

**Protocol for the Control of Methicillin-Resistant  
*Staphylococcus aureus* (MRSA)**

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## Protocol for the Control of Methicillin Resistant *Staphylococcus Aureus* (MRSA)

### 1. Introduction

*Staphylococcus aureus* is a bacterium carried on the skin or in the nose of 20-30% of the general population. It has the potential to cause a range of invasive disease including post operative wound infection; bone and joint infections; endocarditis; urinary tract infection; septicaemia and bacteraemia.

MRSA is an abbreviation of Methicillin Resistant *Staphylococcus aureus*. MRSA is resistant to antibiotics commonly used to treat *Staphylococcus aureus*. It was first reported in 1961 and is now endemic in many UK hospitals. Specific measures have been shown to be effective and are necessary for prevention and control because MRSA can cause serious illness which is harder to treat due to limited therapeutic options and results in additional healthcare costs. The emergence of Vancomycin-intermediate and resistant *Staphylococcus aureus* (VISA and VRSA) are further cause for concern.

Patients and the public are increasingly aware of MRSA and regard it as an indicator of the quality of patient care. They require re-assurance that all healthcare professionals are taking reasonable precautions to minimise spread and it is their professional responsibility to do so.

**This protocol is based on the revised Guidelines for the control and prevention of Methicillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities by the Joint British Society of Antimicrobial Chemotherapy, Hospital Infection Society, and Infection Control Nurses' Association Working Party on MRSA 2006.**

### 2. MRSA Colonisation and Infection

The majority of patients who acquire MRSA are merely colonised, not ill and do not require antibiotic therapy. A proportion, possibly up to one third depending on patient population, develop infection which may become invasive and in some cases contribute to, or result in death.

**MRSA Infection:** There are signs and symptoms of infection caused by MRSA.

**MRSA Colonisation:** MRSA is found on the skin or mucous membranes but there are no signs or symptoms of infection.

### 3. Transmission of MRSA

Patients colonised and infected with MRSA are the prime reservoir of MRSA which may then be transmitted to other patients predominantly via transient carriage on staff hands. Person to person transmission is usually associated with **poor hand hygiene** before and after patient contact.

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Colonised or infected patients or staff can carry MRSA on skin scales or in their sputum, which may result in airborne spread that can contaminate the **general environment** or other patients.

**Equipment** that has not been adequately decontaminated can carry MRSA and with subsequent use MRSA may be passed onto another patient. **Uniforms** and **curtains** can also harbour MRSA.

Staff with eczema, dermatitis and psoriasis should not work in the clinical area while they have active skin conditions, such as breaks in the skin, which can harbour organisms. Nail biters can carry MRSA on damaged skin surrounding the nail as can staff with cuts, insect bites or paronychia (infection of the fold of skin at the margin of a nail).

### 4. Patient Flagging for MRSA

All patients who have previously had or are newly identified with MRSA have their electronic records on EPR marked with a red cross to alert staff to the cross-infection risk (unless they have been screened by PCR only). **It is the responsibility of staff in pre-admission clinic and on admission to the ward to check for MRSA flagging and to act appropriately i.e.**

- screen the patient, if not already carried out
- commence patient on MRSA decolonisation treatment, (if not already given prior to surgery).
- isolate patient (if in-patient)
- inform Infection Control (if in-patient)

### 5. Risk Categories

There is insufficient evidence to suggest that routine screening of all admissions to hospital is either necessary or cost-effective. A targeted approach of screening, cohorting and isolating patients has been adopted in order to minimise the risk of spread to particularly vulnerable or high risk patient groups, in whom MRSA could cause serious infection. Areas of the Trust have therefore been categorised as either **High** or **Low Risk**.

#### High Risk Areas

- Adult ICUs
- Cardiothoracics
- Surgical Directorate (General Surgery, Trauma and Orthopaedics, Plastics, Urology, Vascular, ENT)
- Neurosurgery
- Haematology
- Oncology
- Renal
- Neonatal

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- Wards with high rates of MRSA acquisition on the quarterly Infection Control Composite Scorecard.

### Low Risk Areas

- Acute Medicine
- Care of the Elderly
- Infectious Diseases
- Paediatrics
- Gynaecology
- Obstetrics

## 6. Screening in High and Low Risk Areas

### 6.1 Culture Screening

Culture Screening for MRSA is directed at the common sites of carriage and infection. A routine MRSA screen for culture includes the following;

- **Nose** (anterior nares) – one swab for both nostrils.
- **Groin** – one swab for both groins.
- **Skin lesions, wounds, line sites and other breaks in the skin**
- **CSU** – if catheterised.
- **Sputum** – if productive.

