The Management of Meticillin Resistant Staphylococcus Aureus in the Community Policy

PH 11

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<td>Section 7.1 and Appendix 1 Section 4 changes made</td>
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### Related documents

- Essence of Care (2001)
- Screening for Meticillin-resistant *Staphylococcus aureus* (MRSA) colonisation DH 2006
- The Health Act 2006: Code of Practice for the prevention and control of health care associated infections
- Essential Steps to Safe Clean Care (2006)
- Isolating patients with health-care associated infection. A summary of best practice. DH 2007

### Superseded documents

- Infection Control Policy and Guidelines for Northamptonshire Heartlands Primary Care Trust (2003)
- Infection Control Policy and Guidelines for Northampton Primary Care Trust (2005)
- Infection Control Policy and Guidelines for Daventry and South Northants Primary Care Trust (2005)

### Internal distribution

- All staff

### External distribution

- Health Protection Agency
- Northampton General Hospital
- Kettering General Hospital

### Availability

- Shared drive & Livelink
- Intranet site (primary care staff)
- Internet site (general public)
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1. INTRODUCTION

1.1 The purpose of this policy is to provide guidance on the control and prevention of the spread of Meticillin resistant *Staphylococcus aureus* (MRSA) in in-patient areas and community settings of provider services Northamptonshire teaching Primary Care Trust (NtPCT) in accordance with the revised guidelines from the National Joint Working Party on MRSA (2006). The principles contained within the policy reflect best practices and should be adopted by all staff working in a health care environment.

1.2 Infection prevention and control is the responsibility of all staff involved with patient care and high standards should be maintained at all times. Staff should ensure care is delivered in an equitable way and show respect and value the diversity of individuals to guarantee quality of care.

2. BACKGROUND

2.1 *Staphylococcus aureus* (*S. aureus*) is a bacterium that is present on the skin and in the nose and throat of approximately 30% of the healthy population. On intact skin its presence is harmless. It is the most common cause of localised wound and skin infections. MRSA is a strain of *staphylococcus aureus* that is resistant to commonly used antibiotics, e.g. flucloxacillin. MRSA is no more virulent than an antibiotic sensitive *staphylococcus aureus*; the options for treatment of infection are more limited.

2.2 The risk of acquiring an MRSA infection in the community and primary care is acknowledged as being low and is usually related to a recent hospital or nursing home admission. However with the early discharge of patients from hospital and the increase in minor surgery and invasive procedures now undertaken in primary care, there is the potential for an increase in MRSA infection in the community if the general principles of infection prevention and control are not applied in all healthcare facilities.

2.3 *S. aureus* is an opportunistic pathogen and manifests itself either as a colonising or infecting organism. This is an important characteristic and is fundamental to its management; a description of each is given below:

2.4 **Colonisation;** Colonisation is when an individual carries the *S. aureus* organism on their body, but does not suffer any harmful effects, or associated problems because of its presence. It is likely that the majority of patients who have MRSA will only be colonisers of the organism.
2.5 **Infection:** Infection is described where there is evidence of recognised signs and symptoms of infection. The signs and symptoms are usually in the form of inflammation, pain, swelling, fever, redness and loss of function. Pus may also be present at the affected site.

2.6 In most cases where infection is present, these infections are minor and remain localised to the area of broken skin and can be treated quickly and effectively. In some circumstances infection with MRSA may be problematic particularly, in the elderly and debilitated people and in people with a lowered resistance to infection. In these instances the organism can cause more widespread infection such as septicaemia. This potentially life threatening infection is more likely to affect people who already have a serious underlying condition which has weakened the body’s defence mechanism and urgent treatment is necessary.

3. **Antibiotic Resistance**

3.1 The mainstay of treatment for many years for *S. aureus* infections has been the antibiotics such as Meticillin and flucloxacillin, but strains resistant to these agents have become increasingly prevalent. Hence the term MRSA, it causes the same range of infections as other *S. aureus*, but is much more difficult to treat because of their resistance to many antibiotics.

4. **Transmission**

4.1 MRSA is transmitted primarily by person to person spread, most often on the hands of health care workers (HCW) which may have been transiently contaminated by contact with infected or colonised patients.

