Wrightington, Wigan and Leigh NHS Foundation Trust

POLICY NAME:	**METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) SCREENING POLICY**
POLICY ID NUMBER:	**TW10-116**
VERSION NUMBER :	**8**
APPROVING COMMITTEE:	**INFECTION PREVENTION AND CONTROL COMMITTEE**
DATE THIS VERSION APPROVED:	**MAY 2019**
RATIFYING COMMITTEE:	**PARC (Policy Approval and Ratification Committee)**
DATE THIS VERSION RATIFIED:	**June 2019**
AUTHOR(S):	**CONSULTANT MICROBIOLOGIST/ DEPUTY DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)/ ASSISTANT DIPC**
DIVISION/DIRECTORATE:	**CORPORATE**
LINKS TO OTHER POLICIES/PROCEDURES:	**MRSA TW10-116 (SOP 1)** **MRSA Bacteraemia Procedure for Investigation TW10-116 (SOP 2)** **MRSA Treatment TW10-116 (SOP 3)**
CONSULTED WITH?	**INFECTION PREVENTION AND CONTROL**

Date(s) previous version(s) approved:	**Version:** **1** **2** **3** **4** **5** **6** **6.1** **6.2** **6.3** **7** **7.1**	**Date :** **March 2009** **June 2009** **June 2010** **Nov 2010** **July 2011** **May 2013** **March 2014** **July 2014** **November 2015** **May 2016** **October 2017**
NEXT REVIEW DATE:	**June 2022**	
Manager responsible for review:	**CONSULTANT MICROBIOLOGIST/ DEPUTY DIRECTOR OF INFECTION (DIPC)/ ASSISTANT DIPC**	

The WWL Way

1. INTRODUCTION

Methicillin-Resistant *Staphylococcus aureus* (MRSA) was first identified in the 1960's but continues to pose a problem to hospitals as it is resistant to antibiotics such as flucloxacillin, the standard treatment for *Staphylococcus aureus* infection. MRSA infection remains treatable but requires use of antibiotics such as vancomycin and teicoplanin. These agents are expensive, have to be given by injection and may have side effects. Resistance to these agents has also been reported. Because of these features, emphasis is placed on preventing the spread of MRSA between patients.

2. POLICY STATEMENT

This policy presents recommendations which will reduce the risk of MRSA infection in patients receiving care in Wrightington, Wigan and Leigh NHS Foundation Trust.

3. KEY PRINCIPLES

3.1. The policy requires all admissions (elective and emergency, with a small number of exclusions, see Appendix 3) to be screened for MRSA carriage immediately following emergency admission or prior to elective admission.

3.2. If MRSA carriage is detected by screening, MRSA positive inpatients are required to undergo effective decolonisation. This should be attempted before admission in elective cases. Detection of MRSA in a patient should not affect the eighteen-week pathway limit or targets in the Emergency Care Centre.

4. RESPONSIBILITIES

It is the responsibility of Chief Executive and the Trust Board to ensure that all eligible admissions are screened for MRSA carriage. It is the responsibility of all Trust employees to ensure that all patients under their care have been screened appropriately for MRSA carriage and those with a past history of MRSA colonisation are identified and dealt with in accordance with the Trust MRSA TW10-116 SOP 2.

5. SCREENING OF PATIENTS FOR MRSA CARRIAGE

5.1. Screening method: See Appendix 2 for screening method.

5.2. Pre-admission Screening (Elective Admissions)

5.2.1. All elective admissions including day cases must be screened for MRSA prior to admission unless in a category exempt from the requirement. Patient categories exempt from the screening requirements are detailed in Appendix 3.

5.2.2. Patients found to be colonised with MRSA should undergo effective decolonisation before admission. Patients remaining persistently MRSA positive (for example: remain MRSA positive following two complete courses of decolonisation therapy) or who require urgent admission should be discussed with the Infection Prevention and Control Team.

5.2.3. Patients listed for elective procedures should be screened for MRSA carriage before admission. This should be done 12 weeks (or less) in advance of the surgery. The patient should then be contacted two weeks before surgery and again on admission and asked if they have had any subsequent exposure to MRSA or had an overnight stay in a healthcare setting such as a hospital or nursing home. Patients who have ongoing exposure to MRSA (nursing home residents, health care workers, patients admitted to hospital in the interval between screening and their elective procedure) should be admitted to a side room pending the results of a further screen.

