



Alaska Correctional Officers Association

**Guidelines for Officers in Preventing
Work Place Injury from**

Methocillin Resistant Staphylococcus Aureus (MRSA)





ALASKA CORRECTIONAL OFFICERS ASSOCIATION

"Walking Alaska's Toughest Beat"

December 12, 2007

Correctional Officers,

Methicillin-Resistant Staphylococcus aureus (MRSA) is a dangerous infection. Many cases of MRSA have been found in our institutions and we suspect many others have gone unreported and undiagnosed. Several of your fellow Officers have been painfully incapacitated by this disease. ACOA put this packet together to help educate and inform you using the most recent information available. Please protect yourself and those you love from this infectious disease.

Also enclosed is a copy of a draft Policy and Procedure we are sending to the Department of Corrections. Hopefully, the Department will react by adopting this model Policy and Procedure and will initiate a proactive program to educate inmates and staff on the prevention and control of MRSA. In the meantime, ACOA feels compelled to "start the ball rolling". We must take care of ourselves.

On behalf of ACOA,

**Sergeant Daniel Colang
President**

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WHAT IS MRSA?

MRSA – METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS

Staphylococcus Aureus (known as “Staph”) is a common bacteria which may cause skin infections that look like pimples or boils. Skin infections caused by Staph may be red, swollen, painful, or have pus or other drainage. Most Staph infections are minor and respond to normal antibiotic treatments and/or drainage. Some strains of Staph bacteria, known as **Methicillin-Resistant Staphylococcus Aureus** or **MRSA**, have become resistant to standard antibiotic treatment (including methicillin and penicillin), making MRSA much harder to treat. Staph and MRSA Staph also may lead to more serious infections, such as infections of the bloodstream, surgical sites, or pneumonia.

OVERVIEW OF MRSA INFECTION

Infection with MRSA has long been associated with exposure to a health care environment, particularly the inpatient hospital setting; known as “**hospital-acquired MRSA**” (**HA-MRSA**). MRSA infections affecting persons who have not been recently (within the past year) hospitalized or had a medical procedure (such as dialysis, surgery, and catheters) are known as “**community-acquired MRSA**” (**CA-MRSA**) infections. MRSA strains have evolved to affect previously healthy persons without direct or indirect contact with health care facilities. These community-acquired MRSA infections have particularly affected athletes in close-contact sports, military recruits, men who have sex with men, and inmate populations which is the focus of this report. Persons with complicating medical conditions such as diabetes, HIV infection, chronic skin conditions, indwelling catheters, post-surgical wounds, and bedsores are at increased risk of MRSA infections; however, *even otherwise healthy individuals can develop very serious MRSA infections*. Invasive MRSA infections, where the organism invades the bloodstream, are very dangerous and require intravenous antibiotics.

MRSA IN CORRECTIONAL FACILITIES

Correctional Officers and inmates are now at risk of acquiring MRSA infections not only during hospitalizations, but also within the jail setting, despite the absence of traditional risk factors for MRSA infection, such as a history of recent hospitalization, prior antibiotic usage, injection drug use, or long-term inpatient care. Correctional system CA-MRSA infections have been associated with illicit, unsanitary tattoo practices and poor inmate hygiene, inmates sharing towels, linens, razors, soap or other personal items contaminated by wound drainage, as well as inmates lancing their own boils or other inmates’ boils with fingernails or tweezers.

TRANSMISSION OF STAPH/MRSA

Anyone can get a Staph/MRSA infection. People are more likely to get a Staph infection if they have:

- **Skin-to-skin contact with someone who has a Staph infection**
- **Contact with items and surfaces that have Staph on them**
- **Openings in their skin such as cuts or scrapes**
- **Crowded living conditions**
- **Poor hygiene**

STAPH/MRSA SYMPTOMS

Correctional Officers or inmates with MRSA skin infections may have or complain of **an infected boil, an insect bite, a spider bite, or a sore or lesion** that may occur spontaneously without an obvious source. Staph bacteria, including MRSA, can cause skin infections that can be red, swollen, painful, or have pus or other drainage. Many MRSA infections cause minor inflammation without pain and ***infected inmates may not seek medical attention***. Symptoms can appear in 1-10 days.



