precautions for all visitors to the unit including strict reinforcement of hand hygiene for visiting medical team and allied health professionals.
Reducing the Risk of MRSA Infection: Information for Patients
(Version 3)

Washing with a liquid soap containing a skin disinfectant.
Many germs can live on the skin of healthy people, including MRSA. Usually they do not cause any problem, but if they get into a wound or the blood they can cause infection.

To reduce the risk of MRSA infection, you will be given a special liquid soap, containing a skin disinfectant, to use for personal use when you are admitted to hospital.

This soap reduces the risk of MRSA infection, and should be used for the first five days of your hospital stay. If you are having a surgical procedure or intervention, you may be asked to use the soap two to three days before your hospital admission and for two to three days after the procedure.

You do not have to continue using the liquid soap at home if you are discharged before completion of the 5 days of washes.

For the soap to be effective you must:
- Use it every day for five days while you are in hospital
- wet the skin and apply directly onto your skin using a clean wet cloth or hands (like shower gel)
- wash from head to toe, avoiding your eyes
- wash your hair with the soap at least twice during the five days
- pay particular attention to folds of the skin, e.g. under the arms and between the legs
- leave the soap on your skin/hair for 1 minute before rinsing off from head to toe.

Following these instructions will help stop any harmful germs settling on your skin, which could cause an infection.

If you would like more information or require assistance using the skin disinfectant, please ask the nurse or doctor looking after you.
APPENDIX M

MRSA Screening and Risk Reduction Measures for Patients Not Known to be MRSA Positive

**Types of admission**
- **Elective**
  - Patient has been preassessed?
    - Yes
    - Preassessment screen valid for 18 weeks
    - Patient to commence risk reduction measures 2 days before admission, then day of admission and 2 days after admission (5 days total). Stop on discharge if inpatient for less than 2 days.
    - MRSA screen to be completed within 12 hours of admission and before commencing risk reduction measures.
    - Document the date the screen was undertaken and the sites screened in patients notes.
    - Commence 5 days of risk reduction measures within 12 hours of admission.
    - Stop on discharge if inpatient for less than 5 days.
    - Document when washes have been administered.
    - NB: Nasal Mupirocin is not required for risk reduction measures.

- **Emergency**
  - MRSA screen to be completed within 12 hours of admission and before commencing risk reduction measures.
  - Document the date the screen was undertaken and the sites screened in patients notes.

**Screening Specimens;**
- Nose
- Groin
- Skin lesions and/or wounds
- Insertion sites for devices in-situ at time of screening
- CSU (if catheter in-situ)

**Additional screening following admission**
3. **Very high risk units** (incl. Vascular Surgery, Bone Marrow Transplant, Intestinal Failure Unit) – all patients not known to be MRSA positive must be screened weekly until discharge.
4. **All other areas** - those patients who remain inpatients for over 14 days should be screened every two weeks until discharged.

**Additional Risk Reduction Measures**
Chronic wounds such as leg ulcers, PEG sites, suprapubic catheter sites & similarly inserted devices, tracheostomy sites, IV device insertion sites should be reviewed on admission and an appropriate dressing selected. Refer to Appendix G in MRSA Policy for further detail.

**Surgical/Interventional Procedures on Inpatients**
Inpatients who subsequently require surgical or interventional procedures during their hospital stay should be screened for MRSA 48hrs before their procedure and have a wash/shower on the day of surgery with 4% chlorhexidine (refer to appendix H for guidance for patients with chlorhexidine allergy/ active skin disease)

**Patients found to be MRSA positive**
Should commence a topical decolonisation regime for MRSA eradication using Chlorhexidine 4% body wash (Hibiscrub) for a further 5 days & Nasal Mupirocin (see Appendix F in MRSA Policy)

**All patients found to be MRSA positive must be isolated as per UHS Isolation of Adult Patients with Infectious Conditions Policy (except CMH, Medicine Care Groups, Stroke Unit and Day Units – see Appendix O)**
APPENDIX N

MRSA Clearance

Clearance of MRSA will be considered by the UHS Infection Control Doctor (ICD) on a case by case basis. This is a subjective assessment of risk.

1. Clearance will not be considered for patients with a positive MRSA screen at any site within the last 6 months

2. For patients whose last positive MRSA screen was >6 months ago, MRSA clearance will be considered if a series of negative full MRSA screens are available at least 6 days apart and off antibiotics active against MRSA

<table>
<thead>
<tr>
<th>Positive site</th>
<th>Number of full negative screens required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nose</td>
<td>3</td>
</tr>
<tr>
<td>Groin</td>
<td>3</td>
</tr>
<tr>
<td>Healed wound/skin break</td>
<td>3</td>
</tr>
<tr>
<td>Urine (no catheter present)</td>
<td>3</td>
</tr>
<tr>
<td>Urine (catheter present)</td>
<td>5</td>
</tr>
<tr>
<td>Unhealed wound/skin break</td>
<td>5</td>
</tr>
<tr>
<td>Sputum/throat</td>
<td>5</td>
</tr>
<tr>
<td>Deep site</td>
<td>d/w ICD</td>
</tr>
</tbody>
</table>

If you feel that a patient meets the above clearance criteria you should contact the Infection Prevention Team (IPT) to discuss this. The patient should continue to be treated as MRSA positive until you have confirmation from the IPT that the patient has been cleared and the MRSA alert removed from e-camis.

Antibiotics active against MRSA:

- Vancomycin
- Chloramphenicol
- Doxycycline
- Teicoplanin
- Trimethoprim
- Daptomycin
- Linezolid
APPENDIX O

Guideline on Isolation and Infection Control Precautions for patients with MRSA in

- Emergency Medicine, Specialist Medicine & Medicine for Older People Care Groups
- F8 Stroke Unit
- Countess Mountbatten House

Introduction
Identification, treatment and management of individuals carrying MRSA using interventions such as screening, MRSA suppression/decolonisation regimes, patient isolation and giving appropriate antimicrobial prophylactic regimes can reduce the risk of MRSA infection, including MRSA bloodstream infection, and MRSA transmission between patients.

National MRSA Working Party Guidelines for the control and prevention of MRSA (2006), advocate management of patients in accordance with type of facility, facilities available and associated level of risk. These guidelines consider the impact of MRSA in areas such as the Stroke Unit, to be of a medium category, recommending that control measures should be determined locally by risk assessment in accordance with the MRSA burden and facilities available.

All aspects of the UHS MRSA Policy in relation to the prevention, management and control of MRSA will be adhered on F8 Stroke Unit, Emergency Medicine, Specialist Medicine & Medicine for Older People wards and CMH except the section relating to isolation care. This guideline details the actions required for the isolation of patients colonised or infected with MRSA within these areas.

This guideline focuses on ensuring the appropriate placement, through risk assessment, of those patients colonised/infected with MRSA where the risk of transmission is increased, or those patients who have increased MRSA resistance. This increased risk of transmission may be associated with productive coughs where sputum is MRSA positive, exfoliating or acute skin conditions and multiple wounds/wounds that cannot be covered. Local guidance is needed to maximise the use of single rooms for patients with MRSA, and also other infections such as Clostridium difficile and unexplained diarrhoea.

This Guideline includes:
- Placement of Patients known to be MRSA positive
- Infection Control Precautions for all patients within F8 Stroke Unit, Emergency Medicine, Specialist Medicine & Medicine for Older People wards and CMH

Purpose
The objectives of this guideline is
- To ensure the appropriate placements of patients colonised/infection with MRSA where the risk of transmission is increased.
- To ensure the appropriate placement of patients who have MRSA resistance.
- To prevent transmission of MRSA within F8 Stroke Unit, Emergency Medicine, Specialist Medicine & Medicine for Older People wards and CMH.
Standards to be followed

Patient placement

- Any patient known or found to be MRSA positive must have a risk assessment score undertaken using the MRSA Risk assessment tool.
- MRSA positive patients who score above 1 on the MRSA risk assessment tool require single room isolation and isolation precautions must be implemented as per the Isolation of Adult patients with Infectious conditions Policy.
- MRSA positive patients with a score of 1 do not require isolation and should be cared for with standard infection control precautions (see below)
- The risk assessment score should be reviewed regularly or in the event of the patient’s medical condition/circumstances changing, and the patient placed accordingly.

Infection Control Precautions

A high standard of Infection Control practice must be implemented for all patients within F8 Stroke Unit, Emergency Medicine, Specialist Medicine & Medicine for Older People wards and CMH to minimise the risk of transmission from those patients known to be MRSA positive but also from patients not known to be colonised/infected with MRSA.

- Principles of good practice for all patients should include:
  - Standard infection control precautions for all patients.
  - Wounds and skin lesions should be covered with waterproof dressings where possible, including intravenous devices.
  - Assessment of the location of susceptible patients on the ward.

- High standards of hand decontamination are required to minimise the risk of cross-infection. Alcohol hand gel must be available at every bedside, on note trolleys and at the bay/ward entrance and exit. Hand hygiene must be performed before and after every patient contact.
- High standards of environmental and equipment cleaning are required to minimise the risk of cross-infection.
- Standard Infection Control Precautions must be used for all patients colonised/infected with MRSA as defined in UHS Standard Infection Control Precautions policy.
- For those patients who have a risk assessment score above 1, contact infection control precautions should be implemented in accordance with UHS Isolation of Adult patients with Infectious Conditions Policy.

For patients in isolation the principles of isolation care must be followed according to the UHS Isolation of Adult Patients with Infectious Conditions Policy
**MRSA Risk Assessment Tool**

This tool should be used to determine where to place MRSA colonised or infected patients and those patients at. It should be used in place of the UHS Isolation of Adult Patients with Infectious Conditions Policy to risk assess the location of patients in Medicine/Medicine for Older People Care Groups, at Countess Mountbatten House and on the Stroke Unit.

<table>
<thead>
<tr>
<th>Patient Details or Addressograph</th>
<th>Date: ..........................................................</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk Assessment Undertaken by: ..............................</td>
</tr>
<tr>
<td></td>
<td>Signature: ..................................................................</td>
</tr>
</tbody>
</table>

**NB:** Select the highest applicable score for the patient – you do not need to select every criterion that applies & then total the scores.

