POLICY FOR THE MANAGEMENT OF METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Please be aware that this printed version of the Policy may NOT be the latest version. Staff are reminded that they should always refer to the Intranet for the latest version.

Purpose of Agreement	To provide clear guidance and direction to staff within Solent NHS Trust on the principles of the management of Meticillin Resistant Staphylococcus Aureus (MRSA)
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2	13.06.14	18	Mupirocin 2% dosage changed from tds to BD for 5 days	Immediate
3	08.04.16	17	Mupirocin 2% changed back from bd to tds for 5 days to reflect change in prescribing guidelines	Immediate
4	20.09.17	20	MRSA and MSSA Suppression Regime added as appendix 4	Immediate
5	06.12.17	17	Octenisan added to treatment regime	Immediate

Executive Summary

Meticillin Resistant Staphylococcus Aureus (MRSA) is a strain of Staphylococcus aureus that has over time developed resistance to Flucloxacillin and related antibiotics. MRSA infection can result in additional morbidity and mortality as well as contributing the healthcare costs. Effective control measures have been successful at reducing mortality from MRSA over the past decade. It is imperative to embed these measures within everyday practice in order to provide safe care for all.

MRSA has become endemic within hospital settings and this policy provides evidence based information for all staff on the control measures that must be in place to prevent patients acquiring MRSA in the first instance and to safely manage and treat MRSA carriage and infection.

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1.0 INTRODUCTION & PURPOSE

1.1 "Good infection prevention and control are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be consistently applied by everyone" (The Health and Social Care Act 2008). Meticillin Resistant Staphylococcus Aureus (MRSA) is a significant Healthcare Associated Infection (HCAI) resulting in additional morbidity and mortality as well as contributing to healthcare costs. If basic principles of infection control are followed, the risks of a patient acquiring MRSA or indeed any other HCAI will be effectively minimised in all types of community settings.

1.2 The control of MRSA is an important factor in the provision of safe patient care and this policy outlines measures needed to prevent the acquisition and spread of MRSA. It aims to provide all staff working in Solent NHS Trust with evidence based information about MRSA transmission and the potential risks to patients, healthcare workers and visitors. It will aim to identify strategies to manage these risks effectively.

1.3 Every patient admitted to Solent NHS Trust inpatient beds must be screened for carriage of MRSA; this applies to both elective and emergency admissions (DOH 2010).

2.0 SCOPE & DEFINITIONS

2.1 This document applies to all directly and indirectly employed staff within Solent NHS Trust and other persons working within the organisation in line with Solent NHS Trust's Equal Opportunities Document.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We strive towards demonstrating fairness and Equal Opportunities for service users, carers and the wider community and our staff.

2.3 DEFINITIONS

2.3.1 Staphylococcus Aureus (SA)*:* a gram positive bacterium that commonly colonises human skin and mucosa without causing problems. However it can cause infection if it enters the body through broken skin or a medical procedure for instance. It can then cause skin and soft tissue infections, wound infections, infected eczema, abscesses, joint infections, endocarditis, pneumonia and bacteraemia (blood stream infection).

2.3.2 MRSA: a variant of *Staphylococcus Aureus* that has developed resistance to commonly used antibiotics and is now endemic in both hospitals and community settings.

2.3.3 Screening: the process of testing to identify if MRSA is present upon a person by taking swabs/samples from various sites and sending them to the microbiology laboratory for analysis.

Suppression Therapy (previously known as decolonisation therapy): the method by which an attempt is made to eradicate or reduce the amount of MRSA being carried on a person.

2.3.4 MRSA colonisation: the asymptomatic carriage of MRSA on an individual. Whilst most of the time this does not cause a problem it has the potential to act as a reservoir of the bacteria in a healthcare setting, hence the importance of all staff adhering to good infection control practice

at all times. Colonisation also increases the risk to the individual of going on to develop infection if the right circumstances prevail.

2.3.5 MRSA infection: occurs when the organism invades the skin or deeper tissues and multiplies causing a localised or systemic response.

