INFECTION CONTROL POLICIES

MANAGEMENT OF PATIENTS WITH SPECIFIC ORGANISMS

Policy for the screening of patients for Meticillin Resistant Staphylococcus Aureus (MRSA) and treatment and management of MRSA positive patients

CLASSIFICATION | Infection Prevention & Control
TRUST POLICY NUMBER | IC.7008.7
APPROVING COMMITTEE | Infection Prevention & Control Committee
RATIFYING COMMITTEE | Infection Prevention & Control Committee
DATE RATIFIED | 22 October 2015
DATE FOR REVIEW | 22 October 2018
DISTRIBUTION | All staff
RELATED POLICIES | Introduction to IPAC; hand hygiene; PPE; mandatory reporting of infections; decontamination & disinfection; safe handling & disposal of waste & sharps; management of spillages of blood and body fluid; management of outbreaks; isolation policy; management of staff with MRSA; taking blood cultures.
DIRECTOR LEAD | Jo Thomas, DIPC, Director of Nursing
AUTHOR | IPACT
EQUALITY and HUMAN RIGHTS IMPACT ANALYSIS | AC QVH 058
CONSULTATION | 
THIS DOCUMENT REPLACES | IC.7008.6

This document is available in alternative formats upon request, such as large print, electronically or community languages. In the first instance please contact Staff Experience Co-Ordinator, Human Resources / Learning and Development on 01342 414459
Executive Summary

The occurrence of invasive infection, particularly in vulnerable patients, and limited options for therapy justify continued efforts to limit the spread of MRSA. The requirement for urgent specialist care should not be compromised by control measures, and the patient’s overall needs take precedence. All patients will require a risk assessment in respect of MRSA and intervention varies according to their risk category.

Such risk assessment is detailed in section 4, followed by details on screening (who, when and how); management of MRSA positive patients, their contacts and environment; transfer and transportation of these patients, and management of those requiring surgery.

QVH adheres to the DH MRSA screening guidance. We are committed to screening both our elective and emergency admissions for MRSA and provide training to ensure that clinical staff within the Trust are aware of local screening protocols.

In addition, QVH follows national guidance that recommends monitoring the Trust’s compliance with this commitment regularly, and continually reports to the Trust Board.
<table>
<thead>
<tr>
<th>Content</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2 Scope</td>
<td>6</td>
</tr>
<tr>
<td>3 Duties</td>
<td>6</td>
</tr>
<tr>
<td>4 Risk assessment and categorisation</td>
<td>6</td>
</tr>
<tr>
<td>5 MRSA screening:</td>
<td>7</td>
</tr>
<tr>
<td>5.1 Who should be screened?</td>
<td>7</td>
</tr>
<tr>
<td>5.2 When should patients be screened?</td>
<td>8</td>
</tr>
<tr>
<td>5.3 Screening method</td>
<td>9</td>
</tr>
<tr>
<td>5.3.1 Which sites should be swabbed?</td>
<td>9</td>
</tr>
<tr>
<td>5.3.2 Procedure</td>
<td>9</td>
</tr>
<tr>
<td>5.3.3 Collection of swabs</td>
<td>9</td>
</tr>
<tr>
<td>5.3.4 Notification of results</td>
<td>9</td>
</tr>
<tr>
<td>5 Management of MRSA positive patients</td>
<td>11</td>
</tr>
<tr>
<td>6.1 Immediate actions on confirmation of positive MRSA result:</td>
<td>11</td>
</tr>
<tr>
<td>6.1.1 In patients</td>
<td>11</td>
</tr>
<tr>
<td>6.1.2 Pre-assessment patients</td>
<td>11</td>
</tr>
<tr>
<td>6.1.3 Cataract patients</td>
<td>11</td>
</tr>
<tr>
<td>6.1.4 Outliers</td>
<td>11</td>
</tr>
<tr>
<td>6.1.5 Discharged patients</td>
<td>11</td>
</tr>
<tr>
<td>6.1.6 Out patients</td>
<td>11</td>
</tr>
<tr>
<td>6.2 How the management of MRSA positive patient is recorded</td>
<td>15</td>
</tr>
<tr>
<td>6.3 Nursing methods:</td>
<td>15</td>
</tr>
<tr>
<td>6.3.1 Isolation</td>
<td>15</td>
</tr>
<tr>
<td>6.3.2 Cohort nursing</td>
<td>15</td>
</tr>
<tr>
<td>6.4 Application of standard precautions</td>
<td>15</td>
</tr>
<tr>
<td>6.4.1 Hand washing</td>
<td>15</td>
</tr>
<tr>
<td>6.4.2 Personal protective equipment</td>
<td>15</td>
</tr>
<tr>
<td>6.4.3 Equipment for patient use</td>
<td>15</td>
</tr>
<tr>
<td>6.4.4 Disposal of waste</td>
<td>15</td>
</tr>
<tr>
<td>6.4.5 Disposal of linen</td>
<td>15</td>
</tr>
<tr>
<td>6.5 Decolonisation protocol</td>
<td>17</td>
</tr>
<tr>
<td>6.6 Re-screening</td>
<td>17</td>
</tr>
<tr>
<td>6.6.1 Re-screening result positive</td>
<td>17</td>
</tr>
<tr>
<td>6.6.3 Re-screening result negative</td>
<td>17</td>
</tr>
<tr>
<td>6.7 Treatment of MRSA infections</td>
<td>18</td>
</tr>
<tr>
<td>6.7.1 Blood cultures</td>
<td>18</td>
</tr>
<tr>
<td>6.8 Cleaning regime</td>
<td>18</td>
</tr>
<tr>
<td>6.8.1 Enhanced cleaning</td>
<td>18</td>
</tr>
<tr>
<td>6.8.2 Deep cleaning</td>
<td>18</td>
</tr>
<tr>
<td>6.8.3 Day surgery and Recovery depts – enhanced cleaning</td>
<td>18</td>
</tr>
<tr>
<td>7 Management of patient contacts</td>
<td>19</td>
</tr>
<tr>
<td>8 Management of staff</td>
<td>19</td>
</tr>
<tr>
<td>9 Transportation and transfer of MRSA positive patients</td>
<td>19</td>
</tr>
<tr>
<td>9.1 Portering staff</td>
<td>19</td>
</tr>
<tr>
<td>9.2 Transfer of patients to other hospital departments</td>
<td>19</td>
</tr>
<tr>
<td>9.3 Ward transfer within the Trust</td>
<td>19</td>
</tr>
<tr>
<td>9.4 Transfer to and from other hospitals</td>
<td>19</td>
</tr>
<tr>
<td>9.5 Ambulance transportation</td>
<td>19</td>
</tr>
<tr>
<td>9.6 Discharge of positive patients from hospital</td>
<td>19</td>
</tr>
<tr>
<td>9.7 Deceased patients</td>
<td>19</td>
</tr>
<tr>
<td>9.8 Patients for Sleep Disorder Centre</td>
<td>19</td>
</tr>
<tr>
<td>10 Management of patients</td>
<td>22</td>
</tr>
<tr>
<td>10.1 Antibiotic prophylaxis for surgery in MRSA-positive patients</td>
<td>22</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>10.2</td>
<td>Management of rehab patients</td>
</tr>
<tr>
<td>10.3</td>
<td>Management of paediatric patients</td>
</tr>
<tr>
<td>10.4</td>
<td>Management of patients in the Sleep Centre</td>
</tr>
<tr>
<td>11</td>
<td>Training and awareness</td>
</tr>
<tr>
<td>12</td>
<td>Equality</td>
</tr>
<tr>
<td>13</td>
<td>Review</td>
</tr>
<tr>
<td>14</td>
<td>Monitoring and Compliance with policy</td>
</tr>
<tr>
<td>15</td>
<td>References</td>
</tr>
<tr>
<td>Appendix 1A</td>
<td>Letter to GP from PAC</td>
</tr>
<tr>
<td>Appendix 1B</td>
<td>Letter to GP – no treatment required</td>
</tr>
<tr>
<td>Appendix 1C</td>
<td>Letter to patient and GP prior to surgery</td>
</tr>
<tr>
<td>Appendix 1D</td>
<td>Letter to patient and GP from OPD</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Decolonisation protocol regime / record</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>No appendix 3 – now removed</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Patient information / instructions for use leaflet</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Day surgery procedure – list of those which DO require MRSA screening</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>MRSA pre-admission screening flow-chart</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Protocol for Post Infection Review</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>Inter-healthcare Transfer Form</td>
</tr>
<tr>
<td>Appendix 9</td>
<td>MRSA checklist</td>
</tr>
</tbody>
</table>
1. Introduction

This policy is based on the most recent national guidelines, which were produced as a report by the combined working party of the British Society for Antimicrobial Chemotherapy (BSAC), the Hospital Infection Society (HIS), the Infection Control Nurses Association (ICNA) (2006) and DH Summary of Best Practice (2007), and current recommendations Clean, Safe Care (DH, January, 2008) and the Health and Social Care Act (DH, 2012).

The occurrence of invasive infection, particularly in vulnerable patients, and limited options for therapy justify continued efforts to limit the spread of MRSA. The requirement for urgent specialist care should not be compromised by control measures, and the patient’s overall needs take precedence. All patients will require a risk assessment in respect of MRSA.

The degree of infection control intervention will vary according to the risk category into which a clinical ward/unit or patient falls (Table 1, section 4).

1.1 Who has bacteria?

It is normal for healthy people to have bacteria on their skin. One of the most common types is *Staphylococcus aureus*. One in three people have this bacterium in their noses or skin without it causing any harm. This is generally referred to as “colonisation”.

1.2 What is MRSA?

MRSA stands for “Meticillin resistant *Staphylococcus aureus*. This means that Meticillin (an antibiotic) does not work on this type of bacterium. Therefore, infections with MRSA can be harder to treat with antibiotics. However, the vast majority of patients who develop an MRSA infection are successfully treated with antibiotics. Meticillin resistance infers resistance to other beta-lactam antibiotics such as penicillins and cephalosporins.

Most people with MRSA carry it without any harm to themselves or their family (they are colonised).

