Aseptic Technique in NICU

Sites where Local Guideline applies
- Neonatal Intensive Care Unit, JHCH

This Local Guideline applies to:
1. Adults
   - No
2. Children up to 16 years
   - No
3. Neonates – less than 29 days
   - Yes

Target audience
- All clinicians required to perform aseptic technique for fluid or medication administration in NICU

Description
- Provides information for the clinician to enable competent skills in aseptic technique to minimize risk of infection

Keywords
- asepsis, central lines, infection, NICU, non-touch technique, sterile

Document registration number
- JHCH_NICU_03.01

Replaces existing document?
- Yes

Registration number and dates of superseded documents
- JHCH_NICU_03.01 May 2013

Related Legislation, Australian Standard, NSW Ministry of Health Policy Directive or Guideline, National Safety and Quality Health Service Standard (NSQHSS) and/or other, HNE Health Document, Professional Guideline, Code of Practice or Ethics:
1. Aseptic Technique for medium or Higher Risk Procedures Conducted in Clinical Settings
3. NSW Health Policy Directive PD2017_032 Clinical Procedure Safety

Prerequisites (if required)
- Aseptic Technique in NICU , CVAD Accessing Needleless Connector in NICU and Removal of CVAD (PICC) Competent –My Health Learning

Local Guideline note
- This document reflects what is currently regarded as safe and appropriate practice. The guideline section does not replace the need for the application of clinical judgment in respect to each individual patient but the procedure/s require mandatory compliance. If staff believe that the procedure/s should not apply in a particular clinical situation they must seek advice from their unit manager/delegate and document the variance in the patient’s health record.

Position responsible for the Local Guideline and authorised by
- Pat Marks. General Manager / Director of Nursing CYPFS

Contact person
- Jenny Ormsby Guideline Development Coordinator NICU JHCH

Contact details
- Jennifer.Ormsby@hnehealth.nsw.gov.au

Date authorised
- 10 January 2018

This document contains advice on therapeutics
- No

Issue date
- 10 January 2018

Review date
- 10 January 2021
PURPOSE AND RISKS

This local clinical procedure has been developed to provide instruction to the health clinician and to ensure that the risks of harm to the child associated with incorrect aseptic technique are prevented, identified and managed.

The risks are:
- Infection to the infant
- Contaminated medications and fluids

The risks are minimised by:
- Clinicians having knowledge of aseptic technique
- Clinicians seeking assistance if aseptic technique is outside their scope of practice
- Following the instructions set out in the clinical procedure
- Recognition of the common clinical signs of infection

Risk Category: Clinical Care & Patient Safety

GLOSSARY

<table>
<thead>
<tr>
<th>Acronym or Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTT</td>
<td>Aseptic Non Touch Technique</td>
</tr>
<tr>
<td>CVAD</td>
<td>Central Venous Access Device</td>
</tr>
<tr>
<td>ICC</td>
<td>Intercostal Catheter</td>
</tr>
<tr>
<td>PICC</td>
<td>Peripherally Inserted Central Catheter</td>
</tr>
<tr>
<td>PN</td>
<td>Parenteral Nutrition</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>UAC/UVC</td>
<td>Umbilical Arterial/Venous Catheter</td>
</tr>
</tbody>
</table>

Guideline

This Guideline does not replace the need for the application of clinical judgment in respect to each individual patient.

Staff Preparation

It is mandatory for staff to follow relevant: “Five moments of hand hygiene”, infection control, moving safely/safe manual handling, documentation practices and to use HAIDET for patient/carer communication: Hand hygiene Acknowledge, Introduce, Duration, Explanation, Thank you or closing comment.
Aseptic Technique in NICU - One Page Summary and Checklist

Definitions

Aseptic Technique-prevents microorganisms on hands, surfaces and equipment from being introduced to susceptible site

Aseptic Non Touch Technique (ANTT)-asepsis by protecting key parts by hand hygiene, non-touch technique, sterilised equipment and cleansing to render asepsis

Surgical ANTT-asepsis for critical aseptic field i.e. PICC /UAC insertion.