**CIRCLE Isolation Priority Selected**

1 = Isolation Not Required  
2 = Single Room Isolation  
3 = IDU

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>ISOLATION PRIORITY</th>
<th>PRECAUTIONS</th>
<th>LENGTH OF ISOLATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MRSA POSITIVE (STRAINS 15 &amp; 16)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| MRSA in Spumt & patient has a productive cough | 2 | Isolation required  
Contact precautions | Review when patient no longer has a productive cough |
| Exfoliating skin condition e.g. eczema, dermatitis, psoriasis | 2 | Isolation required  
Contact precautions | Dependent on skin condition |
| Acute skin conditions e.g. Cellulitis | 2 | Isolation required  
Contact precautions | Review when skin condition has resolved |
| Wounds &/or skin lesions that cannot be covered by a waterproof dressing | 2 | Isolation required  
Contact precautions | Review when wounds &/or skin lesions have healed or can be covered by a waterproof dressing |
| Any MRSA infection confirmed by a clinician e.g. MRSA bacteraemia | 2 | Isolation required  
Contact precautions | Continuous unless advised otherwise by the Infection Prevention Team (IPT) |
| MRSA positive in any site, requiring high level of nursing intervention/care e.g. patient highly dependent with care needs or high acuity. | 2 | Isolation required  
Contact precautions | Review if dependency/acuity of the patient changes |
| **OTHER e.g. Nose, Groin, Urine** | 1 | Isolation NOT required  
Standard Precautions | Review regularly – if any of the other conditions listed develop, will then require isolation |
| **MRSA POSITIVE (STRAIN 17 & ANY MRSA with high level mupirocin (Bactroban®) resistance)** | | | |
| MRSA in Spumt & patient has a productive cough | 3 | IDU Isolation required  
Contact precautions | Continuous unless advised otherwise by the Infection Prevention Team (IPT) |
| Exfoliating skin condition e.g. eczema, dermatitis, psoriasis | 3 | IDU Isolation required  
Contact precautions | Continuous unless advised otherwise by the Infection Prevention Team (IPT) |
| **OTHER** | 2 | Isolation required  
Contact precautions | Continuous unless advised otherwise by the Infection Prevention Team (IPT) |
| **Panton-Valentine Leukocidin (PVL) Producing Strains of MRSA** | | | |
| Present in Spumt & patient has a productive cough | 3 | IDU Isolation required  
Contact precautions | Continuous unless advised otherwise by the Infection Prevention Team (IPT) |
| Multiple wounds/abscesses | 3 | IDU Isolation required  
Contact precautions | Continuous unless advised otherwise by the Infection Prevention Team (IPT) |
| Exfoliating skin condition e.g. eczema, dermatitis, psoriasis | 3 | IDU Isolation required  
Contact precautions | Continuous unless advised otherwise by the Infection Prevention Team (IPT) |
| **OTHER** | 2 | Isolation required  
Contact precautions | Continuous unless advised otherwise by the Infection Prevention Team (IPT) |

**REVIEW**

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Score</th>
<th>Isolation Priority</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Appendix P       Guidelines on the Prevention & management of MRSA in Paediatric and Neonatal Patients.

1.1 Scope and Purpose
This guidance details the specific standards required for the detection and management of MRSA in UHS in order to protect paediatric and neonatal patients from infection or colonisation with MRSA, prevent the transmission of MRSA and to safely manage and treat patients who are colonised with MRSA and includes:

- The detection of MRSA by screening paediatric patients
- Actions to be taken when admitting children 17 or under who have or may have MRSA.
- Appropriate placement of children 17 or under with MRSA
- Decolonisation of children 17 or under with MRSA
- Actions required to reduce the risk of infection in children 17 or under who are already colonised with MRSA
- Actions that should be taken to ensure safe, appropriate treatment of MRSA infection
- Risk reduction measures required to reduce the risk of MRSA acquisition and infection in children 17 or under not known to be MRSA positive.
- Communication and patient/parent information.

1.2 Definitions

High risk paediatric patients: includes all patients admitted to PICU, PHDU and E1 HDU, all patients transferred from another hospital and those patients deemed high risk due to their surgical treatment e.g. cardiac or spinal surgery or procedure as per consultant agreement.

High risk units: PICU, PHDU and E1 HDU.

2. MRSA Screening, Decolonisation and Risk reduction

2.1 MRSA Screening

- All paediatric and neonatal patients admitted to UHS (elective and emergency admissions) except for agreed exceptions, are to be screened for MRSA on admission or as part of pre-assessment procedures prior to admission. Children attending Bursledon House will only be screened for clinical reasons. See Appendix P(ii) and P(v)
- Children aged 17 and younger will be screened for MRSA in order to improve patient safety, for the following reasons:
  - Patients found to be positive can be managed to minimise the risk of MRSA infection during their treatment. This may require different antimicrobial prescribing, topical decolonisation prior to a procedure, or other measures.
  - To protect other patients from the risk of colonisation or infection with MRSA during their treatment.
- Additional MRSA screening following admission to UHS will be undertaken as detailed in Appendix P(iii).
- Refer to Appendix C for paediatrics and P(iv) for NNU, for MRSA screening specimen requirements.
Agreed exclusions for MRSA screening of elective and day case admissions within UHS are listed in Appendix P(v).

2.2 MRSA Topical Decolonisation of positive paediatric patients

- All paediatric or neonatal patients known or found to be MRSA positive will receive a 5-day course of topical decolonisation in an attempt to eradicate MRSA, and reduce the subsequent risk of infection, unless this is contra-indicated or there are clinical reasons why this is not appropriate. In these circumstances the reason for not decolonising the patient must be documented. See Appendix P(vi) and P(vii) for details of topical decolonisation.

- Successful decolonisation is unlikely in patients with chronic wounds, permanent tracheostomy, and long-term indwelling devices. Where these risk-factors for long-term carriage are present the patient should be managed as listed immediately below.

- If it is impossible to clear a patient of MRSA prior to the admission for surgery, if they have already had multiple (three) decolonisation attempts previously, or if they have other factors which make successful decolonisation unlikely, bio-burden reduction should be commenced 48 hours pre-operatively in order to reduce the level of MRSA at the time of the procedure, see Appendix P(vi). Additional measures for management of chronic wounds etc. should also be taken if applicable (see Appendix G). These patients must be admitted and managed as MRSA positive.

2.3 MRSA Clearance

- Clearance of MRSA will be considered by the UHS Infection Control Doctor (ICD) on a case by case basis. This is a subjective assessment of risk and will be determined on an individual patient basis. Refer to Appendix L for clearance criteria.

- Clearance is unlikely in patients with risk factors for long term carriage e.g. chronic wounds, permanent tracheostomy, long-term indwelling devices and skin shedders.

- Patient’s should continue to be treated as MRSA positive until there is confirmation from the Infection Prevention Team that the patient has been cleared and the MRSA alert removed from e-camis.

2.4 MRSA risk reduction measures for patients not known to be MRSA positive - specific groups

To reduce the risk of MRSA colonisation and infection, specific patient groups specified within the policy not known to be MRSA positive, will receive routine washes for 5 days containing a skin disinfectant on admission.
Ensure routine risk reduction measures of Octenisan washes are implemented on admission for specific patients including:

- All admissions to very high risk units PICU, PHDU and E1 HDU. Refer to Appendix P(viii)
- All transfers from other hospitals See Appendix P(viii)
- Patients having spinal or cardiac surgery and those having specialist surgery as requested by consultant team on a case by case basis. Refer to Appendix P(ix)
- Some oncology patients as requested by consultant team on a case by case basis.

Additional risk reduction measures will be considered for patients admitted with chronic wounds or indwelling devices. See Appendix G and P(x)

Additional risk reduction measures will be considered for inpatients that subsequently require surgical or interventional procedures during their hospital stay. See Appendix P(x).

See Flow Chart in Appendix P(xi) for MRSA Screening and risk reduction measures for patients not known to be MRSA positive.

3. Isolation Care & Precautions

- All patients with MRSA will be managed with standard infection control precautions. In addition; contact precautions will be implemented in all wards and departments, as defined in UHS Paediatric Isolation Policy, unless stated otherwise in local policy and approved by the Infection Prevention Team.
- An isolation risk assessment must be performed for all MRSA positive patients, as per the UHS Paediatric Isolation Policy and this must be recorded in the clinical notes.
- Single room isolation will be implemented for all patients in accordance with the isolation risk score, unless stated otherwise in local policy and approved by the Infection Prevention Team. Approved exceptions include Bursledon House and Day units.
- Where single room isolation cannot be achieved, the escalation process must be followed as defined in the UHS Paediatric Isolation Policy.
- All patients in isolation must not visit communal areas like play rooms and classrooms. If clinically well they can leave the ward and go outside or use the corridor areas away from other patients. Long stay patients or frequent re-admissions, with several negative screens can be discussed with the IP team on a case by case basis to risk assess use of communal areas. Guidance on clearance/de-alerting of patient guidance can be found in Appendix L.
- See Play equipment, decontamination and maintenance policy for advice re the use of communal toys and those in isolation.

See Appendix P(xiii) for further details on isolation and precautions required.

For information on transferring patients for Diagnostic Investigations and Treatment in other Departments refer to section 5.8 in MRSA policy.

4. Prevention and Management of MRSA in high-risk units.

- Identified Paediatric high risk units within UHS include, but are not limited to, all children on PICU, PHDU and E1 HDU.
- Babies in the NNU will be reviewed on a case by case basis.
- All patients will be screened for MRSA on admission to these identified high risk units and weekly surveillance screening will be performed on all patients not already known to be MRSA positive.
Additional routine measures in paediatric high-risk units will be implemented including administration of Octenisan for bio-burden reduction regardless of MRSA status.

Further detail is provided in Appendix P(xii)


5.1 Documentation
- The MRSA status of all patients must be accurately recorded in medical and nursing notes, including information on risk reduction measures, topical decolonisation therapy and specimen results. This is the responsibility of the medical and nursing teams caring for the patient, and is essential to ensure safe, effective care.
- All patients found to be MRSA positive will be alerted on the e-camis system (also visible on e-quest) by the Infection Prevention Team, and the notes flagged via use of a red alert sticker on the outside of the notes and a yellow MRSA sticker inside the front cover. This will allow staff to identify patients known to be MRSA positive. Responsibility for checking this rests with medical and nursing staff who admit the patient. Areas who decant medical/nursing notes into dedicated folders for the current admission must ensure that an alert sticker is also placed with the decanted notes.

