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<th><strong>Title</strong></th>
<th>Infection Control Policy: Management of methicillin resistant Staphylococcus aureus (MRSA)</th>
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<tr>
<td><strong>Guideline reference number</strong></td>
<td>40</td>
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<tr>
<td><strong>Aim and purpose of guideline / policy</strong></td>
<td>This policy is intended to provide guidance to all staff to manage MRSA in the community setting and reduce the risk of infection transmission.</td>
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<tr>
<td><strong>Author</strong></td>
<td>Infection Prevention &amp; Control Team</td>
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<td>Ratified by:</td>
<td>Clinical Policies and NICE Group</td>
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<tr>
<td>Name of originator/author</td>
<td>Infection Prevention &amp; Control Team</td>
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<td>Approving body/committee:</td>
<td>Clinical Policies and NICE Group</td>
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<td>All LCH Staff involved in direct patient care</td>
</tr>
<tr>
<td>Name of lead Director/Managing Director</td>
<td>Bernie Cuthel</td>
</tr>
<tr>
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<td>Inclusion of text to reflect:</td>
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<td>- Changes in practice and updated evidence.</td>
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<td>- Updated references.</td>
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1 Introduction

Liverpool Community Health (LCH) is committed to preventing and controlling the risks of Health care associated infections (HCAI’s). This policy has been developed to provide guidance to LCH’s employees and their contractors on the HCAI methicillin resistant Staphylococcus aureus.

This policy is required in order to meet the requirements of the national agenda for infection prevention and control all NHS organisations who are monitored by the Care Quality Commission Essential Standards and The Health Act 2006; Code of Practice for the Prevention and Control of Healthcare Associated Infections (HCAI) (DH 2006). The Health Act (2006) stipulates that NHS bodies must, in relation to preventing and controlling the risks of HCAI, have in place appropriate core policies including the control of infections with specific alert organisms.

1.1 Methicillin resistant Staphylococcus aureus

Staphylococcus aureus (S. aureus) is a common bacterium that is carried on the skin of approximately 30% of the population, usually in moist sites such as the nose, axilla (armpit) and perineum, without causing any problems. It is capable of surviving for long periods on dry surfaces, including hands, equipment and in dust (Blake 2005). If the bacteria invades the skin or deeper tissues and multiplies an infection may develop.

Methicillin is an antibiotic that was commonly used to treat S. aureus until some strains of the bacteria developed resistance to it. These resistant bacteria are called MRSA.

The risk of MRSA has now increased in the community setting because many people are now discharged out into the community where they receive invasive treatments in their own homes and in community healthcare facilities (HPA 2005).

1.2 Status

This is a clinical documents policy for use within Liverpool Community Health.

The guidelines outlined in this policy are aimed to assist health care workers caring for patients/clients within the community setting and within the LCH in-patient intermediate care bed base.
1.3 Purpose

The purpose of this policy is to ensure the risks associated with MRSA infection, colonisation or contact are reduced and managed in accordance with best practice in the community and primary care settings in accordance with the revised guidelines from the Joint Working party on MRSA (2006).

1.4 Scope

This policy applies to all staff employed by Liverpool Community Health. However this policy may be used by other organisations and practitioners within the Liverpool area.

2. General policy statement

The Trust is committed to ensuring staff are knowledgeable about MRSA and its transmission, and to the provision of materials and a safe environment in which to work.

LCH Provider Services is committed to ensuring that all staff are trained and equipped to perform their role effectively.

3. Definitions

3.1 Meticillin Resistant Staphylococcus Aureus (MRSA) is a strain of Staphylococcus aureus (S.aureus) that has become resistant to a number of antibiotics.

3.2 Colonisation means that MRSA is present on or in the body without causing any clinical symptoms. Simple hygiene measures such as hand washing can reduce spread.

3.3 Infection means that the MRSA is present on or in the body and is multiplying in the tissues causing clinical changes which will be indicated by two or more of the following; inflammation, pus, pyrexia, pain and swelling.

3.4 Bacteraemia describes the presence of MRSA/S. aureus in the blood.

3.5 Panton- Valentine Leukocidin-PVL associated MRSA is a toxin which destroys white blood cells and is produced by Meticillin-sensitive Staphylococcus Aureus (MSSA) and MRSA. 2% of S. aureus are PVL type.

