Policy for the Detection & Management of Methicillin resistant *Staphylococcus aureus* (MRSA)

Version Number	4	Version Date	August 2020
Guideline Owner	Director of Infection Prevention and Control		
Author	Infection Control Nurse		
Staff/Groups Consulted	Infection Control Doctor Consultant Microbiologist Director of Infection Prevention and Control Deputy Chief Nurse Chief Executive Infection Control Team Ward Sisters Hospital infection Prevention and Control Committee.		
Approved by IPCC	August 2017		
Next Review Due	August 2023		
Equality Impact Assessment Completed		Yes	

1. RATIONALE

1.1. Methicillin resistant *Staphylococcus aureus* (MRSA) is a significant cause of healthcare associated infection. It can result in blood stream infection (BSI) that can be life threatening. MRSA can also cause skin and wound infections, urinary tract infections and pneumonia. These infections require treatment with antibiotics.

1.2. All MRSA BSI's are reported under the national mandatory enhanced surveillance scheme (MESS) to the Health Protection Agency.

1.3. Colonisation by MRSA is harmless and asymptomatic to the patient but in a small number of cases it can cause infection ranging from minor skin infections to (BSI's) bacteraemia. MRSA colonisation can only be identified by taking swabs from the following sites: nose, groin, wounds, sputum (if the patient has a productive cough) and urine sample (if the patient has a catheter in situ).

1.4. Patients colonised with MRSA can be a significant issue in healthcare settings because:

- Patients colonised with MRSA who undergo invasive procedures are at risk of developing an MRSA infection.
- The presence of patients colonised with MRSA in hospitals is a potential source of infection for other patients.
- Should MRSA infections develop they are harder to treat as the antibiotics they are susceptible to are more limited.

2. AIM

2.1. The purpose of these guidelines is to ensure that patients are treated in accordance with the Department of Health (DoH) MRSA Screening Operating Guidance (2010) and Implementation of modified admission MRSA screening guidance for NHS (2014).

2.2. These guidelines also aim to:

- Set out the requirements for all healthcare workers involved in the care and management of patients with MRSA.
- Ensure best practice and high quality of care.
- Ensure treatment of patients who are colonised with MRSA.
- Reduce transmission, acquisition, colonisation and infection with MRSA.
- Ensure MRSA screening is completed and recorded on the appropriate documentation.

3. DEFINITIONS

3.1. ***Staphylococcus aureus*** – a Gram positive bacterium often found on the skin or in the nose of individuals.

3.2. **MRSA – Methicillin resistant *Staphylococcus aureus* (formerly known as Methicillin resistant *Staphylococcus aureus* in the UK)** – a strain of *Staphylococcus aureus* that is resistant to many of the antibiotics commonly used to treat infections.

3.3. **Colonisation with MRSA** – when MRSA is present on humans and not causing symptoms of infection an individual is regarded as colonised.

3.4. **Infection with MRSA** – infections can occur if MRSA gains access to tissues beneath the skin of the mucosa. An infection should be suspected when MRSA is isolated and the patient shows clinical signs of infection.

3.5. **Chronic carriage** – a patient who has received numerous courses of decolonisation and continues to remain MRSA positive.

3.6. **Screening** – is the testing of patients for the presence of MRSA on the most common body sites it is known to colonise.

3.7. **Methicillin** – an antimicrobial agent that is used in the laboratory to determine sensitivity to Flucloxacillin and other related antibiotics such as cephalosporins.

3.8. **MRSA Contact** – a patient who has been residing in the same immediate vicinity as an MRSA positive patient for 48 hours or longer.

3.9. **Contact screening** – screening of MRSA contact patients.

3.10. **High Risk Elective Inpatients** – patients undergoing vascular and orthopaedic implant surgery.

3.11. **Low Risk Elective Inpatients** – all other elective surgical procedures.

3.12. High Risk Maternity cases – high risk of complications in the mother and/or potential complications in the baby, e.g. may need SCBU.

3.13. Transient Carriage of MRSA – when MRSA is carried on the skin such as on the face, hands, arms and inside the nose for a short period of time.

