UNIQUE IDENTIFER NO: C-22-2006
Review Date: March 2018
Review Lead: Lead Infection, Prevention and Control Nurse

Calderdale and Huddersfield NHS
NHS Foundation Trust

Section T

Meticillin-resistant *Staphylococcus aureus* (MRSA) *&* *PVL Staphylococcus aureus* (PVL-SA) *Policy*

Version 9

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Document Summary Table			
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Other Stakeholders Consulted			
Does this document map to other Regulator requirements?			
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Document Version Control	
Version 9	Links have been added to the patient information leaflets for MRSA / MSSA; a link has been added for easy access to the antibiotic prescribing guidelines (p7). An appendix has been added to clarify the MRSA screening process.
Version 8	The title of the policy has been changed as the policy now covers MRSA and PVL-SA (Panton-Valentine Leukocidin Staphylococcus aureus).
Version 7	This policy has been reviewed and now focuses on the management and control of MRSA and PVL-SA. Other resistant organisms are now covered in Section J.
Version 6	The policy has been reviewed and minor changes have been made to the Definitions section, a section has also been added to the Management of Patients with MRSA to include management of patients in the community. An additional appendix has been added giving a one page summary of the policy.
Version 5	The document has been redesigned to ensure that all new and revised procedural documents are set out to a Trust wide format and the content of which includes a minimum set of criteria which include: ▪ the training requirements for implementation ▪ monitoring arrangements for the document ▪ Equality Impact of the document In addition, the monitoring arrangements for this document have been included.

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Contents

1. Introduction

The management of patients with Meticillin-resistant *Staphylococcus aureus* [MRSA] (formerly referred to as Methicillin-resistant *Staphylococcus aureus) and Panton-Valentine Leukocidin Staphylococcus aureus* (PVL-SA) will be covered in this policy.

2. Purpose

The purpose of the policy is to provide information for staff so that they have an understanding of the above organisms and are aware of the appropriate care and precautions that should be taken when caring for patients who may be colonised or have an infection caused by MRSA or PVL-SA.

3. Definitions

Alert organisms and conditions are those identified as posing a public health risk to patients, staff and visitors defined by the Department of Health (DoH 1995).

Anti-Microbial Resistance is a natural evolutionary response of microbes to anti-microbial exposure. The principle of anti-microbial resistance has been described as 'survival of the fittest'. Where anti-bacterial agents kill susceptible bacteria, resistant organisms survive and multiply and may infect / colonise other patients. Resistance can arise via mutation, gene transfer or by the development of inherently resistant species. The importance of these processes varies with the organism, the anti-microbial agent and the clinical setting.

Colonisation is the presence of micro-organisms on or in the body without causing tissue damage e.g. a chronic leg ulcer will always have bacteria present, but these are only colonising the wound if there are no signs of infection.

HCAI (Health Care Associated Infection) can be defined as an infection that occurs as part of health care treatment.

Infection is the presence of micro-organisms on or in the body where damage occurs e.g. where a wound displays symptoms of infection such as heat, swelling, pus, redness.

Meticillin-resistant Staphylococcus aureus (MRSA): some strains of *Staphylococcus aureus* are resistant to some antibiotics i.e. Cefoxitin / Fluclocaxillin; these strains are referred to as MRSA where resistance to Cefoxitin / Flucloxacillin is identified.

Panton-Valentine Leukocidin (PVL) is a cytotoxin that can destroy white blood cells and cause extensive tissue necrosis and severe infection. It is

associated with increased virulence in certain strains of Staphylococcus aureus. PVL-positive strains of Staphylococcus aureus typically cause skin and soft tissue infections (SSTI) with the potential for transmission of both carriage and SSTI between household members and close contacts. On rare occasions, PVL-SA can lead to more severe invasive infections, such as bacteraemia or necrotising pneumonia. The latter is sometimes associated with an influenza-like prodrome or viral respiratory illness.

Source isolation is the physical separation of one patient from another in order to prevent the transmission of potentially harmful micro-organisms / conditions.

