# Meticillin Resistant *Staphylococcus Aureus* (MSRA) for Community Settings Policy

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|-------------------------|---------------------------------------------------------------|
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| In consultation with | Infection Prevention Control Forum  
NSCP Senior Pharmacist |
| To be read in association with | Hand Hygiene policy, Standard Infection Control Precautions policy, Linen policy, Uniform dress policy, Waste policy, Decontamination policy, Asepsis policy, Isolation Policy |
| Ratified by | Infection Prevention Control Forum |
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| Review date | February 2019 |
| This policy supports compliance with the CQC 5 Domains: | Safe  
Caring  
Effective  
Responsive  
Well Led |
| NHSLA Risk Management Standard(s): | 4.6 |

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<tr>
<th>Type of Document</th>
<th>Title</th>
<th>Author</th>
<th>Date</th>
<th>Version</th>
<th>Ratifying Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>MRSA for Community Settings Policy</td>
<td>Suzanne Golding-Ellis</td>
<td>Oct 2012</td>
<td>3</td>
<td>COIG</td>
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<td>Policy</td>
<td>MRSA for Community Settings Policy</td>
<td>Suzanne Golding-Ellis/Laurie Chapman</td>
<td>May 2015</td>
<td>4</td>
<td>Review only</td>
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<td>Policy</td>
<td>MRSA for Community Settings Policy</td>
<td>Suzanne Golding Ellis Reviewed by Julia Bloomfield</td>
<td>Feb 2017</td>
<td>6</td>
<td>Minor amendment made</td>
</tr>
</tbody>
</table>
1. **Introduction**

The prevention and control of Health Care Associated Infections (HCAI) is a priority for all healthcare providers (The Health and Social Care Act 2008). As a result it is essential that all staff are aware of the correct procedures/policies to reduce the spread of Meticillin Resistant *Staphylococcus aureus* (MRSA).

Good hygiene (Standard Infection Control Precautions) is all that is required to prevent the spread of MRSA. Thorough hand decontamination between caring for patients/clients and whenever necessary (before and after all patient contacts), has been shown to be the single most important measure in reducing cross infection.

2. **Purpose/objective of the document**

The purpose of this policy is to ensure that all suspected or confirmed cases of MRSA are promptly identified and appropriately reported and treated, thereby reducing the potential for cross infections.

In line with the Health and Social Care Act (2008), staff education should include training on decontamination procedures, isolation of infected or colonised patients, requirements for transport of patients who are known to be infected or colonised, and how to take the samples.

Staff also need to be aware of the surveillance and reporting requirements as dictated by the Department of Health and associated departments.

3. **Scope**

This policy applies to all staff working in North Somerset Community Partnership involved with patient services in either the healthcare setting or patient’s/client’s own home, including bank, agency, students and volunteers.

Individuals have the responsibility to comply with this policy and to report any incidents/risks that occur.

Managers have the responsibility to ensure staff comply with this policy and for ensuring that adequate hand hygiene resources are available at all times.

4. **Background**

The control of Meticillin Resistant *Staphylococcus Aureus* (MRSA) is recognised by many authorities as being important in all healthcare settings. Controlling the spread outside a hospital environment has often been neglected. However, the recent trends towards early discharge, short inpatient stays, day surgery, minor surgery in community settings, the provision of parenteral therapy at home and the continuous movement of patients means that infection such as MRSA is becoming increasingly common in the community. This highlights the need to implement effective evidence based infection control measures for MRSA in all healthcare settings. Approximately
30% of the population carries the organism *Staphylococcus aureus* (S aureus). This is a bacterium, which is normally found in the nose and on skin. Most healthy people are unaffected by it, however it does have the potential to cause infection in those who have severely weakened immune systems. MRSA is a form of *S aureus*. It is transmitted in the same way, and causes the same range of infections as other strains of *S. aureus*, however it has developed resistance to the more commonly used antibiotics. This makes infections caused by MRSA more difficult and costly to treat, which is why every effort must be made to prevent its spread.

The majority of individuals are colonised which is when the organism lives harmlessly on the body with no ill effects as opposed to infected which is when the organism enters tissue and causes disease.

