Lincolnshire Partnership NHS
NHS Foundation Trust

Lincolnshire Partnership NHS Foundation Trust (LPFT)

Title of Policy

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This policy deals with the management of patients with Meticillin Resistant *Staphylococcus Aureus* (MRSA) infection in accordance with National Guidelines and to prevent further spread of the infection.

There are legal obligations for investigating and reporting of these types of infection.

METICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) MANAGEMENT AND CONTROL

METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) MANAGEMENT AND CONTROL

1.0 INTRODUCTION

1.1 Early identification of patients who are colonised with MRSA, and the appropriate management of these patients, has been shown to significantly reduce the risk of transmission of infection to other patients.

1.2 Mental Health and Learning Disability Trusts are categorised as low risk in the Guidelines for the Control and Prevention of Meticillin-resistant *Staphylococcus Aureus* in Healthcare Facilities (2006). However, LPFT provides care for patients in a variety of settings with a diversity of physical and mental healthcare needs and this policy applies to all situations where care is provided within LPFT.

2.0 POLICY PRINCIPLES

2.1 The purpose of this policy is to minimise the risk of spread of MRSA to patients, employees and visitors within the Trust by-

- Providing LPFT staff with evidence based information about MRSA
- Ensuring the early identification of colonised and infected patients in order to reduce the risk of cross infection, transmission to others or more serious infectious disease such as bacteraemias
- Ensuring that patients identified with MRSA are treated and managed appropriately and do not have their care compromised due to their MRSA diagnosis

3.0 RESPONSIBILITIES

Responsibilities are as set out in the overarching IPC policy 7a

4.0 DEFINITIONS

Colonisation – occurs when a microbe establishes itself in a particular environment such as a body surface, without producing disease or symptoms. This is sometimes referred to as asymptomatic carriage and can be identified by screening. Around 30% of the general population are colonised with *Staphylococcus Aureus*. It may be present on the skin, in the nose, axillae, groin or perineum. It can also colonise wounds and other areas of non-intact skin without causing harm.

Decolonisation – refers to the application of antimicrobial products to body surfaces and cavities in order to eradicate colonising micro-organisms (e.g. MRSA)

Infection - occurs when the bacteria gain access to the body tissues and multiply, causing a host reaction and clinical signs of infection, which may include redness, swelling, pain or discharge in a wound or invasive device site.
Depending on the properties of the infecting micro-organism and the capacity for resistance of the infected host, there may be other effects in the body, including toxin production and spread to other sites.

Bacteraemia – occurs when there is evidence of spread of infection into the bloodstream.

5.0 MRSA INFORMATION

5.1 *Staphylococcus Aureus* (Staph Aureus) is a common bacterium, which may be found on the skin of around one third of healthy adults.

Methicillin Resistant *Staphylococcus Aureus* (MRSA) is a strain of *Staph Aureus* that is resistant to Methicillin (a penicillin) and to many other commonly used antibiotics, in particular flucloxacillin, which is the standard treatment for many staphylococcal infections.

Like *Staph Aureus* it may colonise people without causing illness or may cause clinical infection. It can be carried on the skin or in the nose of healthy people without causing any adverse effects. However, colonisation is considered to be a major risk factor for infections, which may range from mild to life threatening

Although MRSA is no more likely to cause an infection than sensitive *Staph Aureus,* the infection can be more difficult to treat due to a limited choice of antibiotics.

6.0 TRANSMISSION OF MRSA

6.1 MRSA infections

MRSA blood stream infection was once considered to be a healthcare associated infection commonly acquired during hospital admission; however, it is increasingly common in the community. The often continuous and repeated movement of patients between different healthcare settings can increase the risks of HCAI to patients, as well as the emergence of Community Associated strains of MRSA e.g. Panton- Valentine Leukocidin (PVL)

6.2 Routes of Transmission

MRSA can be transmitted either:

- Endogenously. This occurs when a person already colonised with MRSA spreads the organism from one part of their body to another. This is particularly likely if there is a break in the skin such as a minor trauma, the use of an invasive device such as a venous cannula or a large or deep wound such as a venous ulcer or pressure sore.
- Exogenously. This occurs when MRSA is spread from one person to another. This can happen in a variety of ways including:
    - Direct spread via the hands of healthcare workers
    - Indirect spread through equipment that has not been appropriately decontaminated
    - Via transfer of microorganisms from the environment, where contamination is highly significant, as staphylococci can survive for long periods in dust

6.3 Infectious Period

Indefinite. Patients with MRSA may carry it in a variety of sites such as the nose, axilla, groin, elsewhere on the skin and even in the gut. This makes it difficult to eradicate reliably. Even if MRSA decolonisation has been performed and negative screens achieved, the MRSA may reappear at a later date.