5.2 Communication, Parent and Patient Information
- Parents, patients and visitors must be provided with accurate information on MRSA. This is the responsibility of the medical and nursing team admitting or providing care for the patient. This includes information on the risk of infection during procedures, risk reduction measures, and information relating to those found to be positive on their management.
- Every parent of a child who has MRSA, or the teenager themselves, (or child where appropriate) must be given a Trust Paediatric or NNU MRSA leaflet. Information leaflets are available on the public website of the Trust.
- Parents, relatives and visitors must be advised of the precautions required when visiting a patient with MRSA e.g. hand hygiene and wearing of personal protective equipment if contributing to patient care. Parents caring for children with MRSA are not required to wear protective clothing like gloves and apron unless recommended by the Infection Prevention Team in unusual circumstances.
- Parents with siblings in hospital will be advised to visit the non-colonised/infected baby/child first before visiting the one with MRSA. Thorough hand hygiene will be required between visits. IP team and nursing staff will provide advice and support on a case by case basis.
- Siblings who wish to visit should be risk assessed prior to visit to review any health issues they may have. A well sibling can visit but must be assisted with thorough hand hygiene after the visit. If there are any concerns please speak to IP team or clinical staff.
- Breast feeding should continue. The mother should ensure the skin around the nipple area is not broken or damaged. Any problems should be reported promptly to clinical staff.
- Accurate information on MRSA status must be recorded and communicated to other wards and departments within UHS in order to facilitate safe care.
- Accurate information on MRSA status including information on topical decolonisation and specimen results, must be recorded and communicated to staff in primary and community care upon transfer to another organisation or discharge home. Information must be recorded on the patient’s discharge summary and other transfer of care documents.
- Ensure that the Parent Contract is discussed when children are admitted to high risk units. The Parent Contract is a document which outlines the expectations staff have of parents to
ensure infection prevention issues etc are addressed e.g. the number of toys and other related equipment that can be brought into the ward.

6. Action to take if a parent or patient refuses MRSA Screening, Decolonisation or risk reduction Measures.

If a parent or patient refuses to be screened for MRSA or refuses decolonisation/ risk reduction measures the following action should be taken:

▪ A clear explanation must be provided to the parents and/or the patient explaining the rationale for the screening/decolonisation/risk reduction measures.

▪ The potential risks of not undertaking these measures must be explained to the parents and/or the patient so that they understand the potential consequences of not undertaking these actions.

▪ This should extend to an explanation of the need for specific measures when a patient is MRSA positive, for example a patient with MRSA who refuses to have hair clipped off to facilitate effective skin disinfection for internal central venous catheter insertion should have the increased risk of infection explained to them, and this must be documented.

▪ The parents and/or the patient’s refusal and discussions related to the above must be clearly documented in the medical notes.

▪ The patient’s Medical Consultant must be informed of the parents and/or patient’s decisions.
APPENDIX P(i) Southampton Childrens Hospital MRSA Guidelines - Flowchart

PRINCIPLES

AVOIDING SPREAD TO OTHERS

- Screening of all paediatric and neonatal patients admitted to UHS (see Appendix Pii).
  - Elective patients should be screened in pre-assessment clinics if possible.
  - Day case children in general do not require MRSA screening. See Appendix P(v)

Minimal sample set include nose and groin swabs.

If applicable, the following samples should also be taken:
- all skin lesions/wounds, device insertion sites (tracheostomy, gastrostomy, IV insertion sites), CSU if urinary catheter in situ, umbilical swab if < month of age and any other previously +ve sites (see Appendix C)

MRSA screening should be repeated every 2 weeks OR weekly if in high risk area: PICU/PHDU/E1 HDU

If subsequently transferred to another care group or high risk area, screening needs to be repeated on transfer, unless performed in the 48 hours prior to transfer (see Appendix Piii)

AVOIDING MRSA INFECTION IN CHILDREN COLONISED WITH MRSA

- Children known to have MRSA should be isolated as per the UHS paediatric isolation policy (see Appendix M).
  - MRSA clearance will not be considered for any child with a positive MRSA screen in the previous 6 months (see Appendix N)

All children known to have MRSA should be decolonised with mupirocin tds and octenisan od for 5 days unless contraindicated see Appendix P(vi) & P(vii)

Written parent/patient information should be provided about MRSA

HIGH RISK AREA AND HIGH RISK PROCEDURES

- All children, not known to be MRSA Positive, admitted to high risk areas: PICU/PHDU/E1 HDU or undergoing high risk procedures: scoliosis surgery, VP shunt insertion, vagal nerve stimulator insertion, sternotomy, should commence risk reduction washes with 5 days Octenisan.
  - Refer to Appendices P(viii) and P(ix)

All unplanned surgical or interventional procedure during admission, MRSA screen should be repeated 48 hours prior to procedure to allow decolonisation to be commenced prior to the procedure if required.
Appendix P(ii) MRSA Screening of PAEDIATRIC Emergency & Planned (Elective) Admissions

All paediatric patients will be screened for MRSA on admission, or as part of routine pre-assessment procedures prior to admission, with the exception of some day cases

### Screening of Paediatric Emergency admissions

**All paediatric patients** admitted as emergencies to UHS must be screened on admission to hospital. These patients require one screen for MRSA on admission (see Appendix C for screening specimen requirements for paediatrics and appendix P(iv) for NNU)

**Exclusions:**
- Accident & Emergency - Excluded as patients not ‘admitted’
- PAU (only need screening if the patient is admitted – the admitting ward to screen)
- JADW only screen if patient stays overnight or has chronic condition and attends regularly in which case screen monthly.
- Children admitted to Bursledon House

### Screening of Paediatric planned/elective admissions

- Some patients who are planned/elective admissions, including a few day cases, require 1 screen for MRSA, either prior to an elective admission (see below), or on admission to UHS. More detailed guidance for specific specialities and exceptions is detailed within Appendix P(V) and P(ix)
- **Pre-Admission Elective Screening:** Paediatric patients requiring elective admission may be screened for MRSA (see below for screening requirements relating to day cases)
- Screening should take place in pre-assessment clinics whenever possible and should be included as part of routine pre-assessment procedures.
- Pre-assessment clinics must ensure there are clear arrangements for checking, documenting and acting upon the results of screening. This is the responsibility of Divisional Management Teams.
- Laboratory request forms should be completed and clinical details should clearly state ‘Pre-Admission Screen prior to X’ (X = the type of surgery).
- If a patient is found to be MRSA positive at pre-assessment the following actions must be performed:
  - Parents, patient where appropriate, and GP should be notified by the pre-assessment clinic following review of the results by clinic staff
  - The notes should be marked and the e-camis alerted. The patient must also be informed by the department who sent the screen to the laboratory and a patient information leaflet provided.
  - An attempt should be made to decolonise the patient. See Appendix P(vii)

Elective admissions, who do not attend pre-assessment, should be screened on admission to hospital.

### Screening of patients who are Regular Attendees as Day Cases/attendees

Those patients attending hospital as regular attenders to undergo a course of treatment over a period of time should be screened at the beginning of their treatment and then at monthly intervals (or at the next attendance if this is more than four weeks from the previous attendance) whilst they are undergoing their treatment, unless otherwise defined in local guidance and agreed with the Infection Prevention Team/Infection Control Doctor.

Examples include but are not exclusive to, oncology patients attending for chemotherapy, and patients in the Haemodialysis Unit.
**Paediatric Cardiac Admissions**
Patients will be seen in Surgical OPD and screened at this clinic visit

- Elective patients who are MRSA positive should have their admission cancelled until they have received treatment and are clear of MRSA, unless there is a significant clinical need.
- First screen of patients should be requested as ‘Staph aureus’ screen for nose and MRSA screen for groin and any other sites.
- Second screening or screening after admission should be requested as ‘MRSA screen’ (unless there are signs of infection, in which case MC&S should be requested.)
- The following swabs should be taken
  - Nose, groin, umbilicus, lines sites, wounds, sputum and CSU.
  - Throat swab if previous MRSA in sputum but now non-productive
  - MSU if previous MRSA in CSU but now no longer catheterised.

**Screening of Pre-Admission Urgent Transfers**

- Patients requiring urgent transfer to UHS from other centres should be screened as soon as the decision to transfer is made, and risk reduction measures, Octenisan washes and nasal mupirocin, commenced as per this policy. Results of the screen should be communicated to the receiving unit at UHS prior to transfer. This will allow the appropriate prioritisation of single rooms within that unit and priority can be given to patients already known to be MRSA positive on transfer.
- Receiving units within UHS should ask for this information prior to transfer. Transfer must not be delayed if the results of this screening are unavailable. It should be noted that the purpose of this screening is to assist with identification of positive patients rather than to identify those who are negative.
- Patients who are urgent transfers should still be screened on admission to UHS even if they have been screened prior to transfer, and risk reduction / decolonisation measures should be continued / implemented according to this policy.
- Patients transferred from other hospitals should be isolated in single rooms until screening results are available. If there are inadequate cubicles the Paediatric Cubicle Prioritisation Policy must be followed and incident reporting completed. If this is not possible they must be nursed in a bay with contact precautions until screening results are known. Once results are available the patients will either be managed as MRSA positive or negative, as per this policy.
APPENDIX P(iii) Additional MRSA Screening of PAEDIATRICS following admission

1. Screening on transfer between units/Care Groups within UHS:

**Admissions to High Risk Units**
All patients admitted to identified **high-risk units** within UHS will be screened for MRSA, in line with national guidance (DH Saving Lives 2006). This includes, but is not limited to PICU, PHDU and E1 high care. See Appendix L Prevention and Management of MRSA in high-risk units.

**Transfers between different care groups within UHS.**
Patients known to be MRSA positive who are transferred between different care groups within UHS must be managed in accordance with the UHS Paediatric Isolation Policy.

Where patients, who are not known to be MRSA positive, are transferred between different care groups within UHS e.g. NNU to PICU, the following measures must be taken:
- Screen on arrival
- Commence or re-commence MRSA risk reduction measures for 5 days - Octenisan washes (unless within 5 days of admission and original risk reduction measures are still ongoing). This will be prescribed on a case by case basis.
- Implement contact precautions until results of the screen are known

Once results are available the patients will either be managed as MRSA positive or negative, as per this policy

*If the patient has been screened within the previous 48 hours, a screen on transfer is not required.*

2. Routine monitoring for MRSA throughout admission.

**Routine screening in identified high-risk areas.**
- All patients not known to be MRSA positive in identified high-risk units will be screened weekly for MRSA acquisition, in line with national guidance (DH Saving Lives 2006). This includes, but is not limited to; PICU, PHDU, E1 HDU. Each of these patients will have a weekly screen, to include nose, groin, line sites (note: wounds, sputum, and CSU to be sent if clinically indicated for M, C&S). NNU will screen nose or throat, groin and any other sites previously screened using dry blue topped swabs. These swabs to be labelled 'MRSA weekly screening'.

