Please note that it is the responsibility of the document lead to consult with the all relevant staff to whom the document refers, with the staff side representatives where relevant and/or e.g. Health and Safety Committee if necessary. It is important to note that by completing the consultation page and denoting consultation has been undertaken, this confirms that the document lead has completed the appropriate consultation relevant to the subject and is responsible for the process.

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1. **Definition of Terms**

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   - Patients to be Screened
   - Elective Admissions
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   - Consent for Screening
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   - Results
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4. **Training**

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6. Monitoring Compliance and Audit

Appendices

Appendix A – MRSA Decolonisation Treatment Regimen
Appendix B – Referral Form to Community Decolonisation Team
Appendix C – Flowchart for elective MRSA screening
Introduction
This procedure sets out the requirements for MRSA screening. It also describes the management of patients found to be MRSA positive.

Patients may be carriers of MRSA or acquire it without symptoms. Once MRSA infects a wound, respiratory tract or blood, treatment is difficult and morbidity considerable.

Screening for MRSA allows selective use of topical MRSA decolonisation treatment to reduce the risk of infection and of spreading MRSA to other patients. It also allows for isolation or cohorting away from vulnerable patients.

The success of screening strategies is still dependent on compliance with hand hygiene and other Infection Control (IC) practices.

Background to MRSA Screening
MRSA screening in advance of surgery allows decolonisation treatment to be started before the operation and greatly reduces the risk of MRSA infection of the wound. Approximately 5% of patients being considered for surgery are carriers of MRSA. Topical treatment is sufficient to keep a safe level of MRSA until the wound has healed. In one third of cases the organism may then return.

MRSA screening was extended in 2010 to comply with the Department of Health (DoH) requirement for the screening of all elective admissions and day cases (with selected exclusions).

MRSA screening is just one of the IC programmes at Colchester Hospital University NHS Foundation Trust (CHUFT). It also supplements the Saving Lives strategy of the DoH which has been implemented. This strategy includes the Central Venous Catheter (CVC) and peripheral line care bundles, root cause analysis, feedback of surveillance information, observation and feedback compliance with IC practices including hand hygiene.

Objectives
The objectives of this procedure are to:
- make all members of the multi-disciplinary team aware of good clinical practice and their responsibility with regards to patient MRSA screening.
- provide clear guidance on the appropriate preparations to use during MRSA decolonisation treatment regimens as well as its timing.
- provide clear guidance on the appropriate use of isolation and isolation precautions for patients.
- decrease the number of acquisitions and infections with MRSA.
- minimise the patient risk of MRSA infection.
- comply with the DoH’s “MRSA screening – operational guidance July 2008”.

Related Documents
090 – Hand Hygiene Procedure
MRSA Integrated Care Pathway
245 – Clostridium difficile (Cdiff) and Unexplained Diarrhoea Procedure
027 – Consent for Examination or Treatment Procedure
343– Hydrogen Peroxide Vapour (HPV) Decontamination Procedure

1. Definition of Terms

Methicillin-Resistant Staphylococcus aureus (MRSA)
MRSA is a bacteria that is resistant to certain antibiotics e.g. penicillin and flucloxacillin.

MRSA Screening
The collection of swabs for the detection of MRSA in sites of the body where these bacteria can live without causing any disease.

MRSA Colonisation
The detection of MRSA in sites of the body where there is no evidence of disease.
MRSA Infection
The presence of MRSA in a body site where there is evidence of disease.

2. Roles and Responsibilities

Director of Infection Prevention and Control (DIPC)
- Will ensure that the document is updated in line with Trust procedure and in light of new guidance and evidence.
- Include the audit of the procedure within the IC audit programme.
- Promote awareness across the Trust through supporting education programmes.
- To monitor IC reports through the Hospital IC Committee.

Patient’s Consultant
- To follow up results with the support of their clinical teams.
- To promote procedure awareness within their clinical team.
- To ensure that all clinical team members complete mandatory IC updates every 2 years.
- With the support of their clinical teams, ensure results of the patients MRSA screen are included in the patients discharge summary.

Matron
- To promote procedure awareness.
- To ensure that all nursing staff complete mandatory IC updates every 2 years.
- To monitor compliance with this procedure.

