PROCEDURE FOR THE MANAGEMENT OF MRSA & MSSA IN THE COMMUNITY ICP002
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INTRODUCTION
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. Approximately 6% of the population are asymptomatic carriers of MRSA. MRSA is no more virulent than an antibiotic sensitive staphylococcus aureus; the options for treatment of infection are more limited.

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.

This procedure will provide guidance on the control and prevention of the spread of Meticillin resistant Staphylococcus aureus (MRSA) in in-patient areas and community settings of Northamptonshire Healthcare foundation Trust in accordance with the Health & Social Care Act (2008) and Department of Health (DH) guidance on screening. 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.

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. 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 colonised. 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.

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. 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.
There is also evidence to suggest 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.

*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 Healthcare foundation Trust Occupational Health Service.

**MRSA BACTERAEMIA**

An MRSA bacteraemia (MRSA BSI) is when MRSA has been detected in a patient’s bloodstream following blood cultures being taken and cultured within a pathology laboratory. When a case is deemed to be pre-48hr, that is, the bacteraemia has been identified within 48hrs of admission date, then a Post Infection Review (PIR) to identify any possible failings in care and to identify the organisation best placed to ensure improvements are made. The toolkit will ensure consistency in approach and improve the quality of data provided. The PIR replaces the current requirement to undertake Root Cause Analysis (RCA). All NHS trusts across the country have a “zero tolerance” for all MRSA bloodstream infection cases from April 2013.

The PIR process will:

- help identify factors that may have contributed to a MRSA BSI case;
- help to identify any parts of the patient’s care pathway which may have contributed to the infection, in order to prevent a similar occurrence;
- help providers of healthcare and CCGs to identify any areas of non-optimal practice that may have contributed to the MRSA BSI;
- help to identify promptly the lessons learned from the case, thereby improving practice for the future;
- identify the organisation best placed to ensure that any lessons learnt are acted on.

The PIR process requires strong partnership working by all organisations involved in the patient’s care pathway. This close collaboration will enable organisations to jointly identify and agree both the possible causes and any factors contributing to the patient’s MRSA BSI.
SCREENING
Healthcare associated infection (HCAI) risk assessments are undertaken to determine the risk of a patient contracting or spreading a healthcare associated infection and aids care planning and patient placement and transfer or discharge.

Consent
- Patients must be informed of the reason for screening and consent to the swabs being taken.
- Patients must be aware that if they screen positive decolonisation treatment will be advised
- Patients should understand what decolonisation treatment involves

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). All patients admitted to inpatient areas should be screened for MRSA within 24 hours of admission. However, for patients admitted to an in-patient area on a Friday, the screen should be taken on the following Monday (or Tuesday if a Bank Holiday) as there is no transport collection from these areas over the weekend. If a patient is admitted from another hospital and is undergoing a decolonisation regime, the screen should be taken after this regime has stopped i.e. 2 days after completion of the cycle.

Patients being admitted into either a hospice or day hospital for end of life care do not require screening on admission unless their condition improves.

In Community Services for planned admissions and procedures this is to be undertaken for the following services/patients:-

- All Podiatric Surgery patients are risk assessed for preoperative MRSA screening.
  - Patient preoperative screening criteria
    - History of MRSA
    - Nursing/Residential Home resident
    - Recent discharge from acute hospital (within 3 months) either within UK or abroad
    - If the assessing clinician feels the patient is of particular risk e.g. open wound

It will only be necessary to complete admission screening for those patients from:
High risk units i.e. vascular, renal/dialysis, neurosurgery, cardiothoracic surgery, haematology/oncology/bone marrow transplant, orthopaedics/trauma, intensive care units (adult/paediatric ICUs, Neonatal Intensive Care Units, High dependency units, Coronary Care Units)

and/or

those patients that have been previously colonised or infected with MRSA
Patients admitted to the District Nurse caseload and identified as 'High Risk' or have a score of 20+ on the Community Infection Prevention Tool (CIPT) these include:-
- Patients with Chronic wounds i.e. leg ulcers, diabetic ulcers and pressure ulcers.
- Patients with indwelling devices i.e. urethral catheters, supra-pubic catheters and peg sites.

These patients will need to be screened as soon as possible. The MRSA swabs should be taken from the nose, groin, wound, any entry site and a CSU if catheter in-situ. See appendix 1.

