



Policy:

Antibiotic Policy

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Summary of policy

SHSC Antibiotic Policy aims to provide guidance for the effective use of, whilst preventing inappropriate use of, antibiotic medication whilst working to the principles of antimicrobial stewardship and preventing the emergence of treatment resistant micro-organisms.

Target audience	All prescribers, nurses, physicians associated, pharmacy team working within SHSC.
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Keywords	Medication, Antibiotics, Infection
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Storage & Version Control

Version 8 of this policy is stored and available through the SHSC intranet. This version of the policy supersedes the previous version (V7 Oct 2021). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
2	Review	06/2009	Previous guidance in operation updated to policy status
3	Review	12/2011	Updated in line with STH antibiotic prescribing guidelines
4	Review	03/2014	Policy reviewed as past review date
5	Review	02/2017	Policy reviewed as past review date and to update in line with antimicrobial stewardship alert
6	Review	10/2019	
7	Review	09/2021	Policy review and update in line with recent NICE guidance change. C. Difficile guidelines updated in line with recent NICE update. Links to relevant NICE guidelines added to specific infection guidance.
8	Review	12/2023	Policy review in line with Sheffield Area Prescribing Group recommendations referencing NICE Summary of antimicrobial prescribing guidance – managing common infections. Inclusion of guidance within appendix relating to sample taking.

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1 Introduction

The aim of the policy is to give guidance for the appropriate and effective use of antibiotic medication, prevent the miss-use and overuse of antibiotics, therefore preventing the emergence of treatment resistant micro-organisms.

The development of antimicrobial resistance is a major concern for public health. Resistance makes infections more difficult to treat and may result in complications and longer hospital stays.

2 Scope

This policy relates to all areas of the Trust where antibiotics are prescribed, administered or dispensed.

3 Purpose

The aim of the policy is to ensure that antibiotic medications are used appropriately and effectively within the SHSC to help prevent the emergence of treatment resistant micro-organisms.

4 Definitions

- PPI - proton pump inhibitor. A class of drugs that are used mainly to treat peptic ulcers and gastroesophageal reflux disease.
- BNF – British National Formulary
- MRSA – Methicillin-resistant Staphylococcus aureus
- ESBL – Extended-spectrum beta-lactamases
- NICE – The national institute for Health and Care Excellence
- PHE – Public Health England

5 Duties

All professions involved with the prescribing, administration and dispensing of antibiotics should follow the policy to ensure antibiotics are used appropriately.

All staff employed by the trust or any staff working or seconded to work within the Trust when dealing with medicines should follow the relevant SHSC medicines related policies, procedures and where applicable their own professional body's code of practice.

Any health care professional choosing to deviate from these standards will be expected to do so knowingly and be able to justify their course of action to their peers. Adherence to these standards should be the norm.

All staff who have any involvement with medicines are expected to work within their own sphere of competencies. All staff should be aware of and have access to medicines management policies.

Pharmacists

To participate in and support the processes of medicines optimisation throughout the Trust and across organisational boundaries. This will include providing advice to all SHSC staff including cultural & adaptations for service users with special needs.

Chief Pharmacist

Responsible for medicines management throughout the Trust.

Medicines Optimisation Committee

To provide multidisciplinary advice and guidance on medicines management within the Trust.

6 Procedure

In accordance with Sheffield Area Prescribing Group, the local use of the NICE/PHE managing common infections guidance will formulate the antibiotic prescribing guidelines for SHSC:

