CLEARANCE PROCEDURE – MRSA

- Clearance of a MRSA carrier must be conducted in collaboration with the Infection Control Unit / Infectious Diseases Physicians.
- The MRSA carrier must not have any wounds or indwelling devices. Generally, a MRSA carrier must not have been receiving anti – MRSA antibiotics ( ie rifampicin, fusidic acid, vancomycin ) for at least 1 week prior to clearance screening.
- Three (3) negative sets of screening specimens (each set to be collected at least one week apart) must be collected prior to consideration of clearance status.
- Specimens to be collected include:
  - 1 swab : both nostrils (same swab)
  - 1 swab : both groins or both axillas (same swab)
- On pathology request form record test required: “MRSA Screen.”
- Medical officer must sign the request form.
- When the patient is “cleared”, the Administration Alert on Homer will be removed and a MRO clearance sticker placed on the Clinical Summary / Problem List by the Infection Control Unit.

TRANSFERS INTO THE HOSPITAL FROM OTHER INSTITUTIONS

- Patients not already known to be MRSA positive, transferred from any hospital at which they were an inpatient for > 24 hours are to be screened for MRSA on admission.
- Screening specimens consist of:
  - 1 swab: each wound/broken skin/lesion/invasive device
  - 1 swab: both nostrils (same swab)
  - 1 swab: both groins (same swab)
  - 1 specimen any wound drainage
  - 1 specimen of urine if IDC in situ
  - Any other sample thought to be clinically relevant.

TAKING A SCREENING SWAB OR SPECIMEN

1. Clean hands – Soap and water or alcohol based hand gel.
2. Explain reasons and answer any questions regarding screening.
3. Obtain consent prior to taking the swab / specimen.
4. Dry swabs should be moistened with sterile normal saline, ensuring there is no contamination of the tip.
5. A cotton tipped swab should be sent to the lab, preferably within an hour, if between the hours of 0830 – 1700hrs.
6. After hours and on weekends, transport medium swabs should be used. These do not need to be placed in the fridge. Send to the lab as soon as possible.
7. If a specimen of wound drainage fluid, tracheostomy aspirate or indwelling catheter urine needs to be obtained, these should be sent to the lab in a sterile container within two hours.
8. Record on the swab tube / specimen container and pathology request form :
   a) Date / time of collection
   b) Initial request form in the “collector’s initials” box.
   c) Site of specimen
   d) Patient’s name and UR.
9. Record on request form the specific test required.
10. Document in the patient’s case notes which swabs / specimens have been taken.