There is also evidence to suggest that that the environment can act as a reservoir for MRSA, as such; MRSA may be acquired by indirect contact. Because MRSA has the ability to colonise patient’s skin it can then subsequently be dispersed on their skin scales. This may lead to contamination of the environment. Therefore high standards of environmental cleanliness within community settings, particularly to horizontal surfaces should be encouraged, to keep dust (and micro organisms) to a minimum.

If the basic principles of infection control are practiced, regardless of the type of community setting, the risks can be effectively minimised and people colonised with MRSA will not be a hazard to other members of their family, visitors, other residents or staff in nursing or residential homes. This includes healthy babies, children and well pregnant women.
4.2 **S. aureus** organisms, resistant or otherwise are opportunist pathogens and intact skin is an extremely effective barrier. However, staff must remember that those individuals who suffer from dermatological conditions such as dermatitis, eczema or psoriasis are at increased risk of acquiring S. *aureus* infections. It is important then, for those staff who have concerns about these dermatological conditions to seek the advice of their General Practitioner and the Northamptonshire teaching PCT Occupational Health Service (for contact details please see appendix 6)

As a further measure of risk reduction, staff should, at all times be competent in the practice in the highest standards of universal (standard) precautions. This fundamental measure will prevent and stop the spread of MRSA where it is known to be present or where the patient may be an unknown carrier.

5. **ORGANISATIONAL RESPONSIBILITIES**

5.1 The **Chief Executive** has overall responsibility for ensuring that there are effective arrangements for infection prevention and control within Northamptonshire teaching Primary Care Trust.

5.2 On behalf of the Chief Executive the **Director of Public Health** has Executive Director responsibility for ensuring the arrangements are in place.

5.3 The **Director of Public Health** is also the **Director for Infection Prevention and Control** and has the strategic responsibility for Infection Prevention and Control within Northamptonshire teaching Primary Care Trust.

5.4 The **Infection Control Nurse** is responsible for supporting staff in carrying out infection prevention and control procedures through:

- Training and Education
- Policy and Guideline development
- Advising on the management of patients with infection
- Advice and support for developing surveillance programmes and action plans
- Advice regarding new builds/redevelopment of Northamptonshire teaching Primary Care Trust Estates
5.5 **The Infection Control Team**

The Infection Control Team is responsible for providing advice in relation to infection control aspects of care delivery to patients.

The Infection Control Team takes the key role in day-to-day infection control activities and serves as a specialist source of advice. They are an active member of the Infection Control Committee and for example, assist in drawing up infection control policies and participate in and initiate infection control audits. They also provide input in identification, prevention, monitoring and control of infection in the Trust and work with the Service leads and the Infection Control Link staff and others to improve surveillance and reporting of infections to strengthen the prevention and control of infection. The Infection Control Team are proactive in the provision of infection control education for all levels of staff and in particular the development of the Infection Control Link staff.

5.6 **Senior Managers** are responsible for monitoring compliance of all staff in their Directorate with infection prevention and control policies and guidelines. This responsibility also extends to the purchase of equipment and supplies, which facilitate good infection prevention and control practices.

5.7 The **Associate Director of Pharmacy Policy and Prescribing** will support prudent use of antibiotic through the development of policies, training and audit.

5.8 **The Northamptonshire teaching Primary Care Trust Infection Prevention and Control Committee** will:

- To commission the development and production of an annual infection control programme.
- To ensure that the Primary Care Trust fulfils its obligations in relation to the Code of Practice for the Prevention and Control of Health Care Associated Infections, the relevant parts of Standards for Better Health, the relevant parts of the NHS Litigation Authority Risk Management Scheme for Primary Care Trust’s and all other national and regional Infection Control and decontamination policies and guidance.
- To advise the Chief executive of any significant problems or hazards relating to infection control.
- Report to the Trust Board on matters pertaining to Infection Prevention and Control.
- Support the Infection Prevention and Control Policies
5.9 All Northamptonshire teaching Primary Care Trust employees have a responsibility to protect themselves, as well as making all reasonable efforts to reduce the risk of infection for their patients, other staff and the environment. Staff have a duty of care to comply with infection prevention and control policies and guidelines.

