Control and management of patients colonised or infected with Methicillin Resistant *Staphylococcus aureus* (MRSA)

Methicillin Resistant *Staphylococcus aureus* (MRSA)

Control and management of patients colonised or infected with Methicillin Resistant *Staphylococcus aureus* (MRSA)

TARGET AUDIENCE	NHSL wide, Acute, Health and Social Care Partnerships
PATIENT GROUP	All in patients and outpatients

Clinical Guidelines Summary

MRSA is a strain of Staphylococcus aureus, which has become resistant to flucloxacillin and other beta-lactam antibiotics as well as other standard anti-staphylococcal antibiotics. As a result these agents are not appropriate therapy for patients colonised or infected with MRSA. It is vital that any decision to prescribe antibiotic therapy takes account of the patients MRSA status especially in surgical prophylaxis or active infection clinical situations. Further advice available within NHSL acute policies - NHSL Antimicrobial Guidelines | Right Decisions (scot.nhs.uk) or from microbiology.

Staphylococcus aureus is a bacterium which normally colonises the nose, throat and skin of approximately one third of the population. Usually this causes no harm and does not require any intervention or treatment. Commonly, MRSA infections are of the skin and soft tissues such as wound infections and boils. However, more rarely, deep seated infections such as abscesses, bacteraemia (bloodstream) and bone infections may occur. Infections with MRSA are difficult to treat due to reduced treatment options.

Control and management of patients colonised or infected with Methicillin Resistant *Staphylococcus aureus* (MRSA)

Guideline Body

1. INTRODUCTION

This guideline has been developed for use in NHS Lanarkshire (NHSL) in alignment with the National Infection Prevention and Control Manual NIPCM

Chapter 1: Standard Infection Control Precautions (SICPS)
Chapter 2: Transmission Based Precautions: (TBPS)
Chapter 3: Healthcare Infection Incidents, Outbreak and data exceedence.
Chapter 4: Infection control in the built Environment and Decontamination

2. AIM, PURPOSE AND OUTCOMES

- To ensure that patients receive appropriate and timely clinical risk assessment and screening, and management in line with current national guidelines and best practice.
- To ensure that NHSL staff apply the correct precautions to minimise the risks that MRSA pose to vulnerable contacts.

3. SCOPE

3.1 Who is the Guideline intended to Benefit or Affect?

This guideline is designed to safeguard patients, staff and the wider public from the risk of MRSA colonisation or infection.

3.2 Who are the Stakeholders?

This Guideline is aimed at all healthcare staff within NHS Lanarkshire (NHSL).

4. PRINCIPLE CONTENT

MRSA is a strain of Staphylococcus aureus, which has become resistant to flucloxacillin and other beta-lactam antibiotics as well as other standard anti-staphylococcal antibiotics. As a result these agents are not appropriate therapy for patients colonised or infected with MRSA. It is vital that any decision to prescribe antibiotic therapy takes account of the patients MRSA status especially in surgical prophylaxis or active infection clinical situations. Further advice available within NHSL acute policies - NHSL Antimicrobial Guidelines | Right Decisions (scot.nhs.uk) or from microbiology.

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4.1 Patients at risk and routes of transmission

Table 1: Summary

Causative organism	MRSA
Clinical Manifestation	MRSA can cause colonisation or infection see table 2 Case definitions.
Incubation period	Variable.
Period of infectivity	Whilst MRSA positive until 3 **consecutive** negative samples have been obtained, each 48 hours apart
Mode of transmission	Direct and Indirect Contact: • Inadequately decontaminated hands of Health Care Worker (HCWs) • Overuse and misuse of gloves can become tantamount to missing opportunities for effective HH: Appendix 5 - Glove selection chart (scot.nhs.uk) • Contaminated equipment and environment.
Reservoirs	Staff, Patients, Equipment, Environment.
Population at risk of acquisition	• Patients who require frequent hospitalisation. • Patients with invasive devices, pressure sores, underlying diseases or recent antibiotic therapy. Patients nursed in high risk areas e.g. Intensive Care Unit (ICU).
Persons at higher risk of shedding of MRSA	• Individuals who are at higher risk of shedding large volumes of skin scales and MRSA' • MRSA positive patients who have large burn wounds or widespread exfoliating skin conditions. • Patients with upper respiratory tract infections who have nasal colonisation.
Persons colonised with MRSA at higher risk of infection	Patients, who are colonised, have surgical wounds, pressure ulcers or invasive devices. Patients nursed in high risk areas ICU, Surgical High Dependency Unit (HDU), Neonatal, Orthopaedics, Vascular, Transplantation, Burns, Cardiothoracic, Haematology or Renal units have a higher risk of developing infection.
National screening programme	An MRSA Clinical Risk Assessment (CRA) must be undertaken for all elective inpatient admissions at pre-assessment and within 24 hours of admission to wards for all other admissions.