Ward Sister/Charge Nurse
- To promote procedure awareness.
- To ensure adequate supplies of supporting documentation is available i.e. care pathway and patient information leaflets.
- To monitor compliance with this procedure.

Nursing Staff
- To promote procedure awareness.
- To comply with procedure.
- To obtain MRSA screen as per this procedure
- To commence all relevant patients on MRSA care pathway.
- To provide adequate explanation to patient/carers and support where appropriate with Trust MRSA patient information leaflets.
- To refer patients requiring MRSA decolonisation in the community who are also registered with a GP in the North East Essex locality to the Community MRSA Decolonisation team using the referral form in appendix B/ ACE community gateway portal.

Microbiologist
- Will notify clinical staff of positive results which will also be available on the Trust pathology system.
- Provide clinicians with antibiotic treatment options as required

Infection Control Team
- Will notify clinical staff of positive results which will also be available on the Trust pathology system
- Will update patient Information leaflets
- Will provide advice and training as required
- Will enter an infection control alert onto the Medway patient administration system of all patients identified with MRSA
- Will attach a green “MRSA” sticker on the alert section of the case notes (a red page at the front of the case notes) or on the inside back cover of old notes
# 3. MRSA Management Process

## MRSA screening

<table>
<thead>
<tr>
<th>Patients at high risk of carriage of MRSA</th>
<th>Known to have been infected or colonised with MRSA in the past.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A healthcare worker from community or acute setting.</td>
</tr>
<tr>
<td></td>
<td>Recent inpatients to other hospitals including those abroad i.e. within the last 6 months.</td>
</tr>
<tr>
<td></td>
<td>Renal dialysis patients.</td>
</tr>
<tr>
<td></td>
<td>Residents of residential care facilities i.e. nursing and residential care homes.</td>
</tr>
<tr>
<td></td>
<td>Sufferers of chronic skin breaks – including pressure sores.</td>
</tr>
<tr>
<td></td>
<td>Diabetics who have wounds.</td>
</tr>
<tr>
<td></td>
<td>Those with a long term invasive device either placed by a health care worker or self, e.g. urinary catheter.</td>
</tr>
<tr>
<td></td>
<td>Those with partners/spouses/main carers known to be MRSA positive.</td>
</tr>
<tr>
<td></td>
<td>Admitted to Neonatal Unit (routine weekly screening).</td>
</tr>
<tr>
<td></td>
<td>Cardiac patients awaiting transfer to specialist cardiac units (routine weekly screening) e.g. Dedham Ward.</td>
</tr>
</tbody>
</table>

## Patients to be Screened

### Elective admissions (Medical and Surgical)

<table>
<thead>
<tr>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients (including those for arthroscopy and laparoscopy) require screening as per the flowchart in appendix C</td>
<td>Day case ophthalmology.</td>
</tr>
<tr>
<td></td>
<td>Day case dental.</td>
</tr>
<tr>
<td></td>
<td>Day case endoscopy i.e. all endoscopy of the GI tract, bronchoscopy, cystoscopy, hysteroscopy.</td>
</tr>
</tbody>
</table>

### Dermatology

<table>
<thead>
<tr>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screen all patients requiring elective surgery as per the flowchart in appendix C.</td>
<td>Exclude minor procedures (day case)</td>
</tr>
</tbody>
</table>

### Maternity

<table>
<thead>
<tr>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>All maternity patients deemed at MRSA high risk screen at approximately 36 to 37 weeks. Decolonise once positive result known. All maternity patients at high risk for MRSA include: Pre</td>
<td>Maternity patients who do not fall into the maternity MRSA high risk category.</td>
</tr>
<tr>
<td>Previous MRSA. Healthcare workers. Received healthcare intervention within the previous 6 months.</td>
<td>For the purposes of reporting the below are excluded on the premise that cases are reviewed within the Maternity governance process. Any issues noted in this review will be escalated to the Infection Control team for reporting;</td>
</tr>
<tr>
<td>‘All maternity patients deemed at MRSA high risk</td>
<td></td>
</tr>
</tbody>
</table>

Source: Head of Infection Control
Status: Approved May 2016
Issue date: November 2003
Review date: May 2019

Document reference PP(16)112
Screen all elective caesareans at 31-34 weeks, and decolonise patients at 38 weeks (see section on decolonisation regimen for details).

