Meticillin Resistant *Staphylococcus aureus* (MRSA) Screening and Management Policy

POLICY

Reference	CPG-TW-IPC24a		
Approving Body	Infection Prevention and Control Committee		
Date Approved	20/05/2026		
For publication to external SFH website Author to confirm at approval	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	30-July-2026		
Version	V9.0		
Summary of Changes from Previous Version	*Combines the MRSA management policy and screening policy in 1 document. Reduces the amount of screening undertaken in line with new guidance.*		
Supersedes	V8.1 April 2024 – June 2026 (ext2)		
Document Category	• Clinical		
Consultation Undertaken Author to complete	*Infection Prevention and Control Committee*		
Date of Completion of Equality Impact Assessment Author to review Apx C and re-date here	*20/05/2026*		
Date of Environmental Impact Assessment (if applicable)	*20/05/2026*		
Legal and/or Accreditation Implications Author to complete	Compliance with Health and social Care Act 2008 (DH 2015)		
Target Audience	Trustwide		
Review Date GSU to complete as maximum unless shorter/ earlier date recorded	*Enter the next review date for this document (Maximum 3 years from month of approval)*		
Sponsor (Position)	Director of Infection Prevention and Control		
Author (Position & Name)	Nurse Consultant & Deputy Director of Infection Prevention and Control, Sally Palmer		
Lead Division/ Directorate	Clinical Support, Therapies and Outpatients		
Lead Specialty/ Service/ Department	Infection Prevention and Control		
Position of Person able to provide Further Guidance/Information	Infection Prevention and Control Team		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Not Applicable	Not Applicable
Template control	June 2020

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1.0 INTRODUCTION

Modern healthcare has brought unprecedented benefits to generations of patients and their families. Today's healthcare though, brings risks as well as benefits. No risk is more fundamental than the risk of infection.

The Health and Social Care Act 2008 (DH 2015), states that:

> 'effective prevention and control of healthcare associated infections has to be embedded into everyday practice and applied by everyone. It is particularly important to have a high awareness of the possibility of healthcare associated infections in both patients and healthcare workers'.

Sherwood Forest Hospital NHS Foundation Trust (Trust) is committed to reducing and managing risk, ensuring effective and safe practice. The occurrence of invasive infection, particularly in vulnerable patients and limited options for therapy justify continued efforts to limit the spread of Meticillin resistant *staphylococcus aureus* (MRSA).

Prevention of MRSA is of the utmost importance, the Trust follows a targeted approach based to the screening requirements for MRSA, however the requirement for urgent specialist care must not be compromised by control measures, and the patient's overall needs take precedence.

The transmission of MRSA and the risk of MRSA infection can only be effectively addressed if MRSA carriers are identified and treated to reduce the risk of transmission (DH 2007). This policy **must** be read in conjunction with ICP 24 Meticillin resistant *Staphylococcus aureus* policy.

2.0 POLICY STATEMENT

The purpose of this policy is to provide all staff within the Trust with robust information on MRSA screening and management of positive patients at our Trust. It includes all clinical and non-clinical staff (including visiting staff to the Trust) and all clinical areas and patient groups. There are no exclusions to this policy.

3.0 DEFINITIONS/ ABBREVIATIONS

Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the Trust
Staphylococcus aureus	an organism that colonises the skin, in particular the nose, perineum, armpits, hairline and skin folds
Colonisation	Occurs when a microorganism 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 tissue lead to symptoms such as pyrexia and septicaemia, skin and soft tissue infections
Bacteraemia	blood stream infection, this is a life threatening sepsis that can lead to death if not diagnosed early and treated effectively
Anterior nares	Nose
Positive screen	defines the patient as an MRSA positive case
PEG	medical procedure in which a tube is passed into the stomach through the abdominal wall, to provide nutrient when oral intake is not adequate
Decolonisation	treatment for patients who are high risk of acquiring MRSA, to reduce the burden of bacteria colonising the human skin and thereby attempting to minimise the risk of infection
Suppression	treatment used to reduce the colonisation of the skin and nose in patients who are found to be MRSA positive
CSU	Catheter specimen of urine
UKHSA	United Kingdom Health Health Security Agency
IPCC	Infection Prevention and Control Committee
IPCT	Infection Prevention and Control Team
HCAI	Healthcare Associated Infection(s)
MRSA	Meticillin resistant *Staphylococcus aureus*
MSU	Mid-stream specimen of urine
PPE	Personal Protective Equipment
OPD	Out Patient Department
OH	Occupational Health
PVC	Peripheral venous catheter
CVC	Central venous catheter
MC&S	Microbiology culture and sensitive
PEG	Percutaneous endoscopic gastrostomy
ED	Emergency Department
EAU	Emergency Assessment Unit
OD	Once a day
TDS	Three times a day
PII	Period of Increased Incidence

4.0 ROLES AND RESPONSIBILITIES

Each individual has a clinical and ethical responsibility to carry out effective infection prevention procedures and to act in a way, which minimises the risk to the patient.

4.1 Chief Executive

The Chief Executive is ultimately responsible for ensuring that there are effective arrangements for infection prevention and control.

4.2 Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) has Trust wide responsibility for the development of strategies and policies for the management of infection prevention and control.

4.3 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) will provide specialist advice regarding Meticillin resistant *staphylococcus aureus (MRSA)*, and ensure this policy is reviewed and amended at the review date, or prior to this following new development in MRSA management research.

4.4 Consultants and Clinical Chairs

Consultants and Clinical Chairs are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They will actively support all infection prevention and control measures and will have an active role in measuring outcomes and developing action plans for improvement. They will ensure medical teams are allocated appropriately.

4.5 Divisional Directors of Nursing/Matrons

Divisional Directors of Nursing/Matrons are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They are also responsible for ensuring that resources are available for all healthcare professionals to undertake effective standard and isolation precautions. They will actively support all infection prevention and control measures and will have an active role in measuring outcomes and developing action plans for improvement. They will ensure nursing teams are allocated appropriately.

4.6 Sister/Charge Nurses

Sister/Charge Nurses are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They are also responsible for ensuring that all members of staff under their management control are appropriately trained, have access to appropriate personal protective equipment and adherence to safe practices. To keep clear and contemporaneous records re staff training.