In order to control and minimise the spread of MRSA there must be compliance with the following:

- Standard Precautions (formerly known as Universal Infection Control Precautions)
- Cleaning (domestic etc.) must be of a high standard
- Adherence to Infection Control Policies i.e. Waste policy, Laundry, Hand Hygiene
- Infection control training
- Strict adherence to antibiotic policies
- Adequate resources for compliance

The prevalence of MRSA is increasing in the community. There are a number of reasons for this:

- More invasive procedures are frequently carried out in hospitals and in the community, which is an important route of infection.
- Many patients have lowered resistance to infection due to a variety of reasons
- The widespread use of antibiotics sometimes inappropriately

People affected by MRSA do not present a risk to the community at large and should continue their normal lives without restriction. Many individuals are discharged into Care Homes and this should pose no problem to their ongoing care or that of the other residents as long as standard precautions are taken.
5. Definitions

The majority of MRSA carriers are ‘colonised’ as opposed to infected

<table>
<thead>
<tr>
<th>Colonisation</th>
<th>Colonisation is when the organism lives harmlessly on the body with no ill effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>Is when the organism penetrates the tissue and causes disease (usually when the skin is breached, for example, during surgery, or when the immune system is impaired)</td>
</tr>
<tr>
<td>Systemic</td>
<td>Relating to or affecting the body as a whole, rather than individual part and organs</td>
</tr>
<tr>
<td>MRSA Bacteraemia</td>
<td>When MRSA has been detected in a patient’s blood stream following blood cultures being taken and cultured within a laboratory setting</td>
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</tbody>
</table>

6. Control of MRSA in the Community or Hospital setting

Safe working practice

Staff must adhere to North Somerset Community Partnership (NSCP) policies and guidelines in relation to Infection Control, Health and Safety and Risk Management. These precautions should be applied to all clients at all times irrespective of diagnosis.

Whenever practical, if patients are MRSA positive then they should be cared for at the end of the healthcare worker’s case load. Risk assessments should be carried out in healthcare teams to cover the treatment of patients with MRSA.

When patients are discharged from the acute setting staff must ensure that they give both a verbal handover and a written handover and this information must be kept with the patient’s notes. The patients infection status must be recorded as a patient alert on the electronic medical record i.e. EMIS, to pop up when the patient’s medical record is opened. The colonisation or infection i.e. antibiotic resistant bacteria such as MRSA or any other microbiological specimen result must be documented along with the specimen date.

If the patient has been known to be MRSA positive or has recently been tested this information must be included in the electronic medical record and also documented as a patient alert. When setting up a patient alert on the electronic medical record allow external organisations to view the alert.

Discharge summaries to GPs must also detail this information
Patients and relatives/carers are usually also aware if they have had MRSA and could be asked if deemed appropriate. The patient must be assessed for signs of infection on each visit. On initial assessment at the first visit questions must be asked about infection status i.e. has the patient had any antibiotic resistant infections/colonisation such as MRSA.

There is no need to screen household contacts or other residents in care homes for MRSA

It is not necessary for care workers or carers to be screened unless an outbreak is suspected.

Communication is also essential when a patient who has known to be previously MRSA positive is to be admitted / readmitted to an acute setting. This could be done as a verbal communication by the patient/relative, by the GP or by the Community nursing staff as appropriate.

7. Isolation

When a patient is identified as MRSA positive, either because they have an MRSA infection or because they have been identified as an asymptomatic carrier (colonised), they should be isolated, to reduce the risk of transmission to other patients. If single rooms are not available for individual isolation, consideration should be given to separating MRSA positive patients from non-carriers in cohort bays or wards. The decolonisation regime should be applied as soon as a positive result is known, irrespective of the availability of isolation facilities.

In a care setting patient/residents who are MRSA positive should ideally not share a room with other patients if those patients have open wounds or catheters. A documented risk assessment should be conducted. It is not always necessary to keep patients in their own rooms if they have MRSA.

Infection control precautions for MRSA must be continued in hospital until 3 negative MRSA screens have been obtained or the patient is discharged.

On discharge a thorough deep clean must be carried out on the isolation room. This must include floors, bed frame, mattress, lockers, bed table, chair and all equipment and horizontal surfaces. Disposable curtains must be changed (see Cleaning Policy for Infected Clinical Areas).

All equipment in the isolation room must wherever possible be disposable or dedicated for the sole use of the MRSA affected patient. All reusable equipment must be cleaned in accordance with the Decontamination Policy before use on another patient.
8. **Discharge Information**

When patients are discharged from hospital back into the community (including care homes) they may still be undergoing treatment / decolonisation for MRSA. This should be continued as per discharge instructions/transfer letter.