Mental Health Settings
In accordance with Department of Health guidance, from 31 December 2010, patients admitted as an inpatient to mental health trusts who fit the criteria below will require screening for MRSA on admission, due to the risk of these patients developing a MRSA infection:
- those who are admitted to mental health units following surgical procedures
- those that are admitted following admission to an acute trust
- those that are intravenous drug users
- those who self-harm causing skin wounds
- those with chronic wounds, e.g. leg ulcers, or with indwelling devices such as urinary catheters.

These patients will need a nose swab and if necessary either wound, any entry site and a CSU if catheter in-situ. See appendix 1.

The date, time, site of screening, specimen results and any variances to screening must be recorded on the MRSA Screening SystmOne template see Appendix 5.

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.

Decolonisation Treatment
Aims to eradicate or significantly reduce the carriage of MRSA when a positive MRSA result is received. The full decolonisation treatment should be followed even if only one site swabs positive. See appendix 2.

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

Room Cleaning
When cleaning rooms separate equipment should be cleaned using 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 utilising the Microfibre Cleaning System should follow the manufacturer’s guidelines.
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.

Decontamination of Medical Equipment/Devices
Northamptonshire Healthcare foundation Trust employees are required to maintain the safety of all patients, colleagues and visitors by adhering to safe systems as detailed within the Northamptonshire Healthcare foundation Trust 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).

Communication
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.

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.

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.

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.

Transport
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 Healthcare foundation Trust Community Infection Control Team should be sought.

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MANAGEMENT OF PATIENTS WITHIN THE HOME SETTING

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 Healthcare foundation Trust Community Infection Control Team should be sought.

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 Healthcare foundation Trust Community Infection Control Team. Equipment that is on loan from the Equipment Loan Service will be dealt with by them.

Normal laundry procedures are adequate with items washed either by a laundry or in a washing machine on a hot wash cycle. Items that are heat labile should be washed at the highest temperature the garment will withstand.

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.

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.

Residing in a long-term care facility

MRSA is also prevalent in these facilities and carriers of MRSA have the ability to spread it, even if they're not showing signs of infection.

Waste Generated in the Patient’s own Home

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 patent does not effect 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.
OUTBREAKS OF MRSA
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.

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

WOUND MANAGEMENT
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. See appendix 1.

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.

Please seek further advice from the Infection Control Team if required.

Wound positive patients only

Treat the wound with specific antimicrobial topical agents and wound dressings as the wound indicates. Record MRSA status in patient records and inform all other care providers i.e. care home, GP; and if admitted to hospital the admitting hospital/ward.

Invasive Devices
People who are catheterised, have intravenous drips in situ or have feeding tubes or other invasive devices in situ are at higher risk.

PANTON-VALENTINE-LEUKOCIDIN (PVL) TOXIN
Infections caused by PVL-SA are currently uncommon in England and Wales. Less than 2% of all Staphylococcus aureus strains, both meticillin sensitive and resistant, have been found to have the potential to produce a toxin called Panton-Valentine Leukocidin (PVL) which destroys white blood cells and is associated with an increased ability to cause disease. However it is still sensitive to many antibiotics. Like all S.aureus strains, PVL - SA predominantly cause skin and soft tissue infections, but can also cause invasive infections. The most serious of these is a necrotising haemorrhagic pneumonia with a high mortality, which often follows a ‘flu like illness, and may affect otherwise healthy young people in the community. Only 25% of cases may have current or a history of skin lesions.
Staphylococcus aureus (SA) is a bacterium which is a major cause of infection and has a significant ability to adapt to the presence of antibiotics by developing resistance. **Meticillin resistant Staphylococcus aureus (MRSA)** is a strain of staphylococcus aureus that is resistant to commonly used antibiotics, e.g. flucloxacillin. MRSA whilst not easier to contract than SA, is harder to treat (due to the fact that it has built up a resistance to many antibiotics), and the consequences of an immune-compromised person, for example, contracting MRSA can be more severe.

In common with Staphylococcus aureus infections in general, PVL Staphylococcal aureus (PVL-SA) predominantly causes skin and soft tissue infections but it can also cause invasive infections, the most serious of which is a necrotising Haemorrhagic pneumonia.

**MANAGEMENT AND TREATMENT OF PVL**

Following a diagnosis of PVL either MSSA or MRSA the patient will be treated with the appropriate antibiotic depending on the sensitivity as identified by the microbiologist. On completion of the antibiotic and when the lesion has healed, the patient and close contacts will be decolonised using Octenisan and nasal mupiricin for 5 days. Following this NO further swabs are required unless the patient or any close contacts develop any soft tissue infection in the future.