4.7 Clinical Staff
Clinical staff are responsible for complying with the requirements of the Trust infection prevention and control policies, attend appropriate training and use appropriate personal protective equipment. To maintain clear and contemporaneous records about their own training that has been undertaken.

4.8 Non-clinical staff
Non-clinical staff are responsible for complying with the requirements of the Trust infection prevention and control policies, attend appropriate training and use appropriate personal protective equipment.

4.9 Occupational Health
Occupational Health is required to be aware of this policy. Occupational Health is responsible for ensuring that appropriate individual advice is available for staff who are advised they are MRSA positive. Staff need to contact Occupational Health for individual advice if they are advised they are MRSA positive.

4.10 Nominated Infection Prevention and Control Link Representatives and associates
Nominated infection prevention and control link representatives and associates are responsible for disseminating all relevant infection prevention and control information to staff within their own work environment, supporting the IPCT within their own ward/ department.

5.0 APPROVAL

Following appropriate consultation, this revised policy has been approved by the Trust's Infection Prevention and Control Committee.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

Staphylococcus aureus is a gram positive bacterium and is often referred to as Meticillin-sensitive *Staphylococcus aureus* (MSSA). It is very common and usually lives harmlessly on the skin and in the lining of an individual's nose. *Staphylococcus aureus* is loosely attached to the skin, making it easy to remove by conventional means such as hand washing, skin disinfection prior to invasive procedures. In addition, those that remain on the skin can easily be redistributed to other sites either on the individual affected or others. Also we shed skin scales in vast numbers at all times, these contribute to the development of dust on surfaces and equipment, and can be spread via the airborne route to settle on these surfaces as well as on the floor, hence the importance of environmental and equipment cleaning as a key intervention in the control of *staphylococcus aureus.* **Expert opinion is that direct skin to skin transfer, either from sites on the patient's own body or from healthcare workers hands is much more common than acquisition from the environment**.

Some strains of *staphylococcus aureus* have developed resistance to some of the antibiotics commonly used to treat these types of infection. These strains are known as MRSA, having acquired the mecA gene which confers resistance to a range of antibiotics including all beta-lactams and cephalosporin's. MRSA behaves in the same way as MSSA, there is no evidence that MRSA causes more severe infections than MSSA but treatment is often more difficult and expensive. MRSA is not a significant risk to healthy individuals, including healthcare workers and visitors, but as a complication for vulnerable patients it can be a serious infection with significant impact for example leading to removal of prosthetic implants and potentially death.

There is good evidence and strong consensus that screening should be applied to certain groups based on the Trust's patient population and current National and GIRFT guidance.

6.1 Confidentiality

MRSA is part of the patient's diagnosis. Personnel who do not have access to the patient's medical health records and nursing health records must not be told the nature of the illness, but should be given specific infection prevention and control guidance. Divulging a diagnosis inappropriately is a breach of confidentiality.

6.2 Definition for colonisation and infection

The effect of MRSA on individual patients is variable. It is important that staff and patients are aware of the difference between colonisation and infection in relation to MRSA. An individual patient assessment must be undertaken to determine if the patient is colonised or infected and if a suppression therapy needs to be initiated or continued.

Colonisation: isolation of MRSA on one or more occasions from any site in the absence of clinical disease (infection) attributable to MRSA. When a patient is routinely screened for MRSA prior to or on admission, the sites screened are those sites that the bacterium is known to colonise, in other words the microorganism is present on these skin sites but they are not causing the individual any adverse effects. The patient is said to be colonised.

Infection: clinical signs and/or symptoms of infection, such as redness, swelling, discharge, which is confirmed by culture to be MRSA from the site of infection. The term infection is generally used to mean the deposition and multiplication of microorganisms in tissue or on the surface of the body, which are damaged or on mucous membranes, where they can cause adverse effects often resulting in disease (infection). It is impossible to determine from clinical specimens whether an individual has an infection or is merely colonised. In these circumstances the clinical condition of the patient must determine whether they have an infection or not.

Comparing the signs and symptoms of infection and colonisation

Sign and symptom	**Colonisation**	**Infection**
Erythema (redness)	**No**	**Yes**
Pyrexia (raised temperature)	**No**	**Yes**
Cellulitis (inflammation of tissue around the wound)	**No**	**Yes**

Odour	**Yes**	**Yes**
Positive swab result	**Yes**	**Yes**
Purulent discharge (pus)	**No**	**Yes**
Excess exudate (fluid)	**Yes**	**Yes**
Local pain	**No**	**Yes**
Local oedema	**No**	**Yes**

6.3 Definition for acquisition

- **Trust acquired:** MRSA isolated for the first time (new isolate) more than 48 hours after admission

- **Non-Trust acquired:** MRSA isolated for the first time (new isolate) within 48 hours of admission.

6.4 Transmission

Although MRSA can be spread by airborne route (following bed making for a positive case) or on equipment, the most common route is by direct contact between individuals, which underlies the importance of good hand hygiene before and after direct patient contact or contact with the patients immediate surroundings i.e. bed curtains, bed table/locker etc.

The problem is due to the ability of MRSA to spread via hands and equipment to patients who are at risk. Those at greatest risk include patients with:

- Indwelling medical devices such as urinary catheters, intravenous catheters
- Skin lesions and wounds
- Chronic skin conditions
- Surgical intervention

6.5 High-risk groups for MRSA colonisation/infection

It is important to identify patients who are at high risk of acquiring MRSA. Remember if signs and symptoms of infection are present, not every infection is due to MRSA even when the patient is a known carrier. It must be recognised that it is not always possible to eradicate MRSA.

Obtaining swabs is a key component of an effective MRSA prevention programme and certain patient groups are deemed to be a higher risk of contracting serious MRSA infections, therefore the following categories of patients are considered as being at high-risk of MRSA colonisation and/or infection (**note that this is NOT an exhaustive list**):

- Patients who are social or healthcare staff (due to their exposure to MRSA positive patients)
- Other health related staff may also warrant assessment for screening for example veterinary personnel, who have been found to have a relatively high (18%) carriage rate (Loeffler et al 2005)
- Patients with a previous history of MRSA
- Transfers from hospitals outside the Trust including diagnostic procedures and abroad
- Previous hospital stay (longer than 48 hours) within previous 12 months (UK

or abroad)
- Patients admitted from Nursing or Residential Homes
- Patients admitted to the Intensive Critical Care Unit
- Babies admitted to the Neonatal Intensive Care Unit
- All haematology patients
- Patients undergoing an orthopaedic procedure
- Patients having vascular surgery
- Patients with central lines (note: CHG dressing to be used)
- Patients with chest drains
- Chronic wounds including all diabetic foot ulcers
- Patients with indwelling devices e.g. Urinary/suprapubic catheters and nephrostomy/urostomy site etc

6.6 Emergency Admission screening of patients (elective and emergency)

All patients admitted to the Trust as an emergency must have an MRSA screen undertaken within 24 hours of admission. The sites screened must include Nose and perineum/groin as a minimum and any wounds, indwelling devices, CSU.