Components of infection control intervention are:

- Risk assessment and categorisation
- Screening
- Management of patients with MRSA
- Management of patient contacts
- Management of staff
- Management of patient transfer and transportation
- Management of patient’s requiring surgery
- Management of patient discharge.

1.3 ICE – This is the microbiology laboratory reporting database
2. **Scope**
This policy applies to all employees of the Trust in all locations including the Non-Executive Directors, temporary employees, locums and contracted staff.

Please refer to “Introduction to Infection Prevention & Control” for more details.

[Link to Introduction] to Infection Prevention & Control

3. **Duties**
3.1 Chief Executive – has overall responsibility.
3.2 Director of Nursing & Quality / Director of Infection Prevention & Control – has overall responsibility for ensuring staff are educated and compliant when managing confirmed / suspected MRSA patients. Keep the Trust Board updated.
3.3 Infection Prevention & Control Team – has a responsibility to educate staff on the management of confirmed/suspected MRSA patients and conduct audits and make recommendations regarding patient management.
3.4 Matrons and Ward/Department Managers – have the responsibility to be conversant with this policy and ensure that their staff understand the requirements of this policy and their responsibility to comply with it.
3.5 Clinicians and nursing staff – have a responsibility to comply with the policy and report any concerns to their manager. They are also responsible for ensuring that blood cultures are taken for the correct indication and at the correct time, using the correct technique. [Link to blood culture policy]
3.6 Non-clinical staff have a responsibility to comply with the policy with guidance from clinical staff and report any concerns their manager.

4. **Risk Assessment and Categorisation**
A risk assessment is done for all patients screened at the QVH according to Department of Health requirements. Specific control measures against spread of MRSA are categorised according to:
- The risk of spread
- The risk of invasive disease.

These are dependent upon:
- The type of ward or unit
- The type of patient.

For example, high-risk areas comprise those administering intensive patient care, where patient manipulation is maximal and the risk of spread is great, and/or highly vulnerable patients who are at increased risk of invasive disease such as the very young, the elderly, the immuno-compromised and those undergoing surgical intervention.

Risk areas are divided into: Minimal risk, Low risk, Moderate risk and High risk (Table 1). However, in accordance with all nursing care procedures, continual assessment will need to be undertaken to determine whether any changes have occurred to alter the categories that have been identified, such as having plastic surgical admissions admitted onto a low risk area. The control measures to apply to each risk category...
would be determined by individual cases/circumstances and the professional advice from the Infection Prevention and Control Team.

Table 1. Risk definition by area and type of patient

<table>
<thead>
<tr>
<th>Degree of risk</th>
<th>Area/Ward</th>
<th>Type of patient (high risk no matter the area/ward)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk</td>
<td>Burns centre&lt;br&gt;Peanut&lt;br&gt;Theatres&lt;br&gt;Recovery</td>
<td>• Known to be currently MRSA positive&lt;br&gt;• Previously positive patients&lt;br&gt;• Outliers from other hospitals / in patient in last year&lt;br&gt;• Admissions from nursing/care homes</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>Margaret Duncombe&lt;br&gt;Ross Tilley</td>
<td>• Those receiving care from agencies in their homes&lt;br&gt;• Critical care patients&lt;br&gt;• Paediatric patients with long-term condition or transferred from another hospital</td>
</tr>
<tr>
<td>Low risk</td>
<td>Sleep disorder centre</td>
<td>• Patients with chronic conditions who frequently attend as emergencies&lt;br&gt;• Healthcare worker</td>
</tr>
<tr>
<td>Minimal risk</td>
<td>Outpatients Department&lt;br&gt;Radiology Department&lt;br&gt;Photographic Department</td>
<td></td>
</tr>
</tbody>
</table>

5. MRSA screening

5.1 Who should be screened?

There is good evidence and strong consensus that screening should be applied to certain groups based on the Trust’s patient population and current MRSA data (DH 2007). However, there is now a requirement following the Health & Social Care Act 2012 and DH regulations to screen a wider group.

All medical and surgical admissions, including many day surgery patients, should be screened for MRSA in line with the DH MRSA screening – operational guidance 2 (Dec 2008). In addition, from December 2010 there is also a commitment to screen all emergency/trauma admissions (DH 2010).

A full list of all day cases which must be screened are detailed at Appendix 5. The ONLY exceptions are the following groups:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Day case minor dermatology including LOPAS, eg, warts or other liquid nitrogen applications
- Children / paediatrics unless already in high risk group
- Maternity / obstetrics except for elective caesareans and high risk cases
- Mental health patients admitted to mental health facilities.

In addition, the following high risk groups must also be screened:
- All emergency admissions (excluding children unless in a high risk group)
- Critical care, eg, burns patients
- All those known to have been previously positive
- Patients currently known to be MRSA-positive
- Patients admitted from other hospitals or healthcare facilities or receiving nursing care from care agencies in their own homes
- Patients admitted who are normally resident in nursing or care homes
- Those who have been an in patient in any hospital (including QVH) within the last year
- All health care workers admitted for surgery.

5.2 When should patients be screened?

1. Prior to admission for elective surgery at pre-assessment or in out patient clinics. If an emergency or non-elective patient, or pre-assessed by telephone, screening should take place at the time of admission. This is set out in a flow-chart at Appendix 6.

2. If the patient has been screened at pre-assessment and providing their situation has not changed (eg, no hospital admissions) the negative result will be valid for up to 12 weeks.

3. However, should the patient fall into a high risk category (as listed above), they must be screened within the 4 weeks prior to admission at pre-assessment.

4. Where this is not possible due to distance of patient’s home from hospital, disability or other reason, the patient’s GP should be contacted and requested to screen.

5. Where this has not been possible Pre-assessment will highlight on the patient’s notes that the patient should be screened immediately on admission and treated as an outlier until the result is known.

6. Patients attending EBAC or out patients must be screened at their first appointment.

7. Burns elective patients can be screened at EBAC but no longer than 7 days before admission.

8. Sleep studies patients must be screened on admission (nose, groin/perineum).

9. Any elective or trauma patient who has not been screened prior to admission must be screened on admission (within 48 hours) or no more than 7 days before admission

10. Patients being admitted from A&E at another health care provider need to be screened on admission; however, if they have been in A&E for less than 24 hours they do not need to be isolated.
11. Patients on weekend / day leave from any ward do not need re-screening on their return unless it is part of their treatment.

12. If the patient is readmitted to hospital they require an MRSA screen on every admission.

13. Patients who remain in-patients for longer than a week require re-screening every four weeks unless they were previously positive and are currently following the skin decontamination protocol. However, if the patient is being treated for burns, in addition to their regular wound swabs a nasal MRSA screen swab must be sent on a weekly basis, and this documented.

14. Screening is the responsibility of the staff member admitting the patient or conducting pre-assessment clinics and they must document in the notes that the screen has been taken.

15. Those patients screened more than 12 weeks before admission will also require re-screening, either at QVH or via their GP.

16. All clinical departments screening patients must enter the date of the screen on the Trust’s Patient Centre System. It is the responsibility of the nurse in charge to check on a daily basis that this has been done.

17. Where patients attending out patient clinics are identified for surgery they should be screened (including wound swabs) at that time. This also applies to patients seen in spoke clinics when swabs should be taken as per local policy with QVH staff following up the result.

5.3 Screening method

Swabs are processed individually and are reported separately. A microbiology laboratory report will be issued stating either ‘MRSA detected” or ‘MRSA not detected”.

5.3.1 Which sites should be swabbed?

Swabs should be obtained from the following sites:

- Both anterior nares (nostrils) one swab
- Perineum / Groin (both sides) one swab
- All Skin lesions such as eczema, paronychia, psoriasis and wounds if present
- All Manipulated sites if in situ such as:
  - Urinary catheter - catheter specimen of urine (CSU)
  - CVC/PVC line insertion site
  - Tracheostomy/PEG stoma

  One swab per site
- Sputum if productive cough present.
5.3.2 Procedure

- Explain the procedure to the patient, ensure all equipment is assembled and hands of healthcare workers are decontaminated to prevent contamination.

- A **BLACK** capped swab must be used for MRSA screening

- Prior to taking the MRSA screen the swab tip must be moistened in sterile normal saline if swabbing a dry site such as nose/perineum/groin, but not for wet wounds.

- Use the **GREEN** BSUH microbiology form ensuring all patient details are completed.

5.3.3 Collection of swabs

<table>
<thead>
<tr>
<th>Collection Time</th>
<th>1. Collection Points</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>07:30</td>
<td>Switchboard, AWT, Histopathology, Burns, Pre-assessment.</td>
<td>BSUH</td>
</tr>
<tr>
<td>09:30</td>
<td>Switchboard, AWT, Histopathology, Burns, Pre-assessment.</td>
<td>BSUH</td>
</tr>
<tr>
<td>12:00</td>
<td>Switchboard, AWT, Histopathology, Burns, Pre-assessment.</td>
<td>BSUH</td>
</tr>
<tr>
<td>14:50</td>
<td>Switchboard, AWT, Histopathology, Burns, Pre-assessment.</td>
<td>BSUH</td>
</tr>
<tr>
<td>16:30</td>
<td>Switchboard, AWT, Histopathology, Burns, Pre-assessment.</td>
<td>BSUH</td>
</tr>
<tr>
<td>18:00</td>
<td>Switchboard</td>
<td>BSUH</td>
</tr>
<tr>
<td>23:30</td>
<td>Switchboard</td>
<td>Medical Moves</td>
</tr>
</tbody>
</table>

All Bloods sent outside these times must only be due to exceptional urgent requests. These must be authorised by a Site Practitioner.

