Trust Policy

Worcestershire Acute Hospitals NHS Trust

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

Department / Service:	Infection Prevention and Control
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Approved by:	TIPCC 06/11/2025 Medicines Safety Committee 10/12/2025
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All departments
Target staff categories	All clinical staff

Policy Overview:

This policy provides details on the standards required for the detection and management of MRSA in WAHT to protect patients from infection or colonisation with MRSA, prevent the transmission of MRSA and to safely manage and treat patients who are colonised with MRSA.

This policy also provides details on the standards required for the detection and management of MSSA in WAHT in relation to orthopaedic surgery to protect patients from infection or colonisation with MSSA.

Version Control

Date	Version	Amendment	By:
23.03.21	1	Amalgamation of WAHT-INF-003 and WAHT-INF-006 with amendments as required.	L Bailey (SIPCN)
20.04.21	1.1	Amendment to section 6.1.2 – addition of day 14 screening for patients with exfoliating and poor skin conditions	L Bailey (SIPCN)/E Yates (Co-Infection Control Doctor)
09.06.21	1.2	Amendments to section 6.1.3 - addition of comments from Dr Hutchinson regarding pre-operative screening	L Bailey (SIPCN)
03.10.25	2	Full Re-write of WAHT-INF-049	K. Howles (IPCT Matron)/ E. Yiannakis (Co-Infection Control Doctor)

Contents page:

1. Introduction

Staphylococcus aureus (S.aureus) is an organism that is found in the nose or on the skin of humans and is known as a commensal organism. In developed countries, approximately 30% of the population are colonised. In most circumstances this does not cause any harm, however it can cause infections such as bacteraemia and skin and soft tissue infections in the patient population, including those who are undergoing orthopaedic surgery.

Meticillin Sensitive *Staphylococcus aureus* (MSSA) is a form of *S.aureus* that is sensitive to antibiotics commonly used to treat *S.aureus.*

Meticillin Resistant *Staphylococcus aureus* (MRSA) is a form of *S.aureus* that has become resistant to antibiotics commonly used to treat *S.aureus.*

The majority of patients who acquire MRSA are colonised, not ill and do not require antibiotic therapy. Depending on patient population, some patients may develop MRSA infection which may then become invasive and, in some cases, contribute to, or result in death (Coia *et al.,* 2021).

Specific measures have been shown to be effective in preventing and controlling MRSA, necessary as it can cause serious illness which is harder to treat due to limited therapeutic options and results in additional healthcare costs.

Identification, treatment and management of individuals carrying MRSA using interventions such as screening, suppression/decolonisation regimes, and patient isolation/cohort and giving appropriate antimicrobial prophylactic regimes can reduce the risk of infection, including bloodstream infection and transmission between patients.

Screening for MSSA is indicated in specific groups of pre-operative patients as outlined in this policy.

2. Scope of this document

This policy applies to all staff employed or contracted by Worcestershire Acute Hospitals NHS Trust (WAHT) and also to all visiting staff including tutors, students and agency/locum staff and volunteers.

3. Purpose

The objectives of this policy are:

- To prevent the transmission of MRSA within WAHT
- To protect patients from infection or colonisation with MRSA
- To ensure patients who are confirmed to have MRSA are managed safely and appropriately, whilst receiving adequate information about their condition

4. Responsibility and Duties

The Chief Executive (CEO) – As accountable officer is responsible for the overall leadership and management of the Trust and its performance in terms of service provision, financial and corporate viability, ensuring that the Trust meets all its quality and safety, statutory and service obligations and for working closely with other partner organisations. The CEO delegates aspects of this responsibility to relevant Executive Directors.

Executive Director of Infection Prevention and Control (EDIPC) / Director of Infection Prevention and control (DIPC) – is responsible for the management and control of healthcare associated infection (HAI), including implementation of this policy.

Divisional Management Teams – are responsible for monitoring implementation of this policy and for ensuring action is taken when staff fail to comply with the policy.

Ward and Department Managers – are responsible for ensuring that all possible measures are taken to reduce the spread of infection to patients, visitors and staff. All managers are responsible for ensuring this policy is implemented in their areas and for ensuring all staff who work within the area adhere to the principles and standards at all times. All managers are responsible for ensuring that staff have access to up to date training to enable them to adopt safe working practices at all times and are appropriately trained to minimise risks to themselves and others.

Consultant Medical and Surgical staff – are responsible for ensuring that all possible measures are taken to reduce the spread of infection to patients, visitors and staff. They are responsible for ensuring this policy is implemented in their areas and for ensuring all staff who work within the area adhere to the principles and standards at all times. They are responsible for ensuring their junior staff read and understand this policy and adhere to the principles contained in it at all times.

Site Management Team and Bed Managers – are responsible for ensuring patients are placed in accordance with this policy, and for escalating any situations where safe placement cannot be achieved.