In 2005, more than 18,000 deaths are attributed to MRSA according to the Center for Disease Control.

MRSA can begin like this...



... and develop into severe cases that may become life threatening.



PREVENTION OF MRSA

(CORRECTIONAL ENVIRONMENT)



Routinely wash your hands during your entire shift.



Always wear gloves during pat-down searches, strip searches and area searches.



When conducting pat down or strip searches, change gloves between each prisoner.



Use appropriate personal protective equipment when you expect contact with any blood or other body fluids, including saliva. (Gloves, booties, gowns, face and eye protection.)



Always wear gloves when handling soiled linen or clothes. Sheets, towels, prison uniforms, and under clothing should be laundered with hot water and detergent. Dry on the hottest setting or use a disinfectant detergent.



Regularly clean all hard surfaces and high traffic areas like sinks, showers and toilets.



Disinfect fitness equipment after each use.



Disinfect handcuffs, leg irons, or other restraints after each use.



Never share any personal items. Do not allow prisoners to share personal items, such as razors or towels.



All bandages should be handled as medical waste and listed as biohazard.



Remove your uniform and shower as soon as possible after each shift.



Carry with you and use hand sanitizer regularly.



Keep your fingernails cut short. This will minimize bacteria growing under nails.



Launder your uniforms daily.



See your doctor immediately if you experience any swelling; pain; redness or red streaks radiating from the wound site; fever; or a general ill feeling.



Report all injuries, including small cuts, incurred at work to your supervisor on the appropriate forms.

MANAGEMENT OF MRSA

(CORRECTIONAL ENVIRONMENT)



Upon admittance to a Correctional Center all remands should be searched and examined for skin eruptions, such as lesions, pervasive acne, eczema, seborrhea, or insect bites.^{14 15 16}



Offenders with abscesses or other draining skin lesions should be referred to a mid-level practitioner or a doctor immediately.^{17 18}



Incision and drainage should be performed before antibiotics are administered.^{19 20}



Prisoners diagnosed with MRSA with wounds larger than one (1) cm should be isolated. (Administrative or Medical Segregation or housed with like offenders.)^{21 22}



Outbreaks should be reported immediately to the Institutional and Departmental Health Care Officers.²³



Areas should be sanitized and disinfected after an outbreak or cluster has been identified.^{24 25}



All potential opportunities for prisoners to have close physical contact or share communal items should be carefully scrutinized within each facility.^{25 27 28}



All cases should be reported to the state epidemiology lab.^{29 30}



All cases of possible MRSA cases should be cultured.^{31 32 33 34}



Bacterial cultures should be kept for thirty (30) days.³⁵



All inmates with suspected or confirmed MRSA infections should be systematically tracked in order to assess case clusters and help identify common source transmission.³⁶



Personal protection equipment should be provided to all staff.



Contact precautions for all KNOWN cases of MRSA (see policies and procedures).^{37 38 39 40}



Linen should be exchanged every other day.⁴¹



Laundry should be washed in a bleach solution for twenty minutes at 160° Fahrenheit.⁴²



Airborne and droplet precautions should be used when handling soiled linen and clothing to prevent the spread of the organism.^{43 44}



Universal precautions should be used when conducting any barbering or hair dressing.⁴⁵

STATISTICS AND FACTS ABOUT MRSA



MRSA is a bacteria commonly found on the skin, in the nose, in urine, and blood.



MRSA is colonized on about 30% of the population (meaning that it lives on the skin without causing infection).^{1 2}



2 million Americans contract MRSA each year.³



318 out of 100,000 Americans are diagnosed each year with MRSA.⁴



There were 18,650 deaths from MRSA and there were only 12,500 deaths from HIV/AIDS in 2005.⁵



There are two types of MRSA - hospital acquired MRSA (HA-MRSA) and community acquired MRSA (CA-MRSA). They are treated differently and HA-MRSA is harder to treat.^{6 7}