---

<table>
<thead>
<tr>
<th>Collection Time</th>
<th>Collection Points</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>07:30</td>
<td>Switchboard</td>
<td>Medical Moves</td>
</tr>
<tr>
<td>10:00</td>
<td>Burns, Switchboard</td>
<td>BSUH</td>
</tr>
<tr>
<td>18:00</td>
<td>Switchboard</td>
<td>Medical Moves</td>
</tr>
<tr>
<td>23:30</td>
<td>Switchboard</td>
<td>Medical Moves</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collection Time</th>
<th>Collection Points</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>07:30</td>
<td>Switchboard</td>
<td>Medical Moves</td>
</tr>
<tr>
<td>10:00</td>
<td>Burns, Switchboard</td>
<td>BSUH</td>
</tr>
<tr>
<td>18:00</td>
<td>Switchboard</td>
<td>BSUH</td>
</tr>
<tr>
<td>23:30</td>
<td>Switchboard</td>
<td>Medical Moves</td>
</tr>
</tbody>
</table>

All Bloods sent outside these times must only be due to exceptional urgent requests. These must be authorised by a Site Practitioner.
5.3.4 Notification of screening results

The processing of these swabs can take up to 3 days as it is dependent on the laboratory culture conditions and the nature of the patient and their condition.

The screening specimen report will be communicated to appropriate staff (theatres, consultant etc) by the nurse caring for the patient by them accessing the electronic laboratory result system (ICE) directly. The IPACT will also notify the department with a positive result by telephone to ensure they are informed. This must be communicated within 72 hours (preferably on the day of result confirmation) after result confirmation. This will include urgent telephone communication in selected cases.

6. Management of MRSA positive patients

Persons with MRSA may be colonised or infected:

Colonisation:
Occurs when a micro-organism establishes itself in a particular environment such as a body surface or wound without producing disease.

Infection:
Occurs when entry of a pathogen into the body and its multiplication in the tissues leads to symptoms such as pyrexia and septicaemia, skin and soft tissue infections (Ayliffe 2000)

A positive screen defines the patient as an MRSA positive case.

6.1 Immediate actions on confirmation of positive MRSA result

Cancellation of surgical or interventional procedures

Any decision to cancel a surgical or interventional procedure because of the MRSA status will be at the discretion of senior members of the clinical team responsible for the patient’s care. The decision to delay surgery must be clearly documented in the patient’s notes.

- The IPACT will add the patient’s positive result to PAS and keep a record of patients who are found to be positive.

6.1.1 In Patients

On receiving confirmation of a positive MRSA result the following actions should be taken:-

- Nursing staff/clinician responsible for patient care to inform patient and provide patient with MRSA information leaflet once aware of result (see 5.34).
- Place patient in isolation or cohort with other positive patients (discuss cohorting with IPACT first)
- Document result in nursing notes (date, time from where/whom result received).
- Relevant clinical staff will be informed in a timely manner by the nurse caring for the patient.
- Ensure microbiology reports are included in the patient's notes.
- Commence skin decontamination protocol as advised by IPACT.
- Complete MRSA checklist (appendix 9)
- The patient's GP must be informed on discharge.
- If for surgery, patient to be last on the theatre list, providing there are no medical reasons to be done first (e.g., diabetic) and recovery informed.
- If the patient is for outpatient or therapy appointments, where possible they must be seen last on the list and full infection control precautions implemented (see section 6.1.6).

Any deviation from the above should be discussed with a member of IPACT beforehand.

Patients on the end of life care pathway must still receive eradication protocol to protect other patients unless this significantly affects the care of the patient on the pathway. Any decision to discontinue treatment must be discussed with IPACT and documented in the patient's medical notes.

6.1.2 Pre-Assessment Patients

MRSA status will be recorded on the patient centre by the IPACT. Letters are sent to the patient and the patient's GP (Appendix 1A, & 4) by the appropriate pre-assessment clinic once aware of result (see section 5.3.4), informing them of the positive MRSA status and outlining the required treatment.

On admission MRSA positive patients should be isolated and rescreened and the procedure as for in-patients followed. It is the responsibility of the pre-assessment nurse to ensure all precautions are implemented and the relevant departments, including the consultants, are informed.

For those patients attending QVH for day surgery it is the responsibility of the pre-assessment nurse to ensure the day surgery department are informed of either the positive or the unknown status and asked to follow up the result on the day of admission, this must be clearly documented on the front of the patient’s notes. In addition if the patient is not able to attend QVH pre-assessment or their GP surgery for a MRSA screen, the pre-assessment nurse must clearly mark on the front of the patient’s notes that a screen is required and the patient is treated as an outlier. The pre-assessment nurse must ensure all relevant departments are informed prior to admission. The day surgery nurse must also document that the MRSA screen has been taken on Patient Centre.

If the result is positive the patient should be isolated and re-screened and the procedure as for the in-patients followed. It is the responsibility of the day surgery staff, if the patient has not yet had their surgery, to inform the patient and GP and request treatment. (Appendix 1A, and 4.)
6.1.3 Cataract patients

If they are to be an in-patient, patients should be screened at pre-assessment and, if necessary, treated the week before admission with the 5 day decolonisation protocol. The GP and patient must be informed by letter once aware of result (see section 5.3.4) by the corneo pre-assessment nurse (appendix 1A and 4). They should then be re-screened on admission and a further two screens carried out by the patient’s GP surgery (or at QVH if this site is closer for the patient, which the corneo plastic department will have to arrange).

If the result of the re-screen taken on admission at QVH returns positive, a second cycle of treatment should be arranged and, if the patient remains positive thereafter, IPACT should be contacted.

Patients should be isolated on admission and the usual Trust protocol implemented.

However, if the patient remains positive after their first cycle of treatment and has been discharged back into the community setting, they need no further screening regardless of the result, unless they are being admitted for further treatment, at which stage re-screening should be conducted prior to admission as part of the pre-admission procedure.

All treatment should be documented on the electronic discharge note.

If cataract surgery is to be done as a day surgery procedure, no screening is required.

6.1.4 Outliers

Outliers need not be isolated on admission providing the admitting consultant has seen DOCUMENTED evidence of a negative MRSA screen obtained within the last seven days prior to transfer to the QVH (including all sites as specified in the QVH policy). This must be documented in the patient’s notes and an inter-healthcare verbal screening tool completed.

Outliers should be re-screened on admission to the QVH. If results return positive, patients should be treated as inpatients would be treated.

6.1.5 Discharged patients

On receiving confirmation of a positive MRSA result after the patient has been discharged, the following actions should be taken:

- Result to be recorded on PAS by IPACT
- IPACT to send a letter to the patient and GP informing them of the positive MRSA status (Appendix 1B).
- IPACT to notify the patient’s consultant via their secretary.
- If the patient is re-admitted in the future, the patient should be screened prior to admission and, where this is not possible, treated as positive, isolated and re-screened on admission.
- If the microbiologist or another care facility contact the ward out of hours with a positive result, it is the responsibility of the member of staff taking the result
to ensure the result is followed up by contacting the patient and their GP. If this is not successful, the result must be reported to the lead clinician and nurse in charge, and IPACT notified.

6.1.6 Out Patients

On receiving confirmation of a positive MRSA result, the following actions should be taken:

- IPACT will send a letter to the patient, GP and consultant advising them of the result and, if necessary, what treatment is needed.
- IPACT will inform out patient staff via email, who must document in nursing notes (date, time, from where/whom result received) and inform relevant clinical staff, in order to ensure IPAC precautions are in place when the patient is in the department.
- If the patient is to return to QVH for regular dressing changes / appointments (eg twice a week or more), it is the responsibility of the outpatient nurse to get the skin decontamination protocol prescribed at QVH at the patient’s next appointment.
- If the patient is to return to QVH for surgery commence skin decontamination protocol. It is the responsibility of the out patient nurse to get this prescribed at QVH.
- When the patient is attending the out patient clinic, they should where possible be seen last on the list and should not be sat in the waiting area but shown directly into the treatment room. Full infection control precautions must be implemented.
- If the patient is not for surgery or having regular appointments at QVH, no treatment is required.
- If the patient is MRSA positive in their wound and an out patient appointment is not arranged within the next two days, IPACT will ask the GP to review all wounds.
- Should the wound appear infected, the GPs practice nurse or staff at the QVH (if the patient has been seen there), must contact the consultant microbiologist for advice on antibiotics and commence the decontamination protocol.
- Any deviation from the above must be discussed with a member of IPACT beforehand.

High risk patients who require MRSA screening for a local anaesthetic procedure must have their MRSA screen taken in out-patients; however it is the responsibility of the Day Surgery Unit (DSU) staff to ensure the GP and patient are informed (Appendix 1A, 3, 4) once aware of a positive result (see section 5.3.4). Those confirmed positive will require the decontamination protocol prior to surgery, and those confirmed positive after surgery will require an assessment by the DSU staff and IPACT to ascertain if this is still required. Depending on the outcome the patient will either require decolonisation or not. If decolonisation protocol is not required (Appendix 1B) should be sent.

Management of previously positive patients

If the patient was previously positive more than 12 months ago and has had a negative screen subsequently (one or more), they do not require isolation. However, if the
patient was positive within the last 12 months, the patient must be treated as positive until three negative screens have been received.

6.2 How the management of MRSA positive patients is recorded
All screening tests performed and results are recorded in the patient’s health record and results for positive patients recorded on the PAS system. Actions taken by the clinicians are also documented within the patient’s health record.

6.3 Nursing Methods
It is the responsibility of the nursing staff, in conjunction with site management, to ensure timely isolation and barrier nursing precautions are implemented.

6.3.1 Isolation

The need for isolation will depend on the degree of risk of the patient and/or risk definition of the ward/area where they will be cared for (Table 1).

Isolation is NECESSARY for patients CURRENTLY known to be MRSA positive. However, patients with infected or suppurating wounds, infective diarrhoea or other infectious conditions may be given isolation priority over MRSA nasal or skin colonised patients.

Where possible every attempt should be made to nurse MRSA positive patients in a single room. The patient must be informed of the reason for the barrier nursing precautions by the nurse in charge of the shift.

Patients who are in isolation will receive the same level of care as those who are nursed in the ward.

6.3.2 Cohort nursing

Where several MRSA positive patients are known to exist they may be cohorted in a bay. This should be at one end of the ward so as to reduce general traffic through the isolation area and must be agreed by the Consultant Microbiologist.