7.0 SCREENING FOR MRSA

7.1 A new diagnosis of MRSA is often made from a clinical specimen (e.g. wound swab) and not from an MRSA screen. In this instance, please contact the IPC Nurse Specialist for advice on the correct management of the patient.

7.2 Screening is the testing for the presence of MRSA on the most common sites.
A full routine screen consists of:

- Nose swab (anterior nares) – one swab can be used for both nostrils. Perineum/groin swab
- Wound swab- any surgical wounds, other lesions or breaks in the skin
- Swabs from manipulated sites- lines, cannula, drains, PEG sites etc.
- Urine sample if catheterised
- Sputum sample if patient has a productive cough

Swabs should be moistened with sterile saline prior to use on the patient as a moistened swab will pick up more bacteria than a dry one which increases the sensitivity of the test but is also more comfortable for the patient.

If a perineum/ groin swab is inappropriate for any reason, a nasal swab should be sufficient, along with any other swabs that are indicated. The inability to obtain a full screen must be clearly documented

Three full negative MRSA screens are required before an individual is classed as negative. Regardless of MRSA status at the point of discharge all patients should be re-screened on any future admissions.

It is the responsibility of the member of staff taking the screen to ensure that the results are obtained and actioned accordingly.

7.3 Consent for Screening

- Screening must only be carried out after a full explanation and with the patients consent. If there are concerns regarding capacity to consent, then a full discussion of the patients' needs based on a clinical risk assessment should be carried out to ascertain whether screening should go ahead
- If a patient declines screening, this should be documented in the patient record. If there has been a previous positive result for MRSA, advice must be sought from the IPC team regarding management of the patient if necessary

7.4 Staff Screening

- The screening of staff for MRSA is not routinely performed and must only be undertaken at the request of the IPC Team or the Occupational Health Department.
- Where staff screening is advised, this will always be done on a voluntary basis with the consent of staff involved.

7.5 Screening requirements:

In January 2008, the Department of Health issued guidance to mental health inpatient service providers that some patients may carry a greater risk than others of an MRSA infection and because of this screening on admission should be considered in the following patients:

- Those who are admitted to mental health units following surgical procedures
- Those that are admitted following admission to an acute Trust
- Intravenous drug users
- Those who self-harm

- People with a possible diagnosis of delirium,
- People with chronic wounds, e.g. leg ulcers, or with indwelling devices such as
- catheters
- All service users that have remained within a medium or high secure hospital for
- than 5 years

7.5.1 Local Services additional MRSA screening requirements from September 2012:

- All admissions into inpatient services from a nursing home
- All admissions with a dermatological condition
- All service users with a history of MRSA colonisation

7.6 Monthly reporting of admission screening of those patients considered to be high risk and therefore in need of routine screening will continue across the Trust and will be reported on to the Infection Prevention and Control Nurse Specialist for Lincolnshire Combined CCGs.

8.0 DECOLONISATION

8.1 MRSA decolonisation refers to the use of topical agents such as nasal ointment and body wash/shampoo to eradicate or reduce nasal and skin carriage. Complete eradication is not always possible but a decrease of carriage may reduce the risk of transmission into the healthcare setting and therefore the risk to other patients. It will also reduce the risk of transmission into any wounds or indwelling devices that the patient may have.

8.2 Compliance with the treatment is important and once commenced should be completed for the full 5 days. Decolonisation treatment should not be implemented for prolonged periods or repeatedly i.e. more than two courses for five days, as resistance may be encouraged. In cases of repeated colonisation the advice of a medical microbiologist should be sought.

8.3 For patients with eczema, dermatitis or other skin conditions, attempts should be made to treat the underlying skin condition. Advice on suitable eradication protocols for these individuals should be sought from the consultant Dermatologist/Microbiologist

8.4 It is important that all colonised/infected areas are treated simultaneously and treatments are correctly applied

8.5 Nasal decolonisation

Currently the treatment is 2% Mupiricin (bactroban) nasal ointment (or other microbiological approved product such as Naseptin) which should be applied to the inner surface of each nostril (anterior nares) three times daily for five days.

Nasal decolonisation should always be used in conjunction with skin decolonisation.

8.6 Skin decolonisation

Skin decolonisation is useful for eradicating or suppressing skin colonisation for short periods, particularly pre-operatively.

- Patients should bathe/shower daily for five days using the prescribed antiseptic detergent.
- Current recommended agents are either Octenisan or Prontoderm.
- Do not dilute the body wash
- The body wash should be applied neat and left on the skin for 1-2 minutes (refer to product instruction's).
- Applying a diluted solution to the skin will affect its efficacy.
- Special attention should be paid to all carriage sites, such as the axilla, groin and perineal area.
- Hair should also be washed on two separate occasions within the five-day treatment using the same product.
- The antiseptic can also be used for all other washing procedures such as bed bathing.
- Clean clothing, bedding and towels should be provided after each bath/shower/bed bath and hair wash.
- Post treatment screens should be taken 48 hours after completion of decolonisation treatment.

