Meticillin Resistant Staphylococcus Aureus (MRSA) Guidelines
### AMENDMENT HISTORY

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These documents will provide additional information:

<table>
<thead>
<tr>
<th>REFERENCE NUMBER</th>
<th>DOCUMENT TITLE</th>
<th>VERSION</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Dudley CCG Standard Precaution Guidelines.</td>
<td></td>
</tr>
<tr>
<td>CONTENTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1  Background ........................................................................................................</td>
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</tr>
<tr>
<td>1.1 Staphylococcus aureus ..........................................................................................</td>
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<tr>
<td>1.2 MRSA .................................................................................................................</td>
<td>4</td>
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<tr>
<td>1.3 MRSA bacteraemia ...............................................................................................</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>1.4 Panton Valentine Leukocidin (PVL) .................................................................</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2  Purpose ...................................................................................................................</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3  Preventing the Spread of MRSA .................................................................</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3.1 Standard Precautions ..........................................................................................</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>3.2 Screening and identification of patients for MRSA Secondary Care ...............</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>3.3 Sample sites for screening/identification of MRSA .........................................</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>4  Treatment of MRSA ................................................................................................</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>4.1 Colonisation ........................................................................................................</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>4.2 Infection .............................................................................................................</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>5  Management of MRSA ............................................................................................</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>5.1 In the population/Community ............................................................................</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>5.2 Care homes ..........................................................................................................</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>6  Discharge/transfer/re-admission of patients with MRSA ...................................</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>7  Deceased patients ..................................................................................................</td>
<td>10</td>
<td></td>
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<tr>
<td>8  Training Awareness ..............................................................................................</td>
<td>10</td>
<td></td>
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<tr>
<td>9  Audit and monitoring of practice ........................................................................</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Reference List ..........................................................................................................</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Appendix A ................................................................................................................</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Appendix B ................................................................................................................</td>
<td>13</td>
<td></td>
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<tr>
<td>Appendix C ................................................................................................................</td>
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<td>Appendix D ................................................................................................................</td>
<td>19</td>
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1. Background

Meticillin Resistant Staphylococcus aureus (MRSA) remains a significant cause of Healthcare associated infection (HCAI) resulting in increased morbidity and mortality in addition to increased healthcare costs. The transmission of MRSA and MRSA infection can only be addressed effectively if measures are taken to identify and treat those patients who are colonised with MRSA and may be a potential source of infection to themselves or others.

The Department of Health (DH) document ‘The Health and Social Care Act 2008: Code of practice for the NHS on the Prevention and Control of Healthcare Associated Infections and related guidance (July 2015), states that registered providers of health and social care should have policies in place, in relation to preventing, reducing and controlling the risks of infections, including MRSA. In addition Everyone Counts: Planning for Patients 2014/15 - 2018/19, stresses the zero tolerance approach which all NHS commissioners and providers must take towards MRSA.

1.1. Staphylococcus aureus

Staphylococcus aureus (Staph aureus) is a bacterium which is carried harmlessly on the skin or in the nose of around one third of the population. However, it can sometimes cause boils, abscesses and wound infections.

1.2. MRSA

Some strains of Staph aureus have developed resistance to antibiotics commonly used to treat infections. These strains are known as Meticillin Resistant Staphylococcus aureus or MRSA. The presence of Staph aureus on/in a person may be outlined as below:

**Colonisation** is when bacteria such as MRSA are present on the body but the patient does not have any symptoms and may not be aware of it. It may only be found if specifically sought for e.g. Laboratory swab result or an infection occurs. Sites for MRSA colonisation are commonly the nose and groin.

**Infection** may occur if MRSA is able to gain entry into the body via a cut or wound. It may penetrate into the deeper tissues where it can multiply to cause a local or systemic infection. Signs and symptoms of pain, swelling, fever, heat, redness, pus, increased wound exudates, and pyrexia or confusion in the elderly may indicate local or systemic infection.