Table 2: Case definitions

Definition	Criteria

MRSA Colonisation	MRSA can be isolated from the patient's skin or mucous membranes but there are no clinical signs of associated infection.
MRSA Infection	MRSA can be isolated from wound exudates, blood cultures, or other body sites where there is ongoing clinical signs of infection and the MRSA is thought to be at least one of the organisms causing that infection. Infection rather than colonisation usually happens when the bacterium enter the body via broken skin or medical procedures.
Confirmed case	Any individual where the laboratory diagnose MRSA positive from an admission or elective screen or clinical sample.

4.2 Community/Care Homes and Day Centres

Community	There are no specific infection control precautions required for patients with MRSA who live in their own homes. Good environmental and hand hygiene compliance is advised for patients and carers.
Care Homes and Day Centres	Infection control practices should be of the same standard as would apply to any other resident within the home. The resident should be encouraged to live normally. They should be free to: • Share a room with another person providing neither have open wounds; catheters or invasive devices. • Join others in communal areas such as sitting/dining rooms providing any sores/wounds are covered. • Receive visitors and go out of the home e.g. to visit family or friends.

4.3 MRSA and Healthcare Workers

- MRSA rarely cause infections in healthy staff and there are negligible risks to those involved in the nursing of patients with MRSA or their families, providing compliant infection control practice is observed.
- Cuts and abrasions on the hands or forearms must be covered with a waterproof occlusive dressing' and any skin lesions reported to senior staff and/or Salus Occupational Health and Safety for advice.
- Routine screening of staff is not recommended, however, if an outbreak is confirmed this may be undertaken if advised by the Incident Management Team (IMT). Refer to the **Staff Screening during incidents and outbreaks.**

4.4 SICPs / TBPs (refer also to the National Infection Prevention & Control Manual)

SICPs &TBPs	
Patient placement	• A single room should be made available for all patients colonised/ infected with MRSA, preferably with en-suite facilities. If a single room is not available a risk assessment must be completed and documented within the Personal Care Record. In some instances the patient's clinical condition may not support the placement of the patient in a single room a risk assessment must be completed and the reasons documented in the personal care record. • To minimise the spread to adjacent areas side room doors should be closed with appropriate signage fixed to the outside of the door. • Please see Nurse in Charge Poster. • If the door being closed compromises patient care, a risk assessment should be made regarding whether the door may be kept open. This must be documented in the personal care record.
Hand hygiene	• Hand hygiene is the single most important measure to prevent cross-transmission of MRSA. Hands must be decontaminated before and after each episode of direct patient contact and after contact with the patient's environment, including before and after use of PPE. Alcohol Based Hand Rub (ABHR) can be used to decontaminate visibly clean hands. Refer to Hand Hygiene Policy.
MRSA Quick Reference Guide	• Nursing staff are responsible for commencing an MRSA Management Guidance and Screening Record when a patient case is identified, available via the Clinical records page on Firstport: MRSA & PVL S. aureus Management Guidance & Swab Record SAMPLE.pdf

Control and management of patients colonised or infected with Methicillin Resistant *Staphylococcus aureus* (MRSA)

