Methicillin Resistant Staphylococcus Aureus (MRSA) policy

This policy sets out the key principles and protocols for patients who are colonised or infected with Methicillin Resistant Staphylococcus Aureus (MRSA) and also includes the management and screening of patients within Leicestershire Partnership Trust (LPT)'

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Type of Policy Clinical

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Contents

Policy On a Page

This policy provides all clinical staff employed by LPT with the key processes and protocols required to enable them to care for patients who are colonised or infected with MRSA and to ensure that other patients are not put at undue risk.

Healthcare associated infection (HAI) risk assessments are undertaken to determine the risk of a patient contracting or spreading an infection, and aids care planning and patient placement, transfer, or discharge.

Screening for MRSA was adapted in 2014 after advice and publication from an expert committee. This guidance for the NHS in England is applicable to all in-patient areas (inc. Mental health) and has been streamlined to.

1. All patients admitted to *high risk units.
2. All patients previously identified as colonised with or infected by MRSA.
3. For diagnostic reasons (i.e., signs and symptoms of infection are present, as appropriate depending on clinical presentation)
    - Device entry sites
    - Wounds
    - Urine
    - Sputum

High risk is defined as vascular, renal/dialysis, neurosurgery, cardiothoracic surgery, haematology/oncology/bone marrow transplant, orthopaedics/trauma, and all intensive care units.

Screening swabs from the nose and groin should be taken as a minimum and further swab from the list above if for diagnostic reasons.

Decolonisation treatment aims to eradicate or significantly reduce the carriage of MRSA when a positive MRSA result has been received.

Treatment should commence at the earliest possible opportunity, ensuring that the patient is informed of the treatment and its purpose. Decolonisation guide can be located in appendix 1.

The patient **should be** re-swabbed a minimum of 24 hours after the first round of Decolonisation treatment has been completed. If the patient remains positive a second course of treatment may be considered, this should be discussed with the IPC team.

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1.0 Introduction

This Policy provides all staff employed by Leicestershire Partnership Trust (LPT) with the key processes and protocols required to enable them to care for patients who are colonised or infected with MRSA to ensure that other patients are not put at any undue risk.

Colonisation-

Colonisation means that MRSA is present on or in the body without causing an infection. It has been reported that up to 33% of the general population at any one time are colonised with Staphylococcus Aureus (Including MRSA) on areas of their body e.g., Nose, skin, axilla, groin. It can live on a healthy person without causing any harm and most people who are colonised do not go onto develop infection.

Infection-

Infection means that the MRSA is present on or in their body and it is multiplying causing clinical signs of infection such as.

- Bacteriemia-Presence of bacteria in the blood stream
- Pneumonia
- Wound- redness, swelling, pain and/or discharge, difficult to heal.

This policy has been developed to give clear guidance to staff employed by Leicestershire Partnership Trust (LPT) in relation to the procedures for the safe management of patients with MRSA. It also describes the process for ensuring that the delivery of effective infection prevention and control precautions for patients Colonised or infected with MRSA is clearly defined for staff to follow.

This policy forms part of the organisations compliance with the Health & Social care Act (2015) and the Department of Health (DH) guidance on screening.

Staphylococcus Aureus (S aureus) is a bacterium that is present on the skin and in the nose & throat of approximately 30% of the health population. On intact skin its presence is harmless. However, if it does enter a break in the skin, it can cause infection and is one of the most common causes of localised wound and skin infections.

Methicillin Resistant Staphylococcus Aureus (MRSA) is a strain of staphylococcus Aureus that is resistant to commonly used antibiotics such as flucloxacillin.

Approximately 6% of the overall population are asymptomatic carriers of MRSA, though MRSA is no more virulent than an antibiotic sensitive Staphylococcus aureus however the options for treatment of the infection are far more limited.

This policy provides all staff employed by LPT with the key processes and protocols that are required to enable them to care for patients who are colonised or infected with MRSA to ensure that other patients are not put at any undue risk.

- It identifies the main risk factors for cross contamination of MRSA and when source isolation precautions are required for patients and the screening requirements of those patients.
- It gives information regarding what precautions and screening are required for those patients for whom source isolation precautions are not necessary as they are colonised and do not present with the risk factors for transmission.

The risk of acquiring an MRSA infection in the community and primary care is acknowledged as being low and is usually related to recent hospital or nursing home admission. However, with the early discharge of patients from hospital and the increase in minor surgery and invasive procedures now undertaken in primary care, there is the potential for an increase in MRSA infection in the community if the general principles of Infection Prevention & Control are not applied in all healthcare facilities.

MRSA is transmitted primarily by person to person spread, most often this is on the hands of healthcare workers (HCW) which may have been transiently contaminated by contact with infected or colonised patients.

In most cases where infection is present these infections are minor and remain localised to the area of broken skin and can be treated quickly and effectively. In some circumstances infection with MRSA may be problematic, particularly in the elderly and debilitated people and in people with a lowered resistance to infection. In these instances, the organism can cause more widespread infection such as septicaemia. This potentially life-threatening infection is more likely to affect people who already have a serious underlying condition which has weakened the body's defence mechanism and urgent treatment will be necessary.

The mainstay of treatment for many years for S, aureus infections has been the antibiotics such as Meticilin & Flucloxacillin but strains resistant to these agents have become increasingly prevalent hence the term MRSA. It causes the same range of infections as other S. aureus but is much more difficult to treat because of its resistance to many antibiotics.

