

UNISON HEALTH & SAFETY

# Information sheet

## • **MRSA**

*Last Updated October 2010*

*What is MRSA?*

MRSA is the abbreviated term used for Methicillin Resistant Staphylococcus Aureus, which is a type of bacteria usually found on the skin, in the throat and in the nose of healthy individuals. MRSA is quite harmless until it enters the body. MRSA can enter the body through broken skin, abrasions, cuts, wounds, surgical incisions or indwelling catheters causing infections, which maybe mild or serious. A serious infection could be infection of the blood stream, bones or joints. A mild infection maybe pimples or boils. Treatment for the infection is normally antibiotic penicillin; however, most strains of Staphylococcus Aureus (SA) are now resistant to commonly prescribed penicillin.

To date experts have discovered seventeen different strains of MRSA each with various degrees of immunity to antibiotics. MRSA originally appeared in the '60s, but it was not until the '80s that more virulent strains became apparent in health service premises. These epidemic strains (EMRSA) have an enhanced ability to spread and thus constitute a greater hazard.

For most healthy individuals the threat of developing the infection is very slim, even when they are colonised by MRSA. For those whose immune system is compromised they will be at a greater risk of infection as are those who have open access to their body via, for example, wounds, catheters or drips. For these people the combination of easy transferability (e.g. by skin contact), access, and resistance makes it a potent threat. The result could be an infection, which will slow down recovery, and may cause more serious diseases such as blood poisoning or bronchopneumonia (both of which are life threatening).

Evidence shows that MRSA maybe more virulent than ordinary SA, although some reports do not support this. However, as both types are potentially dangerous, procedures should address both equally.

The government and the Department of Health are playing a more active role in trying to combat MRSA, which is now high on their agenda and features prominently in the media.

MRSA kills more than 5000 people per year. The issue is now recognised as a serious health problem. There are concerns that there may even be a degree of underreporting of those infected, which means that the public may not have the true picture. MRSA is spreading and becoming more resilient to commonly used penicillin.

Whilst it is agreed that the biggest threat is to patients, staff can also be at risk from contracting and/or spreading MRSA. There are also a number of employment related issues that may affect staff including cleaning staff. UNISON branch Stewards and safety representatives should be aware of this guidance as it will aid understanding on how MRSA can impact on both staff and patients.

## **KEY POINTS FOR BRANCHES**

- In general, MRSA is a greater risk to patients than staff.
- There is a difference between people infected with MRSA and those who are symptomatically colonised (i.e. carry the bacteria on their body but are not infected), and preventative strategies should reflect this.
- MRSA should be tackled in line with the appropriate health and safety law and subject to risk assessment. It should also be in line with local cleaning and infection control policy and procedures.
- Prevention and control measures introduced should follow a full risk assessment on MRSA.
- Training and education are essential to reassuring staff, patients and visitors.
- Safety representatives should be consulted before policies and procedures that affect staff are developed, agreed and implemented.
- Employers should focus on tackling MRSA rather than scapegoating staff who are carriers of MRSA through no fault of their own.
- UNISON branches should be involved in negotiating agreements on staffing levels and training and should make sure that domestic staff is involved in setting cleaning standards.

## **RISK ASSESSMENT**

A risk assessment is a process that the employer must use to identify and deal with health and safety issues in the workplace. It is a careful examination of what could cause danger and be harmful to people at work.

MRSA risks vary widely between different workplaces in the health service. For instance, the potential risks to patients on burns or transplant units are much higher than general non-surgical wards. Similarly, GP surgeries are usually low risk, but some work practices such as injections and the changing of dressings allow the opportunity for patient infection. For staff, risks are obviously higher if in direct contact with patients infected or colonised by MRSA.