### 6.2 PCR Screening (Polymerase Chain Reaction)

A **nasal swab only** is required when screening by PCR. PCR screening is to be carried out by designated departments, as agreed by Infection Control. These should be sent on the **yellow screening forms** provided.

If a patient is identified as having MRSA by PCR a **full screen** should then be sent for **culture**.

If a patient has been screened by PCR and is negative a culture screen is not required.

### 6.3 Procedure for taking swabs and specimens;

1. Decontaminate hands as per Hand Hygiene Policy 2007
2. Moisten microbiology swabs with normal saline
3. Rub and rotate swab firmly over each area.
4. Up to 4 specimens to be sent to microbiology with multiple screening forms available from the Infection Control Department (xtn. 2459) or available on the Infection Control intranet website. **PCR swabs** to be sent on **yellow** screening forms. All details to be completed on the form.

#### **6.4 Pre-admission screening**

Prior to elective surgery **all** patients to be admitted to **High Risk** areas above, must be screened for MRSA at their pre-admission clinic appointment, including those previously known to have been MRSA positive. On admission to the ward the nurse must check that a MRSA screen has been taken at pre-admission and if not the patient must be screened as soon as possible and within 24 hours of being admitted to the ward.

#### **6.5 Admission and Transfer Screening**

**All** patients admitted or transferred to **High Risk** areas and all **Emergency Admissions** must be screened as soon as possible and within 24 hours, with the exception of:

- Patients already screened in pre-admission clinic,
- Patients transferred from areas in the Trust who have been screened within the previous 48 hours.

Patients admitted or transferred to **Low Risk** areas must be screened as soon as possible and within 24 hours of admission or transfer if they meet any one or more of the following criteria, (**unless they are an emergency admission and have already have been screened within the last 48 hours**):

- They are **previously known** to have been MRSA positive.
- They have been a **hospital in-patient** for >48 hours within the last year.
- They have been **transferred directly from another hospital**
- They live in a **residential or nursing home**

#### **6.6 Weekly Screening**

**Adult ICUs** and **Wards** with the highest rates of MRSA acquisition for the last quarter on the composite scorecard to screen **all patients** (not known to be MRSA positive) **all sites**, weekly, unless they have already been screened within the last 48 hours.

#### **6.7 Outbreak/Cross Infection Screening**

The purpose of outbreak/cross infection screening is to identify new cases of MRSA cross-infection on the ward. Wards must be screened as soon as possible after cross infection or an outbreak has been identified, rather than waiting for the weekend to screen. Specimens to **arrive** in the laboratory no later than **Thursday afternoon**.

##### **6.7.1 Low Risk Areas;**

If **2** new cases of MRSA **acquired in a 14 day period** on the ward; screen **all** patients on the ward (not known to have MRSA) in **all sites**.

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If **further cases** are identified keep re-screening until there are no further cases i.e. **1 negative screen** from all patients, not already known to have MRSA.

### 6.7.2 High Risk Areas

Wards already screening **weekly**, as above, do not need to do screening, unless advised to do so.

Wards **not** screening weekly: if a patient with known MRSA is nursed on the ward **without precautions** or if **1** new case of MRSA is **acquired** on the ward; screen **all** patients (not known to have MRSA) on the ward, in **all sites**.

**2 negative screens** from all patients are required at least 3 days apart before screening may stop.

## 7. MRSA Skin Decolonisation

### 7.1 Decolonisation treatment

Complete MRSA eradication is not always possible but a decrease of carriage can reduce the risk of transmission in healthcare settings. The following regimen should be followed for 5 days.

|  |
|--|
| <p><b>Bactroban® (Mupirocin 2%) nasal ointment.</b> Apply inside each nostril &amp; massage outside of nose until ointment can be tasted at back of throat.</p>  |
| <p>If allergic to Mupirocin - <b>Naseptin® (Chlorhexidine 0.1%, neomycin sulphate 0.5%) cream.</b> Apply inside each nostril &amp; massage outside of nose until ointment can be tasted at back of throat. <b>MUST BE GIVEN FOR 10 DAYS. DO NOT GIVE IF ALLERGIC TO PEANUTS.</b></p> |
| <p><b>Hibiscrub®</b> (4% Chlorhexidine Gluconate in detergent solution). <b>OD</b> For bedbath/bath or shower daily. Apply 25mls to half bowl of water or neat to skin if showering, lather &amp; rinse thoroughly.</p>  |
| <p>If allergic to Hibiscrub - <b>Octenisan (Octenidine) wash lotion.</b> Use for bedbath or shower.</p>  |
| <p><b>Hibiscrub®</b> (4% Chlorhexidine Gluconate in detergent solution). Use on <b>day 1, 3 and 5</b> as shampoo. Apply neat to hair, lather &amp; rinse thoroughly.</p>   |
| <p>If allergic to Hibiscrub - <b>Octenisan (Octenidine) wash lotion.</b> Use as shampoo.</p>   |
| <p><b>CX powder</b> (Chlorhexidine Acetate 1%). <b>OD</b> For axillae i.e. armpits, skin folds and groins.</p>   |
| <p><b>Mupirocin 2% ointment (Bactroban®)</b> Apply to small superficial wounds that are known to be MRSA positive.</p>   |