6. **UNIFORMS**

6.1 The combined approach of using appropriate personal protective equipment and adequate laundering of uniforms will significantly reduce the transmission of MRSA and the advice below should be followed:

6.2 **Personal Protective Equipment (PPE):** In a patient who is confirmed to be or is potentially colonised or infected with MRSA, the use of PPE should be considered to protect uniforms. In most cases the use of a plastic apron is appropriate. For a patient with MRSA there should be no restriction upon visits, i.e. friends and relatives Protective clothing is not necessary but visitors should be encouraged to wash their hands on leaving the care setting. Please refer to NtPCT Personal Protective Equipment Policy June 2007.

6.3 **Laundering:** Staff should change their uniform daily. Thoughtful handling and careful hygiene are needed to avoid the small risk of spreading microbes from the uniforms at home. Please refer to NtPCT Uniform policy.

7. **SCREENING**

7.1 Screening patients either before admission or immediately on admission to hospital would allow for appropriate measures to be taken to isolate and decolonise those carriers of MRSA (DH 2008). The Department of Health has introduced that all elective admissions should be screened for MRSA by March 2009 (DH 2008).

- In Provider Services this is to be undertaken for patients undergoing podiatric surgery, nail intervention and blood transfusion.

Please refer to Appendix 1 at the back of this policy.

The screening of staff is very rarely required - and should only take place in consultation with the Infection Control Team and the Occupational Health department.

7.2 The NtPCT Community Infection Prevention Tool must be used to identify patients at risk of infection, to identify further actions required
DECOLONISATION

8.1 For guidance on topical decolonisation & decolonisation of urine and wounds please refer to Appendix 3.

8. ENVIRONMENTAL CLEANING / DECONTAMINATION

9.1 Where a patient who is known to be colonised or infected with MRSA the following environmental cleaning advice should be followed:

9.1.1 **Room cleaning:** When cleaning rooms separate equipment should be used and should be cleaned using 1000ppm available chlorine in detergent, paying special attention to dust collecting areas and horizontal surfaces. Curtains should be laundered and visible splashes on walls will be washed – full wall washing is not necessary. Those areas utilizing the Microfibre Cleaning System should follow the manufacturer’s guidelines.

9.1.2 **Linen:** Linen and clothing (if applicable) only need to be placed in a red alginate and red plastic laundry bags if the linen is soiled or they have an exfoliating skin condition. Removing and bagging linen should be performed so as to minimise dispersal of MRSA from the bed linen and clothing.

9.1.3 **Decontamination of medical equipment/devices:** Northamptonshire teaching Primary Care Trust (NtPCT) employees are required to maintain the safety of all patients, colleagues and visitors by adhering to safe systems as detailed within the Northamptonshire teaching Primary Care Trust (NtPCT) Decontamination of Medical Devices Policy. This will ensure that all medical equipment and reusable medical devices are properly decontaminated prior to use or repair and that the risks associated with decontamination facilities and processes are well managed (MHRA, 2006).

9. COMMUNICATION

10.1 Effective and timely communication is essential for the successful management of patients with MRSA colonisation/infection. Prior to a patient being discharged from hospital who has been found to be colonised or infected with MRSA, it is the responsibility of the ward nursing / medical staff to ensure that the GP and/or district nurse or the residential/nursing home is informed. This is particularly important if the patient has commenced decolonisation treatment and may require assistance with applying the products and re-screening.
10.2 Colonisation with MRSA should not be a reason for preventing admission to a nursing or residential or care home. Patients with MRSA should be treated like any other; with dignity, respect, in confidence and without prejudice.

10.3 There is no reason to delay or refuse treatment, investigations or therapy because of MRSA. Patients should be encouraged to continue with their normal activities and visitors should be assured that they are normally at no special risk. If a relative is immunocompromised or awaiting surgery and wants further advice they should discuss this with their GP or Practice Nurse.

10.4 If a patient is known or suspected to be MRSA positive and has to attend an outpatient appointment the department concerned should be informed by the GP, nurse or health visitor prior to the patients attendance. This is to allow the department concerned to make any necessary arrangements.