5.3. Admission Screening (Emergency Admissions)

5.3.1. All emergency admissions must be screened for MRSA carriage at admission in the inpatient area unless in a category exempt from the requirement. Patient categories exempt from screening requirements are given in Appendix 3. Screening should be performed as part of the admission procedure. The methodology is given as a flow diagram in Appendix 4.

5.3.2. Patients on the following clinical areas are at increased risk of poor outcome from MRSA infection and should be screened on admission to these units and thereafter as indicated:

5.3.2.1. ICU/HDU – Screen all patients on admission and weekly thereafter. Admit all patients transferred from another hospital or other areas of high MRSA prevalence direct to a side room pending screening results. Commence the MRSA decolonisation regime (see Appendix 5) whilst awaiting the results of the initial screen. This may be discontinued if initial screen is negative and patient does not have a past history of MRSA.

5.3.2.2. SCBU – Screen all patients on admission and weekly thereafter. Admit all patients transferred from another hospital or other areas of high MRSA prevalence to a side room pending screening results.

5.3.2.3. Aspull Ward (Emergency Orthopaedic) – Admissions (elective and trauma) to Aspull Ward at RAEI should be screened on admission. .

Note: Details of previous MRSA colonisation are given within the allergies section of the front sheet in the patient's case notes and in the patient header in HIS. Previously MRSA positive patients are also flagged on the laboratory computer system.

5.4. Patients Transferred from other Healthcare Facilities

5.4.1. All patients transferred from other healthcare facilities must be screened for MRSA carriage on arrival at Trust premises.

5.4.2. Patients in the Cancer Services Centre at RAEI should be screened for MRSA at start of treatment and monthly thereafter. If positive, the lead clinician should be informed. Further advice can be obtained from microbiology if required.

5.5. Screening for MRSA in Areas with Increased Incidence

5.5.1. MRSA colonisations are continually monitored by the Infection Prevention and Control Team. Decisions to screen patient contacts will be made by the Team following assessment based on: ward type, number of new detections, staffing levels and availability of isolation facilities.

5.5.2. Staff screening is not routinely performed. However, staff will be asked about skin lesions. Staff with skin lesions are at increased risk of MRSA colonisation and transmission. Staff with skin lesions will be referred to the Occupational Health Department for screening and management.

5.5.3. Staff screening may be instigated by the Infection Prevention and Control Team in the following circumstances:

5.5.3.1. Continued transmission in a unit despite active control measures.

5.5.3.2. Epidemiology suggestive of staff carriage.

5.6. Informing Patients of Screening Results

All patients should be informed of their MRSA screening results and given written information. For inpatients it is the responsibility of the clinician in charge of the patient to do this. For patients found to be MRSA positive who have already been discharged, the Infection Prevention and Control Team will write to the General Practitioner if the MRSA status is new and update HIS.

6. MRSA BACTERAEMIA

6.1 MRSA bacteraemia (MRSA grown from blood cultures) is reportable through the Department of Health's Mandatory Surveillance Scheme. Every episode of MRSA bacteraemia is entered onto the enhanced surveillance scheme website by a Consultant Microbiologist and verified monthly by the Chief Executive.

6.2 All episodes of MRSA bacteraemia must undergo a Post Infection Review (PIR). This is to be performed by the matron in charge of the area from which the blood culture originated, with the assistance of the Infection Prevention and Control Team. The Trust document on PIR together with the PIR data collection form are both available on the Infection

Prevention and Control website or direct from the Infection Prevention and Control Team. Clinical teams will be formally informed of MRSA bacteraemia episodes by the Infection Prevention and Control Team one working day from occurrence.

7. HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this policy and they have, where appropriate, been fully reflected in its wording.

8. INCLUSION AND DIVERSITY

The Policy has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as the author is aware, there is no impact on any protected characteristics.

9. MONITORING AND REVIEW

9.1. Compliance with the requirement to screen all eligible admissions will be monitored by monthly collection of screen numbers and numbers of eligible admissions.

9.2. Directorates are required to ensure that appropriate decolonisation of MRSA positive patients has occurred and to demonstrate this by audit.

9.3. This document will be reviewed every three years or sooner if additional guidance is published. Review is the responsibility of the Infection Prevention and Control Team and the Consultant Microbiologists.

10. ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats for example: large print, Braille and audio cd.

For more details, please contact the Human Resources Department on 01942 77 (3766) or email equalityanddiversity@wwl.nhs.uk.

