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## Care UK Infection Prevention and Control Policy – Meticillin-resistant *Staphylococcus aureus* (MRSA) (Healthcare only)

Controlled document

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## **1 Standard**

Employers and employees are responsible by law for ensuring that no person, whether that is a patient, visitor or member of staff is exposed to any avoidable risk, as far as is reasonably practicable.

Meticillin-resistant *Staphylococcus aureus* (MRSA) continues to cause concern, this has been mainly due to lack of knowledge on the subject, inappropriate or incorrect advice being given and mistaken media coverage. This policy has been developed from the guidelines for the control and prevention of Meticillin resistant *staphylococcus aureus* (MRSA) in hospitals (2006), and aims to give clear factual information, to ensure that optimum care and management of patients colonised / infected with MRSA, and to minimise the risk of spread to other patients and staff.

This policy should be read in conjunction with other Care UK Clinical and Infection Prevention and Control policies, procedures and guidelines, and assume that everyone is not only familiar with the following practices, but also carries them out at all times:

- MRSA screening
- Hand hygiene
- Use of Personal Protective Equipment (PPE)
- Disposal of clinical waste safely and correctly
- Disposal of linen safely and correctly
- How to manage Service User skin to prevent breakage or damage to the skin (MRSA if present will readily colonise on any broken area of skin)

Further advice can be obtained from Care UK Group Infection Prevention and Control Nurse. Nationally the numbers of MRSA are increasing; these are not just confined to the National Health Service but are equally affecting the Independent Sector, Primary Care and Community Care setting including Residential and Nursing Homes, and Mental Health Residential Homes and Hospitals.

## **2 Aim**

Care UK is committed to limiting the spread of MRSA in community, primary and secondary care settings, and ensuring that patients with MRSA are managed effectively. The purpose of this policy is to provide Care UK staff with comprehensive guidance to detect, prevent and control the spread of MRSA. This will ensure compliance with key elements of the Health Act 2008. The principles contained within this policy reflect best practices and should be adopted by all staff working in a clinical environment.

## **3 Objective**

- Prevent the acquisition of MRSA
- Eradicate it when it does arise
- To explain the precautions that should be taken by Care UK to staff to minimise the spread of MRSA
- To ensure that patients who are discharged into the community with MRSA do not have their care compromised due to their colonisation / infection.

#### **4 Scope of the policy**

This policy applies to all services directly provided by Care UK and all clinical staff should familiarise themselves with the policy. It is the responsibility of each member of staff to reduce Healthcare Associated Infections (HCAI's) and the transmission of infection during interventional procedures. Care UK recommends that members of staff apply the principles of this policy as minimum standards within their practices to ensure that their professional and contractual responsibilities are discharged.

#### **5 Confidentiality**

MRSA is part of the patient's diagnosis. Personnel who do not have access to the patients medical / nursing health records should not be told the nature of the illness, but should be given specific infection prevention and control guidance. Divulging a diagnosis inappropriately is a breach of confidentiality.

#### **6 Documentation in nursing and medical records**

Patients found to be MRSA positive must be clearly identified, so that carriers may be immediately recognised on subsequent admissions to Care UK facilities. For Independent Sector Treatment Centres (ISTC's) the inside front sheet should clearly identify MRSA using an alert sticker. The nursing and medical team must document the MRSA colonisation / infection in the patients' notes and care plan.

#### **7 Terms and definitions**

*Staphylococcus aureus* is loosely attached to the skin, making it easy to remove by conventional means such as hand washing, skin disinfection prior to invasive procedures. In addition, those that remain on the skin can easily be redistributed to other sites either on the individual affected or to others. Also we shed skin scales in vast numbers all of the time, these contribute to the development of dust on surfaces and equipment, hence why environmental and equipment cleaning is a key intervention in the control of this microorganisms.