6.7 Elective admission screening of patients

The Trust will screen Trauma & Orthopaedic and Vascular patients and anyone in any of the high-risk categories below as per the new GIRFT guidance:

High risk categories are:

Anyone identified as colonised with or with a history of MRSA.

Patients admitted to high-risk specialties/units.

Anyone residing in a nursing or residential home.

Anyone having an implantable device fitted that will remain for more than 30 days.

Anyone who is catheterised, has a stoma, nephrostomy etc.

Healthcare staff or those in farming and agriculture.

Those patients admitted to hospital within the past year.

(Please note this list is not exhaustive)

6.8 Personal protective equipment

It is vital that you must wash your hands, and wear appropriate personal protective equipment (PPE) i.e. gloves and aprons prior to collecting any form of specimens and using an aseptic non-touch technique and sterile swabs.

6.9 Screening in-patients

In patients will be re-screened for MRSA if they are a contact of a positive, i.e., in the same bay, or on advice from IPCT and the Consultant Microbiologist.

6.10 Microbiological samples required for MRSA screening

An MRSA screen must consist of the following specimens (unless advised by the IPCT):

- Nasal swab
- Perineal/Groin swab
- Swabs from skin lesions such as eczema, psoriasis and wounds (must not have had an antibacterial dressing on in previous 48 hours) if present
- Samples from the sites of indwelling devices such as:
    - Urinary catheter - Catheter specimen of urine (CSU) (**do not** send MSU for MRSA screen as these will not be tested)
    - Central venous catheter (CVC) or Peripheral venous catheter (PVC) line insertion site (one swab per site)
    - Tracheostomy/PEG stoma (one swab per site)
    - Urostomy/Colostomy sites
    - Chest drain etc
- Sputum if the patient has a productive cough present

When a repeat screen is required for any patient, all sites must be rescreened as detailed above if indicated.

6.11 Procedure

- Charcoal wound swab
- **Nose:** pre-moisten swab with tap water (Weston 2008), and then rotate the swab in each anterior nares (nostril) in turn, using the same swab for both nares
- **Perineum/Groin:** pre-moisten swab with tap water, and then rotate the swab on the perineum/groin. If it is not possible to sample the perineum then the screen can be taken from the groin, remember to state the site of the screen on the microbiology request form. It is not necessary to use one swab for each side.
- **Wounds:** this includes surgical wounds, leg ulcers, pressure ulcers, eczema or other skin lesions. Pre-moisten the swab with sterile normal saline/sterile water, and rotate across the wound (cleanse wound first).
- **Invasive devices:** if the patient has an invasive medical device such as PVC.PEG in situ then the point of entry will require MRSA screening. Pre-moisten swab with sterile normal saline/sterile water and then rotate the swab around the entrance site
- **Urine:** if on admission the patient has an indwelling urinary catheter, a catheter specimen of urine (CSU) is required. Specify on the form for MRSA screening
- **Other specimens:** other specimens are not required routinely but can be undertaken if clinically indicated. This could include sputum, vaginal swab, blood cultures etc

6.12 Decolonisation

For emergency admission all high risk patients should have decolonisation treatment

- Nasal Octenisan for 15 doses over 5 days (3 times a day)
- Octenisan hair and body wash
    - Hair wash twice during the 5 day body wash cycle
    - Body wash daily for 5 days

For elective admission, decolonisation should be given to the patients who meet the below criteria:

1. All patients who are having surgery that require an implantable device
2. All patients undergoing major orthopaedic (e.g. arthroplasty and spinal operations)
3. All patients where there is surgical concern of increased risk of surgical site infection (SSI)

The Preoperative decolonisation should be commenced the day before surgery, use on the day of surgery and then 3 days following surgery.

6.13 Microbiological samples requests

Remember that whatever the specimen may be it must be clearly and accurately labelled; this is the responsibility of the person collecting the specimen. All requests for MRSA screens should be made via ICE where available. If ICE is not available then requests should be made using the standard microbiology blue requests form. Information that **must** be written (in the other tests section or relevant information box) on the form includes:

- MRSA screen
- Either:
    - Elective
    - Emergency
- All sites where swabs were obtained from

This information allows the laboratory staff to process the specimen in the optimum manner.

If Microbiological Culture and Sensitive (MC&S) is also required, the same swab may be used but please make it clear on the form that you also require this test

6.14 Communication of positive results and alerting mechanisms

For all patients with a previous history of MRSA, and newly diagnosed MRSA the following is used to identify them:

- When a patient has a positive result a member of the IPCT will phone the ward/department and inform the Registered Nurse looking after the patient
- The medical notes **must** be clearly labelled '**MRSA positive**' using the printed '**Alert**' labels; a member of the IPCT will alert the Careflow Patient Administration System (PAS) accordingly. The alert label **must not** be removed. If a set of notes does not display an alert label, please contact the IPCT

6.15 Treatment of MRSA colonisation

Complete eradication of MRSA is not always possible, but a decrease of carriage can reduce the risk of transmission, as well as reduce the risk of inoculation to the patient's own surgical wound during surgery. The efficacy of any suppression regime will depend

on the presence of wounds, skin lesions and foreign bodies such as urinary catheters. The suppression therapy is reserved for the treatment of patients who are confirmed MRSA positive. The MRSA suppression therapy should be carried out under the advice of the IPCT.

- **Decolonisation therapy:** The use of an antibacterial hair and body wash and nasal ointment, for patients who are in the high risk categories, to reduce the burden of bacteria colonising the human skin and thereby attempting to minimise the risk of infection in high risk patients. The treatment is prescribed and administered for 5 days and this includes hair washing on 2 days (Treatment given in line with clinical area where patient is).