APPENDIX 1

REFERENCES:

Guidelines for the Control and Prevention of Methicillin-resistant *Staphylococcus aureus* (MRSA) in Healthcare Facilities by the Joint BSAC/HIS/ICNA Working Party on MRSA. Journal of Hospital Infection, 2006; 63, Suppl: S1-S44.

Screening for Methicillin-resistant Staphylococcus aureus (MRSA) colonisation: A strategy for NHS Trusts: a summary of best practice. Department of Health, 2006 (accessed 15 May, 2007 at www.dh.gov.uk/reducingMRSA).

MRSA Screening – Operational Guidance, Gateway Reference 10234 Department of Health, 31 July, 2008.

MRSA Screening – Operational Guidance 2, Gateway Reference 11123 Department of Health, 31 December, 2008.

Screening Elective Patients for MRSA – FAQs. Version 5. Department of Health, May 2009.

Screening Emergency Admissions for MRSA – FAQ. Version 1 Department of Health, March 2010.

MRSA Screening – Operational Guidance 3, Gateway Reference 13482. Department of Health, March, 2010.

Implementation of Modified Admission MRSA Screening Guidance for NHS (2014). ARHAI. June 2014 (accessed 23 May 2019 at: https://assets.publishing.service.gov.uk).

APPENDIX 2

SCREENING METHOD FOR MRSA

1) Routine microbiology swabs should be used. (It is the responsibility of the ward/department manager to ensure all consumables including swabs are stored appropriately and kept at the right temperature.)

2) Samples should be taken under the direct supervision of a member of Trust staff to ensure correct sampling technique is used.

3) The swab should be rubbed and rotated 10 to 20 times over the area to be sampled.

4) The swab should be labelled with patient name, number, date, ward, sampling site. Swabs taken for preadmission screens for elective procedures must be appropriately labelled as being from a preadmission clinic. They must not be labelled as originating from a Ward area as this will lead to failure to identify them as preadmission screening samples.

5) The following sites should be sampled in all cases:

   - Nose.
   - Perineum or groin (send a single swab only. Do not sample both sites).
   - Umbilicus (neonates only).

6) The following should also be sampled if present:

   - Lesions/wounds.
   - Catheter urine.
   - Intravascular catheter sites.
   - Tracheostomy site.
   - Sputum if productive cough present.

Other sites will not be routinely processed by the Laboratory.

7) The samples should be sent immediately, together with a completed request form to the Pathology Laboratory Reception at RAEI.

8) The minimum interval between MRSA screens is 48 hours.

9) Three sets of negative screens are necessary for clearance. They must all include the site(s) originally found to be positive for MRSA. The patient must have discontinued any treatment for MRSA (including antibiotics active against MRSA such as teicoplanin) at least 48 hours before the screens are taken as this is likely to result in a false negative result. For this reason continuous use of decolonisation products is recommended until after the antibiotic is stopped.

10) Screening samples sent from community sources from those colonised with MRSA will only be processed if a relevant clinical indication is given for example: awaiting surgery.

