



**Infectious Diseases Society of America
Emerging Infections Network**

**Comments for Query:
'Routine Contact Precautions for MRSA,
VRE and CRE'**

General / overall policies on Contact Precautions

- We employ a universal approach to pathogens---the devil you don't know might be worse than the devil you do. *[CA]*
- We are in process of revising our policy; we see very little MRSA transmission and will likely change isolation to active infection only, not colonization or history thereof. Would love guidance from CDC which takes into account prevalence of MDRO at particular facilities *[OR]*
- I go to 4 facilities - all hospitals. They have 4 different policies. It is a nightmare. Registry nurses are always confused, doctors are confused, and patients are frightened. We were stupid enough to let this become at least partly a political decision, not a scientific one! *[CA]*
- CP policies were transferred from Infection Prevention Committee (with ID leadership and input) to Nursing (with ID suggestions at least verbally allowed). Interesting outcome. Vast expansion of population on CP (often 65-75% of patients on unit), vast decline in adherence (or meaningless adherence with docs and nurses standing at doorway "talking" to patient) and reduction in several former programs designed to monitor efficacy of CP. *[NY]*
- We use it in the NIUC for colonized MRSA infants and we use contact precautions in the PICU and NICU if there is a highly resistant organism *[OH]*
- We are VA. 25% of our patients are on some sort of precautions. *[MA]*
- I am considering not isolating nasal colonized patients who do not have any skin lesions/wounds, after evaluating isolation and standard precautions compliance. Our H. hygiene compliance has been 95% for last few months. *[MD]*
- There is great need for evidence-based best practices and more guidance from HICPAC and others. *[AK]*
- Contact=single room if possible; gloves & gown on entering room, strict adherence to hand hygiene before and after being in room. *[NY]*
- MRSA policies dictated by state statute. *[NJ]*
- Continue to reassess our processes in light of genomics and the apparent disparate results with surveillance cultured organisms and those infecting the same patients *[LA]*
- Much of the CP is driven by CDC guidelines which are for the most part not-evidenced based. There needs to be a more evidenced-based approach to how CP is used. *[GA]*
- I feel the policies are warranted for MRSA and resistant Gram negatives, but find them unnecessary for VRE. *[GA]*
- We formerly did not use contact precautions for MRSA infection/colonization, but started doing so because of external regulatory pressure. We have not seen a significant decline in MRSA following this change. Elimination of this requirement could result in substantial cost savings and decrease in aggravation of staff, assuming other countermeasures to control MRSA were more acceptable, less costly, and equally successful. *[OR]*

- Much of the CP in effect are probably a waste of money and an impediment to patient care *[NY]*
- I personally am frustrated by the rigid adherence to gowns for CP for any colonized person without evidence they are effective. There is plenty of evidence that CP prevents visits, degrades care, and leads to patient isolation. Wish we had better data and a more flexible, data driven approach. *[MN]*
- We use "contact plus" for c diff and noro for duration of hospitalization *[MA]*
- We have never used contact isolation for MRSA and focused primarily on improving hand hygiene compliance. Despite increased rates of community-onset MRSA over the last 10-15 years, our rates of hospital-onset MRSA have remained low and flat during this time frame suggesting limited horizontal transmission. *[CA]*
- Interested in data. We are looking to deescalate MRSA/VRE based on recent safety reports and studies showing minimal impact of CP *[VA]*
- Our facility is re-examining the evidence for widespread CP use-- based largely on provider frustration and patient complaints. *[MN]*
- Leadership of VA unimpressed with dysimpact on patient interactions per unit time for un-needed contact *[WA]*
- We use it also for metapneumovirus and RSV infections currently both in adults and kids *[PA]*
- Extensively (over)used for viral respiratory agents, even in asymptomatic patients with positive rapid PCR results *[SC]*
- Ongoing tension between effectiveness and decreased patient interaction. *[NE]*
- We also isolate anyone with cough into droplet, any diarrhea into CEP and any open wound into CP regardless of isolate *[WA]*
- We are in the process of considering not using gowns. *[MN]*
- We are moving towards not isolating MRSA colonized patients - working on implementation. *[CA]*
- We have never done CP for MRSA or VRE- none of the large hospitals in my city do. *[CA]*
- Expanding on question #8: We used to place patients in CP for any culture positive or historical surveillance data (pcr swab or culture) but lost this information w/ a change in EMR on Feb 1. Outcomes of this change not yet known. Only pt subset not affected was CRE (+) patients as we had tracked & flagged them prior to the change. *[TX]*
- We are in the process of discontinuing routine use of CP's for patients colonized or infected with MRSA or VRE. *[ME]*
- Looking at reducing CP. Results of the last question will be most useful. *[NM]*

