**Management of Meticillin resistant *Staphylococcus aureus* (MRSA)**

<table>
<thead>
<tr>
<th>Statement of Intent</th>
<th>To provide healthcare staff with clear guidelines for the effective prevention, management and containment of meticillin-resistant <em>staphylococcus aureus</em> (MRSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document number</td>
<td>IPC10</td>
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<td>3.0</td>
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<tr>
<td>Author</td>
<td>Infection Prevention and Control team</td>
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<td>Owner</td>
<td>Infection Prevention and Control team</td>
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<tr>
<td>Approved by</td>
<td>Infection Control Lead</td>
</tr>
<tr>
<td>Date approved</td>
<td>March 2016</td>
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<td>Quality Safety &amp; Performance Unit</td>
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<td>Expiry date</td>
<td>26/03/2018</td>
</tr>
<tr>
<td>Related policies</td>
<td>Infection Prevention and Control Policy and associated procedures</td>
</tr>
<tr>
<td>Applies to</td>
<td>SBC Children, Families and Community Health Staff</td>
</tr>
<tr>
<td>Care Quality Commission Essential Standards of Quality &amp; Safety</td>
<td>Regulation 12 (Outcome 8) Cleanliness and infection control</td>
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**Equality & Diversity**

SBC is committed to promoting equality in all its responsibilities - as a provider of services, as a partner in the local economy and as an employer. This policy will contribute to ensuring that all clients, potential clients and employees are treated fairly and respectfully with regard to the protected characteristics of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
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<th>Page Number</th>
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<td>16</td>
</tr>
<tr>
<td>infected</td>
<td></td>
</tr>
</tbody>
</table>
1.0 Introduction

*Staphylococcus aureus* is a bacterium usually found on human skin, particularly in the anterior nares (nose), axilla (armpit) and perineum (groin). It is found on the skin of approximately 30% of the population.

*Staphylococcus aureus* which is resistant to the *beta* lactam class of antibiotics is referred to as meticillin-resistant *staphylococcus aureus* or MRSA. Meticillin resistance indicates it is resistant to all penicillins and cephalosporins. It is transmitted in the same way as and causes the same infections as other strains of *S.aureus*.

Most healthy people are unaffected by MRSA and it causes no clinical changes, however, it does have the potential to cause infection in those with severely weakened immune systems. As this bacterium has developed resistance to commonly used antibiotics it makes infections caused by MRSA more difficult and costly to treat. Recent trends towards early discharge, short inpatient stays, day surgery, minor surgery in community settings and the provision of parenteral therapy at home means that infections such as MRSA are becoming increasingly common in the community and every effort should be made to prevent their spread.

2.0 Definitions

Colonisation

Colonisation is when the organism lives harmlessly on the body with no ill effects. It may often live in the nose, axilla or groin and most people who are colonised do not go on to develop infection.

Clinical Infection

MRSA infections usually occur in vulnerable patients/residents and can come from the patient’s own resident MRSA (if they are colonised) or by cross infection from another person. Clinical infection will be indicated by two or more of the following being present:

- inflammation
- pus
- pyrexia
- pain
- swelling

Many infections seen within the community are localised wound infections which can often be treated topically using the correct choice of dressing. (refer to patient information leaflet - Advice for those affected by MRSA outside of hospital. Available at [http://www.cleansafecare.nhs.uk/ArticleFiles/Events/MRSA_Advice.pdf](http://www.cleansafecare.nhs.uk/ArticleFiles/Events/MRSA_Advice.pdf))

MRSA bacteraemia

MRSA bacteraemia is the presence of MRSA in the blood and is formally monitored by the Department of Health. All NHS trusts are required to report cases of MRSA bacteraemias via mandatory reporting systems.
PVL-associated Staphylococcus aureus

Panton Valentine Leukocidin (PVL) is a toxic substance produced by some strains of Staphylococcus aureus, which is associated with an increased ability to cause disease.

The incidence of PVL is low at present.

PVL can be produced by both meticillin sensitive and meticillin resistant strains of S. aureus. At present in the UK the majority of isolates are meticillin sensitive.

The infection control measures used to prevent the spread of PVL-positive MRSA are the same as for any type of MRSA infection; this includes screening and the decolonisation regime.

