**Infection Control Risk Assessment Audit**

**Ward/Birthing Centre name: …………………………………..**

Please select up to 10 patients, weekly, to confirm IC risk assessments have been completed on admission. Ensure these risk assessments are retained with the patient’s end of bed notes.

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| **Bed Number, Patient Name** | **Done** | **Not Done** | **COMMENTS** |
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**Some patients will have been MRSA screened in pre-assessment day unit**

Please follow locally agreed plan for entering data

**Date and signature:**

Infection Control Practice Nurse – Jacky Drewitt telephone (01793 60)4991, bleep 1078