Standard ANTT-promoting asepsis when key parts protected e.g line changes

Recommendations for prevention of IVC infection

Scrub ports with Alco wipe x2 for 30 sec each and with vigour - allow to dry

Access only with sterile devices

Wear mask & sterile gloves for Surgical ANNT procedures

Standard ANNT for line changes (every 72-96 hrs.) - wear mask

Environment

Disinfect high touch surfaces once a shift

Do not place lines or tubing near nappy area

Clean crib ports prior to accessing lines

When to use Surgical non-touch technique

Insertion of a central line

Changing a Central Venous Access Device (CVAD) dressing

Removal of bungs for blood collection (from Broviac™)/ Blood collection from an open device

Surgical Aseptic Non-touch Technique-requirements (Photo)

Procedure: Surgical Aseptic Non-touch Technique

Clean trolley-allow to dry

Place sterile plastic and green drape on trolley-minimise handling of drapes

Perform hand anti -sepsis

Don sterile gown and gloves in separate area

Handling of equipment and solutions in the sterile field

Setting up for PN/Lipids/Fluids

When to use Standard ANTT

Closed system and ‘swabable’ bungs in situ

Administration of medications/flushing

IV priming and changing IV giving sets and changing PN/fluid bags

Procedure for Line changes using Standard ANTT

Clean trolley with detergent wipe

Remove jewellery, Apply mask. Observe 5 moments of hand hygiene

Drape trolley with large plastic drape and green drape or dressing pack if less equipment

Alcoholic gel to hands or 10 second hand wash

Connect all lines using ANNT and prime lines with PN/fluids

Clamp PICC and disconnect existing lines

Disconnect existing lines and hold “swabable” safe flow bung off the bed-scrub the bung and allow to dry up to 30 seconds

Connect new lines and commence infusions checking with another RN as per protocol

Appendix 1 Standard ANTT Competency Assessment Tool
Rationale
This procedure provides guidance about the knowledge, application of skills and technique required when preparing and maintaining an aseptic field to ensure or promote asepsis. Infants in the NICU are susceptible to infection; prematurity, stress, immature immune system and complicated medical and surgical problems contribute to their increased susceptibility. The appropriate application of infection control principles and practices can assist in preventing nosocomial infections in these infants.

Outcomes
- All staff to maintain a Surgical Aseptic Non Touch Technique (ANTT) during technically complex procedures e.g. insertion Percutaneous Intravenous Central Catheter (PICC)/Umbilical Venous/Arterial Catheters (UVC/UAC)
- All staff to maintain a Standard Aseptic Non Touch Technique (ANTT) when accessing a closed CVAD (Central Venous Access Device) system.
- Episodes of nosocomial infection such as catheter related blood stream infections are minimised.

Definitions
- Asepsis: Freedom from infection and prevention of contact with micro-organisms (Dorland; 2012)
  - Aseptic Technique: aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites and can be achieved in the ward area (CEC, Infection prevention and control practice Handbook. 2016)
  - Aseptic Non Touch Technique (ANTT): technique ensuring asepsis by identifying and protecting key parts and areas (e.g. catheters and insertion sites) by hand hygiene, non-touch technique, using new sterilised equipment and/or cleansing key parts to a standard that renders them aseptic prior to use (Rowley et al 2010)
  - Surgical ANTT- ensuring asepsis for a critical aseptic field when key parts/sites cannot be protected with covers and caps or handled by a non-touch technique e.g. PICC/UVC and UAC insertion (NSW Health PD 2017_013 Infection Control and prevention Policy)
- Standard ANTT-promoting asepsis when key parts are protected (NSW Health PD 2017_013 Infection Control and prevention Policy) i.e. PICC line attached to ‘swabable’ safe flow bung rendering line closed
Recommendations for the prevention of Intravascular Catheter-related infections