On-Call Managers and the On-Call Executive – are responsible for providing senior and executive leadership to ensure implementation of this policy, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

The Infection Prevention and Control Team (IPCT) – is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required. They are also responsible for the development and dissemination of the policy and for ensuring the policy remains consistent with the evidence-base for safe practice, and

for reviewing the policy on a three-yearly basis unless new guidance is published before this time.

Occupational Health – is responsible for ensuring that appropriate individual advice is available for staff who are advised they are MRSA positive.

All staff working on Trust premises, including agency and locum staff – are responsible for adhering to this policy and for reporting breaches of this policy to the person in charge and to their line manager.

5. Definitions

Colonisation – *S. aureus* is found on the skin or mucous membranes; the nose is the most common site of carriage, with the throat, perineum and groin being other common sites. It is also likely to be carried on areas of inflamed skin such as eczema/dermatitis and any wounds such as leg ulcers and pressure sores. In addition, the presence of a medical device which breaches the normal body defences such as peripheral venous cannulae (PVD), or urinary catheters will predispose to *S. aureus* carriage at that site. There are no clinical signs/symptoms of disease.

Infection – Distinct from carriage, infection implies an invasive process to a greater or lesser degree and some degree of tissue inflammation. Common infections caused by the organism include skin infections such as boils and impetigo, cellulitis, osteomyelitis and infective endocarditis. Within healthcare settings, *S. aureus* can cause infection related to medical devices such as intravenous (IV) lines. There are signs and symptoms of infection – this is usually evident by fever, a rise in the white blood cell count/ CRP or purulent drainage from a wound or body cavity.

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**

Definition for acquisition:

- Trust acquired: MRSA isolated for the first time (new isolate) from day 3 onwards (where day 1 is the day of admission).

- Non-Trust acquired: MRSA isolated for the first time before day 3 of admission (where day 1 is the day of admission).

Bacteraemia – MRSA can enter the bloodstream from a local site of infection, wound or via an invasive device such as peripheral venous cannula or central line, subsequently leading to a blood stream infection (BSI). It is considered unacceptable for a patient to acquire an avoidable MRSA BSI while receiving care in a healthcare setting.

Screening – the process of obtaining microbiological swabs to identify the presence of MSSA/MRSA.

Clearance – *S. aureus* carriage is normal for many people but in healthcare it can be useful to attempt to clear carriage with topical antimicrobials. Patients colonised with MSSA are normally prescribed decolonisation therapy prior to orthopaedic surgery or vascular surgery involving the insertion of metalwork or implants. Patients colonised with MRSA are normally prescribed decolonisation therapy unless there is a clear indication not to.

6. MRSA status

Patients admitted to WAHT must be assessed as to their MRSA status as part of the admission assessment (elective or emergency)

Staff must ensure that PAS is checked for an MRSA alert, if one is present then it is the responsibility of admitting staff to inform the patient's clinician as the management of the patient with an MRSA alert will need to be reviewed.

It is essential that the MRSA status of patients is communicated between healthcare staff on admission, transfer of care and discharge. As a safety precaution to this communication, the IPCT alerts MRSA patients on PAS. Each time the patient is admitted or transferred within WAHT this alert will remind staff that the patient has a history of MRSA.

NB: Not all patients with a history of MRSA will have an MRSA alert on the system.
Examples include:

- Patients who have not previously been admitted to WAHT
- Patients whose MRSA result was processed in a laboratory outside of WAHT

Therefore, it is imperative that the patient is asked if they have a history of MRSA and prior results checked as part of the admission assessment. Inform the IPCT if an alert is not present and one will be added to PAS.

7. MRSA Screening

7.1 Purpose of MRSA screening

- Identify patients colonised with MRSA
- Reduce MRSA transmission
- Reduce risk to patients having procedures which are high risk for MRSA infection
- Allow for decolonisation to be offered
- Check for MRSA clearance following decolonisation treatment
- Outbreak control under the guidance of the IPCT

7.2 Admission / Inpatient Screening

- All adult and Neonatal patients should be screened on admission to the trust, or if in the Emergency Department for greater than 24hrs when the decision to admit has been made.
  Exceptions:
- Obstetric patients only require admission screen if they have **risk factors for MRSA,** (Refer to Section 7.5) or are admitted to TCU
- Paediatric patients only require an admission screen if: they have **risk factors for MRSA.** Refer to Section 7.5

7.3 Pre-Operative Screening

The following patients **require** MRSA screening prior to elective surgical admission:

Table 1: Elective screening Timeframe

Patient groups	Interval before re-screen required
Orthopaedic surgery	12 weeks
Vascular surgery	12 weeks
All other surgical procedures where there is a risk of overnight admission or admission of at least 1 night anticipated	18 weeks
Where the Surgical Consultant feels the risks of MRSA infection would be significant for the patient.	18 weeks

Obstetrics booked for elective caesarean	30-36 weeks (or when decision is made if after 36 weeks)
Patients having day case surgery who have **Risk factors for MRSA.** Refer to Section 7.5	18 weeks

7.4 Pre -Operative Screening Exemption list

The following patients are exempt from pre-operative MRSA screening if there are **no risk factors**, Refer to Section 7.5.