2.3.6 MRSA bacteraemia: describes the presence of MRSA in the blood. This type of MRSA infection can lead to septicaemia very quickly and has a high mortality rate

2.3.7 High Risk Groups: National and local evidence shows that certain people will be at increased risk of having or acquiring MRSA and are as follows:

- Have been MRSA positive in the past
- Have had an admission to a healthcare facility in the last six months
- Live in residential settings (i.e. nursing/residential homes, military barracks)
- Presence of an in-dwelling device i.e. urinary catheter, IV line, feeding tube etc
- Presence of a chronic wound or chronic skin condition such as eczema or psoriasis
- History of intravenous drug use
- Healthcare workers

2.3.8 Healthcare Associated MRSA (HA-MRSA): MRSA strains that are transmitted to and circulate between individuals who have had contact with healthcare facilities. HA-MRSA is endemic in the hospital and healthcare environment.

2.3.9 Community Associated MRSA (CA-MRSA): new strains of MRSA have recently emerged that cause infections in community patients who have no previous history of direct or indirect healthcare contact. These strains have been designated CA-MRSA and are genetically and phenotypically distinct from HA-MRSA (Nathwani et al (2008).

2.3.10 PVL- associated Staphylococcus Aureus: Panton-Valentine Leukocidin (PVL) is a toxic substance produced by some strains of staphylococcus aureus and can be associated with an increased ability to produce disease.

2.3.11 Meticillin Sensitive Staphylococcus Aureus (MSSA): it needs to be noted that these strains of Staphylococcus Aureus can also cause bloodstream infections and outbreaks have been well documented.

2.3.12 Transient: When referred to carriage of MRSA describes that it is short lived, not permanent and easily removed.

3.0 ROLES & RESPONSIBILITIES

3.1 The Chief Executive and Trust Board have a collective responsibility for infection prevention and control within the Trust.

3.2 The Director of Infection Prevention and Control (DIPC) is responsible for ensuring that this policy is implemented and adhered to across the organisation.

3.3 Directors and Managers have a duty to ensure that the responsibilities for prevention and control of infection are reflected in all staff members' job descriptions and are incorporated into annual appraisal. They also have a responsibility to ensure that all staff receive induction

training and attend ongoing infection prevention and control training in line with Trust requirements.

3.4 The Infection Prevention and Control Team (IPCT) are responsible for developing and updating the policy to ensure it complies with Department of Health, Health and Safety Legislation and other national guidance. The IPCT will support the provision of training and education both mandatory and bespoke.

3.5 The Learning and Development Team are responsible for ensuring that staff have access to Induction training on Standard Precautions on joining the organisation and Essential Annual training thereafter.

3.6 Service line managers and modern matrons are responsible for ensuring that staff are aware of their responsibilities under this Policy. They are also responsible for ensuring that staff have the appropriate resources available for use and education and clinical skills in order to comply with the policy.

3.7 Infection Prevention and Control Link Advisors (IPCLA) are healthcare staff selected by their managers to receive additional training in infection prevention and control. The key role of link staff is to develop best practice within their clinical area. The additional training for the IPCLA role is provided by the IPCT in the form of a two day course.

3.8 All staff have individual responsibility to comply with standard precautions of infection prevention and control as applicable to their everyday practice.

4.0 TRANSMISSION OF MRSA

4.1 **Direct contact** is the main route of transmission. The hands of healthcare workers have the potential to transfer MRSA from one person to another or from one body site to another if correct hand hygiene and adherence to basic infection control standard precautions are not followed.

4.2 **Indirect Contact** can occur through the environment and equipment. Therefore it is important to maintain high standards of environmental cleaning to keep dust levels at a minimum. All equipment needs to be routinely and effectively decontaminated.

4.3 **Endogenous spread** is when a person transfers organisms from one part of the body to another. This can be done by the patient themselves or by a member of staff who fails to carry out correct hand hygiene between different episodes of care on the same person.