See Appendix P(xii): Prevention and Management of MRSA in high-risk units.

**Routine screening of long-term in-patients in non-high risk areas.**
- Those patients who remain in-patients for over 14 days should be screened every two weeks until discharged.
- Results must be recorded in the notes, and the patient informed if the result is positive.

**Screening of inpatients prior to Surgery/Interventional Procedures**
Inpatients who subsequently require surgical or interventional procedures during their hospital stay should be screened 48 hrs prior to the procedure where possible. Risk reduction washes should be commenced if recommended by consultant team. See Appendix P(ix) and P(x)
3. Contact Screening
- A single contact screen for patients exposed to someone found to have MRSA will be performed in all areas of the hospital, except Burseldon House and Day surgery unit.
- Contact screening will also not be performed in high risk areas who are sending weekly screens already, unless advised by the Infection Prevention Team (i.e. during an outbreak)
- Results must be recorded in the notes, and the parent and patient if appropriate, informed if the result is positive.

4. Routine Screening of Patients known to be MRSA Positive
Routine screening of known MRSA positive patients following admission is not required except:
- For clearance screening (refer to Appendix N)
- Prior to specific events such as surgery or interventional procedures.

Any patient found to be MRSA positive should commence topical decolonisation
Appendix P(iv)  Screening on Neonatal Unit (Princess Anne Hospital).

MRSA Admission screen for ALL patients admitted onto NNU including those from the delivery suite and wards on PAH as well as those transferred from outside PAH and including PICU:

MRSA screening should be performed using Blue topped swab. Swabs should be used dry as per manufacture/s instructions. (They should not be moistened, either in the medium or sterile solutions due to the increased risk of contamination). **Samples must be labelled MRSA SCREEN**

- Anterior nares - the same swab should be used for both nostrils or throat swab.
- Groin - the same swab should be used for both groins or perineal swab.
- Umbilicus

Samples should also be sent for MRSA from the following sites if indicated:
- Endotracheal (ET) secretions if ET tube in place.
- Catheter Specimen of Urine (CSU) if catheterised.
- Wound and skin lesions when dressings removed.
- Manipulated sites e.g. IV lines, tracheostomy, stoma, gastrostomy sites.

**Weekly Screening of NNU Inpatients for MRSA:**

MRSA screening will be performed routinely on a **Friday** on all in-patients on the Neonatal Unit. **Samples must be labelled MRSA SCREEN**

The following swabs should be taken:
- Anterior nares - the same swab should be used for both nostrils and throat swab.
- Groin - the same swab should be used for both groins or perineal swab.
- Repeat swabs of any previous screening undertaken **NB UMBILICUS** need only be rescreened if positive or wet / oozing or catheter in situ

**Admission Screening for other organisms**

**Admission screen for all babies admitted within 24 hours of delivery.**
- Ear swab

Request “MC&S” on the laboratory/e-Quest form. [This sample will pick up MRSA and resistant gram negatives including *Pseudomonas sp.*.](see attachment).

**NB If there are specific concerns that the patient may have signs of sepsis or site specific infection is suspected separate swabs/samples should be sent with a request for “MC&S” on the laboratory/e-Quest form. Discuss with doctor/ ANNP before any swabs are taken.
APPENDIX P(v)
MRSA Screening Exclusions within UHS
Day Case Exclusions who DO NOT require Screening for MRSA

Within elective admissions and attendances the following patient groups do not need to be routinely screened for MRSA:

| Day case and outpatient dermatology | All |
| Day case ophthalmology, | All |
| Day case dental | Patients attending for dental procedures or for biopsy of lesions on the face or in the buccal cavity. |
| Day case Oral Surgery | All |
| Day case Endoscopy | Patients attending for supervised self-administration of antiviral agents. Patients attending for venesection only as an outpatient to Hepatology (Haemochromatosis) |
| Day case Hepatology | Patients attending respiratory centre for admission avoidance. Patients attending the sleep labs overnight. |
| Day case Respiratory medicine | Patients attending for assessment only. No invasive intervention. |
| Day case Neurology: | Patients attending for written or verbal advice or occasional subcut fluids. Patients attending for a range of Subcutaneous or IM injections (e.g. methotrexate/HUMIRA) |
| Day case Urology | Patients undergoing minimally invasive procedures e.g. joint injections, intramuscular injections. |
| Day case Gynaecology | Hysteroscopy cases. Terminations of pregnancy. |
| Day Case Rheumatology | Patients attending for low risk non-invasive / minimally invasive procedures will be considered on a case by case basis. |
| Day Case Nutritional/Gastrointestinal | Patients attending for one off single transfusions of blood products or at ad hoc irregular periods of time. Those attending regularly should be screened monthly. |
| Day case haematology/General Medical Patients | Patients attending for low risk non-invasive / minimally invasive procedures will be considered on a case by case basis. |
| Interventional Radiology | Refer to agreed local guidance. |
| Children attending Burseldon House | Screen only if clinically indicated. |

Refer to Specific Screening guidance for Interventional Radiology.
APPENDIX P(vi)  MRSA Topical decolonisation

All paediatric patients found to be MRSA positive should receive topical decolonisation as an attempt to eradicate MRSA, and reduce the subsequent risk of infection, unless there are contra-indications or clinical reasons why this is not appropriate. In these circumstances the reason for not decolonising the patient must be documented.

Pre-Admission Elective Patients

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

- Parents, patient if appropriate and GP should be notified by the pre-assessment clinic following review of the results by clinic staff
- The notes should be marked and the e-camis system alerted. The parents, patient if appropriate, must also be informed by the department who sent the screen to the laboratory and a patient information leaflet provided.
- An attempt should be made to decolonise the patient. See Appendix P(vi)
- Repeat screening should be performed a minimum of 48 hours after treatment has stopped
- If repeat screening is negative, a minimum of 2 further screens are required before clearance can be considered (see Appendix N for clearance requirements). 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 these risk-factors for long-term carriage are present the patient should be managed as listed immediately below.

If it is impossible to clear a patient of MRSA prior to the admission for surgery, if they have already had multiple (three) decolonisation attempts previously, or if they have other factors which make successful decolonisation unlikely, bioburden reduction should be commenced 2 days pre-operatively and the day of surgery in order to reduce the level of MRSA at the time of the procedure. Additional measures for management of chronic wounds etc. should also be taken if applicable (see Appendix G). These patients must be admitted and managed as MRSA positive.

All other admissions

Patient’s known to be MRSA positive on admission.
An MRSA Decolonisation Regime should be prescribed on admission and commenced within 12 hours of arrival within the unit. Additional measures for management of chronic wounds etc. should also be taken if applicable (see Appendix G)

Patients Found to be MRSA Positive during admission
An MRSA Decolonisation Regime should be prescribed following confirmation of the positive result. Additional measures for management of chronic wounds etc. should also be taken if applicable (see Appendix G)
When topical MRSA decolonisation is performed in an attempt to eradicate MRSA, the nose, skin and hair must all be treated using the following regime:

### MRSA DECOLONISATION REGIMEN

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Product</th>
<th>Directions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily shower / bath / blanket bath</td>
<td>Octenisan®</td>
<td>Apply product directly to wetted skin using a disposable cloth.</td>
<td>For 5 days (longer courses are not more effective)</td>
</tr>
<tr>
<td>Washing hair twice during period</td>
<td>Octenisan®</td>
<td>Wash hair with product in place of shampoo</td>
<td></td>
</tr>
<tr>
<td>Nasal clearance</td>
<td>Mupirocin ointment 2% (Bactroban®)</td>
<td>Applied to nostrils twice a day</td>
<td>For 5 days</td>
</tr>
<tr>
<td>Nasal clearance NNU</td>
<td>Naseptin</td>
<td>Applied to nostrils 4 times a day</td>
<td>For 10 days</td>
</tr>
</tbody>
</table>

**Action to take if MRSA eradication cannot be achieved prior to procedures.**

When eradication of MRSA cannot be achieved, bioburden reduction should be commenced 3 days prior to the interventional procedure or surgery and continued for 2 days after the procedure (total 5 days) using Octenisan washes (one of which will be on the day of intervention/surgery and will include a hair wash) and nasal mupirocin.

### MRSA BIOBURDEN REDUCTION PRIOR TO PROCEDURES

<table>
<thead>
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<td>Applied to nostrils 4 times a day</td>
<td>For 10 days</td>
</tr>
</tbody>
</table>

Prophylactic antimicrobial therapy should also be administered in accordance with Trust antimicrobial guidelines.

In addition, Radiology guidelines relating to specific interventional procedures should also be followed, as advised by Radiology.