- Day case surgery, including elective and semi-elective procedures
  - Some examples of procedures that are exempt include ENT, cystoscopy, hysteroscopy, breast surgery without implant, simple laparoscopy, vasectomy etc
- Dental surgery
- Endoscopy
- Orthopaedic local anaesthetic procedures (injections)
- Minor dermatology procedures (i.e. treatment of warts and other liquid nitrogen applications)
- Obstetrics (exception if the patient is to undergo an elective caesarean section, or any high-risk cases where there is a risk of complications in the mother and/or baby, for example likely need for admission to the Neonatal unit (NNU) or Transitional Care unit (TCU)
- Ophthalmology day cases

7.5 High Risk Groups for MRSA

It is important to identify patients who are at high risk of acquiring MRSA

- Patients who are social/healthcare staff (due to their exposure to MRSA positive patients)
- Patients with a previous history of MRSA
- Previous hospital stays/diagnostic procedures within 12 months UK or abroad including ITU or HDU
- Patients admitted from Nursing or Residential Homes
- Patients who receive care from either District Nursing Teams or Health/Social Care at home.
- Babies admitted to NNU from other hospitals
- All immuno- compromised patients (defined at:https://assets.publishing.service.gov.uk/media/5a82ce28e5274a2e8ab5970f/Greenbook_chapter_6.pdf)

- Patients undergoing an orthopaedic procedure
- Patients with chronic wounds including all diabetic foot ulcers
- Patients with extensive exfoliating skin conditions
- Patients with indwelling devices e.g. urinary/suprapubic catheters and nephrostomy/urostomy site central lines, chest drains etc
- Patients receiving renal dialysis
- IV Drug users/self- harm (current)

7.6 Re-screening

7.6.1 If screen is negative, patients are to be re-screened:

- As clinically indicated
- On day 14 (for patients with exfoliating and poor skin conditions – e.g. eczema, psoriasis or a high Waterlow Score due to fragile skin)
- Every 28 days thereafter (if remains as an inpatient)
- Weekly on ITU, NNU & TCU
- Every 3 months for patients attending Dialysis

7.6.2 If screen is positive:
Refer to section 8.0 onwards

7.7 Staff Screening

In rare circumstances it may be necessary to screen staff for MRSA colonisation. This will always be guided by the IPCT, and staff screening should not be undertaken without prior arrangement with the IPCT.

Staff found to be MRSA positive (who have been screened as a patient) will be provided advice and support by the Occupational Health Department.

7.8 Screening procedure

- The following sites need to be screened: Nose & Groin (x1 swab for both nostrils, x1 swab for both sides of the groin)
- CSU must be sent if the patient has a urinary catheter
- Wound swab if any wounds present (state site)
- Abnormal areas of skin (e.g. eczema/psoriasis)
- Insertion sites for devices in-situ (e.g. PEG, tracheostomy, IV devices)
- Sputum sample if the patient has a productive cough
- Arteriovenous (AV) fistula sites for Dialysis

The nasal and skin swabs should be moistened with sterile water or normal saline. Use a fresh vial of saline/sterile water for each patient.

Samples sent for MRSA screening will not be investigated for other organisms, send separate swabs for MC&S if infection suspected.

8. Antimicrobial Prophylaxis for MRSA and Treatment of MRSA

8.1 Antimicrobial Prophylaxis for MRSA (History or new MRSA)

MRSA status must be taken into consideration when choosing antimicrobial pre-operative prophylaxis.

Please refer to Antimicrobial Prophylaxis Guidelines on EOLAS for specific procedures and choice of antimicrobial agent

If possible, patients with a history of MRSA should have 3 negative screens prior to surgery

Attempts should be made to eradicate MRSA carriage prior to surgery. If the surgery is urgent and must go ahead prior to decolonisation, the Surgeon must risk assess

8.2 Treatment of MRSA Infection

The prompt commencement of appropriate antimicrobial treatment for those identified with and MRSA infection will reduce the mortality and morbidity associated with this organism.

Refer to EOLAS for Trust Antimicrobial Treatment guidelines.

If there is clinical concern regarding MRSA infection, advice can be sought from the Consultant Microbiologist.

9. MRSA Blood stream infection

MRSA can enter the bloodstream from a local site of infection, wound or via an invasive device such as a urinary catheter or central line, subsequently leading to a blood stream infection (BSI). It is considered unacceptable for a patient to acquire an avoidable MRSA BSI while receiving care in a healthcare setting.

