THE STATE HOSPITALS BOARD FOR SCOTLAND

MANAGEMENT OF MRSA POLICY

Policy Reference Number	IC10	Issue: 6
Lead Author	Senior Nurse for Infection Control	
Contributing Authors	Infection Control Committee	
Advisory Group	Infection Control Committee	
Approval Group	Policy Approval Group	
Implementation Date	22/12/2021	
Next Review Date	22/12/2023	
Accountable Executive Director	Director of Nursing, AHPs and Ops	

The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy/ procedure/ guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies/ procedures/ guidance can be found on the intranet: http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

REVIEW SUMMARY SHEET

No changes required to policy (evidence base checked)	☒

Changes required to policy (evidence base checked)	☐
Summary of changes within policy:	

Contents **Page**

1. Introduction

This policy has been developed by use in The State Hospital as part of the Infection Control Manual. This policy should be read in conjunction with the following policy - chapter 1 & 2 of the Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs).

2. Purpose

To provide appropriate and timely investigation, care and management in line with current national guidelines and best practice and to minimise the risk of spread to other patients and health care workers.

3. Scope

This guideline is designed to safeguard patients, staff and other stakeholders from the risk of MRSA colonisation or infection.

The guideline is aimed at all healthcare staff working in the State Hospital.

4. Principle Content

MRSA is a strain of *Staphylococcus aureus,* which has become resistant to flucloxacillin and other beta-lactam antibiotics as well as other standard anti-staphylococcal antibiotics.

Staphylococcus aureus is a bacterium which normally colonises the nose, throat and skin of approximately one third of the population. Usually this causes no harm and does not require any intervention or treatment. Commonly, MRSA infections are of the skin and soft tissues such as wound infections and boils. However, more rarely, deep seated infections such as abscesses, bacteraemia (blood) and bone infections may occur. Infections with MRSA are difficult to treat due to reduced treatment options.

Table 1: MRSA Summary

Causative organism	MRSA
Clinical Manifestation	*Colonisation* - within the nose, throat and skin without infection *Infection* – wound infections, soft tissue infections, invasive device insertion site infections, bloodstream infections, endocarditis and osteomyelitis.
Incubation period	Variable
Period of infectivity	Whilst MRSA positive until 3 **consecutive** negative samples have been obtained, each 48 hours apart
Mode of transmission	Direct and Indirect Contact: • Unwashed/inadequately washed hands of Health Care Worker (HCWs) • Contaminated equipment and environment.
Reservoirs	Staff, Patients, Equipment, Environment.
Population at risk	• Patients who require frequent hospitalisation. • Patients admitted from a source other than their own home. • Patients with invasive devices; pressure sores; underlying disease or recent antibiotic treatment.
Persons at risk of acquisition	• Patients who require frequent hospitalisation, or those patients who have come in from somewhere other than their own home. • Patients with invasive devices, pressure sores, underlying diseases or recent antibiotic therapy. Patients nursed in high risk areas e.g. Intensive Care Unit (ICU).

Persons at risk of infection	Patients, who are colonised, have surgical wounds, pressure ulcers or invasive devices. Patients nursed in high risk areas ICU, Surgical High Dependency Unit (HDU), Neonatal, Orthopaedics, Vascular, Transplantation, Burns, Cardiothoracic, Haematology or Renal units) have a higher risk of developing infection.

Table 2: Case definitions

Definition	Criteria
MRSA	MRSA can be isolated from the patient's skin or mucous membranes but there are no clinical signs of associated infection.
Colonisation	MRSA can be isolated from wound exudates, blood cultures, or other body sites where there is ongoing clinical infection and the MRSA is thought to be at least one of the organisms causing that infection.
MRSA Infection	Any individual where the laboratory diagnose MRSA positive from an admission or elective screen.

5. Assessment for Screening Patients

Following completion of special studies established to consider the effectiveness of nasal swabbing as a screening tool and discharge testing for MRSA in Scottish hospitals, the MRSA National Programme Board has recommended that minimum screening practice across NHSScotland should take the form of a three question Clinical Risk Assessment that is applied to patients on admission or pre-admission.

Those with one or more positive answers to the three questions asked:

1) has the patient previously been identified as MRSA positive?
2) was the patient admitted from somewhere other than their own home?
3) does the patient have a wound or invasive device present?

At the State Hospital routine screening is **NOT** required.

6. Procedure for Screening Patients

If clinically indicated screening will be undertaken by the Practice Nurse or the Senior Nurse for Infection Control (SNIC).

Specimens for Screening:

- Anterior Nares
- Perineum*
- Skin lesions/wounds
- Indwelling Invasive Devices, e.g. Central Venous Catheters (CVC), Hickman Line, PICC Line
- Catheter urine
- Sputum from patients with a productive cough.