SICPs &TBPs	
Patient Screening	From admission until discharge the screening criteria is as follows: • **All** patients admitted to high risk areas should be screened within 24 hours of admission. • Positive or previously positive patients: ➢ If one negative screen is obtained, screen again after 48 hours. ➢ If this screen remains negative, screen again after 48 hours – there will now be a total of 3 negative screens obtained. • Screen all patients weekly in adult critical care areas unless otherwise instructed by the IPCN. • If a patient is on antimicrobial therapy do not screen patients until 48 hrs following completion of all antibiotics. • Previous positive patients – check past year's screening records and stop precautions when patient has a total of 3 consecutive negative screens in that period including a negative screen on admission. **Specimens for Screening** • Nasal • Perineum* • Skin lesions/wounds. • Indwelling Invasive Devices, e.g. Central Venous Catheters (CVC), Hickman Line, PICC Line. • Catheter urine. • Sputum from patients with a productive cough. *If patient refuses perineal screening they should be offered throat screening. Any modifications to the standard screening should be recorded in the notes.
Decolonisation	• It is recommended that patients who screen positive (colonised/infected) with MRSA should be prescribed a course of decolonisation. If active MRSA infection is present it is advisable to continue with decolonisation whilst the patient is receiving antimicrobial therapy. Treatment advice should be discussed with the Microbiologist. • Process for decolonisation and screening is in Appendix 3 of the MRSA guidelines
Moving between wards, hospitals and departments	• Patient movement should be kept to a minimum. Prior to transfer, HCWs from the ward where the patient is located must inform the receiving ward/hospital of the patient's MRSA status. A record of this can be recorded on the SBAR Transfer document and inserted into the patient's personal care record. When the patient requires to attend other departments the receiving area should put in place arrangements to minimise contact with other patients and arrange for additional cleaning if necessary. • Patients can attend physiotherapy/occupational therapy departments provided SICPs and TBPs are adhered to. The IPCT can be contacted for advice if required.
Equipment	• Use single-use items if possible.

SICPs &TBPs	
	• Where possible allocate equipment for individual patient use e.g. commodes etc.
Equipment & Environmental cleaning	Daily environmental and equipment cleaning must be undertaken with solution of 1,000ppm available Chlorine releasing agent. Dedicated equipment – clean as above after each use.
Personal Protective Equipment (PPE)	Aprons must be worn for direct contact with the patient or the patient's environment/equipment. Gloves and aprons must be worn when exposure to blood and/or body fluids is likely/anticipated. Gloves and aprons are single use and must be discarded immediately after completion of task as clinical waste and hands decontaminated. NB: Gloves and aprons not required for simple tasks such as placing meal trays in room.
Linen	• Linen should be treated as 'infectious linen' as outlined in the Laundry: 'Bagging & Tagging' poster. • Linen hamper bags must be tagged appropriately (e.g. date, hospital ward/care area) to ensure traceability. • Bed linen and patient clothing should be changed daily.
Patient Clothing	There are no special requirements when handling patients clothing, however, advise relatives to wash hands thoroughly after clothing is put into the washing machine. Clothes should be washed at the temperatures advised on the clothing labels. Laundry Guidelines information leaflet is available if required – if this leaflet is provided document this in the personal care record.
Waste	Waste from patients who are MRSA positive must be designated as clinical waste.
Patient Information	The clinical team with overall responsibility for the patient must inform the patient of their status and provide the patient/relatives with a MRSA patient information leaflet. The clinical team should document this in the patient's notes.
Discontinuing TBPs	• Positive and previously positive patients should not be removed from a single room until at least three full consecutive negative MRSA screens have been obtained, or advice sought from IPCT.
Terminal Cleaning ***Following transfer, discharge or once the patient is no longer considered infectious***	Remove all of the following from the vacated single room: • healthcare waste and any other disposable items (bagged before removal from the room); • bedding/bed screens/curtains and manage as infectious linen (bagged before removal from the room); and • reusable non-invasive care equipment (decontaminated in the room prior to removal). The room should be decontaminated using:

SICPs &TBPs	
	• a combined detergent disinfectant solution at a dilution (1,000ppm available chlorine.); The room must be cleaned from the highest to lowest point and from the least to most contaminated point.
Discharge Planning	The clinical team with overall responsibility for the patient must inform the General Practitioner and others in the community care team of the patients MRSA status.
Last Offices	No additional precautions required
Visitors	No restrictions on visitors. Advise visitors to perform hand hygiene with either ABHR or liquid soap and water before entering and leaving the facility.

Risk Assessment in Healthcare Settings

- Effective management of MRSA depends upon assessing the risk to the individual patient and the risk that the MRSA patient could pose to others. Advice on risk assessment can be sought from the IPCT.
- Within 24 hours of admission to hospital each individual patient will undergo the MRSA CRA. The completion of which will determine the probability of MRSA colonisation. If any question is answered 'yes' the patient must be managed in accordance with the guidance contained in this SOP.
- On admission and transfer ensure that TrakCare has been checked to verify if the patient is previously MRSA positive. This is identified on TrakCare by a pink star alert. This symbol identifies an Infection Prevention & Control Alert (MRSA, Vancomycin resistant enterococci (VRE), Carbapenamase resistant enterococci (CPE). Contact IPCT if further information is required.