**Expert opinion is that direct skin to skin transfer, either from sites on the patient's own body or from healthcare workers hands is much more common form of acquisition than from the environment.**

##### **7.1 Meticillin-sensitive *Staphylococcus aureus***

*Staphylococcus aureus* (*S. aureus*) often referred to as Meticillin-sensitive *Staphylococcus aureus* (MSSA) is a Gram positive bacterium. It is very common and usually lives harmlessly on the skin and in the lining of an individual's nose. 20-40% of the general population and approximately 50% of healthcare workers and/or hospital in-patients will be nasal carriers at any given time, without causing any harm to them. However, if *S. aureus* gains access to tissue beneath the skin, the mucosa or blood it may cause infections such as abscesses, wound infections, chest infections. It may, rarely, cause severe systemic infections.

## 7.2 Meticillin-resistant *Staphylococcus aureus*

Some strains of *S. aureus* have become resistant to Meticillin (Meticillin is an antibiotic that is not used clinically), having acquired the *mecA* gene, which confers resistance to a range of antibiotics including all beta-lactams and cephalosporins. Hospital MRSA is often epidemic, which are also resistant to several other antibiotics. The prevalence of MRSA in the population is considerably lower than its counterpart MSSA, this varies from country to country, with the United Kingdom (UK) seeing a significant rise in recent years in the reported MRSA rate (blood stream infections).

MRSA behaves in the same way as MSSA, there is no evidence that MRSA causes more severe infections than MSSA, but treatment is often more difficult and expensive. MRSA is not a significant risk to healthy people, including healthcare workers and visitors, but can cause serious infections in vulnerable patients.

## 7.3 MRSA bacteraemia

MRSA bacteraemia is a blood stream infection, this is a life threatening sepsis that can lead to death if not diagnosed early and treated effectively. Patients who have a MRSA blood stream infection will need to be managed in a general hospital. From December 2006, all healthcare facilities must do all in their power to deliver the objective of zero avoidable MRSA blood stream (bacteraemia) infections in healthcare.

Care UK should under take a root cause analysis for all cases of identified MRSA bacteraemia. Root cause analysis is an effective learning tool to understand why bacteraemia occurs and plan appropriate actions to prevent future cases. The result will help Care UK to gain a better overall understanding of the source and contributory factors associated with severe infections

## 7.4 Definition for Colonisation and Infection

The effect of MRSA on individual patients is variable. It is important that staff and patients are aware of the difference between colonisation and infection in relation to MRSA. An individual patient assessment should be undertaken to determine if the patient is **colonised** or **infected** and if an eradication programme needs to be initiated or continued.

### 7.4.1 Colonisation

*Isolation of MRSA on one or more occasions from any site in the absence of clinical disease (infection) attributable to MRSA*

When a patient is routinely screened for MRSA prior to admission, the sites screened are those sites that the bacterium is known to colonise, in other words the microorganisms is present on these skin sites but they are not causing the individual any adverse effects. The patient is said to be colonised.

## 7.4.2 Infection

*Clinical signs and/or symptoms of infection, such as redness, swelling, discharge; which is confirmed by culture of MRSA from the site of infection*

The term infection is generally used to mean the deposition and multiplication of microorganisms in tissues or on the surfaces of the body, which are damaged or on mucous membranes, where they can cause adverse effects often resulting in disease (infection).

It is impossible to determine from clinical specimens whether an individual has an infection or is merely colonised. In these circumstances the clinical conditions of the patient must determine whether they have an infection or not.

## 7.5 High risk patients

Some patients are known to be at higher risk of subsequently developing infection with MRSA as a result of their hospital care. These patients carry a higher risk of adverse outcomes as a result of MRSA infections as these are more difficult to treat due to antibiotic resistance and this may increase both morbidity and mortality. Patients who are deemed to be at higher risk of adverse outcomes are those requiring complex care including management in High Dependency Units.

### Comparing the signs and symptoms of infection and colonisation

Sign and Symptom	Colonisation	Infection
Erythema (redness)	No	Yes
Pyrexia (raised temperature)	No	Yes
Cellulitis (inflammation of tissue around the wound)	No	Yes
Odour	Yes	Yes
Positive swab result	Yes	Yes
Purulent discharge (pus)	No	Yes
Excess exudates (fluid)	Yes	Yes
Local pain	No	Yes
Local oedema	No	Yes

## 7.6 Definition for Acquisition

### 7.6.1 Care UK Acquired

MRSA isolated for the first time (new isolate), after 48 hours of admission.