*If patient refuses perineal screening they should be offered throat screening. Any modifications to the standard screening should be recorded in the notes.

- Samples will be tested for MRSA only
- Samples will be sent to the laboratory at University Hospital Wishaw
- Re-screen 48 hours after completion of treatment, from a previous positive site

It is recommended that patients who screen positive (colonised/infected) with MRSA should be prescribed a course of decolonisation. If active MRSA infection is present it is advisable to continue

with decolonisation whilst the patient is receiving antimicrobial therapy. Treatment advice should be discussed with the Microbiologist.

Process for decolonisation and screening will be advised by SNIC or Practice Nurse

7. Precautions for Patients with MRSA

There are no specific infection control precautions required for patients with MRSA who live in The State Hospital. Good environmental and hand hygiene compliance is advised for patient's visitors and staff. Patients who are colonised or infected with MRSA should not be stopped from attending the GP or other services and should be encouraged to live normally. They should be free to:

Share a room with another person providing neither have open wounds; catheters or invasive devices.
Join others in day/communal areas such as sitting/dining rooms/ Skye Centre providing any sores/wounds are covered.
Receive visitors or go on outings

Patient activity will be assessed and monitored by Senior Nurse for Infection Control or Practice Nurse where appropriate.

Protective clothing
Aprons must be worn for direct contact with the patient or the patient's environment/equipment. Gloves and aprons must be worn when exposure to blood and/or body fluids is likely / anticipated. Gloves and aprons are single use and must be discarded immediately after completion of task as clinical waste and hands decontaminated.

Hand hygiene
Hand hygiene is the single most important measure to prevent cross-transmission of MRSA. Hands must be decontaminated before and after each episodes of direct patient contact and after contact with the patient's environment, including before and after use of PPE. Alcohol hand gel can be used to decontaminate hands if hands are visibly clean. Refer to Operational Guidance for Hand Hygiene.

In the event that clinical procedures require to be undertaken in the patient's bedroom the patients sink must be utilised as a clinical hand washing sink as per risk assessment (see eControl book).

Equipment
Use single-use items if possible.

Cleaning of room and equipment
Daily environmental and equipment cleaning must be undertaken with solution of 1,000ppm available Chlorine releasing agent (Actichlor).

Dedicated equipment – clean as above after each use.

Linen / patient clothing
Linen should be treated as 'infectious linen' as outlined in the Operational Policy and Procedure for the Safe Management of Linen.

Bed linen and patient clothing should be changed daily.

There are no special requirements when handling patients clothing, however, advise patients and staff to wash hands thoroughly after clothing is put into the washing machine. Clothes should be washed at the temperatures advised on the clothing labels.

Communication
A verbal explanation accompanied by an information leaflet will be given to the patient. If necessary, an explanation leaflet can be given to relatives (contact SNIC for these)

MRSA precautions can only be discontinued upon recommendation by the Infection Control Team (ICT)

Generally, a patient must have 3 sets (48 hours apart) of negative post treatment cultures. At that time, special precautions may be lifted and normal activities resumed.

If re-colonization does occur, then management of this will be directed by SNIC.

8. MRSA and Healthcare Workers

MRSA rarely cause infections in healthy staff and there are negligible risks to those involved in the nursing of patients with MRSA or their families, providing compliant infection control practice is observed.

Cuts and abrasions on the hands or forearms must be covered and any skin lesions reported to senior staff and/or Salus Occupational Health and Safety for advice.

Routine screening of staff is not recommended, however, if an outbreak is confirmed this may be undertaken if advised by Occupational Health, SNIC.

9. Resource Implications

There are no resource implications.

10. Communication, Implementation, Monitoring and Review of Policy

This policy will be communicated to all stakeholders within The State Hospital via the intranet under "The State Hospital Infection Control Manual" and through the staff bulletin.

The Advisory Group will be responsible for the implementation and monitoring of this policy. All documents are monitored and reviewed on an ongoing basis by the Policy Author and Advisory Group as part of working practice. There are a variety of audit methods used across The State Hospital to ensure that food safety is carried out as required. These include external inspections, audits of mealtimes, cleanliness monitoring etc.

This policy will be reviewed every two years or earlier if required.

11. Equality and Diversity

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments

are in place to enable staff to understand and comply with policies and procedures. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy".

This policy is included in the Infection Control Manual EQIA.

12. Stakeholder Engagement

Key Stakeholders	**Consulted (y/n)**
Patients	N
Staff	Y
TSH Board	Y
Carers	N
Volunteers	N