10. TRANSPORT

11.1 Patients colonised or infected with MRSA may be transported with others in the same ambulance without any special precautions. Any wounds are to be covered with an impermeable dressing. However, if transport is required for a patient with a discharging lesion that cannot be covered with an impermeable dressing, or a widespread colonised skin lesion, advice from the Northamptonshire teaching PCT Community Infection Control Team should be sought.

11. MANAGEMENT OF PATIENTS WITHIN THE HOME SETTING

12.1 MRSA does not pose any extra risk to staff or visitors who are pregnant and no additional infection control precautions are required when patients are cared for in their own homes. The patient who is at home poses a minimal risk to family members. If in doubt advice from the Northamptonshire teaching PCT Community Infection Control Team should be sought.

12.2 Any loaned equipment for use within the home should be designated single patient use’ until no longer required. Prior to reuse by another patient, all loaned equipment must be thoroughly decontaminated as per manufacturers’ instructions and local policy, if in doubt contact the Northamptonshire teaching PCT Community Infection Control Team. Equipment that is on loan from the Equipment Loan Service will be dealt with by them.

12.3 Patients should be advised that their laundry should be washed at the hottest temperature suitable for the fabric and can be washed with other household laundry. Heat labile materials (which may be damaged at high temperatures) may be hand washed at a lower temperature.
12.4 Laundered garments should be dried thoroughly before reuse. Hot air drying or ironing will help by further reducing the small number of microbes present.

12.5 Regular environmental cleaning using detergent and water is an effective method of reducing levels of MRSA to harmless levels, levels are further reduced if the surfaces are wiped dry.

12. WASTE GENERATED IN THE PATIENT’S OWN HOME

13.1 Where a patient in the community has been diagnosed with MRSA and is being cared for by a healthcare professional, the healthcare waste is not necessarily infectious. In assessing the risk of infection from the waste produced by a patient, the healthcare professional needs to consider if:

- the patient is colonised with MRSA but not receiving specific treatment for MRSA. If yes, the MRSA status of the patient does not affect the assessment of the waste.
- the patient is colonised with MRSA and receiving treatment then a waste assessment needs to be undertaken
- the patient is infected with MRSA and receiving treatment, and the infection is present in the waste generated. If the answer is yes then the waste should be classified as infectious.

13. OUTBREAKS OF MRSA

14.1 Outbreaks of MRSA are usually due to cross infection and should not occur if the above precautions are followed. If an unusually high number of MRSA patients are identified on a ward the Infection Control team will review the situation, in liaison with relevant organisations, and advise the ward accordingly.

14.2 The Infection Control team will continue to monitor the situation until it is satisfactorily resolved.
14. WOUND MANAGEMENT

15.1 When MRSA is identified in a wound, the practitioner managing the wound must arrange an assessment to determine the need for antibiotic treatment. In many cases, particularly chronic wounds, the wound bed is colonised with MRSA rather than infected. Clinical assessment is essential and only if there are signs of infection should antimicrobial chemotherapy be considered.

15.2 If the patient is colonised with MRSA of the nose, throat, axilla or groin, do not routinely swab. Should such a patient then develop any wounds:

- observe for signs of infection;
- swab if there is any sign of infection in a new wound.

See appendix 5

Please seek further advice from the Infection Control Team if required

15. TRAINING

16.1 Infection Control Training is mandatory for all staff that have direct hands on contact with patients. Attendance at mandatory training is monitored through the Training Department.

16.2 Infection control is also a component of the organisations corporate induction and mandatory training programmes. Every member of staff has a responsibility to attend training and to maintain their knowledge and skills in infection control.

Any infection control education and training, provided by NtPCT’s Infection Control Nurses will reinforce the importance of effective hygiene in preventing the spread of infection while supporting good practice with research. Training needs for staff are regularly identified through the Primary Care Trusts training needs analysis.

16.3 Staff that require further training or information should contact the infection control team at Nene House, Isebrook Hospital.
16. AUDIT AND MONITORING

17.1 A fundamental principle of infection prevention and control is the creation and maintenance of environments and processes that ensure safety for patients, visitors and staff. A systematic approach to this has been developed through a comprehensive programme of audit. These audits are undertaken either as a questionnaire by the Infection Control Team to the relevant clinical areas for completion by the team at a local level or the Infection Control Team visit the clinical areas and undertake an observational audit. This audit can be used to:

- Identify areas for improvement
- Determine whether or not staff are adhering to the policy.
- Help determine if staff require further education or training in the area covered by the policy.
- Help determine if a lack of resources is an obstacle to the correct implementation of the policy.
- Help determine if the policy contains recommendations, which need to be modified.