Screen at approximately 36 to 37 weeks. Decolonise once positive result known.

All maternity patients at high risk for MRSA include:
- Previous MRSA.
- Healthcare workers.
- Received healthcare intervention within the previous 6 months.

Screen all elective caesareans at 31-34 weeks, and decolonise patients at 38 weeks (see section on decolonisation regimen for details).’

### Paediatrics

<table>
<thead>
<tr>
<th>Children 16 years and under do not need to be screened as a general rule other than those detailed.</th>
<th>Include</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All known previous positive patients.</td>
</tr>
<tr>
<td></td>
<td>All patients transferred back from tertiary centres.</td>
</tr>
<tr>
<td></td>
<td>Those who have received healthcare intervention within the previous 6 months.</td>
</tr>
</tbody>
</table>

### Transfers of patients

- Between wards of CHUFT.
- From hospitals outside CHUFT.

### Others

- Patients should be screened by the admitting ward at CHUFT i.e. the ward/department through which the patient is first admitted
- Patients who have been transferred directly from any hospital including abroad should be screened by the admitting ward/department.

### All patients on renal dialysis programmes

- Patients should be screened on admission to the programme, then at monthly intervals thereafter.
- Patients should be screened prior to insertion of vascular or peritoneal access for renal dialysis.

### Patients admitted to Critical Care

- All patients need to be screened on admission to the unit, regardless of where they were referred from.
- All patients require decontamination regimen started on admission and documented on the critical care treatment charts.
- All patients should be screened at weekly intervals.

### Regular day attenders

- Chemotherapy – 8 weekly intervals.
- Haematology – 8 weekly intervals.
Non-invasive radiology procedures do not need to be included in the MRSA screening process.

**Emergency Admissions that Require MRSA Screening**
The MRSA screen should be taken at the earliest opportunity by the admitting department/ward. Screening should not affect the 4-hour wait and will not be seen as an acceptable reason for breaches. The screen **must** be taken within 48 hours of admission. It is imperative that each receiving ward/department checks and documents that the patient has had the MRSA admission screen. This information must be handed over in written form and verbally.

<table>
<thead>
<tr>
<th>Emergency admissions to be routinely screened.</th>
<th>Routine microbiological screening must include all emergency admissions to the Trust. Admissions include those patients being admitted to hospitals on an emergency basis regardless of the route of attendance e.g. through A&amp;E, EAU, GP, or other routes such as an outpatient clinic or a rapid access unit.</th>
</tr>
</thead>
</table>
| Emergency admissions **NOT** to be routinely screened. | Unless identified as high risk (as per page 6) the following groups are not to be routinely screened if admitted as an emergency:  
- Children (from birth to 16 years).  
- Maternity.  
- Mental health/learning disabilities.  
- Patients with a length of stay less than 48 hours. |

**Consent**
The need for testing should be explained to all patients and verbal consent obtained.

There are patient information leaflets available for patients being screened, to support verbal explanation ('MRSA screening for elective surgery', number 907, or 'Screening for patients known to be MRSA positive or at risk of acquiring MRSA', number 749).

Other patient information leaflets are available for those patients subsequently found to be MRSA positive on screening (MRSA your questions answered), number 79.

Patients who are to be admitted for elective surgery will be screened as per the flow chart appendix C.

**Patient Refusal**
It cannot be insisted upon that a patient is screened. If a patient initially refuses to be screened they should be informed that it is CHUFT procedure and can be given a leaflet for information. If the patient continues to refuse, this should be clearly documented in the patient's clinical notes. However the patient's clinical management will not be compromised and they will need to have the same management as a MRSA carrier.
Laboratory
Microbiology Department
CHUFT
214 Turner Road
Colchester
CO4 5JR
Telephone enquiries extension: 7374 or 7314
Fax extension: 7301

Cultures can be sent on any routine specimen run transport but are not processed as on call requests.

