



MONTANA STATE PRISON OPERATIONAL PROCEDURE

Procedure:	MSP HS B-02.6	COMMUNITY ACQUIRED MRSA CONTROL PLAN
Effective Date:	11/01/2010	Page 1 of 3
Revision Date(s):	10/01/2020; 06/30/2026	
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I. PURPOSE

Ensure through a Community Acquired Methicillin-Resistant Staphylococcus Aureus (CAMRSA) infection control plan:

- A. transmission of CAMRSA infection does not occur or is minimized through surveillance and containment activities; and
- B. appropriate care is provided to infected inmates.

II. OBJECTIVES

Screening and Surveillance: Identifying and reporting of CAMRSA skin and soft tissue infections.

Containment: Management of persons who have CAMRSA infection to prevent further transmission.

Assessment: Monitoring and evaluating surveillance and containment activities.

Education: Providing information to staff and inmates regarding CAMRSA.

III. DEFINITIONS (see Glossary)

IV. PROCESS

A. Background Information

1. MRSA infections are staphylococcal infections that are resistant to beta-lactam antibiotics.
2. An infection with MRSA has long been associated with exposure to the health care environment, particularly the inpatient hospital setting.
 - a. Recently, new strains of MRSA have developed in the community.
 - b. These strains are different in that they infect previously healthy people with no direct or indirect association to health care facilities.
 - c. These community-onset MRSA infections have particularly affected inmate populations.
3. Persons with complicating medical conditions such as diabetes, HIV infection, chronic skin conditions, indwelling catheters, post-surgical wounds, and decubiti are at increased risk of MRSA infections.
 - a. However, even otherwise healthy individuals can develop serious MRSA infections such as cellulitis, deep-seated abscess, necrotizing fasciitis, septic arthritis, necrotizing pneumonia, and sepsis.
4. MRSA is transmitted from person to person by contaminated items such as towels, personal hygiene items, athletic equipment, close-contact sports, and sharing injection drug items or tattoo equipment.

5. Persons with MRSA pneumonia in close contact with others can transmit MRSA by coughing up large droplets of infectious particles.
6. Persons with asymptomatic MRSA nasal carriage can also transmit MRSA, especially when symptomatic from a viral upper respiratory infection.
7. MRSA can also cause a toxin-mediated food borne gastroenteritis.

B. Screening

1. Screening will be carried out to identify those who may have CAMRSA infection so they can be started on appropriate therapy.
2. Intake Symptom Screening
 - a. During the admission health screening, inmates will be interviewed and observed to determine whether they have experienced any of the following in the past few weeks:
 - 1) skin conditions;
 - 2) any draining lesions or bleeding;
 - 3) any other alterations in skin integrity such as an open wound;
 - 4) exposure to anything contagious; and
 - 5) seen by a doctor in the past year or hospitalized within the past year.
 - b. Inmates with symptoms suggestive of CAMRSA will be scheduled to be seen.
 - c. Nurses conducting the screening will ensure that all draining wounds are covered, and the inmate does not have systemic symptoms such as fever, hypotension, or tachycardia.
3. General Population Screening
 - a. Correctional staff will be educated on CAMRSA and will report to infirmary staff any skin or soft tissue infections that they observe.
 - b. Inmates reporting boils or "spider bites" through health care request forms will be assessed by nursing according to protocol.
4. Inmates at greater risk for serious MRSA infections are inmates:
 - a. with risk factors such as diabetes, immunocompromised conditions, open wounds, recent surgery, indwelling catheters, implantable devices, chronic skin conditions or paraplegia with decubiti; and
 - b. who should be evaluated for skin infections during routine medical examinations.

C. Diagnosis

1. All skin and soft tissue infections will be cultured by the health care provider (midlevel or doctor) to identify CAMRSA and ensure proper antibiotic selection if antibiotic treatment is deemed necessary.
2. All bacterial culture results should be reviewed in a timely manner to detect new MRSA infections.
3. Obtaining bacterial cultures of the nares is not routinely indicated, unless:
 - a. recommended by the public health authorities in the context of a significant MRSA outbreak; or
 - b. as part of an inpatient surveillance program.
4. Providers will notify the Infection Control Prevention RN of all positive case diagnosis.

D. Containment

1. Patients with MRSA pneumonia should be housed in a single cell.

2. Food Handlers
 - a. All inmate food handlers should be advised on the necessity of self-reporting all skin infections, no matter how minor.
 - b. Food handlers should be routinely examined for visible skin infections.
 - c. Food handlers with suspected or confirmed contagious MRSA should be removed from their duties until no longer infectious.
3. Inmates with MRSA infection are not considered contagious as long as the wound is covered.
 - a. Inmates with wound drainage that is not able to be contained should be in a single cell or housed in the infirmary.

E. Treatment

1. With the increasing resistance of CAMRSA, antibiotic therapy needs to be reserved for those patients who are immunocompromised or show systemic signs of illness.
2. Patients with localized infection should first undergo incision and drainage of the wound.
 - a. If the wound is not resolving within 72 hours, an antibiotic can be prescribed.
3. Patients who show signs of systemic illness such as fever, or who are immunocompromised, should be started on an antibiotic with known susceptibility to CAMRSA.
4. Decolonization is not recommended, except in the case of recurrent infection. This should be considered on a case-by-case basis.

F. Monitoring

1. For patients who fail antibiotic therapy or have recurrent infection, directly observed therapy is recommended to:
 - a. ensure compliance with treatment,
 - b. reduce the risk of further resistance, and
 - c. rule out noncompliance in the case of treatment failure.
2. This can be decided on a case-by-case basis by the health care provider.

V. CLOSING

Questions about this procedure should be directed to the Medical Health Services Manager.