There is also evidence to suggest that the environment can act as a reservoir for MRSA, as such MRSA can be acquired by indirect contact. Because MRSA can colonise a patients skin it can then subsequently be dispersed on their skin scales, which may then lead to contamination of the environment. Therefore, high standards of environmental cleanliness within community settings, particularly on horizontal surfaces should be encouraged, to keep dust & microorganisms to a minimum.

If the basic principles of Infection Prevention & Control are practiced regardless of the type of healthcare setting, the risks can be effectively minimised and people colonised with MRSA will not be a hazard to other members of their family, visitors' other residents or staff in nursing or residential homes. This includes healthy babies, children, and well pregnant women. S aureus organisms resistant or otherwise are opportunist pathogens and intact skin is an extremely effective barrier.

2.0 Policy Requirements and Objectives

The aim of this policy is to ensure that all staff employed by Leicestershire Partnership Trust (LPT) are aware of the appropriate steps they need to undertake to ensure the safety of all patients and colleagues in accordance with the Health and Social care Act (2015).

This policy has been developed to give clear guidance to staff in relation to the procedure for the management of patients who are suspected/confirmed to have MRSA infection. It describes the process for ensuring the delivery of effective infection Prevention and Control management of patients with suspected/confirmed MRSA infection within all LPT settings as well as forming part of the organisation's compliance with the Health and Social Care Act (2015).

3.0 The management of MRSA

3.1 Alert Mechanisms

Patients with a lifelong infection such as MRSA will have this icon.  In the demographic box on systemone to notify staff that the patient has a lifelong infection.

When staff access the patients record there is also an additional pop-up box that will appear on the screen to prompt staff to take the appropriate actions to manage the infection and reduce further transmission risks:

Patient known to have a lifelong infection.
Stop, Think IPC CONTROLS
Placement, Isolation, PPE, BBE, Hand hygiene
Contact the IPC team for further advice on
01162952320

Once the pop-up box has appeared please click ok to acknowledge and close the box.

It is imperative that staff check the infectious status of all patients when they first come under their care,

If these are missing, then please contact the IPC team on 01162952320 who will add the alert to the patient record

3.2 MRSA Blood stream infections

MRSA bacteraemia (MRSA BSI) is when MRSA has been detected in a patient's blood stream following blood cultures being taken and cultured within a pathology laboratory.

All NHS trusts across the country have a' zero tolerance'. For all blood stream infection cases from APRIL 2013.

Case definitions for MRSA bacteraemia are as follows:

- Community acquired (acquired outside of a hospital or healthcare setting)
- Community-associated (detected in an outpatient or within 48 hours of a hospital admission)
- Healthcare-associated (detected more than 48 hours after hospital admission)

If the case is identified as healthcare-associated then a post infection review (PIR) should be completed to identify any possible failings and to identify any improvements required.

The PIR process will:

- Help to identify factors that may have contributed to a MRSA BSI
- Help to identify any part of the patient's pathway which may have contributed to the infection.
- Identify any areas of non-optimal practice or care delivery.
- Identify lessons from learning to improve practice and prevent re-occurrence.

Healthcare associated infection (HAI) risk assessments are undertaken to determine patient placement, transfers, or discharge.

This is relevant to all in-patient areas (inc. Mental health) and has been streamlined to include:

- All patients admitted to *High risk units*.
- All patients previously identified as colonised with or infected by MRSA.
- For diagnostic reasons (i.e., signs & symptoms of infection are present as appropriate depending upon clinical presentation).
    - Device entry sites
    - Wounds
    - Urine
    - Sputum

Screening swabs from the nose and groin should be taken as a minimum and further swab from the list above if for diagnostic reasons.

MRSA swabs (Blue top) should be pre-moistened with sterile water or sodium chloride 0.9% if the site to be swabbed is dry i.e., nose & perineum. The moisture will help any bacteria to adhere to the swab.

High risk is defined as vascular, renal/dialysis, neurosurgery, cardiothoracic surgery, haematology/oncology/bone marrow transplant, orthopaedics/trauma, and all intensive care units.

Please see appendix 2 for patients in mental health services

3.3 Patient placement

The **optimal placement** for a patient with a known infection is a single side room with en-suite facilities.

MRSA is a contact transmission and therefore requires the appropriate PPE in line with standard precautions (Please refer to LPT PPE policy).

Enhanced PPE would only be required for a patient with an infectious pneumonia and/or productive cough.

Please refer to appendix 5 & 6 for patient screening pathways

Please refer to appendix 7 Aide memoire for management of patients with MRSA in an IP setting

3.4 Decolonisation treatment

Decolonisation treatment aims to eradicate or significantly reduce the carriage of MRSA when a positive MRSA result has been received.

Treatment should commence at the earliest possible opportunity, ensuring that the patient is informed of the treatment and its purpose.

Decolonisation guide can be located in appendix 4

The patient should be re-swabbed a minimum of 24 hours after the first round of decolonisation treatment has been completed.

If the patient remains positive a second course of treatment may be considered, this should be discussed with the IPC team.

Where a screening swab is negative, but the patient has a wound bed that tests positive then the practitioner managing the wound must arrange an assessment to determine the need for an antibiotic treatment.

In many cases, particularly chronic wounds the wound bed is colonised with MRSA rather than infected, clinical assessment is essential and only if there are signs of infection should antimicrobial chemotherapy be considered.

3.5 Discharge

Effective and timely communication is essential for the successful management of patients with MRSA colonisation/infection.

Prior to a patient being discharged from hospital who has been found to be colonised or infected with MRSA it is the responsibility of the ward nursing/medical staff to ensure that the GP and/or district nurse or residential/nursing home is informed.

