

MRSA SCREENING POLICY

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1. Introduction

The Health Act (2006) Code of Practice for Prevention and Control of Healthcare Associated Infections requires all NHS bodies to minimise the risk to patients. Screening for MRSA and active decolonisation is a prime consideration in meeting these standards. Department of Health guidance published on Dec 31st 2008 clarifies:

- The planning requirements to support MRSA screening for all relevant patients from April 09;
- The assurances needed by trusts to provide evidence of MRSA screening;
- The roles of SHAs, PCTs, Monitor and DH in assuring and supporting the delivery of MRSA screening.

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_092844

The guidance updates existing guidance but does not replace it. It does not prescribe how the NHS should deliver the commitment, which is a matter for local determination.

Existing guidance includes:

- "Screening for MRSA colonisation: a strategy for NHS Trusts: a summary of best practice" (2006)

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_063138

MRSA screening - Operational guidance (July 2008)

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_086687

This has since been updated:

Operational guidance 2 (December 2008)

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_092844

The commitment in the 2008/09 and subsequent 2009/10 Operating Frameworks to introduce MRSA screening state;

"Meeting the challenge of HCAI will require additional actions across the system... from April 2009, all elective admissions must be screened for MSRA in line with Department of Health guidance... extended to cover emergency admissions as soon as possible and definitely no later than 2011."

The following trust policy statements implement the guidance and mandates listed above and are part of the trusts "Managing patients with Meticillin resistant *Staphylococcus aureus*" (MRSA)" policy.

2. Screening

Screen swab/specimen requirements

- Nose AND Groin (NAG) screen using the one swab technique:
 - Swab the nose, dip swab briefly into transport medium prior to swabbing the anterior nares of both nostrils. Gently insert swab into anterior nares (just inside the nostril) perform circular movement x3 and repeat in other nostril. Use the same swab for both sides of the groin.

Use separate sterile swabs for the below. Each will require a separate request form.

- CSU if catheterised;
- IV infusion site swab; (including CVC site, or other invasive device site)
- Wound(s) swab;
- -Other i.e. eczematous skin lesions
- Sputum if the patient has a productive cough
- Umbilicus in all neonates

3. Screening regimens for different patient groups

3.1 Elective admissions.

All elective cases must be screened, including surgical and medical admissions, day cases, and elective Caesareans. Exceptions are listed in Section 3.2 below. See section 9 for guidance on when elective patients should be screened.

Ideally surgery should be scheduled for day five of decolonisation. If identified MRSA positive on admission, decolonisation should begin immediately.

Screening is mandatory on admission day if no clear screen is available.

3.2 Patients not included in mandatory screening (unless high risk as per 3.3)

- Day case ophthalmology
- Day case dental
- Day case Endoscopy
- Minor dermatology procedures, e.g., warts or other liquid nitrogen applications
- Children/paediatrics (unless in high risk group)
- Maternity/obstetrics except for elective caesareans i.e. high risk of complications in the baby, e.g. likely to need SCBU, NICU because of size or known complication risk factors.
- Termination of pregnancy cases

3.3 High risk patient screening,

The following patients are at higher risk for MRSA acquisition and must be screened on admission:

- All admissions to ICU, Neonatal Unit, and Burns Unit
- All admissions received from ICU.
- Transfers from wards where MRSA outbreaks are suspected
- Transfers from other hospital in the UK or abroad
- Patient who have had previous hospital admissions for one or more nights in the UK or abroad.
- Any patient who is known to have been infected or colonized with MRSA in the past.
- Residents of residential care facilities (including Nursing Homes).

Patients who have prolonged admissions (e.g. for several weeks or longer) but who are MRSA negative on admission are at higher risk of acquisition of MRSA and must therefore be screened on a weekly basis.

4. When not to screen

- During topical eradication regimen and for 2 days after.
- During treatment, and for 2 days after completing treatment, with antibiotics to which the MRSA is sensitive: (Excepting routine periodic ITU screening)
 - Glycopeptides – Teicoplanin or Vancomycin.
 - Linezolid.
 - Rifampicin, Fucidin, Trimethoprim and Doxycycline.

5. Inter-hospital transfers

Patients transferred from other hospitals or healthcare facilities must have a full screen (NAG, wounds and any invasive device e.g. peripheral line, catheter). Ideally inter-hospital transfers will be admitted into a side-room, risk assess with the Infection Control Team if a side-room isn't available. Standard contact precautions should be implemented.

