METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (M.R.S.A.) DECOLONISATION GUIDANCE

PRIMARY CARE

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<th>First Issued by/date</th>
<th>Issue Version</th>
<th>Purpose of Issue/Description of Change</th>
<th>Planned Review Date</th>
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<tr>
<td>10/2008</td>
<td>1</td>
<td>Guidance</td>
<td>August 2011</td>
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Named Responsible Officer: - Approved by Date
Infection Prevention and Control Lead Infection Control Committee 6th August 2008

Policy File: -
Infection Control Policy No 11 Impact Assessment Screening Complete - August 08 Full Impact Assessment Required - No

Key Performance Indicator

1. Community MRSA Bacteraemia rates
2. Attendance levels at infection control training
3. Compliance with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection

UNLESS THIS VERSION HAS BEEN TAKEN DIRECTLY FROM THE PCT WEB SITE THERE IS NO ASSURANCE THIS IS THE CORRECT VERSION
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**Appendix A**

Decolonisation checklist
Wirral PCT

Meticillin Resistant Staphylococcus Aureus (MRSA) Decolonisation Guidance

Introduction

This Guidance should be used in conjunction with ICP 10 Meticillin Resistant Staphylococcus Aureus (M.R.S.A.) Policy

Topical decolonisation is used to try to interrupt transmission of MRSA in secondary care settings. As part of the ongoing work to reduce the incidence of Healthcare Associated Infections Wirral PCT, in conjunction with Wirral University Teaching Hospital, has agreed that it is reasonable to undertake decolonisation therapy of patients in non-healthcare settings found to be MRSA positive, based on a formal Risk Assessment of the individual patient.

This guidance does not apply to those patients identified as MRSA positive as part of the elective pre-admission MRSA screening pathway.

Guidance Aim

The aim of this guidance is to assist PCT healthcare staff and independent contractor services assess the appropriateness of decolonisation therapy for individual patients.

Guidance outcome

Decolonisation therapy will be prescribed appropriately to patients at risk of MRSA bloodstream infection.

Target Group

- Community Nursing Staff
- Specialist Nursing Staff
- Community Matrons
- Independent General Practitioners
- Practice Nurses
- Shared as best practice with Wirral Nursing Care Homes
Specific responsibilities

Chief Executive

The Chief Executive has overall responsibility for ensuring procedures are in place through primary and secondary care to reduce the levels of MRSA infections.

Board

The Board has collective responsibility for ensuring assurance that appropriate and effective procedures are in place to minimise the risks of healthcare-associated infections.

Director of Infection Prevention and Control

It is the responsibility of the Director of Infection Prevention and Control to oversee the development and implementation of infection prevention and control best practice.

Infection Prevention and Control Team

It is the responsibility of the Infection Prevention and Control Team to ensure this guidance is reviewed and amended at the review date or prior to this following new developments in the control of MRSA.

Service Managers

It is the responsibility of managers to ensure that staff have read the MRSA decolonisation guidance.

Staff

It is the responsibility of staff to ensure they follow the advice on the control of MRSA as detailed in this guidance.

Cross reference related PCT Policies/Guidance

- Risk Assessment for the Prevention and Control of Healthcare Associated Infections (HCAI) Guidance
- Meticillin Resistant Staphylococcal Aureus (MRSA) Policy

NB: Always use most current versions of PCT policies as may be superseded at any time.
Background

The Joint Working Party (2006) state that “people colonised with MRSA will not normally require any specific treatment.” MRSA skin or wound contamination can be transient, rarely causing infections. Infections that do occur remain localised to wounds and can be easily treated with antibiotics. However, under certain circumstances colonisation with MRSA may increase the risk of harder to treat infections such as osteomyelitis and septicemia. Patients with a lowered resistance to infection through illness, extremes of age or where conditions or drugs mask the normal early indicators of infection may be at higher risk. Little data exists to determine the effectiveness of topical decolonisation in eradicating and therefore preventing further infections in non-healthcare settings and with prolonged follow-up.

Decolonisation (suppression) regimens are only 50–60% effective for long-term clearance, re-colonisation is common but targeted short term decolonisation regimes are more effective in reducing the presence and shedding of MRSA and so reduce the risk of the patient infecting themselves, transmitting MRSA to other vulnerable patients, allowing natural healing to occur and preventing the development of resistant to decolonisation antiseptics and antibiotics.

Target Patient Group

All patients registered with a Wirral General Practitioner who are been identified as MRSA positive by microbiological culture at any site;

either
  • From a specimen obtained in hospital (either as screening swab or diagnostic specimen) but patient was discharged before the result was available.
or
  • Microbiological diagnostic specimen obtained in the community e.g. wound swab, urine.
and
  • The patient is considered suitable for decolonisation using the MRSA decolonisation assessment tool.
## MRSA Decolonisation Assessment Tool

<table>
<thead>
<tr>
<th>Type of Patient</th>
<th>Treatment advice</th>
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<tr>
<td><strong>HIGH RISK</strong></td>
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</table>
| All MRSA skin and/or nasal colonised patients identified from secondary care units, who have been discharged with **surgical or chronic wounds** or **invasive devices** (Peripheral, central or tunneled IV lines, PEG, urinary catheter, trachestomy) in the following categories | Patient discharged from secondary care on decolonisation therapy:  
- Complete current course of decolonisation therapy  

Patient discharged before decolonisation therapy could be started i.e. results of inpatient screening swabs not available at the time of discharge:  
- Complete 5 day course of decolonisation therapy  