4. Duties and Responsibilities

4.1 The following general (statutory) duties apply:
All LCH Provider Services staff are responsible for co-operating with the
development and implementation of LCH policies as part of their normal duties
and responsibilities. In addition, it is the responsibility of the employee to:

- Receive training in the management and control of MRSA
- Adhere to Standard Precautions, in particular completion of effective hand
  hygiene and wearing protective clothing, as per the relevant CH policies.

4.2 All adverse incidents and near miss events should be reported in line with
LCH Accident and Incident Reporting and Management Policy (Including Serious
Untoward Incidents).

4.3 Trust Board
The Trust Board through its commissioning and governance frameworks will
satisfy itself that services they commission with have appropriate systems in
place to keep patients, staff and visitors safe from HCAI, so far as reasonably
practical.

4.4 Chief Executive
The Chief Executive is ultimately responsible for ensuring that there are effective
arrangements for infection control and adequate resources are available for the
discharge of the trusts’ annual infection control programme, agreed with the Trust
Board. The Chief Executive will designate the prevention and control of
healthcare associated infection as a core part of the organisation’s clinical
governance and patient safety programmes.

4.5 Director of Infection Prevention and Control
The Director of Infection Prevention and Control will report directly to the Chief
Executive and the Board and not through any other officer in relation to HCAI’s
including incidents of MRSA and ensure the continuing high profile of healthcare
acquired infection at strategic level within the organisation.

4.6 Associate Directors and Service Managers. Heads of Service and Service
Managers are responsible for ensuring that their staff have access to and comply
with procedures described in this document, implement access to training to
support the procedures described in this policy and ensure risk assessments are
carried out by appropriate member of staff where necessary.

4.7 Staff
All employees undertaking clinical duties have a responsibility to adhere to this
policy and carry out risk assessments when appropriate.

4.8 Infection Prevention and Control Team (IP&CT)
The IP&CT will monitor effectiveness of the procedures set out in this policy as
defined below and ensure any amendments are incorporated in agreement with
the Infection Control sub-group.
5. Process and Documentation

5.1 Recognising the risk

Patients at Risk of MRSA Infection

- Those with an underlying illness.
- Those who are Immuno compromised (reduced immunity).
- Those who have an indwelling device(s) e.g. urinary catheter, Intravenous (I.V) lines.
- Those with wounds known to have been infected or colonised with MRSA in the past.
- Frequent healthcare facility users.
- Recent inpatients at hospitals abroad or hospitals in the UK which are known or likely to have a high prevalence of MRSA.
- Residents of residential care facilities.

5.2 Routes of Spread

- Direct Contact - Hands provide the most common form of contact between people and their potential contamination with MRSA. It is essential that good standards of hygiene are maintained (see Trusts Hand Washing policy ICM 5).
- Indirect contact - Environmental contamination – Staphylococci survives well in the environment, on skin scales and in dust and can be transferred via hands.
- Contaminated equipment may also act as a reservoir for MRSA. Any piece of equipment that comes in to contact with a patient should be cleaned in between each use, as per Trusts Cleaning and Decontamination of reusable devices policy.
- Airborne - MRSA frequently colonises skin and can be dispersed into the environment and onto equipment when skin scales are shed (DH 2004).

5.3 Possible Sites for MRSA Infection

- Wound Infection – MRSA a common cause of wound infection. This shows as a red, inflamed wound with or without pus. The wound may break open or fail to heal and an abscess may develop.
- Superficial ulcers – pressure ulcers, varicose and diabetic ulcers are often sites of MRSA infection.
• Intravenous line infections – MRSA may infect the entry site of an intravenous line causing local inflammation with pus from which the MRSA can enter the blood stream to cause a bacteraemia (blood stream infection).

• Deep abscesses – If MRSA, or any S. aureus, spreads from a local site into the blood stream it can lodge at various sites in the body and cause one or more deep abscesses distant from the original site. These can be painful with high fever, a high white cell count in the blood and signs of inflammation near the infection. The patient will be very unwell and may have rigors (shivers) and low blood pressure (shock). Over a period the body enters a catabolic state with a breakdown of tissue, loss of weight and failure of essential organs. This is usually linked with an associated septicaemia.