6.4 Application of Standard Precautions

6.4.1 Hand washing

Hand decontamination following a six point technique with soap and water is recommended for use by all ward personnel and visitors following ALL direct contact with a patient, prior to contact with other patients, when entering/leaving an isolation room and following the removal of gloves. Where soap and water are unavailable or impracticable, then if hands are not visibly soiled alcohol gel could be used as an alternative. All staff caring for patients must be bare below the elbows.

6.4.2 Personal Protective Equipment (PPE)

Plastic aprons
Plastic aprons should be used for procedures that involve direct patient care and for bed making; they should be discarded after single use at the bedside. The use of aprons
acts as a visual reminder that the wearer is working in an isolation area and should therefore not be worn when on the general ward (unless in a cohorted bay).

*Covers such as disposable jackets and coats / fleeces should be left outside the room.*

*Disposable gloves*
Disposable gloves should be used for any procedure that involves direct contact with colonised or infected patients, particularly when in contact with body fluids. Gloves are single use only, and must be discarded after each patient contact. Gloves should be disposed of in the orange clinical waste bin by the patient's bed and hands should be decontaminated immediately with soap and water. Where soap and water are not available / impractical, then if hands are not visibly soiled alcohol gel could be used as an alternative.

*Visitors in Hospital*
All visitors in hospital should clean their hands with alcohol rub every time they enter and leave the ward. This should be the case whether the person they are visiting has MRSA or not. If the patient they are visiting is MRSA positive they do not need to wear PPE (gloves and aprons) – hand hygiene is sufficient, unless they are visiting another patient afterwards or carrying out personal care on the patient. If the patient is suspected of having C.diff, only wash hands with soap and water, do not use alcohol gel. Visitors should not handle any patient’s wounds / lines, etc, nor sit on patients beds.

*PPE in Burns* – please refer to the unit dress code policy.

6.4.3 Equipment for patient use

Where possible equipment used for isolated patients should remain in their room until isolation is no longer required at which time it should be decontaminated appropriately. Equipment that is unavoidably needed for another patient should be decontaminated with Chlorclean or according to the manufacturer’s instructions. Articles that cannot be decontaminated such as magazines or library books must be discarded. It is recommended that where possible single use equipment is used for isolated patients e.g. blood pressure cuffs – refer to the Decontamination & Disinfection Policy for more detail.

6.4.4 Disposal of waste

All clinical and household waste generated from infected or colonised patients should be segregated as per waste policy guidelines.

6.4.5 Disposal of linen

All linen should be treated as ‘infected’ and placed in a white plastic bag, which must be secured tightly before it leaves the room. Just outside the room, place this bag into another white plastic bag (double bag), which again must be secured tightly with a hospital identification tag.
6.5 Decolonisation protocol (Appendix 2)

The purpose of decolonisation is to reduce the risk of:

- The patient developing an MRSA infection with their own MRSA during medical/surgical treatment
- Transmission of MRSA to other patients

The decolonisation protocol consists of a **five day course** of a body and hair wash and a nasal preparation.

**Daily change of bedlinen.**

Decontamination **MUST** be documented on the appropriate form (Appendix 2).

After five days discontinue the decontamination protocol. During the following 48 hour rest period the patient should remain isolated but may use their own toiletries. Following the rest period the patient should be re-screened. The decontamination protocol should not be repeated until the results of the re-screen are known.

Advice on MRSA decolonisation should be sought from IPACT if the patient has burns or skin conditions.

If the organism is resistant to the current decolonisation agents, different agents may be recommended.

6.6 Re-screening

If the patient is an in patient, MRSA screens are taken weekly until three consecutive negative screens have been obtained from all positive sites.

6.6.1 Re-screening result positive

A positive result indicates that colonisation is ongoing and the decontamination protocol should be repeated for in patients.

If colonisation is still ongoing after two cycles of the decontamination protocol or recurs at a later date the IPACT should be consulted before any further decolonisation treatment is administered.

Patients who have been discharged back into a community setting need no further screening regardless of result unless they are being readmitted for further treatment when rescreening should be conducted prior to admission as part of the pre-admission procedure (see 3.2)

6.6.2 Re-screen results negative

A negative result indicates that colonisation is not ongoing and decontamination will not need to be repeated although basic infection control measures should continue.
6.7 Treatment of MRSA infections

MRSA most commonly colonises a patient rather than causing active infection therefore rarely requiring systemic antibiotic therapy.

In cases where clinical signs of infection or sepsis are evident, specific antibiotic therapy against MRSA is justified. See Antimicrobial Guidelines. However, it should be borne in mind that MRSA is always resistant to penicillins and other β-lactams, and almost always resistant to macrolides and quinolones, therefore it is important that the use of these agents in MRSA positive patients is strictly appropriate and only commenced after discussion with a Consultant Microbiologist.

6.7.1 Blood Cultures
Where MRSA bacteraemia is suspected ensure any blood cultures that are taken are done so in accordance with the blood culture policy (no 14). If the blood culture result returns blood culture positive, the MRSA bacteraemia must be reported as a serious untoward incident via the Patient Safety Manager. The protocol for Post Infection Review at Appendix 7 must be followed. LINK to blood culture policy

Following the PIR investigation meeting, the Trust may decide to follow the appeals procedure for apportioning of MRSA bacteraemias. This process will be instigated by the IPACT and sent by the DIPC.

6.8 Cleaning regime

In out patient / pre assessment settings a thorough clean with chlorclean is sufficient; there is no need to use the Sentinel machine.

In in-patient / ward areas:

6.8.1 Enhanced cleaning
Enhanced cleaning (increased frequency) is recommended for side rooms or bays where MRSA patients are resident. Chlorclean should be the cleaning solution of choice and cleaning equipment should be kept separate from general cleaning equipment and decontaminated in accordance with the Domestic Services procedures.

6.8.2 Deep cleaning
Deep cleaning is required when an MRSA positive patient vacates a side room, treatment room or designated bay area. The Nurse in Charge has responsibility for contacting the Domestic Supervisor to request deep cleaning in these situations. Deep cleaning will include a thorough clean of the room with soap and water and all equipment followed by decontamination with the Sentinel / hissing side system (side rooms only) and curtains changed according to policy in Recovery (6.8.3). In bay areas, Chlorclean must be used followed by the curtains being changed. In Burns, Chlorclean and Sentinel.

Sentinel cannot be used in main theatres or kitchens – these to be cleaned with Tristel / Chlorclean.
Refer to the Decontamination & Disinfection policy section 6.4 for more details on guidelines on cleaning a room after an infected patient, and ensure the cleaning checklist for nursing and domestic staff following the discharge of an infected patient is completed.

6.8.3 Day Surgery and Recovery departments – enhanced cleaning
Enhanced cleaning is recommended for the MRSA positive / outlier patient’s bed space. Tristel/Chlorclean should be used and the cleaning equipment should be kept separate from general cleaning equipment and decontaminated in accordance with the Domestic Services procedures.

The Sentinel machine is unable to be used due to the open areas; however, the nurse in charge has a responsibility to ensure a thorough clean has been undertaken and that the curtains are changed if they are visibly soiled or if the patient has been resident for over three hours in the department.

7. Management of patient contacts

Screening is not routinely necessary, unless transfer to a higher risk area is anticipated. Screening may be advised by the IPACT in the event of an outbreak on the basis that circumstantial evidence of spread is deemed to have occurred.

Circumstantial evidence of spread is defined as the detection of the same strain of MRSA in two or more previously un-colonised patients, who are under the same nursing or clinical team, or in adjacent beds, and who are not known to have been recently transferred from another hospital, or an MRSA-affected ward or nursing home.

8. Management of staff

Please see separate policy – “Management of Staff with MRSA”.

9. Transportation and transfer of MRSA positive patients

9.1 Portering staff

Prior to leaving the clinical area, lesions of MRSA positive patients should be covered with impermeable dressings. Portering staff should apply standard precautions (see section 6.4.2 above) when entering a side-room or offering “hands-on” assistance to an MRSA positive patient and should be especially vigilant with hand hygiene. There is no requirement to wear PPE during the transfer.

Surfaces of trolleys and wheelchairs, which have been in direct contact with an MRSA-positive patient, should be decontaminated after use with Chlorclean.

9.2 Transfer of patients to other hospital departments

MRSA is not a contra-indication to investigation, treatment and specialist review, however, visits to out-patients and diagnostic departments, such as for X-rays, endoscopy, echocardiography, should be kept to a necessary minimum, and alternative arrangements made where possible.
General points:-

- Staff of the receiving department must be informed if a patient is MRSA positive, so that appropriate precautions can be implemented.
- Where possible MRSA positive patients should be dealt with at the end of the working session. The patient should spend the minimum amount of time in the department, being sent for when the department is ready, and not left in a waiting area with other patients.
- Staff and equipment coming into close contact with the patient should be kept to a minimum. Equipment that has been used should be decontaminated, ideally with chlorclean.
- When transferring patients there is NO need to wear aprons/gloves during the transfer. Standard precautions should apply (once in theatres/x-ray/OPD) if there is to be direct contact with the patient.

9.3 Ward transfer within the Trust

Transfer of MRSA positive patients to other wards should be kept to a necessary minimum, and should involve discussion with the IPACT. All personnel involved with the transfer should be informed of the patients MRSA status. Following transfer, the vacated side-room should undergo deep cleaning.

9.4 Transfer to and from other hospitals

MRSA should not be a contra-indication to transfer to or from another hospital for necessary specialist care. Some centres require that MRSA positive patients be cleared before transfer. If decolonisation has proved ineffective alternative means of decolonisation should be discussed with the IPACT.

MRSA screening prior to transfer is not necessary unless specifically requested by the receiving hospital. It is the responsibility of the nursing and clinical teams to liaise with their counter-parts at the receiving hospital to inform them of the MRSA status of the patient.

All transferred patients should be screened on admission and where possible isolated until proven negative.

All trauma patients must be MRSA screened on admission. In addition, those patients that fall into a high risk category must be treated as an outlier. Doctors must also consider appropriate antibiotic prophylaxis (see section 10.1) if the patient is to undergo surgery.

Vacated rooms should undergo deep cleaning following transfer.

