Meticillin Resistant Staphylococcus Aureus (MRSA) Guidelines

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APPLICABLE LEGISLATION

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.


It is unacceptable for a patient to acquire an MRSA blood stream infection (BSI) whilst receiving care in a healthcare setting. The zero tolerance approach to MRSA was reiterated in ‘Everyone Counts: Planning for Patients 2014/15 to 2018/19’ published in 2013 by NHS England, and this approach remains a priority for the NHS (NHS Improvement, 2018).

From April 2018, post infection reviews (PIR) for MRSA BSIs must only be undertaken for organisations with the highest rates of infection (excluding specialist trusts). In Dudley, all MRSA BSIs are subject to robust clinical review, regardless of the requirement for PIR. These identify best practice and areas for improvement/learning (NHS Improvement, 2018).

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.

1.1. MRSA

Some strains of *Staph aureus* have developed resistance to antibiotics commonly used to treat infections. These strains are known as 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. 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 (BSI) (bacteraemia).

### 1.2. 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.

### 1.3. Panton-Valentine Leukocidin (PVL)

Panton-Valentine leukocidin (PVL) is a substance produced in a small number of *Staph 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 (PHE), and the consultant microbiologist on how they manage the case, as well as undergone 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 both PHE and the 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 staff and members of Dudley Clinical Commissioning Group (CCG) 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. For further information on standard precautions please see the Dudley CCG (2017) Standard Precautions for Infection Prevention Guidelines.

The spread of infection can be significantly reduced by compliance with standard precautions:
- Hand hygiene
- Use of personal protective equipment (PPE) e.g. gloves and aprons
- Disposal of sharps
- Waste management
- Decontamination of equipment and the environment
- Management of spillages

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) (2012) developed an approach which identifies when staff should clean their hands and rationalises when hand hygiene needs to occur. This ensures 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.

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

Guidance from the DH (2014) 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 patient’s General Practitioner will be contacted or 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

Treatment recommendations mentioned in this guideline mirror [The Dudley Group NHS Foundation Trust / Dudley CCG Adult Antimicrobial Guide](#) at the time of writing. In this guide, adult and paediatric information is available for the treatment of MRSA. It is the responsibility of the prescriber to ensure that they follow the most recent guidance available.

#### 4.1. Decolonisation/Eradication of MRSA carriage

For an asymptomatic carrier of MRSA, decolonisation is not routinely required in the community but may be indicated if the person has risk factors (**Appendix A**). Suppression treatment typically consists of an antibacterial solution for body and hair in addition to nasal treatment ([NICE, 2018](#)). If you have any queries regarding the need for decolonisation therapy, please seek advice from the Consultant Microbiologist.

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.

#### 4.1.1. Decolonisation of MRSA carriage /Eradication of MRSA carriage in adults
In patients who are systemically unwell, Mupirocin will only eradicate nasal carriage and additional antibiotic therapy is required.

First Line

- **Nasal eradication**: Mupirocin nasal ointment 2% (Bactroban®); Apply to inside of both nostrils three times daily for 5 days.

PLUS

- **Antibacterial solution for body and hair**: Chlorhexidine 4% skin cleanser used as a body wash ONCE daily. Use to wash hair in place of shampoo TWICE in the 5 days.

- Mupirocin should not be used in the presence of tracheostomy or long-term indwelling urinary catheters as clearance is unlikely.

Second Line / Alternative

For individuals with Chlorhexidine allergy or sensitive skin:

- **Nasal eradication**: Naseptin nasal cream; Apply to both nostrils four times a day (QDS) for 10 days (*not suitable in nut allergy*)

PLUS

- **Antibacterial solution for body and hair**: Skinsan® (Triclosan 1%) skin scrub; Apply undiluted to wet skin and rinse thoroughly each day for 5 days. Also wash hair on two of these days

Treatment Duration:

- 5 days

- If advised to re-swab patient, ensure that this takes place two days after treatment completed (i.e. day 8), and again at day 10 and 12

- If patient still positive re-treat with another 5 day course.

4.2. Decolonisation/Eradication of MRSA carriage in children

Decolonisation Treatment

- Mupirocin will eradicate MRSA carriage from the nose in 85% of carriers

- Mupirocin should not be used repetitively or for a prolonged course of treatment

- Mupirocin alone **should not** be used in children with skin breaks
• If treatment is required, Mupirocin should only be used with a systemically active agent in patients with carriage, or infection at extra nasal sites

• The mere isolation of MRSA is not always an indication to treat. Only treat if there are clinical signs of infection/sepsis (fever, raised white cell count, raised CRP)

• Mild to moderate infections can be treated with oral antibiotics

• Treatment of severe infections is urgent and parenteral treatment is required

• Once a result is available adjust treatment if necessary to reflect the MRSA’s susceptibility pattern

First Line

• Nasal ointment: Mupirocin 2% nasal ointment (4g tube). Apply topically to the inside of both nostrils three times a day (TDS) for 5 days

PLUS

• Antibacterial solution for body and hair: Octenisan antimicrobial wash. Use undiluted as a body wash daily for 5 days (Also wash hair on two of these days)

Treatment Duration:

• 5 days
• Re-swab patient two days (i.e. day 8) after treatment completed, also at day 10 and 12). If patient is still positive, re-treat with another 5 day course

Swabs should be taken from the following sites:

• Nose
• Groin
• Wounds (please ensure that swabs are clearly labelled with location of wound)
• Urine if catheterised
• Manipulated sites (i.e. cannulas)
• Sputum (if productive cough)

PLEASE NOTE: For colonised large wounds, contact tissue viability nurses for advice.