17.2 All audit reports and subsequent activity and outcomes are reported to the Infection Control Committee of the PCT, and are used to demonstrate compliance to the Health Act 2006, Standards for Better Health and NHSLA requirements.
References


Taylor L (1997) MRSA. Nursing Standard 11 (49) Nursing Update


Appendix 1

Meticillin Resistant Staphylococcus Aureus (MRSA) Screening Policy for Community Hospitals

1. Aim

1.1 To minimise the risks of transmission of MRSA within the Community healthcare setting.

1.2 To provide guidelines for healthcare workers involved with the care of MRSA positive patients within Northamptonshire teaching PCT.

2. Context

2.1 The transmission of MRSA and the risk of MRSA infections (including bacteraemia) can only be addressed effectively if measures are taken to identify MRSA carriers as potential sources and treating them to reduce the risk of transmission. This requires screening of patient populations for MRSA carriage either before or on admission in order to identify carriers and implement decolonisation therapy and regimes (DOH 2006).

3. Screening

3.1 High risk patients must be screened routinely for MRSA, either prior to admission at pre-operative assessment clinics (for routine admissions) or on admission to community hospitals for emergency treatment or routine transfers.

High Risk patients have been identified as the following

- Known to have been infected or colonised with MRSA in the past
- Direct inter hospital transfers, i.e. from Northampton General Hospital, Kettering General Hospital etc.
- Patients from a Residential care setting or a Nursing home setting
- Patients who have known to have been an inpatient in any healthcare facility within the previous six months

3.2 All of the above must be screened for MRSA as part of their admission regime. They do not need to be placed into isolation whilst awaiting their results, utilise all available beds until a result is available.
3.3 To minimise transmission risks and to ensure the correct preventative measures are taken all screens should be taken within the first 48 hours following their admission.

3.4 If admission takes place just before or during a bank holiday weekend period, then swabs can be taken within the specified 48 hour period and then stored for up to another 48 hours in a specimen fridge.

4. **Swabbing Guidelines**

4.1 The following swabs must always be taken:

4.1.1 For all high risk patients

- Nose – swab both nostrils
- Groin – swab both sides of the groin

4.1.2 All podiatric interventions and podiatric nail interventions

- Nose swab only – swab both nostrils

4.1.3 Blood Transfusions

- Nose – swab both nostrils
- Groin – swab both sides of the groin

4.2 In addition the following may be required

- Wounds – all post operative wounds, chronic wounds, pressure sores or other lesions
- CSU – If the patient is catheterised
- Sputum – If the patient has a productive cough

4.3 Where swabs are being taken from dry parts of the body i.e. groin, the swab should be moistened prior or sampling using either the transport medium or sterile water/saline.

4.4 Procedure

- Hands should always be decontaminated prior to swabbing and gloves worn.
- Rub and rotate the swab firmly over each area
- Place swab immediately into transport media and label accurately
• Complete fully and accurately the microbiology forms and request an MRSA screen. NB If a sample is sent for an MRSA screen this is the only organism which will be identified.

5. Staff screening

5.1 Staff screening will not be undertaken routinely. It may occur as part of an outbreak investigation and only under the supervision of the infection control team and Occupational Health Service.

5.2 Any investigation or treatment of healthcare personnel is the direct responsibility of the Occupational Health Service.

5.3 Staff confidentiality will be maintained at all times.

Appendix 2

Meticillin Resistant Staphylococcus Aureus (MRSA)
Decolonisation Policy

**MRSA Decolonisation & Treatment**

If a clinical infection is suspected the medical staff must discuss treatment options with a Consultant Microbiologist.

Topical decolonisation treatment must be commenced as soon as possible. This is applied for 5 days then stopped for 2 days and the patient is re-screened on day 8 to determine if the patient is still MRSA positive.