Necrotising pneumonia - has a mortality rate of 75% (McGrath et al 2008). PVL MRSA affects healthy children and young adults and is usually community acquired. Staff should wear face masks during intubation and chest physiotherapy. Closed suction should be used.

3.0 General Principles

It is important to remember that service users may unknowingly be carriers of MRSA; therefore consistent, sound infection control practice is essential to prevent the transmission of MRSA.

The basic principles of infection prevention and control should always be applied when carrying out direct service user care and include:

- Application of Standard Infection Control Precautions
- Rational use of antibiotics and compliance with antibiotic guidelines and policies
- Ensuring clinical and care staff are appropriately trained, receiving yearly infection prevention and control updates
- Advise other healthcare providers before transfer of service users MRSA status

4.0 Control of MRSA in the patient’s own home

In general, people who are infected or colonised with MRSA who live in their own home should be encouraged to lead a normal life. Both they and their partner or close household contacts should be given common sense advice about the importance of good personal hygiene and keeping their home environment clean (refer to patient information leaflet Advice for those affected by MRSA outside of hospital. Available at http://www.cleansafecare.nhs.uk/ArticleFiles/Events/MRSA_Advice.pdf)

People with clinical signs of infection should be assessed by their GP or community nursing team and managed accordingly.
Routine swabbing to determine if MRSA is present in a wound is not advocated. In exceptional circumstances it may be necessary to screen and treat the service user and other close family members following a risk assessment (see appendix 1) or prior to planned healthcare intervention. Advice can be sought from Infection Control team when:

- there are close family members living in the same household with specific risk factors
- relatives and carers are concerned and request screening

6.0 Management of MRSA within a Health Centre setting

It is important to remember that many patients visiting the health centre may be unknowingly colonised or infected with MRSA. However, by ensuring staff adhere to the basic principles of infection prevention and control, prevention of cross contamination can be achieved. This would include:

- Ensuring standard precautions and hand hygiene are followed consistently
- Ensuring general reusable equipment that has been in direct contact with the patient has been cleaned using general purpose detergent or detergent wipes and dried thoroughly (e.g. BP cuffs, couches)
- Ensuring all reusable surgical or medical devices have been decontaminated appropriately in accordance with decontamination procedure and manufacturers instructions
- Where possible/practical it is a sensible precaution to arrange appointment times of service users known to have an infection or other risk factors for transmission, i.e. eczema or psoriasis, at the end of a clinic session

7.0 MRSA Screening

MRSA screening and decolonisation regimes are not routinely carried out within the community setting, there are, however, some circumstances where, following risk assessment, this may be advised by IP&CT (see appendix 1) or if the service user is to be admitted into hospital for planned surgery.

For service users undergoing MRSA screening it is important to identify the sites to be screened. Service users with no risks will have a nose swab only. Any service users identified as high risk will have a full MRSA screen taken. The screening of service users will identify MRSA carriers either before or on admission. This will allow measures to be put into place to reduce the risk of infection for these service users and to other vulnerable service user within inpatient units. All service users will be provided with a patient information leaflet giving details about the screening. Staff must use a yellow MRSA screening form for admission screens.

Where a full MRSA screen is advocated, the following should be carried out:

- nose swab (1 swab should be used to screen both nostrils)
- perineal or groin swab

and the following if applicable:

- wound swabs
- invasive device sites e.g. PEG site
- urine, if urethral catheter in situ
- penile swab if male patient with urethral catheter in situ
- sputum if expectorating
- umbilicus (in neonates only)
- any other broken areas to the skin e.g. pressure ulcers/open lesions

The following groups may not be routinely screened as per Department of Health Operational Guidance
- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Children/paediatrics unless already in a high risk group
- Maternity/obstetrics except for elective caesareans and any high risk cases

Service users with positive MRSA screens will be referred to their GP who will prescribe the appropriate decolonisation regime.

Children/paediatrics are not screened unless in a high risk group (see appendix 1)

8.1 Request forms:
- Use a single request form for all MRSA screening swabs for an individual service user.
- Each swab taken must be appropriately labelled as to where it has been taken from e.g. nose, leg ulcer - left leg
- Request an ‘MRSA Screen’ on the form
- State reason for obtaining the MRSA screen in the box headed ‘clinical details’

9.0 MRSA Infection

Many infections seen are localised wound infections which can often be treated topically using the correct choice of dressing.