  Antibacterial washes must be used un-diluted and in the same way as a liquid soap. Following the completion of treatment it must be discarded.

- **Suppression therapy:** The use of antibacterial hair and body washes, antibacterial nasal ointment or cream to reduce the colonisation of the skin and nose in patients **who are found to be MRSA positive**. The treatment is prescribed and administered for 5 days and this includes hair washing on 2 days.

  - Nasal Octenisan for 15 doses over 5 days (3 times a day
  - Octenisan hair and body wash
    - Hair wash twice during the 5 day body wash cycle
    - Body wash daily for 5 days

  Following the completion of treatment the Nasal Octenisan and Octenisan must be discarded, if a second course of suppression therapy is required use a new supply of nasal Octenisan and Octenisan hair and body wash.

- **Neonates:** For any Neonates who have a positive MRSA result the suppression treatment that should be used is:
  - Nasal Octenisan for 15 doses over 5 days (3 times a day
  - Octenisan antibacterial hair and body wash
    - Hair wash twice during the 5 day body wash cycle
    - Body wash daily for 5 days

If the result is not from a screen, for instance the result was obtained from a wound swab, blood culture, urine sample then a MRSA screen from the nose and perineum, skin breaks must be obtained, prior to commencing the MRSA suppression therapy (this must be commenced prior to these screen results being known).

6.16 Prescribing

The suppression therapy should be prescribed by a Clinician. Mupirocin and Naseptin are **prescription only** medications hence require prescribing on the patient's medication chart. Octenisan body wash and nasal ointment is a cosmetic product and therefore does not require a prescription, but **its administration must be documented daily** on Nervecentre EPMA to ensure that it is acknowledged as being given throughout the course of the

treatment. Any patient being given Octenisan must be given the patient information leaflet as well as being instructed in the correct use of this product (see Appendix A).

6.17 MRSA clearance

The first post MRSA treatment screen must be taken >48 hours after stopping suppression treatment.

Re-screening result (positive): a positive results indicates that colonisation is on-going and the suppression therapy should be repeated for in-patients. If colonisation is still on-going after 2 cycles of the suppression therapy or recurs at a later date the IPCT must be consulted before any further suppression therapy is administered.

Re-screening result (negative): a negative result indicates that colonisation is not on-going and suppression therapy will not need to be repeated although contact infection prevention and control measures must continue until 3 consecutive negative screens 7 days apart have been received.

6.18 Management of MRSA positive patient and histories of MRSA

Patient care **must not** be compromised by the control measures implemented.

- **Communication**: it is the responsibility of the medical staff to inform the patient and relatives of the MRSA status. Written information is available via the intranet (patient information leaflet), which provides information for patients and their relatives/carers. Information must be provided by the nursing staff following the patient being informed by the medical staff. The discussion held must be recorded in the patient medical notes.

- **Contact isolation precautions:** single/isolation with en-suite facilities, with doors kept shut to minimise the spread to adjacent areas, where possible. Contact isolation precautions are required for all known or suspected patients with MRSA. An appropriate sign stating which precautions are required must be displayed on the door of the room or above the bed space if patient has to be nursed in a bay.

  If a patient is being nursed in a Bay, and then identified to be MRSA positive they should be moved to a single room where available and contact isolation precautions commenced. The bed space **must** be cleaned with an Amber clean and the curtains changed. If the patient has been in the bay for more than 24 hours, the other patients in this bay need to be screened for MRSA (potential contacts).

- **Other microorganisms, such as *Clostridium difficile,* may take precedence over MRSA colonisation for isolation.** Any exception **must** be discussed and agreed with the Sister/Charge Nurse or Matron for the area and the IPCT

- **Personal protective equipment (PPE):** yellow disposable plastic apron and gloves must be worn by **all** staff in contact with the patient, contact with secretions, blood and/or body fluids, the patient's immediate environment, linen, waste and equipment. These are **single use items,** and are disposed of as Orange AT waste. Face and eye protection is not normally required unless specifically advised by the IPCT

- **Hand hygiene:** good hand decontamination procedures with soap and water, followed by the use of alcohol based hand rub prior to and after all patient contact, contact with the patients environment and removal of PPE. Hand washing is the single most important means of controlling the transmission of MRSA, as well as other microorganisms and remains the cornerstone of good infection prevention and control practices

- **Waste disposal:** all waste generated form the patient must be processed as orange AT waste (orange bags) and disposed of accordingly to Trust policy (Refer to Trust Waste Management Policy)

- **Laundry:** used linen must be treated as infected and placed in a water-soluble (alginate) red bag then placed inside a white plastic bag prior to being removed from the side room and placed immediately into the disposal hold. Any soiled patient clothing must be placed in a water-soluble bag and then into a patient property bag for relatives to take home. Relatives must be informed that the soiled clothing is there and instructed in the use of the red water soluble bag.

- **Environment:** the bed space remains the responsibility of the domestic staff and must be cleaned at least daily in accordance with Trust policy and as per cleaning schedules. Following discharge of the patient or discontinuation of standard isolation precautions, an Amber clean of the patient's room is required.

- **Patient immediate surrounding equipment:** any equipment not for dedicated use must be removed from the room, any monitoring equipment must be cleaned between patients. Single patient use disposable blood pressure cuffs and tourniquets must be considered (purchased at ward level). If the patient is moved to a different bed, the integrity of the mattress cover and pillows must be ensured, the mattress and pillows must be checked for contamination by ward staff. If the integrity is breached:

    - Mattress: decontaminate the external aspects of the mattress, complete the 'decontamination certificate', and log call via the Helpdesk (extension 3005).
    - Pillows: decontaminate the external aspects of the pillows and place them into an orange waste bag and return to laundry, where a replacement pillow will be issued.

- **Visitors:** are not required to wear PPE unless they are providing and/or assisting with direct patient care, however, they should be asked to wash their hands on entering and leaving the room

- **Patient activity:** all known or suspected MRSA positive patients nursed in a side room are able to mobilise outside their room unless they have a productive cough, exudating wounds, or an exfoliating skin condition when advice should be sought from the IPCT. Patients should wash their hands or use the alcohol based hand rub prior to leaving their room

6.19 Treatment and clinical advice for MRSA infection

Patients suspected of having a MRSA infection, the patient's medical team **must** refer to the Antimicrobial policy and guidelines.