Sites to Screen
- Nose (both nostrils, using the same swab).
- Perineum.
- Sites of catheters and stomas.
- Sputum from patients with a productive cough.
- Skin lesions and/or wounds – one swab from each site; clearly identifying sites on the microbiology form.
- Insertion sites for invasive devices at time of screening – i.e. PEG sites, Catheters.
- Catheter Sample of Urine (CSU) – for patients who have urinary catheters in situ. This must be taken using the correct aseptic non-touch technique and NOT from the bag.
- Any other site that has been previously positive – if the patient has been MRSA positive previously e.g. leg ulcers etc.

Method
Use a plain swab with a white cap for each site. The swab may be moistened in sterile saline and then rubbed over the skin at the appropriate site. Once the specimen has been obtained replace the swab in the sterile swab tube and then put into a specimen bag. A microbiology form should be completed using correct source codes and listing the sites sampled. This form should be sent in the same specimen bag as all the screening specimens from the same patient but use an additional bag/form if there are more than 3 swabs. The screen and form should be sent to the microbiology laboratory as soon as possible after the samples have been obtained.

Details of the date and time of the screen must be recorded in the patient’s notes/care pathway by the person performing the screen.

The Test
Specimens are processed using conventional culture and any presumptive MRSA that is grown will be tested for susceptibility to methicillin.

Results
The MRSA screen results will be available on the pathology system.

MRSA screen results are reported as not detected (negative), or isolated (positive).

Positive results are also telephoned by the laboratory/IC to the clinician/ward/clinic.

Results of the MRSA screen must be recorded in the patient’s record and the paper result filed in the pathology section of the patient’s notes.

Management of Inpatients Before their MRSA Status is Known
For patients who are at high risk of carriage of MRSA and patients who refuse screening for MRSA:
- Isolation precautions should be instituted.
- Patient must be commenced on MRSA care pathway.
- Patient must be provided with information leaflet ‘MRSA – Screening for patients known to be previously MRSA positive or at high risk’.

Source: Head of Infection Control
Issue date: November 2003
Status: Approved May 2016
Review date: May 2019
Document reference PP(16)112
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Relatives/Visitors
Clinical staff must explain to relatives the importance of hand washing prior to entering and upon leaving the patient’s isolation room. The isolation room will have a notice displayed on the door indicating precautions to be followed. Relatives/Visitors do not need to wear aprons and gloves unless undertaking physical care of the patient.

Patients Requiring Surgery and Not Screened as per appendix C Take screening specimen as soon as possible.
- Use isolation precautions until the result is available.
- All patients should start daily Octenisan washes whilst awaiting results
- Give the adapted surgical prophylaxis (see link: http://intranet.rde.local/intranet/publish/INTRANET/departments/Pharmacy/Antibiotic_Management_Team/Guidelines.php)
- If positive, complete the decolonisation treatment course as per this procedure. Re-screening to check for clearance is not necessary except for patients undergoing joint replacement, and vascular implant surgery.

Staff Screening
In most circumstances staff screening is not needed. Most transmission of MRSA occurs on the hands when they have not been washed between patients or touching the local environment. It is not detectable once the hands have been washed. Nasal carriage often involves strains unrelated to that causing infection in the patients.

It may be used if there is a clear associated cluster of cases and is deemed necessary by the IC Team.

Management of Patients according to MRSA Screening Result

MRSA Negative Result
If the specimen results are negative, the patient can be removed from isolation and the MRSA care pathway discontinued.

MRSA Positive Result
Inform the patient of the result. Patient information leaflets are available to explain the significance and implications of MRSA. Continue the MRSA care pathway. If a side room is not available a risk assessment needs to be completed, recorded and discussed with IC who will discuss with the Site Matron/Duty Matron. The patient should be transferred to a side room for isolation at the earliest opportunity ensuring patient safety is not compromised. The patient may be considered for transfer to the isolation unit in line with the Clostridium difficile (Cdiff) and Unexplained Diarrhoea Procedure, document number 245

Commence the 5 day decolonisation treatment regimen immediately as detailed within the MRSA care pathway (see Appendix A).

Ensure the appropriate medications are prescribed and administered accordingly.