3.14. Mupirocin resistant MRSA – when MRSA is resistant to the mupirocin antibiotic

4. ROLES AND RESPONSIBILITIES

4.1. Chief Executive is responsible for:

- Ensuring that appropriate systems and resources are in place to manage infection prevention and control across the organisation.
- Designating an individual as the Director of Infection Prevention and Control (DIPC) with designated time to fulfil this role.
- Ensuring an appropriate Infection Control Assurance Framework is in place for reviewing incidence of alert organisms, outbreaks, Serious Untoward Incidents (SUI) and compliance/performance against the infection control audit programme in clinical areas.
- Ratification of the Infection Prevention and Control Annual Programme of Work.

4.2. Director of Infection Prevention and Control is responsible for:

- Infection prevention and control within the Trust and ensuring that national directives are implemented.
- Chairing the Infection Prevention and Control Committee (IPCC).
- Ensuring the development and implementation of strategies to prevent avoidable Health Care Associated Infections (HCAI) at all levels within the Trust.
- Production of the Infection Prevention and Control Annual Report on progress against the annual programme of work in the reduction of HCAI in collaboration with the Nurse Consultant for Infection Prevention and Control and the Infection Control Doctor.
- Providing assurance to the Trust's Board of Directors that systems are in place and correct policies and procedures are adhered to across the Trust to ensure safer and effective healthcare and comply with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.
- Production of reports and presentations to the Trust's Board of Directors as required, including a quarterly review of progress against the Infection Prevention and Control Annual programme of Work.
- Reviewing of statistics on incidence of alert organisms, conditions and Serious Untoward Incidents.
- Production of a monthly report to the Trust's Board of Directors showing the Trust's position against key performance indicators.

- Ensuring Trust-wide compliance with infection prevention and control policies and procedures.

- Providing evidence of appropriate actions taken following HCAI events.

4.3. Consultants and Medical Staff are responsible for:

- Ensuring the appropriate medical management of patients with MRSA as detailed in these guidelines.

- Ensuring that the patient is reviewed on a daily basis and the outcome of this review is clearly documented in the medical notes.

- Ensuring that they and their teams comply with the infection prevention and control management of MRSA patients and challenge any poor practice.

- Participating in the Post Infection Review (PIR) investigation as required.

4.4. Consultant Medical Microbiologist is responsible for:

- Advising clinical staff on the medical management of patients with MRSA

- Reviewing all inpatients with MRSA as their condition dictates and on request from the medical team and the IPCT.

- Informing the ward, medical team and the Infection Prevention and Control Team (IPCT) of any confirmed cases of MRSA bacteraemia in the Trust.

- Participating in the PIR investigation as required and acting upon any recommendations.

- Disseminating and discussing the PIR findings with the relevant medical/nursing team.

4.5. Infection Prevention and Control Team (IPCT) is responsible for:

- Education and training of Trust staff in the infection control management of hospitalised patients with suspected or confirmed MRSA.

- Auditing of isolation practice of patients isolated with suspected or confirmed MRSA.

- Reporting all laboratory confirmed cases of patients with an MRSA bacteraemia on the Public Health England (PHE) HCAI data capture system MESS.

- Leading on the RCA investigation of patients with hospital attributed MRSA and dissemination of the findings.

- Reviewing all inpatients with MRSA on a daily basis, Monday to Friday, and referring to the Consultant Microbiologist for review as condition dictates.

- Attend the twice weekly antibiotic round when able or as requested by the Consultant Microbiologist, Antibiotic Pharmacist or Infection Prevention and Control Team (IPCT).

- Ensuring that the teams who are caring for the affected patient comply with the infection control management of MRSA patients, noting good practise whilst always challenging any poor practice.

- Liaising with Pre-Assessment Clinic staff when they are informed of positive results so they can organise treatment and liaise with the patient and the GP to organise and commence treatment.