1. Closed systems
2. Scrub port with an alcoholic wipe for 30 seconds with vigor and allow to dry; then repeat process-allow to dry before accessing line. Most effective way is to hold line with non-clean hand and scrub with the clean hand (do not use forceps as unable to gain enough friction to be effective)
3. Access only with sterile devices
4. Standard Aseptic Non- touch technique for line changes- wear mask
5. Wear mask and sterile gloves for Surgical aseptic non touch technique procedures
6. Line changes every 72-96 hours

Environment

- Each shift disinfect high touch surfaces of equipment including but not limited to monitor, ventilator and outside crib surfaces
- Do not place lines or tubing near nappy area
- Clean crib ports prior to accessing lines
- Label crib with move-in date and change after one week
- Empty and disinfect humidity reservoir upon discontinuation of humidity therapy

When to use Surgical Aseptic Non –Touch Technique

- Insertion of a central line (PICC, UAC/UVC)
- Changing a CVAD dressing
- Removal of bungs for blood collection (Broviac™)
- Blood collection from an open device
- Insertion of ICC
- Lumbar puncture, Supra pubic urinalysis

Surgical Aseptic Non Touch Technique

- Chlorohexidine surgical scrub
- 60 second hand wash
- Sterile gloves
- ‘Swabable’ safe flow bung
Procedure: Surgical Aseptic Non-Touch Technique

1. **Sterile drapes should be used to establish a sterile field.**
   - Apply a surgical mask and protective glasses
   - The top of the trolley should be cleaned and allowed to dry prior to placement of the drapes.
   - A sterile plastic drape is used to cover the trolley.
   - A sterile green drape covers the top of the trolley to establish an aseptic barrier which clearly delineates and identifies non-sterile and sterile areas.
   - Sterile drapes should be handled as little as possible. Rapid movement of draping materials creates air currents that migrate dust, lint, and other particles. If a person not scrubbed opens the main drape, two outer corners are held up and the drape gently opened from the back of the trolley and laid forwards. If a scrubbed person is handling the drape then it is opened and laid back over the trolley so that the sterile area of the gown and drape are protected. Once in place the sterile drape should NOT be moved.

2. **Scrubbed persons should function within a sterile field**
   - Perform hand antisepsis by removing all watches, jewelry and rings (NSW Health PD 2017_013 Infection Control and prevention Policy) –plain wedding band permissible but preferable to remove.
   - Wet hands and forearms and apply antimicrobial scrub agent
   - Visualise each finger, hand and arm as having four sides. Wash all four sides effectively beginning at fingers and working up to hands then forearms. Do not go back over areas previously washed. Repeat this process for opposite fingers, hand and arm. This wash should last for one minute
   - Rinse off fingers, then hands and lastly forearms
   - Hold hands higher than elbow and away from attire
   - Dry hands using the sterile towel in gown pack. Use one side of the towel before turning to the other side
   - Scrubbed personnel should don sterile gowns and gloves from an area away from the main instrument table to prevent contamination of sterile field. (Refer to ACORN Standards for Perioperative Nursing 2010-2011, for procedure to don sterile gown and gloves)
   - The front of the sterile gown is considered sterile from the chest to the level of the sterile field.
   - Donning of gloves should be by closed donning method. Sleeve cuffs should be considered contaminated when the scrubbed person’s hands pass beyond the cuff. Therefore the glove should only be placed over the cuff with the hand
remaining in the cuff and not beyond. The hand can be extended once the glove covers it.

- Gloves and gown must be immediately changed if the integrity of the gloves or gown has been compromised.