6. Known MRSA positive patients

MRSA positive patients should be isolated whenever possible. Where it is not possible liaise with the Infection Control Team. Screen on admission and discuss further screening frequency with the Infection Control Team.

Once a patient has 3 clear complete sets of screens, each set 1 week apart, isolation may be discontinued only in liaison with the Infection Control Team.

7. Newly identified MRSA positive patients- in-patients

7.1. Notification of positive MRSA status

The infection control team will notify the nurse in charge or the nurse caring for a newly identified patient with MRSA. If an MRSA infection is suspected the clinical microbiologist will contact the appropriate ward doctor. Out-of-hours results will be reported by the on-call clinical microbiologist.

7.2. The ward doctor and ward sister/charge nurse are responsible for:

- a. Informing all staff who are involved in patient care: nurses, doctors, nursing and medical students, therapists;
- b. Informing the patient of MRSA status and what this means to them individually with regard to isolation, treatment (or not), family, discharge planning and any other relevant issue as raised by the patient.
- c. Explaining isolation procedures to porters, domestic and works department staff who have contact with the patient of isolation precautions.
- d. Commencing topical decolonisation once agreed with the Infection Control Team.
- e. The doctor should review any antibiotic therapy and modify as necessary following discussion with a microbiologist.

7.3. The nurse in charge is responsible for:

- a. Ensuring isolation of positive patients in liaison with the bed manager/site manager.
- b. Arranging terminal clean and curtain change of the patients' bed space.

8. Newly identified MRSA positive patients- pre-admission/out-patients

Out-patients and pre-admission patients identified with MRSA must be informed by the staff who arranged for the screening to occur. The medical staff in these areas are responsible for prescribing the MRSA decolonisation protocol.

9. Pre-operative screening.

- a. Screen pre-operatively in the Pre-Operative Assessment or Outpatient Clinic.
- b. Patients must be screened within 3 months prior to surgery, ideally 2 weeks before admission for elective surgical admissions.
- c. If the patient has a hospital admission within that time period they must be screened ideally in advance of admission, if not-on the day of admission.
- d. On admission for emergency surgical patients
- e. Prior to surgery for any patient (emergency) who is scheduled for surgery but is already an in-patient.

10. The elective surgical admissions ward (David Evans Ward)

MRSA positive patients are not to be admitted, or managed on the elective surgical admissions ward.

11. Regular day attenders

Patients who regularly attend the hospital as day cases e.g.; chemotherapy, pentamidine nebulisation therapy, dermatology, radiological attenders, should be screened at the beginning of their treatment and then monthly thereafter until their treatment period ends.

12. Transfers to other NHS bodies or to other healthcare facilities, including nursing and residential care homes.

Screening prior to discharge is not routine. However, the infectious status of any patient must be declared before transfer to any NHS or 'other' healthcare facility, including MRSA status, in order for the receiving trust to prepare adequate isolation or infection control precautions. This should be documented on transfer documents as well as any verbal 'hand-over'.

There are sometimes concerns from nursing and residential homes about accepting patients back from the Trust once they have been identified with MRSA. The following Department of Health guidance is very clear:

"There is no justification for discriminating against people who have MRSA by refusing them admission to a nursing or residential home or by treating them differently from other residents"

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009587

Although private homes may refuse any patient according to their own policies, NHS homes must be guided by department of health policy. Difficulties with individual homes should be discussed with the Infection Control Team.

13 Discharge screening

Discharge screening of MRSA patients should only be done:

- If a known MRSA patient has not been screened within the last week following decolonisation treatment.
- If the hospital, nursing or residential home requests it prior to transfer.
- If an inpatient has to return for elective or urgent surgery in the near future (3 months)

14 Decolonisation regimen for patients

14.1 Introduction

Topical decolonisation protocol is suitable for nose, throat and groin colonisation (any combination of sites). Complete eradication of MRSA is not always possible but a decrease in carriage can reduce the risk of transmission in healthcare settings and can reduce the risk of inoculation to the patient's own surgical wound during surgery (Coia et al 2006). For patients with eczema, dermatitis or other skin conditions, attempts should be made to treat the underlying skin condition.

14.2 Decolonisation Regimen

There are two regimes use for decolonisation treatment depending on the resistance pattern of the MRSA:

14.2.1 Mupiricin Sensitive MRSA (see Appendix 1)

- Mupirocin in paraffin base t.d.s. to anterior nares of both nostrils for 5 days.