4.6. Matrons and Ward Sisters are responsible for:

- Participating in the PIR's investigation as required and acting upon any recommendations.
- Dissemination and discussion of the PIR findings amongst their teams.
- Ensuring that any actions are put into place in response to any practice issues identified in audits or episodes of increased prevalence.
- Ensuring that they and their teams comply with the infection control management of MRSA patients as detailed and challenge any poor practice.
- Ensuring that enhanced cleaning arrangements are in place in their areas of responsibility for patients with MRSA.
- Ensuring that staff in their area understands and implement the care and management of patients with MRSA as outlined in these guidelines.
- Ward sisters and 28 day resources

4.7. Ward/Clinical Staff are responsible for:

- Ensuring that any patients with a suspected or confirmed diagnosis of MRSA are placed into isolation and informed of the reason why.
- Informing the IPCT and the Clinical Site Managers (CSMs) (out of hours) if for any reason patients with suspected or confirmed diagnosis of MRSA cannot be isolated and completing an incident report.
- Communicating the patient's infectious condition to all necessary parties that have contact with or treat the patient.

4.8. Pre-Admission Clinic (PAC) Staff/Clinician Responsible for Care are responsible for:

- Informing the patient and their General Practitioner (GP) of a patient's MRSA positive status to organise eradication therapy as necessary.
- PAC staff will liaise with the clinician responsible for care.

4.9. Domestic/Housekeeping Staff are responsible for:

- Ensuring that they comply with the infection control management of MRSA patients as detailed and that they challenge or report any poor practice.
- Ensuring that enhanced cleaning is carried out for all MRSA patients in their area.
- Terminal cleans on discharge / negative results.

5. TRANSMISSION OF MRSA

5.1. Contact

Contaminated hands are the main route of spread for MRSA in healthcare settings. Contamination of the patient environment may also result in transmission of MRSA, e.g. in dust and via inadequately decontaminated equipment.

5.2. Airborne

MRSA can be transmitted via the airborne route but is only a significant risk when a patient has a skin shedding condition such as exfoliating eczema or psoriasis.

6. PATIENTS WHO REQUIRE SCREENING FOR MRSA

6.1. Elective Admissions – Appendix A

- Any patients that fit the following criteria or risk factors will be screened for MRSA prior to admission.
- For Orthopaedic procedure with overnight stay
- For admission to 6A, 6B,SCBU, ITU, HDU
- On dialysis
- With chronic wounds
- Indwelling device
- Nursing home resident
- Repatriation from another hospital/ overseas
- With haematological or oncology malignancy
- .Long term inpatient >6months

- This screen will be taken when the patient attends the PAC. Any patients who do not attend PAC will be screened when the decision to admit is made at any of the outpatient clinics. MRSA screens will remain valid for Orthopaedic joint surgery – 3 months and all other surgical procedures 6 months. However if the patient is booked for ward 6A, the screen will be valid for 3 months regardless of the surgical procedure

6.2 Inter-Healthcare Transfers

All patients transferring to the Trust from

- Another hospital
- Other healthcare facility
- Repatriation from abroad
- Nursing/Care home

will be screened as soon as practicable on admission. This must be done on the day of or the day after admission. It is the responsibility of the admitting nurse to screen the patient for MRSA, taking into consideration the patient's history.

6.4 Long Stay Inpatients

All patients that have extended inpatient stays (longer than a month) are at risk of being colonised with MRSA. These patients will be screened at 28 day intervals until discharge or transfer out of the Trust. It remains the responsibility of the ward staff caring for the patient to ensure that the screen is taken and that results are acted on accordingly.

6.6 Neonates

All neonates will be screened on admission to the Special Care Baby Unit (SCBU) 48 hours after delivery and then at weekly intervals.

6.7 ICU

All patients admitted to the ICU will be screened on admission to the unit and then at weekly intervals.

Chemotherapy

Adult chemotherapy patients attending for treatment should be screened at the beginning of the chemotherapy programme, and on return from treatment at another healthcare facility.

6.10 Haematology Oncology Day Unit Patients

All patients should be screened at the beginning of their treatment programme, and on return from treatment at another healthcare facility.

6.11 **Emergency admissions** – Appendix B

- All emergency adult inpatient admissions (excluding maternity) will be screened as soon as practicable on admission. This must be done on the day of or the day after admission. It is the responsibility of the admitting nurse to screen the patient for MRSA on admission, taking into consideration the patient's history.