5. ROLES AND RESPONSIBILITIES

All staff are responsible for implementing and following the advice provided in this guideline

Who	**Roles & Responsibilities**
NHS Board	• To provide a managed system in relation to infection prevention & control across NHSL. • To cooperate with partner agencies (e.g. Local Authority) to protect the local population from hazards to health by preventing, controlling or reducing exposure to these.

Hospital Management Teams	• To take steps to limit damage to health when such exposures occur. • HCWs and the IPCTs in following this guideline. • Cascade new policies to clinical staff after approval by the LICC.
IPCT	• Keep this Policy up to date. • Once notified via the Laboratory that there is a new isolate of MRSA, the IPCT will electronically tag the patient on the Trakcare system with a “Pink Star alert”. • Risk assess and prioritise which wards/patients will be visited post initial identification. If deemed appropriate, contact may only be made with the ward via telephone to advise staff of the patients’ status and direct staff to the policy for information on further screening, decolonisation, treatment and management
Microbiology/ Laboratory staff	• To provide laboratory testing, clinical support and interpretation of results for clinical staff and the IPCT. • To liaise with appropriate reference laboratories to coordinate additional specimen investigation. • Outwith IPCT core hours contact the ward to advise the staff of new isolates of MRSA. • The microbiology laboratory will inform the Infection Prevention and Control Nurse (IPCN) of any new/re-isolates. The results will be reported to the wards via the IPCN, however staff have the responsibility to review any outstanding screens.
Senior Charge Nurse **(Ward Manager)**	• To provide clinical and managerial leadership within the clinical area & act as role models in relation to infection prevention and control. • Ensure all staff follow the guidelines set out in this guideline. • To ensure implementation and ongoing compliance with SICPs and TBPs and take appropriate action to address any area of non compliance. • To report any difficulty in accessing or providing sufficient resource to achieve this. • Recognise and report to the IPCT any incidences of clinical conditions where the signs/symptoms are suggestive of an outbreak.
Health Care Workers	• To ensure implementation and ongoing compliance with SICPs and TBPs. • Ensure MRSA positive patients are managed in accordance with this guideline. • Ensure MRSA CRA is undertaken in accordance with this guideline. • On admission/transfer ensure Trakcare has been checked to verify MRSA status of patient. • On admission and transfer ensure that TrakCare has been checked to verify if the patient is previously MRSA positive. This is identified on TrakCare by a pink star alert. This symbol identifies an Infection Prevention & Control Alert (MRSA,

	Vancomycin resistant enterococci (VRE), Carbapenamase resistant enterococci (CPE) .
Clinicians	• To act as role models in relation to infection prevention and control. • Report to hospital management any difficulty in accessing or providing sufficient resource to adhere to this guideline. • Report any incidences of clinical conditions where the signs/symptoms are suggestive of an outbreak to the IPCT.
PSSD	To provide support services including domestic services to NHSL to maintain the cleanliness and safety of premises in line with local/national guideline.
SALUS Occupational Health & Safety	To provide specialist advice and support to clinical teams and the IPCT in relation to staff health and other matters of health and safety.
Communications Department	To lead on the development and dissemination of media statements and other key information to NHSL and external agencies. To take the lead on public communication.

6. COMMUNICATION PLAN

This policy is available on NHSL intranet. Changes to policy or guidance will be communicated to key personnel via:

- Staff Brief
- Hospital and Health and Social care Partnership Hygiene Groups
- NHSL intranet-Firstport
- NHSL external website

7. ABBREVIATIONS

CPE Carbapenamase resistant enterococci
CRA Clinical Risk Assessment
CVC Central Venous Catheter
HCWs Health Care Workers
HDU High Dependency Unit
HPT Health Protection Team
ICU Intensive Care Unit
IPCN Infection Prevention and Control Nurse
IPCT Infection Prevention and Control Team
MRSA Meticillin-resistant Staphylococcus aureus
NHSL NHS Lanarkshire
PSSD Property and Support Services Department

SICPS Standard Infection Control Precautions
TBPs Transmission Based Precautions
VRE Vancomycin resistant enterococci
IPCD Infection Prevention & Control Doctor

8. REFERENCES

Coia, J.E., et al. (2006), **Guidelines for the control and prevention of meticillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities,** Journal of Hospital Infection, 635, S1-S444.

