Unit 4

Infection Prevention & Control
Hand Hygiene, Safe handling of Sharps and Inoculation Incidents
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As part of the requirements of Clinical Governance, new staff must receive information about Infection Prevention and Control (IPC) during their induction. Thereafter, all staff must receive an annual update. This section of the workbook has been designed by the IPC team to enable staff to undertake mandatory annual IPC update training on a self-directed learning basis.

The focus of this training is on Standard Infection Prevention and Control Precautions. It is designed to enhance and develop your knowledge of Standard Precautions in order to facilitate safe, effective, Infection Prevention and Control practice.

The following topics are covered in this section:
- The Chain of Infection
- Standard Precautions (Hand hygiene and sharps safety)
- Staphylococcus Aureus/Meticillin Resistant Staphylococcus Aureus (MRSA)
- Clostridium difficile
- ESBL producing bacteria
- Norovirus

In addition, references will be made to Blackpool, Teaching Hospitals IPC policies and procedures to guide your learning and practice

THE CHAIN OF INFECTION
Transmission of infection is considered to be a cycle, commonly referred to as 'The chain of infection'. In order to prevent the transmission of infection it is necessary to break the chain.

![Chain of Infection Diagram](image-url)
Infectious agent (Pathogen)
This is any micro-organism that causes infection such as MRSA, Clostridium difficile or influenza.

Reservoirs
This could be a colonised or infected person, or contaminated equipment or environment.

Portal of exit
This is how the micro-organisms leave the reservoir. For example body fluids and respiratory secretions.

Mode of transmission
Contaminated hands are the most common way in which microorganisms are spread but there are other modes such as coughing, sneezing and diarrhoea.

Portal of entry
These infectious agents need a way to enter the body such as ingestion, inhalation and inoculation. Any indwelling device such as a urinary catheter or cannula also allows pathogens to enter the body.

Susceptible host
Reduced immunity through chemotherapy or antibiotics can make some patients more vulnerable to infection. The elderly and the very young are also particularly susceptible.

How do you break the chain?
Standard Precautions apply to all patients and clients at all times. You are personally responsible for implementing standard precautions in your personal practice to reduce the risk of infection to yourself, your colleagues and your patients and clients.

Standard Precautions
Standard Precautions are the basic principles of Infection Prevention and Control that should underpin safe practice, in order to protect both staff and patients/clients from infection. They include:

• Hand Hygiene
• The wearing of Personal Protective Equipment (PPE)
• Safe use and disposal of sharps
• Decontamination of equipment and maintaining a clean environment
• Waste management

HAND HYGIENE
Effective hand hygiene is the single most effective method of preventing the spread of infection.

Hand hygiene includes: -
• Hand washing with soap and water;
  After dealing with body fluids or after being in contact with patients with Clostridium Difficile or diarrhoea and vomiting
• Use of alcohol hand rubs and gels;
  When hands are free of dirt or organic material
• A trust approved wipe when the above is unavailable or inappropriate
Micro-organisms are commonly found on the skin and can be described as:

**Resident flora**
Normal flora or ‘commensal organisms’, form part of the body’s, normal defence mechanisms, and protect the skin from invasion by more harmful micro-organisms. They rarely cause disease and are of minor significance in routine clinical situations.

**Transient flora**
Those acquired by touch from the environment through contact with patients, equipment and patient furniture. They are located superficially on the skin, readily transmitted to the next thing being touched. They are responsible for the majority of healthcare associated infections but are easily removed by hand washing.

**Hands should be decontaminated:**
- Before commencing work/after leaving clinical area
- Before and after direct contact with patients or clients
- After touching patient’s or client’s surroundings
- Before and after wearing gloves
- Before performing aseptic procedures, e.g. catheterisation, wound dressings
- After risk of exposure to body fluids (and after aseptic procedures)
- Before and after handling invasive devices
- Before and after handling food
- After using the toilet
- After leaving patient or client’s environment e.g. domestic setting

Studies show that health care staff frequently use poor hand washing techniques and the most commonly neglected areas are the tips of the fingers, palm of the hand, and the thumb. It is important that hand washing is carried out correctly to prevent the spread of infection. The Trust endorses the World Health Organisation 5 Moments for hand hygiene and a ‘bare below the elbows’ rule for all staff that are in contact with patients or equipment within the patient zone.