MRSA can be carried more easily on broken skin such as wounds, or leg ulcers and can cause boils, abscesses, wound infections, and blood stream infections (bacteraemia).
1.3. MRSA Bacteraemia

Staph aureus including MRSA can enter the blood stream from a local site of infection, a wound or via an invasive device such as a urinary catheter or central line; subsequently leading to bacteraemia and sepsis.

As part of the NHS “zero tolerance” approach to MRSA bloodstream infections, a Post Infection Review (PIR) must be undertaken when an MRSA bacteraemia occurs (DH 2014a). This process is multi disciplinary and should include staff from across the Health and Social care economy as appropriate, but in primary care should be led by the General Practitioner, with the support of Dudley CCG and Health Protection colleagues within Dudley Public Health. In secondary care it will be led by an acute trust but will require active input from the GP practice. The investigation must be carried out in each case to determine a possible cause, whether it was avoidable or not, and come to an agreement on what lessons can be learnt to prevent recurrence. These findings are then reported nationally.

1.4. Panton-Valentine Leukocidin (PVL)

Panton-Valentine leukocidin (PVL) is a substance produced in a small number of Staphylococcus aureus cases including MRSA, which can be toxic to body cells. These are known as cytotoxins. It is associated with increased virulence because of its ability to destroy white blood cells and can in rare circumstances cause extensive tissue death (necrosis) and severe infection. PVL-positive strains typically cause spontaneous skin and soft tissue infections. However, on very rare occasions, it may cause more severe invasive infections, such as bacteraemia or necrotising pneumonia. The latter is sometimes associated with an influenza-like or viral respiratory illness.

Those at higher risk of acquiring PVL in community settings, include those in closed communities/groups, household contacts, and those undertaking contact sports or gym use. Many of those affected in primary care are young and healthy. Where cases occur advice should be sought by the GP from Public Health England, and the consultant microbiologist on how they manage the case, as well as undertake screening of close contacts. In Dudley cases tend to be linked to family groups. IF a GP identifies a family with evidence of persistent boils or abscesses they should seek advice from Public Health England/Consultant Microbiologist.

2. Purpose

The purpose of this document is to provide evidence based guidance to support health and social care workers in the identification and management of patients with MRSA. The guidance applies to all members of Dudley Clinical Commissioning Group and is recommended as good practice guidance for each of the independent contractor organisations e.g. residential care settings.

3. Preventing the spread of MRSA

Staph aureus including MRSA can be spread directly among people having close contact with infected/colonised people. It can also be spread indirectly from contact
with the environment and contaminated equipment. Therefore, it is essential that health and social care workers take necessary precautions before and after contact with a patient and their immediate surroundings.

3.1. Standard Precautions

Standard precautions are a set of infection control practices used by health/social care workers to prevent transmission of diseases. The simplest and most effective of these actions is to clean their hands.

To help staff better understand when they need to clean their hands during the care of a patient/service user the World Health Organization (WHO) developed the Five Moments for hand hygiene.

The approach identifies Five Moments during care when staff should clean their hands. The approach rationalises when hand hygiene needs to occur and therefore aims to eradicate unnecessary hand hygiene; ensuring that staff are cleaning their hands at the critical points for preventing the transmission of micro-organisms which have the potential to cause infections.

Contaminated equipment must be cleaned prior to and following patient use. Cleaning removes debris (body fluids, dust) which microorganisms such as MRSA can survive.

Decontamination of patient equipment should be carried out as per manufacturers’ instructions and in accordance with national legislation and local guidance.

The spread of infection can be significantly reduced by compliance with standard precautions:

- Hand hygiene
- Use of personal protective equipment e.g. gloves and aprons
• Disposal of sharps
• Waste management
• Decontamination of equipment and the environment
• Management of spillages

Staff are at little risk of acquiring MRSA colonisation/infection providing they are healthy, have no uncovered broken skin or wounds and follow precautions discussed within this guidance. Staff are responsible for their practice and must adhere to infection prevention and control practices and procedures set out in this and local/national guidance.