- Maternity admissions are not regarded as emergency admissions and do not need to be screened.

6.12 Paediatric Admission (Excluding Neonates) Elective admissions (Inpatients and Day Cases)

Paediatric elective (inpatients and day cases) and emergency admissions are excluded unless they fulfil the following criteria, in which case they should be screened prior to admission:

- Known to have been infected with or colonised with MRSA in the past.

- Had an inpatient admission to any healthcare facility within the preceding 6 months.

- Currently resident in long term facilities.

- Any paediatric patients who are transferred from another hospital or repatriated from abroad.

6.13 Paediatric Chemotherapy

Paediatric Chemotherapy patients only require screening if they meet any of the criteria outlined in section 6.12 for paediatric emergency admissions. Any patient meeting these criteria should be screened at the beginning of the chemotherapy programme and on return from treatment at another healthcare facility.

6.14 Staff Screening

- Routine staff screening is not necessary but may occur as part of an outbreak investigation or at the discretion of the IPCT, following discussion with the relevant manager.

- Healthcare staff working in acute units should report infected skin lesions to the OHS.

- Healthcare workers who require screening because they are having elective surgery should have their pre-operative screen taken when they have been away from their workplace for a minimum of 24 hours.

6.15 Contact Screening

MRSA screening of patients who have been in contact with another MRSA positive patient is required if they have had 48 hours contact with the said patient. A full screen will be required (See Appendix F / section 6.17)

6.16 What Sites Should Be Screened for MRSA

The sites screened are determined by the type of admission and risk factors for MRSA colonisation. Screens will be composed of either a nasal only screen or a full screen (see Appendix A and B).

6.17 Full MRSA Screens

A full MRSA screen includes swabs from all the following sites:

- Nasal swab – one side only from 1cm inside the nostril (unless PCR test which involves swabbing both sides of the nostrils)
- Groin – one side only
- All broken areas of skin/wounds, e.g. surgical, chronic, PEG sites, tracheostomy sites, etc.
- Catheter Specimen urine (CSU) – only if indwelling catheter present.
- Sputum – only if productive cough present.
- Neonates – nose and umbilicus

6.18 Procedure For Screening

When swabs are taken from dry parts of the body (e.g. groin), the swab must be moistened prior to sampling using the swab medium, sterile water or sterile saline. Swabs taken from wounds with high levels of exudate do not need to be moistened first. The following steps should be taken whilst obtaining a swab:

- Decontaminate hands immediately before swabbing.
- Moisten swabs if necessary.
- Rub and rotate the swab firmly on each area.
- For nasal swabs only swab one nostril and it is not necessary to enter the anterior nares (nostril) more than 1cm. However, if swabbing for a PCR test both nostrils will need to be swabbed with the same swab.
- Place the swab in medium tube and label.
- Each patient screen should be accompanied by a microbiology request form labelled MRSA screen. Swabs for the screen on a single patient may be entered on a single form.

6.19 Reporting Results

- Results should be available on the Pathology system within 24 hours of the screen reaching the lab. The medical staffs are responsible for reviewing and acting upon the results. All MRSA screens positive or negative are recorded on the Pathology system. Positive results are downloaded via the Pathology system onto the ICNet system and reviewed by the IPCT Monday to Friday. At weekends all positive results are telephoned through to the ward staff by the On Call Microbiologist. This is recorded in the patient's notes.

- The entire MRSA pathway is recorded on ICNet.

- Patients should be informed of a positive result by the Nursing/Clinical staff, recording this in the patient's notes on isolation.

7. ACTION TO BE TAKEN IF A PATIENT IS FOUND TO HAVE MRSA AFTER SCREENING

7.1 For the inpatient management of patients with MRSA see Appendix C (for Urinary Carriage) and Appendix D (for Nasal and Groin).

7.2 ICT with create an alert on TrakCare for the patient

7.3 Tagging of patients on ICNet: IPCT have an alert system set up on ICNet to identify any patients admitted with a history of MRSA.

7.4 See Appendix E – "Infection Prevention and Control Precautions for Patients with MRSA" for detailed management of Inpatients with MRSA, including:

- Isolation – see the Trust's Isolation policy.