Areas of hands most frequently missed during hand washing

The Trust endorses the World Health Organisation 5 Moments for hand hygiene and a ‘bare below the elbows’ rule for all staff that are in contact with patients or equipment within the patient zone.
The patient zone; My 5 Moments for Hand Hygiene;

For the Trust’s Hand Hygiene Policy and Procedure follow
http://fcsharepoint/trustdocuments/Pages/default.aspx CORP-PROC-418 CORP-POL-056

**Personal Protective Equipment**

**ALL PPE IS SINGLE USE ONLY**
The selection of PPE must be based on a risk assessment of the risk of transmission of microorganisms to the patient, and the risk of contamination of the healthcare worker’s clothing and skin by patients’ blood, body secretions, or excretions.

**The aim of wearing PPE is:**
- To protect the Health Care Worker from occupational exposure to blood and body fluids.
- To protect patients/clients from infection

**Gloves** must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions or to sharp or contaminated instruments.

**Gowns and Plastic Aprons**
The aim of wearing either a fluid repellent apron or gown is to protect the healthcare workers’ clothing/uniform from contamination with microorganisms, blood and body fluids, secretions and excretions, and protect the patient from microorganisms.

**Eye Protection (Visors and Goggles)**
The aim of wearing eye protection is to prevent contamination or potential exposure to blood, body fluids, secretions and excretions, and chemicals.

**Face Masks**
Surgical face masks protect the wearers’ nose and mouth from exposure to blood, body fluids, secretions and excretions.

**Respiratory protective equipment** e.g. a particulate mask (FFP3) must be used when clinically indicated (to protect the wearer from inhaling airborne pathogens such as TB or influenza). (NB FFP 3 masks must only be used after a risk assessment has been undertaken and the user has been ‘fit tested’ and trained in their use).

Please refer to corporate policy 116 for more information.
The following protective clothing must be available to clinical staff, or easily accessed when required:

- Sterile and non-sterile gloves
- Plastic aprons
- Eye protection (goggles)
- Masks/Respirators
- Impervious gowns

(NB FFP 3 masks must only be used after a risk assessment has been undertaken and the user has been ‘fit tested’) For information on PPE follow

**Health care waste Management**

Community healthcare can take many forms and occurs in various environments. It includes activities undertaken by all healthcare workers who provide services outside of hospitals to patients and client’s in their own homes, residents in care homes (without nursing care) and clinics.

Community health care waste may be:

- Infectious waste
- Offensive/hygiene waste
- Cytotoxic/cytostatic medicinal products.

- Health care workers working in the community and the household environment need to assess the waste they are producing for the hazardous properties it may contain. This should be based on, professional assessment, clinical signs and any prior knowledge of the patient/client.
- **Which colour bag should I use?**
Which colour bin should I use?

• Orange – Sharps for incineration or alternative treatment. Marked “Fully Discharged Sharps” for use with fully discharged sharps not contaminated with prescription only medicines (POMs).

• Yellow – Sharps including infectious sharps for incineration only. Marked with “Medicinal Sharps” For use with sharps waste, including those contaminated with medicines other than those which are cytotoxic/cytostatic.

• Purple – sharps which are contaminated with cytotoxic and cytostatic medicines. Marked “Cyto sharps”.


Safe use and disposal of sharps

Sharps injuries occur following a cut or puncture wound to the skin, most often from a needle or other medical sharp. If the sharp is contaminated with blood there is a risk of transmitting infectious agents such as hepatitis B or C and human immunodeficiency virus (HIV)

• Risk assessment
  • Use safety devices where there are clear indications that they are safer to use
  • Do not re-sheath needles
  • Take a sharps bin to the point of use
  • Keep sharps handling to a minimum
  • Never pass sharps directly from hand to hand
  • Used sharps must be discarded into a BS 7320 standard sharps container

• Sharp’s bins;
  • must not be used for any other purpose than the disposal of sharps
  • must not be filled above the fill line
  • must be disposed of when the fill line is reached
  • should be temporarily closed when not in use
  • should be disposed of every 3 months even if not full, by the licensed route in accordance with local policy