Comments about surveillance testing for MRSA, VRE and/or CRE

- We did away with VRE surveillance: staff satisfaction increased, no change in VRE HAI or VRE clusters/outbreaks. *[CA]*
- Quit doing active surveillance testing for MRSA 3 months ago *[GA]*
- Single orthopedist using preop MRSA nasal screening as routine. Institution contemplating this for all preop patients. Nasal PCR screening for past MRSA positive patients done at each admission with isolation discontinued if no active infection. *[CT]*
- CRE active surveillance testing only for patients exposed to known CRE carriers *[MA]*
- Periodic hospital-wide patient sample surveillance *[NY]*
- Although this is our policy, I have to say that I am not a believer in widespread screening for MRSA or contact isolation for MRSA given the high background carriage rates. *[NJ]*
- We just started to screen a few patients for carbapenemase producers due to recent introduction of a few patients with carbapenemase producing organisms. Lab protocol for the screening is cumbersome and not yet validated. *[LA]*
- CA state mandate for MRSA active surveillance testing- Pending legislation if passed proposes reporting MDRO infection to Ca Health DEPT *[CA]*

- Also do active surveillance for Acinetobacter, ESBL, KPC [MD]
- We do routine surveillance cultures for all infants admitted/transferred to our NICU [OH]
- Maybe stop VRE screening and practice good standard precautions. Targeted MRSA screening may be difficult, we screen everyone on admission except L&D, psych, peds (as we found our rate was very low - 2% in these areas). [MD]
- The surveillance screening for MRSA and VRE (BMT and SOT patients on admission) preceded my arrival to this facility and is not now IPAC-directed. No CRE isolated in 2012 and 2013. [AZ]
- In CA, screening of certain patients for MRSA is legally mandated, but the law only requires educating patients who are positive, and does not require any specific infection control practice. High-risk patients (dialysis, readmission, transfers, ICU) must be screened, but most patients are not screened, and testing the nares is not very sensitive, so most colonized patients probably go undetected. [CA]
- No CRE in our area. Still trying to figure out how to manage it when it gets here. [OR]
- Active surveillance testing for VRE is only done on the oncology ward, in response to increased transmission. [CA]
- Mandated by Washington state legislature to screen ICU pts for MRSA and to isolate all positive cultures (gee maybe legislators doing infectious disease is not such a good idea...). [WA]
- MRSA active surveillance is performed in NICU only. [VA]

Comments about chlorhexidine gluconate (CHG) bathing

- CHG routine washes being contemplated for entire hospital population. [CT]
- We are in the process of considering what populations aside from pre-op Ortho and CAB/Valve will get chlorhexidine washes. [MN]
- Starting pre ortho surgery, already pre cardiac surgery [CA]
- Trial units, slowly rolling it out. [NM]
- We do all ICU pts and all with central line [UT]
- ICU patients with central lines [NE]
- Changes are being explored and a COG study is about to start in oncology patients [CA]
- Adult ICU only [NJ]
- We are considering adding all patients with central lines [CT, OH]
- Used preop for implants: Joints, spine, VP shunt, vascular graft [MD]
- All ICU patients--adults and neonates [GA]
- CABG pts, ICU, SICU, CCU pts [NJ]
- Only for cardiac, elective arthroplasty and colorectal procedures [TN]
- All but neonates / excluding neonates / > 2 months of age in PICU [CA, MD, MD, NC, TX]
- Pre-CV Surgery [DC]
- Select medicine wards (intermediate care) [MN]
- All ICU and oncology patients and patients with central lines including LAVDs [CA]
- Only CABG / hip and knee surgery [MI]
- Chlorhexidine wipes for daily bath [NE]
- Moving to house-wide CHG for bed baths; pan ICU daily CHG since 2007; all preop C sections, spines, total joints [MD]

Comments about *S. aureus* decolonization

- Not sure of value of decolonization attempts except in preop setting. Not sure that your statement about stethoscopes, etc leading to transmission is accurate; certainly not demonstrated to cause infection.
- Decolonization for MRSA is largely at the discretion of the treating physicians. [PA]
- Preop cardiac / cardiovascular and orthopedic [CA, IL, ME, NJ, TN]
- MRSA nasal screening is recent addition and policies regarding decolonization still in process [CT]