Correctional Officers are exposed to both types of MRSA.⁸



MRSA can live for 24 hours on any non-porous surface.⁹



MRSA can live in cotton for up to 3 months.¹⁰



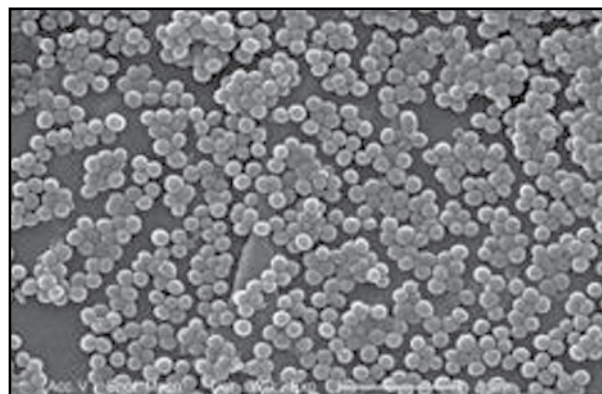
Symptoms appear in 1 – 10 days.¹¹



Common infections of the skin such as impetigo, abscesses, and lesions are generally uncomplicated and resolved with topical antibiotics. MRSA is much more difficult to treat.¹²



More serious infections, where the organism invades the bloodstream, are very dangerous and require intravenous antibiotics.¹³



Electron micrograph of MRSA

**ALASKA CORRECTIONAL
OFFICERS ASSOCIATION**

**PROPOSED
POLICY AND
PROCEDURES
ON MRSA
MANAGEMENT**

Alaska Correctional Officers Association Proposed Policy for Managing MRSA Infections	Effective date	NUMBER:
	Replaces:	
	Formulated:	
STAPH AUREUS & METHICILLIN-RESISTANT STAPH AUREUS (MRSA)		

POLICY

To provide guidelines for preventing the transmission of *Staphylococcus aureus* skin and soft tissue infection, and procedures for the clinical management and housing of offenders with *Staphylococcus aureus* infections, both methicillin sensitive (MSSA) and resistant strains (MRSA).

DISCUSSION

When following this policy, the clinician should keep three goals in mind: 1) proper treatment of the offender with MRSA or MSSA infection, 2) prevention of the emergence of drug resistant staphylococci, and 3) prevention of the spread of staphylococci. At times, more aggressive treatment than is indicated for the first goal will be necessary for attaining the other two goals.

DEFINITION

Staphylococcus aureus has remained a major human pathogen that colonizes and infects both hospitalized offenders with decreased host defenses and healthy immunologically competent offenders within the correctional facilities.

Humans can become intermittently colonized by *Staphylococcus aureus* by harboring the organism in their nasopharynx or on their skin and clothing. From these sites, *Staphylococcus aureus* can contaminate any site on skin or mucous membranes or other individuals by interpersonal transfer by direct contact. *Staphylococcus aureus* may adhere to skin and mucous membrane. If the integrity of the latter (i.e. skin or mucous membranes) are breached due to trauma, underlying dermatologic disorders, etc.; *Staphylococcus aureus* may gain access to the underlying tissue creating its characteristic local abscess lesion(s).

Methicillin-resistant Staphylococcus aureus (MRSA) is historically a nosocomial (hospital-acquired) pathogen, although there are recent reports of MRSA acquired in the community. MRSA in Department of Corrections (DOC) resembles community-acquired more closely than hospital acquired MRSA, particularly in that it retains susceptibility to many other antibiotics. Individuals colonized with *Staphylococcus aureus* have no signs of active disease but can transmit *Staphylococcus aureus* to others.

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PROCEDURES:

I. OFFENDERS SHALL BE SEEN WITHOUT CO-PAY IF THEY ARE PRESENTING WITH A DRAINING SKIN LESION OR BOIL.

II. OFFENDERS PRESENTING WITH SKIN ERUPTIONS (dry skin, bites, eczema, seborrhea, etc)

- A. These offenders are at increased risk for staphylococcal infections because the integrity of their skin is compromised by the underlying condition.
- B. Offenders should be **identified promptly** and referred to the facility physician or mid-level practitioner (i.e. nurse practitioner or physician assistant) as soon as possible for aggressive management.
- C. Offender **education** must be provided to minimize scratching of lesions and to alert offenders to seek medical attention as soon as abscesses or furuncles (boils) are detected.
- D. Physicians/mid-level practitioners should **manage** skin eruptions **aggressively** and should be alert to the presence of early abscesses.
- E. Individuals who fail to respond to management at the DOC facility may be referred to a **Dermatology Clinic**.