Klutymens-Vandenbergh, M. F. & Klutymans, J. A., (2006), **Community-acquired meticillin-resistant *Staphylococcus aureus:* current perspectives**, Clinical Microbiology and Infection

Health Protection Scotland (2019), Protocol for CRA MRSA Screening National Rollout in Scotland, Version 1.10

National Infection Control Manual NIPCM

Appendices

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CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author(s):	• Infection Prevention & Control Team (IPCT)
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Control and management of patients colonised or infected with Methicillin Resistant *Staphylococcus aureus* (MRSA)

	• Chief of Medical Services • Property and Support Services Department (PSSD)
Distribution:	• NHS Lanarkshire intranet - First Port (Internal) • NHS Lanarkshire internet (Public) • Hospital and Health and Social Care Partnership Hygiene Groups • Staff Brief

CHANGE RECORD			
Date	**Author**	**Change**	**Version No.**
08/06/2015	IPCT	Content of Section J revised and updated. New policy template applied.	V1
18/07/2015	IPCT	Content revised and links updated with core group	V2
25/01/2017	IPCT	Content revised and links updated	V3
27-02-2019	LICC Governance and Review group	Changed from a policy to a guideline	V3.1
18-03-2019	Governance and Review group	Reviewed and updated to include a guideline and an SOP	V3.2
06-07-2021	Governance and Review group	Reviewed and updated in line with the Vale of Leven recommendations.	V4
14-06-2023	Infection Prevention and Control	The review date has been extended in line with NHSL guidance:	V4
20-05-2024	Governance and Review group	Reviewed in line with NHSL guidance:	V5

The MRSA National screening policy is a universal programme whereby all elective and emergency admissions where an overnight hospital stay is anticipated will undergo a Clinical Risk Assessment (CRA) as a first line screening test. The CRA identifies patients who are at risk of MRSA colonisation who will then proceed to second line swab based screening. The screening process for the national programme should be undertaken at Pre Assessment for elective patients and within 24 hours of admission to ward for all other admissions.

Control and management of patients colonised or infected with Methicillin Resistant *Staphylococcus aureus* (MRSA)

Admission Screening – National Policy

Screening Process	Clinical Area	Anatomical Swab Samples
CRA for all patients Q1. Has patient any history of MRSA? Q2. Does the patient currently live somewhere other than their own home? (Immediately prior to admission) Q3. Does the patient have any indwelling devices e.g. catheter or wounds?	• General ward areas for patients staying more than 24 hours in acute hospital. • High impact areas: - Renal, Orthopaedics, Haematology, Vascular, Adult Critical Care Areas. • High Dependency Units areas which are part of Critical Care Areas • Orthopaedics	If patient answers "Yes" to any question on the CRA: Nasal and Perineal swabs should be obtained for MRSA Screening. Where there are wounds, and indwelling devices, MRSA Screening swabs should also be obtained. Where infection is suspected separate swabs for culture and sensitivity should also be taken. Where the patient has a catheter a urine sample should also be taken.
		All patients admitted to a high impact area nasal and perineal swabs taken. Where there are wounds, and indwelling devices swabs should also be obtained. Where the patient has a catheter, a urine sample should also be taken. Guidance on infection as detailed above.

Patients Transferred During Their Care

Type of Transfer	When should they be screened?	How should they be screened?
Transfer into a high impact specialty from any source.	Once they have been transferred into their new location, within 24 hours.	• CRA form completed. • Nasal and perineal swabs.
Transfer from one hospital into another hospital (within the same Board, regardless of the specialty), excluding community hospitals.		Note: If the patient has previously been swabbed and the result is awaited from the lab, there is no

Transfer from one Board to another Board.		requirement to swab the patient again.
Transfer from one non-high impact specialty to another non-high impact specialty in the same hospital within the same board.	There is no requirement to undertake another screen during the same admission unless the screen is positive.	N/A

Exclusions:

Patients admitted to the following specialities are not required to be screened under the National programme. (This does not mean that these categories of patients should not be screened if there is a clinical need to do so):

- Day cases or patients with a length of stay which is less than 24 hours (unless previously positive in which case a full MRSA screen should be taken)
- Psychiatry
- Obstetrics
- Paediatrics
- Continuing Care

Appendix 2: Nasal and Skin Decolonisation Regimens

Prior to commencing any decolonisation regimen results from the most recent MRSA screen must be available.