9.5 Ambulance transportation

There is no evidence that ambulance staff or their families are put at risk by transporting MRSA positive patients. Lesions of MRSA positive patients should be covered with impermeable dressings. The ambulance service should be notified in advance by the nursing or clinical team responsible for the patient so that appropriate standard
precautions can be applied. Patients requiring “hands-on” care during transportation should be transported alone or with other MRSA positive patients.

9.6 Discharge of positive patients from hospital

MRSA positive patients should be discharged promptly when their clinical condition allows. The clinical team responsible for the patient should inform the patient’s GP, and the MRSA status documented in the discharge letter.

The psychological well being of each patient must be considered and the nature of MRSA infection/colonisation and the relevant practices and procedures explained to the patient and relatives. Patient information leaflets are available on the intranet or from PALS. The infection control nurses are happy to come and answer any questions patients/relatives may have regarding their MRSA status.

MRSA is not a contraindication to discharge to a convalescent or nursing home and patients should not be denied admission (DH, 1996). If a patient is due to be discharged to either of the aforementioned, the ward nursing/clinical staff have responsibility for informing the receiving staff of the patient’s MRSA status. This should also be documented on the patient’s transfer letter and in the nursing notes. However, if decolonisation has been commenced it is advisable to complete the five-day protocol; this information must also be communicated in the transfer letter.

Following discharge the vacated room must be deep cleaned.

9.7 Deceased patients

Precautions taken during last offices of deceased MRSA positive patients should be the same as during life therefore all standard precautions should apply and the policy for last offices followed. Plastic body bags are not necessary. However, should there be a risk of exposure to blood or bodily fluids one must be used. Lesions should be covered with impermeable dressings.

Following transfer the vacated room should undergo deep cleaning.

The mortuary attendant, undertaker and any portering staff involved in transferring the deceased patient must be informed of the deceased MRSA positive status.

10. Management of patients

10.1 Surgical Patients

MRSA is not a contra-indication to emergency or elective surgery. The following principles should be applied:-

- Where possible, the patient should be placed last on an operation list.
- When calling the ward for your patient, please request the MRSA status of the patient.
 Prior to transfer to theatre the patient should be washed using the recommended skin cleanser and have the recommended nasal treatment applied to both nostrils.

Lesions, other than at the operation site, should be covered with impermeable dressings.

Patients being transferred to theatres should do so in clean sheets and on a clean bed.

Please advise the recovery staff of any MRSA patients as soon as it is known so that they can plan the patient’s care and recover them in the isolation bay.

Please advise the anaesthetist / ODP of the MRSA status of the patient as additional or alternative antibiotic prophylaxis may be required.

Remove all unnecessary equipment from the theatre, the anaesthetic room and the recovery area to facilitate rapid environmental cleaning time. All surfaces will require cleaning with a chlorine-releasing agent such as Tristel or Chlorclean.

Strict application of standard precautions must be observed at all times.

Where possible MRSA positive patients should be recovered in an area of the recovery department that is not occupied by non-colonised patients.

If the MRSA patient had large open wounds / heavy exudate / known skin shedding, it may be advised that they be recovered away from other patients with uncovered wounds / vascular access. In this instance, it would be prudent to recover them in theatres.

Where possible theatre/recovery staff in direct contact with recovering MRSA positive patients should avoid direct contact with other patients during this period.

Theatres used for MRSA positive patients must undergo deep cleaning before being used again.

Refer to the relevant antibiotic surgical prophylaxis guidelines for guidance on which antibiotic to use (see link to Antimicrobial Policy section 6.7).

10.2 Management of MRSA positive Rehabilitation patients

MRSA positive patients who have all wounds covered can go to general public areas such as the Trust restaurants and AWT stair case. However if the patient is being cared for as an in-patient they can go into the communal areas listed above but not communal areas within the wards such as the day room and the Burns gym. If the patient requires a gym environment they must go to the Rehabilitation Unit and the room/area deep cleaned as per policy following their visit.
If the patient requires a kitchen assessment, the kitchen must be clear of all excess equipment, the equipment to be used already out and readily available. The room should be thoroughly chlorcleaned afterwards.

Patients using the kitchen or gym must do so at the end of the day. Staff must wear PPE as per policy.

10.3 Management of paediatric patients

Paediatric patients who fall within the high risk category must be screened for MRSA.

On receiving confirmation of a positive MRSA result the following actions should be taken:

- Nursing staff/clinician responsible for patient care to inform patient and provide patient and/or carer with MRSA information leaflet once aware of result (see 5.34)
- Place patient in isolation
- Document result in nursing notes (date, time from where/whom result received).
- Relevant clinical staff will be informed in a timely manner.
- Discuss with IPACT if MRSA protocol required.
- Ensure microbiology reports are included in the patient’s notes.
- Commence skin decontamination protocol if applicable.
- Complete MRSA checklist (appendix 9).
- The patient’s GP must be informed on discharge.
- If for surgery, patient to be last on the theatre list, providing there are no medical reasons to be done first (eg, diabetic) and recovery informed.
- If the patient is for out patient or therapy appointments, where possible they must be seen last on the list and full infection control precautions implemented (see section 6.1.6).

Steps 6.3, 6.4, 6.8, 9.0-9.7, 10.1 and 10.2 within the policy must also be followed.

If the patient is being seen as an outpatient, PAU staff will be informed of the result by IPACT and asked to review the patient. During the appointment the patient should be taken straight into the treatment room and the above points followed. Best practice is to see the patient last.

10.4 Management of patients in the Sleep Disorder Centre

In-patients must be screened on admission (nose and groin/perineum). Screening is the responsibility of the staff member admitting the patient and they must document in the patient's notes that the screen has been taken.

The staff member must enter the date of screening on the Trust Patient Centre system. It is the responsibility of the staff member in charge to check on a daily basis that this has been done.
Patient nursed in a single room – room cleaned as normal if not identified as high risk category. In these cases, the patient must be nursed in a room with en suite facilities and the room cleaned as per instructions in section 6.8.

Day case patients do not require MRSA screening unless they are going to be admitted.

11. **Training and Awareness**

11.1 This policy will be uploaded onto the Trust intranet.

11.2 Ward / department managers will ensure that staff in their area are aware of the policy.

11.3 Everyone must attend an annual mandatory training session on infection control.

11.4 Individual department training delivered as required.

12. **Equality**

This policy and protocol will be equality impact analysed in accordance with the Trust Procedural Documents Policy, the results of which are published on our public website and monitored by the Equality and Diversity team.

13. **Review**

This policy will be reviewed in three years’ time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

14. **Monitoring and Compliance with Policy**

- Audit will be conducted monthly to assess compliance with screening (Section 5) and DH guidance (Gateway 11103 December 2008).
- Management of MRSA positive patients (Section 6) will be audited every 6 months.
- Risk assessments for the availability of isolation facilities will be conducted by the bed manager and the infection prevention and control team as the need arises.
- Patient safety and adherence to Trust policy will also be audited via Post Infection Review conducted by the appropriate Matron for each bacteraemia case.
- Management of patients who are highlighted as being high risk of having MRSA will be audited annually.

The responsibility for this policy’s implementation and monitoring across the organisation rests with the Quality and Risk Committee via the Infection Prevention & Control Team. This committee reports quarterly to the Trust Board.

15. **References**


department of health (1996) infection control in care homes. london. hmso

department of health (dec 2008) mrSA screening operational guidance. gateway reference number 11123

department of health (march 2010) mrSA screening – operational guidance 3, gateway ref no 14382.


journal of hospital infection, may 2006 guidelines for the control and prevention of mrSA in healthcare facilities by the joint bsac/his/icna working party on mrSA. vol 63, supp 1.

nhs england 2014 guidance on the reporting and monitoring arrangements and post infection review process for mrSA bloodstream infections from april 2014 version 2.
Appendix 1A – letter to patient and GP informing of positive MRSA status and treatment required, from Pre Assessment Clinic

DATE
Patient Name
Patient Address

DOB / Hospital Number
Consultant

Dear

Re – MRSA Screening Results

I am writing to tell you that MRSA has been found in the swabs taken at your pre-operative assessment, which means that you are carrying the MRSA germ but **does not** necessarily mean that you have an MRSA infection.

MRSA is a common germ that lives on the skin or in the nose. Many people have MRSA harmlessly living on their body without experiencing any symptoms or it making them ill. These people are known as MRSA carriers.

If MRSA enters the body through a wound, tube or drip it can develop into a more serious infection in the blood. This is extremely rare because we have many measures in place and do all we can to prevent this happening.

When you came for your pre-operative assessment at the hospital you will be aware that, as part of a national MRSA screening programme, swabs were taken to test if you are carrying MRSA. By finding out which patients are MRSA carriers before they come into hospital, we can take additional precautions to reduce the risk of infection for them and other patients.

Alongside everything else we are doing, you can help to further reduce the risk of infection by using a special body wash and nose ointment in the five days before your operation. These can help to get rid of MRSA on your skin and in your nose.

Your GP has been sent a copy of this letter and will prescribe the following:

- Octenisan wash lotion; please see attached instructions for use.
- Octenisan nasal gel; apply topically to both nostrils twice a day for five days.

Please collect this prescription from your GP and take it to the local pharmacist as you would any other prescription, and commence the treatment 5 days before surgery, so that the last day of treatment is your day of surgery, when your protection is considered to be at a maximum.

If you have any wounds please can you ask your GP to review them to ensure they are healing well and that no treatment is required.

For additional advice, please contact your GP or the hospital’s Infection Control Team on 01342 414341.

Yours sincerely
Pre-Assessment Clinic
Appendix 1B – alternative letter to patient and GP when no treatment is required

DATE

Patient Name
Patient Address

DOB / Hospital Number
Consultant

Dear

Re – MRSA Screening Results

I am writing to tell you that MRSA has been found in the swabs taken at your appointment/admission which means that you are carrying the MRSA germ but does not necessarily mean that you have an MRSA infection.

MRSA is a common germ that lives on the skin or in the nose. Many people have MRSA harmlessly living on their body without experiencing any symptoms or it making them ill. These people are known as MRSA carriers.