**Decolonisation of MRSA positive patients with active skin disease (e.g. eczema, psoriasis)**
• Decolonisation with topical agents alone is likely to be unsuccessful in patients with open skin lesions. Therefore a risk assessment for MRSA bacteraemia or other invasive MRSA infection should be carried out.
• If full decolonisation is advisable (e.g. for those patients at high risk of MRSA bacteraemia/invasive MRSA infection) a combination of topical and systemic treatment is indicated. Paediatric / Neonatologist teams are advised to discuss MRSA sensitivities and systemic antimicrobial treatment with microbiology.
• For low-risk patients, bio-burden reduction with topical agents alone may be appropriate.

| MRSA DECOLONISATION /BIOBURDEN REDUCTION REGIMEN FOR PATIENTS WITH ACTIVE SKIN DISEASE |
|---------------------------------|-------------|-----------------|--------------|
| Procedure                       | Product     | Directions       | Duration     |
| Daily shower / bath / blanket bath | Octenisan®. | Apply product directly to wetted skin using a disposable cloth. | For 5 days (longer courses are not more effective) |
| Wash hair twice during period    | As above    | Wash hair with product in place of shampoo |             |
| Nasal clearance                 | Mupirocin ointment (Bactroban®) | Applied to nostrils twice a day | For 5 days |
| Nasal clearance NNU             | Naseptin    | Applied to nostrils 4 times a day | For 10 days |
APPENDIX  P(vii) Topical decolonisation for eradication of MRSA in the Neonatal Unit

- MRSA decolonisation of neonates should only occur after risk assessment and discussion with the consultant neonatologist, (Paediatric Surgeon, as appropriate) and consultant Microbiologist, Infection Prevention Team, for example there is a need to decolonise a ‘well’ positive neonate if mum is MRSA positive.
- Attempts at eradication of carriage of MRSA, especially at sites other than the nose, may fail.
- A risk assessment should be made in consultation with the Infection Prevention Team (IPT) as to whether the benefits outweigh the risks.
- It may be appropriate to apply the protocol to neonates prior to high risk procedures (e.g. surgery, long term indwelling catheter insertion, tracheostomy) or term babies. This should also be discussed with parents.
- Caution must be undertaken if used in neonates with known allergy. If the neonate has indwelling devices or stomas then application of topical treatment may prove difficult. Unsuccessful decolonisation will still reduce the bio-burden of MRSA, helping to minimise risk of associated problems.
- If systemic treatment is considered then consultation with the Neonatologist, (Consultant Paediatric Surgeon, as appropriate) and the consultant microbiologist must take place.

If is it decided that decolonisation should be attempted, the following treatments are advised:

Nasal:
- Can use Naseptin for <1 year olds for 10 days. If there is a nut allergy use Bactroban for 5 days (no evidence for Bactroban use in <1 year olds).

Skin:
- Neonates should be washed once daily for 5 days with Octenisan irrespective of site of MRSA carriage.

Octenisan is a broad spectrum antimicrobial agent, which is an active biocide at low concentrations. The compound is bactericidal as well as candidicidal and is effective against commensal skin flora. Octenisan is not absorbed via intact or broken skin, or via wounds and mucous membranes.

In view of the absence of percutaneous absorption and good skin compatibility, Octenisan is safe to use on babies and premature neonates. Consultation with the Neonatologists and ICT should occur if there are concerns over the skin integrity of very premature neonates.

Specific directions:
- Neonates should be washed once daily for 5 days as follows
  - Days 1, 3 and 5 wash the whole body, neck, face and hair
  - Days 2 and 4 wash the whole body, neck and face
  - Octenisan should have a contact time of 1 minute

Do not dilute Octenisan in large amounts of water, as the concentration is insufficient. Special attention should be paid to sites such as axillae, groin, perineum and buttock areas or other skin folds. A daily change of bedding / clothing, bonnets etc. is required and should occur at the same time as the neonate is washed with Octenisan solution. In the case of allergic reaction, treatment should be stopped immediately and the Neonatologists and IPT consulted.
APPENDIX P(viii) MRSA Risk Reduction Measures for PAEDIATRIC patients not known to be MRSA Positive

All Paediatric patients admitted to High Risk areas PICU, PHDU and E1 HDU, who are not known to be MRSA positive should receive once-daily washes using Octenisan®. This should be used as a liquid soap and should be applied directly to wetted skin. This should also be used as a shampoo during showers, bathing or washing.

This must be commenced within 12 hours of admission, following MRSA screen, and continue daily for 5 days, or until the patient is discharged (if they are an inpatient for less than 5 days).

NOTE: Nasal Mupirocin is NOT required for risk reduction measures.

Guidance for patients with active skin disease allergy:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients with active skin disease (e.g. eczema, psoriasis)</td>
<td>Octenisan®. Seek dermatology advice if further reaction/problems.</td>
</tr>
<tr>
<td>2. Patients with a documented Chlorhexidine allergy (diagnosis by allergy team or dermatology)</td>
<td>Use Octenisan</td>
</tr>
</tbody>
</table>

Additional risk reduction measures should also be implemented for patients admitted with chronic wounds or indwelling devices etc (see Appendix G).

Information to Patients
If parents or children are performing the personal hygiene, they should be asked to use the product like shower gel or liquid soap. An information leaflet must be provided (Appendix N) They should apply it to wet skin, ensure all parts of their body are covered and rinse thoroughly. They should also use the product to wash the hair if possible. They should be informed to report any skin dryness or irritation to nursing staff.

Action if Skin Dryness or Irritation Occurs
If irritation is severe all products should be stopped, and Paediatric medical staff or neonatologist should be asked to discuss with the dermatology/allergy teams and possible use of topical steroid agents should be discussed with the clinical pharmacist, who will advise on the most appropriate agent to use.
Action to take following receipt of MRSA admission screening result after admission.

Patients found to be newly MRSA positive should commence a topical decolonisation regime for MRSA eradication using Octenisan® body washes for a further 5 days and nasal Mupirocin (see Appendix F).

In addition, patients who are newly confirmed to be MRSA positive in the following sites will need additional specific measures:

- Any wounds
- Peg sites
- Tracheostomy sites
- Other long term device insertion sites

Specific measures to reduce colonisation of these risk sites should be considered, as detailed in Appendix G.

Patients found to be MRSA negative should continue with the routine risk reduction washes using Octenisan washes until the 5 day course is complete, or until the patient is discharged (if they are an in-patient for less than 5 days).
APPENDIX P(ix)  Risk Reduction Measures for patients, not known to be MRSA positive, being admitted for Planned High Risk Surgery or Interventional procedures.

**Babies and children identified as requiring pre-assessment:**
All pre-assessed babies and children will be instructed to have 3 days of Octenisan pre-operative washes (one of which will be on the day of surgery and will include a hair wash) and 2 days of post-operative washes. If they are discharged before this time they can stop the washes.

Some babies and children being admitted for certain cardiac, spinal or other specialist surgery will be screened for MRSA and MSSA. They will be instructed to have 3 days of Octenisan washes and Mupirocin nasal ointment 3 days pre-operatively (one of which will be on the day of surgery and will include a hair wash) and 2 days of post-operative washes.

**Babies and children who do not attend pre-assessment**
- Parents of children who do not attend pre-assessment should be advised to ensure their child has a shower or a bath at home either the night before, or on the day of surgery, preferably with an anti-microbial wash solution. This advice should be incorporated into their routine admission information and Octenisan wash solution provided at their Outpatient Appointment if required.
- MRSA risk reduction measures, using Octenisan wash solution, should be commenced on admission, following MRSA screen, and continue for 5 days or until discharged (if inpatient for less that 5 days) if requested by consultant on a case by case basis
- If found to be newly MRSA positive action must be taken as detailed above.

In addition, Radiology guidelines relating to specific interventional procedures should also be followed, as advised by Radiology.
Exclusions include all groups listed in the exclusion criteria for MRSA Screening in Appendix E.

Patients who are Regular Attenders as Day Cases/attendees

- Routine MRSA risk reduction measures do not routinely have to be implemented for those patients attending hospital as regular day attenders to undergo a course of treatment over a period of time. However, measures to reduce the risk of cross-infection in patients with chronic wounds and invasive device insertion sites should be considered if appropriate, as detailed in Appendix G and P(x).
- Parents and patients where applicable, should be educated regarding the importance of good daily personal hygiene, including hand hygiene, and staff caring for them must maintain a high level of standard precautions.
APPENDIX P(x)  Additional Risk reduction measures for all patients admitted with wounds or invasive devices.

Management of Wounds & Invasive Device Insertion Sites.

Wounds and insertion sites for invasive devices such as gastrostomy sites and suprapubic catheters can provide a focus for infection.

Additional risk reduction measures should also be implemented for patients admitted with chronic wounds or indwelling devices etc (see Appendix G).

Measures to reduce the risk of cross-infection in patients with wounds and invasive device insertion sites should be considered for any patient admitted to UHS.

Additional Risk reduction measures for inpatients that require high risk Surgical or Interventional procedures.

In-patients who subsequently require high risk surgical or interventional procedures during their hospital stay should commence Octenisan washes 48-hours prior to the procedure, or at the earliest opportunity if this is not possible, and continue for 5 days or until discharged (if before completion of the 5 day course).

In addition, Radiology guidelines relating to specific interventional procedures should also be followed, as advised by Radiology.
APPENDIX P(xi)

MRSA Screening and Risk Reduction Measures for PAEDIATRIC Patients Not Known to be MRSA Positive

Emergency admissions to PICU, PHDU, E1 HDU. All transfers from other hospitals

MRSA screen to be completed within 12 hours of admission and before commencing risk reduction measures. Document the date the screen was undertaken and the sites screened in patients notes.

Commence 5 days of risk reduction measures within 12 hours of admission. Stop on discharge if inpatient for less than 5 days. Document when washes have been administered. NB: Nasal Mupirocin is not required for risk reduction measures.

Elective admissions High risk procedures/high risk unit/cardiac, spinal & specialist surgery as requested by the Consultant on a case by case basis

Types of admission

If high risk procedure, Patient to commence 5 days of risk reduction measures with Octenisan washes on admission until 5 days completion

Patient has been preassessed?

Pre-assessment screen valid for 18 weeks Patient to commence risk reduction measures with once daily washes with Octenisan 2 days before admission, then day of admission and 2 days after admission (5 days in total)

If still an inpatient at 14 days, repeat MRSA screen. Rescreen every 14 days thereafter until discharged. Very high risk areas should be undertaking weekly screening. Document the date the screen was undertaken and the sites screened in the patients notes.

Screening Specimens;
- Nose
- Groin
- Skin lesions and/or wounds
- Insertion sites for devices in-situ at time of screening
- CSU (if catheter in-situ)

Additional Risk Reduction Measures
Chronic wounds such as leg ulcers, PEG sites, suprapubic catheter sites & similarly inserted devices, tracheostomy sites, IV device insertion sites should be reviewed on admission and an appropriate dressing selected.