Staphylococcus aureus is a common bacterium with which many people are colonised.

4. Duties (Roles and Responsibilities)

The Chief Executive is responsible for ensuring that there are effective infection prevention and control arrangements in the Trust.

Matrons / Ward / Dept. Managers are responsible for ensuring that this policy is implemented and adhered to in their areas.

The Infection Prevention & Control Team (IPCT) are responsible for undertaking surveillance of multi resistant organisms and in conjunction with the Microbiologist, give expert advice on Infection Control management of cases. The IPCN will initiate investigation in the event of a cluster or outbreak with the infections and will inform the ICD and DIPC.

All staff that have patient contact are required to adhere to this Policy.

5. Scope

This policy applies to all health care workers employed by CHFT and should be used in conjunction with other relevant policies and guidelines, including:

- Standard precautions - Infection Control Policies, Section C
- Major Outbreak of Infection Policy, Section E
- Decontamination and Disinfection Policy, Section F
- Hand hygiene policy - Infection Control Policies, Section H
- Isolation policy - Infection Control Policies, Section K
- Bed management and movement of patients Policy - Infection Control Policies, Section W
- Antibiotic guidelines – Medicines Code

6. Antimicrobial Prescribing

The decision to prescribe an antimicrobial should always be clinically justified and the reason recorded in the patient's medical records and on the patient's medication chart. The Trust's Antibiotic Guidelines should be followed: these can be accessed by opening the hyperlink below or via the CHFT intranet, clinical tools and then click on the Antibiotic Guidelines icon as shown below.

Individual patient and drug-specific factors to consider in all cases include:

- Previous antimicrobial history.
- Previous infection with multi-resistant organisms.
- Allergies.
- Availability of and absorption by oral route.

NB: Flucloxacillin and other Penicillin / Beta-lactams have no activity against MRSA.

7. Surveillance of MRSA

The IPCT will carry out routine surveillance of alert organism data from Microbiology reports to monitor trends to detect outbreaks and 'hot spot' areas of infection. All new cases of hospital acquired MRSA will be reported monthly by wards to each of the clinical Divisions. Each Division has a target for the reduction of hospital acquired MRSA cases.

The IPCT will carry out enhanced surveillance of MRSA bacteraemia cases and report these to Public Health England via the Data Capture system in line with Department of Health (DH) requirements. Post Infection Reviews (PIR) investigations will be performed by the clinical teams for all post 48 hour MRSA bacteraemia cases.

8. Communication and Patient Information

The IPCT will notify the clinical teams, usually the nursing staff, of MRSA positive results. Advice regarding the prevention and control of MRSA will be given by the IPCT verbally and should be documented in the patient's notes. A care plan is available on the nursing documentation repository; this should be downloaded and reviewed regularly by the ward team.

An alert notice will be applied by IPCNs to the Patient Administration System (PAS) for patients who have an MRSA or PVL-SA positive result or who have

a history of either organism. When entering information into the patient's medical notes, IPCNs will apply an orange 'alert sticker' to highlight IPC entries. This should act as a prompt for all staff, including those involved in patient placement, to ensure that patients are appropriately accommodated in a side room, clinical teams informed and appropriate isolation precautions implemented (see Bed Management and Placement of Patients Policy - Section W).

The clinical team need to provide information to the patient regarding colonisation or infection of the identified organism and appropriate management; further information can be provided by the IPCT.

Patient and visitor information leaflets are available from the IPCT including information regarding screening and treatment for both MRSA and Meticillin-sensitive Staphylococcus aureus (MSSA). A patient leaflet should be given to patients when they are screened pre-operatively. The leaflets should be ordered by Wards and Departments from the Infection Prevention & Control Department. Information about MRSA, MSSA or PVL-SA is also available on the Trust intranet site and the CHFT website.

*GB would like a link to the patient information leaflets inserting and thinks they should be available on the CHFT internet.