Mupirocin Sensitive MRSA	• Mupirocin 2% nasal ointment to nostrils three times daily for 5 days • Chlorhexidine Gluconate 4%solution as a body wash in bath/shower daily for 5 days • Chlorhexidine Gluconate 4% solution as a shampoo on days 1 and 4
Mupirocin resistant MRSA	• Naseptin nasal ointment to nose three times daily for 10 days • Chlorhexidine Gluconate 4%solution as a body wash in bath/shower daily for 5 days • Chlorhexidine Gluconate 4% solution as a shampoo on days 1 and 4
Treatment for patients with damaged/broken skin	• Mupirocin 2% nasal ointment to nostrils three times daily for 5 days • Oilatum Plus wash lotion – bath/shower daily for 5 days • Oilatum Plus wash lotion as shampoo on days 1 and 4

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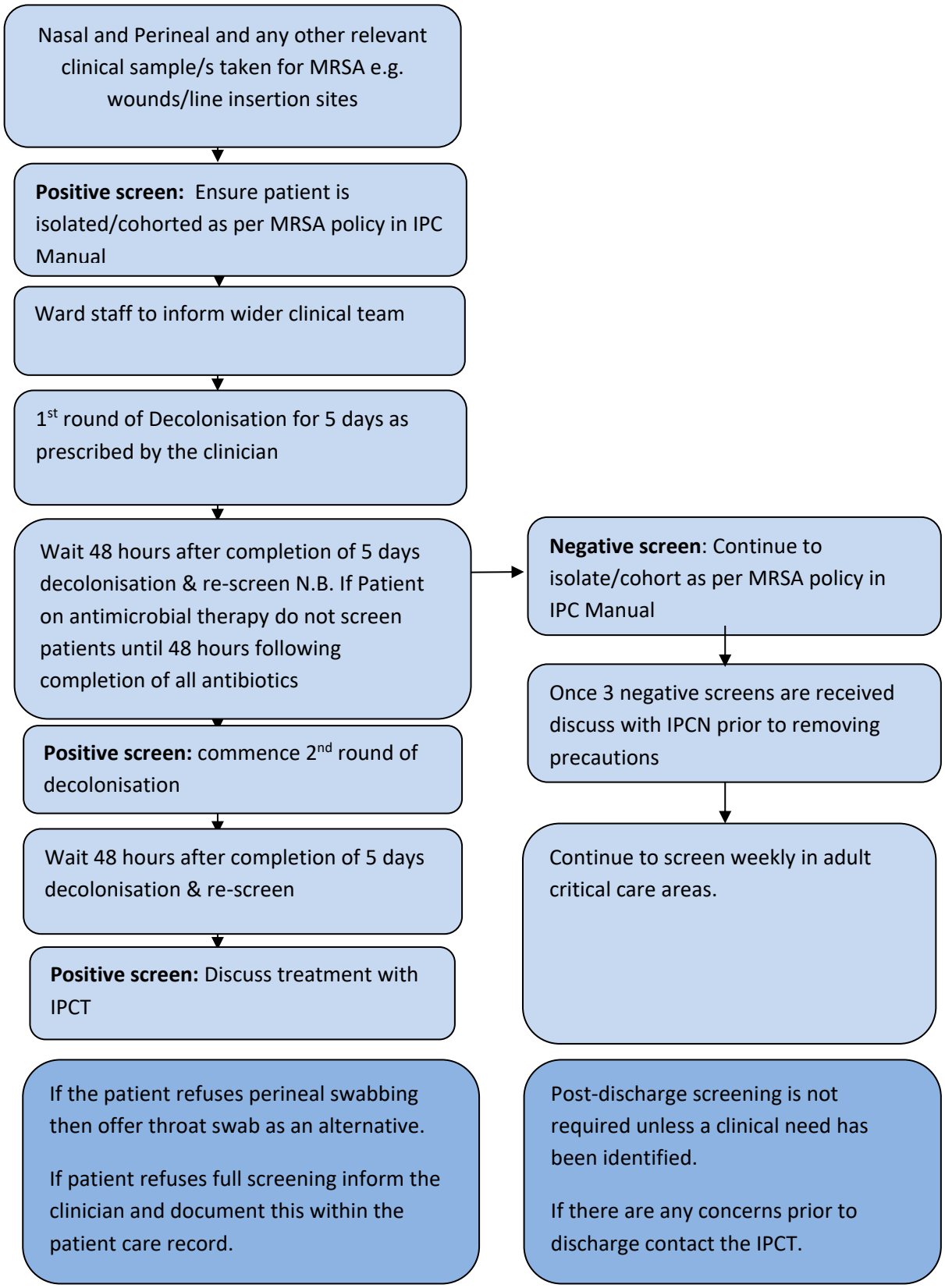
Appendix 3: MRSA Decolonisation and Screening Algorithm