By the time assessments take place, MRSA is already in many health care settings such as hospitals, therefore prevention and control techniques often need to take place hand in hand. Infection control in hospitals is becoming a major issue for the government, as other superbugs appear to be as big a problem as MRSA, although the scale of them is only just emerging. MRSA rates tend to be highest in specialist Trust and lowest in single specialty Trusts. Single specialty Trusts only undertake one speciality such as cancer or children's health for example, whereby a specialist Trust will receive patients referred from one of the specialist services.

## PREVENTION AND CONTROL MEASURES

### Examples of current practice

Methods of dealing with MRSA vary from employer to employer and depend on the nature and type of workplace. UNISON has monitored the systems used in a number of workplaces, and there are widespread varieties in practice. For example:

**Trust A** An acute trust in a small city. It had an isolation ward where all MRSA carriers are treated. Staff were specialised and access to the ward restricted, as is patient movement around the hospital. All new admissions to the ward were routinely screened and colonised staff were treated and given paid leave of absence or re-deployed to non-patient contact areas. There is a high level of testing.

**Trust B** A large inner city teaching hospital trust. It originally screened staff and sought to have discrete areas on large wards for MRSA carriers, but had a high turnover of staff and consequently employed large numbers of agency staff. Access was not controlled and they became unable to contain MRSA. Infection control procedures collapsed and they seemed to be at a loss as to what to do.

**Trust C** A rural community trust. Had a vague policy but inconsistent application. There was little information given out on discharge, and record keeping on MRSA patients was partial. It did not consider that it had a problem.

**Nursing homes** Of the nursing homes looked at, all applied some form of infection control procedures, but some were unaware or seemingly unconcerned about the issue. One had very good links with their local acute trust and their infection control team, which screened residents.

It is essentially that infection control is put in place, and although different preventive measures are appropriate for different workplaces. Cleaning is also a crucial factor in the fight against MRSA. It has been identified as a major area for which there have been several discussions and consultations.

### Infection control

Healthcare associated infection needs intensive control measures. The Department of Health has developed competencies for those in charge of infection and prevention control. It is important that there are identified people who co-ordinate MRSA preventive measures. For most hospitals this will normally involve the ***infection control team***. In the community there should be specific staff with responsibility for infection control. Infection control training for all staff should be closely monitored and integrated into other aspects of good practice, and must not be left for clinical staff to deal with alone. It must involve all levels of the organisation be it residential care homes or hospitals.

#### *Cleaning*

To help prevent the spread of infections, germs and dirt, cleaning standards will have to be high. Employers must ensure adequate staffing levels for their cleaning service if they are to win the fight against MRSA and stem the development of further infections like the so-called super bugs. Cleaning staff should also have sufficient time and the correct equipment to do their job properly. It is vital that hospitals and nursing homes are kept

scrupulously clean at all times as improving the quality of cleaning is likely to be more effective than specific MRSA related or similar virus control measures. It is important that resources are directed in this area along with education and training. Good standards of cleanliness and hygiene are as important as good infection control standards. It is also crucially important that cleaning staff are seen to be part of the health care team and that they have an understanding of infection control. It is essential that hygiene is at the heart of tackling MRSA. Cleaning staff must have correct training and an understanding of the areas that they are cleaning and the potential for infections to spread because of bad practices.

MRSA bacteria can be difficult to eradicate so thorough cleaning of related equipment and rooms is essential. Studies have found MRSA lingering in a number of places, after routine cleaning, such as mattresses and door handles. It is also important that any contract for cleaning specify standards in regards to MRSA patients.

### *Record keeping*

One of the main sources of new infection is patient transfer between hospitals, the community, and nursing and residential homes. Accurate and detailed record keeping will identify patients with MRSA or those who have been carriers. It will alert clinicians to the need for screening prior to transfer or discharge. Sharing the information between appropriate organisations and their departments would ensure that they are able to take any special measures that maybe deemed necessary

In the unlikely event that staff are infected while at work, employers need to report this to their local Health and Safety Executive (HSE) office.