APPENDIX 3

MRSA ELECTIVE SCREENING: PATIENT CATEGORIES TO BE SCREENED AND EXCLUSIONS

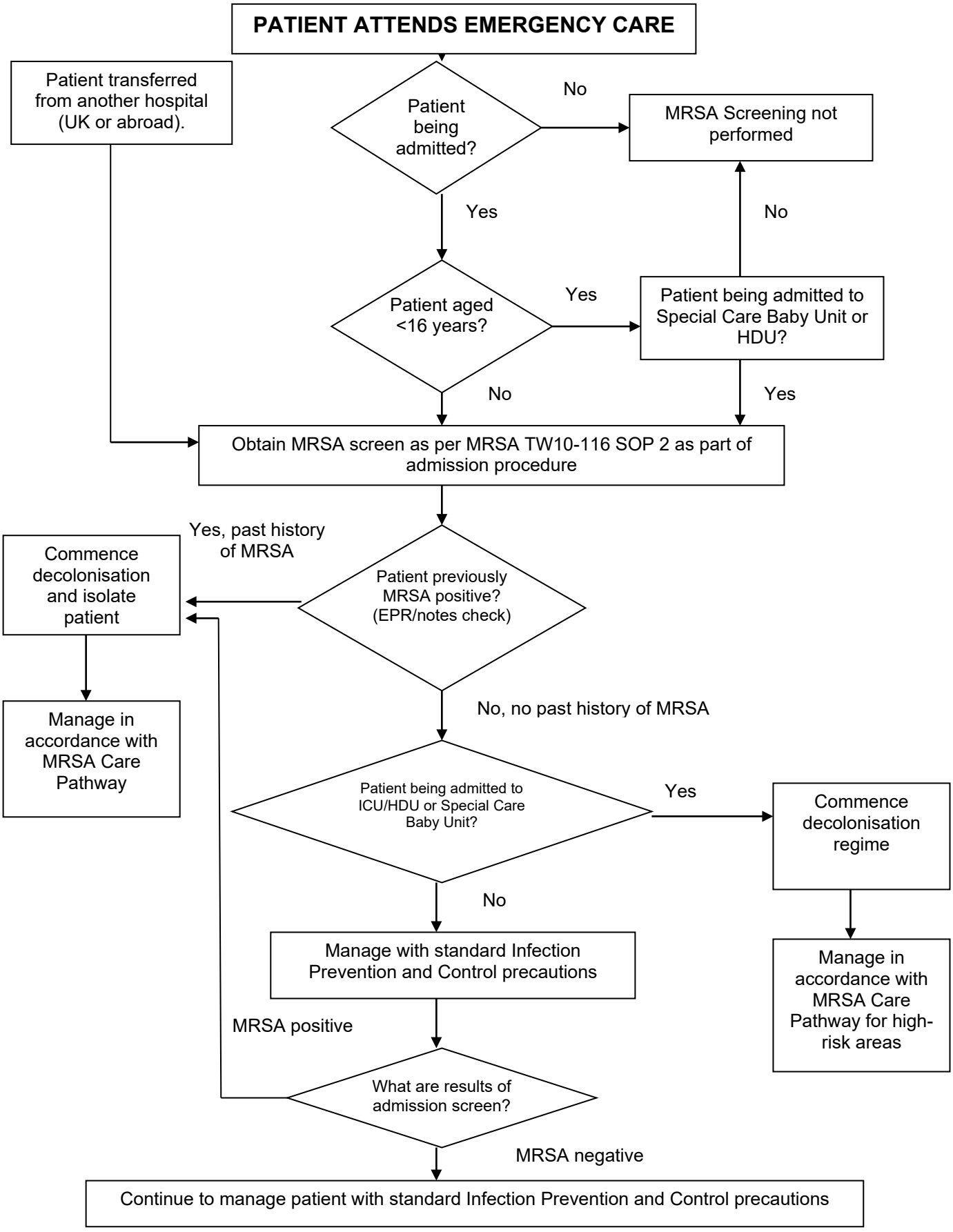
PATIENT GROUP:	PREADMISSION SCREEN TO BE TAKEN IN:	EXCLUSIONS:
Surgery, Adult Elective (including orthopaedics).	Adult Pre-op Clinic.	Day case Ophthalmology. Day case Dental. Day case Chronic Pain.
Surgery, Paediatric Elective (including orthopaedics).	NOTE: Majority are excluded from Elective MRSA screening requirements. 1. Ward. 2. ALW PCT Complex Care Team.	All patients are **excluded** apart from: 1. Past history of MRSA infection/colonisation. 2. Complex Care patients.
Rheumatology, Elective	Department/Ward admitting patient.	Joint injections.
Medical, Adult Elective.	Department/Ward admitting patient.	1. COPD Unit attendees. 2. COPD patients attending as day cases. 3. Liver biopsy day cases. 4. Dermatology day cases including minor operative procedures. 5. Day case endoscopy (all types including: Nasoscope, Bronchoscopy, Cystoscopy, Colonoscopy, OGD).
Medical, Paediatric Elective.	NOTE: Majority are excluded from Elective MRSA screening requirements. 1. Department/Ward for 'high-risk' only. 2. Bridgewater Foundation Complex Care Team.	All patients are **excluded** apart from: 1. Past history of MRSA infection/colonisation. 2. Complex Care patients. 3. 'High-risk' for MRSA for example: admitted from other hospitals,
Gynaecology, Elective.	Department/Ward admitting patient.	Termination of pregnancy.
Obstetrics, Elective.	NOTE: Majority are excluded from Elective MRSA screening requirements. Antenatal Clinic.	All elective Obstetric patients are **excluded** apart from: ▪ Undergoing elective caesarean section. ▪ High risk for MRSA carriage (for example: Health Care Workers). ▪ Baby likely to require Neonatal Unit admission.
Haematology, Elective.	Department/Ward admitting patient.	Admission solely for transfusion.
Oncology, Elective.	Department/Ward.	Nil. Screen at commencement of treatment and monthly thereafter.
Planned Investigation Unit (PIU).	Not applicable.	All PIU attendees are excluded from elective screening requirements.
Neonatal Unit.	On admission.	Nil.