The MRSA Care Pathway must be completed throughout treatment. http://intranet.rde.local/intranet/documents/450/11280/MRSA%20positive%20or%20high%20risk%20draft%2010.5.pdf

Problems when Using the Decontamination Treatment
- For patients with eczema, dermatitis or other skin conditions, attempts will be made to treat the underlying skin condition. Advice on suitable eradication protocols will be sought from the Consultant Dermatologist. Oilatum bath additive or Oilatum plus (with added benzalkonium chloride 6% and triclosan 2%) may be used with these patients, but these should only be prescribed on the advice of a Dermatologist.
- Mupirocin resistance from a clinical isolate; use Polyfax instead of Mupirocin.
Repeat Testing
Re-screening after decontamination should be undertaken where possible two days after the course of treatment is finished. Three consecutive negative screens taken one week apart are required for MRSA clearance.

- If an individual remains positive, a repeat course of treatment should be given but failure to eradicate after 3 courses should be reviewed by the IC Team. For further information please contact the IC Team on extension 4268.
- If the patient is receiving antibiotic therapy, antibiotic present in the specimen may inhibit the growth of bacteria in laboratory cultures producing misleading results, for example, false negative MRSA screens (Wilson 2006). Therefore an MRSA screen should be obtained 48 hours after completion of the antibiotic course.

Transfer/Receipt of Patients who are identified as MRSA Positive

To Other Departments/From Other Hospitals

- Transfer of MRSA positive patients to other wards must be minimised to reduce the risk of spread.
- Prior arrangement must be made with the staff of the receiving department.
- Lesions will be covered whenever possible with an impermeable dressing.
- The trolley or chair will be cleaned with warm water and detergent/detergent wipes after use.
- Attendants who may be in contact with the patient will wear disposable plastic aprons and gloves whilst in direct contact with the patient. Aprons and gloves will be removed and disposed of as clinical waste when contact with the patient has finished.
- Porters/staff do not need to wear gloves and aprons when transporting patients between departments. Gloves and aprons will be worn when having direct contact with the patient at the beginning and end of the transfer.
- Staff will wash their hands thoroughly after contact with the patient and after cleaning the trolley or chair.

To Other Hospitals

- If a MRSA positive patient is to be transferred to another hospital, inform the receiving hospital/department as soon as possible prior to transfer. This will allow the receiving hospital to make necessary provisions to ensure that appropriate precautions are put into place. It is the clinical team’s responsibility to inform the transport/ambulance department at the time of requesting transport.
- A verbal and written handover must be given detailing results, sites and date plus the stage of treatment at point of transfer.
- A clean sheet will be placed on the trolley/chair.
- After discharge/transfer:
  - Arrange an amber clean if the MRSA positive patient has been in the room less than 2 weeks
  - Arrange a red clean if the MRSA positive patient has been in the room over 2 weeks

Guidance for Receiving Department

- Tend to these patients at the end of the session if possible.
- The patient will spend the minimum time in the department, being sent for when the department is ready, and not left in waiting area with other patients.
- Equipment and number of staff attending will be kept to a minimum.
- Surfaces with which the patient has had direct contact will be cleaned with warm water and detergent/detergent wipes.
- An amber clean (as per the Hydrogen Peroxide Vapour (HPV) Decontamination Procedure, document number 343) should be requested if subsequent patients are particularly susceptible to infections e.g. radiotherapy/haematology/oncology department.
- Staff coming into contact with the patient will wear disposable plastic aprons and gloves. Aprons and gloves will be removed and disposed of as clinical waste when contact with the patient has finished. Staff will wash and dry their hands and apply alcoholic hand rub.
- Used linen will be treated as infected – placed into an alginate bag, tied and then put into a white outer plastic linen bag.
Transfer/Receipt of Patients who are identified as previously MRSA Positive  
NB. Once identified as MRSA positive this will remain on the patient’s record indefinitely

Guidance for Receiving Department
- Tend to these patients at the end of the session if possible.
- The patient will spend the minimum time in the department, being sent for when the department is ready, and not left in waiting area with other patients.
- Equipment and number of staff attending will be kept to a minimum.
- Surfaces with which the patient has had direct contact will be cleaned with warm water and detergent/detergent wipes.
- An amber clean (as per the Hydrogen Peroxide Vapour (HPV) Decontamination Procedure, document number 343) should be requested if subsequent patients are particularly susceptible to infections e.g. radiotherapy/haematology/oncology department.
- Staff coming into contact with the patient will wear disposable plastic aprons and gloves. Aprons and gloves will be removed and disposed of as clinical waste when contact with the patient has finished. Staff will wash and dry their hands and apply alcoholic hand rub.
- Used linen will be treated as infected – placed into an alginate bag, tied and then put into a white outer plastic linen bag.