Mupirocin **wound ointment** must **not** be:

- used on or near plastic material e.g. I.V. lines, PEG tubes or drains.
- used on deep extensive wounds longer than 10cm long and 100cm<sup>2</sup>.

**Poly ethylene-glycol**, the ointment base in Mupirocin ointment, can accumulate in patients with mild renal impairment and should not be used on a large surface area,

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when an occlusive dressing is used or on broken or damaged skin e.g. ulcers. It may also damage the integrity of plastic material. (Mupirocin Nasal Ointment dose not contain poly-ethylene-glycol).

**Hibiscrub:** For bedbath; add 25mls to half a bowl of water. Apply neat to skin and rinse thoroughly if showering. Hair conditioner and body moisturiser must **not** be used until 4 hours after application of Hibiscrub.

**Octenisan:** For washing; apply undiluted to a damp facecloth, rub onto the areas of the body to be cleansed, leave for 3 minutes contact time and wash off. For showering or hair washing, use in the same way as normal preparations.

Ensure bed linen, clothing and towels are changed daily. After 5 days dispose of all items dispensed for the protocol (tubes of ointment etc.) to prevent their continued use.

### 7.2 Patients to Receive Decolonisation

**All** patients with a **previous history** of MRSA to be screened and commenced on decolonisation, unless they have had 3 recent negative screens and as advised by Infection Control. **All newly identified** patients with MRSA to commence decolonisation regardless of the site of colonisation or antibiotic treatment. This is both to reduce the risk of spread to other patients and to clear MRSA carriage in individuals.

All patients diagnosed with MRSA immediately **prior to discharge** who have not had decolonisation, regardless of the site, should be given this to take and use at home. Post decolonisation screening **not** required.

Patients who are **discharged** before the result is known, should have a letter sent by the Infection Control Nurse, to their **GP** recommending decolonisation.