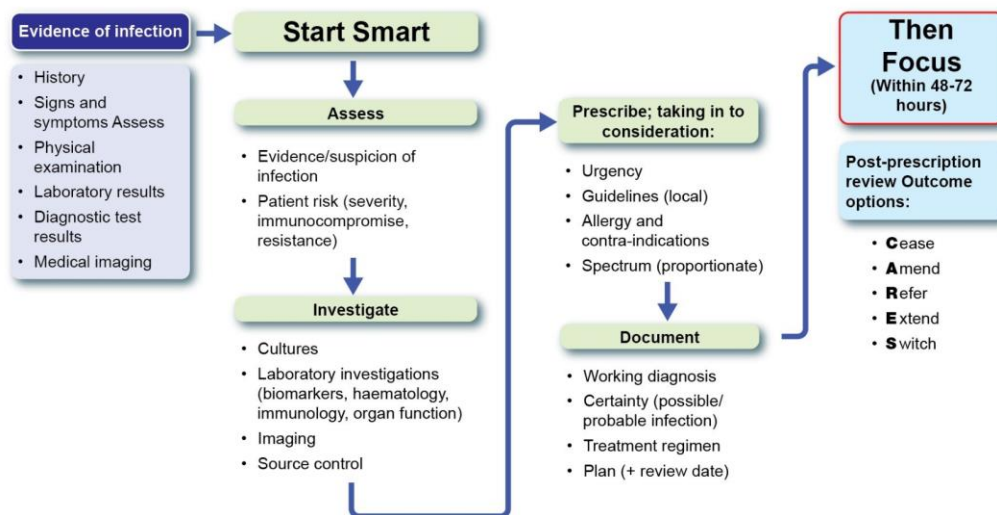
[Antimicrobial stewardship | Topic | NICE](#) - Introduction to guidelines

Access the NICE summary of antimicrobial prescribing guidance – managing common infections via [this link](#) and scroll to first bullet point named 'condensed summary of antimicrobial prescribing guidance – table'. This can also be accessed: [here](#).

These guidelines should be used in conjunction with professional judgement and involving patients in management decisions.

These guidelines will be periodically updated by NICE. The below caveats should also be considered when prescribing antibiotics within SHSC.

Antimicrobial stewardship: Start Smart then Focus Clinical management algorithm



Antimicrobial stewardship: Start smart - then focus

Ref: www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus/start-smart-then-focus-antimicrobial-stewardship-toolkit-for-inpatient-care-settings

6.1 General Guidance

Antibiotics should only be prescribed when there is clinical evidence of bacterial infection. If there is evidence/suspicion of bacterial infection, use guidelines to initiate prompt effective

antibiotic treatment within one hour of diagnosis (or as soon as possible) in patients with life-threatening infections such as severe sepsis.

Please note some common infections are self-limiting and will resolve without the need for antibiotics, for example:

- Antibiotics are not required for simple coughs and colds (viruses).
- Antibiotics are not required for viral sore throats.
- Prescribing for uncomplicated cystitis is limited to three days in otherwise fit women.

- Do not start or change antibiotics without good reason.

- Prescribing of antibiotics via a verbal order should only occur in exceptional circumstances.

- The indication for starting or changing an antibiotic, and the intended duration of treatment, must be clearly documented in the patients' medical notes. Microbiology specimens should be taken wherever appropriate, and any previous results checked in order that antibiotic therapy can be adjusted according to culture results. Ideally specimens for culture should be taken before prescribing antibiotics.

- Where it is necessary to prescribe antimicrobials empirically; early review in the light of microbiological results, clinical progress, etc, is vital so that treatment can be changed or discontinued as soon as possible.

- If patients are causing concern (physically unwell) seek advice from the general medical registrar (patients may need treatment on a medical ward with parenteral antibiotics).

- As with all drugs, prescribers, nurses, and pharmacists/technicians should check the patient's allergy status before prescribing, administering, or dispensing antibiotics.

- Please take a careful history before documenting a patient is penicillin allergic in the notes. Diarrhoea is a common side effect and is not an allergy. Please see BNF regarding cross sensitivity between penicillin's and cephalosporins if prescribing for penicillin allergic patients.

- Seek advice from the microbiologists or the pharmacy department for an alternative drug if the patient is hypersensitive to the suggested drug.

- Prescribers should check that the antibiotic will also be suitable for the patient e.g. patients who are pregnant, or have renal or hepatic impairment.

- Quinolone antibiotics, cephalosporins and co-amoxiclav should be generally avoided as first line choices due to potential for *C.difficile* and promotion of MRSA and ESBL's. If previous history of either of these discuss with the microbiologist.

- The use of quinolone antibiotics should also be avoided due to the risk of tendonitis and aneurysms that are identified side effects.

