CH 13

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NHS

Community Infection Prevention and Control Policy for Care Home settings

MRSA
(Meticillin resistant *Staphylococcus aureus*)

MRSA

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CH 13

MRSA

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This Policy has been adopted by:

Organisation: ..... …

Signed: .....

Job Title: .....

Date Adopted: .....

Review Date: .....

If your organisation would like to exclude or include any additional points to this document, please include below. Please note, the Community IPC Team cannot endorse or be held responsible for any addendums.

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Contents Page

MRSA

MRSA (METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS*)

1. Introduction

Staphylococcus aureus (SA) is a common bacteria that approximately 1/3 of people carry on the skin or in the nose of healthy people without being aware of it.

If the bacteria invades the skin or deeper tissues, and multiplies, an infection can develop. This can be minor, such as pimples, boils, or serious, such as wound infections, pneumonia or bacteraemia.

Meticillin is an antibiotic that was commonly used to treat *Staphylococcus aureus*, until some strains of the bacteria developed resistance to it. These resistant bacteria are called **Meticillin resistant *Staphylococcus aureus*** (MRSA). Strains identified as meticillin resistant in the laboratory will not be susceptible to flucloxacillin – the standard treatment for many staphylococcal infections. These strains may also be resistant to a range of other antibiotics.

MRSA is not usually a risk to healthy people. Research has shown that healthcare workers, who become colonised, have acquired the bacteria through their work, but the MRSA is usually present for a short time only.

Panton-Valentine Leukocidin (PVL) is a toxin produced by less than 2% of *Staphylococcus aureus* (SA). It is associated with an increased ability to cause disease. PVL-SA causes recurrent skin and soft tissue infection, but can also cause invasive infections, in otherwise healthy young people in the community. Staff who develop recurrent skin and soft tissue infections should seek medical advice.

2. Colonisation and infection

Colonisation means that MRSA is present on or in the body without causing an infection.

Up to 33% of the general population at any one time are colonised with *Staphylococcus aureus* (including MRSA) on areas of their body, e.g. nose, skin, axilla, groin. It can live on a healthy body without causing harm and most people who are colonised do not go on to develop infection. Less than 5% of colonising strains in the healthy population who have not been in hospital are meticillin resistant, but it is more common in vulnerable people who are in contact with the health and social care system.

Infection means that the MRSA is present on or in the body causing clinical signs of infection, such as in the case of septicaemia or pneumonia, or for example, in a wound causing redness, swelling, pain and/or discharge.

MRSA infections usually occur in health and social care settings and, in particular, vulnerable people. Clinical infection with MRSA occurs either from the resident's own resident MRSA (if they are colonised) or by transmission of infection from another person who could be an asymptomatic carrier, or have a clinical infection.

3. Residents at risk of infection from MRSA

- Residents with an underlying illness.
- Older people – particularly if they have a chronic illness.
- Those with open wounds or who have had major surgery.
- Residents with invasive devices, such as urinary catheters.

4. Routes of transmission

- Direct spread via hands of staff or residents.
- Equipment that has not been appropriately decontaminated.
- Environmental contamination (*Staphylococci* that spread into the environment may survive for long periods in dust).

5. Treatment

Any treatment required will be on an individual basis. Antibiotic treatment will only be prescribed if there are **clinical signs of infection**. Residents who are colonised with MRSA, i.e. no clinical signs of infection, do not usually require antibiotic treatment.

6. Suppression treatment and screening

In accordance with Department of Health guidance, screening of some patients is undertaken by hospitals. Screening is not usually required in a care home. However, if the care home is requested to take a nasal swab for MRSA, follow the instructions 'How to take a nasal swab for MRSA screening'.

How to take a nasal swab for MRSA screening	
	• Wash hands and apply apron and non-sterile gloves. • Place a few drops of either sterile 0.9% sodium chloride or sterile water onto the swab taking care not to contaminate the swab.
	• Place the tip of the swab inside the nostril at the angle shown. • It is not necessary to insert the swab too far into the nostril.
	• Gently rotate the swab ensuring it is touching the inside of the nostril. • Repeat the process using the same swab for the other nostril.
	• Place the swab into the container. • Dispose of gloves and apron and clean hands after removing each item of PPE, e.g. pair of gloves, apron. • Complete resident details on the container and specimen form. Request 'MRSA screening' under clinical details on the form.

