

Risk Assessment - M.R.S.A. Infections - Service User

A: DETAILS OF SERVICE USER

Name: _____ **Date of Birth:** _____ **GP:** _____

SITE OF INFECTION: _____

B: EXISTING CONTROLS & COMMENTS

Are the following controls being observed?	YES	NO	Observations & Recommendations
Relevant persons informed (define):	<input type="checkbox"/>	<input type="checkbox"/>	
Safe system of work for Domiciliary Care staff:	<input type="checkbox"/>	<input type="checkbox"/>	
Personal Protective Clothing:	<input type="checkbox"/>	<input type="checkbox"/>	
Hand-washing Procedures observed:	<input type="checkbox"/>	<input type="checkbox"/>	
Use of biocidal wash:	<input type="checkbox"/>	<input type="checkbox"/>	
Routine swabs taken (Nursing Staff)	<input type="checkbox"/>	<input type="checkbox"/>	
Proper disposal of clinical waste (see Form No 4-201):	<input type="checkbox"/>	<input type="checkbox"/>	

C: MONITORING ARRANGEMENTS

Details:

D: REVIEW & SIGNATURES

Review Date of this Risk Assessment: _____

Signature: _____ Date: _____