### 7.6.2 Non-Care UK Acquired

MRSA positive within 48 hours of admission or known at the time of admission

## **8 Transmission of MRSA**

The problem is due to the ability of MRSA to spread via hands and equipment to patients who are at risk. Those at greatest risk are those with:

- Indwelling medical devices such as urinary catheters, intravenous catheters
- Skin lesions and wounds
- Chronic skin conditions
- Surgical intervention

### **8.1 How is MRSA spread?**

- Contact usually via the hands of healthcare professionals/workers
- Shed skin scales, which may transfer from another patient or from a member of staff's contaminated uniform
- Droplets from aerosol spray (sneezing/coughing) from a colonised or respiratory infected patient
- The patient may be colonised with MRSA
- A dirty and/or dusty environment, MRSA can remain viable in dust and dirt for a considerable length of time
- Contact with contaminated equipment

Although MRSA can be spread by airborne route or on equipment, the most common route is by contact between people, underlining the importance of good hygiene before and after direct patient contact.

## **9 Screening**

While screening is not a control measure in itself, it allows focusing of effective, infection prevention and control resources on positive patients.

### **9.1 Healthcare settings**

The overall risk of MRSA infection is not high, but MRSA infection as a complication can be serious, for example leading to removal of prosthetic implants and potentially death. By 1<sup>st</sup> April 2009 all elective admissions, including patients treated in non-acute provider units and NHS patients treated by the Independent Sector are required to be screened for MRSA colonisation. In addition, oncology/chemotherapy patients should be screened at the start of their treatment and then at regular intervals or if clinically indicated, as these patients are at particular risk of MRSA bacteraemia because of their immuno-suppression and the procedures for vascular access that are an essential part of their treatment.

Patient groups that are exempt from the screening requirements are:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures e.g. warts or other liquid nitrogen applications
- Children/paediatrics unless already in a high risk group
- Maternity/obstetrics except for elective caesareans and any high risk cases,
- Mental Health Patients.

There are no other exemptions, any local **plans which exempt other groups, such as all day cases, will not be compliant** with the screening requirements in the Operating Frameworks for 2008/09 and 2009/10.

It is also important that Care UK continues to assess all patients' admission groups for screening according to risk at a local level (DH 2008). In particular:

- Patients who are social/healthcare staff, due to their exposure to MRSA positive patients
- Other health-related staff may also warrant assessment for screening, for example veterinary personnel who have been found to have relatively high (18%) rates of MRSA carriage (Loeffler et al, 2005)
- Patients previously known to be MRSA positive
- Previous hospital stay (longer than 48 hrs) within previous 12 months (UK or abroad)
- Admission from Nursing/Residential Homes.

## 9.2 MRSA Screening

### 9.2.1 Healthcare setting

Routine screening for MRSA involves taking swabs from:

- **Nose:** pre-moisten the swab with sterile normal saline, and then rotate the swab in each anterior nares (nostril) in turn, using the same swab for both nares

Please note that in the event of the MRSA screen of the nose showing a positive result or local policies requiring a second swab to be taken a second swab should be taken from the perineum. In such cases please see details of the perineum swab procedures below.

- **Perineum:** pre-moisten swab with sterile normal saline, and then rotate the swab on the perineum. If it is not possible to sample the perineum then the screen can be taken from the groins, remember to state the site of the screen on the microbiology request form. It is not necessary to use one swab for each side. Perineal carriage, especially in women, can pre-dispose to urinary tract contamination

### Other sites that may require screening

**Wounds:** this includes surgical wounds, leg ulcers, pressure ulcers, eczema or other skin lesions. MRSA invades the wound from the outside, therefore it is not necessary to irrigate or clean the wound before taking a normal MRSA screening swab in the absence of clinical signs of infection. If a patient has a wound with MRSA it will be unlikely that the wound will become negative until the wound has healed. Treatment of the wound should follow good wound healing practice that would be used for any wound.