If a MRSA positive result is diagnosed after a resident has been discharged from hospital, the GP will be informed, and if appropriate will prescribe suppression treatment.

Screening swabs following suppression treatment are not required for residents in the community.

Suppression treatment consists of 2 separate treatments

Body and hair treatment

- An antibacterial solution for body and hair treatment, e.g. Octenisan, Hibiscrub or Prontoderm Foam, daily for 5 days, following the manufacturer's instructions.
- For residents with skin conditions, such as eczema, the use of Hibiscrub is not advised, Octenisan or Prontoderm Foam is recommended, daily for 5 days, following the manufacturer's instructions.

Nasal treatment

- Nasal Mupirocin 2% ointment, e.g. Bactroban nasal, 3 times a day for 5 days, following the manufacturer's instructions.
- For residents who have a resistance to Mupirocin, Naseptin nasal ointment should be used 4 times a day for 10 days, following the manufacturer's instructions.

Compliance with the above programme is important and once commenced should be completed in order to prevent resistance to Mupirocin. Both skin, hair and nasal treatment should be started on the same day.

Clean towels, bedding and clothing should be used each day during the treatment.

After completion of the treatment, further screening or treatment is not required unless advised by your local Community Infection Prevention and Control (IPC) or Public Health England (PHE) Team.

Further advice on suppression treatment and products available can be obtained from your local Community IPC or PHE Team. MRSA suppression treatment instructions for residents for Octenisan, Prontoderm and Bactroban are available to download at www.infectionpreventioncontrol.co.uk.

7. Precautions for MRSA

Residents with a MRSA infection

- Residents with an active MRSA infection should be isolated until they are symptom free (usually after a course of antibiotics). Refer to the 'Isolation Policy for Care Home settings'.
- Any infected wound or skin lesion should be covered with an appropriate dressing as advised a healthcare professional, e.g.GP, Tissue Viability Nurse, Community Nurse. The dressing should be checked frequently for signs of leakage and replaced accordingly until the wound is dry.
- During isolation, staff should wear disposable apron and gloves when providing hands on care.
- Hands should be cleaned after removing and disposing of each item of personal protective equipment, e.g. pair of gloves, apron.

Residents colonised with MRSA

- Colonisation with MRSA may be long term, therefore, good hand hygiene practice and standard infection control precautions should be followed by all staff at all times, to reduce the risk of transmission of infection.
- A resident with colonisation of MRSA in their urine who is not catheterised and is continent with no symptoms of a urinary tract infection is very unlikely to present a risk to others.
- Residents with MRSA can share a room unless they or the person sharing the room has wounds, catheters or any other invasive device.
- Residents with MRSA can visit communal areas, e.g. dining room, television room and can mix with other residents.

- Hand hygiene is essential after direct contact with a resident or their surroundings using either liquid soap and warm running water or alcohol handrub.
- Residents should be encouraged to wash hands or use skin wipes after using the toilet and before meals.
- Disposable apron and gloves should be worn when in contact with body fluids.
- Normal laundry procedures are adequate. However, if laundry is soiled with urine or faeces, it should be treated as infected. Items that are soiled should be washed at the highest temperature the item will withstand. Refer to the 'Safe management of linen Policy for Care Home settings'.
- Staff should ensure if the resident has any wounds, they are covered with an appropriate dressing, as advised by a healthcare professional, e.g. GP, Tissue Viability Nurse, Community Nurse.
- No special precautions are required for crockery/cutlery and they should be dealt with in the normal manner.
- Waste contaminated with body fluids should be disposed of as infectious waste - refer to the 'Safe disposal of waste Policy for Care Home settings' for further details.
- Hands should be cleaned after removing and disposing of each item of personal protective equipment, e.g. pair of gloves, apron.
- There is no need to restrict visitors, but they should be advised to wash hands or use alcohol handrub on arriving and leaving.
- Residents should not be prevented from visiting day centres, etc., and may socialise outside the care home.
- If a resident requires hospital admission, the receiving department/hospital staff should be informed of the resident's MRSA status. This will enable a risk assessment to be undertaken to determine whether the resident should be isolated on admission, see Section 9 below.

8. Environmental cleaning

- Whilst a resident is isolated due to an MRSA active infection, enhanced cleaning of their room using a bactericidal product effective against MRSA or a chlorine-based disinfectant solution should be implemented. Refer to the 'Isolation Policy for Care Home settings'.
- Residents who are colonised with MRSA, their room can be cleaned with a pH neutral detergent and warm water, a disinfectant is not required.

