Methicillin Resistant Staphylococcus Aureus (MRSA) — Information for social care settings

MRSA is a type of bacteria that usually lives harmlessly on the skin. But if it gets inside the body, it can cause a serious infection that needs immediate treatment with antibiotics.

→Residents may be transferred from hospital while colonised or infected with MRSA.

→Often these bacteria will be colonising the skin or gut, without causing harm to the resident, and will not cause harm to healthy people.

→Because colonisation can be very long-term, it is not necessary to isolate residents known to be **colonised** with MRSA ; Good hand hygiene and the use of standard precautions will help minimise the spread of these organisms in a care home environment.

→Residents colonised with MRSA will not routinely require repeated sampling or treatment to clear their colonisation. The resident's GP, or the local Health Protection Team will advise when this is appropriate.

→If a resident, previously known to be colonised with MRSA requires admission to hospital, the residents GP should include this information in the referral letter.

→MRSA is not a reason to stop admission to a home or a reason to exclude an affected person from the life of a home.

→In residential settings where people with post-operative wounds or intravascular devices (for example peripheral line, central line , PICC, PORT etc) are cared for, infection control advice should be followed if a person with MRSA is to be admitted or has been identified amongst residents.

Differences between colonisation and infection with MRSA

Colonisation: MRSA is present on or in the body without causing an infection. MRSA can live on a healthy body without causing harm and most people who are colonised do not go on to develop infection. Less than 5% of colonising strains in the healthy population who have not been in hospital are methicillin resistant, but it is more common in vulnerable people who are in contact with the health or social care system.

Infection: MRSA is present on or in the body causing clinical MRSA signs of infection, such as in the case of bacteraemia or pneumonia, or for example, in a wound causing redness, swelling, pain and/or discharge. MRSA infections usually occur in health or social care settings and, in particular, vulnerable people. Clinical infection with MRSA occurs either from the president's own resident MRSA (if they are colonised) or by

IPC practice for residents with a MRSA infection

→Residents with an active MRSA infection should be isolated and have contact 'Transmission based precautions' (TBPs– see guidance at NHS England » Chapter 2: Transmission based precautions (TBPs)) in place **until they are symptom free** (usually after a course of antibiotics, please risk assess and consult the GP if necessary).

→Any infected wound or other skin lesion should be covered with an appropriate dressing as advised a healthcare professional,

→During isolation, staff should wear disposable apron and gloves when providing hands on care.

→Hands should be cleaned after removing and disposing of personal protective equipment (PPE).

→Disposable apron and gloves are not required to be worn by visitors unless they are providing 'hands on care', but strict hand washing must still be performed.

→Residents with an MRSA infection, can still have visitors. However, it's a good idea to warn vulnerable people at risk of MRSA, so they can take special precautions. MRSA, it can be spread to a visitor if you have contact with their skin, especially if it's sore or broken, or if they handle personal items you have used, such as towels, bandages or razors. Visitors can also catch MRSA from contaminated surfaces or hospital devices or items.

→Visitors can reduce the risk of catching MRSA from a hospital patient they are visiting (and the other way around) by: cleaning their hands before and after touching the patient and cleaning their hands before entering and leaving the setting. See full guidance Can a hospital patient with MRSA infection have visitors? - NHS (www.nhs.uk)

IPC practice for residents colonised with MRSA

• Colonisation with MRSA could be long term, therefore, good hand hygiene practice and 'Standard infection control precautions' (SICPs) should be followed by all staff at all times, to reduce the risk of transmission of infection.

• Residents with MRSA can share a room unless they or the person sharing the room has wounds, catheters or any other invasive device.

• Residents with MRSA can visit communal areas, e.g. dining room etc and can mix with other residents.

• Staff should ensure if the resident has any wounds, they are covered with an appropriate dressing, as advised by a healthcare professional

• Hand hygiene is very important after direct contact with a resident or their environment . Residents should be encouraged to wash hands after using the toilet and before meals.

• Disposable apron and gloves should be worn when in contact with body fluids.

• Normal laundry procedures are adequate. However, if laundry is soiled with urine or faeces, it should be treated as infected. Items that are soiled should be washed at the highest temperature the item will withstand.