9. Meticillin-resistant *Staphylococcus aureus* (MRSA)

Staphylococcus aureus is a common bacterium with which many people are colonised. Some strains of *Staphylococcus aureus* are resistant to some antibiotics including Flucloxacillin and all Cephalosporins; these strains are referred to as MRSA. Both MRSA and MSSA can colonise a person's skin as well as cause a range of infections from localised skin infections to life threatening sepsis.

MRSA is not a significant risk to health care workers but can cause serious infection in vulnerable patients and is a common cause of healthcare associated infections.

People who are at increased risk of becoming **colonised** with MRSA include those who have had frequent episodes of healthcare interventions and those with breaches in their external defences e.g. chronic wounds, eczema, invasive devices (gastrostomy, tracheostomy, urethral or suprapubic catheter).

People who are more at risk of **infection** with MRSA are those who are colonised at a clinical site (as above), those undergoing invasive procedures and those with impaired immunity e.g. the immunocompromised, diabetics, frail patients, those with chronic disease and patients with a poor nutritional status.

10. Management of Patients with MRSA

In the acute setting: if a patient has a known history of being colonised or who has had an infection caused by MRSA, s/he should be nursed in single room accommodation and standard isolation precautions implemented (see Isolation Policy - Section K for further details).

The IPCT will liaise with ward staff in order to prioritise the need for isolation and the necessary precautions that should be taken. If single room accommodation is not immediately available, the IPCT should be informed and a clinical incident form completed by ward staff. The IPCT will liaise with ward staff to ensure the appropriate placement of patients following risk assessment and depending upon demand, capacity and epidemiology.

Patients with a history of a positive result for MRSA should be assumed positive even after they have received the 5-day course of colonisation suppression treatment. Patients should be assessed by the IPCT before isolation precautions are discontinued.

In the community: wherever practicable, patients with MRSA colonisation should be seen at the end of a health care worker's caseload or clinic session especially if the individual has MRSA colonisation of eczema or psoriasis where there may be wider environmental contamination through the shedding of skin scales.

People have previously been refused admission to a care home because of their MRSA status. MRSA should not be a contraindication for admission to a care home or a reason to exclude a colonised or infected person from the life of a home.

11. MRSA Screening

The Department of Health (DH) in England introduced mandatory screening of all elective and emergency admissions from April 2009 and December 2010 respectively. MRSA screening guidelines were updated in 2014 by the DH and now recommend focused screening programmes in order to identify and manage high risk MRSA positive patients. The decision has been taken within CHFT to continue MRSA screening for all elective and emergency admissions.

A full screen comprises both **nose** and **groin** swabs**.** One swab for both nostrils (left and right) and one swab for both groins (left and right) is sufficient, plus any **lesions, or drain sites, a catheter specimen of urine** if a urinary catheter is present and a sputum sample if the patient is expectorating. The IPCT will notify the nursing staff if further sites need to be screened.

There is no need to rescreen patients routinely. If this is required the IPCT will advise this to be carried out.

Screening of Acute Admissions

All acute adult patients should be screened with the exception of obstetric women. The responsibility for obtaining the screening swabs is with the admitting ward and should be done as part of the routine admission process and clearly documented. The admission screen should be completed within 12 hours of admission to that ward / area.

Screening of Elective Admissions

A number of exemptions to the screening programme have been identified by the Department of Health (Gateway ref: 10324) as follows:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures
- Children and paediatrics (up to and including 16 years of age) unless in a high risk group
- Maternity / obstetric unless in a high risk group

The IPCT has agreed that a high risk patient in paediatrics is a child with a history of MRSA, those awaiting elective orthopaedic surgery, chronic devices or multi healthcare interventions. A high risk obstetric patient has been assessed as a patient with a history of MRSA and those undergoing emergency or elective caesarean section. These high risk patients will require screening.

Day cases other than those listed above will require screening. Currently the definition of a day case has been assessed as a patient admitted to a ward or the Day Case Unit for their procedure. Patients attending a clinic for a procedure will not require screening unless they have a previous history of MRSA (e.g. Oncology day attenders).