- Check any contra-indications or cautions with the antibiotic before prescribing or for potential interactions with existing treatments.
- If no clinical response within 72 hours, the diagnosis, antibiotic choice, and possible secondary infection should be considered.
- When treating pneumonia, the inpatient status should be considered when differentiating between hospital and community acquire pneumonia. The principles of hospital acquired pneumonia still apply if the patient has been on “short term leave” from the hospital admission. Cases should be discussed with microbiology if there are any uncertainties.

6.2 Treatment Length

Do not prolong antibiotic courses unnecessarily (5 to 7 days is usually sufficient). There are exceptions - if in doubt consult a Microbiologist. Guidelines clearly specify recommended treatment lengths for antibiotic courses.

Ensure that end dates are clearly added to prescriptions, including when these are prescribed on electronic prescribing system.

6.3 Topical Treatment

For skin or soft tissue infections, oral antibiotic therapy is preferred. Topical antibiotics may lead to increased resistance and skin allergy. Consult a microbiologist if you believe a topical treatment is necessary.

6.4 Prophylaxis Treatment

There are limited reasons to prescribe antibiotics prophylactically. Do not prescribe prophylactically without good reason. If in doubt discuss with a Microbiologist. (See summary of antibiotic prophylaxis – [BNF](#) Section 5.1). Patients admitted to inpatient wards on prophylactic antibiotics should receive review as to the appropriateness of continued treatment.

6.5 Contact information

For advice on appropriate investigations, antibiotic regimen, dosing or duration of treatment contact:

- Microbiology (RHH - Ext 12607 / NGH Ext 14527, bleep 2536 or via switchboards).
- For general information, contact the Sheffield Health and Social Care Trust Pharmacy Dept – 18635 or contact the Infection Control Nurse on 18621 or via switch.
- Out-of-hours contact on-call Microbiologist or on-call Pharmacist via switchboard

6.6 Treatment Guidelines

This advice is for the treatment of common infections in adults encountered within the Sheffield Health and Social Care NHS Foundation Trust. For other circumstances or for more information contact the above numbers or consult the current edition of the BNF. This advice refers to treatment before bacteriological results are available. Treatment must be reviewed on receipt of bacteriological results.

Link to Sheffield Teaching Hospitals antibiotic guidelines:

<https://nww.sth.nhs.uk/NHS/AntibioticsGuidelines/>

Link to Sheffield Childrens Hospitals (SCH) antibiotic guidelines (within the context of prescribing for SCH Becton)

https://nww.sch.nhs.uk/jdownload/0_1681718658_iFxd2l/1246v9_Antimicrobial_Dosing_Guideline.pdf

7 Development, Consultation and Approval

Policy was developed using previous version 7 of antibiotic policy with updates to guidelines as recommended by Sheffield ICB.

Infection Prevention Nurses and Microbiologist consulted during policy review.

SHSC Pharmacists consulted during policy review.

Policy reviewed and approved by Medicines Optimisation Committee.

Submitted to and approved by Policy Governance Group December 2023.

8 Audit, Monitoring and Review

The policy will be reviewed on a regular basis to ensure it remains in line with antimicrobial prescribing recommendations/guidelines within Sheffield. It will be subject to a formal review three years after the date of ratification but does not exclude the option to review and update the policy should a significant change in practice occur.

The prescribing of antibiotics will be monitored by Pharmacists working in individual teams (where available) and by the Pharmacy Department. Audits are on-going and reported quarterly to the IPC and MOC to review adherence to the policy.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/committee for action plan development	Responsible Individual/group/committee for action plan monitoring and implementation
Antibiotic prescribing	Screening prescriptions in Pharmacy and on the ward. Quarterly antibiotic prescribing audits within the inpatient wards.	Pharmacy and IPC	On-going quarterly reporting of antibiotic audit results to the IPC	MOC/IPC	Pharmacy and IPC	Pharmacy Department - For implementation IPC – for monitoring

The Policy should be reviewed in 3 years (October 2026) or in light of updated prescribing guidance.