- MRSA decolonisation and treatment.

- Cleaning and decontamination.

- Patient movement.

- Actions to be taken on discharge.

- See Appendix E for the screening of other inpatients coming into contact with known MRSA positive patients.

- If you are unable to isolate an MRSA patient:

- The MRSA patient must be managed in the bay but under strict individual isolation precautions.

- All healthcare workers having contact with the patient must observe these precautions.

- The patient must transfer to single room facilities as soon as practicable.

- Any neutropenic or severely immunocompromised patients must be identified and moved out of this area as soon as possible.

- An incident form should be completed by the ward staff and the reason for not isolating the patient recorded in the patient's notes.

8. SCREENING TO ACHIEVE CLEARANCE OF MRSA

8.1. Three consecutive screens taken at minimum weekly intervals should be taken to ensure removal of MRSA from a site:

- 1st screen should be obtained 48 hours after completion of decolonisation treatment or antibiotics, if administered. If the results are positive then the patient will commence a second topical decolonisation regime.

- 2nd screen should be obtained only if the 1st screen is negative and should then be taken 1 week after the 1st screen was obtained. If the results are returned as positive, compliance to decolonisation treatment should be checked before a further course of topical decolonisation treatment is started.

- 3rd screen should be obtained only if the 1st and 2nd screens are both negative and should be taken a week after the 2nd screen. If the 3rd screen results are returned as positive then the patient will commence a course of topical decolonisation regime.

8.2. If the patient remains MRSA positive after 3 courses of topical decolonisation regime then the IPCT will advise further.

9. PATIENTS FOUND TO HAVE MRSA PRIOR TO ELECTIVE PROCEDURES

9.1. Prior to any planned invasive procedure efforts must be made to minimise the level of risk of infection through topical and systemic decolonisation and prophylactic antimicrobial therapy as appropriate:

- **High Risk Patients** – Patients undergoing orthopaedic implant surgery also have their decolonisation therapy managed by PAC. They will be given 5 days of topical decolonisation therapy as soon as MRSA notification is received by PAC, in an endeavour to gain 3 clearance screens as described in Section 8. If the procedure normally requires patients to have antibiotic prophylaxis, the antibiotic choice should cover MRSA. Please refer to the Antimicrobial Prescribing Guidelines available via YCloud or discuss with the Consultant Microbiologist or Antimicrobial Pharmacist.

9.2. If MRSA is still present despite decolonisation therapy, patients can proceed with treatment, however this is the consultant's decision and advice should be sought from the Consultant Microbiologist.

10. PATIENT MOVEMENT

10.1. Patients known to have MRSA must not be transferred to another ward unless it is to be moved to a side ward or appropriate placement in a ward and if possible should be discussed with the IPCT. Movement of MRSA patients should be kept to a minimum.

10.2. Patients known or suspected of having MRSA can undergo investigations and treatments in other departments:

- The receiving department must be made aware of the patient's MRSA status by the ward in advance of the planned investigations or treatments. Wherever possible plan for the patient to be at the end of any scheduled lists.
- Universal standard infection control precautions must be practised by staff in the receiving department.
- When the patient leaves the area, horizontal surfaces and equipment touched by the patient must be thoroughly decontaminated before the next patient is seen.
- Short term exposure to other patients in clinics or departments is not generally a problem unless the MRSA patient is sputum positive and coughing or has exposed skin sites. In these situations the clinic or department should arrange for the patient to be seen straight away on entry to avoid waiting areas with other patients.
- Aprons and gloves are only required for direct care and are therefore not required for staff transporting the patient, e.g. Portering staff.

10.3. CSMs, other hospitals and/or ambulance control should be informed of a patient's MRSA status before transfer. MRSA is not a reason for a patient to be refused admission to a care/nursing home or hospital.

10.4. Patients with MRSA can be transported in an ambulance with other patients as long as any wounds are covered with an occlusive dressing and the ambulance crew maintain universal standard infection control precautions. Similarly, patients can be transported via the hospital care service as long as wounds are covered.