**Clinical signs of infection:**  
Discuss with Microbiologist |
| Cardiotoracic Surgery |                  |
| Vascular Surgery       |                  |
| Orthopaedic Surgery    |                  |
| Neurological Surgery   |                  |
| Implant Surgery        |                  |
| Renal Medicine         |                  |
| Oncology               |                  |

| **INTERMEDIATE RISK** |                  |
| MRSA colonised patients not included above with the following (primary or secondary care): | Patient discharged from secondary care on decolonisation therapy:  
- Complete current course of decolonisation therapy  

Patient discharged before decolonisation therapy could be started*:  
- Assess patient risk of bacteraemia |
| Extensive or deep surgical or traumatic wounds or pressure sore or leg ulcer with MRSA colonisation/infection | Primary care microbiology culture positive for MRSA:  
- Consider the potential for bloodstream infection  
- Screen for MRSA carriage i.e. nose & perineum/groin  
- Complete 5 day course of decolonisation therapy if risk considered/identified |
| Invasive devices i.e. PEGs, urinary catheters, tracheostomies |                  |
| Eczema or psoriasis with MRSA colonisation of the skin |                  |
| Immunocompromised patient |                  |
| Patients with wounds on immune suppressant drugs e.g. TNF drugs |                  |
| Extensive venous/arterial ulcers with or without diabetes |                  |
| Severe uncontrolled exuding oedema |                  |

| **LOW RISK** |                  |
| All other MRSA colonised patients with no wounds or invasive devices regardless of age or living accommodation | Patient discharged on decolonisation therapy:  
- Complete current course of decolonisation therapy  

Patient discharged before eradication therapy started or diagnosed after discharge:  
- Decolonisation therapy not generally required |
Decolonisation Regime

- The decolonisation regime should only be used if screening swabs (nose & perineum/groin) are positive.

If broken skin only is positive follow appropriate wound management treatments.

Patients should have

- Mupirocin 2% nasal ointment applied to both anterior nares three times daily for five days (apply a match head size amount each time).
- Daily washes with antiseptic body-wash (Octenisan) for five days. If excessive skin drying occurs consider Oilatum Plus (not ordinary Oilatum) as a bath additive.
- Hair washed with antiseptic body-wash twice in five-day treatment period.
- Encourage daily change of flannel, towel and personal clothing and, if possible, bedding.

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<th></th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
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<tbody>
<tr>
<td>Octenisan body wash</td>
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<tr>
<td>Octensan hair wash</td>
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<tr>
<td>Mupirocin</td>
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Re-screening

Screening following decolonisation is not generally required. Discuss any concerns with the PCT Infection Prevention and Control Team.

Patients with infected or colonised ulcers or wounds

In addition to the regimen given above, those patients with broken skin should have a suitable anti-staphylococcal dressing applied e.g. iodine or silver based dressings during the decolonisation programme. Mupirocin is NOT to be applied topically to wounds unless discussed and agreed with the PCT Infection Prevention and Control Team.
Factors which may affect long-term success of topical decolonisation

- Non-compliance with the topical decolonisation regime
- Attempts to decolonise whilst still shedding S. aureus from an infected lesion, e.g. healing abscess, or break in the skin e.g. chronic ulcer
- Re-colonisation from a close contact
- Re-colonisation from the patient's own flora e.g. gut, vagina
- Re-colonisation from the environment
- Presence of a urinary catheter

These factors need to be taken into account when considering a topical decolonisation regimen.

Patient groups where decolonisation may not be appropriate

It is not possible to be prescriptive for all circumstances as decisions need to be based on an assessment of the individual patient.

It is the prescribing clinician's responsibility to assess whether decolonisation therapy is required or is appropriate. In some instances it may be inappropriate to attempt decolonisation due to the patient's condition as it will not improve the patient's outcome and may be unsafe to attempt e.g.

- Patients on Care of the Dying Pathway
- Where treatment may have a detrimental effect on the patients mental wellbeing.
- Very frail patients
- Allergy to any of the products used

This list is not prescriptive or exhaustive.

Patients unable to decolonise independently

The PCT has arrangements in place for patients who have been assessed as requiring decolonization and are unable to undertake this independently. Please contact the PCT Infection Prevention & Control Team to discuss further.
Archiving

Hard and/or electronic copies of previous versions of this document will be held by the Infection Prevention & Control Team for the retention period required under current NHS guidance.

References


List of those consulted in drafting process

Wirral PCT Infection Prevention and Control Team
Wirral PCT Infection Control Committee
Medical Directors Bebington, Birkenhead and Wallasey Localities.
Wirral University Teaching Hospital NHS Foundation Trust (WUTH)
Health Protection Agency (Cheshire and Merseyside Health Protection Unit) (CMHPU)
Cheshire and Wirral Partnership NHS Foundation Trust (CWP)
Appendix A: MRSA Decolonisation Checklist

Patient Details:

Name……………………………………………………DoB……………………………………

Home address……………………………………………………………………………………
………………………………………………………………………………………………
________________________________________________________________

General Practitioner…………………………………………………………………………
Practice…………………………………………………………………………………………

Date MRSA positive isolated……………………………………………………………………

<table>
<thead>
<tr>
<th>(please tick)</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Swab/culture taken by secondary care?</td>
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If yes:
Is decolonisation therapy in progress?
Previous MRSA isolates?
Skin/nasal MRSA colonisation?
Decontamination therapy required in primary care?

Decolonisation record (please sign therapy given)

<table>
<thead>
<tr>
<th>Date</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
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<tr>
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