Definition for Attribution:

- Hospital Onset Healthcare Associated (HOHA) Blood culture taken on the third day of admission onwards (i.e. ≥ day 3 when day of admission is day 1)
- Community-Onset Healthcare-Associated (COHA) Blood Culture taken not determined to be Hospital-Onset Healthcare Associated but where the patient was discharged from the reporting Trust within 28 days prior to the current specimen date (where date of discharge is day 1).

- Contaminated blood cultures will also require investigated by the IPCT and clinical team Division

The source of the infection should be identified in patients presenting with an MRSA bacteraemia and where applicable, the source of infection should be removed e.g. peripheral venous cannula (PVD).

Consultant Microbiologists will advise regarding antibiotics of choice for the MRSA bacteraemia.

MRSA attributable bacteraemias will be investigated by the ward manager, clinician, Divisional Governance Team and wider multidisciplinary team using Patient Safety Incident Framework (PSIRF) methodology. The investigation will be carried out within 48 hours of the MRSA. An incident meeting will be held within 7 days, whereby the investigation findings will be discussed.

The PSIRF process will:

- help identify factors that may have contributed to a MRSA BSI case
- help to identify any parts of the patient's care pathway which may have contributed to the infection, in order to prevent a similar occurrence
- help providers of healthcare and Integrated Care Board (ICB's) to identify any areas of non-optimal practice that may have contributed to the MRSA BSI
- help to identify promptly the lessons learned from the case, thereby improving practice for the future
- Identify the organisation best placed to ensure that any lessons learnt are acted on. The completed PSIRF is then shared with United Kingdom Health Security Agency (UKHSA) by the Infection Prevention Team

10. MRSA screen positive actions

10.1 Notification of positive result

The IPCT will telephone new MRSA results on in-patients to the ward and advise the nurse responsible for the patient's care of appropriate actions to be taken. The IPCT will provide advice and support to the MDT in the management of the patient.

It is however the responsibility of the clinical team obtaining the swab to follow up the results. OPD/pre -op screening results will not be called through by the IPCT. Refer to Appendix A

The nurse responsible for the patient's care must document the patient's new MRSA result in the patient's medical notes and is required to provide the patient or their relative with an MRSA Patient Information Leaflet available from the intranet. The discussion held must be recorded in the patient's clinical notes.

If the patient has been discharged prior to the positive result being received, the positive result must be communicated to relevant healthcare professionals. The patient's GP will be notified by the IPCT.

10.2 Decolonisation & Rescreening

Decolonisation

Refer to Appendix B for MRSA decolonisation recommended regimes

If clearance of colonisation is not achieved, a second course of topical decolonisation treatment can be attempted.

If the patient remains MRSA screen positive following two courses of decolonisation, advice regarding further management can be sought from the IPCT or Consultant Microbiologist.

If the isolate is noted to be resistant to mupirocin (Bactroban®), advice regarding decolonisation should be sought from the IPCT or Consultant Microbiologist.

Decolonisation body wash is used daily for all patients in the Intensive Care Units regardless of MRSA screening results.

Rescreening
Rescreening is required on completion of decolonisation

For the purpose of infection control management, patients can be regarded as clear if they have three negative screens from all appropriate sites taken at least 48 hours apart and whilst not receiving topical or systemic antibiotic therapy that would suppress the growth in culture.

10.3 Management of MRSA in Wounds

For chronic wounds, such as leg ulcers, consider the use of wound dressings that have good anti-staphylococcal activity. Advice can be sought from Tissue Viability.

10.4 Management of PEG sites and Suprapubic Catheters

Insertion sites for indwelling devices such as Percutaneous Endoscopic Gastrostomy (PEG) tubes and suprapubic catheters can become colonised with MRSA and potentially cause deep infection. Where sites are well healed, they can be treated as 'normal' skin during topical decolonisation for MRSA. If the insertion site is infected with MRSA, medical advice should be sought regarding antimicrobial treatment. Advice must also be sought from Pharmacy on the compatibility of any anti-staphylococcal dressings used and the materials the device is made from to avoid potential damage to the device and subsequent rupture.

11. IPC Precautions

All staff must ensure they adhere to the principles contained within the National infection prevention and control manual (NIPCM, 2022) located on the IPCT Intranet Source page: https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/
In addition to Standard Infection Control precautions, Contact Precautions are also required.

11.1 Patient Placement

All MRSA positive patients are required to be isolated in a side room with clinical hand wash basin, en-suite facilities and appropriate isolation signage; this is of particular importance in High-Risk settings e.g. Surgery, Trauma & Orthopaedic, Vascular etc.

