The management of symptomatic MRSA infections in the community will be covered in BSAC guidance being developed.

MRSA-colonised patients are at risk of developing surgical site infections caused by their colonising strains.

MRSA prevalence in UK: <1% of patients living at home, blood cultures.

Where necessary, perform 3 screens (as above), one week apart. Begin at least 48 hrs after end of antiseptic & antibiotic

Where practical, standard infection control procedures should be followed. MRSA-positive patients undergoing medical

Skin

Nasal

Area

Use both nasal and skin regimens

Regimen

Instructions

<table>
<thead>
<tr>
<th>Area</th>
<th>Regimen</th>
<th>Instructions</th>
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<tbody>
<tr>
<td>Nasal</td>
<td>A 2% mupirocin in paraffin base 3 times a day for 5 days</td>
<td>A Apply pea-sized amount to inner surface of each nostril. A Patients should be able to taste mupirocin at back of throat.</td>
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<tr>
<td></td>
<td>A 4% chlorhexidine gluconate body-wash/shampoo Alternatives: 7.5% povidone iodine or 2% triclosan. Daily for 5 days</td>
<td>A Moisten skin and apply undiluted antiseptic then rinse. A Particularly apply to known carriage sites (axilla, groin &amp; perineum). Wash hair using antiseptic body-wash/shampoo. B After washing, use clean towels, sheets &amp; clothing. D Launder items separately from other family members, using as high a temperature as fabric allows.</td>
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</tbody>
</table>

SUPPRESSION OF MRSA

How do I suppress MRSA?

To reduce persistent MRSA carriage, treat underlying skin conditions (e.g. eczema, dermatitis), remove and/or replace invasive devices and treat skin breaks. Choice of skin regimen for patients with underlying skin conditions should consider the potential for skin irritation. Where necessary, seek advice from Dermatologist.

Use both nasal and skin regimens

How do I know if a patient’s MRSA has been suppressed?

POST-SUPPRESSION SCREENING

What do I do if a patient is discharged from hospital MRSA positive?

Where practical, standard infection control procedures should be followed. MRSA-positive patients undergoing medical or nursing procedures in primary care (e.g. wound dressings, minor surgery) should be seen at the end of the list. A patient information leaflet is available from: http://www.prodigy.nhs.uk/patient_information/pils/mrsa.htm

KEY A B C D indicates grade of recommendation

This guidance was produced by the South West GP Microbiology Laboratory Use Group in collaboration with GPs, Association of Medical Microbiologists and experts in the field, and is in line with other UK GP guidance including CKS.

This guidance should be adapted locally to comply with local Trusts’ MRSA screening & admission/administration policies.
An alternative strategy would be to screen patients in sufficient time to allow possible decolonisation regimen and three post-decolonisation screening swabs prior to elective admission. Patients who are MRSA-negative who live in their own home are at minimal risk of colonisation prior to admission however, residents of care facilities are at risk of recolonisation and may require re-screening on admission.

In addition to the nares and wounds, it may increase screening sensitivity to swab the perineum/groin. There is no good quality evidence in the literature regarding which patients and which body sites should be screened and current practice is varied. Recommendations of the Joint Working Party for BSAC, HIS and ICNA are that the following sites should be sampled: anterior nares, skin lesions or wounds, sites of catheters, catheter urine, groin/perineum, tracheostomy and other skin breaks and sputum from patients with a productive cough. However, carriage is most common in the nares and most patients who are positive at other sites are also positive in the nares. Swabbing both nostrils only gives a minor increase in yield, however, most current guidelines recommend swabbing both nares (with the same swab). There is no evidence that moistened swabs have increased recovery compared to dry swabs, however, many guidelines recommend moistening the swab with sterile water or saline prior to swabbing.

The term ‘suppression’ has been used in this guideline where others have used ‘decolonisation’, ‘decontamination’ and ‘reducing the burden’. We consider ‘suppression’ to accurately describe the decrease in isolation of MRSA that can be achieved following antimicrobial regimens.

Chlorhexidine gluconate 4% may not be suitable for patients with underlying skin disease. Kampf and Kramer state that irritant contact dermatitis is highest for preparations containing 4% chlorhexidine gluconate used for hand hygiene and less frequent for preparations with lower concentrations of chlorhexidine gluconate and lowest with well-formulated alcohol-based hand rubs. They found insufficient evidence to investigate irritation caused by triclosan and do not comment on povidone iodine.

References

8. Health Protection Agency. Specimens for Screening for MRSA. *Standard Operating Procedure BSOP 29* 2004; 4:
10. University College London Hospital. MRSA information for primary care *University College London Hospital* 2006.