For Immediate Guidance on action to take following a needle stick or contamination incident
Follow http://fcsharepoint/trustdocuments/Pages/default.aspx
Needle stick Injuries and Accidents Involving Exposure to Blood and Body Fluids in Staff CORP/PROC/100

Decontamination

Decontamination is the combination of processes, including cleaning, disinfection and sterilisation used to render a reusable item safe for use on patients or handled by staff. Decontamination of reusable medical devices and equipment is an essential procedure and must always be done in accordance with manufacturer’s instructions and current guidelines.
Cleaning is defined as the physical removal of accumulated deposits by washing with a general-purpose detergent (GPD), followed by thorough drying. This process will reduce the numbers of micro-organisms and remove dirt, grease and organic matter.

Disinfection is a process that kills or inactivates organisms but not all bacterial spores.

Sterilisation is the complete removal of all organisms including spores.

This concept is absolute, that is an item of equipment is either sterile or not sterile.

Trust approved wipes (clinell universal sanitising wipes) may be used for most patient equipment as they clean and disinfect.

Alcohol wipes fix organic matter to surfaces and must not be used for routine cleaning of equipment unless specifically recommended by the manufacturers.

Decontamination and reprocessing of equipment

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Cleaning</th>
<th>Medium Risk</th>
<th>Disinfection</th>
<th>High Risk</th>
<th>Sterilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Items in contact with intact skin</td>
<td>• Removal of accumulated deposits, by washing with a cleaning solution or Trust approved wipe. This reduces the number of organisms and removes dirt, grease and organic matter</td>
<td>• Items that do not penetrate the skin but are in contact with mucous membranes or non-intact skin</td>
<td>• Partial removal or destruction of organisms, except spores. This reduces the number of organisms present.</td>
<td>• Items that are in contact with broken skin/mucous membranes or introduced into sterile body sites</td>
<td>• Complete removal or destruction of all organisms including Spores.</td>
</tr>
</tbody>
</table>

Re-usable equipment

• It is vital that re-usable equipment is effectively decontaminated between each patient, (barrier nursed or not), to prevent the transmission of infection.

• Alcohol wipes fix organic matter to surfaces and are not to be used for cleaning patient equipment unless specifically recommended by the manufacturers.

• Clinell universal wipes may be used for cleaning smaller pieces of patient equipment, as they clean and disinfect. This includes equipment used for barrier nursed patients. For larger surface areas, equipment should be cleaned with neutral detergent and warm water then dried. If the patient is barrier nursed, the detergent clean should then be followed by a clean with a 1000ppm chlorine based product. For example Haz tabs.

• Commodes should be cleaned with Clinell universal wipes unless the patient has suspected or confirmed Clostridium difficile in which case Clinell sporicidal wipes should be used.
Waste Management

Waste from healthcare settings may be toxic, hazardous or infectious and therefore needs to be properly segregated, handled, transported and disposed of to ensure that it does not harm staff, patients, the public or the environment.

All staff have a duty of care to ensure that waste is segregated and disposed of correctly.

Staff can facilitate the correct segregation of waste by placing the correct bin in the correct place. For example, place black domestic waste bins next to hand wash sinks for the paper towels. Please also note that yellow clinical waste bins should be used for all waste in barrier rooms.

Types of waste:

• Clinical Waste - Any item contaminated with blood or body fluids including sharps.
• Hazardous Waste - Such as cytotoxic products.
• Domestic Waste - All other items of waste e.g. paper towels, wrapping from dressing packs, newspapers and flowers etc.

LINEN

Used hospital linen may be contaminated with micro-organisms that cause infections. The most important measures to prevent the transfer of these organisms are:

• Careful handling of linen i.e. remove with care/wear protective clothing.
• Decontaminate hands after handling used linen.
• Dispose of linen into a skip at the point of removal.
• Ensure that linen is appropriately segregated and stored prior to collection.
• Ensure linen is laundered in an appropriate facility.
• Staff uniforms can be sent to the laundry in orange canvas bags. Uniforms laundered at home must be washed at 60°C.