Elective screens; Rescreening is required for those patients who are admitted to a healthcare setting following an elective screen but prior to surgical intervention. These should ideally be carried out within six weeks

12. Notification of MRSA Colonised Patients

IPCNs will place an alert on the PAS system for patients who have an MRSA positive result so that staff are aware of the infection risk for future hospital visits.

GPs should be informed of positive results; this information must be included in the routine discharge letter.

Healthcare workers found to be colonised with MRSA incidentally should inform Occupational Health Services (OHS) of their positive result.

District Nurses and other healthcare professionals involved with the patient's care after discharge must also be informed of patients with a positive result; this is the responsibility of the discharging team and should be included on the transfer documentation.

13. Treatment of MRSA Colonised Patients

Acute admission patients found to be colonised with MRSA should have a course of colonisation suppression treatment prescribed. If patients are to be discharged prior to completion of the course, this should be included on the discharge prescription. If results become available after the patient has been discharged, IPCNs will inform the community IPCNs.

Wounds / lesions should be kept covered; the use of antimicrobial dressings may be helpful. Refer to the Tissue Viability Nurses if wounds are deteriorating.

The use of emollients is advisable in patients with skin problems or the elderly.

MRSA Colonisation Suppression Treatment

Please see Appendix 1 (p. 18).

To reduce the risk of Mupirocin resistance, the use of Mupirocin should be restricted to two treatments only unless the patient is due for a high risk procedure such as surgery, when the risk of infection is thought to be greater than the risk of resistance. In such cases, it is important to ensure that the MRSA remains sensitive to Mupirocin. These cases should be discussed with the IPCT.

14. Neonates / Infants Under Age Of 12 Months:

Octenidine 0.3% (Octenisan) antimicrobial wash lotion is advised for infants under the age of 12 months. This should be applied undiluted daily for 5 consecutive days. Hair should be washed on day 1 of the regime.

Method of administration: apply undiluted to a damp washcloth and apply to the skin. This needs to be left for 3 minutes before washing off. For hair washing: use in the same way as other hair or skin washing preparations. Leave on for 3 minutes and then wash off.

Avoid contact with eyes and ears and do not apply to broken skin.

15. Elective admission

Patients should receive a course of MRSA colonisation suppression treatment (See App. 1, p19). This should commence prior to the planned surgery / procedure and should continue up to and including the day of surgery. A positive screen should not delay treatment or surgery. Routine surgical antibiotic prophylaxis should be reviewed for patients found to be colonised with MRSA.

Patient Group Directives have been developed for Wards / Departments performing elective screening which allow staff to provide MRSA colonisation suppression packs to patients with an MRSA positive result. Patients who are unable to use the MRSA colonisation suppression treatment will be referred to the primary care staff as per the Elective Screening Process.

If surgery is cancelled following the colonisation suppression treatment, the suppression treatment should be repeated without re-screening prior to further surgery.

The Trust is required to report externally the compliance of MRSA screening of elective patients. This will be done using a 'matched census' approach which looks at overall numbers of screening swabs and the numbers of relevant patients admitted.

The performance of MRSA screening will be managed internally by measuring the numbers of acute admissions and the number of received swabs. This will be reported monthly to Divisional Board, Executive Board and Board of Directors.

16. In primary care

It is not usually necessary to use a decolonisation regime with patients / residents in their own homes, although where patients have been screened in hospital and discharged prior to commencement of a course of colonisation suppression treatment, this may be required upon risk assessment and community staff may be required to assist.

17. Labelling of Screening Swabs

It is important that screening swabs are clearly labelled with the following definitions to enable performance data to be reported correctly. The following definitions have been agreed:

Admission screening: Includes all acute emergency admissions; this will include patients that may have been previously positive during another admission episode.

Elective Screening: Includes all patients screened during the pre-assessment process. It is important that these specimens are clearly labelled with the location as follows:

- Day case
- Pre-op clinic
- Ophthalmology
- Obstetrics

Follow-up screening: Includes the re-screening or follow up swabs for MRSA patients that were found to be either positive on admission or during the hospital stay from a clinical specimen.