- Chlorhexidine 4% skin wash / bath – daily for 5 days. Particular attention should be taken when washing the axillae, groin and skin folds. (The skin must be moistened with water before applying to reduce likelihood of reactions).
- Regimen of Chlorhexidine 4% hair-wash and rinse, every second day of the 5 days (i.e. twice). A normal shampoo and conditioner can be used after the Chlorhexidine each time.
- Linen and bed-wear should be changed daily (in hospital). Out-patients should change bed linen on the last day of treatment (Day 5).

A maximum of two Mupiricin sensitive MRSA decolonisation treatments should be given per hospital episode.

14.2.1 Mupirocin Resistant MRSA (See Appendix 2)

- 10 days of Neomycin (Naseptin) four times a day to both nostrils.
- Five days of 4% Chlorhexidine wash, used as a liquid soap. Particular attention should be taken when washing the axillae, groin and skin folds. (The skin must be moistened with water before applying to reduce likelihood of reactions).
- Hair should be washed with the Chlorhexidine, at least three times during the five days, if possible. A normal shampoo can be used after the Chlorhexidine each time.
- Linen and bed-wear should be changed daily (in hospital) out-patients should change bed linen at least on day 5 and day 10 of treatment.

If the patient has eczema, dermatitis or other skin conditions seek advice from a consultant dermatologist.

14.3 Decolonisation for different patient groups

14.3.1 Newly identified MRSA carriers.

Programme as above for five days. Screen on the 2nd day after completion (i.e. on Day 7). A maximum of two decolonisation treatment protocols should be prescribed per admission episode.

14.3.2 Pre-operatively for patients with known MRSA colonisation.

Patients should be decolonised for known MRSA colonisation as above to reduce risk of infection from own MRSA carriage. Ideally surgery should be scheduled for day five of decolonisation. If identified MRSA positive on admission, decolonisation should begin immediately.

14.3.3 Other known MRSA carriers.

As above, but only if the patient has not attempted decolonisation within the past year.

14.3.3 Decolonisation on discharge

Patients may be discharged with eradication regimen as a medication pack “to take away” (TTA) if they can complete the regimen for themselves. Patient advice on how long to continue the regimen is essential. Patients should be advised to return to their GP for further advice and for rescreening.

14.3.5. Post decolonisation follow-up for Inpatients,

Inpatients should be re-screened 48 hours after completion of the decolonisation treatment unless they are having antibiotic therapy. Three consecutive sets of negative MRSA results screen results, a week apart are required to discontinue isolation. (Only in rare cases is this period shortened. This can only be considered under the guidance of the Infection Control Team). Liaison with the Infection Control Team must take place prior to discontinuation of isolation.

14.3.6. Day Surgery and Short Stay

Day Surgery and Short Stay patients do not need to be re-screened by the hospital.

If MRSA *infection* is suspected, the advice of the Microbiologists should be sought. Therapy for wounds or where indwelling devices, e.g. jejunostomy tubes in-situ should also be discussed with Microbiologists.

15. ITU MRSA Screening and topical decolonisation programme

Screen all patients on admission to ITU for MRSA. (Nose, groin, CSU, wounds, and IV cannula sites and sputum / endotracheal aspirate)

Standard / Contact precautions for known positive MRSA patients.

Initiate decolonization regimen (section 4.2) for MRSA positive patients in liaison with the Infection Control Team.

16. Occupational Health Advice Regarding Staff and MRSA

Screening of staff is not currently undertaken as a matter of routine which is in line with national guidance, although following advice from the consultant microbiologist groups of staff may be required to be screened based on clinical evidence and risk. This confidential screening is undertaken through occupational health.

16.1 Management

- Swabs taken from the nose, groins and any skin lesions
- The staff member should be assessed for suitability for topical treatment and if possible this should be commenced
- The member of staff can return following completion of the decolonisation protocol after treatment has commenced.
- If an MRSA positive member of staff has a partner/close family member that is a health care worker, consideration should be given to taking screening swabs.

16.2 Staff Decolonisation Treatment

Topical treatment is for five days and consists of:

- Mupirocin ointment TDS to both nostrils
- Chlorhexidine body wash, with particular emphasis on axillae, groin and skin folds. (Skin should be moistened with water before applying to reduce the likelihood of reactions)
- Hair should be washed with the Chlorhexidine too, at least three times during the 5 days, if possible. A normal shampoo and conditioner can be used after the Chlorhexidine each time
- Linen and bedding should be changed daily

Staff will be given an advice sheet and any questions discussed.