III. OFFENDERS PRESENTING WITH ABSCESSES OR OTHER DRAINING SKIN LESIONS:

- A. Any offender with a draining skin lesion or abscess must be identified and referred to the facility physician/mid-level practitioner as soon as possible.
- B. If uncertain whether to incise and drain (I&D), the physician/mid-level practitioner should **aspirate** any questionable abscess or draining skin lesion, and perform I&D if pus is present and lesion is too large to manage with moist heat. If I&D is performed, administration of prophylactic antibiotics one hour before the procedure is recommended. (See Section V., "Treatment.")
- C. A **culture and sensitivity** (C&S) must be obtained whenever pus or drainage is obtained from a skin lesion or abscess.

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IV. OFFENDERS PRESENTING WITH OTHER SKIN INFECTIONS USUALLY CAUSED BY OTHER ORGANISMS BUT IN WHICH STAPHYLOCOCCUS AUREUS MUST BE CONSIDERED A POSSIBLE CAUSE (e.g., cellulitis or impetigo)

- A. Consider the possibility of staphylococcal infection when choosing an antibiotic. Generally, use of an antibiotic expected to cover both streptococci and staphylococci is appropriate. TMP/SMX is not recommended for streptococcal infections.

V. Treatment

- A. For suspected MSSA or MRSA when treatment with antibiotics is planned
 1. Based on culture surveillance, most MRSA isolated in DOC will be susceptible to TMP/SMX (e.g., Bactrim-DS®). If the offender is unable to take TMP/SMX, or there is a treatment failure on this drug, consider a combination of doxycycline and rifampin, or consulting an ID specialist for recommendations. Directly Observed Therapy is essential for rifampin containing regimens because of the risk for developing resistance if the drugs are not taken appropriately.
 2. Resistance to clindamycin is increasingly common in DOC, so this drug is no longer recommended as a single agent for empiric therapy. The risk of developing resistance to clindamycin is greater if the organism is resistant to erythromycin. Clindamycin should only be used when necessary and when susceptibility is demonstrated by culture and sensitivity. If the organism is resistant to erythromycin, consider asking the lab to perform a “D test” for inducible clindamycin resistance before using this drug as a single agent.
 3. **If prophylactic antibiotics are used before I&D**, the offender should be given one dose of TMP/SMX (e.g., Bactrim-DS®) and one dose of rifampin 600 mg p.o. or clindamycin 300 mg orally, if (s)he has no known allergies to these drugs. Please note the use of rifampin may cause body fluids to turn orange. Offenders should refrain from wearing contact lenses while on rifampin therapy. Also note that rifampin activates the cytochrome P-450 system, so the possibility of interactions with other medications should be considered.
 4. Rifampin should not be used as a single agent for the treatment of staphylococcal infections because resistance develops quickly when it is used as monotherapy.

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5. For treatment when antibiotic therapy is indicated, TMP/SMX (eg., Bactrim-DS, one BID) is recommended for initial therapy pending receipt of C&S results, usually within two-three days. Consider treating initially with wound care, heat and drainage rather than initiating empiric antibiotic therapy pending culture results, if clinically indicated. Continue treatment with an appropriate antibiotic based on drug susceptibility results.
6. Because of the prevalence of resistance to these drugs, treatment of suspected *S. aureus* infections with a cephalosporin or erythromycin is not recommended.