3.2. Screening and identification of patients for MRSA Secondary Care

Updated guidance from the Department Health (DH 2014b) has recommended a revised risk based approach to MRSA screening programme for those admitted to secondary care. Screening should take place for all patients who have:

• Admission to high risk units/specialities such as neonatal, renal and specialist surgery
• Previously been identified as colonised with or infected by MRSA
• High risk patients (see Appendix A)

In certain circumstances results of screening may not be known prior to discharge of the patient from acute care.

In this case the patients General Practitioner will receive a letter notifying them of the result (Appendix B), which may require them to prescribe treatment.

In General Practice a risk assessment should be undertaken to consider if screening is required prior to undergoing minor surgical procedures, especially taking into account those with a record of previous MRSA. Appendix A will also assist in this decision.

3.3. Sample sites for screening/identification of MRSA

The following areas should be screened for MRSA:

• Nose and Groin (axilla in paediatrics instead of groin)
• Any invasive devices e.g. peg site, Intravenous line site, catheter specimen of urine, tracheotomy site
• Any wound or skin lesion
• Sputum from those with a productive cough
4. Treatment of MRSA

4.1. Colonisation

If MRSA screening has identified MRSA carriage if deemed appropriate, decolonisation treatment should be prescribed as followed:

- **Mupirocin** nasal ointment 2% (Bactroban®); applied to the inside of both nostrils THREE times daily for 5 days, **plus Chlorhexidine** 4% skin cleanser used as a body wash ONCE daily. Use to wash hair in place of shampoo TWICE in the 5 days.

- **Naseptin** nasal cream can be used as an alternative to Mupirocin where indicated by sensitivities or allergy. This should be applied to both nostrils four times a day for 10 days (not suitable in nut allergy seek further advice).

- A small amount of nasal ointment should be placed on a cotton bud or little finger and applied to the inside of each nostril. The nose should be closed by pinching together the sides at each application as this helps spread the treatment. They should then be advised to wash their hands thoroughly.

- **Skinsan**® (Triclosan 1%) skin scrub; can be used as an alternative to Chlorhexidine for those with sensitive skin. This should be applied undiluted to wet skin and rinsed thoroughly each day for 5 days. Also wash hair on two of these days.

- Whichever body wash is prescribed patients should be advised to follow instructions accompanying the treatment. They should also be advised that where possible they should dry themselves using a clean towel each day. After each shower or bath, they should be advised to put on clean clothing or night clothes. Bed linen should be changed after completion of the 5 days treatment.

- Patients identified as colonised with MRSA will require additional information and a patient information sheet is available (Appendix C).

- To assist those caring for those with MRSA Appendix D provides a checklist to assist with the decolonisation process.

Following decolonisation treatment, it may be necessary to take further swabs to confirm clearance. Any swabs must not be taken until three full days following completion of treatment i.e. Day 8. Advice should be short on how and the need to rescreen. If rescreens are still positive treatment should be repeated. However, the same course of treatment should not be used repetitively or for prolonged courses.

4.2. Infection

Many uncomplicated mild infections can be treated with oral **Doxycycline**. However, any decision on best practice treatment should be made making reference to local antimicrobial guidelines and/or advice from pharmaceutical advisors/consultant microbiologist. Patients with infected chronic skin conditions or wounds should be referred to a specialised service such as Dermatology or Tissue Viability.
Mupirocin should not routinely be used on wounds.

5. Management of MRSA

5.1. In the population/Community

People with MRSA do not present a risk to the community at large and should continue their normal lives without restriction. There is little risk to family and friends of those with MRSA and the information sheet contained within this guideline (Appendix C) will provide information on reducing the risk further. Carers are not at risk providing they comply with infection control standard precautions, especially hand hygiene.

MRSA should not prevent intervention with the clinical needs of the patient, neither should it prevent them receiving appropriate clinical treatment, investigations or therapy. MRSA should not prevent discharge to other healthcare settings, including nursing homes or other long term care facilities, providing staff notify the receiving facility.

5.2. Care Homes

Residents with MRSA may be transferred from hospital while colonised, without causing harm to the resident, and will not cause harm to healthy people.