16.3 Follow up of MRSA positive staff

- Repeat screening swabs should be taken 48 hours after completion of the decolonisation protocol and then at weekly intervals until three negative sets have been obtained.
- If the post-protocol swabs are MRSA positive, treatment should be repeated for a further 5 days
- Systematic treatment for chronic MRSA colonisation will be agreed on individual basis by the consultant microbiologist and the occupational health physician.

17. MRSA Screening Data

The MRSA screening target requires NHS trusts to demonstrate more MRSA screens than elective admissions per month. The Care Quality Commission will monitor trusts compliance with MRSA screening commitment because it is part of The Hygiene Code (2008). The Performance Dept are responsible for collating the MRSA screening data and for entering it onto the national database (HES) on a monthly basis. Each directorate is responsible for validating it's MRSA screening data. Compliance with the screening commitment will be reported by the directorates into the Infection Control Committee.

18 References

Working Party Report - British Society for Antimicrobial Chemotherapy, the Hospital Infection Society and the Infection Control Nurses Association (2006). *Guidelines for the control and prevention of methicillin resistant Staphylococcus aureus (MRSA) in healthcare facilities*.
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http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefnursingofficerletters/DH_4004392

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www.npsa.nhs.uk/EasySiteWeb/GatewayLink.aspx?allid=5443

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http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_063138

MRSA screening - Operational guidance (July 2008)
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_086687

MRSA Screening – Operational Screening 2 (December 2008)
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_092844

MRSA Screening Frequently Asked Questions (February 2009)
http://www.dh.gov.uk/en/PublicHealth/Healthprotection/Healthcareacquiredinfection/DH_094120

Impact Assessment of Screening Elective Patients for MRSA (2008)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_091531

Screening for Meticillin-resistant Staphylococcus aureus (MRSA) colonisation: a strategy for NHS trusts - a summary of best practice

Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH

Tel: 020 8746 8000

PRESCRIPTION FOR MRSA DECOLONISATION PROTOCOL
Mupirocin (Bactroban®)-SENSITIVE

Patient Details:

Name:
DOB:
Hospital Number:
Consultant:

Allergies (include drug and nature of reaction):

Medication:

CHLORHEXIDINE GLUCONATE 4% SURGICAL SCRUB

- Use to wash the entire body ONCE daily for 5 days. Use like a shower gel or liquid soap, paying particular attention to the groin and other skin folds and creases. Moisten skin with water before applying.
- Use to wash hair at least THREE times during the 5 days. A normal shampoo may be used after the chlorhexidine each time.

Route: topical Number of days: 5 GP to continue: NO
Quantity: 500mL

MUPIROCIN 2% NASAL OINTMENT (Bactroban Nasal®)

Apply to the inner surface of both nostrils THREE times daily for 5 days.

Route: nasal Number of days: 5 GP to continue: NO
Quantity: 3g

Prescriber's name (Block capitals):

Prescriber's signature:

Date:

Pharmacy Medicines Helpline: 020-8746-8366 (Open Mon-Fri 10am-5pm)

Chelsea and Westminster Hospital
369 Fulham Road
London
SW10 9NH
Tel: 020 8746 8000

PRESCRIPTION FOR MRSA DECOLONISATION PROTOCOL
Mupirocin (Bactroban®)-RESISTANT

Patient Details:

Name:
DOB:
Hospital Number:
Consultant:

Allergies (include drug and nature of reaction):

Medication:

CHLORHEXIDINE GLUCONATE 4% SURGICAL SCRUB

- Use to wash the entire body ONCE daily for 5 days. Use like a shower gel or liquid soap, paying particular attention to the groin and other skin folds and creases. Moisten skin with water before applying.
- Use to wash hair at least THREE times during the 5 days. A normal shampoo may be used after the chlorhexidine each time.

Route: topical Number of days: 5 GP to continue: NO
Quantity: 500mL

CHLORHEXIDINE HYDROCHLORIDE 0.1%, NEOMYCIN SULPHATE 0.5% CREAM (Nasptin®)

Apply to the inner surface of both nostrils FOUR times daily for 10 days
Route: nasal Number of days: 10 GP to continue: NO
Quantity: 15g

Prescriber's name (Block capitals):

Prescriber's signature:

Date:

Pharmacy Medicines Helpline: 020-8746-8366 (Open Mon-Fri 10am-5pm)