- All cardiac surgery patients get preop mupirocin per protocol. Have protocol for screening and selective decolonization before joint replacement surgery but this is not followed reliably as our pre-op clinic is being reorganized [GA]
- Do not use mupirocin, use 3M product [NY]
- Moving towards all pts with MRSA colonization [CA]
- Spinal surgery and cardiac surgery [UT]
- Special attention with preadmission mupirocin for elective surgery involving implantable devices on ortho and cardiovascular services [MO]
- We only use decolonization in patients with positive cultures. [GA]
- Only selected surgeries with implants get screened for *S. aureus* and decolonized with mupirocin [OR]
- SA decolonization of non-preop patients is determined by treating physician. Pre-op decolonization is limited to targeted clean surgeries (Type I wound): specifically procedures with increased rates and SA over representation [FL]
- Including neonates [NC]
- We use nasal PI, not mupirocin [NY]
- 5 days of preop mupirocin/ CHG given to hip knee arthroplasty patients [CA]
- Occasionally might be attempted on an individualized basis for certain pre-op patients. Not routinely done [CA, MI, PA]
- Pre-op for select procedures. Select ICU patients. All colonized NICU patients. [MD]
- Only for open heart, vascular surgery, or joint replacement patients with a positive *S. aureus* nares screen
- With povidone iodine [NY]

Duration of Contact Precautions (Question 2)

- The CDC should formulate clear guidelines on when to discontinue MRSA, CRE and VRE isolation in patients. [ND]
- We are questioning the duration of isolation for MDRs (MRSA, VRE, CRE, ESBL), asking in particular: 1-Is lifetime isolation really necessary? 2-Should we do surveillance cultures on previously infected pts and d/c isolation if they're negative? [OK]
- Not 1 year after last positive culture, but: 4 mon [CA], 3 mon [CA], 2 yrs for MRSA & VRE [GA], 2 yrs [GA, GA & NC], 3 mon for CRE [PA], 6 mon [NJ], 6 mon for CRE [LA], 2 yrs for VRE and MDR-GNR [NY], 4 yrs for VRE / MRSA [DC], 5 yrs MRSA & 1yr ESBL [UT], 18 mon all MDROs [WA]
- Re-assessing MRSA, VRE and have simplified removal if site and reservoir negative off antibiotics and no indwelling device/tube [MI]
- We are considering transitioning from nasal cultures from MRSA to PCR from two sites in allowing selected patients to come out of Contact Precautions. [TX]
- Planning to stop CP for MRSA/VRE unless secretions/drainage present. Will continue CP for CRE until data is more conclusive. [LA]
- We are considering when to stop CP for low risk patients with remote past histories of MRSA or VRE; for years it has been permanently flagged for isolation. CRE will remain permanent isolation status.
- Duration of CP use slightly different if present in sputum [CT]
- MRSA & VRE are rescreened per CDC recommendations prior to removing isolation; CRE is case-by-case [MA]
- MRSA: isolation until 3 negative nasal cultures [OK]
- Until 3 negative MRSA screens [IL, OK, PA]
- Documented decolonization removes CP [OR]
- MRSA - negative culture all sites x 2; VRE, CRE - negative culture x 3 [WA]
- We will recheck on subsequent admissions [MA]
- Usually for duration of hospitalization & MRSA noted with history until clear [CA]

- We haven't had a CRE case, not sure what policy is [CA, OR]
- Indefinitely if + in-house during visit [MO]
- 1 week for MRSA, 3 months for VRE and lifelong for CRE [FL]
- Placed throughout current admission. They are placed when re-admitted and removed only after re-screening yields negative result on rescreening. [FL]
- I think the protocol is if readmitted within 6 months of positive culture [NY]
- MRSA pts are usually "indefinitely", as few go to the trouble to decolonize / document clearance [CT]
- MRSA clearance requires 2 negative cultures or PCR (nares+primary source) at least 48 hrs or 2 admissions apart; VRE clearance requires 3 negative screens (groin+rectal+primary source) each 1 week apart [CT]
- Recheck for MRSA after one year. Would like to do PCR, but we don't have it in our hospital. [WA]
- Need negative cultures from original site if not from sterile source, plus a surveillance culture is checked as well (ie, if positive B/C, a nares or groin surveillance is obtained as well). Clinical and surveillance cultures must both be negative. X3. [GA]
- For MRSA and VRE -- 90 days since isolation but also protocol with surveillance culture to assess if still colonized [TN]
- The policy for CRE in peds is in evolution. [OH]
- Until two negative cultures [TX]
- CRE clearance will be reconsidered if numbers rise [MA, SK]
- Pts not eligible for MRSA clearance cultures until >1 yr has elapsed from most recent positive. [DE]
- "Cleared" varies by MDRO. For MRSA- no clinical cx for 12 months, negative nares screen x2 1 week apart, off abx, no open wounds, indwelling lines/drains/devices. VRE requires 3 consecutive negative per-anal/rectal cx, 1 week apart, off abx for 1 week before screens, and no wounds/lines/drains /indwelling devices. CRE requires 3 consecutive negative axilla and groin cx 1 week apart, off abx a week before screens, no lines/drains/devices. Cdiff-- CP with diarrheal illness until CDI ruled out; if positive, in CP until on therapy AND no diarrhea for minimum of 48 hours [MN]
- Infection control has resisted taking out of precautions, even with three negatives off antibiotics for a week each time [WA]
- There are criteria to stop precautions based on negative cultures but they take so long that most patients are taken off after one year [PA]
- Case by case for VRE and CRE [MD]
- MRSA rescreened 3 months after last positive culture and off anti-MRSA antimicrobials for >48 hours
- MRSA negative nasal/groin; CRE negative rectal and source [NJ]
- Generally 3-6 months, depending on organisms, antibiotic use, other patient characteristics - all assume clearance from clinical/colonization sites [MI]
- CRE in isolation for 1 year then evaluated for removal on case by case basis [NE]
- D/C'ing isolation for MRSA & VRE based on 3 negative surveillance cultures off abx and at least 3 mos from last clinical infection; cultures must be 24 hours apart for MRSA and 1 week apart for VRE [PA]
- MRSA isolation on subsequent hospitalization if culture positive within 3 yrs [NJ]
- CRE- case by case; usually if from LTAC or SNF they stay in isolation upon readmission. [CA]
- NJ state law - 3 years for MRSA [NJ]
- 90 days for CRE, no isolation for MRSA, VRE unless in surgical floor or draining wounds [MI]
- Until portal of exit resolved [NY]
- We place all 3 on isolation for duration of current encounter. MRSA and VRE for 5 years if not found by multidimensional tests to be decolonized, CRE is isolated for life [UT]
- 3 months from original positive culture for VRE & CRE unless actively infected on new admission [NJ]
- CP continued thru hospitalization and if re-admitted 90 days after [TN]