The door to the single room must be kept closed; if this affects patient safety in any way, e.g. the patient is at high risk of falls then a risk assessment must be made and documented in the patient's medical notes as to whether the door must remain open. The door must remain closed during any procedures that may generate *staphylococcal* aerosols i.e. chest physiotherapy, wound dressing or bed-making.

Equipment in the room must be kept to a minimum as a cluttered environment cannot be cleaned easily. This includes mobile workstations. The patient must be provided with their own equipment, if this is not possible then such items must be effectively decontaminated following use.

On occasions when there are insufficient side rooms available to isolate patients individually, a group of MRSA positive patients can be nursed together in a defined area of the ward or department. Advice must be sought from the IPCT in these circumstances.

For further information, please refer to the Trust's Isolation and Bed Management Policy (WAHT-INF- 045): http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1520

11.2 Personal protective equipment (PPE)

Disposable single use aprons are required by all staff in direct contact with the patient and or their environment. Consider the use of gloves, fluid shield surgical mask and eye/face protection if there is a risk of exposure, splashing or spraying of blood or body fluids.

11.3 Hand Hygiene

Hand hygiene is considered one of the most important ways to reduce the transmission of infectious agents that cause healthcare associated infections (HCAIs). Perform hand hygiene:

- before touching a patient.
- before clean or aseptic procedures.
- after body fluid exposure risk
- after touching a patient; and
- after touching a patient's immediate surroundings

Always perform hand hygiene before putting on and after removing gloves.

11.4 Waste management

All waste generated form the patient must be processed as infected waste (orange bag) and be disposed of in accordance with the Trust Waste Management Policy (WAHT-CG-481). http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1315

11.5 Linen management

Used linen must be treated as infected and placed in a water-soluble (alginate) red bag, then inserted in to a white plastic linen bag outside of the room and placed immediately into the disposal hold. Refer to Trust Linen and Laundry Policy (WAHT-INF-040) http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1532

11.6 Environmental Cleaning

The room should be cleaned daily using Tristel. Nurses and domestic staff must be aware of their cleaning responsibilities. Refer to Cleaning Policy (WAHT-CG-494). http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1320

Following discharge of the patient the isolation room requires a hydrogen peroxide clean. If the patient is discharged/transferred from a bay, an amber clean and curtain change is sufficient. Call Facilities to organise this via switchboard.

11.7 Visitors

Visitors should be advised of any precautions which may be necessary (for example hand decontamination on leaving the room or cohort area). Protective clothing is not usually necessary unless the visitor is involved in direct patient care in which instance Contact precautions are required. Refer to Section 11.1.

11.8 Theatres and Procedures

Known or suspected MRSA patients requiring invasive procedures within theatre and procedure departments must be treated as for infected cases. The Theatre Co-Ordinator or Procedure Co-Ordinator must be informed of the patient's MRSA status prior to the surgery/procedure being carried out. Refer to Theatre RAG poster, located on the IPCT Source page: Cleans and Decontamination of Equipment

11.9 Outpatients

Colonised patients attending out-patient appointments should attend as normal and not be segregated using Contact precautions

12.Transfer and Discharge of Colonised or Infected Patients

12.1Transfer within the Trust

Wherever possible, transfers must be kept to a minimum. However, this should not compromise patient care in any way.

When patients are ready for transfer from ICU or HDU areas to a general ward, if a side room is required but not available, please contact the IPCT for advice. ICU and HDU beds should not be blocked

When transferring patients to other wards, the receiving ward must be informed of the patient's MRSA status before transfer so that arrangements can be made regarding contact precautions and a side-room is available if required.
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Staff involved in the transportation of the patient must wash their hands after transferring the patient. Gloves and aprons do not need to be worn unless there is a risk of contact with body fluids.

Any lesions/wounds on the patient should be covered with an impermeable dressing where possible.

Following transfer and before use with another patient, the trolley or chair must be thoroughly decontaminated.

Where the patient is leaving one ward to be admitted to another, they should be transferred to a bed with clean linen. The patient's original bed and bed linen should be left behind on the ward for decontamination, unless the patient is not well enough to be transported by other means.

12.2. Discharge of Patients

The patient's GP must be informed and any other healthcare agencies involved in providing care to the patient. This should take place as part of the discharge planning and is the responsibility of the clinical team.

If the patient is discharged to a Care home, the medical and nursing staff should be informed in advance. MRSA colonisation should not prevent discharge to a Care Home.

Patients should not be routinely screened prior to discharge into the community.

The patients and their relatives should be provided with appropriate advice in relation to the risk posed by MRSA in the home setting.

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12.3. Transfer to another Hospital

When a patient is transferred to a hospital in another Organisation, the receiving ward/department must be informed of the patient's MRSA status prior to transfer. This communication is vital as the receiving Organisation will not have access to our systems.