• Bacteraemia/septicaemia – MRSA/ S. aureus can enter the normally sterile blood stream either from a local site of infection (wound, ulcer, and abscess) or via intravenous catheter. Bacteraemia describes the presence of MRSA/S. aureus in the blood. Septicaemia can follow and is the clinical term for a severe illness caused by the bacteria in the blood stream. The symptoms are not specific to MRSA. Typically symptoms can include high fever, raised white cell count, rigors, disturbance of blood clotting with a tendency to bleed and a failure of vital organs.
## 5.4 Management of MRSA in the Community

<table>
<thead>
<tr>
<th>CARE ENVIRONMENT</th>
<th>RECOMMENDATIONS</th>
<th>COMMENT</th>
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<tbody>
<tr>
<td>Care Homes/Inpatient areas</td>
<td>Single room preferable. Can share as long as other patient has no open wounds or indwelling catheters (as far as practically possible)</td>
<td>Can socialise as normal. All wounds to be covered. Ensure good hand hygiene.</td>
</tr>
<tr>
<td>Own home</td>
<td>No isolation in patient’s home. Encourage the patient and family to maintain good hand hygiene.</td>
<td>Standard infection control precautions – refer to trust procedure – Standard precautions Policy</td>
</tr>
<tr>
<td>GP practice</td>
<td>Standard infection control precautions</td>
<td>Treatment in clinical rooms, thoroughly clean room in accordance with trust Environmental disinfection and decontamination of reusable devices policy.</td>
</tr>
<tr>
<td>Treatment Rooms</td>
<td>Standard infection control precautions, as per Trusts Standard Precautions policy</td>
<td>Thoroughly clean room in accordance with trust Environmental disinfection and decontamination of reusable devices policy.</td>
</tr>
<tr>
<td>LCH in-patient intermediate care beds</td>
<td>All patients must be screened as per trust’s MRSA policy</td>
<td>As per Care Home guidance. Contact Infection Prevention &amp; Control Team for further guidance</td>
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<table>
<thead>
<tr>
<th>Areas for consideration in all care environments</th>
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<tr>
<td><strong>Crockery and cutlery</strong></td>
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<td><strong>Domestic services</strong></td>
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<td><strong>Hand washing</strong></td>
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<td><strong>Dressings</strong></td>
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<td><strong>Protective clothing</strong></td>
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<td><strong>Personal hygiene</strong></td>
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<td><strong>Social activities</strong></td>
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<tr>
<td><strong>Staff with skin disorders</strong></td>
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<tr>
<td><strong>Swabbing</strong></td>
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</tbody>
</table>
5.5 Good Infection Control Points to Remember;

- MRSA status of patients is not always known therefore it is essential that standard precautions, as per Trusts Standard Precautions Policy, are implemented and adhered to at all time.
- Wear a clean uniform daily.
- Blood and body fluids should be dealt with immediately, as per Trusts spillage procedure.
- Sharps should be disposed of into a rigid sharps container at the point of use, as per Trusts Waste Policy.
- Patient equipment such as commodes, beds, BP machines, hoists should be cleaned thoroughly with general purpose detergent and hot water after use, as per Trusts decontamination procedure.
- Daily cleaning of the patients area should include; fresh bed linen each day (folding bedding “corner to corner” in an attempt not to disperse skin scales into the environment), horizontal surfaces to be clutter free and decontaminated as per Trusts decontamination procedure, where possible vacuumed with a hepa filter vacuum.
- On discharge or once the resident has been cleared of infection, the room should be cleaned thoroughly. Where possible emptying the room, to clean, and discarding anything that cannot be cleaned. Carpets / soft furnishings should be vacuumed (where possible with a hepa filter vacuum) and all horizontal / vertical surfaces cleaned, as per Trusts decontamination procedure.

5.6 Managing a Patient with MRSA;

5.6.1 Referral - People with MRSA should not be refused admission as this can be considered as discrimination (DH 1996).

Referral to a Care Home;

When referring an MRSA affected patient to a care home it is advised that the following people be informed;

- The manager, matron or designated member of staff with infection control responsibilities.
- The patient’s GP.
- Any member of the Health Care Team who may be visiting the patient.

Referral to a Community / Acute Hospital;

- Inform hospital prior to admission / document on the referral form the patients MRSA status.
- Inform the IP&CT if the person is to receive in-patient treatment.
• Relevant department should be informed if the person is to receive outpatient treatment.

5.6.1 Transfers to LCH in- patient intermediate care bed base

Patients transferred to ward 35 within Aintree Hospital, Ward 9 and 11 within Royal Liverpool and Broadgreen hospital site and ward 2A on Royal Liverpool site including A+E, or other hospitals have responsibility to implement this national guidance. The ward on receipt of such patients should ensure appropriate screening has taken place.

5.7 MRSA Screening in the Community;

All GP admissions to LCH intermediate care beds must be screened.