6.20 Prevention through appropriate antibiotic prescription

Antibiotics should be prescribed only when there is clinical evidence of bacterial infection. The indications for starting antibiotics **and** a stop/review date for the antibiotic must be clearly documented in the patient's medical records. The Trust antibiotic guidelines for patients are available on the Antibiotic intranet website

6.21 Low risk areas

This includes areas such as outpatients, diagnostic imaging, etc where the risk of acquisition and spread are deemed to be minimal as long as standard precautions are followed at all times, paying particular attention to hand washing and the use of PPE for clinical procedures. Examination/procedure couches must be cleaned between each patient and clean paper roll applied. All equipment which has had direct contact with the patient must be cleaned prior to use for another patient, using green Clinell wipes.

6.22 Transfer of the patient

Transfer to other hospital, between wards and within wards and departments must be kept to a minimum, but when necessary, the actions detailed below must be adhered to:

- On transfer of a patient to another ward or Trust the ward staff must inform a member of the IPCT, during the next office hours on extension 3525 or leave a message on the answer phone.

- All internal transfers, information about the patient's infectious status must be provided to the receiving ward. Patients who are MRSA colonised can visit other hospital department for treatment, investigations following consultation with the Sister/Charge Nurse.

- Portering staff must wear disposable gloves and aprons **only** when required to have direct contact with the patient for instance helping with moving and handling. PPE must be disposed of as clinical waste, and hands must be decontaminated. Hands must also be decontaminated prior to moving the patient through the hospital. The trolley/wheelchair must be decontaminated with the universal sanitising wipes after use and prior to use for another patient

- Transfer to other hospitals: the transferring ward is responsible for informing the receiving hospital if the patient is colonised/infected with MRSA. Before transfer, the clinician responsible for the patient care should inform the receiving ward and the Infection Prevention and Control Team of the receiving hospital. A transfer form must be completed for all patients giving full details of the MRSA status and MRSA treatments.

- Patients with MRSA should be discharged promptly, when their clinical condition allows to either their own home or social care i.e. care home. No special precautions are required. The care home must be informed of any specific requirements prior to being transferred. Patients GP/District Nurses must be informed of the patient's MRSA status on the discharge letter and any on-going treatment by the discharging medical team. Once discharged, continuation of care concerning the patients MRSA status is the responsibility of the GP and its their responsibility to inform the Community IPCT

- Transport and the use of ambulances: there is no evidence that ambulance staff/hospital drivers or their families are put at risk by transporting patients with MRSA. Ambulance liaison must be made aware of the MRSA status of the patient by the ward or department staff, the ambulance must be cleaned and decontaminated in accordance with their policies

- Liaison with outside agencies: if input from outside agencies is required, the ward as normal must arrange this. A member of the trust IPCT will give advice if required. Once the patient has been discharged, further advice can be obtained from the Community IPCT

- Patients should be advised that if they are re-admitted to hospital at any time, they should advise the admitting staff that they have previously been identified as colonised/infected with MRSA, in order to ensure that they are appropriately managed.

It is crucial that the patient, their relatives and/or carers must be fully briefed on MRSA and informed that there is no risk of infection to healthy relatives and contacts outside the hospital, and that normal social interactions should not be compromised.

6.23 Deceased patients

There is no specific risk from the body to relatives, nursing staff or undertakers. The precautions taken in laying out the deceased patient must be the same as those observed during life. The patient should **only** be placed in a cadaver bag before being transferred to the mortuary if there is the potential for body fluids to leak from the deceased during transportation. Any lesions that leak should be covered with an impermeable dressing. There are no requirements to use a cadaver bag because the deceased was MRSA positive.

6.24 Management of MRSA outbreak

If there is deemed to be an increased amount of MRSA in a ward the IPCT will convene a Period of Increased Incidence (PII) or an outbreak meeting. It is deemed as an outbreak if there are two or more positive cases on the same area within a 28 day period and the samples are the same SPA type. The Sister/Charge Nurse will be informed of the incident through the datix system.

6.25 Patient Safety Incident Investigation

All MRSA bacteraemia must undergo a Patient Safety Incident Investigation (PSII). This process will be led by the Consultant in charge of the patient's care. This process requires a time line to be completed from the patient's admission to time of the blood culture being taken.

6.26 Staff screening

Staff screening will not be undertaken routinely and will only be carried out at the request of the IPCT in consultation with the Occupational Health Department (OH).

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS Author – please review this information and amend as applicable. Ensure it is realistic and achievable and if asked, could evidence be provided for assurance to the trust

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Emergency/Elective admission screening	IPCT	Audit	Monthly	IPCC
New MRSA positive results	IPCT	Audit	Monthly	IPCC
Treatment Compliance	IPCT	Audits	Monthly	IPCC
Outbreak Investigations	IPCT	Audits/Meetings	As occurs	IPCC

8.0 TRAINING AND IMPLEMENTATION

All healthcare workers will be aware of the Infection Prevention and Control policies and guidelines for the Trust by attending the mandatory, induction day, annual clinical update programmes, and formal infection prevention and control sessions and by their Sister/Charge Nurse of clinical and non-clinical areas. All training sessions are outlined in the Trusts Training, Education and Development Opportunities intranet site. Infection prevention and control training is part of the Trust wide mandatory training for all staff and is monitored via attendance records.

All clinical staff are to be aware of and have read this policy. Information about any updates will be communicated via the Divisional Management Team/weekly bulletins.

9.0 IMPACT ASSESSMENTS

Delete/ amend as applicable:

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix F
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- GIRFT. 2025. Guide to preoperative testing: Adult MRSA screening and suppression/eradication prophylaxis for patients who are on an elective surgical pathwayGIRFT. 2025. Preoperative decolonisation interventions and washes before elective surgery.