If a new lesion occurs or there is reoccurrence of a previous lesion a swab should be taken from the site of the skin infection (ideally pus should be collected) and sent to the microbiology lab clearly stating on form previous PVL and history of recurrent skin infections.

Await sensitivities before treating, for boils consider incision and drainage as per guidance. Treat with antibiotics as per guidance.

When patient has completed the antibiotics and lesions healed all close contacts to be decolonised as before. No further swabs are required unless symptoms reoccur.

This pattern of treatment and decolonisation will be repeated at each occurrence of soft tissue infection / boils etc. and will be dealt with following a risk assessment by the Public Health England of close contacts.

**EQUALITY CONSIDERATIONS**

The author has considered the needs of the protected characteristics in relation to the operation of this policy and protocol to align with the outcomes with IP&C Assurance Framework. We have identified that ensuring that communication reaches all vulnerable groups. The service has been designed to ensure communication relevant to any outbreaks or other healthcare associated infections reaches all sections of the community. This includes taking into consideration communication barriers relating to language or specific needs to reach the whole population. IP&C work closely with multi agency groups and community partners where appropriate we will undertake engagement and outreach activity. We targeted action to relevant groups follow public health England’s communication framework. Some groups are particularly vulnerable in relation to their
protected characteristics, e.g. age, ethnic minority communities and disability and where we identify that, the expectation is that staff will meet the needs appropriately.

REFERENCING AND BIBLIOGRAPHY


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

Department of Health Screening for MRSA colonisation – a strategy for NHS Trusts: a summary of best practice and MRSA Screening – Operational Guidance issued on 31 July (2008), Gateway reference 10324


APPENDIX 1 - SWABBING OF SCREENING SITES

Method of swab taking
- Collect required swabs, urine and sputum containers (if applicable)
- Wash your hands
- Break the top of the swab container and either dip the swab into the transport medium or into saline to moisten it. Take care not to contaminate the swab.

Nose screen:
Use one swab. Insert gently just inside nostril, turn upwards and rotate. Take the swab out and gently insert into the other nostril and repeat. Remove and place securely into the transport medium.

Groin screen:
Use one swab. Run the moistened swab down each groin and across the perineum, rotating the swab for maximum pick up. Remove and place securely in the transport medium.

Wound and invasive devices screen:
Remove dressing and use a separate swab for each wound or device entry site.

Swabs should be sent immediately to microbiology during office hours
- Request MRSA screening and include current or recent antibiotic treatment on the microbiology laboratory form
- Label all swabs with the date, patient’s name, site of specimen.

If the patient has a positive result for MRSA then commence decolonisation treatment

HOW TO TAKE A NASAL SWAB
HOW TO TAKE A WOUND SWAB

• Explain the procedure and purpose of the sampling to the patient and gain verbal consent
• Wash and dry hands thoroughly
• Apply gloves and apron
• Position the patient comfortably, ensuring that their privacy and dignity are maintained throughout
• Cleanse the wound using either normal saline or water depending on site of the wound, ensuring all debris, pus or any other foreign matter is removed
• Remove the swab from the sterile packaging. If the area to be swabbed is relatively dry, the swab may be moistened using sterile sodium chloride - this will help to ensure that any organisms adhere to it

• Gently pass the swab over the area in a zig-zag motion, ensuring it is turning in a circular movement to totally cover the swab. The nurse should ensure that there is minimal discomfort for the patient.
• Swab from the centre to the outside of the wound
• If there is exudate present, ensure it is thoroughly absorbed by the swab

• Use a separate swab if there is a pocket or sinus in the wound
• Remove the top from the culture tube and place the swab inside, closing firmly.
COLLECTION OF A CATHETERS SPECIMEN OF URINE (CSU)

Samples should only be taken from catheters for valid reasons such as suspected infection and should never be taken from the catheter bag but instead from the sample ports on the bag’s draining tubing. Rationale for taking the specimen must be documented in the patient notes or on the care bundle.

**Equipment required:**
Sterile 5 ml syringe (if not a needle-less port - a blue 23G needle is also needed)
2% chlorhexidine 70% Isopropyl alcohol wipe
Disposable gloves/apron
Sterile Urine specimen container
Laboratory request form
Sharps box if necessary

Identify patient and gain consent. Check name, date of birth and hospital number to ensure that the correct patient is identified for the purpose of obtaining a sample and possible need for treatment.