12.4 Ambulance Transportation

The Ambulance service must be notified in advance by the responsible clinician or delegated ward staff of the patient's MRSA status.
Most patients can be transported with other patients in the same ambulance without any special precautions other than changing any linen used by the patient.

However, if the patient being transported has a heavily discharging wound that cannot be contained with an impermeable dressing, or the patient has widespread exfoliating skin lesions advice should be sought from the IPCT. It may be necessary to transport this patient alone.

13. Care of the Deceased

Contact precautions are the same for handling deceased patients with MRSA as those used in life. There is no requirement for the use of a body bag.

Wounds must be covered with an impermeable dressing.

14. Surveillance

Surveillance is undertaken routinely as part of the Trust's annual programme by the IPCT, and the data must be a recognised element of the clinical governance process. The purpose is to determine whether or not the MRSA is healthcare associated, or community acquired. Furthermore, this surveillance enables the IPCT to rapidly identify MRSA clusters or outbreaks. Surveillance data should be fed back to hospital staff routinely.

15. MRSA Outbreak Identification and Management

The IPCT monitors MRSA acquisition within the Trust. Increases in MRSA acquisition are readily identified and action taken. Action taken is dependent upon the numbers involved, the speciality or area and the background of MRSA. Any outbreaks identified will be managed according to the Trust's Policy for Outbreak Reporting and Control, including Major Outbreaks (WAHT-INF-044):
http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1535

16. MSSA Screening

Patients who require elective Orthopaedic surgery are also at increased risk of MSSA infection.
Please refer to Appendix C for screening protocol and management in these instances.

Attempts should be made to eradicate MSSA carriage prior to surgery. If the surgery is urgent and must go ahead prior to decolonisation, the Surgeon must risk assess and consider antimicrobial prophylaxis specific for MSSA.

17. Implementation of key document

a. Plan for implementation

An implementation plan will accompany any policies submitted for approval to Trust Infection Prevention & Control committee (TIPCC), as per the Trust Policy for Policies. This will ensure awareness of roles and responsibilities, and training requirements are identified.

b. Dissemination

- Instruction to all clinical staff of revised policy via weekly Trust Brief.
- Ward and departmental based clinical staff via Infection Prevention Link Nurses.
- Updated policy to be made available via the Trust Key Documents intranet page.

c. Training and awareness

It is a mandatory requirement that all new Trust employees must attend a Trust corporate induction programme, which includes IPC training. It is the responsibility of

the line manager to ensure that IPC issues are covered in all local inductions and that this is documented. It is a mandatory requirement that all clinical and non-clinical staff update their infection control training annually, either by attendance at a formal session, or using and completing online or eLearning resources. It is the line manager's responsibility to ensure that this occurs. Different modalities are available to facilitate compliance with mandatory training requirements. These include attendance at formal lectures, ad hoc teaching, and access to online training. Records of staff training are kept centrally on the ESR database and locally by Directorates as required.

18. Monitoring and compliance

Please refer to the table below with regard to the manner in which the Trust will monitor compliance with this Policy

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Compliance with MRSA Screening Operational Guidance	MRSA screening audits Ward and Department audits	Monthly	Ward Managers IP Link Practitioners	Trust Infection Prevention and Control Committee (TIPCC)	Monthly
	Measurement of the appropriateness of decolonisation treatment (correct agents/dosages for correct time) and follow up.	Ward and Department audits. Retrospective clinical audit.	Monthly	Ward Managers Antimicrobial Pharmacists	TIPCC	Monthly
	Incidence of SSI and causative organism. Blood stream infection	Root Cause Analysis (RCA)	As arises	Multidisciplinary Team (MDT)	Divisional Reports, TIPCC, DATIX	As arises
	Review of patients with MRSA colonisation/infection	Audit	Weekly	IPCT Ward Managers	Divisional Reports and TIPCC	Monthly

	Monitoring of outbreaks	Alert system	As arises	MDT	Divisional Reports, TIPCC, DATIX	As arises

- **19. Policy Review**

This policy will be reviewed every three years or earlier if regulations change by the named individual on the front of the policy and circulated for comment prior to approval by the Trust Infection Prevention and Control Committee (TIPCC).

Dissemination of the document will be as per the Trust Policy for Policies (WAHT-CG-827). Reference to the relevant Infection Prevention policies will also be made during induction, annual and other update sessions for staff. The policies will be available to view on the Trust Key Documents page on the intranet.