5.0 MRSA SCREENING

Patients

5.1 All patients admitted to Solent NHS Trust in-patient areas must be screened for MRSA. This will enable the identification of MRSA carriage, implementation of treatment if appropriate and the application of necessary precautions in order to reduce the risk to the patient and others within the vicinity. (Appendix 1: **How to Screen for MRSA***)*

5.2 Screening should be carried out within 24 hours of admission but should not delay any urgent treatment.

5.3 Routine admission screening includes the **nose** and the **groin**. In addition to this swabs/samples will need to be taken from the following if present:

- Wound and skin lesions (except new trauma wounds)
- Invasive devices i.e. intravenous/central lines, tracheotomy or feeding tube sites
- If a urinary catheter is in situ a catheter sample of urine (CSU) needs to be obtained using an aseptic technique

PLEASE NOTE

Swabs need to be labelled correctly with three points of identification and placed with the microbiology request form in the appropriate collection area

If any wound or site appears to be infected you must also request Microscopy, Culture and Sensitivity (MC&S) in addition to MRSA

5.4 Admission documentation needs to clearly state if an MRSA screen has taken place.

5.5 For patients admitted on a Friday or Saturday the screening should take place on the Sunday OR Monday am so that the samples are not left in the collection fridge over the weekend

5.6 If it is not possible to obtain an MRSA screen due to clinical reasons or refusal this must be documented clearly in the admission notes. In areas where RIO is used there is a specific MRSA care plan for this purpose. Further attempts to obtain an MRSA screen should be made as the clients condition stabilises. For the purposes of auditing– a valid reason for a screen not having taken place, accurately documented will be considered to be fully compliant. Patients previously known to be MRSA positive should be discussed with the Infection Prevention Team and Standard Infection Precautions followed at all times

5.7 If a patient is already undergoing a course of suppression therapy on admission, do not screen but continue the treatment and document clearly on admission paperwork.

5.8 Following a course of suppression therapy it is not considered necessary or helpful to rescreen for MRSA in the community unless for specific reasons. Contact IPCT for further advice.

Staff

5.9 Staff carriage of MRSA can be transient and easily removed with good hand hygiene and adherence to infection control standard precautions, therefore routine screening of staff for MRSA is not recommended practice and will only be instigated in exceptional circumstances on the advice of a consultant microbiologist. This may be necessary as part of an MRSA outbreak management plan the Microbiologist/IPCT may advise staff screening especially if epidemiological factors indicate that staff members may be a source of an increased rise in cases of MRSA among a particular group of patients. If staff screening is required it will carried out in conjunction with Occupational Health to ensure confidentiality is maintained

5.10 Healthcare workers must report any signs of deterioration in skin integrity, particularly the hands, to Occupational Health or GP.

5.11 It is essential that any clinical staff who has a visible skin lesion on the hands or face that cannot be covered should report to Occupational Health for advice prior to working.

6.0 IN-PATIENT MANAGEMENT OF MRSA

6.1 Isolation: If it is possible to isolate a patient who is known to have MRSA with a wound, skin shedding condition such as eczema, psoriasis or MRSA in sputum and they are expectorating it is always advisable to do so. However it is recognised that this is rarely possible in Adult or Older Persons Mental Health Units, therefore advice should be sought from the IPCT on how to manage the situation following a risk assessment.

6.2 If the patient is isolated for one of the reasons above the door of the room should be kept closed to minimise spread to adjacent areas. If this is likely to compromise patient safety this will not be possible but the door must be closed during activities such as bed making or chest physiotherapy for example when aerosols may be generated.

6.3 Treatment: Suppression therapy may need to be instigated following consultation with the IPCT (Appendix 2: MRSA Suppression Therapy Regimen). For in-patients the suppression therapy will need to be prescribed clearly on the prescription chart.

6.4 All patients with MRSA will be treated with standard infection control precautions. Risk assess the amount of contact required for any episode of care and use the correct Personal Protective Equipment (PPE).

6.5 Observation: Staff need to be aware that a patient with an MRSA infection will need careful monitoring so that any deterioration or signs of sepsis are quickly identified and medical help obtained.

6.6 If infection is suspected general observations of temperature, pulse, respirations need to be increased to QDS (Four times per day) and regular review of any wounds or invasive devices needs to take place and be documented clearly. Any deterioration needs to be reported to the Doctor caring for the patient.

6.7 MRSA infection should be considered (even if the patient has not recently been screened or had a negative screen) if the patient has any factors that place them at increased risk of acquiring MRSA. It should also be considered if the patient has a wound, urine, chest or skin infection that is not responding to first line antibiotic treatment. Any history of MRSA, however long ago, should always be recognised as important.