This is particularly important if the patient has commenced decolonisation treatment and may require assistance with applying the products.

There is **no reason** to delay or refuse treatment, investigations, therapy or discharge home/nursing/residential home.

Patients should be encouraged to continue with their normal activities and visitors should be assured that they are normally at no risk.

If a relative is immunocompromised or awaiting surgery and requires further advice, they should discuss this with their GP or practice nurse.

Patients colonised or infected with MRSA **may be** transported with others in the same ambulance without any special precautions, it is important that this is discussed first with the ambulance service.

Any wounds are to be covered with an impermeable dressing, however if it is not possible advice should be sought from the Infection Prevention and Control team.

3.6 Environmental Management

3.6.1 Room cleaning

When cleaning rooms, separate equipment should be used and the environment cleaned using detergent, paying special attention to dust collecting areas and horizontal services.

Curtains **must be** laundered (If re-usable) and visible splashes on walls will be washed (Full wall washing is not required).

If disposable curtains are in use these **must be** removed and re-placed with new curtains.

All disposable curtains **must** clearly display the date on which they were changed.

3.6.2 Decontamination of medical equipment and devices

LPT employers are required to maintain the safety of all patients, colleagues and visitors by adhering to safe systems as detailed within the LPT medical devices policy.

This will ensure that all medical equipment and reusable medical devices are properly decontaminated prior to use or repair and that the risk associated with decontamination facilities and processes are well managed (MHRA 2006).

3.6.3 Linen and Clothing (Where applicable)

Linen & clothing **only need** to be placed in a red alginate and white plastic bag if the linen is **soiled** or the patient has:

- an exfoliating skin condition,
- A leaking wound
- Or undergoing decolonisation therapy.

Removing and bagging of all linen should be performed to minimise the dispersal of MRSA from the bed linen and clothing.

Gloves do not need to be worn for handling of un-soiled linen

3.7 Community nursing teams including paediatrics.

It needs to be recognised that many clients being cared for in their own homes will have long standing complex health conditions that place them at higher risk of MRSA acquisition.

Some clients will have chronic MRSA colonisation which in turn suggests that the home itself will be colonised.

It is therefore important for staff to adhere to strict infection Prevention and Control precautions to prevent onward transmission of MRSA to other clients.

Hand hygiene needs to be carried out on **entering** and **leaving** the patients home as well as **prior to** any episodes of care. Staff **need to be 'bare below the elbow'** for any episodes of clinical care.

If it is not possible to use hand washing facilities within a patient home following risk assessment, then individual hand wipes should be used prior to using the alcohol hand sanitiser.

Uniforms must be protected by a plastic apron when close contact with the client or environment is anticipated.

Equipment utilised by staff should be kept in good condition and cleaned regularly, refer to decontamination policy or contact the IPC team for further advice.

Community staff are encouraged to discuss any concerns regarding care of MRSA colonised/infected clients with the IPC team, it may be necessary to formulate an individual plan for that person.

Previous history of MRSA should always be considered as relevant

Chronic wounds are a potential cause of skin and soft tissue infections as there is an increase in bacterial burden often including MRSA, it is therefore necessary to adhere to the principles of asepsis for wound care.

Wound swabs should be taken if there are signs and symptoms of infection i.e.

- Redness
- Inflammation
- Discharge
- or non-healing of the wound persists.

Any waste generated by a healthcare worker as a result of wound care in a domestic setting that is considered to be infected by MRSA will need to be disposed of following the correct infected waste collection service.

When taking a swab, the wound **should be** cleaned first to remove surface contaminants and any slough.

A brief history of the patient and current or recent antibiotic treatment should be included on the laboratory request form.

Results of wound swabs should be obtained as soon as possible so that there is no delay in the correct treatment being prescribed if needed,

Please refer to appendix 8 Aide memoire for management of patients with MRSA in a community setting

3.8 Podiatry services

Podiatry services provide care for many patients with increased risk of developing infection in chronic wounds. Diabetes in particular will be of significance as raised blood glucose levels increase the risk of ulceration and infection.

Diabetes can also cause suppression to normal inflammatory responses that may mask signs of infection so this needs to be taken into account when assessing a wound.

When high risk interventions are being considered it is recommended that the MRSA status of the patient is reviewed,

If positive or previously positive, then suppression therapy and antibiotic prophylaxis **may be** considered on an individual basis and for further advice contact the IPC team or Microbiologist.

Wound care needs to be carried out using the principles of asepsis in accordance with the Asepsis Technique Policy. This will prevent the introduction of pathogens to the site.

Every attempt needs to be made to ensure that requests for swabs or antibiotic treatment is timely so that treatment, when necessary, can commence at the earliest opportunity.

Due to the invasive nature of some podiatry procedures, there is a risk of contamination of inanimate objects such as couches etc with body fluids. Therefore, the correct cleaning and decontamination materials need to be at hand and used correctly following risk assessment.

Wound swabs should be taken if there are signs and symptoms of infection such as:

- redness
- inflammation
- discharge
- or non-healing of the wound persists.

When taking a swab, the wound should be cleaned first to remove surface contaminants and any slough.

A brief history of the patient and current or recent antibiotic treatment should be included on the laboratory request form to aid a more comprehensive laboratory report.

Results of wound swabs should be obtained as soon as possible so that there is no delay in the correct treatment being prescribed if needed.