**Non-infected wounds:** pre-moisten the swab in sterile normal saline and rotate across the wound. For large ulcers, take the swab over at least 1cm<sup>2</sup> of the wound bed

**Clinically infected wounds:** if the wound is showing signs of clinical infection, this could be a deep-seated infection; therefore it is important to sample the wound bed. The swab should be taken before the wound is cleaned, although excessive exudates and adhering debris should be gently removed. Care should be taken to not contaminate the specimen with normal (commensal) flora from the wound margins. Pre-moisten the swab in sterile normal saline and rotate in either the discharge, if present, or the base of the wound. By rotating the swab you will ensure that a good contact with the wound as been achieved.

Wounds that were positive and now healed: **pre-moisten the swab in sterile normal saline and rotate over the healed area. By rotating the swab you will ensure that a good contact with the wound as been achieved**

**Invasive devices:** if the patient has an invasive medical device, such as a PEG in situ then the point of entry will require MRSA screening. Pre-moisten the swab with sterile normal saline, and then rotate the swab around the entrance site

**Urine:** if on admission the patient has an indwelling urinary catheter, a CSU is required. Specify this on the form for MRSA screening

**Other specimens:** Other specimens are not required routinely but can be undertaken if clinically indicated. This could include sputum, faeces, vaginal swab and blood cultures. Occasionally you may be asked to swab a patient awaiting hospital treatment or to determine the extent of colonisation. Remember a negative screen does not guarantee that the patient is completely MRSA negative.

### **Follow up screens on known MRSA positive patients**

Once the eradication therapy is completed, a period of 48 hours is needed before screening swabs can be taken to allow time for the eradication therapy to wear off. Three complete sets of negative swabs, taken over three consecutive weeks, have been obtained from all relevant sites; after which they can be declared 'clear' and isolation precautions discontinued.

All patients still in hospital after 7 days must be screened weekly for MRSA acquisition / colonisation until discharge. If they are subsequently found to be MRSA positive from any site, the MRSA treatment must be commenced and isolation precautions implemented. This must be raised as a clinical incident.

If any of the screening results are positive please discuss this with the Care UK Group Infection Prevention and Control Nurse prior to taking any further screening swabs. Staff should only initiate further eradication therapy protocols following discussion with the Care UK Group Infection Prevention and Control Nurse.

### 9.2.2 Staff screening

Efforts to prevent the spread of MRSA should be concentrated on the emphasis of good personal hygiene, maintaining a clean environment, maintaining clean equipment and the use of standard infection prevention and control precautions. The joint working party (JWP) of the British Society of Antimicrobial Chemotherapy, the Hospital Infection Society and the Infection Control Nurse Association (JWP) (2006) does not advocate routine screening of staff, however, in certain circumstances it may be necessary. For instance, if new MRSA colonisations are found among patients on a ward, and transmission continues despite active control measures.

Screening should only be conducted on the advice of the Care UK Group Infection Prevention and Control Nurse or the Care UK Occupational Health Manager.

Staff found to be MRSA positive will be offered an appropriate course of treatment and should be re-screened three times (one per week for three weeks) before they can be considered clear of MRSA. In principle, only staff members with colonised or infected hand lesions are required to be off work whilst receiving treatment for eradication.

**Important:** if a member of staff has a lesion(s), sore hands or areas of eczema or dermatitis on their hands or arms, Occupational Health must assess them. Medical advice should be sought during exacerbation of any skin condition, in these circumstances staff should not be involved in direct patient care. **It is essential that staff found to be MRSA positive are treated in the strictest confidence and with full regard of confidentiality and data protection issues.**

## 10 Admission

### 10.1 Healthcare setting

All patients for elective surgery should be assessed prior to surgery. They should therefore arrive on the ward to be admitted with a known MRSA status, and have undergone the eradication programme if found to be colonised with MRSA. Patients who have not been assessed pre-admission pose a risk not only to them selves but also to other if admitted and subsequently found to be colonised with MRSA.

## 11 Clinical management of patients (known or suspected of MRSA)

The infection prevention and control team should be informed if any patients with MRSA are admitted/transferred. Patients found to be MRSA positive must be clearly identified by flagging their electronic/hard copy records so that carriers may be immediately recognised on subsequent admissions.