9 Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version to archive.	Facilitated by Katie Pawley/Pharmacy Admin	End of December 2023	Awaiting approval of policy
Email all relevant staff/ communications to	Facilitated by Katie	End of	Awaiting approval of policy

be sent out once new policy approved.	Pawley/Communications/Pharmacy Admin	December 2023	
Quarterly audit to be completed and presented at MOC and IPC.	Facilitated by audit pharmacist	Ongoing	Ongoing

10 Dissemination, Storage and Archiving (Control)

The policy will be disseminated via the Medicines Optimisation Committee and the Infection Control Committee. Updates to the policy will be disseminated to all relevant medical professionals.

The policy will be made available for all staff on the policies section of the intranet.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
2.0	July 2009	July 2009	Unknown	
3.2	December 2011	December 2011	Unknown	
4.0	March 2014	March 2014	Unknown	Dissemination via pharmacists in teams.
5.0	April 2017	April 2017	Unknown	Dissemination via pharmacists in teams.
6.0	November 2019	November 2019	Unknown	Dissemination via pharmacists in teams.
7.0	September 2021	September 2021	Unknown	Dissemination via pharmacists in teams.
8.0	December 2023	December 2023	December 2023	Dissemination via pharmacists in teams. Dissemination to doctors, non-medical prescribers and physicians associates via appropriate channels.

11 Training and Other Resource Implications

In line with the alert for antimicrobial stewardship – training for nursing staff will be captured as part of the mandatory Medicines optimisation training.

All Trust prescribers, pharmacists and pharmacy technicians are required to complete the E-Learning course titled '**Introduction to antimicrobial resistance package**'. This package can be undertaken by logging on as usual via the Trust E-Learning system. The training is completed as a one-off requirement.

12 Links to Other Policies, Standards (Associated Documents)

- Infection Prevention and Control Policy
- Medicines Optimisation Policy

13 Contact Details

<i>Title</i>	<i>Name</i>	<i>Phone</i>	<i>Email</i>
Chief Pharmacist	Abiola Allinson	18633	Abiola.allinson@shsc.nhs.uk
Senior Pharmacist	Katie Pawley	18633	Katie.porter@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – Relevance - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement.
I confirm that this policy does not impact on staff, patients or the public.

I confirm that this policy does not impact on staff, patients or the public.
 Name/Date:

YES, Go to Stage 2

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – Policy Revision - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	No		
Disability	No		
Gender Reassignment	No		
Pregnancy and Maternity	No		

Race	No		
Religion or Belief	No		
Sex	No		
Sexual Orientation	No		
Marriage or Civil Partnership	No		

Please delete as appropriate: no changes made.

Impact Assessment Completed by:
Name /Date : Katie Pawley October 2023

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
Engagement		
1.	Is the Executive Lead sighted on the development/review of the policy?	Y
2.	Is the local Policy Champion member sighted on the development/review of the policy?	N/A
Development and Consultation		
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Y
5.	Has the policy been discussed and agreed by the local governance groups?	Y
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Y
Template Compliance		
7.	Has the version control/storage section been updated?	Y
8.	Is the policy title clear and unambiguous?	Y
9.	Is the policy in Arial font 12?	Y
10.	Have page numbers been inserted?	Y
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Y
Policy Content		
12.	Is the purpose of the policy clear?	Y
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Y
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Y
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Y
16.	Does the policy include any references to other associated policies and key documents?	Y
17.	Has the EIA Form been completed (Appendix 1)?	Y
Dissemination, Implementation, Review and Audit Compliance		
18.	Does the dissemination plan identify how the policy will be implemented?	Y
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Y
20.	Is there a plan to i. review ii. audit compliance with the document?	Y
21.	Is the review date identified, and is it appropriate and justifiable?	Y

Appendix C

Guidelines for Management of MRSA Colonisation

All cases should be brought to the attention of the Trust infection control nurse. Cases should also be discussed with microbiology if there are concerns for skin or soft tissue infections or if antibiotics are required.