9. Referral or transfer to another health or social care provider

- Prior to a resident's transfer to and/or from another health and social care facility, an assessment for infection risk must be undertaken. This ensures appropriate placement of the resident.
- Transfer documentation, e.g. an Inter-Health and Social Care Infection Control (IHSCIC) Transfer Form (see Appendix 1) or patient passport, must be completed for all transfers, internal or external and whether the resident presents an infection risk or not. Refer to the 'Patient placement and assessment for infection risk Policy for Care Home settings'.
- There are no special transport requirements.

10. Information for residents, family and visitors

Information about MRSA should be given to residents and/or family and visitors. Information and factsheets are available to download at www.infectionpreventioncontrol.co.uk.

11. Infection Prevention and Control resources, education and training

The Community Infection Prevention and Control (IPC) Team have produced a wide range of innovative educational and IPC resources designed to assist your Care Home in achieving compliance with *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance* and CQC registration requirements.

These resources are either free to download from the website or available at a minimal cost covering administration and printing:

- 29 IPC Policy documents for Care Home settings
- 'Preventing Infection Workbook: Guidance for Care Homes'
- 'IPC CQC Inspection Preparation Pack for Care Homes'
- IPC audit tools, posters, leaflets and factsheets
- 'IPC Bulletin for Care Homes'

In addition, we hold educational study events in North Yorkshire and can arrange bespoke training packages and 'Mock IPC CQC Inspections'. Prices vary depending on your requirements and location.

Further information on these high quality evidence-based resources is available at www.infectionpreventioncontrol.co.uk.

12. References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Department of Health and Health Protection Agency (2013) *Prevention and control of infection in care homes – an information resource*

Department of Health (2007) *Essential Steps to safe, clean care managing MRSA in a non-acute setting: a summary of best practice*

Health Protection Agency (2008) *Guidance on the diagnosis and management of PVL-associated Staphylococcus aureus (PVL-SA) infections in England* http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1218699411960

National Institute for Health and Care Excellence (last revised October 2018) *Clinical Knowledge Summaries: MRSA in Primary Care*

NHS Commissioning Board (2013) *Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections*

NHS England (2014) *Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections version 2*

NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy*

Public Health England (September 2017) *Infection Prevention and Control: An Outbreak Pack for Care Homes "The Care Home Pack"*

13. Appendices

Appendix 1: Inter-Health and Social Care Infection Control Transfer Form

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Inter-Health and Social Care Infection Control Transfer Form

The *Health and Social Care Act 2008: Code of Practice on the prevention and control of Infection and related guidance* (Department of Health 2015), states that "suitable accurate information on infections be provided to any person concerned with providing further support or nursing/medical care in a timely fashion". This form has been developed to help you share information with other health and social care providers. The form should accompany the patient and, where possible, a copy filed in the patient's notes.

Patient Name: ..... Address: ..... NHS number: ..... Date of birth: ..... Patient's current location:	GP Name and contact details:

Receiving facility, e.g., hospital ward, hospice: .....

If transferred by ambulance, the service has been notified: Yes ☐ N/A ☐

Is the patient an infection risk:
Please tick most appropriate box and give details of the confirmed or suspected organism

☐ Confirmed risk Organisms: .....
☐ Suspected risk Organisms: .....
☐ No known risk

Patient exposed to others with infection, e.g., D&V, Influenza: Yes ☐ No ☐ Unaware ☐

If yes, please state: .....

If the patient has a diarrhoeal illness, please indicate bowel history for last week, if known, (based on Bristol Stool Form Scale):

.....

Is diarrhoea thought to be of an infectious nature? Yes ☐ No ☐ Unknown ☐

Relevant specimen results if available

Specimen:				
Date:				
Result:				

Treatment information:

Is the patient aware of their diagnosis/risk of infection? Yes ☐ No ☐

Does the patient require isolation? Yes ☐ No ☐

If the patient requires isolation, phone the receiving facility in advance: Actioned ☐ N/A ☐

Additional information:

Name of staff member completing form: .....

Print name: .....

Contact No: ..... Date .....

Community Infection Prevention and Control, Harrogate and District NHS Foundation Trust April 2017
www.infectionpreventioncontrol.co.uk