3. **Items used with the sterile field should be sterile**
   - Packaging should be inspected to ensure seal integrity. If integrity is uncertain then the item should be considered unsterile. Also expiry date should be verified.
   - All items introduced to a sterile field should be opened, dispensed and transferred by methods that maintain item sterility and integrity.
   - All loose wrapper edges should be secured when supplies are presented to the sterile field.
   - Sharp and heavy objects should be handed to the sterile person and not dropped onto the sterile field. They could penetrate the sterile barrier if dropped onto the sterile field.
   - Solutions receptacle on the sterile field should be placed near the edge of the trolley or held by the scrubbed person. Contents should be poured slowly to avoid splashing. Check correct anti-microbial solution for prepping the skin and the expiry date with the scrubbed personnel. Chlorhexidine™ and alcohol for infants ≥ 1000gms and Povidone™-iodine for infants <1000gms

4. **A sterile field should be maintained and monitored constantly.**
   - Sterile items should only be opened and prepared in the location in which it will be used. Moving tables stirs air currents that can contaminate.
   - Sterile fields should be prepared as close as possible to the time of use.
   - Sterile fields should NOT be covered as removing the cover may result in a part of the cover that is below the trolley being drawn above the table level or air currents drawing micro-organisms from a non-sterile area to the sterile field.
   - If the scrubbed person needs to remove an unsterile item they must use sterile forceps (then discard), they are never to use their hands.

5. **All personnel moving within or around a sterile field should do so in a manner that maintains the sterile field.**
   1. Scrubbed person must remain close to the sterile field. Walking outside the sterile field’s periphery increases the potential for contamination.
   2. The assistant will wear a sterile gown, surgical hat and a mask.
   3. **Any person entering the environment must wear a mask.**
   4. Scrubbed person should keep their arms and hands above their waists at all times. Hands should remain in front of the body and be visible at all times.
   5. Any contamination must be acted upon and re-gowning and gloving must occur.
6. Specific Issues relating to setting up for PN/Lipid/Fluids and drug infusions when PICC/UVC inserted

PN/Lipid/Fluids may be set up and connected to the PICC/UVC by the Clinician who has inserted the line. Otherwise the nurse caring for the infant will be required to follow the Standard Aseptic Non Touch Technique.

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Fluids</th>
<th>PPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trolley</td>
<td>Appropriate pumps</td>
<td>Mask</td>
</tr>
<tr>
<td>Sterile drapes – 1 x large, 1 x small</td>
<td>PN/Lipids/Fluids</td>
<td>Gel</td>
</tr>
<tr>
<td>Plastic drape</td>
<td>Fluid orders</td>
<td>Gloves if preferred</td>
</tr>
<tr>
<td>Dressing pack</td>
<td>Alco Wipe x2</td>
<td></td>
</tr>
<tr>
<td>Burette set and Infusion set</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bifurcated light safe extension set with filters and swabable valve needleless connector™ and accessing luer lock syringe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add extra burettes and lines if other infusions or sidelines are to be changed, for example Morphine or if they are due later consider synchronising line changes with PN/Fluids to minimise line breakages.

The PN and Lipid order needs to be checked by 2 Registered Nurses. Ensure the PN recipe on bag correlates with the pharmacy order and is within the use by date. Check the MRN and the baby’s name against the baby’s ID label, the fluid bags and the medical order on the fluid order sheet.

Procedure can be performed with or without gloves – however ‘gel of hands’ with alcohol rub without gloves is preferred.

**When to use Standard Aseptic Non Touch Technique**

- Closed system and ‘swabable’ bungs are on
- Administration of medications/flushing
- Priming and changing IV giving sets.
- IV PN/fluid bag changes

**Procedure for Line Changes using Standard Non touch technique**

1. Clean trolley with large alcohol wipe
2. Apply mask
3. Drape trolley with a large plastic drape and a green drape to act as a clean surface for lines or dressing pack if less equipment
4. Remove all jewelry (NSW health Policy Directive PD 2017_013 Infection Control and prevention Policy), plain wedding band permissible but preferable to remove
   10 second hand wash or alcoholic hand gel
5. Connect all lines using Standard Aseptic Non touch technique
6. Prime lines
7. Clamp PICC line
8. Disconnect the existing lines taking care to hold the ‘swabable’ safe flow bung with the non-clean hand. Scrub port with an alco wipe for 30 seconds with vigor and allow to dry then repeat process-allow to dry before accessing line. Most effective way is to hold line with the non-clean hand and scrub with the clean hand (do not use forceps as unable to gain enough friction to be effective)
9. Connect the new lines and commence the infusion/medication as charted. (checking with another RN as per protocol)