If the post discharge decolonisation is unsuccessful i.e. the patient has been re-screened and is still found to be MRSA positive one further attempt should be undertaken if:

- It is known or is likely that the individual will be admitted to hospital in the foreseeable future
- The patient has invasive devices e.g. catheter
- The patient has broken skin
- The patient has skin conditions e.g. eczema

9. **Residents / Individuals diagnosed in the Community**

Open wounds will often be colonised with microorganisms including MRSA, although this does not mean that the wounds will go on to develop a clinical infection. Many of these wounds will continue to heal despite the colonisation and no specific treatment is required other than good wound management.

It is only when a wound is failing to heal and showing signs of critical colonisation and infection that treatment of microorganisms including MRSA should be considered using topical antimicrobial and antibiotics when clinical infection is identified.

Routine swabbing to determine if MRSA is present in a wound is not advocated. Wound swabbing should only be carried out when clinical signs of infection is present. Please see flow chart in Appendix A.

Patients/clients with clinical infection caused by MRSA should always be treated promptly. If they are receiving systemic antibiotics but the wound remains clinically infected following the completed course of antibiotics, a wound swab should be taken 48hrs after treatment is completed. Please state on the pathology request form that this is a post MRSA and the treatment given.

Individuals in the community who are colonised with MRSA will not generally require decolonisation unless it is known that they will be admitted to hospital in the foreseeable future. The Department of Health expect that all patients who test positive for MRSA on screening prior to admission to be effectively decolonised.

10. **MRSA Treatment and Decolonisation Protocol**

A decolonisation regime consists of the use of an antibacterial shampoo and body wash daily, for example Octenisan or Hibiscrub, and the application of an antibacterial nasal cream three times a day for five days, for example Mupirocin 2%.
The purpose of decolonisation is to reduce the risk of:

- The patient developing an MRSA infection with their own MRSA during medical or surgical treatment
- Transmission of MRSA to another patient

The decolonisation regime is only 50-60% effective for long term clearance but, as soon as the procedure is implemented, the presence and shedding of MRSA are reduced significantly and the risk of the patient infecting themselves or transmitting MRSA to another patient is much reduced.

**Treatment Regime:**

- Mupirocin nasal ointment should be applied three times a day to the anterior nares of both nostrils for 5 days then stopped for 48 hours.
  - If the MRSA is Mupirocin resistant a 10 day course of Naseptin nasal ointment four times a day should be prescribed.
- Octenisan or Hibiscrub body wash should be applied neat to wet skin/hair as a substitute for soap or shampoo. Left on for at least one minute and then rinsed off in the normal way.
  - It should be continued until the patient is discharged or until 3 negative screens are received.
- 48 hours after the Mupirocin nasal ointment course is completed an MRSA screen should be taken. A total of three clear screens are required before isolation precautions are stopped.
- An MRSA screen is defined as a nose swab, a CSU if a catheter is present, any wound swab and a sputum if there is evidence of a productive cough.

**11. Transfer to Hospital or other Care Setting**

Good communication is essential to ensure that the patient is managed safely across healthcare settings.

If the patient/client is to be readmitted to hospital then the receiving ward/unit must be made fully aware of MRSA status either currently or in the past. This ensures that the hospital can take the appropriate precautions.

If the patient client is being transferred to a care home/residential home the home needs to be made fully aware of the resident’s MRSA status if known.

**12. Ambulance Transportation**

The South West Ambulance Service Trust (SWAST) classifies patients who are MRSA positive into two categories;

**Category 1**-Patients colonised by MRSA or who have infected wounds or skin lesions which are covered by an occlusive dressing, may be transported with other patients and require no special precautions.
Category 2 - Patients who are heavily colonised by MRSA and are considered to be heavy shedders e.g.:

- have severe psoriasis or eczema
- Patients who have infected exposed wounds or skin lesions, external fixation devices, burns etc. should be transported by themselves
- Patients who are clinically infected
- Patients who are colonised in the upper respiratory tract and present with active symptoms, for example, a productive cough.

Patients in Category 2 should not be transported with others. The Ambulance service will implement appropriate precautions applicable to this category.