8.7 Throat carriage of MRSA is very difficult to eradicate and this should only be undertaken with the advice of a Consultant Microbiologist.

The presence of dentures makes mouth and throat clearance difficult as MRSA adheres to synthetic material

9.0 ANTIBIOTIC THERAPY

9.1 As antimicrobial use is a recognised risk factor for MRSA acquisition, all patients with MRSA should have their current antibiotic therapy reviewed. **Any unnecessary agent should be stopped.**

9.2 Antibiotics are not indicated unless there are clinical signs suggestive of infection. Prescribers should refer to the Antimicrobial Prescribing Guidelines (2012) and discuss with the duty Microbiologist for further advice if needed.

10.0 CONTROL OF MRSA

10.1 Basic Principles

Standard IPC precautions must be implemented at all times in all settings to reduce the risks and should include all of the following:

- Hand Hygiene –
  Compliance with hand hygiene is essential and will significantly reduce the risk of transmission and cross infection.
  Decontamination of hands should be carried out before and after every episode of direct patient care or contact with the patient's environment and equipment.
  Effective hand hygiene can be achieved using soap and water or alcohol gel (on visibly clean hands)
  In some clinical areas use of alcohol hand rub may not be possible due to the complex clinical issues.
- The Correct use of Personal Protective Equipment (PPE)
- Safe Management of Laundry (Refer to local procedures)

- Safe Management of Waste (Ref to LPFT Waste Management Policy and National Guidance)
- Decontamination of Equipment. Single Use or single patient use equipment should always be considered where possible.

10.2 Additional Advice for specific clinical settings

10.2.1 Inpatient Areas

- Consult with the IPC nurse specialist at the earliest opportunity when positive results are received

- Isolation is not usually necessary within low risk areas but will depend on the site of colonisation, behaviour of the patient and the vulnerability to infection of the other patients.

- A risk assessment should be carried out by the Clinical Team to determine whether the patient is suitable or necessary for isolation. If unsuitable, a daily review should be carried out and documented in the patient's case notes.

- If isolation is advised but the patient is unable to be isolated in a single room, it is advisable that the patient is NOT nursed adjacent to patients who are immunocompromised or with wounds, catheters, IVI or other invasive devices.

- An individualised nursing care plan must be implemented on diagnosis (see appendix)

- Staff must ensure that wounds are covered with an impermeable dressing at all times. If strike through occurs, the dressing must be changed by the appropriate HCW as soon as is reasonably practicable.

- There is no requirement for the provision of separate crockery or cutlery and no need to separate items of crockery or cutlery which can be washed in the dishwasher using the normal procedures.

- Patients can mix with other residents in communal areas e.g. dining room, TV room

10.2.2 A single room is essential in the following circumstances:

- a patient is sputum positive and actively expectorating
- a patient has multiple colonised sites
- a patient has a skin condition which produces excessive skin shedding
- extensive wound leakage

10.2.3 Any equipment within the room must either be single use and disposed of immediately after use or single patient use only

10.2.4If isolation is deemed necessary a colour coded card should be placed on the door to the side room to alert staff and visitors to the need for additional precautions.

10.2.5 The side room door should be kept closed at all times where possible but particularly during clinical interventions, including bed making

10.3 Environmental Cleaning.

- A clean environment is important and will contribute significantly to reducing the risk of transmission of MRSA.

- The patients' immediate environment should be cleaned more frequently using dedicated colour coded cleaning equipment and particular attention should be paid to cleaning of high touch points, high and low horizontal surfaces where dust gathers.

- Additional cleaning of the immediate environment must take place following all high risk clinical interventions at the bedside e.g. wound dressings

Refer to the Isolation Cleaning Reference Pack for solutions, dilution rates or speak to the Estates and Facilities Advisor

10.4 Discharge/transfer

- In the majority of cases MRSA should not prevent or delay discharge or any essential treatment or interventions e.g. physiotherapy and occupational therapy if the patient is deemed to be clinically well enough.

- Staff must liaise with the receiving team/department/ward and ensure that the details of MRSA are made available to the receiving area

- Medical staff are responsible for making the GP aware of the MRSA diagnosis in the discharge summary.

- The IPC Nurse Specialist is responsible for ensuring that an alert is placed on the patients Electronic record for the diagnosis.

- The ward staff must ensure that community agencies are informed and, if the patient is being discharged to a nursing or residential home, that the home is fully aware before the discharge so they may put any necessary precautions in place.

- Transport services must be made aware by ward staff so they may put any necessary precautions in place according to their policy

10.5 Outpatient Clinics

- Patients who are ambulant and who would normally attend an outpatient clinic or Health Centre should continue to do so. Patients, known to be colonised with MRSA wherever possible, should be seen at the end of the clinic / session.
- Clinicians should perform hand hygiene after seeing the patient using soap and running water or alcohol hand rub.