MRSA EMERGENCY SCREENING: PATIENT CATEGORIES TO BE SCREENED AND EXCLUSIONS

PATIENT GROUP:	ADMISSION SCREEN TO BE TAKEN IN:	EXCLUSIONS:
Surgery, Adult Emergency (including orthopaedics).	Surgical Admissions Unit or admitting ward (Surgery). Aspull Ward or admitting ward (Orthopaedics).	Nil.
Surgery, Paediatric Emergency (including orthopaedics).	1. Admitting ward.	All patients are **excluded** apart from: 1. Past history of MRSA infection/colonisation. 2. Complex Care patients.
Rheumatology, Emergency.	Department/Ward admitting patient.	Nil.
Medical, Adult Emergency.	Medical Admissions, Clinical Decision Unit, Admitting ward/Department for example: CCU, ICU. All patients to have MRSA screening performed within 48 hours of admission.	Nil.
Medical, Paediatric Emergency.	1. Admitting ward.	All patients are **excluded** apart from: 1. Past history of MRSA infection/colonisation. 2. Complex Care patients. 3. 'High risk' for MRSA for example: admitted from other hospital.
Gynaecology, Emergency.	Department/Ward admitting patient.	Nil.
Obstetrics, Emergency.	Maternity Ward/Labour Ward.	All elective Obstetric patients are **excluded** apart from: ▪ Patients requiring emergency caesarean section. ▪ Past history of MRSA infection/colonisation. ▪ Baby likely to require Neonatal Unit admission.
Haematology, Emergency.	Department/Ward admitting patient.	Nil.
Oncology, Emergency.	Department/Ward admitting patient.	Nil.
Neonatal Unit.	On admission.	Nil.

APPENDIX 4

MRSA SCREENING OF EMERGENCY ADMISSIONS



APPENDIX 5

DECOLONISATION OF MRSA POSITIVE PATIENTS

Decolonisation method

Use of Octenisan Nasal Gel

- Apply a small amount of Octenisan Nasal Gel to the inside of both nostrils with a cotton-wool swab twice times daily for five days. Alternatively, the tip of a gloved finger may be used.
- Octenisan Nasal Gel should always be used in conjunction with antiseptic skin wash (see below).
- Do not re-sample the nose until treatment has been stopped for at least 48 hours.

Application of antiseptic skin wash

- Patients should bathe or shower daily for 5 days with antiseptic skin wash using the following method:

  - The skin should be moistened and the antiseptic skin wash applied directly to all areas before rinsing in a bath or shower. The skin wash should **not** be added to the bath water.
  - Particular attention should be paid to known carriage sites: axilla, groin and perineum.
  - The hair should be washed daily with the same antiseptic skin wash preparation.
  - The hair may subsequently be washed with conventional shampoo if desired.
  - If skin irritation develops, the Infection Prevention and Control Team should be contacted.
  - The standard antiseptic skin wash is “Octenisan” containing 0.3% octenidin hydrochloride. Alternative preparations that can be used in case of intolerance/allergy or product non-availability include:

    - 4% Chlorhexidine cleansing solution (Hibiscrub).
    - 7.5% or 10% povidone iodine skin wash (Betadine, Videne).
    - 2% triclosan skin wash (Aquasept).

- Patients who are pregnant, have abnormal thyroid function or are hypersensitive to iodine should not use skin washes containing iodine.
- Patients with eczema, dermatitis or other skin conditions are likely to require treatment for these before eradication therapy. The Dermatology Department should be consulted for advice.
- Clean clothing and bedding should be provided each day and at the end of a course of treatment.