13. Care of deceased Residents / Patients

The precautions for handling these patients are the same as when they are alive, that is, by using Standard Infection Control Precautions. Lesions should be covered with an impermeable dressing. Body (cadaver) bags are not necessary since there is no risk to healthy contacts unless the deceased patient has extensive burns, skin loss and/or extensive discharging rooms. There are no contraindications for last offices, including viewing.

14. MRSA / Bacteraemia Reporting / Data

An MRSA bacteraemia is when MRSA has been detected in a patient’s blood stream following blood cultures being taken and cultured within a pathology laboratory. NSCP will receive notification of all confirmed Community MRSA bacteraemia cases from Weston Area Health Trust, North Bristol Trust and University Hospital Bristol.

When a case is deemed to be Community, that is, the bacteraemia has been identified within 48hrs of admission date, then a Post Infection Review (PIR) will be conducted within the Community, led by the infection control nurse, but contributions made by the Community Teams.

NSCP has responsibility for providing the Clinical Commissioning Group (CCG) (by the next working day) with the information and acting upon root causes that may have been identified as a result of conducting the root cause analysis.

NSCP will also conduct root cause analysis of community cases identified at University Hospitals Bristol and North Bristol Trust for NSCP patients.

15. Screening

MRSA admission screening is the microbiological testing of a sample taken from the potential carriage site of a patient on or before admission. It is the process by which patients who are colonised with MRSA are identified. If they are found to be MRSA positive then they must be actively decolonised.
The MRSA screen will be in the form of swabs from the nose and if present from wounds, catheters and from the groin according to individual risk factors.

In 2014 new guidance was issued from the Department of Health (DH) entitled “Implementation of modified admission MRSA screening guidance for the NHS which outlines a more focused, cost effective approach for MRSA screening.

At North Somerset Community Hospital all patients are screened on admission to the in-patient unit if their MRSA status is unknown.

16. Training

All staff will receive Infection Control Training at Induction.

All staff will receive annual updates in Infection Control as per North Somerset Community Partnership Training Matrix.

The Preventing Infection Network Group (PING) has been introduced throughout the organisation. This group meets quarterly to discuss new guidance and topical infection control issues and cascades information and training back to clinical areas.

17. Audit

A monthly hand hygiene audit and a quarterly Infection Control Audit will be undertaken to monitor compliance with infection control practice. MRSA Screening audits will be undertaken annually at North Somerset Community Hospital.

The scope of this policy covers all North Somerset Community Partnership staff and therefore there is an expectation that audit will be carried out by all Teams.

This document shall be reviewed and updated every 2 years or as changes in best practice standards, guidance or legislation occurs.

18. References

Department of Health 2007. “Essential Steps to safe, clean care. Working together to reduce healthcare associated infection (including MRSA)”


Guidelines for the prophylaxis and treatment of Meticillin-resistant Staphylococcus Aureus (MRSA) infections in the UK. (2006) Journal of Antimicrobial Chemotherapy 2006 57(4): 589 – 608 published by Oxford University press. All rights reserved for permission, please e mail
Health & Safety at Work Act (1974)

Department of Health (2005) A simple guide to MRSA

Department Of Health (2008) The Health & Social Care Act
Health Protection Agency
www.hpa.org.uk/infections/topicsaz/primarycareguidance/Antibioticsguide250506.pdf
Department Of Health London
National Patient Safety Agency www.npsa.nhs.uk

“Infection Control Guidelines for Care Homes” Issued 19th June 2006
www.dh.gov.uk

www.his.org.uk Website for the Hospital Infection Society

Saving Lives Reducing infection, delivering clean, safe care. “Antimicrobial Prescribing

www.nice.org.uk/C139

Implementation of modified admission MRSA screening guidance for the NHS (2014). Department of Health expert advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)

19. Appendices
Appendix 1  MRSA Policy for the Community

Meticillin Resistant Staphylococcus Aureus (MRSA) Policy for the Community

Treatment of MRSA in a Wound

<table>
<thead>
<tr>
<th>MRSA Positive</th>
<th>MRSA Positive wound static deteriorating clinical signs of local or spreading infection</th>
</tr>
</thead>
</table>
| Wound healing steadily | For exuding wounds ACTICOAT or LODOFLEX  
Applied every 3 days for 2 – 4 weeks  
(They also use Octenilin wound irrigation / Cutimed Sorbact as discussed with the Tissue Viability Nurse) |
| Treat wound according to Wound Management formulary  
Antimicrobial therapy is not required.  
Ensure wound is covered at all times with a secure dressing to prevent cross infection.  
Adhere to infection control guidance:  
• Hand Washing  
• Apron  
• Disposal of dressings | Treat wound for 2 weeks and then review to consider if further 2 weeks treatment is required |