10.6 Patients Own Home

- MRSA does not present a risk to other healthy individuals and colonisation should not prevent an individual from continuing with normal unrestricted activities

- Wherever possible, patients with a known MRSA infection should be seen at the end of the healthcare professionals visiting list.
- Hand hygiene and standard basic precautions should be employed by all staff involved in the care of a patient at home
- Avoid taking non-essential equipment in to the home.
- Encourage patients and carers to undertake regular hand washing.
- Family members should be advised to cover any skin lesions they may have with an impermeable dressing and to maintain regular hand hygiene.
- Advise the patient/family that regular environmental cleaning using detergent and water is an effective method of reducing levels of MRSA.
- Patients should be advised that their laundry should be washed at the hottest temperature suitable for the fabric and that it can be washed with other household laundry. Laundered garments should be dried thoroughly before reuse. Drying in a tumble dryer or ironing will help further reduce the amount of MRSA present.
- Patients should be encouraged to continue with their normal activities/routines.

11.0 MRSA REPORTING

11.1 The Government considers it is unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) whilst receiving care in a healthcare setting. From April 2013 Healthcare providers have been set the challenge of demonstrating zero tolerance of MRSA BSI

11.2 All MRSA BSIs are considered to be serious untoward incidents and are reportable and required to be investigated using a post infection review (PIR) process

11.3 The Organisation to which the MRSA BSI is assigned will lead on the PIR and will be responsible for completing the process within one week of it being assigned

10.4 The PIR process requires strong partnership working by all organisations involved in the patient's care pathway

10.5 This process has been developed to help identify factors that may have contributed to the MRSA BSI. The aim is to identify lessons to be learned and to improve practices in order to prevent a similar occurrence.

12.0 TARGET AUDIENCE

All Trust Staff involved in clinical care delivery

13.0 TRAINING

13.1. The IPC Nurse Specialist can assist with access to additional training on request which will include information contained in this policy.

13.2. All members of staff have an individual responsibility to ensure that they access IPC mandatory training.

14.0 CHAMPION AND EXPERT WRITER

14.1 The Champion for this policy is the Director of Nursing and Quality
14.2 The Expert Writer is the Infection Prevention and Control Nurse Specialist

15.0 CONSULTATION.

Consultation for version 1 occurred through:

- Infection Prevention and Control Committee
- Nursing Executive members
- Public Health England

Additional Consultation for the revised version:

- Head of Physical Healthcare, IPC, Medical Devices and Smoking Cessation.
- IPC link practitioners
- Matrons
- Physical Healthcare Practitioners

16.0 LEGISLATION, GUIDANCE AND REFERENCES

- The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (Revised 2015) (Department of Health) London.
- Health and Safety at Work Act 1974
- National Patient Safety Agency (2006). Safer Practice Notice 15: Colour coding hospital cleaning materials and equipment. NPSA, London.
- NHS Estates (2004). The NHS Healthcare Cleaning Manual, Department of Health, London.
- Ross, S., Furrows, S. Rapid Infection Control Nursing 2014 Wiley Blackwell. ChichesteR
- Nottinghamshire Healthcare IPC Policy 18.07

17.0 MONITORING COMPLIANCE

17.1 Compliance with this policy will also be monitored through the IPC Audit Programme

17.2 Any Post Infection Review or Root Cause Analysis should include evidence of adherence to this policy

17.3 Untoward incident reports and serious incident reports will be reported to the Patient Safety and Experience Committee bi-monthly and at IPC Link Practitioner meetings. Any good practice or lessons to be learnt will be detailed in the minutes and fed through to the relevant Trust management systems either through distribution of the minutes or through escalation processes as laid out in the terms of reference

17.4 Surveillance data of infections and untoward incidences that include HCAIs will be reviewed at the Patient Safety and Experience Committee and action taken as necessary

18.0 RELEVANT TRUST POLICIES & PROCEDURES

7b. Hand Hygiene
7d. *Meticillin Resistant Staphylococcus Aureus* (*MRSA*) Management and Control
7f. Isolation
7g Decontamination
7h. Surveillance of Alert Organisms and Dissemination of Information
7i Management of Sharps
7j Occupational Exposure to Blood Borne Viruses

7n Correct use of Personal protective Equipment in the Healthcare Environment

19.0 REVIEW DATE

This policy/procedure will be reviewed in 3 years or in light of organisational or legislative changes.