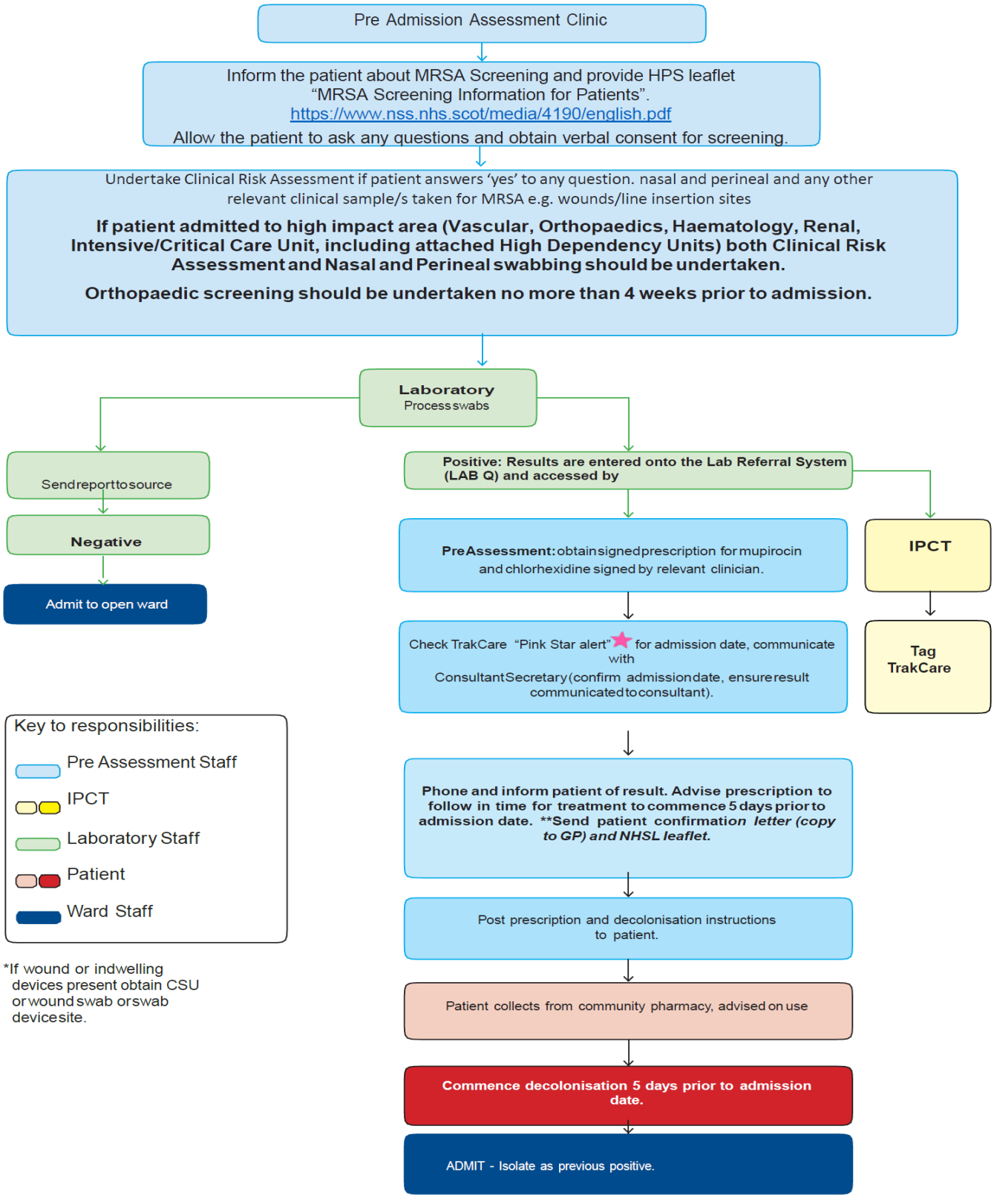


Control and management of patients colonised or infected with Methicillin Resistant *Staphylococcus aureus* (MRSA)