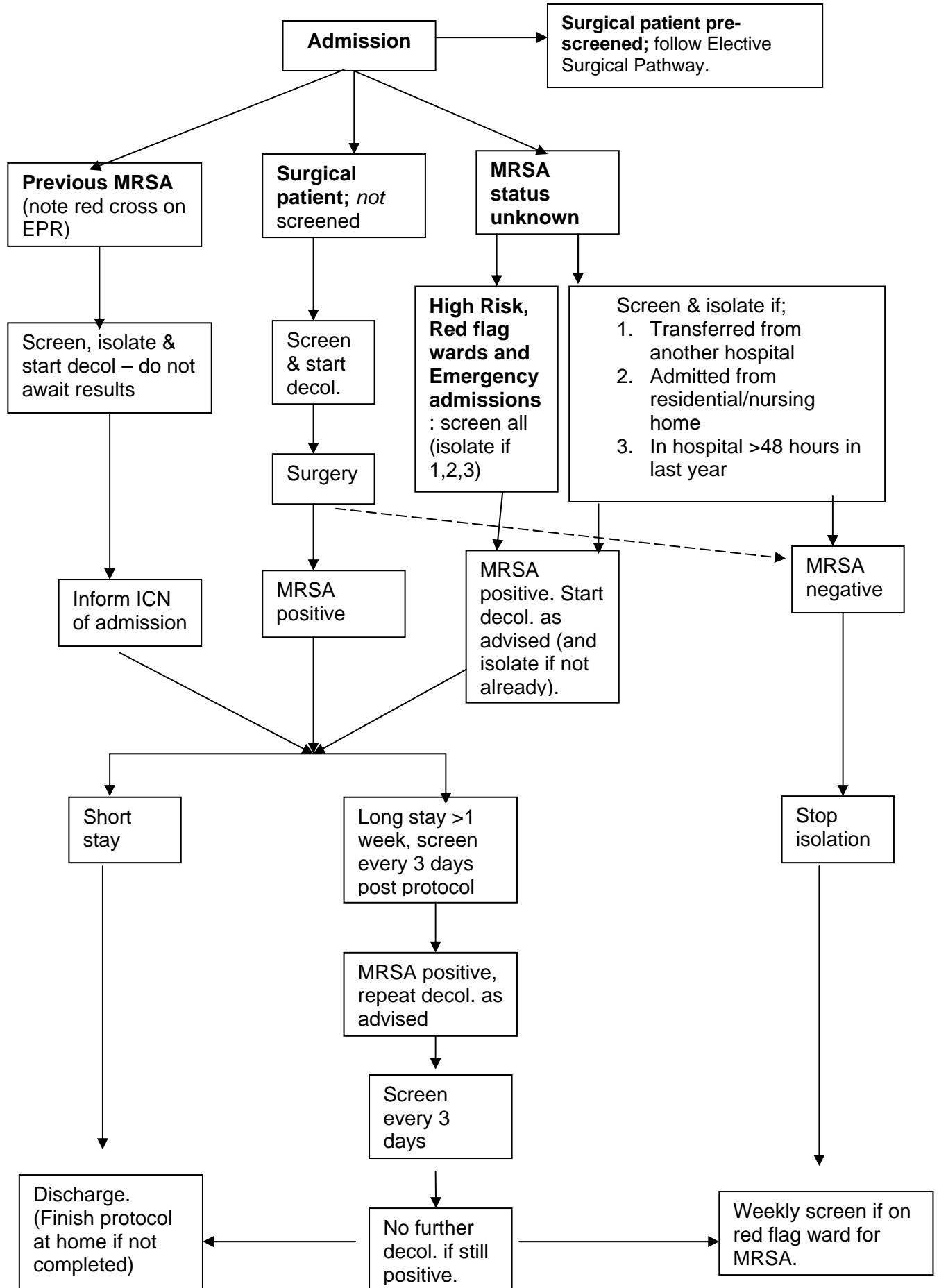
### 7.3 Screening and Repeat Treatments

For in-patients with MRSA in **urine, sputum, deep wounds, lines and drains;** after completion of the protocol do **not** re-screen and do **not** repeat protocol. **Isolation precautions to continue.** (If patient is still in hospital and no longer has a catheter, productive cough, deep wounds, lines or drains which were previously positive then; re-screen and if still positive in nose, groin or superficial wounds repeat decolonisation.)

For in-patients with MRSA in **nose, groin or superficial wounds;** re-screen **7 days** after completion and **repeat** decolonisation if still positive. Re-screen every 3 days (unless positive) and if 3 negative screens isolation precautions may cease.

If the patient remains in hospital a maximum **2 decolonisations** should be given in a **6 month** period. If the patient is **discharged** and **re-admitted** they should commence the pathway again.

## 8. MRSA Screening and Decolonisation Pathway



## 9. Action to be taken if patient is found to be MRSA positive (High and Low Risk Areas)

1. The nurse caring for the patient must inform the patient or next of kin of the result, provide them with a MRSA information leaflet and give verbal explanation, as required.
2. Following a risk assessment by the nurse-in-charge, if necessary in conjunction with Infection Control;
  - The patient should be moved to a side-room, preferably with en-suite facilities, and nursed in source isolation. A source isolation sign must be placed on the door. The door should remain shut, *provided this does not compromise care*, particularly during procedures that may generate MRSA aerosols e.g. chest physiotherapy or bed-making.
  - If this is not possible they must be cohorted with other MRSA patients on the ward, preferably in a defined area with designated staff. This may mean the temporary creation of a mixed-sex bay. A “gloves and aprons” sign must be placed over the bed or a sign at the entrance to the bay. Ideally such areas should be capable of physical separation from other ward areas.
3. The patient’s vacated bed-space should be deep-cleaned using Chlor-Clean by domestic staff. Equipment must be cleaned by nursing staff, using Chlor-clean for non-electrical equipment. Curtains must be changed. See **Cleaning and Decontamination**.
4. The patient must be screened in all sites if not already carried out.
5. The MRSA protocol must be commenced regardless of the site of MRSA carriage. See **MRSA Skin Decolonisation and Screening**.
6. Document the MRSA positive status in the nursing/medical notes and care plan.

## 10. Hand Hygiene and Protective Clothing

Hands must be decontaminated before and after patient contact, and on leaving the isolation room or bay, either by washing with soap and water or with alcohol gel/rub.

Disposable gloves and aprons must be worn by all staff having direct contact with the patient or their immediate physical environment i.e. when entering the side-room, cohort or isolation bay.

