Leamington Mennonite Home
Long Term Care

INFECTION CONTROL
POLICY AND PROCEDURE

CATEGORY: **Screening & Immunization**	**SUBJECT:** **Prevention & Control of MRSA & VRE**	**SECTION:** **D** **POLICY:** **10**
DATE: **July 12, 2022** **REVISION DATES:** **November 2023**	**Administrator's Signature:** J. Im! **IPAC Lead's Signature:** L Coppola, RN.	

PREVENTION & CONTROL OF MRSA & VRE

PURPOSE:

To prevent and/or control the transmission of MRSA (Methicillin Resistant Staphylococcus Aureus) and VRE (Vancomycin Resistant Enterococcus).

POLICY:

The Leamington Mennonite Home will implement procedures to prevent and/or minimize the transmission of MRSA and VRE between residents in the facility. This includes the use of Routine Practices at all times in the care of all residents, as well as Additional Precautions when indicated. LMH will manage cases of MRSA and VRE according to the most current best practice recommendations.

PROCEDURE:

Any resident admitted to the Home will be screened for risk factors for MRSA and VRE using the MRSA and VRE Admission Screening Form. The screening will occur within 24 hours of admission. All residents will be screened for MRSA and VRE upon readmission after having been admitted to hospital. No resident with a previous diagnosis of MRSA or VRE will be refused from moving into the Home.

The Nurse will:

1) Review order from the Medical Directives.
2) Explain the procedure to the resident.
3) Obtain swab kit. Perform hand hygiene and put on clean gloves.
4) Proceed with MRSA Screening Procedure for Cultures/Molecular Detection:
    - Pre-moisten all swabs with sterile normal saline or with transport medium prior to taking a specimen
    - Swab anterior nares (use the same swab for both nostrils). Use a circular motion to touch as much mucous membrane as possible
    - Swab perianal/perineal skin or groin with a new swab
    - Swab wounds/skin lesions/incisions/ulcers if present with separate swabs
    - Swab exit sites of indwelling devices if present

5) Proceed with VRE Screening Procedure for Cultures/Molecular Detection:
    - Stool or a rectal or anal swab may be used for VRE screening. Stool specimens are preferred as the yield is higher
    - If a swab is used, pre-moisten swab with sterile normal saline or with transport medium prior to taking a specimen
    - Swab around external rectal orifice. If visible stool is not obtained on the swab, insert it a few millimetres into the rectum until visible stool is obtained
    - If resident has a colostomy, take the specimen from the colostomy output
6) Place swabs into sterile receptacle and ensure each is labeled with the resident's name and date of birth, source, test type, and date of collection.
7) Remove gloves and perform hand hygiene.
8) Complete one lab requisition, including the sites from which the specimens were taken, and place in specimen cooler for lab pick up by 1300h.
9) Document procedure in resident's electronic health record.
10) If a new admission is identified as high risk for ARO colonization or infection as per the Admission Screening Form, the resident should be placed on contact precautions while awaiting the culture results.
11) Initiate contact-based precautions for any resident testing positive for MRSA and/or VRE.
12) The Nurse is to place out *Just the Facts Worksheet: MRSA or VRE* for PSW staff and email the fact sheet to department leaders to relay to their staff.

The IPAC Lead will:

13) Note if there is a concern about the increase in MRSA colonization in the Home, and consult with the DNPC, Public Health Unit, medical director, and IPAC team. If an increase is noted, the review of transmission and control measures need to be reviewed again with all staff through education and audits. If transmission continues, decolonization may be a recommendation by the medical director as a further action or outbreak control measure. Decolonization of residents with wounds or residents whose risk of MRSA transmission is low is not recommended.

    Note: Specimens may show a false negative result if resident is on an antibiotic to which the microorganism is sensitive. MRSA may not show up on specimens taken from residents who have recently had an antimicrobial bath. Surveillance specimens should be taken once the antibiotic has been discontinued for 48 hours.

Resident Accommodation:

1. If at all possible, the resident with MRSA or VRE should be placed in a private room with individual toileting facilities.
2. When a private room is not available, residents with MRSA should be cohorted with other residents with MRSA and residents with VRE should be cohorted with other residents with VRE.
3. If cohorting is not possible, residents with MRSA should **not** share a room with:
    - Individuals who have open wounds or decubitus ulcers
    - Individuals who have urinary catheters, feeding tubes, or other invasive devices
4. Residents with MRSA and VRE can leave their rooms and can participate in the daily activities of the home. Residents with MRSA and VRE must be encouraged to/assisted with performing hand hygiene frequently, especially before leaving their rooms.