• No special precautions are required for crockery/cutlery and they should be dealt with in the normal manner.

• Waste contaminated with body fluids should be disposed of as infectious waste. Hands should be cleaned after removing and disposing of PPE.

• There is no need to restrict visitors, but they should be advised to wash hands or use alcohol hand rub on arriving and leaving.

• Residents should not be prevented from visiting day centres, etc, and may socialise outside the care home.

Pertussis (Whooping Cough) : Whooping cough infections cases are on the rise

⇒ New data published by the UK Health Security Agency (UKHSA) shows there has been a continued increase in pertussis (whooping cough) cases at the start of this year, with 553 confirmed in England in January, compared with 858 cases for the whole of last year (2023).

⇒ With whooping cough on the rise, it is important that families come forward to get the protection they need.

⇒ If you are pregnant and have not been vaccinated yet, or your child is not up-to-date with whooping cough or other routine vaccinations, please contact your GP as soon as possible, and if you or your child have symptoms ask for an urgent GP appointment or get help from NHS 111.

Pertussis (whooping cough) is an acute respiratory infection caused by the bacteria Bordetella pertussis.

Who is affected by pertussis?

→ Pertussis can affect people of all ages.

→ The highest incidence occurs in infants under three months old, who are too young to be directly protected by routine immunisation and for whom the disease

Transmission

⇒ Transmission of the infection is by respiratory droplet, and cases are most infectious during the early catarrhal phase.

Incubation period :

⇒ The incubation period is between six and twenty days and cases are infectious from six days after exposure to three weeks after the onset of typical paroxysms.

Infectious period:

⇒ A case is considered infectious from onset of symptoms until 48 hours of appropriate antibiotic treatment OR for 21 days from onset of symptoms if appropriate antibiotic therapy has not been completed.

Complication :

⇒ Bronchopneumonia, repeated vomiting leading to weight loss, and cerebral hypoxia with a resulting risk of brain damage.

⇒ Severe complications and deaths occur most commonly in infants under six months of age.

⇒ Minor complications include subconjunctival haemorrhages, epistaxis (nosebleeds), facial oedema, ulceration of the tongue or surrounding area, and suppurative otitis media.

Personal Protective Equipment (PPE): Appropriate PPE for respiratory infections transmitted by droplet route includes surgical mask and use of gloves and apron if appropriate. Guidelines for the Public Health Management of Pertussis in England (publishing.service.gov.uk)

GP practices: Patients with suspected pertussis should be seen in a single room, staff members should wear appropriate PPE and the room should be terminally cleaned after use. Patients should not wait in the waiting area and should be seen as soon as possible. The room may need to be 'fallowed' between patients, time is dependant on ventilation and air changes.

What to look out for ?

You should suspect pertussis infection if someone presents with an acute cough lasting for 14 days or more without an apparent cause plus one or more of the following:

⇒ paroxysms of coughing

⇒ post-tussive vomiting

⇒ inspiratory whoop

⇒ undiagnosed apnoeic attacks in young infants

or

⇒ someone with signs and symptoms consistent with pertussis who has been in contact with a confirmed case in the previous 21 days

or

⇒ someone who is known to be part of any ongoing outbreak investigation in a specific group of people. For example, children attending the same school or nursery where pertussis is known to be been circulating

Adult Social Care (ASC) Infection Prevention and Control (IPC) update

From 1 April 2024, the following changes will be made to COVID-19 testing to align with other respiratory infections while continuing to protect those at higher risk of serious illness:

⇒ **Outbreak management** for COVID-19 will align with other acute respiratory infections (ARIs). This means routine supply of free COVID-19 LFD tests for outbreak management in care homes will end. Instead, the local UKHSA Health Protection Team (HPT) or other local partner will advise if PCR testing is deemed appropriate to test for a wide range of respiratory viruses and identify the cause of an outbreak. Providers should continue to follow guidance, notify their HPT or other local partner of any suspected outbreak, and initiate risk assessments where able.