Staphylococcus aureus is a bacterium which colonises the skin, particularly the nasal passages and warm moist areas of skin and the umbilicus in babies. Colonisation occurs when the bacterium lives in these areas without detection and without causing symptoms.

Topical Treatment

The treatment of patients with MRSA will be guided by the Infection Prevention & Control Team. It will usually follow the measures described below.

Nasal treatments –

**check sensitivities before prescribing as Mupirocin resistant strains are in circulation.*

2% Mupirocin (Bactroban) three times daily to both nostrils for **five days**
or

Naseptin Nasal Ointment four times daily to both nostrils for **ten days** (***Note that naseptin products may contain arachis oil – verify if the patient has an allergy to peanut or soya and if so, take care to ensure arachis oil free version is supplied**)

Skin treatment

- Patients carrying MRSA in any site should bathe/wash/shower daily for five days using an antiseptic wash such as chlorhexidine gluconate 4% (Hibiscrub or Hydrex) or Octenisan (Octenidine). Skin wash should be used for the same length of time as nasal treatments if a nasal treatment is prescribed.
- The antiseptic wash must be applied directly to the skin on a disposable cloth and not diluted in water in a bowl, shower or bath and applied for the correct 'contact time'; before rinsing off.
- The hair must be washed twice weekly with the antiseptic wash selected. Ordinary shampoo can be used afterwards if desired.

Allow 48 hours after completing the course of treatment before re-screening

Follow up after decolonisation treatment

At least three negative screens including previously positive sites should be available before assuming that MRSA has been cleared and barrier precautions can stop.

Ciprofloxacin should NOT be used in any patients who are, or previously have been, MRSA colonised or infected. If there is no alternative, this should be discussed with the microbiologist and the patient must be on topical decolonisation treatment while they are taking ciprofloxacin and for 48hrs after the cessation of ciprofloxacin.

For further information please contact the Infection control nurse: tel: 16720

Appendix D

Recommended microbiology sampling for antibiotic treatment

Microbiology specimens should be taken wherever appropriate, and any previous results checked in order that antibiotic therapy can be adjusted according to culture results. Ideally specimens for culture should be taken before prescribing antibiotics but empirical treatment can be started to avoid delay in treatment.

Infection	Guidance	Source
Cellulitis & Skin Wounds	<p>Consider taking a swab for microbiological testing from people presenting with or confirmed cellulitis or erysipelas to guide treatment, but only if the skin is broken and in cases where:</p> <ul style="list-style-type: none"> • there is a penetrating injury/exudate and/or • there has been exposure to water-borne organisms and/or • the infection was acquired outside the UK and/or • There is deterioration to the damaged skin/surrounding area 	<p>From NICE Cellulitis and erysipelas: antimicrobial prescribing Overview Cellulitis and erysipelas: antimicrobial prescribing Guidance NICE</p>
Impetigo	<p>Impetigo is usually a clinical diagnosis and investigations are not needed.</p> <p>Swabs (of exudate from a moist lesion or de-roofed blister) for culture and sensitivities should be considered in cases which are persistent despite treatment, recurrent, or widespread.</p>	<p>From NICE Impetigo Clinical Knowledge Summary Impetigo Health topics A to Z CKS NICE</p>
Urinary Tract Infection	<p>A sample should be sent for urine culture in all women with suspected lower UTI who:</p> <ul style="list-style-type: none"> • Are pregnant • >65 years • Have symptoms that are persistent or do not resolve 	<p>Urinary tract infection (lower) - men Health topics A to Z CKS NICE</p> <p>Urinary tract infection (lower) - women Health topics A to Z CKS NICE</p>

with antibiotic treatment.

- Have recurrent UTI (2 episodes in 6 months or 3 in 12 months).
- Have a urinary catheter in situ or have recently been catheterised. *(If the catheter has been changed the sample should be collected from the newly placed catheter — using aseptic technique drain a few mL of residual urine from the tubing then collect a fresh sample from catheter sampling port. Ensure the microbiology request form states that this is a suspected catheter-associated infection and details of any antibiotic prescribed.)*
- Have risk factors for resistance or complicated UTI such as abnormalities of genitourinary tract, renal impairment, residence in a long term care facility, hospitalisation for more than 7 days in the last 6 months, recent travel to a country with increased resistance or previous resistant UTI
- Have atypical symptoms
- Have visible or non-visible (on urine dipstick) haematuria

In **men** with symptoms suggestive of a UTI, confirm the diagnosis by urine culture and sensitivity, by arranging collection of a mid-stream urine (MSU) or catheter specimen of urine (CSU), to determine the infecting micro-organism.