11. ACTIONS TO BE TAKEN ON DISCHARGE OF AN MRSA POSITIVE PATIENT

11.1. The presence of MRSA in all patients where it has been identified must be included within any correspondence to other healthcare professionals on discharge. Patients undergoing decolonisation at the time of discharge should continue the course until completion and it is important that community staffs are aware of any actions taken by the hospital. The need for completion of a decolonisation course alone should not prevent discharge from hospital.

11.2. It is the responsibility of the discharging nurse to ensure that arrangements are in place to continue the decolonisation course and discuss screening arrangements. This must be included in the discharge summary with details of when the course was started and when the patient needs to be rescreened.

11.3. Once the bed space/side ward has been vacated a terminal clean will be required prior to admitting a new patient.

12. URINARY DECOLONISATION OF MRSA

12.1. It has been recognised that the urinary tract of catheterised patients is a common source of MRSA BSI. These patients may be colonised in the urine for many weeks prior to invasion into the bloodstream.

12.2. If a patient is found to have MRSA in their urine and a MRSA screen has not been performed then a full MRSA screen is required. This will include nose, groin, and sputum, if the patient is expectorating, and all breaks in the skin including ulcers.

12.3. Systemic antibiotic treatment

If a patient is found to have MRSA in their urine an antibiotic to which the MRSA is sensitive should be given, e.g. orally, for seven days. The course should preferably begin at the same time as topical decolonisation treatment. For any further information or advice regarding antibiotic therapy please contact the Consultant Microbiologist.

12.4. Change of catheter

On day 3 or 4 of the antibiotic treatment the urinary catheter should be removed and replaced, if still required.

12.5. Follow up screening

Three consecutive screens taken at a minimum of weekly intervals should be taken to ensure removal of MRSA from a site:

- 1st screen should be obtained 48 hours after completion antibiotics. If the results remain positive then further guidance should be sought from the Consultant Microbiologist or the IPCT.
- 2nd screen should be obtained only if the 1st screen is negative and then 1 week after the 1st screen was obtained. If the results are returned as positive then further guidance should be sought from the Consultant Microbiologist or the IPCT.
- 3rd screen should be obtained only if the 1st and 2nd screens are both negative and taken a week after the 2nd screen. If the 3rd screen results are returned as positive then further guidance should be sought from the Consultant Microbiologist or the IPCT.

13. WOUND COLONISATION OF MRSA

13.1. In order to reduce the number of wounds colonised with MRSA, reduce the risk of bacteraemia and the spread of MRSA within the hospital environment, treatment and management of wounds colonised or infected with MRSA suggests antimicrobial dressings. Some wounds will not be suitable for an antimicrobial dressing and in such cases this must be clearly documented in the medical notes.

13.2. The Tissue Viability (TV) team must be informed of all MRSA positive wounds for review and assessment.

13.3. Antimicrobial dressings

- All patients who have been identified as MRSA carriage to their wounds need to be referred to the TV team for assessment and review. The TV will then organise the antimicrobial dressing or suitable alternative.

- All antimicrobial dressing treatments continue for 14 days with a 2 day break before rescreening for MRSA on day 16 (see Appendix J).

13.4. Topical Negative Pressure Therapy

Patients who are undergoing topical negative pressure therapy will continue care as this type of therapy offers a closed wound drainage system which reduces the spread of infection via contaminated dressings. These wounds may or may not use an antimicrobial dressing; this will be agreed in discussion with the TV team.

14. MRSA IN STAFF

14.1. Transmission of MRSA can occur from patient to staff via close contact. Carriage is usually transient; in that by the time staff returns to work after a previous shift they no longer carry MRSA.

14.2. Routine staff screening is not necessary but may occur as part of an outbreak investigation or at the discretion of the IPCT in discussion with the OHS. Screens for staff should be taken at the beginning of their shift to rule out transient carriage if it has been deemed necessary to screen staff.

14.3. The Management of any required staff screening will be discussed on an individual basis with infection control service and the Trusts Occupational Health Service.

14.4. Staffs that return a positive screen will have another full screen to eliminate transient carriage.

14.5. Decolonisation therapy for staff is the same as for patients as detailed in Appendix D. The IPCT will advise if an alternative skin cleanser is required. The treatment is applied for 5 days then stopped for 2 days and rescreened on day 8 to determine if still MRSA positive.