5. Added measures for residents whose conditions put them at higher risk for contaminating the environment (e.g. uncontainable drainage or incontinence) should be determined on a case by case basis after consultation with the DNPC.

Precautions:

1. Any resident who is MRSA or VRE positive should be cared for using Contact Precautions, in addition to Routine Practices. Always provide care to non-positive roommate prior to positive resident.
2. Gloves must be worn when providing direct care to any resident who has MRSA or VRE. Direct care means providing hands on care, such as bathing, washing, turning resident, changing clothes/incontinent products, dressing changes, care of open wounds/lesions or toileting (feeding and pushing a wheelchair are not classified as direct care).
3. A long-sleeved gown must be removed and discarded immediately upon leaving the room or bed space of a resident with MRSA or VRE. Hand hygiene should be performed immediately after the personal protective equipment (PPE) has been removed.
4. No special handling of trays, linens, or waste is required for residents with MRSA or VRE.

Screening and Swabbing: Contacts

1. Any resident who has had physical contact (e.g. roommate) with a MRSA or VRE case is to have at least two specimens taken on different days, with one taken a minimum of seven days following the last exposure. If the contact is negative and continues to share a room or have physical contact with the positive resident the contact will be screened on an annual basis for the appropriate infection, or more often if deemed necessary. Contacts should be screened if there is on-going transmission (when new cases of MRSA continue to be identified despite active control measures).
2. Contact precautions may be instituted before culture results are available for residents believed to be at particularly high risk of being colonized or infected with an ARO.
3. When a new case of MRSA or VRE is identified, the DNPC will make every effort possible to try to determine the source of the organism.

Screening and Swabbing: Point-Prevalence

1. Consider conducting point-prevalence screening on the affected floor if additional cases are found after doing contact tracking.
2. Continue to screen until no further transmission is detected; in general, this means at least two prevalence screens taken at least one week apart after the last transmission was detected.

Discontinuation of Precautions:

1. Repeat testing of an MRSA positive resident will be conducted every three months. Three complete sets of negative swabs, collected at least one week apart, are required to consider the resident MRSA-free. If one swab is positive, the other 2 swabs are not required.
2. If a previously positive resident has had three complete sets of negative swabs, collected at least one week apart, precautions can be discontinued.

3. Previously positive residents who have had three complete sets of negative swabs, one week apart, should continue to be screened every month for six months after the precautions have been discontinued, to monitor for any changes in ARO status.
4. Re-screening for VRE is not currently recommended. Colonization with VRE tends to persist for long periods of time and there is little literature to support recommendations to re-screen at this time.
5. VRE re-screening MAY be considered under specific circumstances, in consultation with the IPAC Lead and DNPC.
    - For discontinuation of Additional Precautions, begin re-screening no sooner than 3 months after last positive and take 3 cultures at least one week apart, for 3 consecutive negative cultures.
6. The IPAC Lead will track residents with AROs and document when re-screening specimens are required in the nursing daybook on each floor.

Decolonization:

1. The Medical Director will determine whether decolonization therapy for residents with MRSA and/or VRE should occur.
2. In situations where a resident colonized with MRSA is implicated in an outbreak, the DNPC may discuss decolonization with the Medical Director.
3. Decolonization should be considered for staff colonized with a strain of MRSA that has been epidemiologically linked to an outbreak.

Environmental Cleaning & Equipment Use:

1. When possible, dedicated equipment (e.g. wheelchair, lift sheet, blood glucose meter, thermometer, etc.) should be used to provide care to residents with MRSA or VRE.
2. In the event that any equipment must be shared, thorough cleaning and disinfection of all such equipment will occur before use with another resident (e.g. Virox wipes). When possible, the resident with MRSA/VRE will use the equipment last, followed by a thorough cleaning.
3. As per Routine Practices, rooms and surfaces used for residents with MRSA or VRE must be thoroughly cleaned daily and upon discharge of the resident. The standard housekeeping products will suffice. Stringent protocols are required for the daily cleaning of rooms contaminated with VRE due to the identified increase in environmental contamination.
4. Upon discontinuation of precautions, transfer, or discharge, the resident's room will receive terminal cleaning. All privacy curtains will be taken down and sent for laundering. All disposable items including unused paper towels and toilet paper will be thrown away.

Visitors:

1. Visitors need not be restricted from visiting the resident with MRSA or VRE. They should be instructed on correct hand hygiene procedures with an emphasis on the importance of hand hygiene after physical contact with the resident and on exit from room.
2. If a visitor is providing direct care, the visitor should be instructed to wear the same PPE as staff.