**Mupirocin (Bactroban) Nasal Ointment x 3 daily to nostrils**
**Octenisan/Hibiscrub x 1 daily wash - include at least 2 hair washes during the decolonisation regime**

If the patient remains positive after the first course of decolonisation a further course of topical treatment should be carried out (as previously described), followed by a further screen. If the second course of topical treatment is unsuccessful the Infection Control Nurses must be contacted to discuss further options.

The issues associated with the treatment for decolonising wounds is complex and should be discussed with a member of the Northamptonshire teaching PCT Infection Control Team.

Decolonisation therapy must be prescribed and staff must record decolonisation as per the attached Topical Therapy Chart.
<table>
<thead>
<tr>
<th>MRSA ISOLATED IN:</th>
<th>DATE</th>
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<tbody>
<tr>
<td>NOSE</td>
<td></td>
</tr>
<tr>
<td>GROIN</td>
<td></td>
</tr>
<tr>
<td>WOUND</td>
<td></td>
</tr>
<tr>
<td>CATHETER/URINE</td>
<td></td>
</tr>
<tr>
<td>INDWELLING DEVICES</td>
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<table>
<thead>
<tr>
<th>SCREENING SWABS</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
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<tbody>
<tr>
<td>NOSE</td>
<td>TICK</td>
<td>RESULT</td>
<td>TICK</td>
</tr>
<tr>
<td>GROIN</td>
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<td></td>
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<td>WOUND</td>
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<td>CATHETER/URINE</td>
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<tr>
<td>INDWELLING DEVICES</td>
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</table>
This patient has been swabbed positive to MRSA. He/she will need the following nursing and medical care. Topical treatment (Octenisan/Hibiscrub and mupirocin) to be prescribed by the doctor.

For FIVE DAYS …………………………… Should receive the following care.

Please sign and date each box to say this treatment has been given.

<table>
<thead>
<tr>
<th>EITHER</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
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<tr>
<td>Bath or wash daily using Octenisan/Hibiscrub</td>
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</tr>
<tr>
<td>Wash hair in Octenisan/Hibiscrub twice in five days</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mupirocin to nose three times daily</td>
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<td></td>
<td></td>
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<tr>
<td>Clean night and day clothes for five days</td>
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<tr>
<td>Daily change all bed linen and damp dust the horizontal surfaces afterwards</td>
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<tr>
<td>Wash the floor with hot water and detergent</td>
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IMPORTANT NOTES ON MRSA

PLEASE ENSURE YOU DISCUSS MRSA TREATMENT PRIOR TO COMMENCEMENT WITH EITHER COMMUNITY INFECTION CONTROL TEAM OR MICROBIOLOGY DEPARTMENT

- Write on inpatient drug chart as “MRSA Topical Therapy” – see chart and note starting date, duration of therapy (5 days)

- Give five days topical therapy and stop (Remove all remaining topical therapy from room and discard)

- Re-screen all sites (including where previously positive) – nose, groin, any wounds, CSU if catheterised, 48 hours after completion of treatment (72 hours if course completed on Friday)

- If all specimens negative for MRSA continue isolation and repeat screen at weekly intervals.

- If all specimens NOT negative for MRSA discuss with Community Infection Control Team (ICT).

- If the patient has three concurrent weekly sets of negative screens discuss removal of isolation with Infection Control Team.

- **URINE**
  Urine colonisation/infection must be treated – please see MRSA Policy or discuss with Microbiologist or ICT

- **WOUNDS**
  MUPIROCIN is NOT to be applied topically to wounds unless discussed and agreed with Infection Control Team.
  Iodine or Silver based dressings are advised but please consult the “MRSA in Wounds” guidance from Tissue Viability or contact ICT.

- **ANTIBIOTIC ADVICE**
  For management of MRSA infection please discuss with the Infection Control Team.