20. Abbreviations:

Arteriovenous	AV
Blood stream infection	BSI
Chief Executive	CEO
Community Onset Hospital Acquired	COHA
C-reactive protein	CRP
Director of Infection Prevention and control	DIPC
Ear, nose & throat	ENT
Executive Director of Infection Prevention and	EDIPC
General Practitioner	GP
Health Care Acquired Infection	HCAI
Hospital Onset Healthcare Associated	HOHA
Intensive Care Unit	ICU
Infection Prevention and Control Team	IPCT
Integrated Care Board	ICB
Intravenous	IV
Meticillin Resistant *Staphylococcus aureus*	MRSA
Meticillin Sensitive *Staphylococcus aureus*	MSSA
National Infection Prevention and Control Manual	NIPCM
Neonatal Unit	NNU
Neonatal Intensive care	NNICU
Neonatal High care unit	NNHCU
Outpatient Department	OPD
Patient Safety Incident Response Framework	PSIRF
Percutaneous Endoscopic Gastrostomy	PEG
Peripheral venous cannulae	PVD
Personal Protective Equipment	PPE
Red, amber, Green	RAG
Staphylococcus aureus	*S.aureus*

Transitional Care Unit	TCU
Trust Infection Prevention & Control Committee	TIPCC
United Kingdom Health Security Agency	UKHSA
Worcestershire Acute Hospitals NHS Trust	WAHT

21. Supporting Documents

	Code:
WAHT Isolation and Bed Management Policy	INF-045
WAHT Cleaning Policy	CG-494
WAHT Outbreak Reporting and Control, including Major Outbreaks	INF-044
WAHT Policy for the Management of Linen and Laundry Services	INF- 040
WAHT Waste Management Policy	CG - 481
Coia, J.E. 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)". *The Journal of Hospital Infection* [Online] Available at: https://www.journalofhospitalinfection.com/article/S0195-6701(21)00360-1/fulltext [Accessed 08.10.2025]	
DoH (2014) Implementation of modified Admission MRSA Screening Guidance for NHS (2014) Department of Health expert advisory committee on Antimicrobial resistance and healthcare Associated Infection (ARHAI) June 2014. [Online] Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/345144/Implementation_of_modified_admission_MRSA_screening_guidance_for_NHS.pdf [Accessed 08.10.2025]	
DoH (2015) Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.[Online] Available at: https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance [Accessed 08.10.2025]	
H. Humphreys et al. (2023) "Rituals and behaviours in the operating theatre – joint guidelines of the Healthcare Infection Society and the European Society of Clinical Microbiology and Infectious Diseases". *The Journal of Hospital Infection* [Online].Available at: https://www.journalofhospitalinfection.com/article/S0195-6701(23)00193-7/pdf. [Accessed 08.10.2025]	
Loveday et al (2013) The patient experience of the MRSA screening process and the impact of an MRSA positive result: a qualitative study. *Antimicrobial Resistance and Infection Control*, 2:56. [Online]. Available at. https://doi.org/10.1186/2047-2994-2-S1-P56 [Accessed 24.10.2025]	

NHS England (2025) Guide to preoperative testing: Adult MRSA screening and suppression/eradication prophylaxis for patients who are on an elective surgical pathway [Online] Available at: https://www.bing.com/search?pglt=171&q=girft+mrsa&cvid=5feb547f30704201b992906dcf080f58&gs_lcrp=EgRIZGdlKgYIABBFGDkyBggAEEUYOTIGCAEQABhAMgYIAhAAGEAyBggDEAAYQDIGCAQQABhAMgYIBRAAGEAyCAgGEOkHGPxV0gEINDQwNmowajGoAgiwAgE&FORM=ANNAB1&PC=U531 [Accessed 08.10.2025]	
NHS England (2025) National infection prevention and control manual (NIPCM) for England [Online] Available at: NHS England » National infection prevention and control manual (NIPCM) for England [Accessed 08.10.2025]	
Pelfort et al (2019) Reduction of periprosthetic *Staphylococcus aureus* infection by preoperative screening and decolonisation of nasal carriers by undergoing total knee arthroplasty. [Online] Available at: https://www.aott.org.tr/en/reduction-of-periprosthetic-staphylococcus-aureus-infection-by-preoperative-screening-and-decolonization-of-nasal-carriers-undergoing-total-knee-arthroplasty-166639 [Accessed 08.10.2025]	
Pratt et al (2014) Epic3: National Evidence Based Guidelines for preventing Healthcare-Associated Infection in NHS Hospitals in England. *Journal of Hospital Infection*, 65 (1): Supplement 1.	
UKHSA (2017) The Green Book Immunisation against infectious disease[Online] Available at: Immunisation against infectious disease - GOV.UK[Accessed on 01.11.2025]	
UKHSA (2025) Annual epidemiological commentary: Gram-negative, MRSA,MSSA bacteraemia and C.difficile infections[Online] Available at: (Annual epidemiological commentary: Gram-negative, MRSA, MSSA bacteraemia and C. difficile infections, up to and including financial year 2022 to 2023 - GOV.UK [Accessed 08.10.2025]	

22. Background

a. Consultation

Contribution List

This key document has been circulated to the following individuals for consultation.