⇒ **Routine COVID-19 discharge testing** of asymptomatic patients transferring from NHS settings into a care home will end, consistent with admissions from other care settings and the community. In conjunction with care home providers, acute health providers should have trusted assessment arrangements to facilitate safe discharges. Together with the care home, hospitals should assess the risk in the period before planned discharge, seeking advice on proposed changes to testing arrangements from Local Authority Public Health Teams or UKHSA Health Protection Teams, if needed. Following discussion with care home providers and any advice from Public Health or Health Protection Teams, hospitals may decide to undertake an LFD test, for example if there is a local outbreak within the hospital setting. Any testing will be undertaken by the hospital. The care provider should speak to the hospital to raise any concerns about a planned discharge. Where a care provider is providing services commissioned by a local authority or the NHS and has concerns about a planned discharge that cannot be resolved with the acute hospital provider, they may wish to contact the relevant commissioner.

The cohort of people eligible for COVID-19 treatments has been expanded following updated NICE recommendations to include:

⇒ People in care homes or hospital who are aged 70 years and over, or who have a BMI of 35 or more, or who have diabetes or heart failure.

⇒ People aged 85 years and over outside of care homes or hospital.

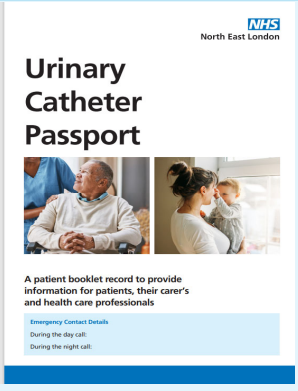
⇒ People with end-stage heart failure who have a long-term ventricular assistance device.

⇒ People on the organ transplant waiting list.

Providers should familiarise themselves with the full eligibility criteria for COVID-19 treatments, identify people who may be eligible and ensure LFD tests are available if needed. In line with updated recommendations, NHS England is expanding access to symptomatic LFD testing from 1 April 2024 to include people who meet the criteria above in addition to previously set-out criteria. These tests should be accessed via the NHS via a local pharmacy. The UKHSA multiple registration spreadsheet will remain available to support care settings to report COVID-19 LFD test results from tests supplied by the NHS. Further details on how to access COVID-19 treatments are available via the NHS. As part of these changes, the 119 phone number service currently used for testing queries will also end from 1 April, with a redirect message in place for anyone calling after this date advising on appropriate routes to report any questions or concerns. These changes will be reflected in due course in the IPC guidance for acute respiratory infections, which outlines wider IPC measures providers should continue to take. Vaccination remains one of the most important defences against both COVID-19 and flu, and providers should continue to encourage staff and service users to get vaccinated. This spring, a COVID-19 vaccine will again be offered to those most at risk of serious illness, in line with advice from the Joint Committee on Vaccination and Immunisation. In addition, providers should ensure standard infection control precautions (SICP) are in place; ensure staff know how to monitor and manage service users with symptoms; and ensure staff know how and when to use PPE. The supply of free PPE for COVID-19 needs was extended in 2023 to run until the end of March 2024, subject to stocks. Further details on the PPE portal will be announced in due course. While applying IPC measures, providers should continue to facilitate visits in care homes and encourage visits out per residents' preferences, in line with the new CQC fundamental standard on visiting and accompanying.

NEL Catheter Passport update

→ Every patient with a urinary catheter in North East London should be provided with a NEL Catheter Passport. If a resident if your setting have a urinary catheter and you need catheter passports, please email **nelondonicb.ipc@nhs.net**



Source Images : https://openclipart.org/detail/286088/important

IPC Team contact details

Generic email for advice: nelondonicb.ipc@nhs.net

Email

Sandra Smith

Deputy Director of

Infection Prevention and Control

Tel: 07769 382399

Gyanu Adhikari

IPC Clinical Nurse Specialist

Tel: 07551 564659

Luca Comisi

IPC Clinical Nurse Specialist

Tel: 07551 593253

References :

⇒ Pertussi brief for healthcare professionals (publishing.service.gov.uk)

⇒ Green Book Chapter 24 v3_0 (publishing.service.gov.uk)

⇒ Guidelines for the Public Health Management of Pertussis in England (publishing.service.gov.uk)

⇒ NHS England » Chapter 2: Transmission based precautions (TBPs)

⇒ Can a hospital patient with MRSA infection have visitors? - NHS (www.nhs.uk)

⇒ Guidelines for the Public Health Management of Pertussis in England (publishing.service.gov.uk)