Routine screening: Includes specific high risk patients who are routinely screened at regular intervals. Currently these include all ICU and SCBU patients and all patients with central venous access devices (CVADs) or at the request of an IPCN.

18. Transfer of patients with MRSA

If a patient with MRSA is to be admitted to hospital or a care home, the receiving clinical staff should be informed. This allows the receiving area to take necessary measures to protect other vulnerable patients/residents.

19. PVL (Panton-Valentine Leukocidin) Staphylococcus aureus

Staphylococcus aureus (SA) is a type of bacterium (germ) commonly found living on healthy skin. It particularly likes moist surfaces of the body, such as the nostrils, armpits and groin. People carry many different strains of SA, some potentially causing more infections than others. Some strains can produce the Panton-Valentine Leukocidin (PVL) toxin. These strains commonly cause boils or skin abscesses and are occasionally associated with more serious infections of the lungs, blood, joints and bones. Some strains of MRSA present in the community can also produce PVL toxin.

(HPA, 2008)

Community-acquired infections

Skin and soft tissue infections (SSTIs)

The majority of patients admitted to hospital with PVL-SA will be admitted for incision and drainage of abscesses; a smaller number will be admitted with other SSTIs, such as cellulitis. The principles for MRSA prevention and control should be applied to those affected by PVL-SA (MSSA or MRSA). These include isolation in a single room, use of personal protective equipment (PPE - most commonly plastic apron and gloves), meticulous hand hygiene, and environmental cleaning.

Necrotising pneumonia

Transmission of PVL-SA to staff has occurred following contact with respiratory secretions during intubation of a case of necrotising pneumonia where PPE was not worn. Healthcare workers (HCWs) should wear PPE, including face and eye protection (e.g. surgical mask with integral eye protection), during intubation and respiratory care of a patient with possible necrotising pneumonia. HCWs in direct contact with respiratory secretions (particularly during intubation or mouth-to-mouth resuscitation from a PVL-positive patient) and who were not protected by appropriate PPE should be screened three to seven days after the exposure and advised to report to a physician should symptoms of infection present subsequently. Screening should be arranged through the Occupational Health Department in liaison with the IPCT. HCWs not in direct contact with respiratory secretions should not be screened.

Hospital-acquired infections

If a case of PVL-SA infection was acquired in hospital, suitable investigations need to be undertaken. Screening other patients and staff should be performed based on risk assessment and decolonisation of positive individuals undertaken. Frequently, questioning patients and staff for previous individual and family history of recurrent skin infections identifies a potential source. The Microbiology Department should search its database for *S. aureus* isolates epidemiologically linked to the index case any isolates, if still available, sent to the Staphylococcal Reference Unit for PVL-testing. This will help to ascertain any unidentified clusters of cases in the hospital.

(HPA, 2008)

20. Transfer of Patients with MRSA or PVL-SA

If a patient with MRSA or PVL-SA is transferred to another healthcare institution, the receiving clinical and infection control staff should be informed. This allows the receiving institution to take necessary measures to protect vulnerable patients. In general MRSA does not present a risk to the general public however, the receiving staff should be informed.

The next section outlines the advice given to **staff transporting, caring for / attending** to MRSA or PVL-SA in specialist areas such as: Operating Theatre, Outpatients, Physiotherapy, Occupational Therapy and Accident and Emergency.

- Visits by patients who are colonised / infected with MRSA or to other departments should be kept to a minimum.
- The ward should inform the relevant department of the patient's MRSA or PVL status.
- Patients should be seen at the end of the working session where possible, unless clinical need is a priority.

- They should spend the minimum amount of time in the department, being sent for when the department is ready and **not** kept waiting for long periods of time with other patients.

Hands

Hands must always be washed before and after attending patients even if gloves have been worn. Liquid soap and warm water should be used following all patient contacts or alcohol gel can be applied to visibly clean hands. Hand decontamination is vitally important in preventing HCAIs. Always cover cuts and lesions with a waterproof dressing whilst on duty. Visitors should also be advised to wash or gel their hands before and after visiting a patient. If hands are cracked / sore, staff should attend the Occupational Health Dept. Please refer to Section C in the Infection Control Policy Manual, Standard Precautions for further information.