High Risk Surgical/Interventional Procedures on Inpatients
Inpatients who subsequently require high risk surgical or interventional procedures during their hospital stay should commence Octenisan washes 48-hrs prior to the procedure, or at the earliest opportunity if this is not possible, and continue for 5 days or until discharged (if before completion of 5 day course)

Patients found to be MRSA positive
Should commence a topical decolonisation regime for MRSA eradication using Octenisan body wash for a further 5 days & Nasal Mupirocin
All patients found to be MRSA positive must be isolated as per Paediatric Isolation Policy (except Burseldon House and John Atwell Day Unit)
APPENDIX P(xii)  Prevention and Management of MRSA in high risk units:

Additional requirements

Units that fall into the category ‘high risk’ are:

- PICU
- PHDU
- E1 HDU

In high-risk units caring for paediatric patients the following routine measures will apply:

- All patients will be screened for MRSA on admission to the unit
- For the first 5 days of admission all patients will receive Octenisan washes to reduce the bioburden regardless of MRSA status. This must be prescribed on the drug chart.
- If the patient is discharged to a ward, or transferred to another high-risk unit within the first 5 days, the course of topical therapy must be completed in the receiving area.
- When a patient transfers from one high-risk unit to another, the 5-day course should continue, rather than being restarted from day 1. If a 5-day course has already been completed, the receiving unit should NOT commence a second course.
- Weekly surveillance screening will be performed on all patients not already known to be MRSA positive
- Bio-patch should be considered for use on all CVC device insertion sites in patients who are MRSA positive

Strict implementation of Standard Infection Control Precautions for all parents and visitors to the unit including strict reinforcement of hand hygiene for visiting medical teams and allied health professionals.
APPENDIX P(xiii)  Source Isolation and Contact Precautions for MRSA.

Rationale for source isolation
Source isolation refers to the physical isolation of patients with infections, or colonisation with some resistant micro-organisms including MRSA. It indicates that the patient is the “source” of infection. It is designed to prevent the transmission of pathogens from an infected/colonised patient to other patients, hospital personnel and visitors.

Mode of Transmission of MRSA
- **Contact transmission** is the most important and frequent mode of transmission and involves either direct person-to-person contact or indirect contact via a contaminated intermediate object.
- **Droplet transmission** occurs rarely with MRSA. If a patient has MRSA colonisation of their sputum and has a productive cough, droplets are generated mainly during coughing, sneezing or open suction procedures. These droplets are propelled a short distance only; hence special ventilation is not required to prevent transmission. If these patients are nursed in close proximity to other patients, transmission of MRSA may occur.

Isolation Facilities
Source isolation can be achieved by placing patients in:
- **Single rooms**.
- **Cohort**: When single rooms/isolation rooms are not available and where several patients with the same confirmed organism have been identified, these patients may be placed together in a bay/ward: this includes patients with MRSA.

Hand Hygiene
Hand hygiene is essential before and after contact with the patient or their environment, and before and after wearing gloves and other protective clothing. Refer to UHS Hand Hygiene Policy.

Use of Protective Clothing
The use of protective clothing is an important principle of isolation care to prevent transmission of MRSA. Transmission-based precautions, in addition to standard precautions, should be implemented for patients in Source Isolation. The choice and use of protective clothing should be based on how pathogens are spread in order to minimise that spread to both other patients and the healthcare worker, the following is required for MRSA source isolation:

Parents are not required to wear gloves, apron or gown when handling their baby/child unless requested by the Infection Prevention Team in unusual circumstances.

<table>
<thead>
<tr>
<th>MRSA</th>
<th>Gloves</th>
<th>Apron/Gown</th>
<th>Mask and Eye protection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact precautions required</strong></td>
<td>By staff on entering the room if contact with the patient or their environment is anticipated</td>
<td>By staff on entering the room if contact with the patient or their environment is anticipated</td>
<td>Only required as part of standard precautions: during procedures &amp; patient care activities likely to generate splashes or sprays of blood, secretions or excretions.</td>
</tr>
<tr>
<td><strong>Single room</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Contact Precautions

<table>
<thead>
<tr>
<th>Contact precautions required</th>
<th>Bed/cot space</th>
<th>Apron or gown if in contact with the patient or if taking the baby out of the cot in NNU</th>
<th>Only required as part of standard precautions: during procedures &amp; patient care activities likely to generate splashes or sprays of blood, secretions or excretions</th>
</tr>
</thead>
<tbody>
<tr>
<td>By staff if in contact with the patient or the equipment associated with the patient</td>
<td>By staff if in contact with the patient or the equipment associated with the patient</td>
<td>By staff if in contact with the patient or the equipment associated with the patient</td>
<td>By staff if in contact with the patient or the equipment associated with the patient</td>
</tr>
</tbody>
</table>

### Source Isolation and contact precautions – NNU

**Isolation/cohorting**

- Neonates with MRSA should ideally be nursed in a single cubicle or cohorted with other neonates colonised with MRSA. If this is not possible the situation should be risk-assessed but, as a minimum, MRSA positive babies should usually receive 1:1 nursing.
- For babies in a single cubicle a yellow Source Isolation notice must be placed on the nursery/side room door and the door would remain closed. For babies not isolated in a single room a yellow notice should be placed on the side of the incubator/cot. All other babies in the room will be placed on contact precautions and have a contact precautions sign on their incubator/cot.
- Handwashing facilities should be within the isolation room
- Personal Protective Equipment must be available (gloves, disposable aprons, gowns, protective face wear if indicated e.g. mask, visor, goggles)
- All clinical staff must adhere to contact and standard precautions. Contact precautions signage must be attached to the incubator/cot.
- Where ever possible the nurse caring for a known MRSA positive patient should not care for or attend other non-colonised neonates during the same shift.

**Where patients are unable to be isolated based on significant clinical risk assessment, an adverse event report should be completed.**

**Environmental & Equipment Cleaning** as per Isolation of Adults with Infectious Conditions Policy.

Refer to UHS Isolation of Paediatrics with Infectious Conditions Policy for further detail

### Management of MRSA Positive Day cases

Patients known to be MRSA positive who are admitted as day cases to day case units do not require isolation unless they are skin shedders or sputum colonised with a productive cough, providing that standard precautions are implemented and any equipment that has been in contact with the patient is cleaned after use. These children should be confined to their bed area and not permitted in the communal play area. Any patient who subsequently requires overnight hospital stay must be isolated as per the Isolation Policy.

Patients known to be MRSA positive that are skin shedders or sputum colonised with a productive cough should be isolated in single rooms as per the Isolation of Paediatrics with Infectious conditions Policy
<table>
<thead>
<tr>
<th>Infection</th>
<th>Isolate Y/N</th>
<th>Cohort Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staphylococcus Aureus</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>MSSA*</td>
<td>N (Unless skin shedder)</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Infective Diarrhoea</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Diff</td>
<td>Y</td>
<td>Y (See below)</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>Y</td>
<td>Y (See below)</td>
</tr>
<tr>
<td>Norovirus</td>
<td>Y</td>
<td>Y (See below)</td>
</tr>
<tr>
<td>Salmonella</td>
<td>Y</td>
<td>Y (See below)</td>
</tr>
<tr>
<td>Adenovirus</td>
<td>Y</td>
<td>Y (See below)</td>
</tr>
<tr>
<td>VRE</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

*In the event of an outbreak of D&V, patients with the same infection may be cohorted*  

<table>
<thead>
<tr>
<th>Respiratory Viruses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>H1N1 (Influenza A)</td>
<td>Y</td>
<td>Y (Only with H1N1)</td>
</tr>
<tr>
<td>RSV</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Parainfluenza</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Adenovirus</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Influenza (except H1N1)</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Moraxella</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Haemophilus</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox (Varicella)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Measles</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Mumps</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>ESBL</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Pseudomonas*</td>
<td>N</td>
<td>NA</td>
</tr>
<tr>
<td>E. Coli*</td>
<td>N (Unless ESBL E.Coli)</td>
<td>NA</td>
</tr>
</tbody>
</table>

From UHS Isolation of Paediatrics with Infectious Conditions Policy:

'5.1.2 Prioritisation of cubicles. When isolation facilities are limited use the Red, amber, Green scoring system to prioritise cubicle usage.’

Use of IDU (C5) for those aged 17 and under will be discussed by the Care Group and the Infection Prevention Team prior to movement of the patient. A full risk assessment will be required as well as consideration of provision of 1:1 nursing.

Children found to have Mupirocin resistant or MRSA 17 must be nursed in IDU (C5) with appropriate paediatric governance procedures.
APPENDIX P(xiv)

Care Bundle for the Prevention and Management of MRSA
(Children under 17yrs of age)

Aim
- To reduce the risk of MRSA transmission.
- To protect patients from colonisation or infection with MRSA.
- To ensure patients who are identified as MRSA colonised/infected are managed safely and appropriately.

Introduction
MRSA has the potential to cause a range of infections including minor skin infections, surgical site infections and blood stream infections. It can cause serious illness, significant mortality and morbidity and results in significant additional healthcare costs. It also has serious financial implications for the Trust.

The transmission of MRSA and the risk of infection can only be effectively reduced by implementing basic infection prevention precautions e.g. hand hygiene, all of the time; by taking measures to identify MRSA carriers as potential sources and by treating those carriers to reduce the risk of transmission to others. Measures aimed at preventing MRSA acquisition and preventing MRSA infection where colonisation has occurred are key to preventing MRSA bloodstream infections.

Why use the care bundle?
This care bundle is based on the Trust MRSA Policy (and associated guidelines) which incorporates expert advice and other national infection prevention and control guidance. The purpose of this care bundle is to act as a way of improving and measuring the implementation of key elements/standards of care.

The risk of MRSA acquisition, associated infection and transmission reduces when all elements within the care process are performed. The risk of MRSA acquisition, associated infection and transmission increases when one or more elements of the care process are excluded or not performed.

Responsibilities of staff, competency & training
All staff are responsible for adhering to the Trust MRSA policy and in ensuring that the policy standards are implemented in order to reduce the risk to patients. Staff should be appropriately trained and competent in any stated procedure or care process.