The recommended treatment for clinically indicated infections comprises:
- appropriate wound care (see appendix 5)
- appropriate, timely use of prescribed antibiotic therapy
- GP/medical staff must check microbiology results for sensitivities

Service users who are suffering from clinical infection with MRSA may require antibiotic therapy, dependant on individual risk factors and clinical symptoms. Treatment with oral or IV antibiotics should be determined by the service users GP/ Medical Clinician (advice from the microbiologist may need to be sought).

Treatment of MRSA infection with either antibiotics or topical dressings will not necessarily fully eradicate the organism from the patients/residents skin, throat and other carriage sites. To reduce persistent MRSA carriage, treat underlying skin conditions (e.g. eczema,
dermatitis), remove and/or replace invasive devices and treat skin breaks. No further swabs are necessary once healing is achieved and if not clinically indicated.

11.0 Treatment for MRSA carriage

Although routine screening and decolonisation is not Normally recommended for service users in the community, there are some circumstances where following risk assessment or prior to planned healthcare intervention this may be advised by IP&CT.

The recommended treatment for those who require decolonisation prior to planned healthcare intervention comprises:

- Apply five days nasal Mupirocin (if sensitive) and subject to availability. Alternative nasal MRSA treatments include Naseptin
- Five days 4% Chlorhexidine gluconate or Octenisan solution skin disinfection

The MRSA Treatment programme leaflet for outpatients should be given prior to the start of treatment.

12.0 Pregnancy and Infants

Service users identified with MRSA colonisation during pregnancy can follow a five day course using 4% Chlorhexidine Gluconate or Octenisan. If further screens continue to show MRSA colonisation advice will be given by IP&C.

Octenisan for skin disinfection solution is suitable for use on babies and premature infants (Manufacturers instructions must be followed).

13.0 Clearance of MRSA

If a prescribed decolonisation regime is necessary, a maximum of two attempts at MRSA clearance is advised.

If MRSA is detected from any of the three clearance screens, a second attempt at clearance is advised as above. A further three clearance screens should be obtained after the second course of treatment. If the patient remains MRSA positive, the notes will remain flagged and the patient managed accordingly.

Three full negative MRSA screens need to be obtained for service users requiring planned orthopaedic admission to hospital (see appendix 4). The first screen should be obtained at least 48 hours after the patient has stopped antibiotic treatment / decolonisation. Screens 2 and 3 should then be obtained at least four days apart.

If MRSA is detected from any of the three clearance screens, a second attempt at clearance is advised as above. A further three clearance screens should be obtained after the second course of treatment. If the service user remains MRSA positive, the hospital notes will remain flagged and Chlorhexidine or Octenisan skin washes will continue to be applied to suppress colonisation whilst the service user is placed within the hospital setting.

Any day surgery patient or any other elective surgery patient who has MRSA detected from their preadmission screen will be sent a letter by the GWH IP&C team requesting they obtain a prescription from their GP for mupirocin and 4% Chlorhexidine Gluconate. Instructions for
their use will be included. This treatment should be commenced just before admission. A letter will also be faxed to the GP asking them to provide the appropriate prescription.

When the service user is admitted for planned surgery, staff should check that the patient has followed the instructions to start the MRSA regime before their admission.

14.0 Management of Staff

Staff with chronic skin lesions or any conditions which affect the integrity of the skin e.g. eczema or psoriasis, will be assessed by the Occupational Health Department at the time of employment and risks will be managed appropriately.

Routine screening of staff is not recommended. **All staff should practice good hygiene at all times**, this is important to prevent the spread of all infections not just MRSA. Staff should cover cuts and grazes with a waterproof dressing before commencing work and should follow the infection control guidelines outlined within this document and in line with SBC policy and procedures.

Any staff experiencing exacerbation of conditions, such as eczema or psoriasis, should seek advice, in conjunction with the staff member’s General Practitioner or Occupational Health Department.

15.0 Responsibilities

Registered Managers and service managers are responsible for ensuring staff are aware of this procedure and compliant with all aspects.

Managers are also responsible for ensuring staff have adequate supplies of equipment particularly consumables to ensure compliance with this policy.