6.8 Certain broad spectrum antibiotics may encourage the growth of MRSA and a delay in appropriate treatment will increase the risk of the patient developing serious infection such as an MRSA bacteraemia

6.9 Antibiotic treatment should be carefully assessed and used in accordance with local antibiotic prescribing guidelines. If in doubt guidance should be sought from a microbiologist.

6.10 If an MRSA bacteraemia is suspected the patient will need to be transferred to secondary care for appropriate investigations and treatment.

6.11 On confirmation of an MRSA bacteraemia a Post Infection Review (PIR) will commence in with DH guidance. The PIR will be lead by the IPCT but key clinicians will be asked to contribute. A panel meeting will be organised and actions for learning identified. A decision will be reached as to whether the bacteraemia was avoidable or not. Findings will be submitted to Public Health England within a 28 working day time frame.

6.12 A Serious Incident Requiring Investigation (SIRI) will be raised only if death is on part one of a death certificate. However in exceptional circumstances a SIRI can be requested by the DIPC or IPCT.

6.13 Any patient with MRSA must not be refused treatment, investigations or therapy, they must be treated like any other patient, with dignity respect and in confidence.

6.14 An MRSA diagnosis must be 'medical in confidence'. Consequently non-medical staff i.e. domestic, housekeeping or voluntary staff need to be aware of any precautions required but not the actual diagnosis.

6.15 Patients with MRSA in community settings may join other patients for social activities such as meals or group sessions. If in doubt liaise with IPCT

6.16 Visitors are not required to wear gloves and aprons unless they are providing personal care. They must be advised to practice good hand hygiene on entering and leaving the clinical area.

6.17 Any spillages of body fluids will need to be cleaned up as soon as possible in accordance with decontamination and standard precautions policies.

6.18 Laundry from a patient with known MRSA carriage or infection must be treated as infectious. An alginate water soluble bag needs to be taken to the point of care and sealed prior to placing in the appropriate bag.

6.19 Personal clothing needs to be washed separately on the highest temperature recommended by the manufacturer, tumble dried when possible and ironed.

6.20 Maintain a clean and clutter free environment paying particular attention to horizontal surfaces where dust settles.

7.0 DISCHARGE OR TRANSFER OF MRSA POSITIVE PATIENT

7.1 The receiving ward, department or residential care home must be informed of the patient's MRSA status prior to transfer.

7.2 The MRSA status of the patient needs to be clearly documented in any transfer documentation accompanying the patient.

7.3 Complete the recommended transfer form and send with the patient. **(Appendix 3).**

7.4 If the patient is still on suppression treatment this must be sent with the patient with clear instructions on how to complete the course.

7.5 Generally there are no special precautions needed above standard precautions, if in doubt contact the IPCT for advice.

7.6 Enhanced/deep cleaning of the room or bed space will be required once the patient has left. This will need to be requested via the domestic supervisor with as much notice as possible.

8.0 CARE OF THE DECEASED PATIENT WITH MRSA

8.1 The same standard infection control precautions should be used for a deceased patient as with the living.

8.2 Black body bags must not be used unless there is evidence that the patient also has a notifiable disease (MRSA is not a notifiable disease)

8.3 There is negligible risk to mortuary staff as long as they adhere to basic infection control standard precautions.

9.0 OUTBREAKS OF MRSA

9.1 An outbreak may be declared if there is an exponential rise in the number of cases in one area.

9.2 Assessment and management of the outbreak will be led by the IPCT in consultation with a consultant microbiologist and DIPC.

9.3 Screening of staff will only be carried out following the decision of a Microbiologist/IPCT.

10.0 MRSA AND COMMUNITY NURSING TEAMS (including Paediatric Nursing Teams)

10.1 It needs to be recognised that many clients being cared for in their own homes will have long standing complex health conditions that place them at higher risk of MRSA acquisition. Some clients will have chronic MRSA colonisation which in turn suggests that the home itself will be colonised. It is therefore important for staff to adhere to strict infection control precautions to prevent onward transmission of MRSA to other clients.

10.2 Hand hygiene needs to be carried out on entering and leaving the patients home as well as prior to any episodes of care. Staff need to be 'bare below the elbow' for any episodes of clinical care

10.3 If it is not possible to use the hand washing facilities within a patient's home following risk assessment then individual hand wipes should be used prior to using the alcohol hand gel.