5.0 References

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Lister, J. Hofland & H. Grafton (Eds.), The Royal Marsden manual of clinical nursing procedures Wiley-Blackwell. Accessed online 25/05/21 [Home - Royal Marsden Manual (rmmonline.co.uk

LPT The management of a patient requiring source isolation precautions policy 2024

LPT waste management policy 2024

LPT Personal Protective Equipment for use in healthcare policy 2023

LPT Hand Hygiene policy 2024

LPT Cleaning & Decontamination of equipment medical devices & the environment, (Including the Management of blood & body fluid spillages) policy 2025.

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

NHSE National Infection Prevention & Control Manual for England, V2:12 Updated July 2025.

6.0 Roles and Responsibilities

Roles and responsibilities including duties of relevant individuals and groups.

Lead Executive Director
Responsible for ensuring that this policy is carried out effectively and that MRSA infection is manged effectively across the organisation.

Will communicate, disseminate, and ensure directorates commence implementation of this policy and provide assurance through the trusts quality Governance Framework.

Executive Management Board
Responsible for ensuring that his policy is carried out effectively and MRSA infection is addressed and manged effectively across the organisation.
Will communicate, disseminate, and ensure directorates commence implementation of the policy and provide assurance through the rusts quality governance framework.

Governance Group level 1 and 2
Responsible for ensuring that all relevant staff are aware of the policy and adhere to the principles and guidance that is contained within it.

Policy Team
To ensure that the policy is reviewed in accordance with identified timescale and implementation of monitoring and effectiveness has been planned and is reviewed by the directorates and appropriate governance group.

Policy Authors
Responsibility for ensuring that the Infection, Prevention and Control team identify best learning and practice to inform this policy and update accordingly.
To ensure that this policy is reviewed in accordance with identified timescale and implementation of monitoring and effectiveness has been planned and is reviewed by the directorate and appropriate governance group.

Operational leads
Are responsible for ensuring implementation within their area and for ensuring all staff who work within the are adhere to the principles of this policy at all times.

Staff
Each individual member of staff, substantive and temporary worker within the trust is responsible for complying with this policy.
Clinical staff involved in care of patients with MRSA will ensure that they familiarise themselves with the content of the policy and work in accordance with this.

Staff will also ensure that they provide support and education to the patient, carer and family where appropriate. They will also be a source of knowledge and skill for

colleagues where appropriate as well as ensure that they remain up to date with training in line with competencies of their job role.

7.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/or in writing. Someone could also give non-verbal consent if they understand the treatment or care that is about to take place.

Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Rember that information
- Use the information to make the decision.
- Communicate the decision.

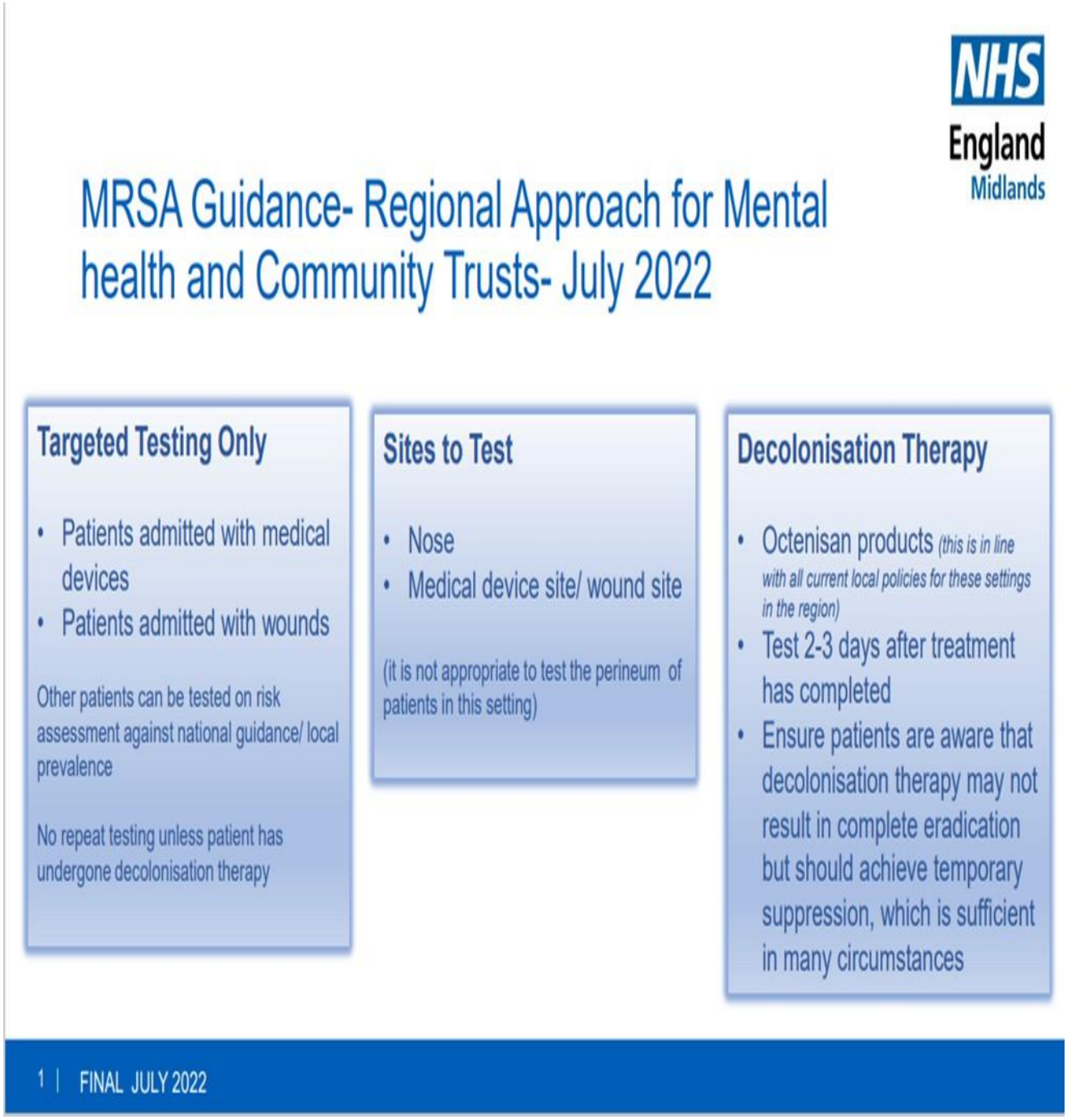
If a person's ability to make a decision is doubted, a capacity assessment should be undertaken. If the person lacks capacity and they have made an advance decision to refuse treatment (ADRT) which is valid and applicable in Relation to MRSA infection, then treatment should not be provided.