Elements of the care process
There are 3 elements to the care bundle:

<table>
<thead>
<tr>
<th>Prevention of Spread (applies to all patients regardless of MRSA status)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hand hygiene:</strong></td>
</tr>
<tr>
<td>• Staff aware of and performing correct hand hygiene as per Trust hand hygiene policy.</td>
</tr>
<tr>
<td>• Staff/area compliant with hand hygiene training requirements.</td>
</tr>
<tr>
<td>• Staff/area compliant with hand hygiene standards (e.g. achieving 95% compliance with hand hygiene audits).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Environmental and equipment Cleaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Performed as per Trust policy and agreed service level agreements.</td>
</tr>
<tr>
<td>• Clinical cleaning standards meeting national cleaning specifications.</td>
</tr>
<tr>
<td>• Domestic Cleaning standards meeting national cleaning specifications.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard precautions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implemented as per Standard Precautions Policy.</td>
</tr>
<tr>
<td>• Personal protective equipment available selected appropriately and changed between uses.</td>
</tr>
<tr>
<td>• Staff/area complaint with PPE standards (e.g. achieving 95% compliance with PPE audits).</td>
</tr>
</tbody>
</table>
### Patient Management (prior to positive MRSA result)

<table>
<thead>
<tr>
<th><strong>MRSA Screening</strong></th>
<th>undertaken on admission or in pre-assessment &amp; documented in patients notes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk reduction measures</strong></td>
<td>for high risk paediatric patients (PICU, PHDU, E1 HDU) and specified neonates commenced within 12 hours of admission and documented (See Appendix P xii of MRSA Policy) or commenced pre-admission for high risk paediatric elective patients.</td>
</tr>
<tr>
<td><strong>Additional MRSA screening</strong></td>
<td>undertaken following admission e.g on admission. Weekly screening in PICU, PHDU, NNU and E1 HDU. Every 14 days for all other inpatients. Contact screening as required. (Appendix Piii of MRSA Policy).</td>
</tr>
<tr>
<td><strong>Additional risk reduction measures</strong></td>
<td>considered for patients with chronic wounds, peg tubes, suprapubic catheters and similar devices &amp; documented on MRSA risk reduction measures care plan (record as N/A on care plan if not applicable). (Appendices G of MRSA Policy)</td>
</tr>
</tbody>
</table>

### Patient Management (following confirmation of positive MRSA result)

<table>
<thead>
<tr>
<th><strong>Patient isolation:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient to be isolated</td>
<td>within 4 hours of receipt of presumptive result.</td>
</tr>
<tr>
<td>Isolation Risk Assessment</td>
<td>completed (&amp; appropriate score given). (Refer to Isolation Policy &amp; Paediatric Isolation Policy)</td>
</tr>
<tr>
<td>Isolated</td>
<td>in a single room or cohort bay.</td>
</tr>
<tr>
<td>Isolation posters</td>
<td>on display.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Chlorine-based cleaning implemented</strong></th>
<th>(Clinical &amp; Domestic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All isolation rooms/bedspaces, where there are patients with confirmed/suspected infectious conditions, must be cleaned daily using Actichlor Plus, a chlorine based solution of 1,000 parts per million available chlorine (including floors). Nursing/medical equipment should be damp dusted daily.</td>
<td></td>
</tr>
<tr>
<td>Domestic staff should be informed by ward staff on a daily basis which isolation rooms/bedspaces require cleaning with Actichlor Plus.</td>
<td></td>
</tr>
</tbody>
</table>

| **Source and Contact precautions** | implemented and staff aware (Appendix Pxi Pof MRSA Policy) |

<table>
<thead>
<tr>
<th><strong>MRSA positive status documented:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; medical notes.</td>
<td></td>
</tr>
<tr>
<td>Patient’s medication chart</td>
<td>(nursing staff to document MRSA positive status on medication chart – in allergy section. NB: if multiple charts, MRSA positive status must be documented on all).</td>
</tr>
<tr>
<td>Medical notes labelled</td>
<td>(Red &amp; White “Alert” sticker on outside cover &amp; Yellow MRSA sticker inside front).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Topical decolonisation therapy prescribed.</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All children 1 month to 17 screened and found to be MRSA positive should receive topical decolonisation (Nasal Mupirocin (bactroban) &amp; Octenisan washes), as an attempt to eradicate MRSA and reduce the subsequent risk of infection, unless there are contra-indications or clinical reasons why this is not appropriate. In these circumstances the reason for not decolonising the patient must be documented. (Appendix Pvi of MRSA Policy)</td>
<td></td>
</tr>
<tr>
<td>See Appendix Pvi: for Topical decolonisation for eradication of MRSA neonatal unit PAH</td>
<td></td>
</tr>
</tbody>
</table>

| **Management of MRSA in wounds and invasive device insertion sites** | Documented evidence that options for management of MRSA in wounds and invasive device insertion sites have been considered. (Appendix G of MRSA Policy) |

<table>
<thead>
<tr>
<th><strong>Antimicrobial prescribing.</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients receiving oral or parenteral antibiotics either:</td>
<td></td>
</tr>
<tr>
<td>Documented evidence that MRSA status has been considered when selecting antibiotic treatment, or</td>
<td></td>
</tr>
<tr>
<td>Prescribed antibiotics with activity against MRSA.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Patient Information:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and/or relative supplied with MRSA information leaflet.</td>
<td></td>
</tr>
</tbody>
</table>
Using the care bundle

The purpose of the care bundle is for improving and measuring the implementation of key actions to minimise the risks of infection. The use of this care bundle will support review and continuous improvement, which will deliver appropriate and high quality patient care.

Enhanced surveillance of new cases of MRSA acquisition will be performed by the Infection Prevention Team and fed back to clinical teams. This surveillance will;

- Clearly identify when actions within the care bundle have or have not been performed.
- Provide information to support the development of plans to resolve any issues and improve the quality of care
- Support a culture of continuous Improvement.

References:

University Hospital Southampton, MRSA (Meticillin-resistant *Staphylococcus aureus*) Policy (Adults, Paediatrics and Neonates)

University Hospital Southampton, Isolation Policies (adult and Paediatric)

University Hospital Southampton, MRSA screening, risk reduction and decolonisation within maternity service
### Checklist for Isolation Care Flow Chart

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Complete Isolation risk assessment in the Paediatric Admission Record and sign and date.</td>
</tr>
<tr>
<td>2.</td>
<td>Inform nurse in charge/ward sister and bleep holder that you have an MRSA positive child and explain what procedures you have undertaken so far. This will be handed over to the site team for a central record.</td>
</tr>
<tr>
<td>3.</td>
<td>Discuss MRSA and the reasons for Isolation with both patient and relatives</td>
</tr>
<tr>
<td>4.</td>
<td>Place into side room for Isolation within the 4 hour time period set on Isolation Policy</td>
</tr>
<tr>
<td>5.</td>
<td>Place yellow Isolation sign outside side room</td>
</tr>
<tr>
<td>6.</td>
<td>Red Alert sticker to be placed on outer cover of notes.</td>
</tr>
<tr>
<td>7.</td>
<td>Yellow MRSA sticker on the inside cover of notes – remember to place date on the sticker.</td>
</tr>
<tr>
<td>8.</td>
<td>MRSA status must be written in nursing notes and on drug chart (in the allergy Section)</td>
</tr>
<tr>
<td>9.</td>
<td>Ask Doctor to prescribe Nasal Mupirocin ointment (BD/TDS) 2% (Bactroban) and daily washes with Octenisan must be recommenced (both for 5 days).</td>
</tr>
<tr>
<td>10.</td>
<td>Daily cleaning with Actichlor plus to be carried out so inform ward cleaner. Nursing staff to carry out daily damp dusting with Actichlor plus. All medical equipment cleaned with Clinell universal sanitising wipes after every use.</td>
</tr>
<tr>
<td>11.</td>
<td>Inform the IP team and ensure your IP link nurse for your area is informed and matron for the area.</td>
</tr>
<tr>
<td>12.</td>
<td>Check with infection prevention about re-screening plan. Infection Prevention Team – ext 8165</td>
</tr>
</tbody>
</table>

**Date and Initial**
Appendix P(xv)

What is an MRSA screen?

This is when swabs are taken from your child usually inside the nose and the groin. These are then processed in the laboratory to see if MRSA grows. Sometimes more areas are screened. This is dependent on where your child was found to be positive i.e. wound, gastrostomy site, urine or sputum. How many negative screens is dependant on where your child was positive, it may be three or five sets of swabs. Screens are taken a minimum of at least 6 days apart.

Will MRSA stop friends and family visiting my child in hospital?

Your child can still have visitors. They can reduce the risk of spreading MRSA to other people if they do not sit on beds and clean their hands before and after visiting either with soap and water or hand gel. Visiting siblings should not go to the play room or other communal areas within the ward environment.

Each child will be reviewed on a case by case basis and additional advice maybe given.

Useful links for more information on MRSA

www.uhs.nhs.uk MRSA on your child


http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/119494747699+

MRSA (Meticillan resistant Staphylococcus aureas) and your child on discharge

Child Health
Southampton General Hospital
Tremona Road
Southampton
Hampshire
SO16 6YD
What is MRSA? - MRSA is Meticillin resistant Staphylococcus aureus (S.aureus). S.aureus is a common germ that can live harmlessly on the skin and on or in the nose of 1 in 3 people. It can affect people in the community as well as in hospital.

MRSA is a type of S.aureus that has become resistant to a number of different antibiotics. It is still treatable with other antibiotics.

Where are the most common places to detect MRSA?

MRSA is commonly found in the nose, back of the throat, armpits, skin folds of the groin and in wounds.

MRSA colonisation - About 30% of people are colonised with S.aureus. 3% of people are colonised with MRSA. People colonised with or carrying MRSA are not ill. Some carry it for a few hours, others may carry it for weeks or for life. Most people will be unaware that they carry MRSA because they do not have any symptoms.

Why is MRSA significant in hospitals?

Patients in hospital are more vulnerable to acquiring MRSA infection if they have open wounds e.g. after surgery, if they have urinary catheters, intravenous lines or chronic skin conditions. This is why simple measures, such as hand hygiene are vital in the prevention of the spread of MRSA.

MRSA infection - MRSA can cause harm when it gets an opportunity to enter the body, through a cut or wound. It can then cause pimples and boils, wound infections, chest infections and in more serious cases bloodstream infections.

How did my child get it?

It is rarely possible to know exactly how your child may have acquired MRSA. MRSA is not restricted to hospitals and care homes. Without good basic hygiene, germs on a person's hands or skin can be passed on unknowingly and caught by others. So your child could have picked up MRSA at anytime, anywhere.

How will my child be managed when they are in hospital?

Different precautions will be undertaken when your child is in hospital. They will be nursed in a single room and may commence treatment for decolonisation which consists of washes with an antimicrobial wash and cream for inside the nose. Staff will wear apron and gloves when caring for your child.

What happens when I go Home?

Family life should continue as normal. MRSA is extremely unlikely to harm healthy people outside of hospital including, babies, children and pregnant women. You can still breast feed your child, just be aware of the signs of mastitis as usual. Washing and bathing as usual.