Role of the Estates department in preventing infections

The Estates department are responsible for the maintenance & surveillance of the healthcare environment including that of the water supply for pathogenic bacteria. They work closely with Infection Prevention team and together they have established a Water Safety Group to help prevent the transmission of infections to vulnerable patients such as neonates, haematology and critical (augmented) care patients.

To support this work staff in all clinical areas have a responsibility to ensure that all water outlets are run and that this is recorded in the appropriate water flushing log book. This crucially important yet simple task will prevent infections such as Legionella and Pseudomonas. Please refer to your local log book for instructions on how to do this as the flushing regime may differ from area to area.

Isolation Precautions

‘Isolation precautions’ is another term for barrier nursing. It is considered best practice to isolate patients with infections in a single side room with the door closed to form a barrier, (hence the term barrier nursing). Where this poses the risk of physical or emotional harm to a patient, a risk assessment must be carried out and any deviation from best practice must be documented in the patient’s case notes.

Isolation precautions are additional precautions and are recommended for infections or micro organisms transmitted by the following routes:
Airborne
Infections transmitted by the inhalation of micro-organisms on droplet nuclei. These particles are expelled from the respiratory tract and may remain suspended in air for a long time. Isolate patients in single side rooms with the door closed. Limit patient movement. Masks recommended for some procedures. Gloves and aprons should be worn when handling respiratory secretions.

Respiratory droplets
Infections transmitted by contact with respiratory secretions, including particles produced during coughing and sneezing. These particles do not travel far or remain airborne. Many of these infections are also spread by direct contact with infective material. Isolate in a single room with the door closed. Limit patient movement. Wear gloves and aprons. Masks may also be required.

Contact transmission
Infections transmitted by direct contact with patients (e.g. by touching their skin, lesions or nasal secretions). Some micro-organisms may also be able to survive in the immediate environment and be transferred by contact with surfaces or equipment. Isolate in single side rooms preferably or cohort. Limit patient movement. Use gloves and aprons for all contact with the patient and their immediate environment.

Faecal oral route
Some microbes, when ingested, cause gastrointestinal infection which is excreted in faeces. Transmission to another person occurs when these micro-organisms contaminate hands or surfaces, through inadequate hand hygiene, which in turn contaminate the next person’s hands and are then ingested.

Staphylococcus Aureus
The Trust has a comprehensive screening strategy for Staphylococcus aureus and all patients who are MRSA positive, and certain high risk patients that are MSSA positive must be commenced on the Staph aureus Integrated Care Pathway.

Staphylococcus Aureus lives harmlessly on the skin and the nose of about one third of people. Staph aureus can be sensitive (MSSA) or resistant (MRSA) to Meticillin which is an antibiotic used for testing purposes. MRSA is resistant to some of the commonly used antibiotics eg. Flucloxacillin and is therefore often more difficult to treat.

Staph aureus tends to live in the nose, arm pit, groin and wounds of people. It can also be found in the environment in dust and has been found in the community as well as hospitals. Staph aureus usually spreads from person to person by direct skin contact or by contaminated equipment or surfaces. It can ‘hitch a ride’ to the next patient on the hands of health care workers that have not been effectively decontaminated.

People carrying Staph aureus on their skin are said to be colonised, but not infected. If this bacterium is allowed to enter body tissues, it can cause abscesses, boils and local infections. If Staph aureus is allowed to enter the blood steam it can cause septicaemia (blood poisoning). Presence of MRSA in blood cultures is known as MRSA bacteraemia.

CLOSTRIDIUM DIFFICILE
Clostridium difficile is a spore-forming anaerobic toxin-producing bacillus. These spores survive in the environment and are resistant to heat and disinfectants. Clostridium difficile causes a spectrum of clinical syndromes from asymptomatic carriage, to the development of, in severe cases, pseudo membranous colitis. 3% of the general population and 15% of hospital patients are thought to be colonised.
Normal gut flora help limit C. difficile growth. However, when antibiotics disturb the balance of bacteria in the gut, C. difficile can multiply rapidly producing toxins which cause diarrhoea and colitis.

C. difficile has a significant morbidity and mortality rate. It predominantly affects older people and is rare in people under 45.