- **OTHER TREATMENT AND MANAGEMENT**
  To be discussed with Infection Control Team

**IF FURTHER ASSISTANCE IS REQUIRED PLEASE CONTACT: COMMUNITY INFECTION CONTROL TEAM**
Appendix 3

MRSA De-Colonisation Treatment Chart

MRSA POSITIVE RESULT

Skin colonisation –
Antibacterial wash for 5 days
Nasal colonisation –
Antibacterial ointment for 5 days

After 5 days -STOP antibacterial wash
(use new soap/wash flannel/towel)
STOP antibacterial ointment

1. Wait 2 days

2. Full screen if patient to have surgery/requested by clinician

DO NOT
Repeat antibacterial treatments for more than
TWO 5-DAY COURSES.
Contact ICN or Microbiologist

POSITIVE

NEGATIVE

3. R

CONTACT INFECTION CONTROL
to discuss appropriate precautions

Octenisan/Hibiscrub recommended first choice antibacterial wash
Mupirocin 2% first choice antibacterial nasal ointment
If any patients have adverse reaction – Contact ICN for advice

Page 24 of 30
Flowchart for the Management of MRSA in Community Hospitals

In-patient with MRSA

Does patient have the following risk factors?
- Productive cough
- Heavy exfoliating skin condition
- Heavily exudating wound

YES

Nurse in single room
Topical or systemic treatment should be discussed with the Infection Control Team and/or the consultant microbiologist prior to commencement of treatment.
Decolonise patient with antimicrobial body wash and nasal antibacterial ointment. If an exuding wound is present treat wound appropriately. If patient has a heavily exfoliating skin condition treat as necessary.
Standard precautions should be in place (refer to policy) Linen and waste does not require double bagging All communal equipment should be cleaned and disinfected after use. Final deep clean to occur following patient discharge.

NO

Nurse in bay
Standard precautions should be in place (refer to policy) Linen and waste does not require double bagging All communal equipment should be cleaned and disinfected after use. Final deep clean to occur following patient discharge.

If risk factors develop
### Appendix 5

**Reducing the risk of chronic wound related blood stream infections (DH 2007)**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Assessment</th>
<th>Cleansing</th>
<th>Wound Management</th>
<th>Patient Involvement in Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wound deterioration</td>
<td>Ineffective cleansing</td>
<td>Inappropriate wound management materials to reduce colonisation or infection</td>
<td>Patient's action increases risk</td>
</tr>
</tbody>
</table>

**Signs and symptoms/indications**
- Clinical signs of inflammation or infection are present
- Dressing adherence is affected and build up of wound debris is noticeable
- Choice of dressing should be based on assessment and specialist advice from the Tissue Viability Nurse. Complete and maintain documentation records as per local policy
- Dressings are not intact and/or poor levels of hygiene are visible

**Actions**
- Screen for MRSA and take a wound swab for microscopy, culture and sensitivity. Document wound assessment and consult with the tissue viability nurse if the wound is infected.
- Gentle irrigation with warm water is usually adequate to remove debris and assist in the removal of previous dressings.
- Decolonise the wound following local guidelines; use appropriate products containing iodine or silver, as part of the cleansing process. Please refer to NtPCT Dressing Formulary.
- Ensure that the patient understands how to carry out self care, and provide information on hand washing, intact dressings, hygiene and nutrition.
<table>
<thead>
<tr>
<th>Standard infection control precautions</th>
<th>Assessment</th>
<th>Cleansing</th>
<th>Wound Management</th>
<th>Patient Involvement in Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always decontaminate hands before and after all patient contact. Gloves and aprons are single use item sand should be removed and discarded immediately after any care activity has occurred.</td>
<td>Protect the surrounding environment with a single-use waterproof sheet under the wound if leakage is likely.</td>
<td>Use appropriate dressing technique and cleaning procedure.</td>
<td>Follow hand hygiene procedures and ensure that waste products are disposed of safely.</td>
</tr>
</tbody>
</table>
## Appendix 6

### Contact Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lin Marlow</td>
<td>Community Infection Control Nurse</td>
<td>01536 494001 (ansaphone)</td>
</tr>
<tr>
<td>Jenny Boyce</td>
<td>Community Infection Control Nurse</td>
<td>01536 494903</td>
</tr>
<tr>
<td>Health Protection Agency</td>
<td></td>
<td>0116 263 1400</td>
</tr>
<tr>
<td>Kettering General Hospital</td>
<td></td>
<td>01536 492000</td>
</tr>
<tr>
<td>Northampton General Hospital</td>
<td></td>
<td>01604 634700</td>
</tr>
<tr>
<td>Occupational Health Team</td>
<td></td>
<td>01604 545359</td>
</tr>
</tbody>
</table>
### Community Infection Prevention Tool (CIPT)

**INDICATOR OF RISK**

**Patient Name:** ................................................................................................................ **DOB:** ................................ **Date:** ............................................................