Masks are occasionally necessary for staff such as when generating staphylococcal aerosols e.g. during sputum suction or chest physiotherapy.

Visitors do not need to wear protective clothing unless they assist with patient care. They must decontaminate hands on entering and leaving the room.

## 11. Cleaning and Decontamination

**11.1 Equipment** (e.g. sphygmomanometers, stethoscopes, lifting slings) used on patients with MRSA should preferably be single use or designated for use on known MRSA patients. Before items may be used on other patients they should be decontaminated appropriately in accordance with manufacturer's recommendations and as per see Infection Control and Decontamination Policies. Use Chlor-clean for non-electrical equipment and detergent wipes where Chlor-clean cannot be used.

### 11.2 Daily cleaning

The isolation room must be cleaned daily with Chlor-clean, using separate equipment, as appropriate, which should be stored in the room.

### 11.3 Terminal cleaning

Following discharge or transfer of a patient a terminal clean must take place before the bed may be used for the next patient. The Deep Clean Team should be contacted by the nursing staff. (If the Deep Clean Team are unavailable then the ward domestic must be informed). The following should be undertaken:

- Bed to be stripped and area cleared of all disposable items of equipment by nursing staff prior to domestic staff commencing cleaning. The decontamination of *non-electrical* medical equipment to be carried out by the Deep Clean Team (or ward domestic) as well as bed mattress and frame, locker, table, any other surfaces, including floor. Special attention to be paid to all surfaces where dust may settle. Use Chlor-clean for all surfaces and *non-electrical* equipment. Use detergent wipes (or agreed alternative) when Chlor-clean cannot be used.
- **Curtains** to be changed if the patient has been in the bed-space for >12 hours.
- **Linen** to be disposed of as infected; placed in a white plastic bag inside a red plastic bag.
- **Wall-washing** to hand height.

## 12. Prophylaxis and Treatment of MRSA Infections

Antibiotic therapy may be appropriate for patients with MRSA infections, suspected infections or for peri-operative prophylaxis. Advice should be sought from Medical Microbiology, as required.

Patients should not be swabbed for MRSA clearance while receiving antibiotic therapy for MRSA. This includes IV *Teicoplanin/Vancomycin, Rifampicin, Ciprofloxacin, Fusidin* or *Linezolid*. They must be off therapy for 48 hours before re-screening.

Do not discontinue antibiotic treatment for routine screening. Once treatment is completed wait 48 hours before re-screening the patient.

MRSA skin decolonisation may be commenced while the patient is on antibiotics.

### **13. Patients Undergoing Surgery or Invasive Procedures**

Prior to any planned surgery, efforts should be made to minimise the risk of infection through topical and systemic decolonisation and prophylactic antimicrobial chemotherapy, where appropriate.