If cellulitis is present systematic antibiotics will be required

Monitor wound closely. If no improvement refer to NSCP IPC Specialist Nurse, Tissue Viability Nurse or Podiatrist
Appendix 2 Flow chart for patient treatment and screening

FLOW CHART FOR PATIENT TREATMENT AND SCREENING

Systemic treatment discussed with Microbiologist

MRSA positive patient

Topical treatment prescribed:
Mupirocin (Bactroban) or Naseptin to nose t.d.s for 5 days (if Naspetin this will be a 10 day course)
Octenisan or Hibiscrub

No treatment for 2 days Bed linen and patient clothing changed

1st screen (to be taken 2 days after cessation of topical treatment)
Nose
Groin
Wound(s)
Previous positive site(s)
Urine if catheterised
Sputum if productive cough

Negative

Record as first negative screen (if patient off systemic treatment)
2nd screen of sites as above

One or more sites positive

No more than two courses to be given unless advised by Microbiologist or Infection Control Nurse

Positive

Record as 3rd negative screen
Completion of Care Pathway

Negative
# Equality Impact Assessment

## Section 1: Initial Assessment

<table>
<thead>
<tr>
<th>Policy Author</th>
<th>Date of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suzanne Golding-Ellis, Julia Bloomfield</td>
<td>February 2017</td>
</tr>
</tbody>
</table>

### Title of Policy

**MRSA Policy**

**Is this a new or existing policy?**

**Existing**

---

### 1. Briefly describe the aims, objectives and purpose of the Policy / Guidance Document:

Guidance Document: To provide clear guidance as to the management and control of MRSA cases.

### 2. Who is intended to benefit from the proposed process and in what way?

Staff, Patients and Visitors to give a clear protocol to follow in the event of infection to provide a clean and safe work and care environment.

### 3. Who are the main stakeholders in relation to this Policy/Guidance?

Staff, Patients and Visitors

### 4. Are there concerns that the Policy/Guidance does, or could have, a differential impact due to any of the equality areas? (Y/N – delete as appropriate)

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes/No</th>
</tr>
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<tbody>
<tr>
<td>Age</td>
<td>N</td>
</tr>
<tr>
<td>Disability</td>
<td>N</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>N</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>N</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>N</td>
</tr>
<tr>
<td>Race</td>
<td>N</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>N</td>
</tr>
<tr>
<td>Sex</td>
<td>N</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>N</td>
</tr>
<tr>
<td>5. What existing evidence (either presumed or otherwise) do you have for this?</td>
<td></td>
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<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>IT applies to all groups equally.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Based on the answers given in questions 4 &amp; 5 is there potential for an adverse impact in this policy/guidance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Can this adverse impact be justified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
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</tbody>
</table>

If you have not identified adverse impact or you can justify the adverse impact, finish here.

If you have identified adverse impact that cannot be justified, please continue to Section 2

**Section 2: Full Impact Assessment**

<table>
<thead>
<tr>
<th>8. What experts/relevant groups have you approached to explore their views on the issues? Please list the relevant group/experts, how they were consulted and when.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relevant groups/experts</strong></td>
</tr>
<tr>
<td>How were the views of these groups obtained?</td>
</tr>
<tr>
<td>Date contacted</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Please explain in detail the views of these groups/experts on the issues involved:</th>
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</tbody>
</table>

<table>
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<tr>
<th>10. Taking into account the views of the groups/experts and the available evidence, what are the risks associated with the policy, weighed against the benefits of the policy if it were to stay as it is:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risks</strong></td>
</tr>
</tbody>
</table>
If you have found that the risks outweigh the benefits you need to review the policy further and put together an implementation plan which clearly sets out any actions you have identified as a result of undertaking the EIA. These may include actions that need to be carried out before the EIA can be completed or longer-term actions that will be carried out as part of the policy or development.

<table>
<thead>
<tr>
<th>11. Monitoring arrangements and scheduled date to review the policy and Equality Impact Assessment:</th>
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<tbody>
<tr>
<td><strong>Review Date</strong></td>
</tr>
</tbody>
</table>