- Coia et al. 2021 *Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities.* Journal of Hospital Infection

- DH. 2015. *The Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance*

- DH. 2014. *Epic3 guidelines*

Related SFHFT Documents:
MRSA prevention and control policy (ICP24)

11.0 KEYWORDS

words ***not*** in the published title but thought useful when using the intranet search engine to help find the document

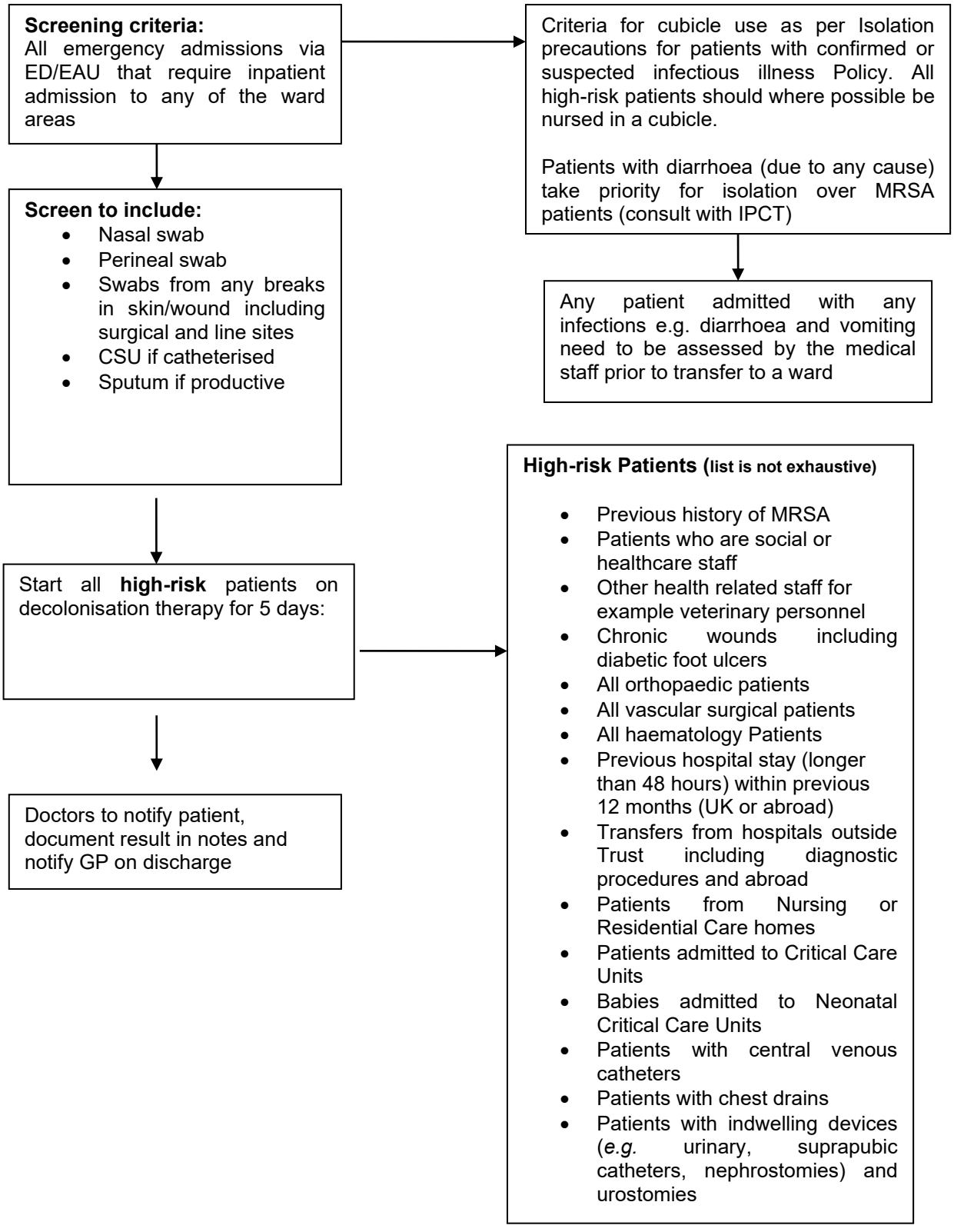
infection prevention control, Emergency, MRSA, Elective

12.0 APPENDICES

Appendix A	MRSA Screening process for emergency admission
Appendix B	MRSA screening process
Appendix C	MRSA screening process for elective admission
Appendix D	Guidance for managing MRSA positive patients awaiting elective procedures
Appendix E	Octenisan Information Leaflet
Appendix F	Equality Impact Assessment