If the patient does not have an ADRT then the decision will need to be made in the persons best interest under the MCA, unless they have a registered power of attorney for health and welfare then consent should be sought from the appointed attorney.

Appendix One Definitions

Bacteremia	The presence of bacteria in the blood
Colonisation	Where an infection is present in the nose and on the skin but causing no harm to the person. People who are colonised will not. display signs or symptoms of infection. People who are colonised with MRSA are often called MRSA carriers (carriage)
Decolonisation (in relation to MRSA)	The reduction or elimination of MRSA skin carriage through the use of antibacterial washes and nasal preparations in conjunction with increased infection prevention and control and hygiene measures. It aims to eradicate or significantly reduce the carriage of MRSA. Decolonisation treatment reduces the risk to the patient and others. and if successful the patient may not require further isolation.
Heavily exfoliating skin condition (i.e., eczema or psoriasis	A skin condition that creates a large amount of shedding skin, which then contaminates the environment.
Heavily exudating wound	A wound that produces discharge or exudate which cannot be. contained within a dressing and necessitates a change of dressing every 24 hours or sooner.
MRSA (Methicillin resistant Staphylococcus aureus)	A type of Staphylococcus aureus bacteria resistant to certain antibiotics, including Methicillin and many other commonly prescribed antibiotics.
MSSA (Methicillin sensitive Staphylococcus aureus)	A type of staphylococcus aureus bacteria that is sensitive to many antibiotics. It is an opportunist pathogen. It can either be colonized or infected.
MRSA screening	The taking of swabs from patients to test for the presence of MRSA. This will be nasal screening for those patients screened as laid out in the Department of Health requirement and screening of risk factors for other patients where appropriate.
Opportunistic infection	(Bacteria, viruses, fungi, or protozoa) that take advantage of an opportunity not normally available, such as a host with a weakened immune system, an altered microbiota (such as a disrupted gut flora) or breached integumentary barriers.
Outbreak/increased incidence	The occurrence of two or more cases of the same infection, linked in time and place, or a situation where the observed number of cases exceed the number expected.
Personal protective equipment (PPE)	Specialised clothing or equipment worn by employees for protection against health and safety hazards and includes nitrile gloves, aprons, masks, and eye protection.
Productive cough	A cough that produces sputum.

Appendix Two MRSA Guidance Mental Health & Community trusts.



Appendix Three: Making a New referral to the Infection Prevention & Control team

Choose one of 3 methods below if a patient has an infection / suspected infection or is a known carrier.

Phone: 0116 295 1668 (Answerphone service)

Staffnet: Send an automated email alert to IPC via Staffnet.
https://staffnet.leicspart.nhs.uk/support-services/infection-prevention-control/contact-us/ipcform/

E-Referral on SystmOne:

Patients with a lifelong infection will have this icon ⚠ in the demographic box on SystmOne, if missing contact the IPC Team.

It is imperative that staff check the infectious status of all patients when they first come under their care.

Appendix Four: Guidance for the use of antibacterial body wash/shampoo & Bactroban Nasal ointment.

Infection Prevention and Control Team

Guidance for the use of Antibacterial Body Wash/Shampoo and Bactroban Nasal Ointment