MRSA is not a contra-indication to admission to a home or a reason to exclude an affected person from the life of a home. However, in residential settings where people with post-operative wounds or intravascular devices are cared for, infection control advice should be sought regarding management of the case from the Public Health, Heath Protection Team.

Because colonisation can be very long-term, it is not necessary to isolate residents known to be colonised with MRSA, providing staff follow good hand hygiene practices and the use of standard precautions to help minimise the spread of these organisms in a care home environment.

Residents will not routinely require repeated sampling or treatment to clear their colonisation, but the resident’s GP, will advise the home if this is required. If a resident previously known to be colonised with antibiotic-resistant bacteria requires admission to hospital, the residents GP should include this information in the referral letter.

Routine screening of staff is not recommended practice. Any staff screening must be assessed on an individual basis. Advice can be sought from the Consultant Microbiologist at Dudley Group of Hospitals or the Public Health, Health Protection Team.

Staff with a known active infection with Staph aureus should not carry out direct clinical care of patients until any wounds or lesions are healed.
6. Discharge/transfer/re-admission of patients with MRSA

When patients are discharged to their own home, the GP should be informed of the patients MRSA status in the discharge letter to the GP. GP’s should be informed if a patient is identified as a new case of MRSA

When admitting/transferring someone with an infection to another care setting it is vital to inform the receiving ward or unit if they have an infection.

Staff in charge of residential care settings should be informed of the patients’ MRSA status prior to their admission. MRSA is not a contraindication to admission to a home, or a reason to exclude an affected person from taking part in the social activities of a home.

7. Deceased patients

There is little risk to mortuary staff from patients with MRSA providing standard precautions are followed at all times for all patients.

8. Training Awareness

It is the responsibility of individual providers to ensure that staff are aware of this guideline and trained in infection prevention and control standards.

9. Audit and monitoring of practice

Audit of clinical practices and procedures for the prevention of MRSA as detailed in this guideline are the responsibility of the provider. These audits can form part of the assurance process for the purpose of registration with the CQC.

The Public Health, Health Protection Team, on behalf of commissioners will also audit services, to ascertain the level of compliance with the environmental and infrastructure standards that are required to support infection prevention and control clinical practice.

MRSA bacteraemia cases are a Serious Incident (SI). Those providing care will need to participate in any investigation, in the form of Post Infection Review (PIR). The purpose of the PIR is to identify if anything could have been done differently to prevent the infection occurring and share those lessons.
Reference List


Appendix A

Those at higher risk of MRSA include:

- Those from a residential care home setting
- Previous MRSA carriers
- Patients with skin lesions/wounds/pressure sores
- Previous hospital admission (within last 12 months)
- Renal patients undergoing dialysis
- Diabetic patients
- Those with long term conditions
- Those with chronic skin complaints e.g. eczema.
- Patients with invasive devices (urinary catheter/PEG/hickman line)
- Healthcare workers
APPENDIX B.

Our Ref: ENR/LNW
Dear Doctor,

RE: Meticillin resistant Staphylococcus aureus (MRSA)
MRSA has been isolated from your patient:

NAME: ..........................................................................................................
DOB: ..................................
ADDRESS: ...........................................................................................

Screen swab: ☐ Routine culture: ☐

MRSA site(s): .................................................................................................
DATE: ..........................................................

MRSA is resistant to many first-line antibiotics but is predominantly a problem in highly susceptible patients or those in a healthcare setting. Transmission is usually mediated on the hands of carers, and good hand hygiene after contact is the most important element of control.

1. Specific Treatment

Some patients are colonised with MRSA whilst others are infected. The management of your patient depends on individual circumstances but we advise the following options for treatment:

Colonisation

Colonisation of skin or nasal cavities: 4% chlorhexidine/detergent skin antiseptic (eg, Hydrex). Use undiluted to apply to all areas of the skin when bathing/showering during the 5 days of treatment. The hair should also be washed. Those applying treatment should wash their hands thoroughly following the application of treatment. However if your patient has a skin condition consider Skinsan (triclosan 1%) antimicrobial wash. Nasal carriage should be treated with mupirocin (nasal formulation) three times daily for 5 days.