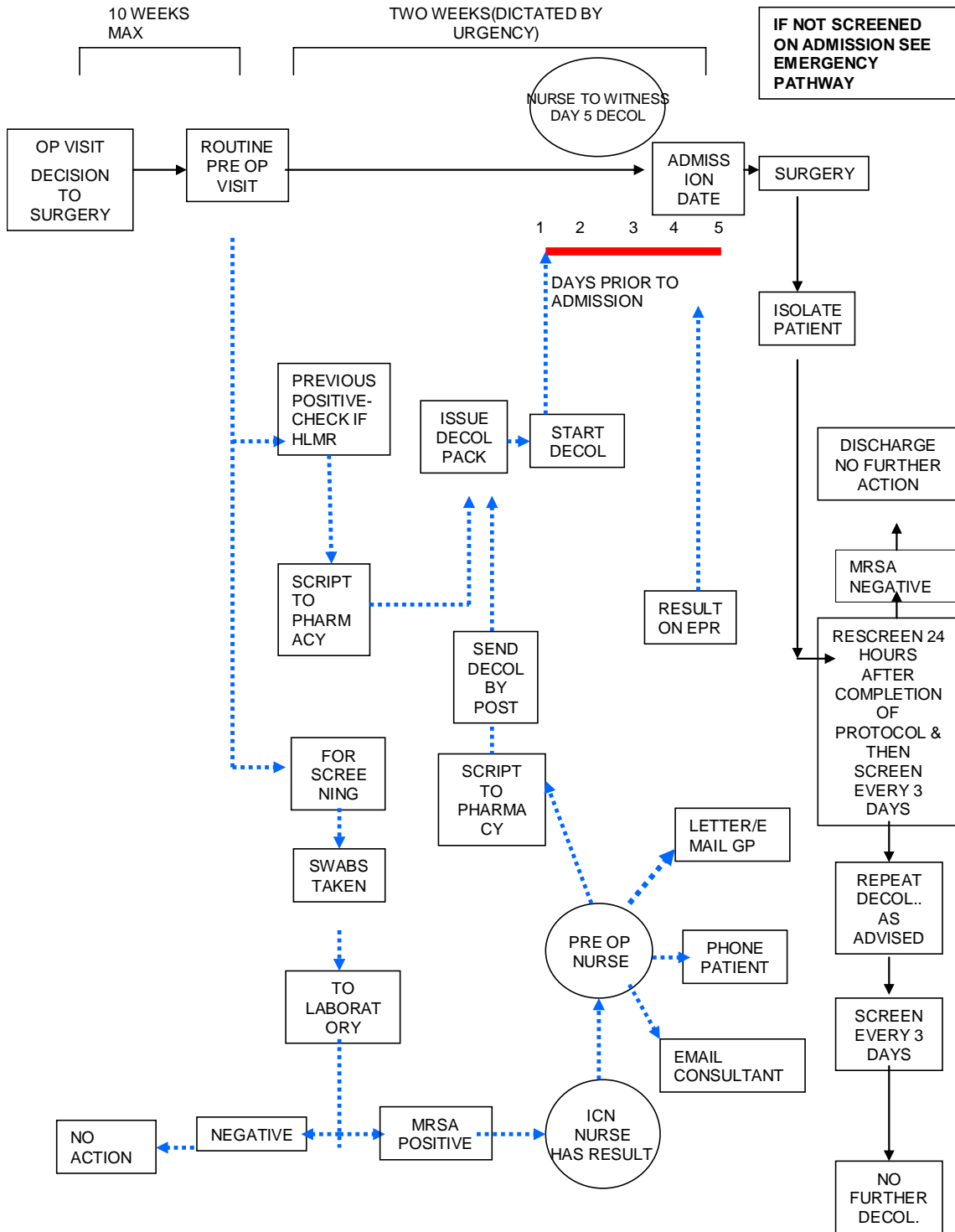
#### **13.1 Preparing the patient for theatre**

- The theatre must be informed, in advance of surgery, that the patient has MRSA.
- Vancomycin or Teicoplanin should be given prophylactically to cover implant surgery, e.g. joint replacement, in colonised or infected patients, following discussions with a Consultant Medical Microbiologist.
- The patient does not need to be placed at the end of a theatre list; effective theatre ventilation systems will provide adequate air changes to provide a safe environment within 15 minutes of removal of the MRSA patient from the operating theatre.

#### **13.2 Theatre and Recovery**

- Extraneous equipment should be removed from the theatre.
- Theatre personnel should be kept to a minimum.
- Anaesthetic staff and non-scrubbed staff should wear ordinary theatre clothing and a plastic apron.
- The theatre and equipment used for the MRSA case should be cleaned using detergent wipes for electrical equipment and Chlor-clean for non electrical equipment and surfaces.
- Patients must be segregated as best as possible within the recovery area and nursed by staff dedicated to their care employing source isolation precautions.

### 14. Elective Surgical Pathway



## 15. Transfer of MRSA Positive Patients

### 15.1 Transfer within the Trust

This should be kept to a minimum wherever possible, in order to minimise the risk of spread, but should not compromise other aspects of patient care.

Inter-ward transfers will be unavoidable under some circumstances. Patients may be moved either for **clinical** reasons (e.g. a patient requires transfer to a specialist ward or to a higher dependency ward) or for **non-clinical** reasons (e.g. patient requires urgent admission from A&E or an outlying patient needs to be moved so that their bed on a specialist ward is made available).

It is the **responsibility of the Bed Management team** to ensure that this guidance is observed at all times, including nights and weekends so that Ward Nurses are not asked to accept inter-ward transfers that they feel present an infection control risk.

Local ward MRSA cohorting practice should be respected and this should inform where the patient is placed. This may not always allow compliance with single sex bays.

#### Non-Clinical Inter-Ward Transfer

|   | <b>Proposed transfer to High Risk Area</b>  | <b>Proposed transfer to a Low Risk Area</b>  |
|---|---|--|
| <b>MRSA positive patient.</b>                         | Patient should <b>not</b> be transferred unless either; <ul style="list-style-type: none"> <li>• a side-room or</li> <li>• an appropriate bed in a bay containing MRSA and non-MRSA patients is available.</li> </ul>   | Either; <ul style="list-style-type: none"> <li>• admit to side-room or</li> <li>• to an appropriate bed in a bay containing MRSA and non-MRSA patients.</li> </ul>         |
| <b>Patient has been screened but awaiting result.</b> | Patient <b>not</b> to be transferred before the screening result is known.<br><br>In times of unusual pressure where a bed is urgently required, the patient should be moved to an appropriate bed in a bay containing MRSA and non-MRSA patients and nursed with gloves and aprons, until the result is known. | In exceptional circumstances where a transfer is urgently needed the patient will be assumed to be MRSA negative and moved to an appropriate bay. No precautions required. |
| <b>Patient known to be MRSA negative.</b>             | If a bed is available in a clean bay then the inter-ward transfer can occur.<br><br>If <b>&gt;50% of patients in a bay</b> are known to be MRSA positive then a negative patient must <b>not</b> be transferred to this bay.  |  |