National MRSA Screening Programme

Screening of elective admissions

NHS Lanarkshire



Lead Author	**Lee Macready**	**Date approved**	**20-06-2024**
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Methicillin Resistant *Staphylococcus aureus* (MRSA) – (VRE) Aide Memoire

Daily Risk-assessments – only complete sections required	**Notes**	**Dates and initials for each risk-assessment assessed**					
Patient symptoms and/or organism (if suspected or confirmed) - ***Please state***							
Identified infection control risk e.g. unable to isolate/not safe to close single-room door/no en-suite room available - ***Please state***							
Reason unable to isolate patient in a single-room/ close door to single room e.g. falls risk/close observation required/ deteriorating patient - ***Please state***							
Mitigations put in place to reduce patient to patient transmission if no single room available e.g. nursed next to a clinical hand-wash basin, placed at rear of room or ward/provided with own commode/shared toilet decontaminated after each use/ clinical waste bin placed next to bed space - ***Please state***							
Patient (and family/visitors as appropriate) have been provided with IPC advice to help reduce risk of transmitting infection e.g. verbal/patient information leaflets/Hand-washing advice - ***Please state***							
IPC team have been made aware of the risk-assessment for this patient and inability to implement the recommended IPC precautions? ***Please state***							
Please provide information regarding resolutions to any of the risks noted above e.g. patient transferred to a single room/ clearance criteria for organism now met/ patient discharged from facility ***Please state***	If risk assessments are no longer required, please date and sign below: - **Date:** **Sign:**						

Control and management of patients colonised or infected with Methicillin Resistant *Staphylococcus aureus* (MRSA)

Follow NHS Lanarkshire MRSA guidance if patient is suspected, previously or currently known to be MRSA positive:

- On admission and transfer ensure that TrakCare has been checked to verify if the patient is previously MRSA positive. This is identified by a pink star
- Implement the MRSA guidance for IPC control measures, as outlined in the blue box →
- For more information refer to National Infection Prevention and Control Manual (NIPCM) Transmission-Based Precautions (TBPs) Chapter 2.
- Isolate in a single room with en-suite facilities.
- Contact the IPCT to support with risk-assessing the patients.
- Keep the door to the patients' room closed – if risk assessed as not suitable this should be documented in the patient notes.
- Where possible, dedicate single-patient use equipment.

Notifiable disease – No.

Risk-Assess Daily

No To any

- Has the patient had two, full consecutive negative MRSA screens, taken 72 hours apart, following decolonisation therapy?
  NB. No screening to take place while patient on treatment and for 48 hours after completion of treatment.

Yes To all

- Ensure that a Terminal Clean of the patient's room (or bed space as appropriate) is carried out.
- Discontinue TBPs.
- Document risk-assessment in the patient's notes.

MRSA – guidance for IPC control measures

Patient Placement – while patient is MRSA positive, isolate patient in a single-room with en-suite facilities or if no single-room available, seek advice from the IPCT.
Hand Hygiene – Liquid soap and water or hand rub.
Personal Protective Equipment (PPE)- Disposable gloves and apron for patient contact.
Patient Environment – Twice daily cleans with 1,000ppm chlorine releasing agent.
Patient Equipment – Clean between patients and after each use with 1,000ppm chlorine releasing agent and at least on a twice daily basis.
Laundry – Treat as infectious linen- double-bag - into a red alginate bag then a clear plastic bag and place in red hamper bag.
Waste – Treat as infectious and dispose of into clinical waste stream.

MRSA organism – general information

.
Incubation Period – Variable

Period of Communicability- As long as MRSA can be isolated from the patient's specimens and until two consecutive negatives screens have been obtained.

Notifiable disease- No

Transmission route- direct, indirect contact.

Lead Author	**Lee Macready**	**Date approved**	**20-06-2024**
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