Infection

Superficial Lesions Infected by MRSA: Mupirocin can be applied to small superficial wounds three times a day for 5 days. Alternatively a dressing impregnated with povidone-iodine or Flaminal should be used if regular applications of mupirocin are impractical.

Minimally Invasive Infections (eg, septic wounds, lower respiratory infections): Treatment choice should be based on first line individual susceptibility test results, but if sensitive we suggest: Doxycycline 200mg STAT PO first day followed by 100mg OD orally for 5 days
initially. In addition, topical dressings may also be applied in conjunction with the Doxycycline.

**Serious Invasive Infections**: Parental antibiotic therapy (vancomycin) in hospital may be required. Please discuss with Microbiologist or hospital medical staff.

2. **Eradication Therapy**

Patient is managed depends on the circumstances of the case, so seek advice if unsure.

**Follow-up: Decolonisation**: Following decolonisation therapy it is not necessary to send further swabs for clearance, unless the patient is awaiting surgery, has an invasive device or a surgical wound.

**Follow-up: Infection**: If there is no evidence of clinical infection, further investigation is not necessary. If a clinical problem seems to be related to persistent carriage, we suggest that swabs from lesions, invasive devices and carrier sites (nose, groin) are submitted for MRSA screening.

**Follow up: chronic wounds**: Many patients with chronic wounds colonised with MRSA are simultaneously colonised elsewhere on the body (Nose and groin). It is important that repeated courses of chlorhexidine/mupirocin are avoided to prevent skin irritation and the build up of resistance. Therefore, until the wound bed is healthy or heeling, do not routinely screen the nose or groin, but seek advice.

3. **General Management**

**MRSA in Care Homes**: For those with heavily exudating wounds or respiratory infection caused by MRSA, ‘barrier nursing’ should be undertaken where possible. However, the most important action is that staff follow good infection control practices, including hand hygiene, environmental cleaning, and the use of appropriate Personal Protective Equipment (PPE). Always seek advice on implementing ‘barrier nursing’, as it may be distressing for residents and unnecessary.

**MRSA in the home**: Cleaning surfaces with detergent-based cleaners or disinfectants is effective at removing MRSA from the environment, as are routine laundering procedures for clothes and linen. However, clothes heavily soiled with exudate from wounds should be washed separately. Relatives, carers and the patient should be encouraged to wash their hands thoroughly after cleaning or dealing with potentially infected material.

**Transfer between healthcare providers**: You have a duty as part of your CQC registration to inform other healthcare providers of infection control risks. Therefore you must notify the trust prior to/on admission of a patient with known MRSA, so that hospital staff can be alerted and reduce the risk of transmission.

4. **Further information**

If you require information on the treatment of an infection, contact Microbiology on: 01384 456111
For information on the nursing management of individual patients, contact the Public Health, Health Protection Team on 01384 816246.

Yours sincerely

Elizabeth N Rees
Consultant Microbiologist
Appendix C: Patient Information

What is MRSA?

MRSA stands for Meticillin Resistant Staphylococcus Aureus. MRSA is part of the Staphylococcus aureus family of bacteria (germs).

Staphylococcus aureus is a type of bacteria that lives harmlessly on the skin and in the nose in a very small percentage of the population. If you have a skin condition, or a break in your skin it can cause an infection or enter your blood stream. It can be easily treated with commonly used antibiotics.

MRSA is a type of Staphylococcus aureus that has developed resistance to some commonly used antibiotics such as penicillin. This makes the bacteria more difficult to treat. However, MRSA can also live harmlessly on the skin, nose and in some wounds such as chronic leg ulcers. People who have MRSA on their body, but are unharmed by it are described as being colonised.

Where is MRSA found and how can I catch it?