If MRSA enters the body through a wound, tube or drip it can develop into a more serious infection in the blood. This is extremely rare because we have many measures in place and do all we can to prevent this happening.

When you came for your appointment at the hospital you will be aware that, as part of a national MRSA screening programme, swabs were taken to test if you are carrying MRSA.

Your GP has been sent a copy of this letter. No treatment is required at this point. However if you require admission or attendance to any other hospital in the future, it would be helpful for the hospital to be informed. If you have any wounds, please can you ask your GP to review them to ensure they are healing well and that no treatment is required.

For additional advice, please contact your GP or the hospital’s Infection Control Team on 01342 414341.

Yours sincerely

Infection Prevention & Control Team
Appendix 1C – letter to patient and GP from OPD prior to surgery

DATE
Patient Name
Patient Address

DOB / Hospital Number
Consultant

Dear

Re – MRSA Screening Results

I am writing to tell you that MRSA has been found in the swabs taken at your out patient appointment, which means that you are carrying the MRSA germ but does not necessarily mean that you have an MRSA infection.

MRSA is a common germ that lives on the skin or in the nose. Many people have MRSA harmlessly living on their body without experiencing any symptoms or it making them ill. These people are known as MRSA carriers.

If MRSA enters the body through a wound, tube or drip it can develop into a more serious infection in the blood. This is extremely rare because we have many measures in place and do all we can to prevent this happening.

When you came for your out patient appointment at the hospital you will be aware that, as part of a national MRSA screening programme, swabs were taken to test if you are carrying MRSA. By finding out which patients are MRSA carriers before they come into hospital, we can take additional precautions to reduce the risk of infection for them and other patients.

Alongside everything else we are doing, you can help to further reduce the risk of infection by using a special body wash and nose ointment in the five days before your operation. These can help to get rid of MRSA on your skin and in your nose.

Your GP has been sent a copy of this letter and will prescribe the following:

- Octenisan wash lotion; please see attached instructions for use.
- Octenisan nasal gel; apply topically to both nostrils twice a day for five days.

Please collect this prescription from your GP and take it to the local pharmacist as you would any other prescription, and commence the treatment 5 days before surgery, so that the last day of treatment is your day of surgery, when your protection is considered to be at a maximum.

If you have any wounds please can you ask your GP to review them to ensure they are healing well and that no treatment is required.

For additional advice, please contact your GP or the hospital’s Infection Control Team on 01342 414341.

Yours sincerely
Out Patient Department
Dear

I am writing to tell you that MRSA has been found in the swabs taken at your outpatient appointment on ……………..

MRSA is a common germ that lives on the skin or in the nose. Many people have MRSA harmlessly living on their body without experiencing any symptoms or it making them ill. These people are known as MRSA carriers.

If MRSA enters the body through a wound, tube or drip it can develop into a more serious infection in the blood. This is extremely rare because we have many measures in place and do all we can to prevent this happening.

The microbiologist has recommended that you be commenced on our MRSA decolonisation protocol, commencing as soon as possible.

Your GP has been sent a copy of this letter and will prescribe the following:

- Octenisan wash lotion; please see attached instructions for use.
- Octenisan nasal gel; apply topically to both nostrils twice a day for five days.

Please collect this prescription from your GP and take it to the local pharmacist as you would any other prescription.

If you have any wounds please can you ask your GP to review them to ensure they are healing well and that no treatment is required.

Should you need further advice, please contact QVH Infection Prevention & Control Team on 01342 414341, who will be happy to help.

Yours sincerely

Out Patient Department
MRSA Protocol Form for In Patients

Record of Skin Decontamination

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Hospital Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward:</td>
<td>Date of isolate:</td>
</tr>
<tr>
<td></td>
<td>Site:</td>
</tr>
</tbody>
</table>

1. All patients who have been identified as MRSA positive are to commence a programme of skin decontamination, unless stated otherwise by the medical team or IPACT.

2. The form must be filled in accurately each day whilst treatment is in progress.

3. **Use the protocol for 5 days, stop for 2 days, then re-screen**
   - Re-commence protocol if result of screen is positive.
   - If negative, re-screen weekly until 3 negative screens.
   - Do not exceed more than 2 cycles of the protocol without further discussion with IPACT.

   *Do not use if known allergy to Octenidine.*

**Protocol consists of:**

**Otenisan Nasal Gel**
Apply topically to the anterior nares, massage into both nostrils, TWICE a day for FIVE days.
DO NOT recommence treatment without discussing with IPACT for further guidance.

**Octenisan body and hair wash**
As per procedure protocol apply undiluted to wet skin daily for five days; pay special attention to hands, perineum, groin, axilla and hairline. Use disposable washcloths. Leave in contact with the skin/hair for ONE minute then wash off. Change nightwear, bedlinen and towels daily.
Starting on day one, wash hair on alternate days to complete one cycle of treatment.

### Protocol 1

<table>
<thead>
<tr>
<th>Date started:</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Rest day</th>
<th>Rest day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body wash</td>
<td>Daily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair wash</td>
<td>Alternative days</td>
<td>xxxxxxx</td>
<td>xxxxxxx</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal gel</td>
<td>08:00 hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20:00 hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swabs done end of Protocol 1: Yes / No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Result:</td>
<td></td>
</tr>
</tbody>
</table>

### Protocol 2

<table>
<thead>
<tr>
<th>Date started:</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Rest day</th>
<th>Rest day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body wash</td>
<td>Daily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair wash</td>
<td>Alternative days</td>
<td>xxxxxxx</td>
<td>xxxxxxx</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal gel</td>
<td>08:00 hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20:00 hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swabs done end of Protocol 2: Yes / No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Result:</td>
<td></td>
</tr>
</tbody>
</table>

Stop protocol and discuss with IPACT (ext 4341)
Appendix 3  Out patient information / instruction sheet

Octenisan

Patient Information for MRSA Decolonisation

What is MRSA?

MRSA stands for Meticillin Resistant *Staphylococcus aureus*. MRSA is a germ that can be found harmlessly on the skin and in the nasal passage. Anyone can be a carrier of MRSA and not be harmed. This is known as “colonisation”.

Why is it important to decolonise?

There is a risk that if you have a wound or break in the skin from indwelling devices such as catheters and cannulae, MRSA germs can be transmitted from the skin into the wound and then into the blood. The MRSA germs can then cause an infection. It is also possible that MRSA bacteria may be transferred to other people in hospital, putting them at risk. It is therefore important to remove the bacteria from your skin. This is why you have been given a body wash for your skin and a nasal gel for your nose.

What is Octenisan?

Octenisan is a disinfectant which effectively removes MRSA from your body.

Is there anything else I can do?

You should try to ensure that you change your underwear, clothes and also your bed linen daily during the period you use Octenisan. This will help reduce the chances of the bacteria returning to the skin. You should also use a clean washcloth and towel every time you wash. Also, make sure that you wash your hands frequently and, if a carer or member of your family or a friend visits, they should also clean their hands with normal soap and water before and after touching you.

Using Octenisan

Please apply and use the lotion for washing your body and hair, and the nasal gel for the inside of your nostrils, by following the directions overleaf. Please follow the regime below, unless instructed otherwise.

### Personal Protocol for MRSA Decolonisation

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body</td>
<td>Body</td>
<td>Body</td>
<td>Body</td>
<td>Body</td>
</tr>
<tr>
<td>Hair</td>
<td>Hair</td>
<td>Hair</td>
<td>Hair</td>
<td>Hair</td>
</tr>
<tr>
<td>Nasal am</td>
<td>Nasal am</td>
<td>Nasal am</td>
<td>Nasal am</td>
<td>Nasal am</td>
</tr>
<tr>
<td>Nasal eve</td>
<td>Nasal eve</td>
<td>Nasal eve</td>
<td>Nasal eve</td>
<td>Nasal eve</td>
</tr>
</tbody>
</table>
MRSA decolonisation protocol using Octenisan® Body Wash and Octenisan® Nasal Gel

Do not use if known allergy to Octenidine

- Patient can wash all over (including hair if hair wash day) with their usual products after treatment.

**Using Octenisan® Nasal gel**
- Apply it to EACH nostril TWICE a day for 5 days (morning and night)
- Try and synchronise at least one application with your daily Octenisan® body wash
- Blow your nose or use a wet cotton bud to remove any debris from the nostrils before applying the Octenisan® Nasal Gel.
- Apply a small blob of the nasal gel onto a clean cotton bud and apply to the front part of the inside of the nostril.
- Do the same for the other nostril using a NEW cotton bud.
- Close the nostrils by pinching the sides of the nose together and massage between the thumb and forefinger to spread the gel and coat all areas of the nostril.
- Take care not to introduce the gel too deep into the nose.

**Using Octenisan® body/hair wash**
- Shower or bathe using the Octenisan® body wash ONCE a day for 5 days
- Wash your hair using the Octenisan® body wash on days 1, 3 and 5.

**If using it in the shower as a body wash:**
- Wet your skin.
- Turn the shower off.
- Apply 30ml (about 2 tablespoonfuls) of the wash onto a clean flannel / disposable cloth. Use a clean/new cloth each day.
- Beginning with the face and working downwards, apply the Octenisan® thoroughly to all parts of your body – face, neck and ears, eyes, upper body, lower body, urethra, catheter entry sites, legs - paying particular attention to areas around your nose, skin folds, groin, armpits and the spaces between fingers and toes.
- Leave it in contact with your body for 1 minute.
- Rinse off.

**If using it as a body wash in the bath:**
- Do not pour the Octenisan® into the bath as it will be too dilute to be effective.
- Wet your skin in the bath.
- Step out of the bath.
- Apply 30ml (about 2 tablespoonfuls) of the wash onto a clean flannel / disposable cloth.
- Beginning with the face and working downwards, apply the Octenisan® thoroughly to all parts of your body, paying particular attention to areas around your nose, skin folds, groin, armpits and the spaces between fingers and toes (see above for more detail).
- Remain outside the bath and leave it in contact with your body for 1 minute.
- Rinse off in the bath.
Washing your hair

- Wet your hair.
- Apply undiluted Octenisan® to your hair and wash your hair and scalp thoroughly.
- Leave it in for 1 minute.
- Wash it out.
- You may use your normal shampoo and conditioner after washing with Octenisan®.