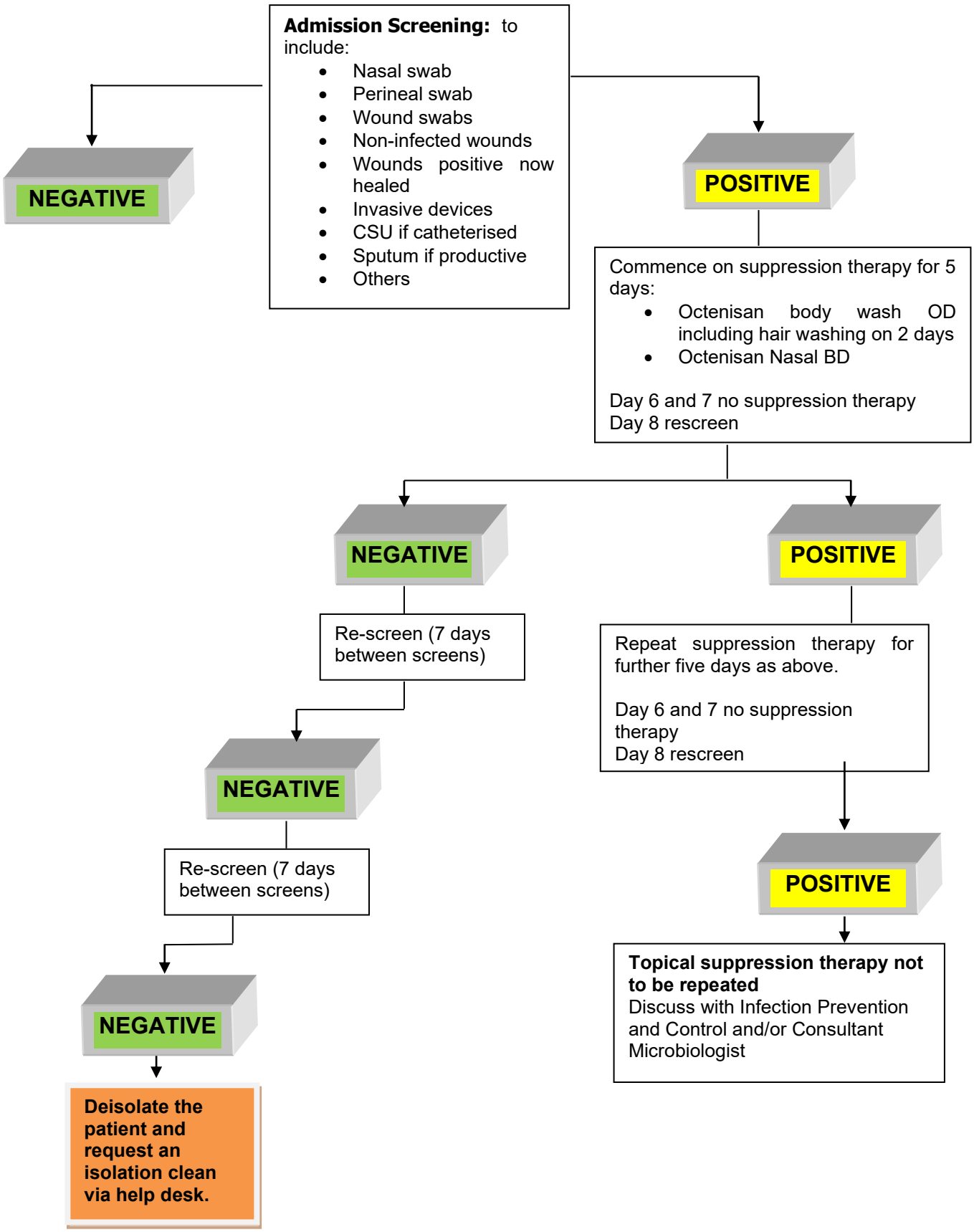
Appendix A

MRSA Screening Process for Emergency Admissions



Appendix B

MRSA Screening Process

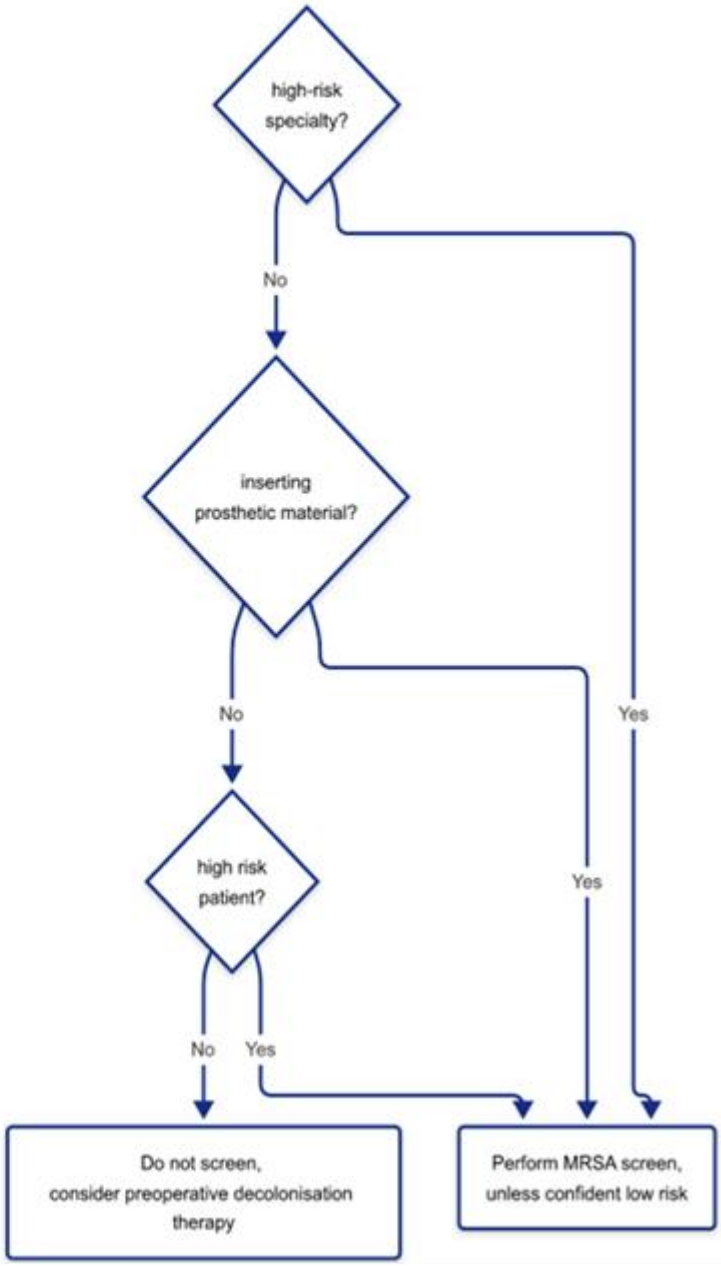


Appendix C

MRSA Screening Process for Elective Admissions

Action 1:Patients should be screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) in certain specific circumstances.

- **When** undergoing surgery within a high-risk specialty (Vascular, Renal/Dialysis, Neurosurgery, Cardiothoracic Surgery, Trauma and Orthopaedics, Oncology, Haematology, Bone Marrow Transplant) **OR**
- **When** the procedure involves the insertion of prosthetic material **OR**
- **When** the patient is identified as being at higher risk of MRSA carriage (e.g., healthcare worker, recently admitted to hospital within the last year, previously had MRSA, working in farming and agriculture[1], currently residing in a nursing care home or other care facility).
- **Unless** the local team, after careful consideration, is confident that the procedure and admission area is sufficiently low risk to render MRSA screening unnecessary, despite the specialty being high risk (For example, arthroscopy, in a low risk patient, performed as a day case away from primary arthroplasty patients).



Appendix D

Guidance for managing MRSA positive patients awaiting elective procedures

Since March 2009, NHS Trusts are required to screen all elective and day-case admissions for MRSA (except day-case ophthalmology, day-case dental, minor dermatology, day-case endoscopy, paediatrics unless already in a high risk group and low-risk obstetrics). This will inevitably mean that a greater number of MRSA positive asymptomatic carriers are identified who are awaiting elective procedures.