Decontaminate hands with soap and water or hand sanitizer. Put on disposable apron and gloves.

If needle-less collection port system:
  - Clean the sample port with a 2% chlorhexidine & 70% Isopropyl Alcohol wipe. Allow to dry for 20 seconds.
  - Insert the syringe and withdrawing sufficient urine to send for culturing.
  - Swab the sample port again and remove any clamp used.
  - Remove and dispose of gloves and wash hands.
Complete pathology request form and urine specimen container with patient details, include name, date of birth, date sample taken and clinical area of the patient.

If syringe collection port system:
  - Clean the sample port with a 2% chlorhexidine & 70% Isopropyl Alcohol wipe. Allow to dry for 20 seconds.
  - Attach needle to syringe and insert into port at 45° angle, aspirate urine and remove needle from port.
  - Separate needle from syringe using aperture on sharps box to prevent sharps injury.
  - Place urine into specimen container and dispose of syringe to reduce infection & allow free drainage of urine.
  - Swab the sample port again and remove any clamp used to confirm patients details and for safe transportation.
  - Remove and dispose of gloves and decontaminate hands.
  - Complete pathology request form and urine specimen container.
If specimen has to be kept overnight, this should be stored in a specimen fridge and sent to the laboratory immediately the following day. If specimen fridges are not available then the specimen should be taken the next working day.

**Sampling of urine from the catheter Port - without needle**

Ensure aseptic technique is used.

**Sampling of urine from the catheter Port - with needle**

Ensure aseptic technique is used.
APPENDIX 2 – DECOLONISATION REGIME

How to use your Meticillin Resistant Staphylococcus Aureus (MRSA) body wash and nose ointment

Ensure that you read any leaflets enclosed with your medication

You recently had some swabs taken either by your District Nurse, Podiatrist or at the GP surgery and MRSA was found.

This leaflet explains how to use the medication you have been given to remove or reduce the amount of MRSA on your skin. The treatment covers 5 days and at the end you should throw away any leftover ointment and body wash.

NOSE OINTMENT (Bactroban)

This is applied 3 times each day for 5 days

Place a small amount of ointment, about the size of a match head, on a cotton bud or on your finger and apply it to the inside of one nostril. Repeat for the other nostril. Pinch the nostrils together; this will spread the ointment out.
Each day wash the body and on days 2 and 4 wash the hair as well.

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<tbody>
<tr>
<td>Body</td>
<td>Body &amp; hair</td>
<td>Body</td>
<td>Body &amp; hair</td>
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**Step 1**
Ensure hair and body are wet

**Step 2**
Put body wash on a clean damp washcloth. Use a clean washcloth each day and do not share with others.

**Step 3**
Wash the body all over for 1 minute. On days 2 & 4 wash hair as well. Make sure you wash the armpits, stomach & groin area thoroughly.

**Step 4**
Rinse off thoroughly

**Step 5**
Dry with a clean towel. Use a fresh towel each day.

**Step 6**
Put on clean day and night clothing each day.
APPENDIX 3 - MRSA DE-COLONISATION TREATMENT CHART

MRSA POSITIVE RESULT

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

DO NOT
Repeat antibacterial treatments for more than TWO 5-DAY COURSES.
Contact Community Infection Control 01933 235857

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

1. Wait 2 days

2. Rescreen - Nose, groin and any access points i.e. wound, catheter and await result

3. Result

POSITIVE
If any screened site returns a positive result, the full decolonisation process should be followed even if only one site has a positive result.

NEGATIVE

Octenisan is the recommended first choice antibacterial wash
Mupirocin 2% antibacterial nasal ointment/Octenillinnasal gel are the preferred options for nose decolonisation.
If any patients have adverse reaction – Contact ICN for advice

CONTACT INFECTION CONTROL to discuss appropriate precautions
APPENDIX 4 - STANDARD OPERATING PROCEDURE - PREOPERATIVE MRSA SCREENING FOR NHFT PODIATRIC SURGERY PATIENTS

The Department of Health (DH) in England introduced mandatory screening of all elective and emergency admissions for April 2009 and December 2010, respectively, however in 2014 the DH recommended that the current practice of mandatory MRSA screening of acute and elective admissions to NHS hospitals in England is streamlined to the following:

- All patients admitted to high risk units e.g. vascular, renal dialysis, ICU’s
- All patients previously identified as colonised with or infected by MRSA
- In addition, a local risk assessment should be used to define other potential high MRSA risk units/specialities.