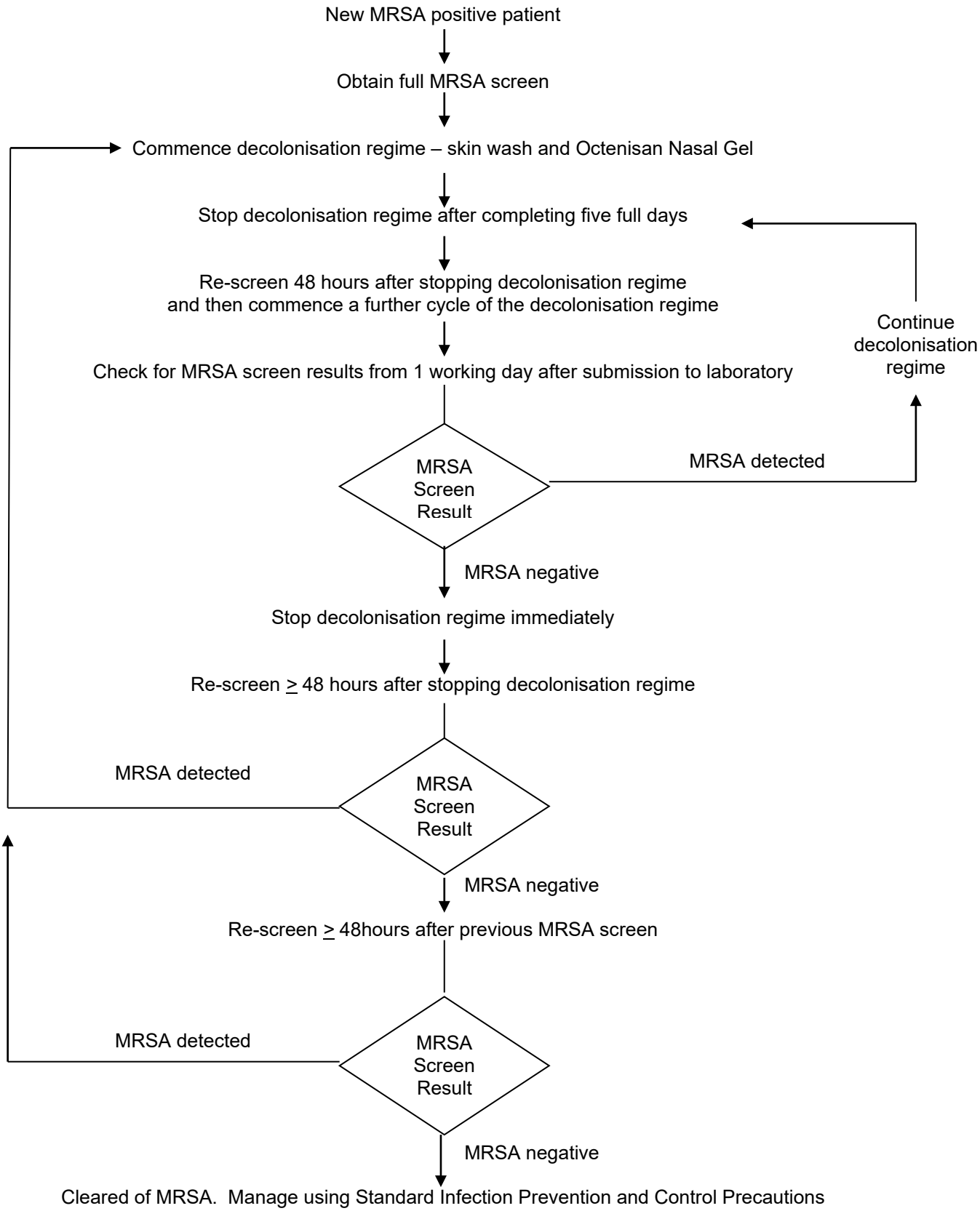
Decolonisation regime

Follow flow charts below for either:

- New MRSA positive patients [Figure 5(1)].
  Or
- Emergency admission of patients known previously to be MRSA positive [Figure 5(2)].