### 11.1 Treatment of infection

Patients suspected of having a MRSA infection must be treated with anti-MRSA drugs. Advice regarding specific anti-microbial therapy can be obtained from your local Consultant Microbiologist, and your local antimicrobial prescribing guidelines. MRSA should be considered as one of the potential pathogens should a patient

present with signs and symptoms of infection/sepsis. Early recognition and treatment is essential.

## **11.2 Treatment of colonisation**

Complete eradication of MRSA is not always possible, but a decrease of carriage can reduce the risk of transmission, as well as reduce the risk of inoculation to the patient's own surgical wound during surgery. The efficacy of any eradication regime will depend on the presence of wounds, skin lesions and foreign bodies such as urinary catheters. The MRSA eradication program should be carried out under the advice and supervision of the Infection Prevention and Control Team.

### **11.2.1 Healthcare setting**

The eradication program should be followed for a 5 day period following any positive MRSA result. It should be prescribed by a Clinician (or Nursing staff if under a Patient Group Directive). If the result is **not** from a screen, for instance the result was obtained from a wound swab, blood culture, urine sample, then a MRSA screen from the nose, axilla and perineum should be taken prior to commencing the MRSA eradication program. Refer to the Care UK MRSA screening policy for the MRSA eradication program.

## **12 Control Measures**

Patient care must not be compromised by control measures.

### **12.1 Standard isolation precautions**

Single room doors should be kept closed whenever possible to minimise spread to adjacent areas. If this is likely to compromise patient care, a risk assessment should be made, and documented by the nursing staff as to whether the door may be kept open. However, doors **must** be closed for procedures that may generate aerosols, for example chest physiotherapy, bed making or wound dressing. Standard isolation precautions are required for all known or suspected patients with MRSA. An appropriate sign stating 'Infection Control precautions please contact nursing staff before entering' should be displayed outside the patients room (Refer to Care UK isolation policy).

If a patient is being nursed in a Bay, and then identified to be MRSA positive, they must be moved to a single room and standard isolation precautions commenced. The bay bed space should be cleaned using Actichlor Plus / Chorclean 1.000ppm. If the patient had been in the bay for more than 48 hours then the other patients in the bay should be screened for MRSA.

Standard isolation precautions may usually be discontinued once three consecutive negative screens have been received from all sites that require screening. Check with the Infection Prevention and Control Team first before discontinuing isolation.

**Other microorganisms, such as *Clostridium difficile*, may take precedence over MRSA colonisation for isolation. The Infection Prevention and Control Team will discuss this with the ward nursing staff.**

## **12.2 Personal Protective Equipment (PPE)**

Disposable plastic aprons and gloves must be worn by all staff in contact with the patient, contact with secretions, blood and/or body fluids, their environment, linen, waste and equipment.

- **Gloves:** use single use, non-sterile, non-powdered gloves. Gloves should be worn when carrying out intimate care tasks or where there is a risk of contact with blood or body fluids. **This is a standard infection prevention and control precaution practice and applies whether MRSA is present or not**
- **Aprons:** single use plastic aprons should be worn when there is close contact with patient or risk of contact with blood or body fluids
- **Disposal of PPE:** aprons and gloves should be disposed of after **one use only**, as clinical waste

## **12.3 Hand Hygiene**

Healthcare workers should follow good hand decontamination procedures with soap and water, followed by the use of alcohol based hand rub prior to and after all patient contact and after removal of PPE. Hand washing is the single most important means of controlling the transmission of MRSA, as well as other microorganisms and remains the cornerstone of good infection prevention and control.

## **12.4 Waste Disposal**

Waste should be placed in clinical waste bins and disposed off accordingly (Refer to Care UK Waste Management Policy and Guideline).

## **12.5 Equipment**

**Ideally, all equipment should be dedicated to the use of the patient in standard isolation and kept in their room until discharge or discontinuation of isolation precautions.** Equipment shared between patients such as stethoscope must be thoroughly cleaned using either a general purpose detergent and hot water or a detergent wipe, followed by a disinfectant wipe or an alcohol wipe before being used on another patient. All equipment must be decontaminated prior to removal from the patient's room. Equipment on loan, such as special mattresses, should be returned after they have been decontaminated and a Permit to Work form completed (Refer to Decontamination of Equipment).