Protective Clothing

All staff that have direct contact with the patient, their immediate environment or blood / body fluids must wear single-use plastic aprons and nitrile gloves. Protective clothing must be removed and discarded after each use and before leaving the room, with the exception of removing items to the sluice. In such instances, be aware of contact points that may have been contaminated. These will require cleaning following removal of PPE.

It is not necessary for visitors to wear protective clothing unless they are attending to the patient's hygiene etc. Please refer to Section C in the Infection Control Policy Manual, Standard Precautions for further information.

Booking of Patients for Ambulance Transport

Most carriers of MRSA or PVL-SA can be transported with other patients with no extra precautions.

Arrangements should be made for patients to travel alone if any of the following apply:

- Open wounds such as skin grafts or exudating wounds that cannot be covered by an impermeable dressing
- Excessively expectorating sputum and may not be able to effectively dispose of / manage with tissues etc.

If in doubt seek advice from the IPCT.

Assessment Prior to Discharge

Staff should ensure that the following assessments have been made prior to patient's discharge / transfer:

- Catheters emptied before discharge.
- Wounds covered with an impermeable dressing and the wound checked for visible exudate.
- All peripheral venous cannulae removed prior to discharge.
- If expectorating sputum, provide clean tissues for the patient; consider lone transportation if the patient cannot effectively dispose of / manage tissues independently.

Discharge Lounge

Providing the above risk assessment has been completed, patients with MRSA or PVL-SA can be sent to the discharge lounge.

21. Staff with an MRSA positive result

Staff screening

The IPCT will advise when to screen staff. This may occur if transmission of MRSA continues on a Unit / Ward despite active infection control measures i.e. if epidemiological aspects of an outbreak are unusual or if they suggest persistent MRSA carriage by staff. Staff with a positive MRSA result will be referred to Occupational Health Services for MRSA suppression treatment and further screening. The IPCT will advise on exclusion from work if required; this will be an individual assessment. In principle, only staff members with hand lesions should remain off work while receiving courses of suppression treatment.

Staff found incidentally to be colonised with MRSA

Staff may be found to be positive through MRSA screening as part of the CHFT elective or acute admission screening pathways. In such cases:

- The staff member should be referred to Occupational Health Services (OHS). S/he will need to be assessed for the presence of possible MRSA-disseminating lesions (e.g. wounds, eczematous lesions etc.). If present, these will be investigated and treated accordingly.

- Assuming no such lesions, the staff member will be prescribed a 5-day course of the currently recommended MRSA colonisation suppression treatment and the need to observe good standards of hand hygiene will be reiterated. There is no requirement for the staff member to take time off work or to be re-screened for MRSA following completion of the course of suppression treatment.

- The timing of decolonisation should follow that of the relevant treatment pathway (e.g. if the staff has planned elective surgery, decolonisation should be timed to end on the day of surgery).

The IPCT should be informed of such a staff member so that recent MRSA data from his / her clinical area can be checked to see if there may be associated MRSA cases that had not been flagged as a possible outbreak. Subsequent actions will depend on the results of this investigation.

Staff found to be colonised with MRSA through Occupational Health screening

Staff may be found positive through being screened for MRSA as part of the OHS requirements of other employers (e.g. following job offers or prior to work placements). Actions taken will be the same as above with additional actions as determined by the Organisation that requested the MRSA screening.

Staff found to be positive for MRSA during an outbreak investigation

A decision may be made by the Outbreak Committee to screen staff for MRSA as part of an investigation into a possible MRSA outbreak or if there are unusually high levels of MRSA in a clinical area. In most situations the screen will be nasal only:

- In this situation, it is compulsory for staff to be screened as an unscreened staff member may continue to act as a source of MRSA transmission to patients.

- Screening will be carried out jointly by ward staff and OHS, with records maintained by OHS.