- Obtain a urine sample for culture before starting empirical drug treatment.
- Only send a urine sample for culture in a man with an

	indwelling catheter if there are features of systemic infection.	
Otitis Externa	<p>Consider swabbing the ear canal for culture to identify likely pathogens and susceptibilities in the following circumstances only:</p> <ul style="list-style-type: none"> • The condition does not improve after initial empirical topical treatment • Otitis externa is recurrent or chronic • After ear surgery • Topical treatment cannot be delivered effectively • There is suspicion that the infection has extended beyond the external auditory canal • The condition is severe enough to require systemic antibiotic treatment 	<p>From Ordering and interpreting ear swabs in otitis externa <i>BMJ</i> 2014; 349 doi: https://doi.org/10.1136/bmj.g5259 (Published 01 September 2014)</p>
Infective exacerbations of Chronic Obstructive Pulmonary Disease and Suspected Chest Infections	<p>Sputum culture to identify organisms only if sputum is persistently present and purulent and in cases where symptoms have not improved following 2-3 days of antibiotic treatment</p>	<p>From NICE Chronic obstructive pulmonary disease in over 16s: diagnosis and management Overview Chronic obstructive pulmonary disease in over 16s: diagnosis and management Guidance NICE Scenario: Acute exacerbation Management Chronic obstructive pulmonary disease CKS NICE</p>
Clostridium difficile Infection (C. difficile)	<p>Stool samples to be taken in suspected <i>C difficile</i> in all patients:</p> <ul style="list-style-type: none"> • If a patient has diarrhoea (Bristol Stool Chart types 5-7) that is not clearly attributable to an underlying condition (e.g. inflammatory colitis, overflow) or therapy (e.g. 	<p>From Public Health England's guidance on diagnosis and reporting for recommendations on stool sample tests as referenced in NICE Clostridioides difficile infection: antimicrobial prescribing Available at: Clostridioides difficile: guidance, data and analysis - GOV.UK (www.gov.uk)</p>

	laxatives, enteral feeding)	Overview Clostridioides difficile infection: antimicrobial prescribing Guidance NICE
Community-Acquired Pneumonia	<p>Do not routinely offer microbiological tests to patients with low-severity (CURB-65 score 0-1) community-acquired pneumonia.</p> <p>For patients with moderate (CURB-65 score 2)- or high (CURB-65 score 3-5)-severity community-acquired pneumonia:</p> <ul style="list-style-type: none"> take blood and sputum cultures and consider pneumococcal and legionella urinary antigen tests. 	<p>From NICE Clinical Guideline Pneumonia in adults: diagnosis and management</p> <p>Overview Pneumonia in adults: diagnosis and management Guidance NICE</p> <p>Chest infections - adult Health topics A to Z CKS NICE</p> <p>CURB-65 score, 1 point for each:</p> <ul style="list-style-type: none"> Confusion (new) Urea >7mmol/L Respiratory rate ≥30/min Low Blood pressure (systolic <90mmHg or diastolic ≤60mmHg) Age ≥65 years
Hospital Acquired Pneumonia	<ul style="list-style-type: none"> Sputum samples and blood cultures to be taken prior to treatment of hospital acquired pneumonia. Antibiotic treatment should be started as soon as possible after establishing a diagnosis of hospital-acquired pneumonia, and certainly within 4 hours. Do not delay antibiotic treatment, and when microbiological results are available review the choice of antibiotic(s) and change the antibiotic(s) according to the results, using a narrower-spectrum antibiotic, if appropriate. 	Recommendations Pneumonia (hospital-acquired): antimicrobial prescribing Guidance NICE
Bacterial Vaginosis	<p>Take a high vaginal swab (or use a self-taken low vaginal swab) for Gram staining and to exclude other causes of symptoms from all women of reproductive age with vaginal discharge if:</p> <ul style="list-style-type: none"> The woman is postnatal or post miscarriage, pre or post gynaecological surgery, or pre or post termination of pregnancy. 	Bacterial vaginosis Health topics A to Z CKS NICE