Management of MRSA Screening for elective Surgical Patients
For patients having elective surgery, a negative MRSA screen from the preceding 12 weeks will be required for entry to the operating theatre.

MRSA Negative Result
The surgery can go ahead.

If the MRSA Result is Positive
All patients who are screened positive should be informed of the result and given the leaflet ‘MRSA your questions answered’. Any concerns that the patient has should be addressed as fully as possible by Pre-admission Clinic, or midwife who may refer to IC.

Patients screened positive should be given a decontamination regimen (see Appendix A). This regimen should be given within the 18 week pathway.

Re-screening to check for clearance is not necessary except for patients undergoing joint replacement, and vascular implant surgery.

Patients who are MRSA positive in these groups will require screening in the same sites as before. This will be organised by the community decolonisation team providing the patient is registered with a GP in the North East Essex locality.

Re-screening should be done two days after their last dose of mupirocin and octenisan i.e. at day eight of the decolonisation regimen.

If these screens are positive, then an additional decolonisation regimen should be given as above. The re-screening process should be repeated.

If the screens are again positive, a discussion about the management of the patient should be had between the consultant caring for the patient and the Consultant Microbiologist.

On admission to the hospital the patient’s MRSA status should be highlighted by the admitting nurse.

If the patient has screened MRSA positive prior to admission, he/she should be managed as if MRSA positive, despite having received decolonisation. The patient should be isolated in a side room and appropriate IC precautions started.
Surgeons, theatre staff and the anaesthetists must be aware of the patient’s MRSA status and this should be highlighted to staff. MRSA positive patients require special precautions i.e. appropriate antibiotic prophylaxis and additional cleaning after their procedure.


MRSA positive patients should be last on the operating list and an amber clean of the theatre undertaken after the procedure.

| The aim of using a course of decolonisation treatment is to decrease the amount of MRSA present on the skin and reduce the risk of subsequent wound and bloodstream infection. |

The MRSA Positive Patient is an Outpatient and has attended a Pre-admission Clinic

<table>
<thead>
<tr>
<th>Informing the Pre-admission clinic</th>
<th>The results of MRSA screens will be checked by the pre-admission clinic nurse on the pathology system. The pre-admission clinic nurse will record the results in the patient’s record to ensure the results are accessible when the patient returns for their surgery. The clinic will alert the patient to their result.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to the community MRSA decolonisation team</td>
<td>The clinic will complete the referral form (Appendix B/ACE community gateway portal) for patients whose GP is in the North East Essex locality. The community MRSA decolonisation team will organise giving the decolonisation treatment. If the patient’s GP is NOT in the North East Essex locality the pre-admission clinic nurse will liaise with the patients GP to organise MRSA decolonisation treatment. The decolonisation treatment should be started such that day 5 of the decolonisation treatment protocol is the planned date of surgery where possible. If there is not enough time to complete the 5 day decolonisation treatment prior to surgery, a discussion should take place between the patient’s Surgical Consultant and Consultant Microbiologist.</td>
</tr>
</tbody>
</table>

The MRSA Positive Patient has to have Repeat Surgery

Use a further course of decolonisation treatment, ideally allowing 1 to 2 days of decolonisation treatment protocol before surgery and completing a full 5 days post-operatively.

Follow Up Courses of Decolonisation Treatment

The aim of these subsequent courses of decolonisation treatment is to decrease the amount of MRSA present on the skin, such that the patient does not serve as a reservoir. In some patients it may also result in MRSA eradication.