- Staff with an MRSA positive result will be assessed for the presence of possible MRSA-disseminating lesions (e.g. wounds, eczematous lesions etc.). If present these will be investigated and treated accordingly.

- Assuming no such lesions, the staff member will be prescribed a 5-day course of the currently recommended MRSA colonisation suppression treatment and the need to observe good standards of hand hygiene will be reiterated.

- The decision to continue working during the period of decolonisation needs to be assessed individually with input from the Infection Control Doctor or Consultant Microbiologist and OHS.

- Staff will be re-screened two days after completion of decolonisation. If still MRSA positive, they will receive a further five days of decolonisation with re-screening two days after completing the course. If they remain MRSA positive, an individual plan will be agreed following discussion between an OHS Doctor, the staff member and the IPC Doctor (or deputy) on a case-by-case basis.

22. Training and Implementation

The policy will be available on the Trust Intranet and communicated through existing clinical forums, senior managers, briefings, divisions, induction and mandatory training.

23. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnership.

24. Monitoring Compliance with Procedural Document

Compliance will be monitored monthly via the IPC Dashboard and reported to the Executive Boards, also via the key performance indicators and the IPCT and Saving Lives.

25. References

1. Department of Health and Standard Advisory Committee (2000) The ***path of least resistance.*** DOH, London

2. Department of Health (2007) ***Saving Lives: reducing infection, delivering clean safe care.*** DH Publications, London.

3. Joint BSAC/HIS/ICNA Working Party on MRSA (2006) ***Guidelines for the control, and prevention of Meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities.*** The Journal of Hospital Infection. Volume 63, supplement 1. ISSN 0195-6701

4. Health Protection Agency (2008). **Guidance on the diagnosis and management of PVL-associated *Staphylococcus* aureus infection (PVL-SA) in England.** 2nd Edition. 7th November 2008.

5. Assessment of risk to close contacts of patients with lower respiratory tract infection due to Panton-Valentine leucocidin-positive Staphylococcus aureus in England: Version 1.3. PHE 2013. Gateway Ref No: 2013963.

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

Appendix 1

MRSA Screening process

When:

On admission to CHFT or if the patient is being pre-assessed.

Who:

Currently **ALL** emergency and elective admissions to CHFT.

What: A full screen:

- One swab for both nostrils
- One swab for both groins
- Swab any lesions / drain sites / PEG site
- CSU if urinary catheter present

How:

Nose:

- Carefully insert one swab into the patient's nostril, up to 1 inch (2.5cm) from the edge of the nares (adult patient)
- Roll the swab 5 times
- Repeat with the other nostril
- Place the swab into its container

Groin:

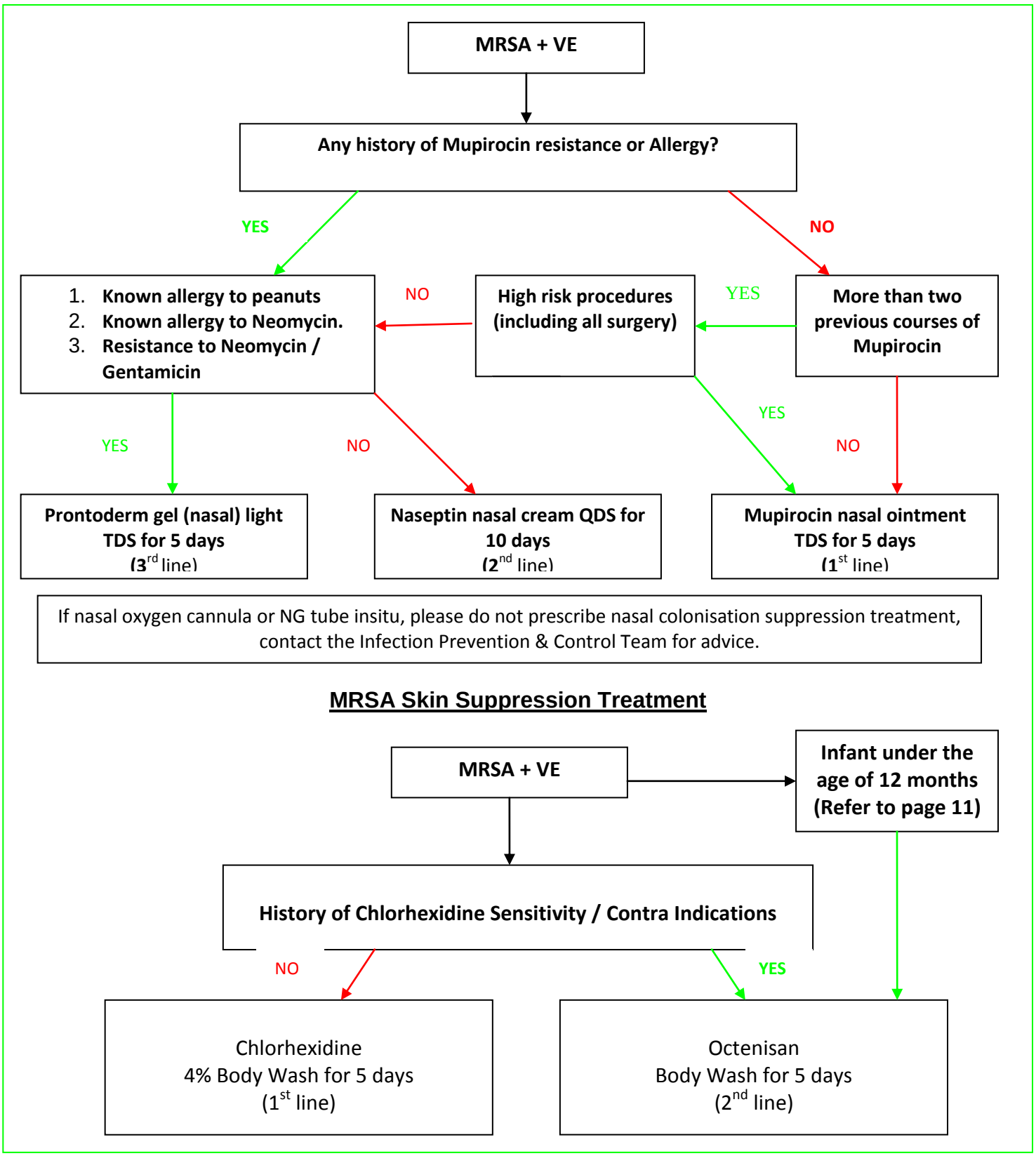
- Swab the patient's groin area using a rotating technique for 3 seconds
- Place swab in container

DO NOT give to the patient to perform. All swabs to be taken by HCWs who are aware of the appropriate techniques.

Appendix 2

Infection Control Department

MRSA Nasal Colonisation Suppression Treatment



If nasal oxygen cannula or NG tube insitu, please do not prescribe nasal colonisation suppression treatment, contact the Infection Prevention & Control Team for advice.

MRSA Skin Suppression Treatment

Appendix 3

MRSA Care Plan

Please refer to the nursing repository for the latest version using the following link.

http://nww.cht.nhs.uk/no_cache/clinical-documentation-repository/

Appendix 4

Summary of the Policy

This Policy document describes the management of patients with an MRSA or PVL-SA positive result.

The essential components are:

- Prompt identification of the organism and correct treatment regime
- MRSA screening of all elective and emergency patients
- Prompt prescribing of MRSA colonisation suppression treatment
- Staff screening
- Standard Infection Prevention Control precautions, including the use of PPE and Hand Hygiene
- Prompt Isolation of the patient when necessary
- Transfer of patients with MRSA or PVL-SA
- There is a post-infection review (PIR) for all cases of MRSA bacteraemias

The Policy describes the duties required by the Chief Executive to all members of staff who come into contact with patients. The policy is aimed at ensuring safe treatment and care of all patients is maintained; it further links to other relevant sections of the Infection Prevention and Control Manual.