Antibacterial Body Wash/Shampoo

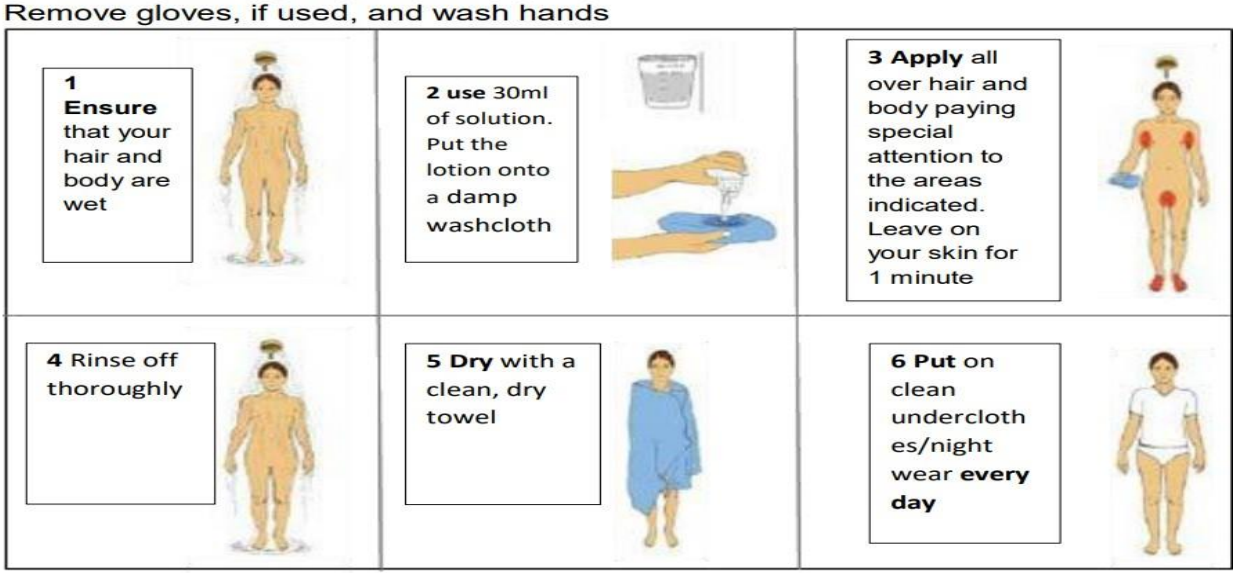
How to use the body wash/shampoo

- Use the antibacterial body wash everyday as a liquid soap, for a shower, bath, or wash. Avoid direct contact with eyes when washing
- Use the antibacterial body wash as a shampoo to wash hair twice a week

Bactroban nasal ointment (Mupirocin 2%)

How to use the Bactroban nasal ointment

- Place a small amount of ointment (about the size of a match head) on a cotton bud, swab or on a gloved finger and apply to the front part of the nostril
- If the patient is self-administering and does not have access to gloves, then a clean finger can be used.
- Close the nostrils by pressing the sides of the nose together – this will spread the ointment through the nostrils
- Remove gloves, if used, and wash hands

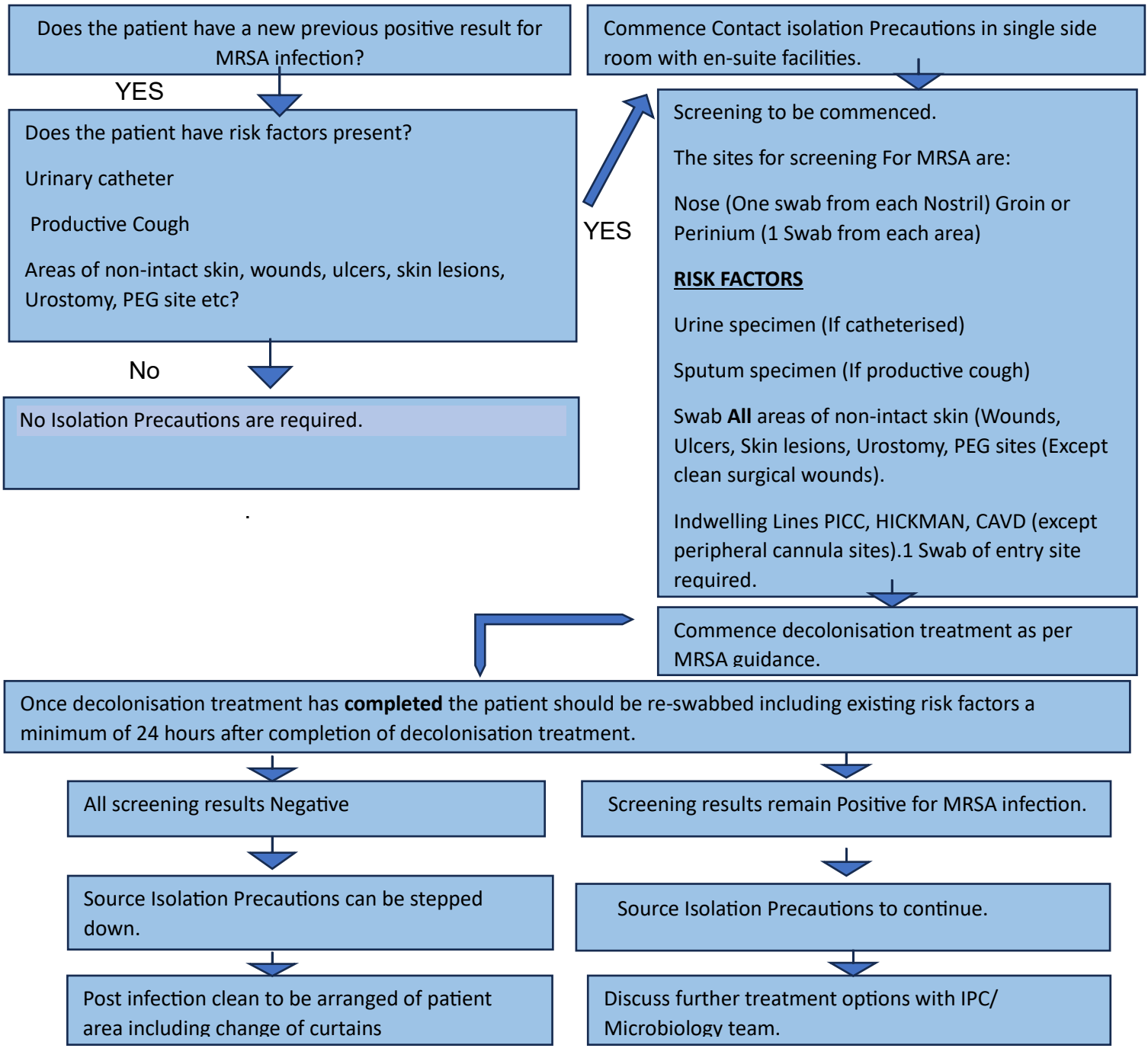


Day 1	Day 2	Day 3	Day 4	Day5
Body	Body & hair	Body	Body & hair	Body

Appendix Five MRSA Previous carriage Patient Pathway

This pathway is only required for patients who have been identified with <u>Previous MRSA carriage</u>.