MRSA is not just found in hospitals. It can be found in care homes, clinics, at home and the community in general. It can also be found in the environment or on equipment used by people carrying the bacteria, if basic hygiene is not followed. MRSA can be passed from person to person, most commonly on peoples’ hands. People can carry MRSA without knowing it, so it may be acquired before admission to hospital, or acquired while in hospital. People who have MRSA do not look any different to anyone else.

Is MRSA dangerous?

MRSA usually affects the elderly and people with some long-term health problems. It generally does not harm healthy people, and this includes pregnant women, children and babies. MRSA can cause problems when it gets into the body through a break in the skin or via a medical device such as a drip or a catheter. MRSA infection can potentially spread into the blood causing bacteraemia (blood poisoning); however, this very rare. There are some antibiotics available to treat infections caused by MRSA. In rare cases MRSA can be fatal. The most vulnerable patients are those who are already very ill and have a reduced immune system.

What can I do to protect family, my carers, visitors and myself and help stop the spread of infection?

Some of the things you can do to protect yourself and others are:

- Wash your hands after visiting the toilet, before and after you eat, before and after dealing with wounds, invasive devices, or applying MRSA treatment.
- Do not touch your wounds, drips or catheters.
- Do not take dressings off your wounds to show family or friends.
- Shower / bathe frequently.
- Do not share equipment with other people for example towels and clothes.
- Remind all staff caring for you/visitors to wash or gel their hands.
Your visitors should not visit you if they are unwell.

**How will I know if I have MRSA?**

Your GP or staff caring for you may take swabs from your nose and other areas of your body. These are sent to the hospital laboratory for testing. If the samples are growing MRSA your GP will be informed and will use these results to decide which treatment to give you. You can also get further information from the Public Health, Health Protection Team on 01384 816246.

**How will I be treated?**

If you have MRSA on your skin, hair or nose you will be given an antiseptic wash for your body and hair and an antibiotic ointment for your nose. These should be applied all together for a period of 5 days and as instructed on the label.

The body wash is to be used as liquid soap (like shower gel). Apply approximately 30 mls (a tablespoon full) directly onto wet skin and must not be diluted. You should preferably shower or bathe every day for 5 days, paying particular attention to your hands, around the nostrils, arm pits, groin and other skin folds. However if you are unable to shower or bath, the body wash can be used as a liquid soap whilst washing at the bedside.

The body wash should be in contact with the skin for at least ONE minute, then rinse thoroughly from head to toe.

You should wash your hair **TWICE** during the **5 days** with the same solution if possible.

If you have infected wounds or infection elsewhere in your body your doctor may treat you with antibiotics.

**Will having MRSA mean that I am treated any differently?**

While in hospital or in another care setting, you may be moved into a single room or into another bay to prevent the spread of MRSA to other vulnerable patients and residents. This decision will be taken in conjunction with doctors, care staff and Infection Control Team.

**What will happen at home?**

You, your family, carers and friends may be worried. The precautions taken whilst in a care setting are aimed at preventing the spread of infection to other ill and vulnerable patients. When you are at home, whether this is your own home or a care home, these risks are reduced. Your carers, doctors and nurses may still wear gloves and aprons when they give you care. This is because they may then go and
care for other sick people. Your family and visitors do not need to wear gloves and aprons, unless they care for other sick people.

**It is important that you maintain good personal hygiene.**
Handwashing is the most important measure you can take, to prevent the spread of MRSA. Clothes and bed linen should be washed at the highest temperature the fabric can withstand and tumble dried if possible.
MRSA can survive in the environment so you should keep your bedroom and areas where you spend most of your time as clean and dust-free as possible. While at home you should not restrict your usual activities, family and work life should continue as normal. There is no need to restrict your visitors, unless they are unwell themselves. Your children and visiting children are not at risk from MRSA unless they have a medical condition or are ill.

If you are readmitted to hospital, or see any doctors or nurses for treatment please inform them that you have previously had MRSA.

If you require more advice ask your GP, nurse or the Health Protection Team in the Office of Public Health, Dudley MBC on 01384 816246.
## Appendix D: MRSA decolonisation checklist

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Please tick as appropriate.