### **Staffing**

Staffing levels play a key role in cross infection as heavily overworked staff find themselves in a difficult position trying to complete cleaning practices while in constant non-stop demand. Low staffing levels are a health and safety issue. Similarly staff experience and training has a direct effect on the spread of the infection. Some services use dedicated staff to restrict infection spread between patients and wards. This is recognised as good practice.

The high use of agency staff in some workplaces can cause problems, as they maybe less aware of local practices within a workplace. If they are carriers they may also spread the infection across a range of different workplaces as they move between jobs. If agency staff have to be used, it is recommended that regular staff or those that can stay in one workplace for a long time are used whenever possible, in MRSA affected areas. However, regardless of the circumstances it is crucially important that Agency staff are given adequate information and training on the procedures in the place to prevent or control the risk of MRSA.

### **Screening and Testing**

Screening involves sweeping swabs across likely colonisation sites and then sending these for analysis. There are different views as to who should be screened. Regular screening of all staff and patients is costly and maybe unnecessary. It maybe more appropriate to target groups such as those who have a recorded history of MRSA colonisation or who come from known problem areas such as patients from particular hospitals or nursing and residential homes.

Although colonisation of staff or patients with lesions or skin problems is obviously of concern, the nasal testing of MRSA has also raised questions. In some workplaces, screening appears to have become an end in itself. Screening is most valuable if there is a defined reason for doing it and a proposed course of action following the screening of an individual.

It is important that other risk prevention measures are also in place, whether screening takes place or not.

### **Prophylaxis (antibiotics used before colonisation/infection)**

Antibiotics are being used to prevent staff spreading the bacteria in some workplaces. The use of some antibiotics such as mupirocin to treat MRSA nasal carriers is widespread. However, the transferability of the disease from such carriers has been questioned. Additionally, the evidence of increasing resistance to this drug means that the use of this and other antibiotics as a preventive measure needs to be rigorously assessed.

### **Isolation**

This is by far the most effective preventive and control measure. Isolation varies between a dedicated ward, individual rooms, and designated parts of general wards. Isolation of MRSA carrying patients can prevent the spread of infection, but for some high dependency patients or those with mobility problems there may be difficulties. Unfortunately, the problems of resources and hospital design mean that implementation can be difficult. In addition, isolation in single rooms can cause psychological problems for patients.

Some experts recommend the so-called “search and destroy” technique when a new or small outbreak is identified. This involves total isolation with restricted access, high levels of barrier nursing, effective antibiotics and screening of all staff that have come in contact. This has proved highly successful in some workplaces, although for areas already heavily infected this may not be practical.

Often employers use finance as a reason not to set up isolation facilities. The short-term costs of such facilities need to be set against the potential costs of serious outbreaks spreading to and closing ICU or surgical wards.

### **Patient transfer**

MRSA infected patients have the potential to increase the risk of spreading MRSA when being moved around from one unit or ward to another. A reduction in patient transfers and movement between departments should be investigated as an option of control.

### **Barrier nursing**

Studies have shown that poor hand washing significantly increases the risk of transfer between patients. Basic barrier nursing and the use of appropriate antiseptic detergents should be rigorously applied. Other protection, such as the use of masks, gloves or aprons, needs to be used. Where such protection is used a further risk assessment may be needed.

Staff with lesions need to ensure that these are covered. Eating, chewing, and smoking, which involves hand contact with the mouth must be avoided when dealing with patients.

## **Training**

There is also a need for continuing education. Not just for those who are specialists or clinical staff but for all those who may come into contact with MRSA.

## **Information**

Staff, patients and relatives should be educated about MRSA and the reasons for the safety measures in place to aid infection control and prevention. This will calm their fears and explain and encourage the use of gloves and aprons, which may be essential procedures.

## **Clinical waste**

All hospitals must have procedures for dealing with clinical waste in line with the Health Services Advisory Committee publication, *Safe Disposal of Clinical Waste*. Most MRSA contaminated material will count as Category A waste and should be placed in yellow sacks and disposed of safely. Contaminated sharps are Category B waste and should be placed in safe bins. MRSA infected materials should never be placed in ordinary black sacks.