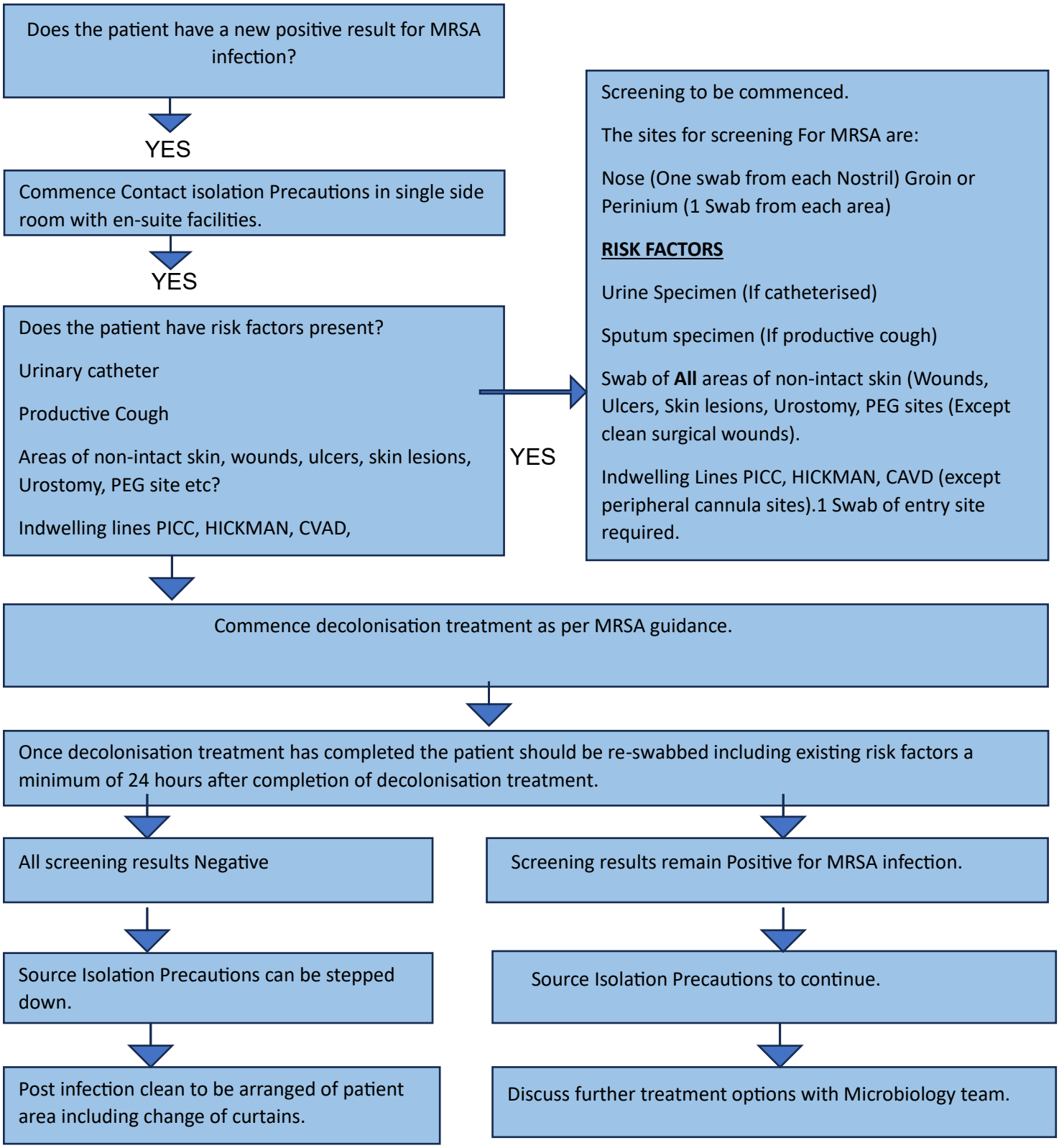
Any patients admitted who are known carriers of MRSA must be referred to IPC team.



Appendix Six MRSA New Positive Patient Pathway

This pathway is only required for patients who have been identified with a <u>New MRSA infection.</u>

Any patients admitted who are known carriers of MRSA must be referred to IPC team.



Appendix Seven MRSA Aide Memoire for management of a patient suspected/confirmed to have MRSA infection in a Community Hospital Inpatient setting:

Leicestershire Partnership Trust Infection Prevention & Control Team

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA Aide Memoire (Lifelong Infection)

Consult Policy and isolate in a single room with:

- ✓ Ensuite/own commode
- ✓ Door closed.
- ✓ IPC yellow sign on door
- ✓ Dedicated equipment
- ✓ Care checklist completed daily.

Patient is assessed daily.

YES

- ✓ Stop Isolation Precautions
- ✓ Undertake terminal clean of patient room, including change of curtains.

NO

MRSA infection -Guidelines for patient Isolation

Personal Protective Equipment (PPE)

Gloves, Apron, FRSM (Risk assess visor and Gown if risk of splash from Blood/body fluids) FFP3 Mask for AGPS.