Name	Designation
Dr Emma Yates	Infection Control Doctor/Consultant Microbiologist
Dr Tia Yiannakis	Infection Control Doctor/Consultant Microbiologist
Liz Watkins	Director of Infection Prevention and Control
Emma Fulloway	Infection Prevention Nurse Manager
Kerrie Howles	Senior Infection Prevention Nurse
Sadiya Hussain	Antimicrobial Stewardship Pharmacist
Usman Ahmed	Consultant Orthopaedic Surgeon

Harsha Mistry	Consultant Anaesthetist. Pre-op assessment Clinical Lead
James Hutchinson	Consultant Anaesthetist
Linzi Wright	Senior Sister Pre-Op Assessment
Hugh Morton	Consultant Microbiologist
Lara Greenway	Matron Neonatal Services
Dana Picken	Matron Paediatrics
Claire Bayliss	Maternity Matron
Mr Stephen Goodyear	Divisional Director (Surgery) Consultant Vascular and Endovascular Surgeon
Emma Tandy	Matron Theatres and Interventional Radiology
Rachel Harris	Deputy Director for SCSD
Mandy Bodily	Senior Infection Prevention and Control Nurse
Eve Neale	Senior Infection Prevention and Control Nurse
Siji Paul	Infection Prevention and Control Nurse
Nichola Thomas	Infection Prevention and Control Nurse
Melody Hancock	Infection Prevention and Control Nurse
Angela Roxburgh-Powell	Senior Infection Prevention and Control Nurse
Ezgi Seager	Paediatric Doctor
Faiza Khan	Chief Pharmacist

This key document has been circulated to the chair(s) of the following committee's / groups for comments.

Committee
Trust Infection Prevention and Control Committee (TIPCC)
Medicines Safety Committee (MSC)

b. Approval Process

The draft document will be submitted to TIPCC for awareness prior to the receipt of comment, and again for approval once comments received before document code and version number are confirmed and the policy is released for placement on the Trust intranet. The final draft will be checked to ensure it complies with the correct format and that all supporting documentation has been completed.

Appendices:

Appendix A - Elective screening flowchart

WAHT-INF-049
Appendix A Elective

Appendix B - MRSA Decolonisation

MRSA Policy
Appendix B MSC appr

Appendix C - Trauma and Orthopaedic MSSA Screening protocol

WAHT-INF-049
Appendix C Trauma

Supporting Document 1 – Equality Impact Assessment form

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Tracey Cooper, DIPC**

Details of individuals completing this assessment

Name	Job title	e-mail contact
Lara Bailey	**Senior Infection Prevention Nurse Advisor**	**larabailey@nhs.net**
T Cooper	**DIPC**	**tracey.cooper27@nhs.net**
E Fulloway	**Infection Control Nurse Manager**	**e.fulloway@nhs.net**

Date assessment completed	**29.06.2021**

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Meticillin Resistant *Staphylococcus aureus* (MRSA) Screening and Management Policy and Meticillin Sensitive *Staphylococcus aureus* (MSSA) Screening for Pre-Operative Elective Orthopaedic Patients.			
What is the aim, purpose and/or intended outcomes of this Activity?	This policy provides details on the standards required for the detection and management of MRSA in WAHT in order to protect patients from infection or colonisation with MRSA, prevent the transmission of MRSA and to safely manage and treat patients who are colonised with MRSA. This policy also provides details on the standards required for the detection and management of MSSA in WAHT in relation to orthopaedic surgery in order to protect patients from infection or colonisation with MSSA.			
Who will be affected by the development & implementation of this activity?	✓ ✓ ❑ ❑	Service User Patient Carers Visitors	✓ ❑ ❑ ❑	Staff Communities Other _____
Is this:	✓ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	• National MRSA guidelines 2014 and consultation draft of new national guidelines awaiting publication • Consultation with Trauma and Orthopaedics and Pre-Operative Assessment in relation to their experience of MRSA in the patient group			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Policy was circulated to TIPCC members and subsequently approved following comments.			
Summary of relevant findings	Policy approved and meets national requirements.			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	✓			Evidence shows the very old and the very young are at increased risk of MRSA. By screening those at increased risk, we can detect colonisation and take steps to reduce the risk of infection.
Disability	✓			Evidence shows that those receiving care or resident in long-term care facilities are at increased risk of MRSA. By screening those at increased risk, we can detect colonisation and take steps to reduce the risk of infection.
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		
Religion & Belief		✓		
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

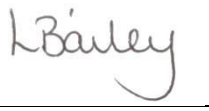
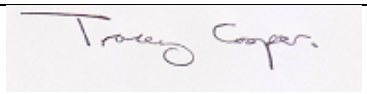
What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		

How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**When the policy is reviewed and updated.**			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Lara Bailey 
Date signed	29.06.2021
Comments:	
Signature of person the Leader Person for this activity	 T Cooper
Date signed	29.06.2021
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.