Protocol for Determining MRSA Clearance ¹

Application: Minimum standard for the approach taken in ‘clearing’ individuals with Methicillin Resistant Staphylococcus aureus (MRSA) within the DHHS

Approved by: HAI Steering Committee (via the Tasmanian HAI Advisory Group)

Effective Date: 13th July 2011

Custodian and Review Responsibility: Tasmanian Infection Prevention & Control Unit

Review Date: January 2013

Version: 1.0

Replaces: New protocol

Background

This document has been issued by the Tasmanian Infection Prevention and Control Unit (TIPCU) to provide consistent criteria and a minimum standard for the approach taken in determining when an individual has been ‘cleared’ of methicillin resistant Staphylococcus aureus (MRSA) infection and colonisation. The protocol outlines the criteria to be used in determining whether an individual has been ‘cleared’ of MRSA for the purposes of ensuring a standardised approach for patient MRSA alert removal in the Patient Administration System.

¹ For the purpose of this document the terms “Cleared” and “Clearance” do not imply MRSA has been totally and permanently eradicated from a person. A person is deemed to be ‘cleared’ of MRSA when, in accordance with this protocol, MRSA can no longer be isolated from surveillance swabs. In these circumstances, a person ‘cleared’ of MRSA implies that the patient falls into a group at lower risk of transmission of MRSA than a person from whom MRSA can be isolated.

The following has been considered in developing this protocol:

- Existing practices within hospitals
- Need for a consistent minimal standard for determining clearance
- Lack of consistent published high level evidence in relating to clearance criteria
- An approach that supports compliance with the MRSA and VRE Screening in Acute Care Hospitals, (DHHS Policy, Document No P0027/2010)
Procedure

Consult/liaise with relevant infection control unit regarding the development of an agreed patient specific clearance plan.

Minimum criteria for determining MRSA clearance

The following criteria need to be met in order to establish MRSA clearance:

1. >3 months since last positive screen/result/test
   AND
2. No exposure to antiseptic body wash within 2 weeks of screening
   AND
3. No anti-MRSA antibiotic therapy within 3 months prior to screening
   AND
4. No indwelling device present that has been previously implicated in MRSA infection or colonisation
   AND
5. Negative screening swabs on 2 or more occasions taken at least one day apart from nose, throat, groin/perineum and any clinically relevant sites including:
   a. Chronic wound or ulcer
   b. Sputum if patient has sputum production and has previously been infected or colonised in the respiratory tract.
   c. Urine if indwelling urinary catheter in-situ
   d. Swab from the entry site of any other indwelling device e.g. PEG tube
   e. Any additional previous MRSA positive site

Actions following clearance (based on above criteria)

If the criteria for determining clearance have been met:

1. DHHS infection control units in Area Health Services should end-date the MRSA alert in IPM and create a new alert:
   a. In the case of LGH the alert is an MRSA-I alert.
   b. In the case of the STAHS and NWAHS, the alert is an MRSA-H alert

2 The LGH have a process for the end-dating of an MRSA-I alert. This requires a person to have three negative screens 12 months after the last positive result. When a person at the LGH meets the criteria to end date an MRSA-I alert, an MRSA-H alert will be commenced.
Other considerations

1. It is not within the scope of this document to outline microbiology laboratory techniques for MRSA detection.

2. Only staff working in infection control units within the DHHS or delegates of infection control units are permitted to end date individual MRSA alerts and commence new alerts in IPM.

3. If a person meets the criteria described in this document, MRSA alert may be end dated, regardless of the region in which they live. For example an person from the NW receiving treatment in the RHH may have an MRSA alert end dated by the RHH infection control team, if the criteria in this document are met.

4. Communication between AHS infection control teams regarding individual MRSA management of specific patients may be required.

Responsibilities/Delegations

Infection Prevention & Control Units within the DHHS are responsible for developing and monitoring MRSA clearance programs, using this guidance as the framework for consistency within the DHHS.

Definitions

MRSA – Methicillin resistant *Staphylococcus aureus*

MRSA I – Methicillin resistant *Staphylococcus aureus* Inactive. The LGH have a specific application and use of this alert.

MRSA H –Methicillin resistant *Staphylococcus aureus* History.

TIPCU – Tasmanian Infection Prevention and Control Unit

DHHS – Department of Health and Human Services (Tasmania)

Review & Risk Mitigation

During the first twelve months following implementation, the protocol will be audited by the following process:

- Infection control units that identify a patient under an MRSA-H alert who is subsequently found to have a positive MRSA results are to report this to TIPCU, with a brief summary of the case details. This data will be collated by TIPCU

- The review of this procedure will include considering information provided to the TIPCU and any risk this may pose.

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Related Documents/Legislation

**DHHS**
- [Hand Hygiene Policy](#), DHHS Policy, Document No 20090713_dOC ID.doc
- [MRSA and VRE Screening in Acute Care Hospitals](#), DHHS Policy, Document No P0027/2010

**OTHER**
- Health Protection Agency / Association of Medical Microbiologists - Meticillin Resistant *Staphylococcus aureus* (MRSA) Screening and Suppression, www.hpa.org.uk
- QLD Health (CHRISP), www.health.qld.gov.au

**Attachments**

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