Give a second course of decolonisation treatment after the first if MRSA is isolated again from any clinical sample (e.g. wound or sputum).
Give a third course of decolonisation treatment if MRSA is isolated from any clinical sample (e.g. wound or sputum) taken in the subsequent weeks.

Subsequent courses of decolonisation treatment require microbiology/IC approval.

4. Training
This needs completing on induction and via e-learning as per the Trust Training Needs Analysis in the Planning and Delivering Risk Management Training Procedure, document number 203.

5. Evidence Base
Department of Health (2009) Screening Elective patients for MRSA – FAQs Department of Health LONDON

Department of Health (2008) MRSA Screening Operational Guidance 2. Letter from Christine Beasley Chief Nursing Officer, David Flory Director General. Department of Health LONDON

Department of Health (2008) MRSA Screening Operational Guidance. Letter from Christine Beasley Chief Nursing Officer, David Flory Director General. Department of Health LONDON


6. Monitoring Compliance and Audit
Responsibility for ensuring compliance with the processes for screening lies with each divisional Associate Director with support from the ICT.

Internal monitoring of compliance with elective pre-admission and emergency MRSA screening will be by the individual Divisions, with progress monitored through the Divisional Governance Committees. Non-compliance will be reported to the Hospital Infection Control and Executive Patient Group who will require divisions to develop action plans to achieve and maintain compliance. The monitoring and reporting will take place on a monthly basis.

The DIPC reports the results to the quality patient safety committee monthly.

This procedure is available on the Trust intranet. All staff are notified via email, of the procedure and any amendments.
Background
In the past MRSA colonised patients were given so-called “eradication” treatment. However, MRSA eradication is unlikely in patients with long term devices (e.g. catheters, PEG tubing, IV Lines etc) chronic wounds, those who receive multiple courses of antibiotics, had multiple hospital admissions, or are residents in care homes.

For this reason the objective has changed from “eradication” to “decolonisation” or “Suppression” of MRSA. A reduction in the bacterial load of MRSA on the skin minimises the risk of spread of MRSA to other inpatients, and of introducing infection in the individual patient at the time of surgery or procedure.

The protocol is used for 5 days and commenced promptly upon notification of an MRSA positive result.

<table>
<thead>
<tr>
<th>Nose</th>
<th>If Mupirocin sensitive apply mupirocin nasal ointment 2% to inside of the nose three times daily for 5 consecutive days using the Patient Group Directive (PGD) if competent. If Mupirocin resistant Polyfax ointment to be used.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body</td>
<td>Wash daily. Use undiluted octenadine &amp; allantoin (octenisan), or an equivalent skin cleanser, as a liquid soap for 5 consecutive days. The skin must be moistened and the octenisan applied to a disposable cloth and then applied directly to all areas of the skin before rinsing.</td>
</tr>
<tr>
<td>Hair</td>
<td>Use undiluted octenadine &amp; allantoin (octenisan) as a shampoo on days 2 and 4 of the treatment cycle.</td>
</tr>
<tr>
<td>Open Wound/s</td>
<td>Cover with occlusive dressing/s. If there are clinical signs of infection e.g redness, swelling, pyrexia discoloured exudate then medical advice should be sought. Medical staff can liaise with a Microbiologist about the need for systemic antibiotics.</td>
</tr>
<tr>
<td>Clothing</td>
<td>In hospital: Use hospital nightwear where possible (change daily after bath or shower). Treat clothing as infected item (red alginate bag then a white plastic bag).</td>
</tr>
<tr>
<td>Bed-Linen</td>
<td>In hospital: Change completely on a daily basis. Apron, gloves and hand hygiene when handling linen. Minimise dispersal of skin cells by folding, rather than pulling or shaking the sheet and put it straight into the red alginate bag. Treat bed-linen as infected item (red alginate bag then a white plastic bag). At home: Change before bathing or showering. Ideally daily but if not possible more important on the first days of using the protocol. Bed linen can be adequately dealt with by washing in a domestic washing machine with a detergent.</td>
</tr>
</tbody>
</table>
REQUESTING ARRANGEMENT FOR DECOLONISATION OF POSITIVE MRSA PATIENT ON DISCHARGE FROM HOSPITAL