The following factors increase the risk of developing CDI:

- Elderly patients (>65 years of age)
- Long length of stay in healthcare settings
- Recent use of high risk antibiotics (Co-amoxiclav, Quinolones and 2nd/3rd generation Cephalosporins)
- Recent major surgery (especially gastrointestinal)
- Serious underlying disease or illness
- Immuno-compromising conditions

Symptoms of C. difficile infection (CDI) include mild to severe offensive watery diarrhoea, abdominal pain/tenderness, fever and dehydration.

CDI is spread through direct patient-patient contact via healthcare staff e.g. contaminated hands and through the use of contaminated equipment such as commodes.

Thorough hand washing with soap and water is essential when caring for patients with C. difficile as alcohol hand rub does not effectively kill spores.

Please see Corporate Guideline 092 for more information

ESBL (Extended Spectrum Beta Lactamase)

Some types of bacteria have developed the ability to be resistant to many commonly used antibiotics by producing an enzyme called ESBL. This enzyme blocks the effect of some antibiotics making the bacteria resistant. Not only are they resistant, but ESBL producing bacteria can also pass on this resistance to other species of bacteria.

The types of bacteria that most commonly develop this ability include:

- E. Coli
- Klebsiella
- Proteus
- Pseudomonas
- Enterobacter
- Acinetobacter

These bacteria are known as Gram-negative bacilli. If these bacteria cause an infection, for example, urinary tract infection, pneumonia or surgical wound infection, they can be very difficult to treat as they are resistant to many antibiotics.

Source isolation, environmental cleaning and strict hand hygiene are necessary to prevent the spread of ESBL producing bacteria.

Please see Corporate Guideline 542 for more information
Carbapenemases-producing Enterobacteriaceae (CPE)

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However, these organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. They include species such as Escherichia coli, Klebsiella spp. and Enterobacter spp. Carbapenems are a valuable family of antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae). They include meropenem, ertapenem and imipenem. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. They are made by a small but growing number of Enterobacteriaceae strains. There are different types of carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common.

In the UK, over the last five years, there has been a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

Carbapenem antibiotics are a powerful group of β-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria. Unless we act now, learning from experiences elsewhere across the globe, rapid spread of carbapenem-resistant bacteria has great potential to pose an increasing threat to public health and modern medicine as we know it in the UK.

Therefore patients who have been hospitalised here or abroad in the past 12 months require screening for CPE.

Please refer to Corporate Policy 359 for more information regarding patient screening

NOROVIRUS

Norovirus is also referred to as gastroenteritis, Norwalk and winter vomiting disease. It is a community acquired infection that rapidly spreads through healthcare settings once introduced.

It is highly infectious and the main symptoms are sudden onset of projectile vomiting and diarrhoea.

Alert the IPC team if any patients develop symptoms of unexplained projectile vomiting or if two or more patients and/or staff develop symptoms of D&V.

Wards and/or bays may be closed to admissions and patient movement will be kept to a minimum. Strict isolation, hand hygiene and the use of PPE is necessary to limit the spread.
Unit 4A assessment:
Infection Prevention & Control (Clinical staff only)

Q1. Which of the following is NOT a link in the chain of infection?
(a) Infectious agent
(b) Reservoir
(c) Portal of exit
(d) Antibiotics

Q2. Which of the following is NOT a component of Standard Precautions?
(a) Hand hygiene
(b) Use of personal protective equipment
(c) Audits
(d) Decontamination of equipment

Q3. Which of the following is NOT one of the 5 moments of Hand Hygiene but is still considered good practice?
(a) Before touching patient surroundings
(b) Before patient contact
(c) Before clean or aseptic procedure
(d) After body fluid exposure risk

Q4. “Hands do not need to be decontaminated after removal of gloves.”
(a) True
(b) False

Q5. Which area of the hands is most commonly missed during hand washing?
(a) Palms
(b) Thumbs
(c) Fingers
(d) all of the above

Q6. “Staff are required to wear surgical face masks only when performing aerosol generating procedures on patients who have flu.”
(a) True
(b) False

Q7. When should sharps bins be disposed of, even if not full?
(a) After 3 months
(b) After 6 months
(c) After 12 months
(d) There is no requirement on the amount of time bins are left open for use if they have not reached their fill-line.