MRSA bacteraemias are reported to the Health Protection Agency (HPA). The HPA provide national annual reports benchmarking regions and Trusts throughout England.

19.0 Training

Formal education supporting the MRSA procedure, including screening is provided by the IP&C team mandatory training sessions and the infection control link network (ICLN). Link workers are responsible for ensuring the information and knowledge received is cascaded to health and social care workers within their area of responsibility. Responsibility for the provision of appropriate facilities and compliance with the MRSA procedure lies with the service managers within each directorate.

20.0 Monitoring framework

Auditing compliance with the MRSA procedure is a joint responsibility between all clinical staff and the IP&C team. Actions and recommendations arising from the audits will be collated by the Infection Control team and used to inform all clinical staff, and the organisation.
References


6. Screening FAQ - Department of Health February 2009
Appendix 1

Risk Assessments

For service users within the Community: On rare occasions, if a service user is already known to be MRSA positive within the community setting, further screens and skin decolonisation treatment may be required if it was felt to be beneficial to their health and well-being. Yes to any of the statements in the table below indicates the need for further investigation.

<table>
<thead>
<tr>
<th>Service users known to have MRSA positive status:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is service user immuno-compromised or have an underlying chronic medical condition?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does service user have a surgical wound?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does service user have a peripheral or central IV line present?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does service user have a chronic skin condition such as eczema or psoriasis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is service user concerned and requesting an MRSA screen?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Very rarely, close household contacts of known MRSA carriers may require MRSA screens dependent on whether they also have risk factors present. In this instance always seek advice from the Infection Prevention and Control Team.
Appendix 2

**MRSA Decolonisation Regime**

- The MRSA skin disinfection regime must be documented within the service user’s records as part of the service users plan of care.
- Nasal carriage - apply nasal mupirocin three times daily for 5 days. **NB**: this needs to be prescribed. Nasal naseptin (10 days) is a suitable alternative if mupirocin resistance is evident or mupirocin is unavailable.
- 4% Chlorhexidine should be used for bathing or showering and applied at least daily. Octenisan solution may also be used.

1. Wet skin. Apply approximately 30mls of Octenisan or Chlorhexidine 4% directly onto wet skin using the hands or disposable cloth.

2. Use the Octenisan or chlorhexidine as a liquid soap and shampoo. Wash from head to toe. Wash vigorously, paying particular attention to the following areas:
   - Hair
   - Around and just inside the nostrils
   - Under the arms
   - Between the legs and perineal area
   - In skin creases e.g. under breasts

**NB** Octenisan should be in contact with the skin for about **3 minutes**.

3. Rinse from head to toe.

4. Dry intact skin using a clean towel.

5. Continue skin disinfection regime for five days.

An MRSA clearance screen should be obtained 48 hours after the decolonisation regime and **all antibiotics** have been stopped. Three screens are required with a minimum of four days between each screen for those patients being admitted to hospital.

**NB**: Should any of the swabs from the post decolonisation screens prove to be positive, repeat the full MRSA decolonisation regime once more and obtain clearance screens as above.

**Seek advice from Infection Prevention and Control Team** should further positive swabs be obtained following completion of a second course of treatment.
Appendix 3

MRSA Treatment Algorithm for service users known to be MRSA positive within the Community Setting

MRSA isolated

Emphasise good hygienic practices (good standard of hand hygiene, general hygiene and home cleanliness)

Is service user being admitted to hospital for planned surgery?

No

Carry out risk assessment of service user as set out in appendix 1. Are further screens or a decolonisation regime necessary?

Yes

Obtain full MRSA screening swabs (section 8.0):

- nose swab (1 swab for both nostrils)
- perineal swab
- wound swabs
- invasive device sites e.g. PEG site
- urine, if urethral catheter in situ
- penile swab if male patient with urethral catheter in situ
- sputum if expectorating

No repeat swabs are necessary unless clinically indicated

Where clinically indicated, treat any chronic wounds with appropriate dressing. See appendix 5

If signs of systemic infection are present, ensure timely antibiotics are prescribed. Check results and antibiotic guidelines for selection of appropriate antibiotic

Use prescribed MRSA decolonisation regime for 5 days and follow advice set out in appendix 2

Yes

Service user to undergo further MRSA screening at Cherwell Pre-assessment Centre, GWH