10.4 Uniforms must be protected by a plastic apron when close contact with the client or environment is anticipated.

10.5 Equipment utilised by staff should be kept in good condition and cleaned regularly, refer to decontamination policy of contact IPCT for advice.

10.6 Community staff are encouraged to discuss any concerns regarding care of MRSA colonised/infected clients with the IPCT. It may be necessary to formulate an individual plan for that person.

10.7 Previous history of MRSA should always be considered as relevant.

10.8 Chronic wounds are a potential cause of skin and soft tissue infections as there is an increase in bacterial burden often including MRSA. It is therefore necessary to adhere to the principles of asepsis for wound care.

10.9 Wound swabs should be taken if there are signs and symptoms of infection i.e. redness, inflammation, discharge or non-healing persists.

10.10 Any waste generated by a healthcare worker as a result of wound care in a domestic setting that is considered to be infected by MRSA will need to be disposed of following the correct infected waste collection service.

10.11 When taking a swab the wound should be cleaned first to remove surface contaminants and any slough.

10.12 A brief history of the patient and current or recent antibiotic treatment should be included on the laboratory request form.

10.13 Results of wound swabs should be obtained as soon possible so that there is no delay in the correct treatment being prescribed if needed. Contact IPCT to obtain results if necessary.

11.0 PODIATRY SERVICES AND MRSA

11.1 Podiatry services provide care for many patients with increased risk of developing infection in chronic wounds. Diabetes in particular will be of significance as raised blood glucose levels increase risk of ulceration and infection. Diabetes can also cause suppression to normal inflammatory responses that may mask signs of infection so this needs to be taken into account when assessing a wound.

11.2 When high risk interventions are being considered it is recommended that the MRSA status of the patient is reviewed. If positive or previously positive then suppression therapy and antibiotic prophylaxis may be considered on an individual basis and for further advice contact IPCT or Microbiologist.

11.3 Wound care needs to be carried out using the principles of asepsis in accordance with the Aseptic Technique Policy. This will prevent the introduction of pathogens to the site.

11.4 Every attempt needs to be made to ensure that requests for swabs or antibiotic treatment is timely so that treatment when necessary can commence at the earliest opportunity.

11.5 Due to the invasive nature of some podiatry procedures there is a risk of contamination of inanimate objects such as couches etc with body fluids. Therefore the correct cleaning/disinfection materials need to be at hand and used correctly following risk assessment.

11.6 Wound swabs should be taken if there are signs and symptoms of infection i.e. redness, inflammation, discharge or non-healing persists.

11.7 When taking a swab the wound should be cleaned first to remove surface contaminants and any slough

11.8 A brief history of the patient and current or recent antibiotic treatment should be included on the laboratory request form to aid a more comprehensive laboratory report.

11.9 Results of wound swabs should be obtained as soon as possible so that there is no delay in the

correct treatment being prescribed if needed. Contact IPCT to obtain results if necessary.

12.0 TRAINING

12.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies to this policy subject matter, please refer to Training Needs Analysis (TNA) on the intranet.

12.2 All training undertaken must be recorded on the Organisational Learning Module (OLM) of the Electronic Staff Record (ESR) taken from signing in sheets. Monitoring of training attendance will be carried out by Learning and Development Department. Please refer to the Induction and Mandatory Training Policy. Non-attendance will be managed according to the procedure detailed in the Learning and Development Policy.

12.3 All new staff receives a local induction programme which includes attendance at corporate induction.

12.4 All clinical staff must carry out an annual hand hygiene competency assessment in their clinical area.

12.5 Infection Control update is an annual mandatory requirement for clinical staff and available now as E learning via Learning and Development

12.6 Bespoke infection control training will be provided by IPCT on request.

12.7 Further training is available for staff who undertake the Infection Prevention and Control Link Advisor role. This is in the form of a two day course, generally run twice yearly. IPCT can be contacted for details.

