



HPA/BPSU Study of Bacteraemia Caused By Methicillin-resistant *Staphylococcus aureus* (MRSA)

BPSU Reference:

Case definition: Isolation of methicillin-resistant *Staphylococcus aureus* (MRSA) from blood cultures of children less than 16 years of age

Questionnaire Completed by: _____

Date Completed: _____

Consultant Responsible for the Reported Case: _____

Telephone Number: _____

Email: _____

1.0 Patient Details

- 1.1 Date of birth (dd/mm/yy) / / 1.2 Sex (please circle) **M** **F**
- 1.3 Patient hospital number: _____
- 1.4 For neonatal patients, please give best estimate of gestational age at birth: (in weeks) _____

2.0 Patient Ethnicity (Please tick relevant box)

- | | | | | | |
|-----------------|---|--------------------------|-----------------|---|--------------------------|
| Black Caribbean | 1 | <input type="checkbox"/> | Chinese | 6 | <input type="checkbox"/> |
| Indian | 2 | <input type="checkbox"/> | Black other | 7 | <input type="checkbox"/> |
| White | 3 | <input type="checkbox"/> | Bangladeshi | 8 | <input type="checkbox"/> |
| Black African | 4 | <input type="checkbox"/> | Other (specify) | 9 | <input type="checkbox"/> |
| Pakistani | 5 | <input type="checkbox"/> | | | |

Thank you for taking the time to fill in this questionnaire. When finished, please return it in the pre-paid envelope (even if you cannot complete all the sections) to:

**The Paediatric MRSA Bacteraemia Study Co-ordinator,
Dept of Healthcare-Associated Infection & Antimicrobial Resistance
Communicable Disease Surveillance Centre,
Health Protection Agency Centre For Infections
London NW9 5EQ**

BPSU Reference:

3.0 Details of MRSA Bacteraemia Episode

3.1 Date of **first** MRSA-positive blood culture **after** 01/06/2005? ___/___/___

3.2 Date of subsequent MRSA-positive blood cultures: (dd/mm/yy)
1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___

3.3 Was MRSA isolated from other samples from this patient in the week prior to, or on the same day as MRSA was first isolated from blood? (Please tick relevant box) **Yes** **No**

If "Yes", please specify sample types and dates collected from patient.

	<u>Sample Type</u>	<u>Date Collected</u>
1.	_____	___/___/___
2.	_____	___/___/___
3.	_____	___/___/___

3.4 Which of the following clinical signs were present on the date of the first MRSA-positive blood culture? (Please tick relevant box) **Yes** **No** **Not Known**

Fever (skin temperature $\geq 38^{\circ}\text{C}$)

Sepsis Syndrome

3.5 If 'Yes' for Sepsis Syndrome, did the patient have:
Tachycardia
Hypotension
Tachypnoea

4.0 Invasive Procedures

4.1 Did the patient undergo any of the following invasive procedure(s) during the week prior to the first MRSA-positive blood culture? (Please tick relevant box) **Yes** **No** **Not Known**

Vascular/ Cardiac Catheterisation
Surgery
Endoscopy
Other

If "Other", please specify: _____

4.2 Did the patient have a central venous line at the time of **first** MRSA bacteraemia? **Yes** **No** **Not Known**

If "Yes", was MRSA isolated from the line?

BPSU Reference:

5.0 Details of Hospitalisation

5.1 Name of hospital: _____

5.2 Date of admission (dd/mm/yy): ____/____/____

5.3 Patient's primary diagnosis: _____

5.4 Reason for hospital admission when MRSA bacteraemia first occurred:

5.5 Where was the patient admitted to your hospital from?
(Please tick relevant box)

	Yes	No	Not Known
Family home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other UK hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital abroad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (e.g. Residential home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "Other", please give details: _____

5.6 If admitted from home, had the patient been an in-patient within the last 3 months at;
(Please tick relevant box)

	Yes	No	Not Known
Your hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.0 Ward/ Unit Details

6.1 On which ward was the patient based at the time of the first MRSA positive blood culture was taken?
(Please tick relevant box)

Post-natal ward	<input type="checkbox"/>	SCBU/NICU	<input type="checkbox"/>
General paediatric medical	<input type="checkbox"/>	Paediatric surgical	<input type="checkbox"/>
Specialist paediatric medical	<input type="checkbox"/>	PICU	<input type="checkbox"/>
Other	<input type="checkbox"/>		

If "Other" or "Specialist paediatric medical" ward, please define:

6.2 Was the patient transferred there from another ward or unit within the same hospital?

	Yes	No	Not Known
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes", specify the unit and date of transfer:
Unit: _____ Transfer Date: (dd/mm/yy): ____/____/____

BPSU Reference:

7.0 Management of MRSA Bacteraemia

7.1 Please provide details of antibiotic treatment given for the first episode of MRSA bacteraemia:

	Antibiotic Given	Date Started	Duration of Treatment	Route of Administration
1.	_____	___/___/___	_____	_____
2.	_____	___/___/___	_____	_____
3.	_____	___/___/___	_____	_____

7.2 Was the patient already receiving antibiotic(s) at the onset of MRSA bacteraemia? Yes No Not Known

If "Yes", please specify the antibiotic(s) together with data and duration.

	Antibiotic Given	Date Started	Duration of Treatment	Route of Administration
1.	_____	___/___/___	_____	_____
2.	_____	___/___/___	_____	_____
3.	_____	___/___/___	_____	_____

8.0 Clinical Evidence

8.1 Was there any clinical evidence of the following at the time that the first positive MRSA blood culture was taken? (please tick relevant box and provide available information) Yes No Not Known

Lower respiratory tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin or soft tissue infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgical site or wound infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intra-abdominal infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mechanical ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total parenteral nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neutropaenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.2 Please give details of clinical evidence here:

