PUBLIC HEALTH SERVICES

# Guidance for the Decolonisation of Methicillin Resistant *Staphylococcus aureus*

## A Guide for Health Care Workers

### Background

Patients colonised with methicillin resistant *Staphylococcus aureus* (MRSA) are at an increased risk of developing active MRSA infection and are a potential source of cross infection. Decolonisation is a targeted control measure for reducing the transmission risk of MRSA. Topical antimicrobials are used to eliminate or suppress MRSA colonisation by reducing the bacterial load and therefore lowering the risk of endogenous infection and exogenous transmission

Strategies for decolonisation should be determined by risk assessments to identify patients at high risk of infection or areas with high endemic rates.

Health care organisations with specific policies for the decolonisation of persons with MRSA should follow their local policy.

### Who could benefit from MRSA decolonisation?

Patients who are:

- To undergo high risk surgical procedures, e.g. cardiothoracic surgery, joint replacement or implantation surgery
- In a group at high risk of Staphylococcal bacteraemia, e.g. patient undergoing haemodialysis
- Admitted to a high risk area, e.g. intensive care units, burns, haematology, oncology and renal units
- Implicated in an MRSA outbreak within an acute healthcare facility.

### Who would not benefit from MRSA decolonisation?

MRSA decolonisation is unlikely to be successful and is not recommended in the following situations unless there are other extenuating factors:

- Patients with an active MRSA infection
- Patients with scabies or exfoliative skin conditions
- Patients with chronic wounds, ulcers or other areas of skin breakdown
- Patients with indwelling medical devices, whether temporary or long term e.g. intravenous (IV) devices, urinary catheters, percutaneous endoscopic gastrostomy (PEG) tube.

Advice from an infectious disease physician or clinical microbiologist will be helpful in the situations described above.

## Applying a MRSA decolonisation regime

A recommended regimen (if no documented allergies to the products listed) is as follows:

1. Mupirocin 2% ointment intra-nasally two times a day for 2 days

**PLUS**

2. Chlorhexidine 2% or 4% body wash[1] for 5 days

**PLUS**

3. Wash hair daily with chlorhexidine 2% or 4% body wash[2] 5 days

**PLUS**

4. Consider mouth rinse of chlorhexidine gluconate, 0.2% undiluted, 2 x 10ml for 5 days. If the patient has dentures/partial plates they should be soaked nightly in a denture cleaning product.

**AND**

5. If not an inpatient, change and wash all bed linen on the hottest wash cycle available on day 1, 2 and 5 of therapy.

## Additional considerations

- If throat decolonisation is required, advice should be sought from an infectious disease specialist or clinical microbiologist
- People undergoing a home-based decolonisation regime should be given specific and comprehensive written guidelines.
- Screening post decolonisation may commence 2 weeks after therapy has been ceased
- If decolonisation therapy fails, consult an infectious diseases consultant or clinical microbiologist for advice on further measures.
- A patient undergoing treatment for a current MRSA infection does not preclude concurrent decolonisation, however it is important to note that the patient will not fulfill the criteria for clearance.

Public Health Services

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[1] Alternatives include Hexachlorophane 3% emulsion, Triclosan 1 % body wash

[2] Alternatives include Cetrimide 20% shampoo 3rd daily