Decolonisation treatment to be prescribed and monitored by GP as per appendix 4
Appendix 4  MRSA Algorithm for all service users requiring planned health care intervention (see section 8.0 for exempt groups)

Patient seen at pre-operative clerking at GWH Initial swabs taken

Patient MRSA +ve

GWH fax patient details to GP practice and Infection Control Nurse

Prescription is prepared by GP and collected by patient Patient advised as per treatment policy

See MRSA Policy appendix 3 for treatment protocol

GP LES starts

Orthopaedic surgery

All other planned surgery

Patient commences treatment and makes appt for days 7, 11 and 15

Patient returns to GP Practice after 7 days for first swab to be taken

Results received after 4 days

MRSA +ve Patient receives prescription 2 and recommences treatment from the beginning

See PCT MRSA Policy appendix 3 for repeat treatment protocol and repeat treatment

MRSA +ve

Contact Infection Control Nurse Tel: 01793 465509

MRSA -ve Repeat swabs at days 11 and 15

After 3 sets of negative swabs, re-refer to GWH Cherwell Unit 01793 646010

Planned surgery patients commence treatment 4-5 days before admission.
No further treatment necessary

Modified March 2010

Claims for payment must be made date prescription signed.
See claim form for details
### Appendix 5  Wound care colonisation/critical colonisation and infected

<table>
<thead>
<tr>
<th>Wound type</th>
<th>Aim of Treatment</th>
<th>Exudate level</th>
<th>Flat/Cavity Wound</th>
<th>Secondary dressing</th>
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<tbody>
<tr>
<td><strong>NECROTIC (NON ISCHAEMIC)</strong></td>
<td>Rehydrate &amp; Debride; Protect peri-skin</td>
<td>NONE</td>
<td>Honey; Activon Tulle</td>
<td>Wool pad Tape</td>
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<tr>
<td></td>
<td><strong>Sloughy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deslough; Debride; Manage exudates; Protect peri-skin</td>
<td>HIGH</td>
<td>Aquacel, Silver Alginate</td>
<td>FOAM e.g. Biatain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MODERATE</td>
<td>Acteion Honey</td>
<td>NIL-LOW Exudate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LOW-NIL</td>
<td>Actilite</td>
<td>ACTIVHEAL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ODOUR</td>
<td>Clinisorb over non-adherent wound dressing</td>
<td>LOW-MOD Exudate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PROTECTION</td>
<td>e.g. atrauman; Carboflex can go directly</td>
<td>MOD-HIGH Exudate</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>onto wound bed.</td>
<td>BIATAIN</td>
</tr>
<tr>
<td></td>
<td><strong>CLINICAL SIGNS OF INFECTION</strong></td>
<td>HIGH</td>
<td>Honey and Aquacel, Silver alginate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduce Infection/Odour; Manage exudates; Protect peri-skin</td>
<td>MODERATE</td>
<td>Honey and aquacel Acticoat absorbent for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>LOW-NIL</td>
<td>spreading infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ODOUR</td>
<td>Clinisorb over non-adherent wound dressing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PROTECTION</td>
<td>e.g. atrauman; Carboflex can go directly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>onto wound bed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Clean/Granulating</strong></td>
<td>HIGH</td>
<td>Physiotuille Ag</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promote Granulation; Maintain moist environment; Protect new tissue</td>
<td>MODERATE</td>
<td>Actilite (Honey mesh)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>LOW-NIL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PROTECTION</td>
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<td></td>
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<td></td>
<td><strong>Re-epithelising</strong></td>
<td>LOW-NIL</td>
<td>Physiotuille Ag, Actilite (Honey mesh)</td>
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<tr>
<td></td>
<td>Protect new tissue; Allow maturation</td>
<td></td>
<td>Atrauman Ag</td>
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</tbody>
</table>

Ischaemic digits etc. - use Inadine if moist. Consider using Prontosan solution and Prontosan gel for cleansing

Diabetic feet - refer to Lead Diabetic Podiatrist - Mon/Wed/Thurs 01793 428511/428539 and Tues/Fri 017903 6043900

**THE CHOICE OF ADHESIVE/NON-ADHESIVE FOAM WILL BE DEPENDANT UPON THE PATIENTS SKIN INTEGRITY**