20.0 Record of changes

Date	Author	Policy/Procedure	Details of change(s).
November 2017	J. Lord	7 d	• Widespread grammatical changes • Changes of job title • Responsibilities clarified • New Introduction added • Format changed for consistency • Revised references added/updated • Record of changes added • Appendices added

Appendix 1 MRSA Screening Requirements on Admission

Some service users may carry a greater risk than others of an MRSA infection Because of this, screening should be carried out on admission in the following patients:
All service users who are admitted to Mental Health units following surgical procedures
All service users admitted from an Acute Hospital Trust
All service users who self-harm
All service users who are known to be intravenous drug users
All service users with a possible diagnosis of delirium,
All service users with chronic wounds, e.g. leg ulcers, or with indwelling devices such as catheters
All service users that have remained within a medium or high secure hospital for more than 5 years
All service users admitted into inpatient services from a nursing home
All service users with a dermatological condition
All service users with a history of MRSA colonisation

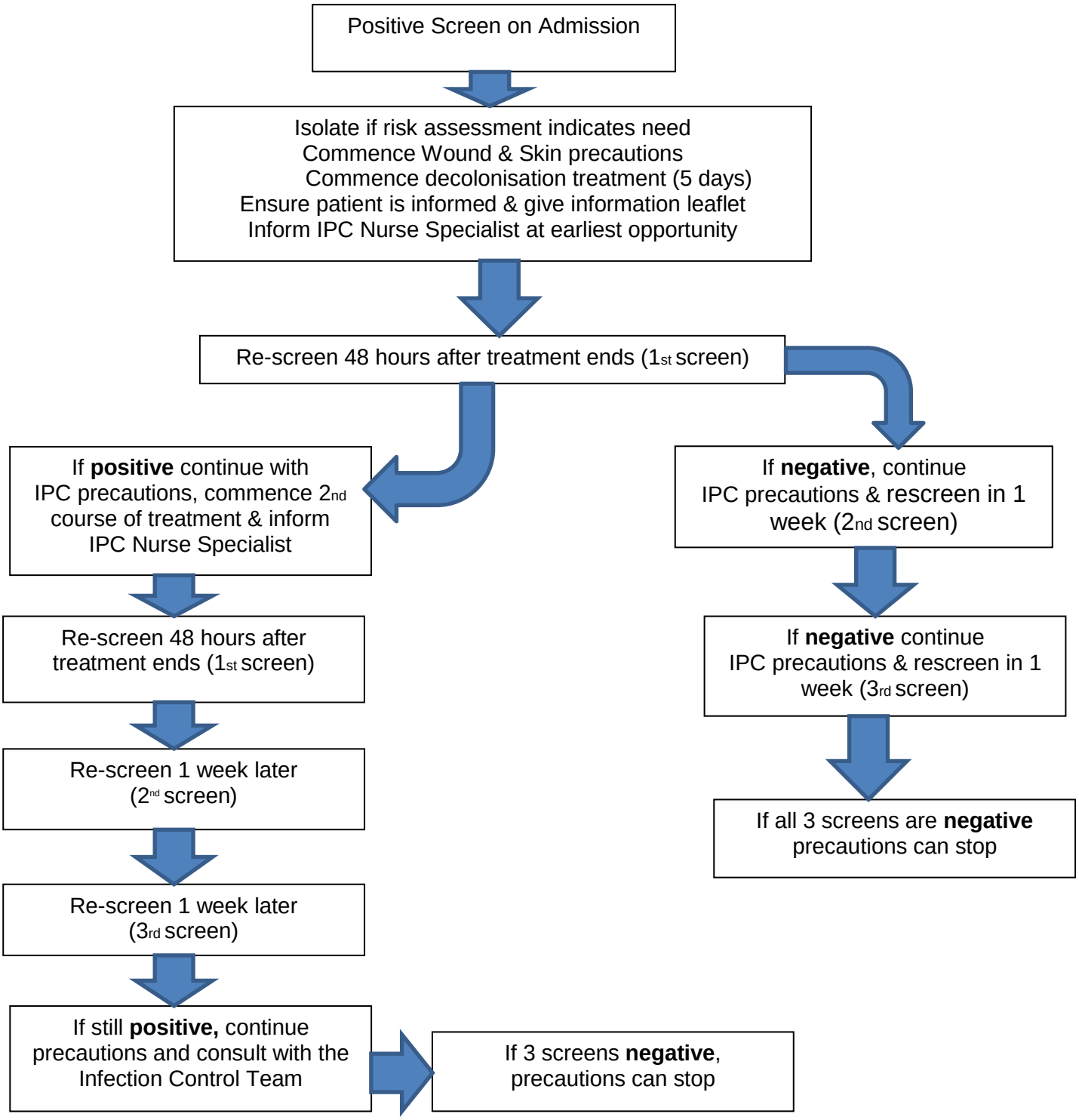
Screening is the testing for the presence of MRSA on the most common sites. A full routine screen consists of:-
Nose swab (anterior nares) – one swab can be used for both nostrils and swab should pre moistened with sterile saline
Perineum/groin swab
If groin swab is inappropriate, nose swab may be sufficient

Additionally:

Wound swab- any surgical wounds, other lesions or breaks in the skin
Swabs from manipulated sites- lines, cannula, drains, PEG sites etc
Urine sample if catheterised
Sputum sample if patient has a productive cough
Three full negative MRSA screens are required before an individual is classed as negative.
Regardless of MRSA status at the point of discharge all patients should be re-screened on any future admissions.
Please note: In some patients it may not be appropriate to swab a certain site. If this is the case, the inability to obtain a full screen must be clearly documented.