Observe the 5 moments for hand hygiene throughout procedure (NSW Health PD 2017_013 Infection Control and prevention Policy)

Standard Non touch technique

[Images of protective eyewear, non-sterile gloves, hand wash, alco wipes, swabable safe flow bung/syringe]
References

ACORN Standards for Perioperative Nursing 2010-2011: including Nursing Roles, Guidelines and Position Statements. Publisher: The Australian College of Operating Nurses Ltd. South Australia


Lyndall Moore, CNE Paediatric Oncology JHCH. Paediatric and Adolescent Central Venous access Devices (CVAD’s) Powerpoint presentation. April 2011


National Health and Medical Research Council, Australian Guidelines for the Prevention and Control of Infection in Healthcare. 2010, Canberra: Commonwealth of Australia,


Pamela R. Paulson, RN, MS, CPNP. Kellee M. Miller, RN, BS. Peripherally Inserted Central Catheters: Recommendations for Prevention of Insertion and postinsertion Complications. 2008

Perlman SE, Saiman L, Larson EL. Risk factors for late-onset health care-associated bloodstream infections in patients in neonatal intensive care units


Susan Bowles, MSN, RNC, Janet Pettit, RN, NNP, MSN, Nick Mickas, MD, Courtney Nisbett, RN, MS, Teresa Proctor MSN, RN, David Wirtschafer, MD on behalf of the Perinatal Improvement Panel (PQIP), California Perinatal Quality Care Collaborative (CPQCC) Hospital acquired infection prevention March 2007
Aseptic Technique in NICU JHCH_NICU_03.01

Teresa Proctor MSN, RN, David Wirtschafer, MD on behalf of the Perinatal Quality Improvement Panel (PQIP), California Perinatal Quality Care Collaborative (CPQCC) www.ihi.org Central Line bundles


RELATED LEGISLATION, DEPARTMENT OF HEALTH CIRCULARS, AREA POLICIES ETC:


HNELHD CVAD Intravenous Administration Set Change HNELHD GandP 16_19

Author Joanna Kent - Biggs (original author)

Updated by Julie Gregory CNE NICU JHCH
Jenny Ormsby CNE NICU JHCH

Approved by NICU, Operational, Planning& Management Committee 18/12/2017

Clinical Quality& Patient Care Committee 19/12/2017
# Appendices

## Appendix 1

### NICU Standard non-touch Aseptic Technique Competency Assessment Tool

**COMPETENCY:** Standard non-touch Aseptic Technique

### Assumed Knowledge

All Clinical Staff are expected to demonstrate the following:

- Knowledge and understanding of general concepts relating to aseptic procedures, standard and transmission based precautions
- Familiarity with the MOH Policies - HNELHD policies and clinical guidelines
- Knowledge and understanding of any limitations regarding their scope of practice

### Meets the Assumed Knowledge

<table>
<thead>
<tr>
<th>Element</th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
</table>

### Element 1. Integrates knowledge and assessment findings

#### Sub Element 1.1

**Questioning Criteria**

All Clinical Staff can identify the following appropriate documents/ actions necessary for the procedure:

- Relevant MOH and HNELHD policies
- NICU CPG 2.2.9
- Relevant Documents, Patient progress notes and Infection Control Manual
- 5 moments of hand hygiene, moving safely/safe manual handling and documentation practices
- Ensures the task sits within their scope of practice.