Inter ward transfers between LCH beds would not require repeat MRSA screening

Patients are not routinely screened in the community however early detection of MRSA colonisation and commencement of decolonisation therapy may prevent the patient from potentially becoming infected, septic and requiring hospitalisation.

MRSA screening may be appropriate if one or more of the following apply:-
• Chronic skin condition, recurrent boils or chronic wound / pressure sore which may not be responding to treatment.
• In receipt of an MRSA positive clinical specimen e.g. mid- stream urine (MSU) / catheter specimen of urine (CSU), wound swab, sputum.
(Advice regarding the appropriateness of screening can be discussed with the IP&CT)

Screening Method for MRSA

• Routine microbiology swabs should be used.
• The swab should be moistened with sterile saline if a dry swab is used
• The swab should be rubbed and rotated 10 – 20 times over the area to be sampled
• The swab should be labelled with patient/residents name, location/address and the site of sample i.e. nose, groin, etc
• Unless directed otherwise, swabs collected within Liverpool Community Health should be sent to the Royal Liverpool Hospital or Aintree University Hospital Microbiology Department and those collected in North Sefton sent to Southport and Ormskirk DGH microbiology Department.

Nose and Groin samples should be taken in all cases:
In some cases a throat swab may be requested. This is not routine within community but may be requested from Acute Trusts in line with their local policies and procedures.

The following should also be sampled if present:

- Lesions/wounds
- If urinary catheter present then swab exit site at urethral meatus (opening of the urethra)
- Intravascular exit sites
- PEG sites (stomach feeding tube)
- Tracheotomy site

5.8 Decolonisation of MRSA

5.8.1 Risk factors

A patient in the community will require a risk assessment prior to treatment for MRSA colonisation. This assessment should include the presence of risk factors such as the presence of a wound, an indwelling urinary devise, a feeding tube or an intravenous line.

If risk factors are present in a resident with MRSA colonisation in a shared care setting then to reduce the risk of infection and cross infection decolonisation treatment should be prescribed.

A patient without risk factors rarely requires decolonisation treatment.

Should it be advised to commence decolonisation by the GP, IP&CT or microbiologist, the trusts guidance is as follows:-

a) In the presence of clinical infection. Antibiotic therapy should only be given where there is evidence of a clinical infection. Treatment should be discontinued as soon as the clinical condition allows.

b) To decrease the amount of skin colonisation, to reduce the risk to the patient and others e.g. prior to admission to hospital, surgery or where progression to infection will prove detrimental to the patient e.g. immune-compromised patient.

5.8.2 Procedure

Decolonisation consists of applying topical agents to the skin, nose of a colonised person. Mupirocin should always be used in conjunction with antimicrobial skin wash. The product of choice is Octenisan and or Hibi scrub.
Patients suffering from chronic skin conditions should only be treated once advice is sought from the Microbiologist.

Patient should bath/shower for five days with Octenisan using following method. Octenisan antimicrobial five – day eradication protocol

Day 1 – Body
Day 2 – Body & Hair
Day 3 – Body
Day 4 – Body & Hair
Day 5 – Body

- Use a disposable damp cloth to apply Octenisan leave on for three minutes then wash off.
- For shower and hair use in the same way you would use normal preparations of shower gel and shampoo.
- Clean clothing / night wear and bedding should be used each day and at the end of the decolonisation therapy.

When patients are discharged from an Acute Trust on a decolonisation programme they will be provided with instructions from the discharging hospital to be followed within the community setting. Decolonisation regimes may differ slightly, depending on local policy and therefore further advice maybe required from the Community IP&CT

To ensure accurate microscopy and culture it is essential that the appropriate clinical details be given with the specimen e.g. treatment histories, factors which affect the patients resistance to infection or the presence of the symptoms of infection (such as cellulitis).

5.8.3 Screening Following MRSA Decolonisation Treatment

The criteria to identify if patients are fully cleared of MRSA is to obtain three full screens at least seven days apart. The first screen must be collected at least 48 hours following the completion of eradication treatment and the screens must include any wounds, lesions or devices.
N.B. obtaining clearance screens in this way is common practice when managing MRSA in acute settings, however, it is rarely necessary in the community unless there are clinical indications and clear benefits for doing so, or, as directed by the acute and community IP&CT

5.8.4 Staff Screening

MRSA does not generally affect healthy individuals and therefore routine staff screening should not be undertaken. In an outbreak situation, staff screening may be instituted in conjunction with the Occupational Health Department. All suspected outbreaks should be notified to the Health Protection Unit (HPU). Further advice will be given to staff by IP&CT should such circumstances arise.