Following consultation with the NHFT Lead Infection Prevention and Control Nurse and following a department risk assessment taking into account the DH document ‘Implementation of Modified Admission MRSA screening guidance for NHS (2014)’, the following applies:-

**All Podiatric Surgery Patients are risk assessed for preoperative MRSA screening**

**Patient preoperative screening criteria**

- History of MRSA
- Nursing/Residential Home resident
- Recent discharge from acute hospital (within 3 months) either within UK or abroad
- If the assessing clinician feels the patient is of particular risk e.g. open wound

For further information the MRSA please see the NHFT Procedure for the Management of MRSA & MSSA in the Community.
# APPENDIX 5 SYSTMONE SCREEN

## Community Infection Prevention Tool (CIPT)

### CIPT Assess - CIPT Outcome - Clinical Guidance - Guidance

**Community Infection Prevention Tool** 
Please ensure all questions are answered; scroll or tab to the bottom of the list

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA colonised</td>
<td>N/A</td>
</tr>
<tr>
<td>MRSA infection</td>
<td>N/A</td>
</tr>
<tr>
<td>Own home or respite care?</td>
<td>N/A</td>
</tr>
<tr>
<td>Residential Care home?</td>
<td>N/A</td>
</tr>
<tr>
<td>Any broken skin areas?</td>
<td>N/A</td>
</tr>
<tr>
<td>History of frequent admission in to hospital?</td>
<td>N/A</td>
</tr>
<tr>
<td>Previous infections including MRSA?</td>
<td>N/A</td>
</tr>
<tr>
<td>Invasive device eg long term catheter?</td>
<td>N/A</td>
</tr>
<tr>
<td>Does the patient have diarrhoea?</td>
<td>N/A</td>
</tr>
<tr>
<td>Is the diarrhoea thought to be of an infectious nature?</td>
<td>N/A</td>
</tr>
<tr>
<td>Has patient been prescribed antibiotics in the past 9 weeks?</td>
<td>N/A</td>
</tr>
<tr>
<td>Is the patient taking Proton pump inhibitors?</td>
<td>N/A</td>
</tr>
<tr>
<td>Previous C-diff infection?</td>
<td>N/A</td>
</tr>
<tr>
<td>Age</td>
<td>N/A</td>
</tr>
<tr>
<td>Evidence of weeping vesicles?</td>
<td>N/A</td>
</tr>
<tr>
<td>Skin shedding e.g. eczema or psoriasis?</td>
<td>N/A</td>
</tr>
<tr>
<td>Suspected/confirmed staphylococci lice or ringworm?</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Case management risk assessment score**

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**CIPT Outcome**

*Assessment Completed* [ ]

On completion of the assessment, please tick this box THEN click on the pencil icon in order to enter the total risk score in the notes:

**Risk Level & Next Steps**

**HIGH RISK, TOTAL SCORE = 20+**

- High risk
- Review CIPT tool monthly or if the patient’s condition changes & only take swabs if there is a clinical indication.

- MRSA swab:
- Inpatients only - MRSA Screening not needed

**MEDIUM RISK, TOTAL SCORE = 11-19**

- Medium risk
- Review CIPT tool 6 monthly or if the patient’s condition changes & only take swabs if there is a clinical indication.

- History of MRSA?
- MRSA swab:
- Inpatients only - MRSA Screening not needed

**NOT AT RISK, TOTAL SCORE = 0-10**

- Not at Risk
- No further action required.
- Review the CIPT 12 monthly if remains on the caseload or sooner if the patients clinical condition changes.

Refer to Trust Policy for decolonisation guidance - link to infection control Policy [MRSA swab]

If the patient has been treated for MRSA, re-screen at 2 days post treatment.
If the patient remains MRSA positive after 2 decolonisation treatments contact the Infection Prevention & Control team for further advice regarding patient management.

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*Assessment Completed* [ ]

No previous values
All swabs should be sent to the laboratory for MC & S
Swabs should only be taken if there is a clinical indication to do so i.e.:-

- Symptomatic bacteriuria then a urine sample should be taken. Either as a clean catch specimen or a catheter specimen of urine.
- Inflamed discharging wound – wound swabs should be taken.
- If patients have an access device e.g. cannula/ suprapubic catheter/ PEO, swabs should be taken from these sites if inflammation/ discharge is present.

MRSA screens – nose & groin if patient positive for MRSA in any site

If the patient has diarrhoea, a stool sample must be sent.