- B. In offenders with 1) MRSA, 2) serious MSSA infection, or 3) with diabetes or HIV infection and either MRSA or MSSA infection, all anti-**Staphylococcal** antibiotics must be administered under a program of **Directly Observed Therapy**, as in the case of active TB cases. An acceptable alternative for these offenders is to dispense the medications at the pill line with daily or every other day compliance monitoring. If an offender receiving his medication in the pill line misses >10% of the expected total number of doses of antibiotic they must be placed on Directly Observed Therapy.
- C. Anti-**Staphylococcal** antibiotics may be **KOP** (Kept On Person) only in the case of minor MSSA infections or for non-draining, uncultured skin infections being presumptively treated for MSSA, in offenders who do not have diabetes or HIV infection.
- D. **Follow-up antibiotic therapy** should be guided by the sensitivity report and the clinical situation. Duration of therapy is based on clinical judgment, but generally should not be less than 7 days, and should extend several days past clinical resolution, once the decision to start antibiotics has been made.

VI. MANAGEMENT OF OFFENDERS WITH RECURRENT STAPHYLOCOCCUS SKIN AND SOFT TISSUE INFECTIONS.

- A. An offender shall be considered to have recurrent **Staphylococcus** skin and soft tissue infection when they have > 3 infections in a six month period. These 3 or more infections should be based on both clinically diagnosed and culture proven cases, since some infections, such as cellulitis, may not have positive cultures.
- B. The acute infection should be diagnosed and treated as outlined in section IV.

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- C. Make an evaluation of and treat any dermatologic diseases.
1. Diagnose and treat any underlying skin disease.
 2. Refer to dermatology clinic as indicated.
- D. Decolonization.
1. Culture of the external nares to document colonization. (The laboratory request **must** state that the specimen is to be cultured for MRSA.) Although other body sites may be colonized, about 95% of persons with colonization of other body sites will also have nasal colonization.
 2. Have offender shower with chlorhexidine containing soap (i.e. Hibiclens) for five days. Note: obtain non-formulary approval for chlorhexidine soap.
 3. Apply mupirocin 2% ointment to external nares twice a day for five days (obtain non-formulary approval). Rifampin may act in concert with topical antimicrobial agents for **decolonization** of the carrier state. Most offenders being decolonized should also receive rifampin at 600 mg PO q day for 5 days under a program of **directly observed therapy**.
 4. Two weeks after decolonization, repeat the nasal culture to verify that decolonization was successful. If the nasal culture is still positive after decolonization, the process may be repeated once. If decolonization fails twice, it is unlikely to be successful with additional treatments.
- E. Other factors to consider in the management of offenders with recurrent **Staphylococcus** skin and soft tissue infections.
1. Evaluation of personal hygiene.
 - a. Offenders should be evaluated for adequacy of showering and bathing; offenders should generally have a **daily** bath or shower with soap and water.
 - b. During therapy **all** clothing including socks, underwear, towels, bath cloths and items including bedding should be replaced with clean items daily. Contact security for authorization to obtain clean linen for daily bedding change.
 - c. Obese offenders with skin folds need to keep the skin in these folds dry to prevent maceration of the skin. This may require use of powder applied after bathing.

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- F. Evaluation of offenders for underlying systemic disease/condition.
1. **Staphylococcus** skin and soft tissue infections are associated with underlying diseases including diabetes mellitus, obesity, HIV infection, and other diseases and/or drugs causing immunosuppression.
 2. Offenders with recurrent infection should be evaluated for underlying predisposing diseases and conditions as indicated.
 - a. History and physical exam.
 - b. Urine glucose, fasting blood sugar.
 - c. HIV test.
 - d. Referral to specialty clinics as indicated.
 3. Control underlying disease.
 - a. Obtain good control of blood glucose for diabetics.
 - b. Encourage weight reduction for obese offenders.
 - c. Optimize therapy for offenders with HIV infection/AIDS.
 - d. Use alternate drugs in place of glucocorticoids where possible.
 4. A one-on-one education counseling session should be conducted with the offender to minimize the dissemination (i.e. spread) of microorganism by colonized offenders. (See Attachment B - **Staphylococcus aureus** Fact Sheet)

VII. HOUSING AND ISOLATION

- A. Offenders with an active MRSA infection must be managed under contact isolation precautions when they are treated in a medical setting such as an infirmary or dialysis unit.
- B. Offenders with MRSA infections who are outpatient offenders may be housed in the general population if their lesion is small (less than 1 cm), easily covered, and the offender understands the treatment regimen and is compliant (eg, infected ingrown toenail).
- C. **Special Housing** (single cell or housed with another offender(s) with like condition and **sensitivity**) shall be instituted under the following circumstances:

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1. Any offender **unwilling/unable to understand follow-up** management, or who is non-compliant with antibiotic treatment or therapy;
 2. Any offender with a **large abscess** or draining skin lesion that cannot be adequately covered and kept dry and clean (eg, scalp, decubitus, etc.);
 3. Any offender who is **immunocompromised** or who has cellulitis, lymphangitis, or sepsis as a complication. (Offender should be **hospitalized** or placed in an infirmary setting as his or her level of care warrants.)
- D. Offenders on special housing should be assigned to **infection showers** rather than showering with the general population. This is not necessarily a separate shower facility. Infection showers are differentiated from standard showers in that:
1. Offenders on contact isolation do not shower at the same time as the general population.
 2. The shower and dressing areas are cleaned with a detergent and disinfected with an antistaphylococcal disinfectant (e.g., bleach or Double-D) according to DOC policy after the infection shower period is over, before the general population uses the facility again.
 3. Offenders are issued two towels and are instructed to use one to sit upon as a barrier when using the bench in the dressing area.
- E. Special housing may be **discontinued** when:
1. The lesion is clinically resolved; or
 2. There is no longer cellulitis, lymphangitis, or drainage from a clinically open lesion (eg, decubitus) and the offender has completed a minimum of 3 days (72 hours) of the course of antibiotics.
- F. Upon completion of special housing the offender's cell should be thoroughly cleaned and disinfected.

VIII. HOUSING AND JOB ASSIGNMENT CONSIDERATIONS FOR COLONIZED OFFENDERS AND THOSE WITH RECURRENT STAPHYLOCOCCUS SKIN AND SOFT TISSUE INFECTION

- A. Offenders who meet the definition of recurrent **Staphylococcus** skin and soft tissue infection (i.e. >3 infections in a six month period), and offenders who fail decolonization procedures twice, should be housed according to the guidelines set forth in Section VII.C, Special Housing (single cell or housed with another offender(s) with like condition and **sensitivity**).

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- B. Offenders who fail decolonization should generally not be assigned to work in the following areas.
- Medical department
 - Barber shop
 - Food handlers/processors

IX. PERSONAL PROTECTIVE EQUIPMENT

- A. **Gloves** must be worn prior to touching any offender with abscesses or open, draining skin lesions.
- B. Upon removal, gloves must be properly discarded and hands must be **washed** no less than 10 seconds using proper hand washing techniques.
- C. **Gowns** should be worn for close contact when clothing is likely to be soiled.
- D. Whether **dressings changes** are done in the infirmary or by the offender, provisions must be made for appropriate disposal of contaminated materials.

X. REPORTING

- A. All cases of methicillin sensitive *Staphylococcus aureus* (MSSA) and methicillin resistant *Staphylococcus aureus* (MRSA) **must** be reported to the Medical Director by the facility nurse utilizing the appropriate Surveillance Form (Attachment A).
- B. Reports must be submitted within 7 days of receipt of the culture result on the facility.

Attachment A

Staph Aureus Surveillance Reporting Form

Upon receipt of a positive MSSA or MRSA culture report, complete all fields on this form and promptly FAX it **along with a copy of the laboratory report** to the Medical Director for the Department of Corrections.

Last name: _____ First name: _____

DOC #: _____ Unit: _____

DOB: ___/___/___ Race: B H W O Sex: M F

Date cultured: _____

Culture result (check one): Methicillin-Resistant Staph Aureus (MRSA)

Methicillin-Sensitive Staph Aureus (MSSA)

Was this culture for (check one): Infection Nasal Colonization

If this was an infection:

Date onset signs/symptoms: ___/___/___

Location of skin lesion: N/A (not skin infection) Head and neck

Upper extremity Torso Genitorectal Lower extremity

Other _____

Type of Infection: Minor skin/soft tissue Serious skin/soft tissue

Cellulitis Impetigo Pneumonia Sepsis

Other (specify) _____

Attachment B

Staph aureus and Methicillin-Resistant Staph aureus Offender Education Fact Sheet

Clinical evidence has led your healthcare provider to conclude that you do (or may) have an infection of staph aureus (*S. aureus*) or methicillin-resistant Staph aureus (MRSA).