**12.6 Laundry:** used linen must be treated as infected and placed in an alginate bag then placed inside a red plastic bag prior to being removed from the room.

**12.7 Environment:** following discharge of the patient or discontinuation of standard isolation precautions, vacation cleaning of the patient's room is required.

This includes thorough cleaning of all horizontal and patient contact surfaces with Actichlor Plus/Chlorclean 1.000ppm. Curtains, including shower curtains, need to be removed before vacation cleaning is commenced if patient has been in the bed space for more than 24 hours.

**12.8 Visitors:** are not required to wear PPE unless they are providing and/or assisting with direct patient care. However, they should be asked to wash their hands on entering and leaving the room.

**12.9 Patient activity (healthcare setting):** all known or suspected MRSA positive patients nursed in a side room are able to mobilise outside their room unless they have a productive cough, exudating wounds or an exfoliating skin condition when advice should be sought from the Infection Prevention and Control Team. Patients should be discouraged from entering other patients bay areas, day rooms, or ward kitchens, but they can go off the ward. Patients should decontaminate their hands with alcohol based hand rub prior to leaving their room.

### **13 Operating theatre management**

Where possible, all known positive patients and those admitted for surgery without pre-admission screening should be placed last on the list, or 15 minutes must be allowed between cases for comprehensive environmental cleaning. Standard precautions require a robust adherence to optimum peri-operative clinical practices should preclude any additional precautions being required. Therefore, prior to any planned surgery, efforts should be made to minimise the risk of infection through topical and systemic decolonisation, and prophylactic antimicrobial chemotherapy, where appropriate. Preparing the patient for theatre:

- Medical/Nursing staff must inform the theatre co-ordinator that the patient has MRSA colonisation/infection. The patients confidentiality must be maintained
- Medical staff should consult the Microbiologist to discuss chemoprophylaxis and inform the theatres of the known/suspected cases.

#### **13.1 Anaesthetic room**

If MRSA patients are anaesthetised in the anaesthetic room it is imperative measures are taken to reduce potential contamination of equipment in the room prior to use by another patient.

- Powder-free, disposable, non-sterile gloves and disposable plastic apron must be worn by all staff for contact with the patient, their environment and equipment
- Clean all patient contact areas with a general purpose detergent and hot water or detergent wipes
- Clean and disinfect all reusable equipment

#### **13.2 Recovery**

MRSA patients who are last on the list should be recovered within the operating theatre where appropriate. However, they can be recovered in the main recovery area with the following precautions:

- Recover as far as possible from other patients, leaving a minimum of one bed space between
- Remove all unwanted equipment and unnecessary disposables from the bed space area
- Standard isolation precautions to be followed at all times
- Wash hands or decontaminate with alcohol based hand rub prior to and after contact with the patient, their environment and equipment
- Clean the bed space after the patient has been transferred with Actichlor Plus/Chlorclean 1.000ppm, disposing of all waste as **clinical waste**
- Linen must be treated as infected and placed into an alginate bag

## 14 Low risk areas

This includes areas such as outpatients, diagnostic imaging, endoscopy etc, where the risk of acquisition and spread are deemed to be minimal. As long as standard precautions are followed at all times, paying particular attention to hand washing and the use of PPE for clinical procedures. Examination/procedure couches must be cleaned between each patient and clean paper roll applied. The environment should be decontaminated after the patient has been treated, only if the patient has undergone a procedure requiring the removal of their clothing, which increases the likelihood of environmental contamination i.e. endoscopic procedures. All equipment which has had direct contact with the patient must be cleaned prior to use for another patient.

## 15 Transfer of the patient

### 15.1 Healthcare setting

All internal transfers must have the transfer check list completed prior to the transfer taking place. Patients who are MRSA colonised can visit other hospital departments for treatment, investigations following consultation with the Manager/Deputy of the department. Procedures should ideally be booked at the end of the session to allow time for cleaning and disinfection of staff and patient contact areas.

Portering staff should wear disposable gloves and apron **only** when required to have direct contact with the patient for instance helping with moving and handling. PPE should be disposed of as clinical waste, and hands must be decontaminated. Hands should also be decontaminated prior to and following contact with the patient and prior to moving the patient through the hospital.

