GUIDANCE AT A GLANCE- *MRSA*

These guidelines support the control and prevention of MRSA in community and Primary Care settings. They reflect best practice/national guidelines of the DH and local protocols

KEY POINTS

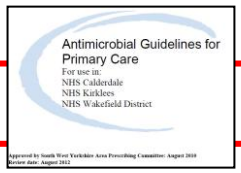
Meticillin Resistant Staphylococcus (MRSA) refers to the resistance of a strain of Staphylococcus aureus to the Beta lactam class of antibiotics. MRSA can colonise or cause infections in patients. It survives well in the environment, on skin scales and in dust and can be carried transiently on hands. The main route of transmission is through direct contact mainly by the hands.
If a patient has had a positive MRSA result in the last three years then it is good practice to consider them still positive.

My patient is colonised with MRSA...

Colonisation with MRSA may be identified when patients have been screened in hospital and discharged prior to the result being known. Sometimes it may be appropriate for the patient to have a course of colonisation suppression. The IPC team will inform the patient, providing written information and an MRSA alert card. This card (pictured) should be shown to future health and social care providers to enable informed decisions about treatments and isolation.

My patient has an MRSA infection ....

Clinical infection with MRSA requires systemic treatment when symptoms of infection are present. See the Community Antimicrobial Guidelines 2013 or contact the microbiologists at the acute hospital (via the hospital switchboard) for advice on antibiotics. As above, the IPC team will write to the patient, providing written information and an MRSA card.



My patient has a history of MRSA....

If a patient with a history of MRSA presents with an infection that you suspect maybe Staph aureus, consider their history when deciding on antibiotic treatment and take a specimen to confirm the causative organism so treatment can be altered as soon as possible if needed.
Patients with MRSA may not respond to usual empirical antibiotics treatment (e.g. amoxicillin, flucloxacillin). If any patient is not responding to treatment as expected, please consult microbiology for antibiotic advice.

My patient has recurrent abscesses...

Panton Valentine Leukocidin (PVL) can be a cause of recurrent skin abscesses or boils. PVL can be MRSA or MSSA. If swabbing recurrent boils consider PVL. First line treatment for small PVL lesions is incision and drainage, not systemic antibiotics.

Communicating infection risk

- If admitting a patient with a history of MRSA, notify the receiving area so appropriate isolation can be instigated.
- The IPC team will write to your patient supplying a leaflet and card information to be sent to the practice.
- The infection risk should be documentated on the patient record as guided by the IPC team.

Preventing spread

Key actions to take:

- *See MRSA cases at the end of a list where possible*
- *Hand hygiene before and after each patient contact*
- *Aprons to be worn for examination*
- *Clean equipment after each use including the couch*

Resources

- Antimicrobial guidelines
- Patient held card
- MRSA patient information leaflet *(also available in easy read)*
- Transfer stickers – *(available from the IPC team)*

Infection Prevention and Control Team for resources and advice on Tele: 01484 225598 or infection.control@kirklees.gov.uk
Microbiologist for prescribing and treatment advice (SWITCHBOARD) CHFT – 01484 342000, MYHT – 08448 118110
Thanks to Calderdale IPC Team for allowing adaptation of this guide