Staph aureus is a common organism found on human skin that causes no harm under normal circumstances. If the bacteria enters the body through the skin, such as a cut or ingrown hair, it can cause an infection which appears as a boil or abscess. The boil can be as small as a pimple or become a large draining sore on any part of the body. The size and location of the boil or abscess will determine what type of care is needed.

In the past, penicillin was used to treat staph infections. Then, after a time, some strains of the bacteria became resistant to penicillin and a new drug, called methicillin, was developed to treat those infections resistant to penicillin. Once again, some strains of the bacteria began to find ways to resist methicillin. This is why methicillin-resistant staph aureus (or MRSA) infections are now being seen. For those individuals who have a resistant infection there are limited antibiotics available; therefore, it is extremely important that you take all medications prescribed for you. You will not be able to keep these medications on your person. A nurse or other medical worker will need to watch you while you take each dose. Failure to take all antibiotic dosages prescribed for you, helps increase resistance of the *S. aureus* bacteria.

There are other ways to prevent the spread of *S. aureus* and it is everyone's responsibility to help in this effort. *S. aureus* spreads easily by direct skin-to-skin hand contamination. Therefore, **HANDWASHING** is the most effective and important method in preventing its spread when there is more than incidental contact with someone who has the infection.

Incidental contact for security staff would be simply touching someone under normal circumstances (like pat searching). If there is more contact than this, and there is likelihood of soilage, gloves should be worn. Articles and objects handled by people who have MRSA are not as likely to transmit the bacteria as someone who fails to use good handwashing technique. Good handwashing technique means using soap and water and really washing for 10 seconds, then drying your hands thoroughly.

People with recurrent staph infections should take special precautions to contain the spread of the disease. It's important that you bathe or shower daily with soap and water. All clothing, including socks, underwear, towels, bath cloths and items including bedding should be replaced with clean items daily. Obese offenders with skin folds need to keep their skin in these folds dry to prevent breakdown of the skin. This may require applying powder after bathing.

Offenders who have underlying diseases, such as HIV, diabetes, skin disorders and/or obesity, are especially prone to staph infections and need to closely follow the instructions of their physicians to obtain good control of their underlying diseases. In other words, diabetics should try to maintain excellent control of their blood sugars, weight reduction is encouraged for obese offenders, HIV/AIDS offenders should take all medications prescribed for them without fail.

If you have any questions, or for more information, contact your unit medical department.