<table>
<thead>
<tr>
<th>PATIENT DETAILS</th>
<th>Please write clearly.</th>
<th>Do NOT use sticky labels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Mr/Mrs/Ms/Miss</td>
<td>D.O.B:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post code:</td>
<td>Telephone no:</td>
<td>Mobile no:</td>
</tr>
<tr>
<td>NHS Number:</td>
<td>Unit No:</td>
<td>Consultant:</td>
</tr>
<tr>
<td>GP:</td>
<td>Tel No:</td>
<td>Ethnicity:</td>
</tr>
<tr>
<td>PMH:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any known Allergies:</td>
<td></td>
<td>Invasive Sites:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobile: Yes / No</th>
<th>Housebound: Yes / No</th>
<th>Lives alone: Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please state where the patient is on MRSA pathway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cycle 1</td>
<td>Cycle 2</td>
<td>Cycle 3</td>
</tr>
<tr>
<td>Date started</td>
<td>Date started</td>
<td>Date started</td>
</tr>
<tr>
<td>Day</td>
<td></td>
<td>Day</td>
</tr>
<tr>
<td>Date of Re-Screen due</td>
<td>Date of Re-Screen due</td>
<td>Date of Re-Screen due</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSON REFERRING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Sender</td>
<td>Signature</td>
</tr>
<tr>
<td>Contact Tel number</td>
<td>Dept:</td>
</tr>
<tr>
<td>Please FAX to...</td>
<td>01255 201593</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date screen taken:</th>
<th>Nose</th>
<th>PEG site</th>
<th>Other state:</th>
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</thead>
<tbody>
<tr>
<td></td>
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<thead>
<tr>
<th>Please tick all MRSA positive sites/specimens</th>
<th>Perineum/groin</th>
<th>Tracheostomy site</th>
<th>Wound:</th>
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Incomplete forms will be returned

Patient informed of positive result: Yes ☐ No ☐ Informed by: Date:

Does the patient have any known hypersensitivity to topical antiseptics? E.g. Chlorhexidine. If yes detail overleaf and discuss with the Infection Prevention and Control Team

Leaflets provided 'Decolonisation for MRSA Positive result'

Important – Please use the Private and Confidential Continuation Sheet to provide additional written information to support the referral form. E.g. patient has been sent home with Hibiscrub/Octenisan etc. For further advice, please contact the TASC Team on 01255 206210

Source: Head of Infection Control
Status: Approved May 2016
Issue date: November 2003
Review date: May 2019

Document reference PP(16)112
### REQUESTING ARRANGEMENT FOR DECOLONISATION OF POSITIVE MRSA PATIENTS

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>DOB:</th>
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<tbody>
<tr>
<td>Date/time</td>
<td>Notes</td>
</tr>
<tr>
<td></td>
<td>Please list any other information you may think relevant (e.g., is patient due further surgeries).</td>
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</tbody>
</table>
Flowchart for elective MRSA screening

Assess patient for any MRSA risk factors
(see MRSA ICP)

Yes risks present

MRSA screen to be obtained in pre admission clinic

MRSA isolated
Pre-admission clinic Nurse to:
inform patient of result, organise for patients to receive decolonisation regimen in the community via the Community MRSA decolonisation team or GP
inform patient’s surgical Consultant of result.

NB re-screening to check for clearance is not necessary except for patients undergoing joint replacement, and vascular implant surgery.

MRSA NOT isolated
Providing the patient has not had any healthcare contact with 12 weeks of surgery. No further MRSA screening is required.

Patient to deliver MRSA screen swabs to Microbiology laboratory & notify pre-admission clinic nurse MRSA screen has been undertaken

MRSA isolated
Patient will require MRSA decolonisation treatment. Pre-admission clinic Nurse to:
inform patient of result, organise for patients to receive decolonisation regimen in the community via the Community MRSA decolonisation team or GP
inform patient’s surgical Consultant of result.

NB re-screening to check for clearance is not necessary except for patients undergoing joint replacement, and vascular implant surgery.

MRSA NOT isolated
Surgery goes ahead as planned.

No risks present

Give patient swabs and leaflet on how to obtain an MRSA screen. Patient to obtain MRSA screen 4 weeks prior to TCI date.

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