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- Lesions should be covered where possible/applicable with an impermeable dressing.
- Staff who may be in direct contact with the patient should wear disposable plastic aprons to protect their uniforms whilst in direct contact with the patient. Aprons should be removed when contact with the patient has finished and be disposed of as clinical waste.
- Gloves need only be worn if staff transporting the patient have skin abrasions.
- Staff **must** decontaminate their hands with alcohol hand rub immediately after the transfer of the patient has been completed and before any contact with another patient or piece of equipment.
- The trolley/chair **must be thoroughly cleaned with detergent wipes after use** and before being used for another patient.
- All bed linen must be treated as contaminated/infected.
- The Nurse in charge of the ward must inform the receiving ward, in advance of transfer that the patient is MRSA positive.

### 15.2 Transfer to another Hospital

Inter-hospital transfers should not be prevented or delayed because a patient is MRSA positive, although unnecessary movement should be avoided. The transferring ward is responsible for informing the receiving ward, in advance, that the patient is MRSA positive.

## 16. Visits to Outpatients and Other Departments

Visits by MRSA positive patients to other departments should be kept to a minimum but compromising investigation or treatment should be avoided. If visits are necessary, **prior arrangements should be made with the staff of the receiving department, so that infection control measures for that department can be implemented.**

### 16.1 Where possible:

- The patient should be seen at the **end** of the list.
- The patient should spend the **minimum** amount of time in the department, being sent for when the department is ready and not left in the waiting area with other patients.
- Staff having **direct contact** with the patient must wear a disposable apron and ensure that they decontaminate their hands following contact with the patient and/or contaminated equipment.
- **Equipment** and the **number of staff** attending the patient should be kept to a minimum.

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- **Surfaces and equipment** with which the patient has had direct contact should be thoroughly cleaned using detergent wipes, and equipment cleaned with detergent wipes or decontaminated according to manufacturer's instructions.
- **Linen** should be treated as infected/contaminated.

### 16.2 Hydrotherapy Pool

Patients with MRSA may use the hydrotherapy pool provided they;

- have no open wounds.
- shower before entry.
- are on their own in the pool with the physiotherapist.

Staff must **wait 20 minutes** after the MRSA patient has vacated the pool before it can be used by other patients (MRSA positive patients do not have to use the pool at the end of the day).

### 17. Ambulance Transportation

The risk of cross-infection from a MRSA colonised or infected patient to other patients in an ambulance is minimal. Good infection control practices and routine cleaning should be sufficient to prevent cross-infection.

- The ambulance service should be **notified in advance by the ward staff** of the patient's MRSA status.
- **Most MRSA carriers** may be transported in the same ambulance as others **without** special precautions other than changing the bedding of the carrier. Hands should be decontaminated with alcohol gel/rub but aprons and gloves should only be worn for direct care.
- If transporting a potentially **heavy disperser**, i.e. large skin lesions, the patient should be transported alone and the handling staff should wear a disposable apron and gloves, **decontaminate their hands with alcohol hand rub** following removal of apron/gloves and wipe down surfaces in contact with the patient with detergent wipes.
- High risk patients (those susceptible to infection, e.g. neutropenic) should **not** be transported in the same ambulance as a known MRSA patient.
- Patients with MRSA **can** be discharged home via a hospital car. **No** special precautions are required, and there is no evidence that ambulance staff/hospital drivers or their families are put at risk by transporting patients with MRSA.
- No additional cleaning of the ambulance, or hospital car, is required after transporting a MRSA positive patient. Further information is available in

“National Guidance and Procedures for Infection Prevention and Control” Ambulance Association (June 2004).

## 18. Discharge of Patients

Patients with MRSA should be **discharged promptly** from hospital when their clinical condition allows.