Other measures

- Put on clean clothes and underwear after each wash
- If practicable, change bed sheets, duvet covers and pillow cases daily, before washing with Octenisan®.
- Clean glasses, combs/hair brushes daily with Octenisan or soap and water.
- Do not share your towel with any one else.
- You may apply a moisturiser or sun cream after washing provided you are not sharing these with anyone else.
- Other items worn by patients, such as spectacles, jewellery, prostheses, etc, can be decontaminated by firstly washing in mild detergent, rinse and then apply Octenisan® lotion, leave for one minute and rinse off.
- Brush teeth or false teeth twice daily with an ordinary / electronic toothbrush.
- Wash cloths should be disposed of after use.
### Day Case Procedures which DO require MRSA screening

<table>
<thead>
<tr>
<th>Specialty Code</th>
<th>Specialty</th>
<th>Code</th>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>OPERATIONS ON SEPTUM OF NOSE - SEPTOPLASTY OF NOSE NEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>DRAINAGE OF MIDDLE EAR - MYRINGOTOMY WITH INSERTION OF VENTILATION TUBE THROUGH TYMP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON TURBINATE OF NOSE - SUBMUCOUS DIATHERMY TO TURBINATE OF NOSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>SURGICAL ARREST OF BLEEDING FROM INTERNAL NOSE - CAUTERISATION OF INTERNAL NOSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON MAXILLARY ANTRUM - PUNCTURE OF MAXILLARY ANTRUM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER PLASTIC OPERATIONS ON NOSE - SEPTORHINOPLASTY NEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER THERAPEUTIC FIBROPTIC ENDOSCOPIC OPERATIONS/OESO - FIBROPTIC ENDOSCOPIC DILATION OF OESOPHAGUS NEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON FRONTAL SINUS - INTRANASAL ETHMOIDECTOMY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON INTERNAL NOSE - POLYPECTOMY OF INTERNAL NOSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON MAXILLARY ANTRUM - INTRANASAL ANTROSTOMY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON FRONTAL SINUS - UNSPECIFIED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON INTERNAL NOSE - EXTIRPATION OF LESION OF INTERNAL NOSE NEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON THYROID GLAND - BIOPSY OF LESION OF THYROID GLAND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON TONGUE - INCISION OF FRENUM OF TONGUE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON EUSTACHIAN CANAL - INTUBATION OF EUSTACHIAN CANAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON EXTERNAL EAR - OTHER SPECIFIED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON MIDDLE EAR - REMOVAL OF VENTILATION TUBE FROM TYMPANIC MEMBRANE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON PALATE - OPERATIONS ON UVULA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>DILATION OF SALIVARY DUCT - DILATION OF PAROTID DUCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>EXTIRPATION OF LESION OF MIDDLE EAR - EXCISION OF LESION OF MIDDLE EAR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>EXTIRPATION OF LESION OF MIDDLE EAR - OTHER SPECIFIED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>EXTIRPATION OF LESION OF OTHER PART OF MOUTH - EXCISION OF LESION OF MOUTH NEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON SEPTUM OF NOSE - BIOPSY OF LESION OF SEPTUM OF NOSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON SEPTUM OF NOSE - INCISION OF SEPTUM OF NOSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON SEPTUM OF NOSE - OTHER SPECIFIED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON THYROGLOSSAL TISSUE - EXCISION OF THYROGLOSSAL CYST</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OPERATIONS ON TURBINATE OF NOSE - DIVISION OF ADHESIONS OF TURBINATE OF NOSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON INTERNAL NOSE - OTHER SPECIFIED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON MASTOID - OTHER SPECIFIED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER OPERATIONS ON THYROID GLAND - OTHER SPECIFIED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>OTHER THERAPEUTIC ENDOSCOPIC OPS/OESOPHAGUS USING RIGID - ENDOSCOPIC DILATION OF OESOPHAGUS USING RIGID OESOPHAGOSCOPE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>PLASTIC OPERATIONS ON NOSE - SEPTORHINOPLASTY USING GRAFT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>REPAIR OF EARDRUM - TYMPANOPLASTY NEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GYN</td>
<td>OTHER REPAIR OF PROLAPSE OF VAGINA - ANTERIOR AND POSTERIOR COLPORRHAPHY NEC</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OPEN OPERATIONS ON SYNOVIAL MEMBRANE OF JOINT - PARTIAL SYNOVECTOMY
OPERATIONS ON NIPPLE - EXTIRPATION OF LESION OF NIPPLE
FREEING OF TENDON - PRIMARY TENOLYSIS
OPERATIONS ON UMBILICUS - PLASTIC OPERATIONS ON UMBILICUS
OTHER OPEN OPERATIONS ON BONE - DEBRIDEAMENT OF BONE NEC
OTHER RECONSTRUCTION OF LIGAMENT - RECONSTRUCTION OF INTRAARTICULAR LIGAMENT NEC
PRIMARY REPAIR OF TENDON - PRIMARY SIMPLE REPAIR OF TENDON
STABILISING OPERATIONS ON JOINT - TRANSPOSITION OF MUSCLE FOR STABILISATION OF JOINT
AMPUTATION OF HAND - AMPUTATION OF FINGER NEC
DIVISION OF FASCIA - UNSPECIFIED
EXCISION OF MUSCLE - PARTIAL EXCISION OF MUSCLE NEC
OPERATIONS ON AMPUTATION STUMP - OTHER SPECIFIED
OTHER ARTERIOVENOUS OPERATIONS - OTHER SPECIFIED
OTHER RECONSTRUCTION OF LIGAMENT - RECONSTRUCTION OF EXTRAARTICULAR LIGAMENT NEC
PRIMARY REPAIR OF TENDON - PRIMARY REPAIR OF TENDON USING TEMPORARY PROSTHESIS
PROSTHESIS FOR BREAST - REVISION OF PROSTHESIS FOR BREAST
SPLIT AUTOGRAFT OF SKIN - UNSPECIFIED
TRANSPOSITION OF TENDON - TRANSFER OF TENDON TO TENDON NEC
AMPUTATION OF TOE - AMPUTATION OF PHALANX OF TOE
CORRECTION OF MINOR CONGENITAL DEFORMITY OF FOOT - AMPUTATION OF SUPERNUMERARY TOE
EXCISION OF SHEATH OF TENDON - TENOSYNOVECTOMY
EXCISION OF VULVA - REDUCTION LABIA MINOR
FUSION OF OTHER JOINT AND EXTRAARTICULAR BONE GRAFT - PRIMARY ARTHRODESIS AND EXTRAARTICULAR BONE GRAFT NEC
FUSION OF OTHER JOINT AND OTHER ARTICULAR BONE GRAFT - PRIMARY ARTHRODESIS AND ARTICULAR BONE GRAFT NEC
OPERATIONS ON AMPUTATION STUMP - EXCISION OF LESION OF AMPUTATION STUMP
OPERATIONS ON BURSA - EXCISION OF BURSA NEC
OPERATIONS ON NIPPLE - EXCISION OF NIPPLE
OTHER DIVISION OF BONE - OSTEOTOMY AND INTERNAL FIXATION NEC
OTHER EXCISION OF BONE - EXCISION OF OVERGROWTH OF BONE
OTHER EXCISION OF OTHER FASCIA - REVISION OF DERMOFASCIECTOMY
OTHER EXTERNAL FIXATION OF BONE - REMOVAL OF EXTERNAL FIXATION FROM BONE NEC
OTHER OPEN OPERATIONS ON JOINT - EXCISION OF LESION OF JOINT NEC
OTHER OPERATIONS ON CRANIUM - EXTIRPATION OF LESION OF CRANIUM
OTHER OPERATIONS ON LIGAMENT - OTHER SPECIFIED
OTHER OPERATIONS ON PENIS - OTHER SPECIFIED
OTHER OPERATIONS ON PERIPHERAL NERVE - UNSPECIFIED
OTHER OPERATIONS ON SHEATH OF TENDON - OTHER SPECIFIED
OTHER OPERATIONS ON TENDON - OTHER SPECIFIED
OTHER PLASTIC OPERATIONS ON NOSE - OTHER SPECIFIED
OTHER PRIMARY FUSION OF OTHER JOINT - UNSPECIFIED
PROSTHETIC INTERPOSITION RECONSTRUCTION OF JOINT - PRIMARY PROSTHETIC INTERPOSITION
<table>
<thead>
<tr>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroplasty of joint</td>
</tr>
<tr>
<td>Release of contracture of joint - other specified</td>
</tr>
<tr>
<td>Repair of urethra - closure of fistula of urethra</td>
</tr>
<tr>
<td>Secondary repair of tendon - secondary repair of tendon using graft</td>
</tr>
<tr>
<td>Amputation of toe - unspecified</td>
</tr>
<tr>
<td>Correction of congenital deformity of hand - unspecified</td>
</tr>
<tr>
<td>Correction of congenital deformity of leg - other specified</td>
</tr>
<tr>
<td>Correction of deformity of lip - other specified</td>
</tr>
<tr>
<td>Distant flap of skin and muscle - distant myocutaneous subcutaneous pedicle flap nec</td>
</tr>
<tr>
<td>Excision of muscle - debridement of muscle nec</td>
</tr>
<tr>
<td>Excision of muscle - other specified</td>
</tr>
<tr>
<td>Excision of other fascia - plantar fasciectomy</td>
</tr>
<tr>
<td>Excision of other fascia - revision of plantar fasciectomy</td>
</tr>
<tr>
<td>Excision of tendon - other specified</td>
</tr>
<tr>
<td>Excision of vulva - excision of excess labial tissue</td>
</tr>
<tr>
<td>Excision reconstruction of joint - revision of excision arthroplasty of joint</td>
</tr>
<tr>
<td>Extirpation of lesion of fascia - excision of lesion of fascia</td>
</tr>
<tr>
<td>Fixation of epiphysis - unspecified</td>
</tr>
<tr>
<td>Freeing of tendon - other specified</td>
</tr>
<tr>
<td>Incision of breast - drainage of lesion of breast</td>
</tr>
<tr>
<td>Insertion of skin expander into subcutaneous tissue - insertion of skin expander into</td>
</tr>
<tr>
<td>subcutaneous tissue of breast</td>
</tr>
<tr>
<td>Open debridement and irrigation of joint - open debridement and irrigation of joint</td>
</tr>
<tr>
<td>Open operations on synovial membrane of joint - total synovectomy</td>
</tr>
<tr>
<td>Opening of abdomen - reopening of abdomen nec</td>
</tr>
<tr>
<td>Operations on amputation stump - revision of coverage of amputation stump</td>
</tr>
<tr>
<td>Operations on nipple - biopsy of lesion of nipple</td>
</tr>
<tr>
<td>Operations on septum of nose - biopsy of lesion of septum of nose</td>
</tr>
<tr>
<td>Operations on thyroGLOSSAL TISSUE - excision of thyroGLOSSAL CYST</td>
</tr>
<tr>
<td>Operations on urethral orifice - meatoPlasty of urethra</td>
</tr>
<tr>
<td>Other arteriovenous operations - excision of congenital arteriovenous malformation</td>
</tr>
<tr>
<td>Other division of bone - osteotomy and external fixation nec</td>
</tr>
<tr>
<td>Other division of bone - unspecified</td>
</tr>
<tr>
<td>Other excision of bone - disarticulation of bones nec</td>
</tr>
<tr>
<td>Other excision of bone - excision of excrescence of bone</td>
</tr>
<tr>
<td>Other excision of bone - excision of natural protuberance of bone</td>
</tr>
<tr>
<td>Other excision of breast - partial excision of breast nec</td>
</tr>
<tr>
<td>Other excision of skin - excision of sweat gland bearing skin of axilla</td>
</tr>
<tr>
<td>Other graft to peripheral nerve - primary graft to peripheral nerve nec</td>
</tr>
<tr>
<td>Other open operations on bone - other specified</td>
</tr>
<tr>
<td>Other open operations on joint - exploration of joint nec</td>
</tr>
<tr>
<td>Other open repair of ligament - open repair of extraarticular ligament nec</td>
</tr>
<tr>
<td>Other operations on cranium - biopsy of lesion of cranium</td>
</tr>
</tbody>
</table>
MRSA Pre-Admission Screening