Q8. Which is the correct sharps bin/container for the disposal of medicinally-contaminated sharps that are NOT cytotoxic/cytostatic?
(a) Orange-lidded
(b) Yellow-lidded
(c) Blue-lidded
(d) Purple-lidded
Q9. What would your immediate response NOT be to a needle stick injury to a finger?
(a) Wash it under running water
(b) Encourage it to bleed
(c) Suck it.
(d) Carry out a risk assessment of the injury.

Q10. MRSA is most commonly spread through which mode of transmission?
(a) Airborne
(b) Direct contact
(c) Respiratory droplets
(d) Faecal/Oral route

Q11. How is Clostridium difficile most commonly acquired in a healthcare setting?
(a) Inhalation
(b) Inoculation (sharps injury)
(c) Ingestion of spores
(d) Contact with skin

Q12. Name the main risk factor that contributes towards patients developing diarrhoea associated with Clostridium difficile?
(a) Antibiotics
(b) High Waterlow score
(c) Poor dietary intake
(d) Enemas

Q13. Approximately how long can Clostridium difficile spores survive in the environment?
(a) 5 hours
(b) 5 days
(c) 5 weeks
(d) 5 months

Q14. Extended Spectrum Beta Lactamase (ESBL) and Carbapenemase are enzymes that can be produced by certain bacteria to block the effect of some antibiotics?
(a) True
(b) False

Q15. What are the main classic symptoms of Norovirus?
(a) Diarrhoea & vomiting.
(b) Headache & vomiting
(c) Joint pain & diarrhoea
(d) Vomiting & nausea
Unit 4a: Infection Prevention & Control (Clinical staff only)
Completion Statement

PLEASE only sign and return when you are satisfied that your staff member has completed all of the relevant mandatory units and correctly answered questions.

A PHOTOCOPY of this completion statement ONLY, MUST be sent to Learning and Development. This is for input on to the Trusts Central Training Data Base (OLM) as evidence that your staff member has completed the Mandatory Training Assessment Pack.

A further copy should be placed in your staff members personal development file.

This is to confirm the Mandatory Training Assessment has been completed by:

Surname: (Block Capitals)

Forename: (Block Capitals)

Job Title: ...............................................................................................................................................................................

Department/Ward: .................................................................................................................................................................

Division/Directorate: .............................................................................................................................................................

Date Completed: (This must be within 12 weeks of receipt) ..............................................................................................

Staff Signature: ........................................................................................................................................................................

Manager: (Printname) .............................................................................................................................................................

Manager: ( Signature) ..............................................................................................................................................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, 42 Whinney Heys Road, Blackpool, FY3 8NR

An electronic copy can be emailed to: olm@bfwhospitals.nhs.uk

Date Sent: .........................................................

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Unit 4B assessment:
Infection Prevention & Control (Non-clinical only)

Q1. Which of the following is NOT a link in the chain of infection?
(a) Infectious agent
(b) Reservoir
(c) Portal of exit
(d) Antibiotics

Q2. What is the single most-effective method of preventing infections from spreading?
(a) Wearing gloves
(b) Good hand hygiene
(c) A clean environment
(d) Waste management

Q3. Which is the preferred method for cleaning your hands after visiting the toilet?
(a) Soap & water
(b) Alcohol hand-gel

Q4. Which area of the hands is most commonly missed during hand washing?
(a) Palms
(b) Thumbs
(c) Fingertips
(d) Backs of hands

Q5. Which of the following is NOT one of the 5 moments of hand hygiene but is still considered good practice?
(a) Before touching patient surroundings
(b) Before patient contact
(c) Before clean or aseptic procedure
(d) After body fluid exposure risk

Q6. What are the main, classic, symptoms of Norovirus?
(a) Diarrhoea & vomiting.
(b) Headache & vomiting
(c) Joint pain & diarrhoea
(d) Vomiting & nausea
Unit 4b: Infection Prevention & Control (Non-clinical only)
Completion Statement

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Staff Signature: ..............................................................................................................................................................

Manager: (Printname) ......................................................................................................................................................

Manager: ( Signature) ......................................................................................................................................................

Return a copy to Learning and Development, Blackpool Teaching Hospitals, Learning and Development Department, 42 Whinney Heys Road, Blackpool, FY3 8NR

Date Sent: ......................................................

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