13.0 SUCCESS CRITERIA / MONITORING EFFECTIVENESS

13.1 The IPCT will monitor the effectiveness of this policy by:

- Compliance with MRSA screening will be monitored on a quarterly basis. This will be carried out using Point Prevalence Surveillance (PPS). Results will be shared with service line managers/modern matrons and form part of the infection control reports. These reports are submitted to the Infection Prevention and Control Committee
- Actions and recommendations will be disseminated back to service line managers/modern matrons
- The results of PPS will form part of the reports for the Assurance Committee
- IPCT will regularly review MRSA related infections through the process of on-going surveillance
- The continued reporting of MRSA bacteraemia infections in line with DH guidance and therefore identifying actions for learning.

14.0 EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

14.1 This policy aims to improve safety and reduce risk of spread of infections and consequently improve patient/service user care and outcomes and staff safety. As part of Trust Policy an

equality impact assessment (Steps 1 & 2 of cycle) was undertaken (*See Appendix 4*). The Infection Prevention and Control Team are not aware of any evidence that different groups have different priorities in relation to the use Standard Infection Control Precautions in their care or that any group will be affected disproportionately or any evidence or concern that this Policy may discriminate against a particular population group

15.0 REVIEW

15.1 This policy may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after three years.

16.0 LINKS TO OTHER DOCUMENTS

- Decontamination Policy
- Hand Hygiene Policy
- Standard precautions policy
- Aseptic Technique Policy

17.0 REFERENCES

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18.0 GLOSSARY

MRSA	Meticillin Resistant Staphylococcus Aureus
DIPC	Director of Infection Prevention and Control
IPCT	Infection Prevention and Control Team
IPCLA	Infection Prevention and Control Link Advisor
CSU	Catheter Specimen of Urine
MC&S	Microbiology, Culture and Sensitivity
QDS	Four times a day
PIR	Post Infection Review
SIRI	Serious Incident Requiring Investigation
OLM	Organisational Learning Module
ESR	Electronic Staff Record
PPE	Personal Protective Equipment
PPS	Point Prevalence Surveillance

CQC Care Quality Commission
BD Twice a day
TDS Three times a day

Appendix 1

HOW TO SCREEN FOR MRSA

All emergency or elective patients admitted to hospital require a full MRSA screen according to organisational policy.

All clinicians in both hospital and community settings should consider taking an MRSA screen if, in their professional judgement, it is considered prudent to do so.

Verbal consent needs to be obtained from the patient before obtaining any swab/sample.

The swabs used need to be used dry in accordance with manufacturer's instructions.

Assess the level of contact needed with the patient and/or their environment to carry out the screen and use the appropriate PPE.

Anterior Nares (nostrils)

Perform hand hygiene and use appropriate PPE.
The same swab should be used for both nostrils.
Check expiry date of the swab.
Insert the swab into the anterior nare (nostril) Sweep round and gently upwards
Repeat process with same swab in the other nostril
Without contaminating the swab place back into the culture medium within the container Remove any PPE and dispose of according to organisational policy
Perform hand hygiene
Label swabs accurately before moving onto next part of screen

Groin Swabs

Ensure groin swabs are carried in a private area and that the patient's dignity is maintained at all times. The patient may be able to carry this out themselves under supervision.

Perform hand hygiene and use appropriate PPE
The same swab should be used for both sides of the groin
Check expiry date of the swab
Insert the swab to the left of the inner thigh and groin area using a gentle sweeping motion
Repeat process with same swab in the right hand side of the groin
Without contaminating the swab place back into the culture medium within the container Remove any PPE and dispose of according to organisational policy
Perform hand hygiene
Label swabs accurately before moving onto next part of screen

Wound/ Device/ Skin Lesion Swabs

A full screen will need to include the above if present but may have to be carried out at a different time to the basic nose and groin screen.

All of the above principles apply. Wounds (with the exception of new trauma wounds that should be NOT be swabbed) should be cleaned prior to swabbing.

Catheter Specimen of Urine

If the patient has an indwelling catheter at the time of admission a Catheter Specimen of Urine. (CSU) obtained using a sterile technique

It must be obtained using a sterile technique from the correct sampling port.

Ensure all the patient details are correct on the microbiological request form.

The swabs/specimens can be placed together with the one form.

If swabs or the form is not completed the test will not be carried out.