Hand Hygiene

Use soap and water staff to remain BBE.

Environment

Area to be cleaned twice daily, Full post infection clean including change of curtains once SIPS have been stepped down.

Laundry

All linen and laundry will need to be treated as infective and will need to be disposed of in the appropriate waste streams.

Waste

All waste will need to be treated as infective waste and will need to be disposed of into the

Period of isolation. Dependent upon clinical assessment of the patient. No isolation required if there are no risk factors present.

Risk factors: Productive cough, heavily exudating wounds, heavily exfoliating skin conditions, indwelling urinary catheter, indwelling devices.

Transmission route

Direct contact

For further advice contact the IPC team on 01162952320

Appendix Eight MRSA Aide Memoire for management of a patient suspected/confirmed to have MRSA infection in a community setting

Leicestershire Partnership Trust Infection Prevention & Control Team

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA Aide Memoire (Lifelong Infection)

What is this?

Methicillin-Resistant Staphylococcus Aureus (MRSA) is a staphylococcus infection which is resistant to many common antibiotics that are used to treat infections. MRSA typically starts on the skin and can lead to serious infections if untreated.

For further guidance please refer to: LPT The-management-of-patients-with-MRSA-policy

What are the signs & symptoms?

The signs and symptoms of MRSA can vary depending on the location of the infection, but common symptoms can include the following:

High temperature C

Pain at the site of infection

Poor healing at the site of infection if wound affected.

Site of infection feels warm to the touch.

Wound leaking excess exudate/looks red/swollen.

What is the incubation period for this infection?

The incubation period for MRSA typically ranges from 1-10 days after exposure-However even after treatment individuals with MRSA will remain carriers of the infection for life.

How long are IPC measures required for?

IPC visiting precautions will need to remain in place dependent upon the clinical assessment of the patient and if any of the following risk factors are present:

Risk factors: Productive cough, heavily exudating wounds, heavily exfoliating skin conditions, indwelling urinary catheter, indwelling devices.

MRSA infection - Guidelines for patient visits

Personal Protective Equipment (PPE)

Gloves, Apron, (Risk assess visor and Gown if risk of splash from Blood/body fluids) FFP3 Mask for AGPS.

Hand Hygiene

Use soap and water staff to remain BBE.

Environment

Only take minimal amount of equipment required during visit-

Post visits all equipment will need to be cleaned with Chlo clean.

Waste

All waste will need to be treated as infective waste and will need to be disposed of into the appropriate waste streams.

Risk factors

Individuals with a weakened of suppressed immune system are at greater risk.

Individuals with chronic health conditions are at greater risk.

Individuals who may have wounds.

Recent close contact with someone colonized/infected with MRSA.

Transmission route

Direct contact

For further advice contact the IPC team on 01162952320

Appendix Five Governance

Version control and summary of changes

Version number	Date	Description of key change
Version 1	January 2010	Policy review – Amalgamation of: • Infection control guidelines for the management of patients with MRSA in in-patient settings (NP 0167 2007) • guidelines for the management of patients in primary care (NP 0168). Reviewed to meet Department of Health MRSA screening operational guidance (2006). Reviewed to meet NHSLA requirements. Reviewed to meet the Health and Social Care Act (2008)
Version 2	March 2010 May 2010	Circulated for consultation to all members of the LCCHS infection control sub-committee. Circulated to Dr Debbie Modha (consultant microbiologist UHL) for consultation.
Version 3	July-November 2010	LLR WHE discussion and proposal regarding emergency screening. Proposals approved by LLR DIPAC and Leicester City and Leicestershire County infection prevention and control commissioning group. Proposals incorporated into the policy
Version 4	November 2010	Circulated for consultation to all members of the LCCHS infection control sub-committee.
Version 5	December 2010	Comments received and incorporated into document and forwarded to LCCHS infection control sub-committee
Version 6	March 2012	Incorporation of adult mental health, mental health services for older persons and learning disability services Department of Health screening Requirements.
Version 7	August 2014	Review of policy. Deletion of advice relating to theatres, day surgery and endoscopy services that are no longer under the care of LPT infection prevention and control services
Version 8		Review of policy
Version 9	November 2021	Reviewed and update of policy in line with national guidance.
Version 10	October 2022	Reviewed and updated in line with national guidance.
Version 11	May 2023	Reviewed and updated in line with screening requirements.

Version number	Date	Description of key change
Version 12	March 2026	Reviewed and updated in line with national guidance.

Responsibilities

Responsibility	Title
Executive Lead	*Group Chief Nurse*
Policy Author	*Head of Infection Prevention & Control*
Advisors	
Policy Expert Group	*Infection Prevention & Control Assurance Group.*

Governance

Governance Level	Name
Level 1 Assurance Oversight	*Quality & Safety committee*
Level 2 Delivery Group for policy approval and compliance monitoring	*Infection Prevention & Control Assurance Group.*

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
Should describe how you are monitoring what you say you will do in the policy e.g., 100% of nurses will be on the NMC register	*Where will this information be reported, what format and how often?*
Monitoring will be conducted through: Isolation audit tool PSIRF (As applicable) Hand Hygiene Audit tool on AMAT Cleaning & Decontamination Audit	*IPC Assurance Group* *As required by clinical cases/incidences*

Training Requirements

Training
What relevant training is available for staff to support the understanding and implementation of this policy. *Infection Prevention & Control Level 1 E-learning* *Infection Prevention & Control Level 2 E-learning*