Do I need to take any special precautions with cleaning the house or doing the laundry?

No special precautions are required continue with your normal regime. Wash clothes at the hottest temperature for the fabric, use your usual detergent and avoid overloading the washing machine.

What about the family pets can my child still play with them?

Yes just wash hands after handling pets.

Can my child still do their normal leisure activities?

It should not stop your child attending nursery or going to school. You do not have to inform the nursery or school. MRSA does not prevent your child from swimming, socialising or taking part in sports activities. If your child has any open wounds these should be covered with a waterproof dressing when taking part in sports. Whether your child has MRSA or not swimming should be avoided if they have open wounds.

Do I need to tell people that my child has MRSA?

You do not have to tell anyone that your child has MRSA. But it would be advisable to ensure that you share this information with any healthcare practitioner. This is important because they may decide that if your child needs an invasive procedure or an operation then decolonisation may be required in advance.

What will happen if my child needs readmitting to Hospital?

If your child needs to return to hospital they are usually nursed in a single room. Your child may not be able to mix with other children in the ward or play in the play room. This will need to be reviewed by the ward staff.

Can my child be cleared of MRSA?

Sometimes MRSA can disappear and your child may have several negative screens. In this case the ward will contact the Infection Prevention Team to see if your child can be cleared. This would not be considered if your child has had a positive screen within 6 months.
Appendix P(xvi)

What is an MRSA screen?
This is when swabs are taken from your baby usually nose, ear, umbilicus, groin, gastric aspirate. These are then processed in the laboratory to see if MRSA grows. Sometimes more areas are screened. This is dependent on where your child was found to be positive i.e. wound, gastrostomy site, urine or sputum. How many negative screens is dependent on where your baby was positive, it may be three or five sets of swabs. Screens are taken a minimum of at least 6 days apart.

Will MRSA stop friends and family visiting my baby in hospital?
Your baby can still have visitors. They can reduce the risk of spreading MRSA to other people by cleaning their hands before and after visiting either with soap and water or hand gel. If your baby is one of a twin/triplet that is also being cared for within the NNU, we would advise that visitors hold the baby colonised with MRSA after they have visited their sibling. Ensuring that good hand hygiene is undertaken between visiting each baby and after visiting is essential.

Each baby will be reviewed on a case by case basis and additional advice maybe given.

Useful links for more information on MRSA
www.uhs.nhs.uk MRSA on your child
http://www.thh.nhs.uk/documents/_Patients/PatientLeaflets/infectioncontrol/MRSA/DoH_MRSA_Advice.pdf
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947417699+

MRSA (Meticillan resistant Staphylococcus aureas)
and your Baby on Discharge

University Hospital
Southampton NHS Trust
Neonatal Unit

Child Health
Southampton General Hospital
Tremuna Road
Southampton
Hampshire
SO16 6YD
What is MRSA? - MRSA is Meticillin resistant Staphylococcus aureus (S. aureus). S. aureus is a common germ that can live harmlessly on the skin and on or in the nose of 1 in 3 people. It can affect people in the community as well as in hospital.

MRSA is a type of S. aureus that has become resistant to a number of different antibiotics. It is still treatable with other antibiotics.

Where are the most common places to detect MRSA?
MRSA is commonly found in the nose, back of the throat, armpits, skin folds of the groin and in wounds.

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Patients in hospital are more vulnerable to acquiring MRSA infection if they have open wounds e.g. after surgery, if they have urinary catheters, intravenous lines or chronic skin conditions. This is why simple measures, such as hand hygiene are vital in the prevention of the spread of MRSA.

MRSA infection – MRSA can cause harm when it gets an opportunity to enter the body, through a cut or wound. It can then cause pimples and boils, wound infections, chest infections and in more serious cases bloodstream infections.

How did my baby get it?
It is rarely possible to know exactly how anyone may have acquired MRSA. MRSA is not restricted to hospitals and care homes. Without good basic hygiene, germs on a person’s hands or skin can be passed on unknowingly and caught by others. So your baby could have picked up MRSA at anytime, anywhere.

How will my baby be managed when they are in hospital?
Different precautions will be undertaken when your baby is in hospital. They will be nursed in a single room or an incubator. Staff will wear gloves and a gown/cape when handling your baby. Treatment for decolonisation consists of washes with an antimicrobial wash and cream for inside the nose. For more information on care in hospital please visit our website. WwW.uhs.nhs.uk MRSA and your child.

What happens when I go Home?
Family life should continue as normal. MRSA is extremely unlikely to harm healthy people outside of hospital including babies, children and pregnant women. You can still breast feed your baby, just be aware of the signs of mastitis. Washing and bathing as usual no extra precautions required.

Do I need to take any special precautions with cleaning the house or doing the laundry?
No special precautions are required continue with your normal regime. Wash clothes at the hottest temperature for the fabric, use your usual detergent and avoid overloading the washing machine.

Can my Baby still do their normal leisure activities?
It should not stop your baby attending nursery or in the future going to school. You do not have to inform the nursery or school. MRSA does not prevent your baby from swimming, or socialising. Whether your baby has MRSA or not swimming should be avoided if they have open wounds.

Do I need to tell people that my Baby has MRSA?
You do not have to tell anyone that your baby has MRSA. But it would be advisable to ensure that you share this information with any healthcare practitioner. This is important because they may decide that if your child needs an invasive procedure or an operation then decolonisation may be required in advance.

What will happen if my Baby needs readmitting to Hospital?
If your baby needs to return to hospital they are usually nursed in a single room. Your baby may not be able to mix with other children in the ward or play in the play room. This will need to be reviewed by the ward staff.

Can my Baby be cleared of MRSA?
Sometimes MRSA can disappear and your baby may have several negative screens. In this case the ward will contact the Infection Prevention Team to see if your baby can be cleared. This would not be considered if your child has had a positive screen within 6 months.
APPENDIX Q

Occupational Health Advice Regarding Staff and MRSA

Routine staff screening for MRSA
Screening of staff is not currently undertaken as a matter of routine in line with national guidance, although following advice from the consultant microbiologist groups of staff may be required to be screened based on clinical evidence and risk. This confidential screening is undertaken through occupational health.

All screening undertaken by occupational health is undertaken in strictest medical confidence. Staff and managers are reminded that they must not access the laboratory results for themselves or other staff via the trust laboratory results system.

Contact transmission is the most important and frequent mode of transmission and involves either direct person-to-person contact or indirect contact via a contaminated intermediate object.

Reducing the risks
To reduce the risk of infection to both staff and patients’ staff must not work in clinical areas while they have exposed broken skin. Skin, which is broken, should be covered with a waterproof dressing. Where this is not possible or where the broken area is on the hands no clinical work may be undertaken until the area is healed. Advice must be sought from Occupational Health.

- Staff must not undertake self screening
- Staff who undertake any self-screening which is not undertaken via occupational health may be subject to disciplinary action.
- Staff who consider they may have colonised MRSA, e.g. because they may have unhealed lesions, should contact Occupational Health for additional advice.

MRSA Screening
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.
- Clinical details must include current antibiotic therapy
Staff found to be MRSA positive:
Staff will be treated with empathy, respect and in confidence and will commence a topical decolonisation regime. Staff who work in the following ‘very high risk’ areas will not be able to undertake clinical work until 24 hours after the commencement of treatment. Non-clinical work may take place.

Units that fall into the category ‘very high risk’ are:
- General ICU
- Cardiothoracic ITU
- Neuro ITU/HDU
- Paediatric ITU
- Neonatal unit
- Medical HDU
- Surgical HDU
- Cardiothoracic HDU
- Paediatric HDU
- Theatres
Other areas may be considered a higher risk dependant on specific clinical risk.

Treatment
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:

<table>
<thead>
<tr>
<th>MRSA DECONTAMINATION REGIMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure</td>
</tr>
<tr>
<td>Daily shower / bath</td>
</tr>
<tr>
<td>Wash hair twice during period</td>
</tr>
<tr>
<td>Nasal clearance</td>
</tr>
</tbody>
</table>

48 hours after the 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, with advice from a Consultant Microbiologist.
# MRSA (Meticillin Resistant Staphylococcus Aureus) Policy
(Adults, Paediatrics & Neonates)

## Document Monitoring Information

<table>
<thead>
<tr>
<th>Approval Committee:</th>
<th>Infection Prevention Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Approval:</td>
<td>4 July 2016</td>
</tr>
<tr>
<td>Ratification Committee:</td>
<td>Policy Ratification Group (PRG)</td>
</tr>
<tr>
<td>Date of Ratification:</td>
<td>17 August 2016</td>
</tr>
<tr>
<td>Signature of ratifying Committee Group/Chair:</td>
<td>Chair of PRG</td>
</tr>
<tr>
<td>Lead Name and Job Title of originator/author or responsible committee/individual:</td>
<td>Head of Infection Prevention Unit</td>
</tr>
<tr>
<td>Policy Monitoring (Section 6) Completion Date:</td>
<td>June each year</td>
</tr>
<tr>
<td>Target audience:</td>
<td>All Trust Staff</td>
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<tr>
<td>Key words:</td>
<td>MRSA, infection, screening, decolonisation, isolation, risk reduction.</td>
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<td>Main areas affected:</td>
<td>Trust Wide</td>
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<td>Summary of most recent changes if applicable:</td>
<td>Adult and Paediatric MRSA Policies combined. Changes to adult surgical day case screening. Changes to additional risk reduction measures prior to surgery. Additions to adult very high risk areas. Addition of weekly screening requirements for defined specialist groups of patients. Inclusion of Guideline for Isolation and infection control precautions for adult patients with MRSA in Medicine Care Groups, F8 stroke unit and Countess Mountbatten House.</td>
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<td>Infection Prevention Committee</td>
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<td>Equality Impact Assessment completion date:</td>
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</tr>
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<td>Number of pages:</td>
<td>81</td>
</tr>
<tr>
<td>Type of document:</td>
<td>Level 1</td>
</tr>
<tr>
<td>Does this document replace or revise an existing document</td>
<td>Revises/Replaces: Adult MRSA policy, Paediatric MRSA Policy, Guidelines for Isolation and infection control precautions for adult patients with MRSA in Medicine Care Groups, F8 stroke unit and Countess Mountbatten House.</td>
</tr>
</tbody>
</table>
The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This MRSA Policy (Adults) has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it, regardless of their individual differences, and the results are available on request.