4.2.1. Rescreens

• Advice should be sought from either Consultant Microbiologist or the Health Protection Team at Dudley Council on how and the need to rescreen.

• After completion of decolonization treatment, further screening or treatment is generally not required unless advised otherwise (NICE, 2018).

• If necessary to take further swabs to confirm clearance, swabs must not be taken until three full days following completion of treatment (i.e. day 8)
If rescreens are still positive treatment should be repeated. However, the same course of treatment should not be used repetitively or for prolonged courses.

### 4.3. MRSA infections

- The mere isolation of MRSA is not always an indication to treat. Only treat if there are **clinical signs of infection/sepsis** (fever, raised white cell count, raised CRP).
- Once a result is available adjust treatment if necessary to reflect the MRSA’s susceptibility pattern.
- Many uncomplicated mild infections can be treated with **oral Doxycycline** even in the community.
- More severe, complicated deep-seated infections or those associated with prosthetic material will require **intravenous (IV) Vancomycin**.
- Any decision on best practice treatment should be made making reference to local antimicrobial guidelines and/or advice from pharmaceutical advisors/consultant microbiologist.

### 4.4. MRSA in wounds

- According to the Wound Care Management Guideline (Dudley CCG, 2018), if swabbing a wound to screen for infection, a separate swab should be taken to screen for MRSA. If wound is then identified as MRSA positive, swabs should be taken from the patient’s groin and nose.
- Topical antimicrobials can help to reduce the bio-burden when critical colonisation or a biofilm is suspected – please follow the Dudley CCG Wound Care Management Guideline.
- When a wound infection is present refer to The Dudley Group NHS Foundation Trust / Dudley CCG Adult Antimicrobial Guide.
- In both cases treatment should only be prescribed for 14 days with a clear plan to review treatment objectives.
- Mupirocin **should not** be used in the presence of chronic wounds as clearance is unlikely.
- Patients with infected chronic skin conditions or wounds should be referred to a specialised service such as Dermatology or Tissue Viability.

### 4.5. Precautions
The Medicines and Healthcare products Regulatory Agency (MHRA) has issued a warning for healthcare professionals in 2014 advising them to bear in mind the risk of severe chemical injuries when using alcohol-based or water-based chlorhexidine solutions on preterm infants (babies born before 37 weeks of pregnancy are completed).

Please seek advice from consultant microbiologist if in doubt.

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 Health Protection Team at Dudley Council.

- 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 from hospital, 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.

10. **REFERENCE LIST**


https://www.who.int/gpsc/5may/residential-care.pdf?ua=1 [Accessed 8 January 2020].
APPENDIX A – PEOPLE AT HIGH RISK OF MRSA

Those at higher risk of MRSA include:

- Those living in a residential care home setting
- Previous MRSA carriers
- Patients with skin lesions/wounds/pressure sores
- Previous hospital admission within the 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 e.g. urinary catheter/PEG/Hickman line
- Healthcare workers
Dear Doctor

RE: Meticillin resistant Staphylococcus aureus (MRSA)

MRSA has been isolated from your patient:

………………………………………………………………….………………. 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 or those in a healthcare setting. Transmission is usually mediated on the hands of carer, 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 Octenisan antimicrobial wash. Nasal carriage should be treated with Naseptin four times daily for 10 days.

Infection

Superficial lesions infected by MRSA: A dressing impregnated with povidone-iodine or Flaminal can be used.

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 200 mg STAT PO first day followed by 100 mg OD orally for 5 days initially. In addition, topical dressings may also be applied in conjunction with doxycycline.

Serious invasive infections: Parenteral antibiotic therapy (vancomycin) in hospital may be required. Please discuss with microbiologist or hospital medical staff.
2. **Eradication Therapy**

Patient is managed depending on the circumstances of the case, so see 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 to 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/Naseptin 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 patients 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 Office of Public Health Infection Prevention and Control Team on: 01384 816242.

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 bloodstream. 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 Health Protection Team at Dudley Council. The team can be contacted by calling Council Plus on 0300 555 2345.

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.

**Visitors**  
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 at Dudley Council. The team can be contacted by calling Council Plus on 0300 555 2345.
APPENDIX D: MRSA DECOLONISATION CHECKLIST

Please tick as appropriate

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