- If the ward is contacted regarding a positive MRSA result on a patient **not previously known** to be MRSA positive, and the patient has already been discharged, **the Infection Control Team will send a letter of the result to the patient’s GP** and a copy to the patient’s hospital Consultant.
- Patients colonised with MRSA should complete the 5 day course of decolonisation protocol at home if it has already been commenced prior to discharge. If they are about to be discharged when the result becomes known they should be given the protocol to take and use at home. The patient’s **General Practitioner** must be informed of the patient’s MRSA status on the discharge letter, and arrangements made for re-screening in the Community **only** if clinically indicated.
- It is **essential** that patients, their relatives and carers should be fully briefed on MRSA, and informed that there is **no risk** of infection to healthy relatives and contacts outside the hospital, and that normal social interaction should not be compromised. Where contact will be with relatives or friends who may be hospital workers with patient contact, or with individuals who may be receiving hospital treatment, individual cases may be discussed with the Infection Control Team and Occupational Health Department.
- Patients should be advised that if they are re-admitted to hospital at any time, they should advise admitting staff that they have **previously been identified** as a carrier of MRSA in order to ensure that they are appropriately managed.
- There is **no** indication for **routine** screening before hospital discharge to the community.
- The **Nurse in Charge of the Ward** should inform Matrons of Nursing or Residential Homes of the patient’s MRSA status.

## 19. Deceased Patients

Deceased bodies require no additional precautions other than standard **Universal Precautions**. There is negligible risk to mortuary staff or undertakers provided that universal precautions are employed.

## 20. Staff

### Staff Screening

#### 20.1 Screening of staff is not carried out, or recommended, routinely.

However, if transmission of MRSA occurs on a ward despite active control measures, if the epidemiological aspects of an outbreak are unusual, or if they suggest persistent MRSA carriage by staff, screening **may** be requested by the Infection Control Team.

- Pre-employment, if there is a **history of MRSA carriage** re-swabbing should be considered to confirm current MRSA status. An eradication protocol should be started, if appropriate, if a positive MRSA result is obtained, before employment begins.
- If new patients are identified with MRSA, staff on the ward (including Bank and Agency staff) should be asked about skin lesions, eczema or psoriasis. **Staff with such lesions should be referred to the Occupational Health department for MRSA screening and review.**
- If it is suspected that a patient has acquired MRSA in theatre, theatre staff may require screening.
- In the event of staff screening being required, care must be taken to distinguish between **transient carriage**, i.e. nasal carriage which is lost within a day or so of removal from contact with MRSA positive patients and carries little risk of onward transmission, and **prolonged carriage**, especially with skin lesions. **Therefore, any staff screening must be taken at the start of a shift before any patient contact and not as staff leave at the end of a shift.**
- Nurses, doctors, physiotherapists and other allied-health professionals and non-clinical support staff (e.g. porters), **may** be included in the staff screening exercise.
- Screening sites for staff should include the nose and broken skin in the first instance. (Consider screening throat, hairline and groin for staff found positive on initial screens.)
- **The screening, investigation and treatment of healthcare personnel is the responsibility of the Occupational Health Department with support from the Infection Control Team. Staff confidentiality will be maintained at all times.**

#### 20.2 Treatment of Staff Carriers

**The Occupational Health Department has primary responsibility for the treatment of staff.**

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- Staff **nasal carriers** should be treated with MRSA decolonisation treatment and may continue working while undergoing decolonisation treatment.
- Staff with MRSA in **lesions other than on hands** may continue working, even in high risk areas, provided the lesion is covered and they maintain good hand hygiene. Staff should be commenced on skin decolonisation including lesions, if superficial, but do not require screening in other sites prior to treatment.
- Staff members with colonised or infected **hand lesions** should be **deployed to a non-clinical area** or excluded from work while they are receiving decolonisation treatment. Where hands are colonised there is greater risk of transmission than with nasal colonisation.
- Staff must be screened every 3 days and **three negative screens** obtained over three consecutive weeks before they can be considered to be MRSA negative.
- Failure to eradicate MRSA after 2 courses of treatment should be reviewed by the Infection Control Doctor. Persistent colonisation may require antibiotic therapy.
- **Exclusion of staff for infection control purposes is not deemed sick leave.**

Treatment of staff members infected during the course of their work at St. George's to be funded by the Trust. Every effort will be made to effect clearance of the organism but where this is impossible or significantly delayed the Trust may declare a staff member unsuitable for employment as they are unable to carry out the duties of the post due to the risk of cross-infection.

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*Date of Review: 2009*

## **21. References**

Guidelines for the control and prevention of Methicillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities by the Joint British Society of Antimicrobial Chemotherapy, Hospital Infection Society, and Infection Control Nurses' Association Working Party on MRSA 2006.