The IPCT and Consultant Microbiologists advice in this situation is as follows:

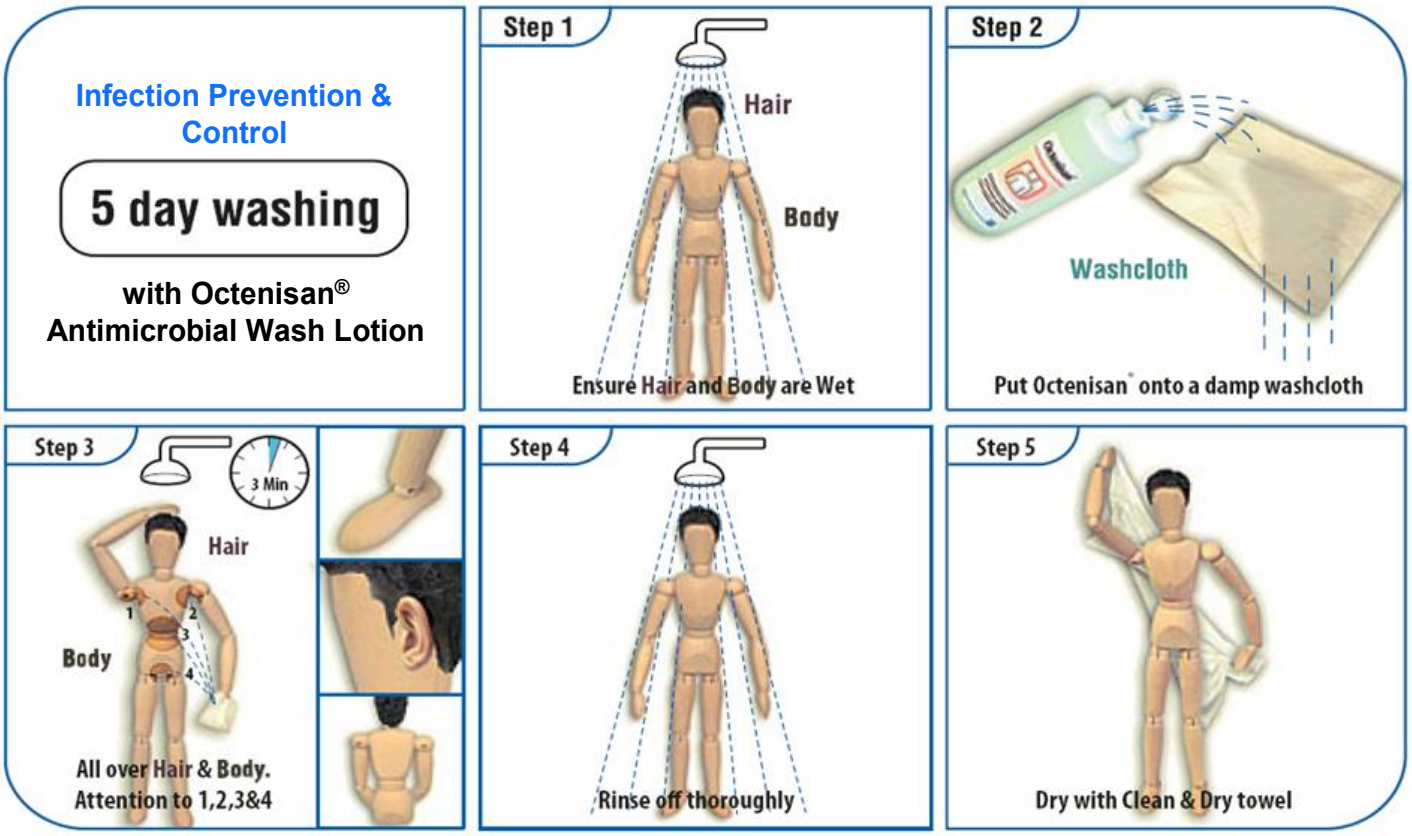
- Being MRSA positive does **not** mean automatic cancellation of the planned procedure
- Most patients can proceed to have the procedure on the original date
- Where possible MRSA suppression therapy (Octenisan) should be given prior to surgery.
    - If there is sufficient time, a full 5-day treatment course should be followed by repeat MRSA swabs after a further 48 hours, otherwise eradication therapy should be started within 48 hours pre-operatively and continued post-operatively to complete a 5-day treatment course
- If the surgery usually involves antibiotic prophylaxis, this will need to include an antibiotic with MRSA activity
    - This must be done with all recently MRSA positive patients, even if they have completed a 5-day suppression therapy course or are currently on topical eradication therapy at the time of the procedure
    - Consultant Microbiologists can advise on appropriate antibiotic choice.
- If there is particular concern regarding the risk of MRSA infection for high-risk procedures, a risk assessment must be done to weigh up the pro et contra of postponing surgery i.e. an assessment of the urgency of the clinical indication for the procedure versus the risk of MRSA infection. Advice can be sought from the Consultant Microbiologists

For patients who are found to be MRSA colonised, 3 complete negative MRSA screens taken a week apart are required before infection control precautions can be discontinued. This means that for most MRSA patients identified by pre-admission screening there will not be time to obtain 3 sets of negative results, thus appropriate precautions will need to be taken during the procedure and post-surgery.

Appendix E

OCTENISAN INFORMATION LEAFLET

Sherwood Forest Hospitals NHS
NHS Foundation Trust



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

For more information, please ask a member of staff

Sept 08 BB1

APPENDIX F – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Sally Palmer		**Date of EIA completion: 20/05/2026**
Department: Infection Prevention and Control		**Division: CSTO**
Name of service/policy/procedure being reviewed or created: MRSA screening and management policy		
Name of person responsible for service/policy/procedure: Sally Palmer		
Brief summary of policy, procedure or service being assessed: **This policy covers the requirements in the event of an infectious outbreak and actions that need to be taken in each OPEL level.**		
Please state who this policy will affect: Staff, Stakeholder organisations,		
Protected Characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Provide a brief summary of what data or supporting information was considered to complete this assessment?**
Race and Ethnicity	No	This is a review of a current policy and we have consulted with people who are already using the policy to obtain this information. We also use our networks of link professionals.
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	
Pregnancy and Maternity	No	
Gender Reassignment	No	
Marriage and Civil artnership	No	

Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)	No	

What consultation with protected characteristic groups including patient groups have you carried out? With all members of the Infection Prevention and Control Committee which includes representatives from all Divisions, Occupational Health, Medirest, Health & Safety, Skanska, UKHSA and ICB representatives.
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? No

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)						
Positive			**Negative**			
High	**Medium**	**Low**	**Nil**	**Low**	**Medium**	**High**
If you identified positive impact, please outline the details here:						

Signature: S Palme

I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form

Date: 20/05/2026