	<ul style="list-style-type: none"> • The woman has vaginitis without discharge. • Symptoms are not characteristic of BV. • Symptoms are recurrent (four or more cases a year). • It is within 3 weeks of intrauterine contraceptive insertion. • Previous treatments have failed. 	
Helicobacter pylori Infection (<i>H. Pylori</i>)	<p>The presence of <i>H. pylori</i> should usually be confirmed before starting eradication treatment. Patients that should be tested for <i>H.pylori</i> include:</p> <ul style="list-style-type: none"> • Patients with uncomplicated dyspepsia unresponsive to lifestyle change and antacids, following a single one month course of proton pump inhibitor (PPI), without alarm symptoms. • Patients with a history of gastric or duodenal ulcer/bleed who have not previously been tested. • Patients before taking NSAIDs, if they have a prior history of gastro-duodenal ulcers/bleeds. • Patients with unexplained iron-deficiency anaemia, after negative endoscopic investigation has excluded gastric and colonic malignancy, and investigations have been carried out for other causes, including: cancer; idiopathic thrombocytopenic purpura; vitamin B12 deficiency <p>However empirical eradication maybe required for high risk patients such as those with an acute gastrointestinal bleed associated a duodenal ulcer (not on a NSAID).</p> <p>Testing for <i>H.pylori</i> can be conducted at STH via a stool</p>	<p>From NICE BNF treatment summaries: Helicobacter pylori infection Available at Helicobacter pylori infection Treatment summaries BNF NICE</p> <p>Sheffield Teaching Hospital H. Pylori guidance</p>

	<p>antigen test, serology or endoscopy based biopsy via urease (CLO) tests. Prior to testing, the following washout periods are recommended if the patient is taking any of the following:</p> <ul style="list-style-type: none"> • PPIs- 2 weeks • Bismuth or antibiotics - 4 weeks • H2-receptor antagonists – 48 hours 	
<p>MRSA</p>	<p>These patients should be assessed upon admission and offered screening within 48hrs:</p> <ul style="list-style-type: none"> • All those admitted to mental health inpatient units or care homes following surgical procedures • Transfers from another hospitals including A+E • Individuals transferred from residential or nursing care homes • Intravenous drug users • Those who self harm by breaking the skin • People with a possible diagnosis of delirium • People with chronic wounds. e.g. leg ulcers, • People with indwelling devices such as urinary catheters, PEG etc... • People who are previously known to be MRSA positive <p>Full MRSA Screen consists of:</p> <ul style="list-style-type: none"> • Nose • Groin OR perineum • Invasive devices e.g. catheters, tracheotomy, PEG's 	<p>As Per SHSC MRSA Guidance</p>

	<ul style="list-style-type: none"> • All broken/ compromised skin areas • pressure ulcers • surgical wounds • eczema, psoriasis, dermatitis • cuts and abrasions • tracheostomy sites • Urinary catheter exit site – only if producing exudates • Catheter Specimen Urine – if catheterised (suprapubic & urinary) • Sputum – if patient has a productive cough <p>NB: Axilla and throat swabs are NOT required for routine MRSA screening</p>	
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Infections typically seen at SHSC in which samples are not typically required include:

- Acne – Follow recommendations from dermatology
- Dental Abscesses
 - Antibiotics are generally not indicated for otherwise healthy people at low risk of complications when there are no signs of spreading infection. In the absence of immediate attention by a dentist, only prescribe an antibiotic:
 - For people who are systemically unwell or if there are signs of severe infection (for example fever, lymphadenopathy, cellulitis, diffuse swelling).
 - For high-risk individuals to reduce the risk of complications (for example people who are immunocompromised or have diabetes).
- Conjunctivitis