5.9 MRSA Bacteraemia

MRSA can enter the normally sterile blood stream either from a local site of infection (wound, ulcer, and abscess) or via an intravenous catheter (placed there for their medical care). Bacteraemia describes the presence of MRSA in the blood. Septicemia can follow and is the clinical term for a severe illness caused by the bacteria in the blood stream. The symptoms are not specific to MRSA and can be the same for other bacteria that cause septicemia. Typically symptoms can include high fever; raised white cell count; rigors (shaking); disturbance of blood clotting with a tendency to bleed and failure of vital organs. This is the kind of MRSA infection that has the highest death rate.

5.9.1 Root Cause Analysis - RCA

All MRSA Bacteraemia infections that have originated in the community setting will be thoroughly investigated by the Community IP&CT through a formal process of RCA. The investigation should identify if the bacteraemia was avoidable or unavoidable and possible or likely causes. Action plans and Recommendations of each RCA will be presented to the Infection Control Committee, local Acute IPCT and any other clinical team or individual deemed necessary to learn lessons and prevent reoccurrence.

Multidisciplinary co-operation is essential for this investigation during data collection, action planning, and implementation of recommendations. It must be noted the purpose of any RCA is not to encourage a culture of blame, but to improve practice across all services by identifying potential route causes.

5.10 Panton- Valentine Leukocidin -PVL associated MRSA

PVL is a toxin which destroys white blood cells and is produced by Meticillin-sensitive Staphylococcus Aureus (MSSA) and MRSA. 2% of S. aureus are PVL type.

Like other S. aureus strains, PVL-SA predominately cause skin and soft tissue infections, such as boils, abscesses and cellulitis but can also cause invasive
infections, such as necrotising haemorrhagic pneumonia, necrotising fasciitis, osteomyelitis, septic arthritis and pyomyositis.

5.10.1 Risk Factors for PVL-SA

Risk of PVL-SA is increased when there is a compromise to the patient’s skin integrity, or having skin to skin contact or sharing hygiene items such as towels or flannels. PVL-SA infections are associated within community settings, although incidences in hospital settings have occurred. The following settings/activities have been identified as higher risk:

- Households
- Close contact sports
- Military training camps
- Gyms
- Prisons

5.10.2 Management of patients and contacts with suspected PVL-SA

The IP&CT and Health Protection Agency (HPA) must be made aware of individual cases of PVL-SA and will investigate cases, including identification and management of contacts. Management and treatment of cases and contacts including screening is dependent on factors including clinical features and risk factors. PVL sub-group of the Healthcare Associated Infection Steering group have produced “Guidance on the Diagnosis and Management of PVL-associated Staphylococcus aureus infections (PVL-SA)” in England which should be consulted in conjunction with ICT which describes in detail, full guidance relating to all aspects of PVL-SA management including treatments of individual cases, contacts and screening.

6. Training Requirements

LCH aims to ensure that all members of staff receive the level of training necessary for them to fulfil their individual responsibilities identified in this policy.

Training is provided through MANDATORY training courses. Those members of staff detailed in the policy with specific responsibility will receive the appropriate training for those tasks. Training is accessible via the Learning & Development Bureau.

This policy has been developed in consultation with the Infection Control Committee and Health Protection Committee, approved by the Governance Committee and ratified by the Trust Board.

7. Implementation, Monitoring and Review

7.1 The Director of Nursing & Therapies is responsible for implementing this policy. This process has been delegated to the
Infection Control Lead. The policy will be implemented and disseminated via the training programme and through electronic publication on the intranet.

7.2 The Director of Nursing & Therapies is responsible for ensuring that this document is reviewed and, if required revised in the light of legislative guidance or organisational change. This has been delegated to the authors of the policy.

7.3 The policy will be monitored via observational audit, staff questioning and adverse incident reporting. Clinical line managers are responsible for ensuring that all staff adheres to this policy. Adherence to policy will be audited using the National Clinical Audit tool.

7.4 Review will be three yearly unless practice changes in the interim, review will be undertaken by the author/s of this policy.

8. Impact Assessment
An impact assessment as per LCH guidance has been undertaken in relation to this policy on review in December 2009.