RISK FACTORS FOR ACQUIRING CA-MRSA

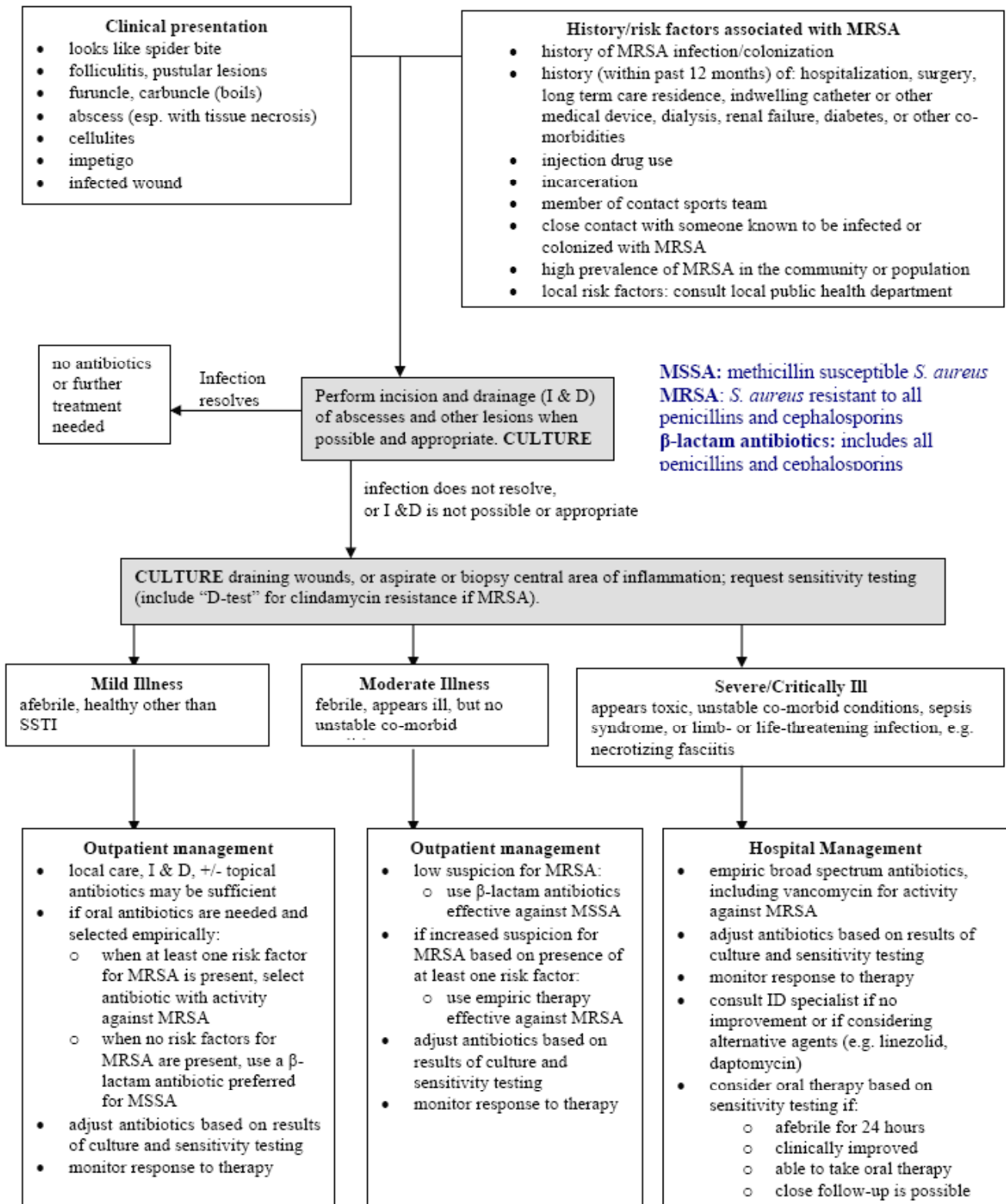
The following risk factors should increase suspicion for CA-MRSA in offenders presenting with compatible signs and symptoms:

- History of MRSA infection or colonization in offenders or close contact
- High prevalence of CA-MRSA in local community or offender population
- Recurrent skin disease
- Crowded living conditions (e.g. homeless shelters, correctional facilities)
- History of incarceration
- Participation in contact sports
- Skin or soft tissue infection with poor response to B-lactam antibiotics
- Recent and/or frequent antibiotic use
- Injection drug use
- Member of Native American, Pacific Island, Alaskan Native populations
- Child under 2 years of age
- Male with history of having sex with men
- Shaving of body hair

COMPARISON OF HOSPITAL-ACQUIRED MRSA (HA-MRSA) AND COMMUNITY-ACQUIRED MRSA (CA-MRSA)

	HA-MRSA	CA-MRSA
Health Care Contact	Yes	No
Mean Age at Infection	Older	Younger
Skin and Soft Tissue Infections	35%	75%
Antibiotic Resistance	Many Agents	Some Agents
Resistance Gene	SCC<i>mec</i> Types I, II, III	SCC<i>mec</i> Types IV, V
Strain Type	USA 100 and 200	USA 300 and 400
PVL Toxin Gene	Rare (5%)	Frequent (almost 100%)

Guidelines for management of suspected *Staphylococcus Aureus* skin and soft tissue infections (SSTI).



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THIS REPORT AND PROPOSED POLICY AND PROCEDURES FOR THE MANAGEMENT OF MRSA
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