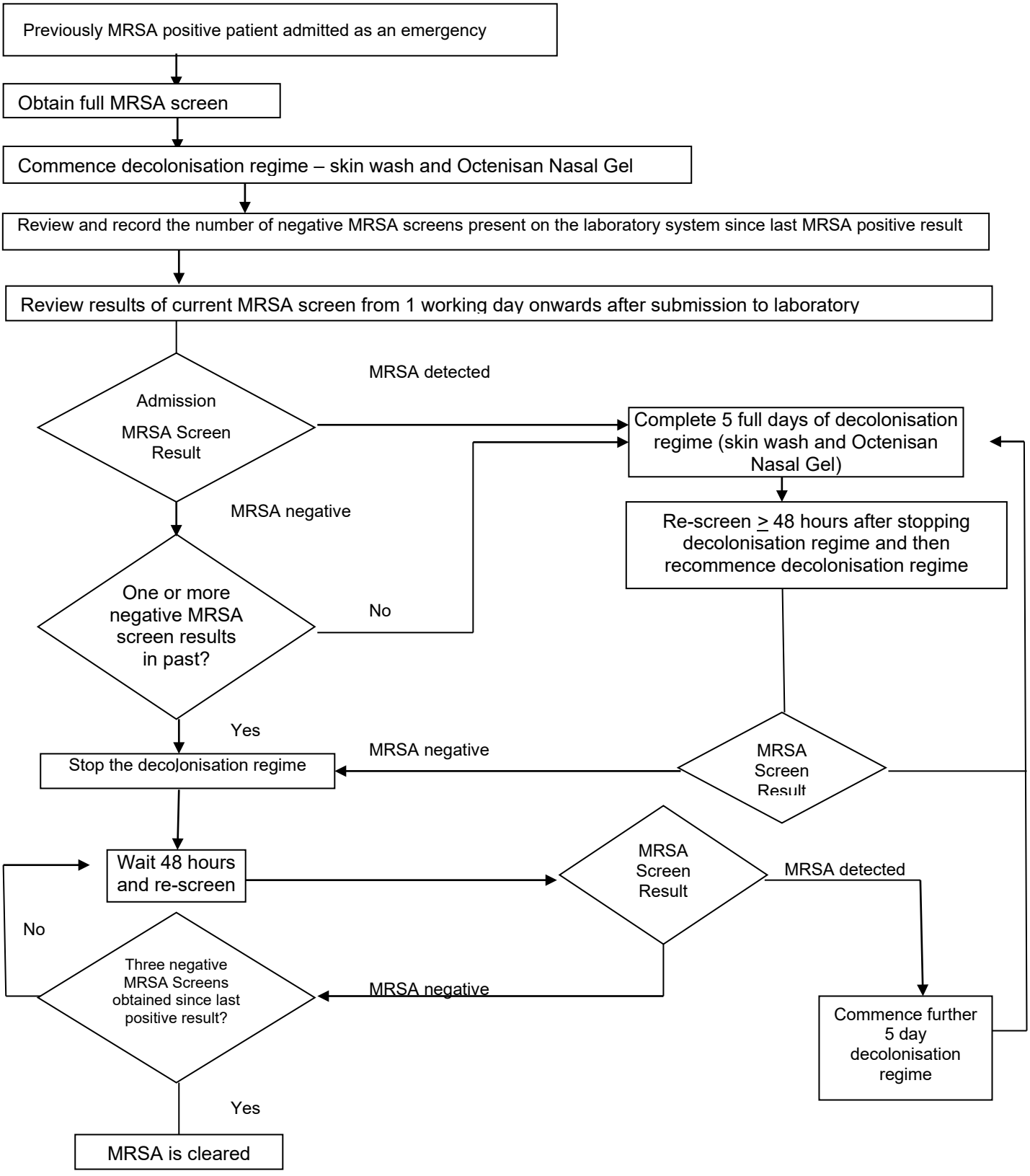
The decolonisation regime should recommence immediately after the screen is obtained. If the screening result is negative (and the patient was not on any treatment for MRSA (including antibiotics such as teicoplanin) at least 48 hours before the screens were taken, then decolonisation can stop.

APPENDIX 5 continued: FIGURE 5 (1) - SCREENING AND DECOLONISATION OF NEW MRSA POSITIVE PATIENTS



APPENDIX 5 continued

FIGURE 5 (2) - SCREENING AND DECOLONISATION OF EMERGENCY ADMISSIONS KNOWN PREVIOUSLY TO BE MRSA POSITIVE



APPENDIX 6

STANDARD OPERATING PROCEDURES (SOP)s RELATING TO THE TW10-116 MRSA SCREENING POLICY

SOP NAME	SOP NUMBER
MRSA	TW10-116 SOP 1
MRSA Bacteraemia Procedure for Investigation	TW10-116 SOP 2
MRSA Treatment	TW10-116 SOP 3

APPENDIX 7

EQUALITY IMPACT ASSESSMENT FORM

This form MUST be completed and included in all Polices. It should also be included in any SOP (Standard Operating Procedure) document that is not linked to an existing policy

STAGE 1 – INITIAL ASSESSMENT (PART 1)

Division:	Corporate Nursing		**Department:**	Infection Prevention and Control
Person(s) completing this form:	Dr Robert Nelson		**Tel No:**	01942 822943
Others involved:	Lynda Barkess-Jones Rebecca Gerrard		**Start date of this assessment:**	May 2019
Title of policy being assessed:	MRSA Screening Policy		**Policy implementation date:**	March 2009
What is the main purpose (aims / objectives) of this policy?	Inform all Healthcare workers within the Trust of the roles and duties in preventing Healthcare Associated Infections (HCAI's).			
Is the policy existing and being reviewed or a new policy? (tick the relevant box)	Existing and Being Reviewed	✓	A NEW Policy	