## **Laboratories and mortuaries**

Guidance for workers in clinical laboratories can be found in the Health Services Advisory Committee booklet, *Safe Working and the Prevention of Infection in Clinical Laboratories*, and for mortuary workers, *Safe Working and the Prevention of Infection in the Mortuary and Post-Mortem Room*. Again employers must have policies which ensure that workers are protected from infection. The Control of Substances Hazardous to Health (COSHH) regulations and in particular the schedule on biological agents, are of particular importance here.

## **Ambulances**

Although ambulance staff should be notified if patients are known to be colonised or infected, they are at no more risk than other health care staff. The maintenance of high standards of cleanliness on all surfaces and equipment is crucial in the prevention and control of infection in ambulance vehicles. Local agreements around procedures should indicate what cleaning agents are currently supplied within the service and ensure adequate information is given regarding specific requirements for the application of different products. Staff should be trained and have a knowledge of correct techniques and procedures, especially concerning handwashing and the use of gloves.

If staff feel that the ambulance is not fit for the purpose then they must ask control or line managers for the vehicle to be taken off the road and cleaned. If this does happen, then it must be reported as a near-miss incident. Those cleaning ambulances need to be given sufficient time and resources to make the vehicle ready for the next call out. Ambulance staff have an individual responsibility to keep the ambulance clean and thus reduce the risk of cross infection to colleagues patients and themselves. Cross infection procedures should be used and patient contact restricted.

Where possible, single use disposable clinical equipment is advocated. Equipment that is directly in contact with the patient must be properly cleaned and disinfected to the standards required by the ASA guidelines quoted below.

The environment normally plays a relatively minor role in transmitting infection, but dust, dirt and liquid residues will increase the risk. Dirt and dust, etc. should be kept to a

minimum by regular cleaning with hot water and disinfectant and by having good design features in equipment, fittings and fixtures. Cleaning equipment, such as brushes, cloths and mop heads should always be colour coded for use in specific areas, for example, green for ambulance garage areas and for the blue ambulance interior. In any event, to eliminate the risk of cross contamination, mops, disposable cloths, and buckets should not be transferred between different areas. For the management of blood and bodily fluids, disinfectant, disposable cloths and paper towels should be used.

Single use linen is also advocated and non disposable linen must be segregated and put into appropriately colour coded bags for laundering. Gloves and protective clothing should be used when handling contaminated laundry.

Staff uniforms are personal protective equipment. They should be laundered as per manufacturers recommendations and the employers local infection control policy. This should not involve a cost to staff.

The Ambulance Service Association has produced National Guidance on ambulance cleaning and decontamination. UNISON fully endorses and support this guidance, which helps protect both UNISON members and service users. Further information on the guidance can be obtained from the ASA web site [www.asa.uk.net/archive](http://www.asa.uk.net/archive)

### **GP surgeries, nursing homes and community workers**

Levels of risk vary in different workplaces. Open wounds and injection sites provide an opportunity for MRSA infection. As only limited numbers of staff are involved in such procedures, the risk in these areas is limited. However good infection control practices are essential to limit potential cross infection. For other staff an awareness of MRSA and potential problems will help to calm unnecessary fears.

Employers must have health and safety policies. They must also conduct assessments, and if they have more than five staff, these must be recorded in writing.

### **POLICIES**

Most trusts now have MRSA policies. Many are based on the revised guidelines for treating EMRSA. They give sound general advice and are appropriate for many workplaces. Unfortunately, in over-stretched departments in many trusts these guidelines fall by the wayside. It is important that policies are always implemented, reviewed and updated regularly. Regular review and update will ensure that new research and developments around eradicating MRSA are taken into account. Failure to do so increases the risks to staff and patients, and opens employers up to the possibility of action by the Health and Safety Executive, as well as civil action.

### **EMPLOYMENT ISSUES**

MRSA is easily transferred by skin contact and members of staff can become colonised. In some, it can be difficult to eradicate the colonisation and they become carriers of the bacteria.