Appendix 2

INPATIENT AREAS
Screening & Decolonisation Protocol for patients with positive MRSA admission screen



Appendix 3

Infection Prevention and Control Care Plan for a patient within Mental Health Services with positive screening for **Methicillin Resistant *Staphylococcus Aureus* (MRSA)** (2016)

Patient Demographic/Label

IPC Care Plan for a patient within Mental Health Services with MRSA:

Statement: This Care Plan should be used with patients who are known to be colonised with MRSA. This Care Plan should be followed to help to reduce the risk of passing MRSA to other patients, staff, carers and visitors. If it is not possible to follow this Care Plan, you should notify the Infection Prevention and Control Nurse Specialist who will help you to carry out a Risk Assessment on how best to care for this patient.

Date	No	Issue/Problem	Action To Be Taken	Ongoing Assessment/ Review Date	Signature	Action From Assessment Review	Action Discontinued Date/Signature
	1	**Accommodation**	• Isolation is not usually necessary within low risk areas but will depend on the site of colonisation, behaviour of the patient and the vulnerability to infection of the other patients. • A risk assessment should be carried out by the Clinical Team to determine whether the patient is suitable or necessary for isolation. If unsuitable, a daily review should be carried out and documented in the patient's case notes. • If isolation is advised but the patient is unable to be isolated in a single room, it is advisable that the patient is **NOT** nursed adjacent to patients who are immunocompromised or with wounds, catheters, IVI or other				

Date	No	Issue/Problem	Action To Be Taken	Ongoing Assessment/ Review Date	Signature	Action From Assessment Review	Action Discontinued Date/Signature
			invasive devices.				
	2	**Hand Hygiene**	• Hand hygiene **MUST** be performed with water and liquid soap or alcohol hand gel after **ALL** direct patient care. • Encourage the patient to wash their hands regularly with water and liquid soap especially after using the toilet and before eating. • Encourage the patient to keep their nails short and clean.				
	3	**Personal Protective Equipment (PPE)**	• Single-use disposable gloves and aprons **MUST** be worn for **ALL** direct patient care. • Gloves and aprons **MUST** be disposed of into the infectious waste stream after every use and hands should be decontaminated with water and liquid soap. • Visitors are **NOT** required to wear gloves and aprons.				
	4	**Decontamination of Patient Equipment**	• Where possible, equipment such as chairs, hoist sling etc should be kept for the use of the colonised/infected patient **ONLY** and stored in their room. • If equipment is taken out of the patient's room, it **MUST** be cleaned with 1000ppm chlorine based detergent (10000ppm if contaminated				

Date	No	Issue/Problem	Action To Be Taken	Ongoing Assessment/ Review Date	Signature	Action From Assessment Review	Action Discontinued Date/Signature
			with bodily fluids). • Crockery, cutlery and medicine pots can be removed from the room and washed in the normal way. • Keep items and equipment to a minimum in the isolated room or patients bedspace.				
	5	**Specimens**	• Routine specimens are not normally required unless there are clinical signs of infection. • Consultant Microbiologist can be asked to advise if specimens are thought to be required.				
	6	**Laundry**	• If the patient is in isolation or isolation precautions are being followed, used linen should be placed in a water soluble bag prior to washing. • Clean linen should be taken into the patient's room only when required. **DO NOT** store clean linen in the isolated room.				
	7	**Waste**	• Waste generated as a result of clinical care should be disposed of in the infectious waste stream.				
	8	**Environmental Cleaning**	• If the patient is in isolation or isolation precautions are being followed, Nursing staff are responsible for the cleaning of patient related equipment twice daily using chlorine based				

Date	No	Issue/Problem	Action To Be Taken	Ongoing Assessment/ Review Date	Signature	Action From Assessment Review	Action Discontinued Date/Signature
			detergents. • Floors, sinks, surfaces and toilet **MUST** be cleaned twice daily by the domestic staff using chlorine based detergents. • When the room is vacated, Nursing staff should clean patient related equipment with chlorine based detergents and remove equipment from the room. Domestic staff should then carry out a thorough terminal clean of the room according to the isolation cleaning pack • When the room is dry, it is safe to use.				
	9	**Information to Patient and Carers**	• Ensure that the patient and relatives are given information on MRSA and given the opportunity to discuss this. This should be documented in the clinical notes. The leaflet is attached below • If the patient is isolated, explain to both the patient and relatives the reasons for isolation.				
	10	**Visitor Restrictions**	• Visitors **DO NOT** have to wear PPE but **MUST** wash their hands with water and liquid soap **BEFORE** and **AFTER** visiting.				
	11	**Personal Patient Clothing**	• There are **NO** special washing instructions. • All used patient clothing should be				