Will patients, carers, the public or staff be affected by this policy?	**Patients**	Yes				
	Carers	Yes				
	Public	Yes				
	Staff	Yes		**If staff, how many individuals / Which Groups of Staff are likely to be affected?**	Any group involved in an outbreak where staff screening is judged necessary.	
Have patients, carers, the public or staff been involved in the development of this policy?	**Patients**	Yes				
	Carers	Yes				
	Public	Yes				
	Staff	Yes				
If yes, who have you involved and how have they been involved:	Through staff and patient representatives on Trust Infection Prevention and Control Committee.					
What consultation method(s) did you use?	As above.					
How are any changes / amendments to the policy communicated?	Infection Prevention and Control Committee minutes, Policy Library.					

EQUALITY IMPACT ASSESSMENT TABLE (POLICIES/SOP's)

Equality Target Group	Positive Impact High Low None	Negative Impact High Low None	Reason/Comments for Positive Impact (Why it could benefit any / all of the Equality Target Groups)	Reason/ Comments for Negative Impact (Why it could disadvantage any / all of the Equality Target Groups)	Resource Implication Yes / No
Men	High	None	Detection of previously unknown MRSA carriage allows decolonisation and/or treatment to be offered to patients.		**No**
Women	High	None			**No**
Younger People (17-25) and Children	High	None			**No**
Older People (60+)	High	None			**No**
Race or Ethnicity	High	None			**No**
Learning Difficulties	High	None			**No**
Hearing Impairment	High	None			**No**
Visual Impairment	High	None			**No**
Physical Disability	High	None			**No**
Mental Health Need	High	None			**No**
Gay/Lesbian/ Bisexual	High	None			**No**
Transgender	High	None			**No**
Faith Groups (please specify)	High	None			**No**
Carers	High	None			**No**
Other Group (please specify)	Very seldom when patients do not comply with Infection Prevention and Control precautions and place other patients and/or staff at risk of HCAI.	The Trust will seek to protect other patients and/or staff from HCAI by applying its duties of care under the Infectious Diseases Act.			**No**
Applies to ALL Groups					**No**

High: There is significant evidence of a negative impact or potential for a negative impact.
Low: Likely to have a minimal impact / There is little evidence to suggest a negative impact.
None: A Policy with neither a positive nor a negative impact on any group or groups of people, compared to others.

INITIAL ASSESSMENT (PART 3)

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

No

(b) How are you going to gather this information?

N/A

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following Equality Target Groups?

Please delete as appropriate.

Age (Younger People (17-25) and Children / Older People (60+)		**No**
Gender (Men / Women)		**No**
Race		**No**
Disability (Learning Difficulties / Hearing Impairment / Visual Impairment / Physical Disability / Mental Illness)		**No**
Religion / Belief		**No**
Sexual Orientation (Gay / Lesbian / Bisexual / Transgender)		**No**
Carer		**No**
Other		**No**

Any Other Comments

Assessment Completed By Dr R Nelson Date Completed: May 2019

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

If required, the Full Equality Impact Assessment Form Template can be downloaded from either the Policy Library Intranet Page or the Equality and Diversity Intranet Page.

PLEASE RETURN COMPLETED FORMS VIA E-MAIL TO:

DEBBIE JONES, EQUALITY AND DIVERSITY PROJECT LEAD (for Service related policies) debbie.jones@wwl.nhs.uk.

EMMA WOOD, EQUALITY AND DIVERSITY PROJECT LEAD (for HR / Staffing related policies) emma.wood@wwl.nhs.uk.

APPENDIX 8

MONITORING AND REVIEW ARRANGEMENTS

NAME OF POLICY/SOP or CLINICAL GUIDELINE: MRSA Screening Policy TW10-116

Para	Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
MRSA Screening Policy TW10-116	Policy is monitored and reviewed every two years	Monitored via the Monthly Business Informatics Performance Review	Business Informatics / Consultant Microbiologist / Associate DIPC	Monthly	Infection Prevention and Control Committee / Finance and Investment Committee / Trust Board / PARC	Minutes of Infection Prevention and Control Committee meeting / Minutes of Finance and Investment Committee	Microbiology Secretary RAEI / Intranet