Document clearly in the admission details that the screen has been completed and reasons why if this has not been possible. Please ensure results are followed up.

Appendix 2

MRSA SUPPRESSION THERAPY REGIMEN

Procedure – daily shower / bath / blanket bath

Duration – 5 days

First line treatment - Hibiscrub® (Chlorhexidine 4%) or Octenisan® wash

- Apply once daily directly to wet skin. Do not dilute in large amounts of water. In hospital settings disposable wipes should be used by staff
- If flannels or wash cloths are used these need to be laundered after each use
- Wash body, neck and face paying particular attention to axillae, groin, perineum, buttocks and other skin folds
- Rinse off thoroughly
- In the hospital setting clean bedding and clothes should be supplied daily during the treatment
- Within the patient's own home this may not be possible and may affect the success of the treatment
- Hair should be washed if possible during this 5 day period using the treatment
- Minor skin dryness or irritation can be controlled by a simple emollient such as E45 cream
- As with any medication if the patient experiences signs of allergic reaction or severe skin irritation the treatment should be immediately discontinued

For patients with a documented chlorhexidine allergy or the patient has dry skin or a known skin condition the following options should be considered after seeking medical advice

Second line treatment where Chlorhexidine or Octenisan are not suitable **– Dermol 500®**

For contraindications, special warnings and other interactions, please refer to the latest British National Formulary medical compendium for manufacturer's advice.

NOSE

Procedure – apply to both nostrils three times per day

Duration – 5 days to coincide with topical washing

First line treatment - Mupirocin 2% (Bactroban®) –Three times daily for 5 days

- Using a clean finger the patient should apply a pea-sized amount of the ointment around the inside of each nostril and squeeze their nose for few seconds
- As with any medication if the patient experiences signs of allergic reaction or severe irritation the treatment should be immediately discontinued

Repeated or prolonged courses of Mupirocin 2% must be avoided due to the possible development of resistance

For patients with a Mupirocin resistance or allergy the following option should be considered after

seeking medical advice

Second line treatment – Chlorhexidine hydrochloride 0.1%, neomycin sulphate 0.5% (Naseptin®)

For contraindications, special warnings and other interactions, please refer to the latest British National Formulary medical compendium for manufacturer's advice.

Please note that for in-patients the MRSA Suppression Therapy needs to be prescribed correctly and clearly on the patient's prescription chart.

Inter-healthcare infection control transfer form

Patient/client details: (insert label if available) Name: Address: NHS number: Date of birth:	**Consultant:** **GP:** **Current patient/client location:** **Transferring facility – hospital, ward, care home, other:** **Contact no:** Is the ICT aware of transfer? Yes/No
Receiving facility – hospital, ward, care home, district nurse **Contact no:** Is the ICT/ambulance service aware of transfer? Yes/No	Is this patient/client an infection risk? ***Please tick most appropriate box and give confirmed or suspected organism*** ☐ Confirmed risk Organism: ☐ Confirmed risk Organism: ☐ Suspected risk Organism: ☐ No known risk Patient/client exposed to others with infection eg D&V Yes/No

If patient/client has diarrhoeal illness, please indicate bowel history for last week:
(based on Bristol stool form scale, see previous page)

Is the diarrhoea thought to be of an infectious nature? Yes/No

Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant enterococcus SPP, *C. difficile*, multi-resistant *Acinetobacter* SPP) and treatment information, including antimicrobial therapy:

Specimen:				
Date:				
Result:				

Treatment information:

Other information:

Is the patient/client aware of their diagnosis/risk of infection? Yes/No

Does the patient/client require isolation? Yes/No

Should the patient/client require isolation, please phone the receiving unit in advance.

Signature of staff member completing form: .....

Print name:

Contact number:

For further advice, please contact your infection control team/adviser

Appendix 4

MRSA and MSSA Suppression Regime

Information for patients, staff and carers.

MRSA is short for (Meticillin-Resistant *Staphylococcus aureus)*
MSSA is short for (Meticillin-Sensitive *Staphylococcus aureus)*

You are being given this treatment because you either carry or are at increased chance of carrying MRSA or MSSA on your skin or up your nose. It is not always necessary to treat this however there will be times when your clinician feels it would be beneficial for you to use this treatment to reduce the risk of complications.

