Appendix 8

Guidelines for Screening & Topical Decolonisation Treatment in Neonatal Intensive Care Unit (NICU)

1. Screening
   1.1 Babies
   An admission screen should be taken from babies who meet the following criteria:
   - babies who are admitted to NICU and are less than 30 weeks
   - babies who are ventilated or have central lines (unless they have previously been screened)
   - babies needing CPAP or Hi Flow (unless they have previously been screened)
   - babies transferred from another unit (unless screened <24 hours prior to transfer)

   The MRSA screen should include a swab from nose/ears/groins (one swab total if possible). If ear swabs and gastric aspirates are sent for routine bacteriology as part of an infection screen after birth then additional MRSA swabs are not required. In addition any manipulated invasive device exit site e.g. cannula or long line in situ should be swabbed if signs of infection (this will be less relevant to direct admissions from birth and more relevant for hospital transfers).

   If the result of the first swab is positive:
   - Nursing in an incubator is satisfactory as this is a barrier to cross infection. If a baby can be moved safely to a side room after careful risk assessment then this would be desirable
   - Commence topical decolonisation treatment, as for an adult (using nasal Bactroban), except add Octenisan, in place of Chlorhexidine Gluconate body wash. Octenisan is less drying than other topical preparations but may also cause drying of the skin. Topical Prontoderm is an alternative
   - Screen the mother.
   - Screen other babies in the same room if there is thought to be a risk of transmission eg if the index case has not been nursed in an incubator

   If the baby has clinical signs of infection, contact the Microbiologist for advice (ext: 4105).

   1.2 Mothers
   If the mother is positive:
   - Commence topical decolonisation treatment.
   - Contact the Microbiologist for advice if there are signs and symptoms of infection.

   Mothers who are found to be MRSA positive should not be permitted to bring their babies into the sitting room in NICU.

   1.3 Screening of Other Relatives
   The father of the baby and other relatives do not normally require screening. Any further screening will be requested at the discretion of the Microbiologist.

   1.4 Staff Screening
   The decision whether staff should be screened will be made at the discretion of the Director of Infection Prevention & Control (DIPC), Microbiologist and the Infection Prevention and Control Team, in conjunction with the Occupational Health & Safety Services (OHSS). This is a decision made on clinical judgement and risk assessment, if there is an MRSA Outbreak or clusters of cases within their clinical area. (See Appendix 12).

2. Topical Treatment
   Topical treatment should be given as outlined in section 2.2.6 of the policy, except that octenisan is to be used instead of chlorhexidine as it is less drying to the skin. The octenisan should not be diluted in the bath but applied to moist skin directly with a moist cloth. If the baby is positive in umbilicus or eyes, contact the Microbiologist for advice. (NB: Naseptin contains peanut oil and should not be used for babies).

   Where both mother and baby are positive, courses of topical treatment should be co-ordinated so that they finish on the same day. A repeat screen should be taken 48 hours after the topical decolonisation treatment has finished. If the screen is positive, a repeat course of topical decolonisation treatment
should be given. If more than two courses of topical decolonisation treatment are required, the Microbiologist should be contacted for advice.

3. **Isolation precautions**

All babies who are MRSA positive should be risk assessed as for need of any additional isolation. Most babies will be in an incubator and this can be considered as being isolated and barrier nursed from other babies who may be at risk. Staff/parent hand hygiene, PPE and environmental decontamination is obviously important to help limit any spread to other babies at risk. Please refer to the NICU isolation policy for further information.

Bed or unit closure is not normally required. This may be necessary if there is a potential outbreak with evidence of likely cross transmission or a high number of MRSA positive cases. The DIPC, Microbiologist and the Infection Prevention and Control Team must be consulted prior to any decision to close bed or unit.