Is patient for:
- Ophthalmology?
- Dental?
- Endoscopy?
- Minor dermatology (LOPAS)?

Yes

Is patient any of the following:
- Previously positive?
- Care home resident?
- From another hospital?
- In patient in last year?
- Healthcare worker?
- Receiving care from care agency at home?

Yes

SCREEN:
- Nose / Groin
- Skin lesions
- Manipulated sites, eg catheter
- Sputum if productive cough

No need to screen

No further action required

Is the result positive?

No

Yes

Inform patient of positive result

Contact GP – arranging decontamination protocol

Admit as Day Case patient on planned date

Is the patient:
- Paediatric with long term condition or transfer from another hospital?
- Patient with chronic condition/s who frequently attends as an emergency?
- Critical care patient?
- To be admitted to an adult inpatient ward?
- To come in for day surgery?
APPENDIX 6

Protocol for Post Infection Review (PIR)

- When an MRSA bloodstream infection has been identified, QVH IPACT will enter core data onto the Public Health England (PHE) Data Capture System (DCS).
- The organisation with responsibility for conducting the PIR will automatically be notified as such by the DCS.
- If an acute trust is leading the PIR, the Clinical Commissioning Group (CCG) with responsibility for the patient will also be notified that a PIR has been initiated.
- PIR to be led by acute trust – day of admission day plus 2 (day 3) identified.

1. A Datix form and PIR form must be completed for each case by the Matron for the patient's care group within 3 days of assignment (and, where applicable, a Serious Untoward Incident (SUI) form – this can be confirmed by the Patient Safety Manager).

2. A copy of the MRSA response checklist for patients must be sent to the Infection Prevention & Control Team (IPACT).

3. The IPACT will email the PIR form to the Matron for completion prior to the review meeting.

4. The PIR investigation meeting is to be held 3 days after confirmation. This is to be attended by at least four of the following:
   - Director of Infection Prevention & Control
   - Medical Director
   - Infection Prevention Nurse Specialist
   - Matron
   - Consultant Microbiologist
   - Clinician / Consultant
   - Anaesthetic representative.

5. Following the meeting, the Matron is to make any adjustments to the PIR form and return it to IPACT.

6. The IPACT / DIPC will submit the outcome of the PIR onto the DCS within 14 days of the initial notification. If the duly assigned organisation is different from the organisation leading the PIR, a notification will be sent to the assisting organisation who will be provided a further 2 days to indicate whether they agree or disagree with the outcome of the PIR.

   If the PIR suggests that there have been no possible failings in care and that neither the acute trust nor the CCG are best placed to ensure improvements are made then Third Party assignment may be considered (led by the Regional Director of Nursing or Medical Director).

7. The DIPC will submit the PIR and, where applicable, the SUI report to the CCG.

8. The outcome summary of the PIR will result in information recorded on the DCS by the local provider, which can then be requested by CQC, CCG's, Monitor, NQB and PHE. Only the recording of the summary information on the DCS will be mandatory.

9. Director of Public Health review panel to convene within 28 days and report the result and provide feedback to the organisation.
Who inputs the core dataset to the DCS?

Who takes the sample?
- Acute trust (inpatient, day case, A&E, etc.)
- GP (including cases in Nursing Homes, or taken by a nurse responsible to a GP)
- Secondary care hospital trust (e.g., mental health trusts, community trusts)

Who processes the sample?
- Lab in acute trust taking sample
- Lab in another acute trust
- Private lab not hosted by an acute trust
- Lab in an acute trust
- Private Lab not hosted by an acute trust
- Lab in an acute trust

Who is responsible for ensuring data is input to DCS?
- Acute Trust taking sample
- Acute Trust taking sample is responsible for ensuring data is input
- Acute Trust taking sample is responsible for ensuring data is input
- GGG taking sample is responsible for ensuring data is input, possibly by the laboratory via contract
- Provider taking sample is responsible for ensuring data is input, possibly by the acute trust

Who will actually enter the data on the DCS? (Alternatives)
- Acute Trust taking sample
- Acute Trust processing sample
- Private lab
- GGG
- Acute Trust processing sample
- Provider taking sample
- Private lab
- Provider taking sample
Appendix 7

B.4 Inter-healthcare Transfer Form for Infection Prevention & Control

All infection control concerns (eg MRSA status, C Diff/Norovirus, Group A Strep, CPE) to be included

<table>
<thead>
<tr>
<th>Patient/Client details: (insert label if available)</th>
<th>Consultant &amp; contact number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Date of birth:</td>
<td></td>
</tr>
<tr>
<td>NHS Number:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transferring facility: (Hospital &amp; ward)</th>
<th>Receiving facility: (Hospital, ward, care home, district nurse, GP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact name:</td>
<td>Contact name:</td>
</tr>
<tr>
<td>Contact number:</td>
<td>Contact number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis: (Confirmed organism)</th>
<th>Infection: Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Colonisation Yes / No</td>
</tr>
</tbody>
</table>

Microbiological identification (specimen result):

<table>
<thead>
<tr>
<th>Date symptoms started</th>
<th>Specimen type</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Treatment information (if appropriate): (including type of medication, dose & duration)

Infection prevention & control precautions required/in place:

Other information relevant to the patients care:

Has ambulance service been informed: Yes / No (if no give reason)

Is the patient/client aware of their colonisation/infection status: Yes / No (if no give reason)

Has patient received information about their status (patient leaflet): Yes / No (if no give reason)

Name of staff member completing form:

<table>
<thead>
<tr>
<th>Print name:</th>
<th>Contact number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date form completed:</td>
<td></td>
</tr>
</tbody>
</table>


# Response Checklist for Patients with Confirmed Meticillin Resistant *Staphylococcus Aureus* (MRSA)

**Date patient screened:**  
**Sites screened:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Isolate patient immediately on admission</strong>, ensure dedicated commode or bathroom facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Excess equipment removed from room before patient transferred in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>If patient moved from a bay, bedspace and bathroom thoroughly cleaned with Chlorclean, and curtains changed before next patient admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Door of patient’s room closed and isolation poster displayed on room door, ensure PPE supplies available – minimise number of staff caring for patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Handwashing with soap and water reinforced with all staff and visitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Bare below the elbows reinforced with all staff groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Personal Protective Equipment should be applied on entering the patients room and discarded on leaving into an orange bin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>All waste from the patient’s room must be disposed of in orange bin before leaving</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 9. | Enhanced cleaning initiated – Chlorclean, and increased frequency including patient equipment:  
   - Nursing staff informed  
   - Domestic/housekeeping staff informed |   |    |
| 10. | Linen placed in white bag inside room and doubled bagged just outside of the room |   |    |
| 11. | Patient observations monitored at least QDS – temperature, pulse, BP |   |    |
| 12. | MRSA screening result documented in the patient’s nursing notes (date, time, from where / whom result received) |   |    |
| 13. | Relevant clinical staff (Doctor, IPACT, Nurse in Charge) informed of MRSA screening result |   |    |
| 14. | Commence decontamination protocol and ensure prescribed on drug chart |   |    |
| 15. | Linen changed daily |   |    |
| 16. | Date of rescreen documented on record of skin decontamination |   |    |
| 17. | Advice sought from IPACT if patient remains positive |   |    |
| 18. | Only transfer patient between departments if essential and relevant department informed prior to transfer |   |    |
| 19. | Information leaflet given to patient if MRSA is confirmed |   |    |
| 20. | Post Infection Review completed by Matron if MRSA Bacteraemia is confirmed |   |    |

If “NO” to any of the above, please state why below:

NB – patients can be removed from isolation when 3 consecutive negative screen results have been obtained.

**Name of person completing the form:**  
**Date completed:**