14.6. Staff working in high risk areas such as ICU/HDU/SCBU and theatres should be excluded from working in this area until a clear screen has been obtained. Staff who work in low risk areas that are found to have MRSA can return to work 24 hours after commencing decolonisation therapy. Each case will be managed by the OH.

14.7. Any difficulties in achieving MRSA clearance will be discussed with the IPCT / Consultant Microbiologist.

14.8. There is no reason to exclude pregnant or breast-feeding staff from caring for patients with MRSA.

15. ACTIONS TO BE TAKEN ON IDENTIFICATION OF AN MRSA BACTERAEMIA (BLOODSTREAM INFECTION)

15.1. The identification of an MRSA BSI is a significant event. The Consultant Microbiologist will liaise directly with the patient's clinical team advising on the best course of treatment.

15.2. On identification of an MRSA BSI a PIR will be initiated to identify the factors contributing to the infection. The PIR will be conducted by the clinical team with support from the Community IPCT if the bacteraemia is pre-48 hours of admission and by the Acute Trust IPCT if the bacteraemia is post-48 hours of admission. This investigation must be commenced within 24 hours of notification of the MRSA BSI and must be completed within 15 working days.

15.3. The actions that must be completed are outlined in Appendix G for cases that were inpatients for less than 48 hours prior to blood cultures being taken and Appendix G for cases that were inpatients for longer than 48 hours prior to blood cultures being taken.

16. IMPLEMENTATION, MONITORING & EVALUATION

16.1. Compliance with these guidelines will be audited regularly as part of the IPCT audit programme and the results will be monitored quarterly at the IPCC meeting. Inpatients with MRSA will be monitored during their stay on a daily basis (Monday to Friday) by the IPCT on their clinical rounds to ensure that all patients with MRSA comply with these guidelines.

16.2. Monthly auditing of MRSA screening compliance for Emergency and Elective screening will be carried out by the Trust's Informatics Department, and reported Trust-wide by the IPCT as part of the monthly dashboard. Remedial actions taken in response to suboptimal compliance rates should be addressed by the relevant division, and actions taken reported via the Trust's Governance Structure.

17. APPENDICES

17.1. APPENDIX A – Emergency admission screening flowchart

17.2. APPENDIX B – Elective admission screening flowchart

17.3. APPENDIX C – Inpatient Management for Patients with MRSA Urinary Carriage

17.4. APPENDIX D – Inpatient Management for Patients with MRSA Nasal/Groin Carriage

17.5. APPENDIX E – Infection Prevention and Control Precautions for Patients with MRSA

17.6. APPENDIX F – Management of Contacts of MRSA Patients

17.7. APPENDIX G – MRSA Bacteraemia Reporting – Pre-48 Hours

17.8. APPENDIX H – MRSA Bacteraemia Reporting – Post-48 Hours

17.9. APPENDIX I – Topical Therapy Chart

17.10. APPENDIX J – Topical Therapy Wound Chart

17.11. APPENDIX K – Mupirocin Resistant Topical Therapy Chart

17.12. APPENDIX L – Procedure for obtaining routine MRSA swabs

17.13. APPENDIX M – Procedure for obtaining PCR MRSA swabs

18. REFERENCES

18.1. Our NHS Our Future – NHS next stage review. Interim Report DH October 2007.

18.2. Saving lives: Reducing Infection, delivering clean and safe care.

18.3. EPIC 2: National Evidence Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England 2007.

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

18.5. MRSA Screening – Operational Guidance – Department of Health - 31 July 2008

18.6. MRSA Screening – Operational guidance 2 – Department of Health – 31 December 2008.

18.7. MRSA Screening – Operational Guidance 3 – Department of Health – 31 March 2010

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Name of Document: **Guidelines for the Detection & Management of Meticillin resistant *Staphylococcus aureus* (MRSA)**

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

For advice or if you have identified a potential discriminatory impact of this procedural document, please refer it to The Equality & Diversity Lead, Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Signed **Lisa Eastmead-Hoare** Date: Feb 2016