Disinfection / Cleaning

- Xenex radiation machine now being used in OR's and if available in MRSA & C diff rooms [CA]
- Just purchased UV and HPO machines, haven't started using yet. [GA]
- Our use of UV light emitters for patients on contact precautions is part of a 28-month cluster randomized CDC-funded trial. [NC]
- Also use UVC monitors [NY]
- Problems w multidrug R Acinetobacter, mostly pulmonary and wounds in ICU has disappeared w use of H2O2 vapor system! [MS]
- Considering UVC or H2O2 [NJ]
- We employ terminal cleaning using floor flooding with accelerated peroxide (H2O2 and HCL) using OR class floors. As an LTAC, we are concerned re the high prevalence of MDR's in incoming pts. [NJ]
- Testing UVC and blacklight inspection of terminal cleaning is done intermittently as a spot check. [NJ]
- We are in the process of purchasing IVC machines for terminal cleaning of rooms of patients who were in CP for C difficile as well as Operating Rooms. [TX]
- Building management people bought a UV decontamination unit over our strenuous objections. [MN]
- UV daily in rooms on psych ward during norovirus season and for some discharges from precaution rooms on request or when available or in the setting of clusters of infection [MA]
- Environmental monitoring in our institution at present is minimal but a committee has started to try and incorporate some monitoring in the near future. [SK]
- We trialed the ATP bioluminescence system recently and will be purchasing this system to help with monitoring environmental cleaning [PA]
- UVC only used for Clostridium difficile. [PA]
- We use bleach cleaning for all rooms on the oncology ward because of increased rates of CDI [CA]
- We started routine UV on discharge last year...routine for all rooms in the ICU and special care high risk units and for isolation rooms in the other units. [MD]

Compliance with Contact Precautions and hand hygiene

- Compliance is periodically monitored via direct observation (surreptitious). [NY]
- Attempt is made to ensure compliance for all who enter rooms, but it is difficult to enforce for some groups--visitors, and persons who are not full-time ward/unit personnel. [TX]
- We have focused on hand hygiene compliance; as compliance has risen above 90%, the frequency of MRSA transmission has steadily declined. [MO]
- In the current climate of "the patient is our customer," we routinely see family members that refuse to honor CPs, and administratively we do not confront them. This leads to bad morale on the part of the staff, who resent the CPs and (correctly) point out our inconsistent approach. This has become a difficult public relations issue for us. [AL]
- We do NOT require visitors to use gloves, gown when entering the room of a patient with MRSA or VRE [NC]
- I have never been convinced that our observed CP compliance is very accurate. I monitored observed compliance for all patients with C. diff isolation in 2011 and found max 60% compliance [PA]
- Difficult to enforce with so many situation that require CP and the importance CP diminishes. So, consequently staff perceive the MRSA colonization and extensive CRE SSIs are of equal importance, but using a tier approach is too complicated. [CA]

Environmental waste issues

- Huge waste with new breathable cotton suits which are expensive and not impervious [NY]
- Has anybody consider the environmental implications of the amount of non-latex gloves that we throw away every day now? Can this be recycled? [CA]