The trolley/wheelchair should be decontaminated with a general purpose detergent and hot water or detergent wipes after use and prior to use for another patient.

#### 15.1.1 Transfer to other Hospitals

The transferring ward is responsible for informing the receiving hospital if the patient is colonised/infected with MRSA. Before transfer, the clinician responsible for the patients care should inform the receiving ward and the Infection Prevention and Control Team at the receiving hospital. A transfer form must be completed for all patients giving full details of their MRSA status and MRSA treatments.

### **15.1.2 Discharge**

Patients with MRSA should be discharged promptly, when their clinical condition allows. No special precautions are required; there is no evidence that ambulance staff/hospital drivers or their families are put at risk by transporting patients with MRSA.

If the hospital is contacted regarding a positive MRSA result on a patient not previously known to be MRSA positive, and the patient is either about to be discharged or has already been discharged, the a copy of the result should be forwarded to the patient's General Practitioner (GP) and inform the relevant PCT Infection Prevention and Control Lead.

Patients colonised with MRSA should complete the 5 day course of the MRSA eradication programme at home, if it has already been commenced prior to discharge. The patient's GP should be informed of the patient's MRSA status in the discharge letter and any ongoing treatment by the discharging medical team.

Patients should be advised that if they should be re-admitted to hospital at any time, they should advise the admitting staff that they have previously been identified as colonised/infected with MRSA, in order to ensure that they are appropriately managed.

It is crucial that the patient, their relatives and/or carers should be fully briefed on MRSA and informed that there is no risk of infection to healthy relatives and contacts outside the hospital, and that normal social interaction should not be compromised. Where contact will be with relatives or friends who may be hospital workers with patient contact or with individuals who may be receiving hospital treatment, the individual case should be reviewed with a member of the Infection Prevention and Control Team and the Occupation Health Manager.

## **16 Deceased patients**

There is no specific risk from the body to relatives, nursing staff or undertakers. The precautions taken in laying out deceased patients must be the same as those observed during life. The patient should be placed in a cadaver bag before being transferred to the mortuary/undertakers, **only** if there is the potential for body fluid to leak from the decease during transportation. Any lesions that leak should be covered with an impermeable dressing. There are no requirements to use a cadaver bag because the deceased was MRSA positive.

## **17 Management of MRSA outbreaks**

If there is deemed to be an increased amount of MRSA in a Unit the Infection Prevention and Control Team will convene an Outbreak Committee (OC), please refer to Care UK Outbreak Management Policy.

The OC may consider screening other patients and/or staff (medical, nursing, therapists etc). The extent of such screening will be determined by the local Infection Prevention and Control Team, and clear lines of accountability and

responsibility for screening will be established. The sites to be screened will be determined by the OC, but will usually be restricted to nose and skin breaks/lesions. If the screening programme indicates widespread colonisation of patient/staff, the OC will consider implementing a treatment protocol for all patients/staff, regardless of their MRSA status as a means to control the spread. In such circumstances, it may be recommended to close the Unit to new admissions and/or discontinue operative procedures and/or non-essential clinical work. This decision will be made by the OC after consultation with appropriate senior managers.

In the unlikely event of a widespread outbreak, liaison with the service locations local Consultant in Communicable Disease Control (CCDC) at the Health Protection Agency (HPA) is vital. The CCDC has a statutory responsibility under the Public Health Act to ensure that adequate arrangements are in place to control any outbreak. They should be invited to attend the OC meetings.

### **18 Patient and relative information**

MRSA is not a problem for healthy individuals, therefore there is no reason why relatives and friends should not have contact with a person colonised or infected with MRSA. They should be advised to wash their hands after visiting. They do not need to wear gloves or aprons, these are only required if the relative is actively involved in the patients care. If any relative has re-existing serious illness, further advice may be required from their GP or the infection prevention and control team. The patient and/or their relatives should be given an explanation of MRSA by the nurse/doctor caring for them, reinforced by an MRSA information leaflet. There should be a stock of information leaflets kept in each area.

### **19 Training requirements**

Care UK aims to ensure that all members of staff receive the level of training necessary for them to fulfil their individual responsibilities identified in this policy.

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