Please read this sheet carefully and follow all of the instructions. If you need help to do this, please ask a nurse / carer / relative to assist you.

What does the treatment involve?

You will be given a treatment soap to wash with and some nasal cream to put up your nose. You should use both for 5 days.

- Wash all over with the treatment soap once a day for 5 days
- Put the cream up your nose 3 times a day for 5 days

What is the treatment soap?

The soap you will usually be given is called Hibiscrub. It is a pink, lightly perfumed liquid soap containing chlorhexidine. You should not use it if you have an allergy to chlorhexidine (alternatives are available). Hibiscrub should not be used on children.
Sometimes you may be given an alternative soap called Octenisan. This works in the same way but has different ingredients.

How often should I use the special soap?

You should wash your whole body using this treatment soap
Once a day for 5 days.

How do I use this treatment soap?

- You can use the treatment soap in the bath or shower
- Do not dilute the treatment soap in water.
- Wet your face and body first.

- Pour undiluted soap onto a clean washcloth then wash **all over, leaving the soap on your skin for at least 1 minute.**
- Pay special attention to your face, armpits and groin but do not use inside the body.
- Wash your hair with the treatment soap on days 1 and 3 of treatment. You can use your normal shampoo/conditioner in between.
- Use the treatment soap generously the bottle provided is the correct amount for the entire treatment
- To increase effectiveness of the treatment clean towels and fresh clothes should be used after washing. Bed sheets, pillows and nightclothes should be changed daily.

What is the ointment that I put up my nose?

The ointment is called Mupirocin (Bactroban®). It is an antibiotic ointment. It does not contain penicillin. You should not use the ointment if you are allergic to Mupirocin or paraffin cream (alternatives are available).

How do I use this ointment?

Using a clean finger, you should wipe a pea-sized amount of ointment around the inside of each nostril and squeeze your nose. You should be able to taste the ointment in the back of your throat when you have finished. If you cannot, you should apply a small amount of extra cream. **You must wash your hands after this.**

How often should I put the ointment up my nose?

You should put the ointment up your nose ***three times a day for 5 days***.

Are there any risks to me?

The ointment sometimes causes irritation to the skin in your nose. If this happens, stop using the ointment and talk to a member of staff.

After 5 days, your treatment is complete. Please do not continue with the ointment or soap beyond 5 days.

You will not routinely be re-swabbed for the presence of MRSA or MSSA after completing the treatment.

Further Information:

Infection Prevention Team Solent NHS Trust
Enablement Services Building
St Mary's Community Health Campus
Milton Road, Portsmouth, PO3 6AD

Telephone: 02392 685433
Team email: snhs.infectionteam@nhs.net

Appendix 5

EQUALITY AND HUMAN RIGHTS IMPACT ASSESSMENT

	Answer
1. What are the main aims and objectives of the document?	To provide clear guidance and direction to staff within Solent NHS Trust on the principles of the management of Meticillin Resistant *Staphylococcus Aureus* (MRSA) within a variety of community settings.
2. Who will be affected by it?	All staff and patients/service users of Solent NHS Trust services.
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Compliance with: > Health & Social Care Act 2008 > Care Quality Commission Care Standard > Standards for better Health (DH 2004)
4. What information do you already have on the equality impact of this document?	This document is unlikely to have an adverse equality impact
5. Are there demographic changes or trends locally to be considered?	Not aware of any local incidents which would have increased local population susceptibility to infections .e.g. public health incident.
6. What other information do you need?	None

Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully against any group?		X	
2. Can any group benefit or be excluded?	X		Of potential benefit to all patient/service users.
3. Can any group be denied fair & equal access to or treatment as a result of this document?		X	
4. Can this actively promote good relations with and between different groups?	X		
5. Have you carried out any consultation internally/externally with relevant individual groups?	X		Internal consultation.
6. Have you used a variety of different methods of consultation/involvement	X		
Mental Capacity Act implications		X	
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)		X	.

If there is no negative impact – end the Impact Assessment here.

28.01.2016: At this time no negative impact identified.

At this time positive impact identified- Compliance with Health & Social Care Act 2008 and CQC Care Standards would minimise infection risk and increase safety for patient/ service users and staff groups