**Patient Address:** ..........................................................................................................................

**Diagnosis** ................................................................................................................................. **GP:** ................................ **Surgery:** .................................................................

### MRSA RISKS

<table>
<thead>
<tr>
<th></th>
<th>Pts</th>
<th>C. DIFFICILE RISKS</th>
<th>Pts</th>
<th>AGE</th>
<th>Pts</th>
<th>SKIN/WOUND RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA Colonised</td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td>Skin Infection</td>
</tr>
<tr>
<td>MRSA Infection</td>
<td>2</td>
<td>Does the patient have diarrhoea?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own home &amp; respite care?</td>
<td>1</td>
<td>Is the diarrhoea thought to be of infectious nature?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Home?</td>
<td>5</td>
<td>Any catheters/lines eg: peg feeds, IV’s?</td>
<td></td>
<td></td>
<td></td>
<td>Wound Infection</td>
</tr>
<tr>
<td>Any broken skin areas?</td>
<td>2</td>
<td>Has patient been prescribed antibiotics in the past 8 weeks?</td>
<td></td>
<td></td>
<td></td>
<td>Exudate from lacerations, boils and carbuncles</td>
</tr>
<tr>
<td>Any catheters/lines ie: peg feeds, IV’s?</td>
<td>5</td>
<td>Is patient taking Proton Pump Inhibitors?</td>
<td></td>
<td></td>
<td></td>
<td>Peripheral line infections</td>
</tr>
<tr>
<td>History of frequent or transfer into Hospital</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Venous or pressure ulcer wounds</td>
</tr>
<tr>
<td>Previous infections/MRSA</td>
<td>5</td>
<td>Previous C. difficile infection?</td>
<td></td>
<td></td>
<td>6</td>
<td>Other slow to heal wounds.</td>
</tr>
<tr>
<td>Hospital aboard</td>
<td>1</td>
<td>Please state when</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SPECIAL RISKS

<table>
<thead>
<tr>
<th></th>
<th>Pts</th>
<th>URINARY TRACT RISKS</th>
<th>Pts</th>
<th>OTHER INFECTION RISKS</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of foreign travel?</td>
<td>1</td>
<td>Suspected/confirmed urinary tract infection (UTI)?</td>
<td>3</td>
<td>Fever/confusion of unknown origin?</td>
<td>2</td>
</tr>
<tr>
<td>If living in a care home are they in a shared room?</td>
<td>3</td>
<td>Recurrent UTI with the risks for multi-resistant ESBL (and antibiotic history)?</td>
<td>6</td>
<td>History of foreign travel?</td>
<td>1</td>
</tr>
<tr>
<td>Urinary catheter in situ or inserted in past 6 weeks?</td>
<td>5</td>
<td>Suspected/confirmed scabies/headlice or ringworm?</td>
<td>1</td>
<td>If living in a care home are they in a shared room?</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total points =**

- **< 10 not at risk**
- **10 + Medium risk**
- **15 + High risk**

On completion of the assessment consider:

What immediate actions will need to be taken? i.e: protective clothing such as gloves and apron, hand hygiene and environmental cleaning. N.B. ALCOHOL GEL MUST NOT BE USED IN CASES OF DIARRHOEAL INFECTION.

Does the patient need to isolated? EQUIPMENT SHOULD NOT BE SHARED BETWEEN PATIENTS UNLESS IT IS CLEANED BETWEEN PATIENT USE.
Always practice good hand hygiene. Use soap and water for hand washing when:

- hands are visibly soiled
- The patient is experiencing vomiting and/or diarrhoea
- When in contact with any body fluids
- After wearing gloves and apron

Handwashing Technique

1. Palm to Palm
2. Backs of hands
3. Between fingers
4. Finger tips
5. Thumbs and wrists
6. Nails

Remember! The six step handwashing technique