Date	No	Issue/Problem	Action To Be Taken	Ongoing Assessment/ Review Date	Signature	Action From Assessment Review	Action Discontinued Date/Signature
			placed in a patient clothing alginate and taken home by the carer or relative for home laundering. • If the patient's clothing is being washed on site, ensure **ALL** used laundry is placed in a water soluble bag.				
	12	**Transfer to Another Department or Hospital**	• Movement to other hospital departments should be kept to an absolute minimum and receiving departments MUST be informed of the patient's MRSA status prior to travel. • Prior to transfer, the receiving area or department **MUST** be informed of the patient's MRSA status using the Inter/Intra agency transfer form.(attached) • Ward staff should inform the Infection Prevention and Control Nurse Specialist of planned transfer to allow a risk assessment of the patient to be carried out and also a risk assessment of the receiving area. This is to ensure the most appropriate patient placement. • The Inter/intra agency transfer form must be completed when the decision to transfer has been made at any stage of the patient's care including after they have fully				

Date	No	Issue/Problem	Action To Be Taken	Ongoing Assessment/ Review Date	Signature	Action From Assessment Review	Action Discontinued Date/Signature
			recovered from their infectious illness				
	13	**Psychological Impact of Being Isolated**	Patients in isolation may be prone to feelings of loneliness and depression as well as feeling there is a stigma attached to them. These feelings can be lessened by: • Ensuring the patient understands why they are being isolated. • Encouraging the patient to express their concerns. • Providing verbal or written information about the reason and providing a leaflet if available. • Ensuring the patient has items to relieve boredom such as newspapers and television.				
	14	**Treatment or Eradication as Appropriate**	• If decolonisation is indicated, the process described in the MRSA policy MUST be followed. • If there are clinical signs of infection, the Infection Prevention and Control Nurse Specialist **MUST** be contacted for advice.				

Appendix 4

MRSA Patient Information Leaflet

What is MRSA?

MRSA stands for meticillin-resistant *Staphylococcus aureus*. *Staphylococcus aureus* (SA) is a common skin bacterium. It can cause skin infections such as boils and impetigo or infected cuts and grazes. Occasionally, it can lead to more serious infections.

MRSA is a type of SA which is resistant to an antibiotic called meticillin and a range of other antibiotics. This **does not** mean that someone who has an infection caused by MRSA cannot be treated, just that they will have to be given different antibiotics to the ones usually used.

Colonisation with MRSA

About one in three of us permanently carries SA bacteria in our nose or on the surface of our skin (especially in folds like the armpit or groin) without being aware of it or getting an infection. This is completely normal and is known as being **colonised** by the bacteria.

Another one third of people will carry SA from time to time. In the same way, people can carry MRSA in their nose or on their skin without them being aware of it or having any symptoms. The number of people who are colonised with MRSA is much smaller than the number who carry SA. But people who have recently been in hospital or are admitted frequently are more likely to carry MRSA.

Who is most at risk of an MRSA infection?

MRSA does not normally infect healthy people, even if they are colonised.

Although it is possible for people outside hospital to become infected, MRSA infections are most common in those who are already in hospital. This is because:
• they often have an entry point for the bacteria to get into their body, such as a surgical wound or a catheter
• they tend to be older and more poorly than the general population, which makes them more vulnerable to infection
• they are surrounded by a large number of other patients and staff, so the bacteria can spread more easily (usually through direct contact with other patients or staff).

What treatment do I need?

If you are colonised with MRSA:
Your doctor will prescribe a skin lotion for you to wash with as well as an ointment that you need to apply to the inside of your nose.

How do I use these and when?

Skin wash
You will be given a bottle of antiseptic wash and a small tube of an antibiotic nasal ointment called Bactroban or Naseptin.

For five days you must:

• Use the antiseptic wash as a liquid soap/shampoo for a shower, bath or wash every day. Wet your skin and then put undiluted wash on a clean, damp flannel and thoroughly clean your whole body, working downwards.

• Pay particular attention to your hair, face, nose, armpits and groin. Avoid getting it in your eyes or your ears.

• After washing all these important areas, rinse off with clean water.

• Next, wash your hair with the wash and rinse it off thoroughly. Wash your hair on day one, three and five.

• Do not share your bottle with other patients.

• Do not use with it with other shampoos, soaps or moisturisers.