Employers have reacted to this in a number of ways – redeployment, suspension on full pay, sick leave, inaction and even ill-health retirement. UNISON is opposed to staff being victimised for being carriers. To some extent, the nature of the risk and the staff member's work situation will dictate what the most appropriate course of action is. However, this should be line with the risk assessment, policies and negotiated agreements. Any action

taken should also take account of relevant employment legislation and the Disability Discrimination Act.

### **Agenda for Change terms and conditions**

The Agenda for Change terms and conditions includes a section on Special Leave, which includes:

*'...special leave with pay shall be made available in the following circumstances: - absence from duty following contact with a notifiable disease.*

Agenda for Change terms and conditions deal in more detail with pay and allowances for staff suspended from duty to prevent the spread of infection. These include a section on Nursing and Midwifery, Ancillary, PTA and Ambulance Staff.

### **Disciplinary cases**

In addition to a number of attempted sackings on the grounds of ill-health or capability, a number of MRSA related disciplinary problems have occurred. In one trust a member of staff was disciplined for seeking to conceal their MRSA status. Another trust scapegoated a nurse with eczema by re-deploying and downgrading her rather than tackling the infection. (She has since joined UNISON). Elsewhere members who were checking their own files to see whether they had tested positive before the results were released, were disciplined for using confidential data.

Any proposed disciplinary action must be dealt with under local procedures and in negotiation with union representatives. What needs to be ensured is that health care staff are not made scapegoats because of poor policies and procedures, staff shortages, inadequate risk assessments, or inappropriate preventive measures.

### **CONSULTATION AND UNISON SAFETY REPRESENTATIVES**

Employers have a legal obligation to consult safety representatives and safety committees over their risk assessments and the measures that they intend to introduce to prevent and control MRSA. Often policies and procedures are introduced without consultation and without the involvement of those directly involved. Policies forced on staff without consultation, will be less effective.

UNISON safety reps are encouraged to raise with their employer the issue of MRSA, the risks that members face and measures that are being introduced to prevent the spread of the infection.

### **HEALTH AND SAFETY LEGISLATION**

The Health and Safety at Work Act 1974 introduced the concept of the 'duty of care' under which the main responsibility for staff is with the employer. The Management of Health and Safety at Work Regulations 1999 added further duties, introducing risk assessment and reinforcing the need to construct management systems and procedures to deal with health and safety problems. The Health Service Advisory Committee produced guidance in 1994 on these regulations for directors and managers, *Management of Health and Safety in the Health Services* (HSE Books). There is no excuse for employers who have not addressed the management of health and safety.

## **Control Of Substances Hazardous to Health Regulations (COSHH)**

All infections that can be contracted by staff from their work are covered under the COSHH Regulations.

These require employers to:

- carry out risk assessments,
- put in place preventive and/or control measures,
- provide health checks for staff,
- provide staff with information and training,
- review and keep up to date risk assessments.

Schedule 9 of the COSHH regulations deals with provisions for biological agents.

## **Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR)**

Health service employers who are notified by a doctor that an employee has an MRSA related infection must send a completed disease report form (F2508A) to their local HSE office.

## **Safety Representatives and Safety Committee Regulations 1977**

These require employers to consult with safety reps on health and safety matters. MRSA, as a potential hazard, should be discussed at safety committees.

### *Further Information*

*UNISON has produced a range of guidance and information sheets which safety representatives can use to tackle any health and safety problem faced by members. These are available from UNISON's Health and Safety website at: <http://www.unison.org.uk/safety>*

*The following UNISON Publications are also available free (to UNISON members) from the Communications Unit, UNISON, 1 Mabledon Place, London WC1H 9AJ. Please quote the stock number when ordering.*

*The Health and Safety Six Pack (stock no. 1660)*

*Risk Assessment Guide (stock no. 1351)*

*Caring for Cleaning Staff (stock no. 1793)*