9. Linked areas / Information
Other related Policies, Procedures or Work Instructions:

Risk Management Strategy
Health and Safety Manual
Accident and Incident Reporting and Management Policy
Hand Hygiene Policy
Standard Precautions Policy
Waste Management Policy

All Clinical guidance documents of LCH Provider Services are available on the organisation’s intranet site.

10. Relevant Legislation/Statutory Requirements

The Health and Social Care Act 2008:
Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance

11. List of Appendices

Management of MRSA in General Practice
Management of MRSA in Community Health Centres

12. References


Health Protection Agency North West, Interim Infection Control Guidance for Care Homes (2005) [www.hpa-nw.org.uk](http://www.hpa-nw.org.uk)


Guidelines for Environmental Infection Control in Health-Care Facilities – Recommendations of CDC and Healthcare Infection Control Practices Advisory Committee (HICPAC), (2003), U.S. Department of Health and Human Services, Centres for Disease Control and Prevention, Atlanta, Georgia.

Appendix A

Management of MRSA in General Practice

MRSA does not pose a risk to healthy people in the community and affected people should be encouraged to pursue all their normal activities. 90% of people with MRSA are colonised and are not infected. There are many more that remain undetected.

MRSA is easily transmitted on the uncleansed hands or by handling contaminated equipment.
A number of undetected cases of MRSA will also be managed in general practice.
The following measures (Standard Precautions), when applied to

- all patients
- all of the time
- by all staff

Will protect staff and patients from recognised and unrecognised cases of infection or colonisation. The same risks are posed by both!

1. No need for isolation.
2. Wear gloves when in touch with blood or body fluids except sweat.
3. Cleanse hands before and after patient contact and after removing gloves.
4. Ensure treatment couch is wiped down (soap and water) and fresh blue roller applied between patients.
5. Avoid using cloth towels and bar soaps; both harbour bugs.
6. Avoid sheets and blankets for privacy, unless laundered between patients.
7. Cover broken skin with a waterproof dressing.
8. Ensure re-usable patient care devices are decontaminated between patients.
Screening and treatment

1. Pre admission screening of all elective inpatients is required; from 2010 pre admission screening is required for all admissions. Refer to screening policy for advice on decolonisation regime.

2. Avoid treating MRSA unless there is a specific indication e.g. clinical infection. Routine use of eradication agents can promote further resistance.

3. **DO NOT PRESCRIBE REPEATED DOSES OF DECOLONISATION**, if advice is required please contact the Community Infection Prevention and Control team

4. Where treatment has been started by the hospital, assess each patient individually as to whether treatment should continue. The risk in the patient's home or residential setting is extremely low.
Appendix B

Management of MRSA in Community Health Settings

MRSA does not pose a risk to healthy people in the community and affected people should be encouraged to pursue all their normal activities. 90% of people with MRSA are colonised and are not infected. There are many more that remain undetected.

MRSA is easily transmitted on the uncleansed hands or by handling contaminated equipment.

A number of undetected cases of MRSA will inevitably be managed in the various settings in the community.

The following measures (Standard Precautions), when applied to

- All patients and contaminated equipment
- All of the time
- By all staff

Will protect staff and patients from recognised and unrecognised cases of infection or colonisation, the same risks are posed by both!

9. No need for isolation.
10. Wear gloves when in touch with blood or body fluids except sweat.
11. Cleanse hands before and after patient contact and after removing gloves.
12. Adhere to aseptic technique when dealing with non-intact skin, mucous membranes and susceptible sites.
13. Ensure treatment couch is wiped down if visibly soiled with soap and water. Additionally wipe with hard surface disinfectant (70% alcohol) wipe and apply fresh blue roller between patients.
14. Avoid using cloth towels and bar soaps; both harbour bugs.
15. Avoid sheets and blankets for privacy, unless laundered between patients.
16. Cover broken skin with a waterproof dressing.
17. Ensure re-usable patient care devices are decontaminated between patients.
Screening and treatment

1. Pre admission screening of all elective inpatients is required; from 2010 pre admission screening is required for all admissions. Refer to screening policy for advice on decolonisation regime.

2. Avoid treating MRSA unless there is a specific indication e.g. clinical infection. Routine use of eradication agents can promote further resistance.

3. DO NOT PRESCRIBE REPEATED DOSES OF DECOLONISATION, if advice is required please contact the Infection Control team: 0151 295 3036.

4. Where treatment has been started by the hospital, assess each patient individually as to whether treatment should continue. The risk in the patient’s home or residential setting is extremely low.