FAQ: Guidelines for Implementation of MRSA Initiative in Spinal Cord Injury Centers (SCIC)

1. We have so many patients who already have MRSA. How do we begin to engage staff in working towards the elimination of MRSA transmission?
   The best way to get started is to review your data with your Infection Control Practitioner, MRSA coordinator and Unit Nurse manager to come up with a risk assessment to guide your goals and plans. The risk assessment could be based on:
   a. Prevalence, incidence, and trends in MRSA colonization and infection in the SCIC
   b. Prevalence, incidence, and trends in infection and colonization with other organisms of epidemiologic importance such as *Clostridium difficile*, vancomycin-resistant enterococci and multi-drug resistant gram-negative rods
   c. The availability of isolation rooms and private bathrooms on the unit
   d. An assessment of all shared facilities, including wound care facilities, shower areas, lifts, therapy areas, outpatient clinic areas, and recreational and outside areas.
   e. Volume of inpatient and outpatient visits and use of other services
   f. Availability of appropriate supplies such as gowns, gloves and hand hygiene lotion dispensers

2. What is a reasonable goal for a SCIC?
   In areas with high existing prevalence of MRSA colonization among patients, a feasible goal could be reducing MRSA acquisition among MRSA-negative patients. Success for this goal would be assessed through discharge screening of MRSA-negative patients.

3. We have a lot of resistant organisms and *C. difficile* already on the unit. Can we set priorities for the use of private rooms with patients with multiple organisms?
   a. Your staff should address this in the risk assessment and goals setting. Severe *C. difficile* may be a bigger threat to your patients than MRSA.
      i. Many areas would prioritize the use of private rooms for these patients due to the high morbidity/mortality and outbreak potential with *C. difficile*.
      ii. When the episode of *C. difficile* diarrhea has been fully treated in a MRSA-positive patient, the patient may be bathed prior to transfer to an MRSA-cohort room, and the private room terminally cleaned, including the use of bleach.
      iii. Additional or modified contact precautions signage should be used to convey the need for conventional hand hygiene after contact with a *C. difficile* patient, as well as the use of bleach for terminal cleaning.
   b. Cohorting patients with other resistant organisms may depend on the risk of roommates for invasive infection; i.e. central venous catheters. The MRSA
coordinator or your facility Infection Control Practitioner should be involved in decisions involving cohorting patients with multiple MDROs.

4. How can we address rehabilitation and therapy needs (e.g., PT, OT) while maintaining contact isolation?

In spinal cord injury settings, intensive therapies are the norm, and therapists are likely to contaminate their clothing while working with MRSA-positive patients. Preventive measures include:

a. for the patient, hand hygiene on leaving the room for the session
b. for the therapist, hand hygiene before and after the session, BEFORE donning and after any glove change or removal, PLUS
   i. gloves and gown for any contact with the patient during therapy
   ii. gloves should be changed between each patient
   iii. for sessions where a isolation gown may not cover all areas in contact with the patient, additional barriers may be considered (e.g., using a new set of cloth scrubs to be changed and laundered after each MRSA-positive patient’s therapy session, or using disposable scrubs for each session)
   iv. wipe down mats and other equipment after each therapy session with a patient in Contact Precautions with a hospital-approved disinfectant.

5. How should patients be transported to other areas of the facility?

Transport practices should be consistent throughout facilities, so SCICs should coordinate with the local MRSA coordinator. In general, for patients in Contact Precautions being transported to areas such as Radiology, the patient should don a clean cover gown and perform hand hygiene prior to transport. After helping the patient onto a stretcher or into a wheelchair, staff remove their gown and gloves and perform hand hygiene on leaving the room with the patient.

6. Some of our patients have turned up MRSA-negative in the nares yet positive on wound culture. Should we be using a MRSA screen on wounds?

Given the high prevalence of chronic wounds in SCIC patients, wound cultures can be considered to avoid missing any MRSA-positives in this population. In addition, urine cultures positive for MRSA may indicate bladder colonization in chronically catheterized patients.

7. How do I screen wounds?

a. If PCR is used for wound screening, the edge of the wound should be swabbed, as too much material such as blood or pus on the swab will result in an indeterminate PCR result.

b. If conventional cultures are performed, select a wound with a moist area such as under the rim of a decubitus. This will provide better yield than an area with dry tissue or eschar. If using PCR, pick a similar area, but without too much gross purulence

   More than one wound may be swabbed if there are multiple wounds. Moist wounds, particularly those near the perineum, are the most likely to be colonized.
8. How can we manage our rooms and admission flow?
   Decisions on cohorting should be made based on test results. Patients who test negative for MRSA should be cohorting with other MRSA-negative patients.

9. Our MRSA-positive patients leave their rooms and touch multiple surfaces throughout the day. How do we manage this?
   Patient education and hand hygiene are key: alcohol hand disinfectant must be placed at a convenient height for patients and visitors to use throughout the unit. Identify high-touch areas such as door pushes and handles, countertops, and tables in communal areas and have these wiped with disinfectant twice daily.

10. Can we allow our patients to go into rooms of other patients in Contact Precautions?
    Social interaction and peer coaching is encouraged in the SCIC. However, the Guidelines do not preclude adherence to other standard Infection Control practices, and staff should assure the integrity of Infection Control protocols when more mobile patients visit those confined to their rooms. Mobile patients who visit other confined patients need to perform hand hygiene meticulously before and after the visit, and adhere to standard Infection Control practices.

11. For many of our patients, we may go in the room to answer a request, but do not have any direct contact with the patient or the environment. Do we need to gown and glove on room entry as for Contact Precautions elsewhere in the facility?
    Some facilities have addressed this by putting tape or other markers on the floor to create a “safe zone”. If providers step beyond the safe zone, they need to gown and glove. If they can communicate with the patient while standing in the safe zone, full personal protective equipment is not required. Providers should perform hand hygiene since contaminated surfaces on or around the door may be contacted.

12. We do not have enough single or double bed rooms to isolate patients. Should we cancel admissions?
    No. These guidelines are intended to provide general recommendations to the SCICs. However, it is recognized that there may be conflicts between the overall goals for the patient in the SCIC (rehabilitation, recovery of function, maximal independence) and MRSA management. Admissions should not be cancelled to isolate a MRSA positive or MRSA negative patient.

13. We are moving patients frequently in an attempt to cohort MRSA patients. What is the best strategy to minimize the constant shifting of patients?
    It is widely understood that there are many factors involved in the room placement of patients in the SCIC including gender, rehabilitation status, infection control, and psychological/mental health factors. These factors need to be weighed in making room placement decisions.