• Ask us for a new bottle if you run out.

Ointment

For the five days when you are also using the skin wash you must:

• Put the antibiotic ointment on the insides of your nostrils three times a day.

• Making sure your finger is clean, use it to gently press both nostrils together for a few seconds to thoroughly spread the ointment over the inside of your nose.

•The nursing staff will help you with this if you need them to.

Re-swab

After five days of using the skin wash and the ointment you will have a two-day break and then be re-swabbed on the third day. This is to see if the MRSA bacteria have gone. The results take several to come back. If you still have the bacteria on your body you will have to repeat the five-day skin wash and ointment treatment.

Will colonisation affect my care?

If you are colonised or have an MRSA infection, all staff looking after you will wear gloves and an apron to prevent the spread of the bacteria.

It will not affect your care in any other way, for example, if you need investigations or a procedure.

Do I or my visitors need to take any special precautions?

Keep your hands clean by washing them frequently and avoid touching any wounds or dressings.

All visitors must clean their hands before they enter and leave the ward/room by using soap and water or alcohol hand rub. They do not need to wear gloves or aprons.

What happens when I get home?

As soon as you are well enough you can go home. MRSA will not prevent or delay you from leaving hospital. It should not affect any aspects of your home life, including your usual daily activities.

Do I need to tell anyone I have/have had MRSA?

We will tell your GP or community nurse, but it is a good idea to remind them the next time you visit the practice. You should always anyone caring for you that you have, or have previously had, MRSA. In particular, let them know:

- when you are admitted to hospital
- before you are admitted to a nursing or residential home
- before an outpatient appointment or a visit to your GP

APPENDIX 5

Lincolnshire Partnership NHS
NHS Foundation Trust

Trust Inter/ Intra Agency-Healthcare Transfer Form

This form must be completed in conjunction with other discharge/ transfer documentation and kept with any multi-disciplinary notes

Patient/Client details: (insert label if available) **Name:** **Address:** **Date of birth:** **NHS number:**	**Consultant:** **Contact no:** **GP:** **Contact no:**	
Transferring facility: *(hospital, ward, care home, other)* **Contact name:** **Contact no:**	**Receiving facility:** *(hospital, ward, care home, district nurse [if applicable], GP)* **Contact name:** **Contact no:**	
Diagnosis: *(confirmed organism)*	Infection Yes ☐ No ☐	Colonisation Yes ☐ No ☐

Microbiological identification (specimen results):

Specimen & Results	Specimen type	Date	Result
Screen/diagnostic			
Confirmatory			
Other			
Further screening required?			

Treatment information (if appropriate): *(including type of medication, dose and duration)*

Infection prevention & control precautions required / in place:

Other information relevant to patient's care:			
Has ambulance service been informed?	Yes ☐	No☐	If No, give reason

Is the patient/client aware of their colonisation/infection status?	Yes ☐	No☐	If No, give reason
Has patient received information about their status? (patient leaflet)	Yes ☐	No☐	If No, give reason
Has the nearest relative/ carer received information about their status? (patient leaflet)	Yes ☐	No☐	If No, give reason

Name of staff member completing form:

Print name		**Contact number**	

Appendix 6 Equality Analysis Form

Name of Policy/ project/ service	**Methicillin-Resistant *Staphylococcus Aureus* (MRSA) Management & Control 7d**		
Aims of policy/ project/ service	**This policy details the arrangements for the management and control of Methicillin-Resistant *Staphylococcus Aureus* (MRSA) in Lincolnshire Partnership Foundation Trust**		
Is this new or existing?	Existing		
Person(s) responsible	Jane Lord		
Key people involved	Jane Lord		
Who does it affect?	Service users □√	Staff □√	Wider Community □√

Is the policy/ project/ service likely to have an effect on any of the protected characteristic groups? (please tick)

	Positive	Negative	None	Is action possible to mitigate any negative impact?	Details of action planned (including dates or why action is not possible)
Age	√				
Disability	√				
Sex	√				
Gender Reassignment	√				
Sexual Orientation	√				
Race	√				
Religion and Belief	√				
Marriage and Civil Partnership	√				
Pregnancy and Maternity	√				

Carers	√				

Any other information that is relevant to the equality impact of the policy/ project/ service?

Detail any positive outcomes for any of the protected groups listed above

The policy will ensure best practice to prevent transmission of infectious disease

Result of Equality Analysis

Based on the information above- what is the outcome of the Equality analysis?

a) No change √ □	b) Adjust the activity □	c) Stop/remove the activity □
Detail any adjustments that are to be made and how these will be monitored		

Person who carried out this assessment	Jane Lord
Date assessment completed	04/11/2017
Name of responsible Director/General Manager	Anne-Maria Olphert
Date assessment was signed	
Date of next review	03/11/2020