Demonstrates knowledge and understanding of these policies/ guidelines and documents

### Element 2. Safely and effectively performs an aseptic procedure

#### Sub Element 2.1

**Observable Criteria**

1. Introduces self to parent if at the bedside, and explains the procedure.
2. Identifies the patient for correct site and correct procedure, administering analgesia if required in the case of wound care.
3. Checks fluids, medication as per NICU protocol with another RN
4. Ensures the immediate environment minimises the risk of contamination
5. Gel/cleans Hands
6. Applies mask and PPE glasses
7. Cleans trolley with large alcohol wipes/neutral detergent starting in the middle and working outwards & allows to air dry
8. Gathers required equipment, ensures sterility by checking package condition & expiry dates and place on clean bottom shelf of trolley
9. Gels/cleans hands (if allergic to antibiotics or handling blood products then wear gloves but remove and
<table>
<thead>
<tr>
<th>Step</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>Opens sterile pack and necessary sterile equipment onto sterile field, gels hands and connect all lines using standard non-touch aseptic technique. Draw up medications and prime lines and/or syringes using the standard non-touch aseptic technique.</td>
</tr>
<tr>
<td>11.</td>
<td>Load new IV lines or syringes to appropriate devices</td>
</tr>
<tr>
<td>12.</td>
<td>Adjusts bed to suitable height and observes patient IV swabable safe flow bung in a position where it can be accessed. Open crib doors and turns boost curtain on (Giraffe bed only)</td>
</tr>
<tr>
<td>13.</td>
<td>Gel/cleans hands (change gloves if wearing them)</td>
</tr>
<tr>
<td>14.</td>
<td>Disconnect the existing patient lines taking care to hold the ‘swabable’ safe flow bung off the bed. Scrub the ‘swabable bung’ on patient line with an alco wipe for 30 seconds vigorously and repeat process-allow to dry.</td>
</tr>
<tr>
<td>15.</td>
<td>Connect the new lines and commence the infusion/medication as charted. (checking with another RN as per protocol)</td>
</tr>
<tr>
<td>16.</td>
<td>Sharps disposed of at point of use and other waste contained appropriately</td>
</tr>
<tr>
<td>17.</td>
<td>Gel/cleans hands (remove glasses, mask and gloves if worn, and then gel hands)</td>
</tr>
</tbody>
</table>

**Specific to wound care**

1. Clean wound, working away from clean to less clean area, and allow area to air dry
2. If dressing a wound, removes used dressing using forceps provided in the dressing pack and discards forceps and used dressing appropriately
3. Handles sterile items correctly to maintain sterility
4. For wound dressing - using non-dominant hand to lift items from sterile field, transfers to dominant hand to effect treatment and apply dressing materials
5. Sharps disposed of at point of use and other waste contained appropriately
6. Performs hand hygiene

**ELEMENT 3. Completes the procedure correctly**

<table>
<thead>
<tr>
<th>Sub element</th>
<th>Observable Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Demonstrates post procedure care of patient, equipment and environment</td>
</tr>
<tr>
<td>1.</td>
<td>Performs hand hygiene and dons non sterile gloves if required</td>
</tr>
<tr>
<td>2.</td>
<td>Discards waste appropriately i.e. general, clinical, sharps, cytotoxic etc</td>
</tr>
<tr>
<td>3.</td>
<td>Removes gloves (if worn) and cleans/gels hands</td>
</tr>
<tr>
<td>4.</td>
<td>Cleans, replaces and disposes of equipment appropriately</td>
</tr>
<tr>
<td>5.</td>
<td>Cleans/gels hands</td>
</tr>
</tbody>
</table>
6. Document relevant information on appropriate charts and in patient progress notes.

### NICU Standard non-touch Aseptic Technique Competency Assessment Tool.

<table>
<thead>
<tr>
<th>Assessed Competent</th>
<th>Yes / No</th>
<th>Date</th>
<th>Participants Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assesors Name</td>
<td></td>
<td></td>
<td>Participants Signature</td>
</tr>
<tr>
<td>Assesors Signature</td>
<td></td>
<td></td>
<td>Employee Number</td>
</tr>
<tr>
<td>Facility/ Unit</td>
<td></td>
<td></td>
<td>Designation</td>
</tr>
</tbody>
</table>

#### Follow up and Assessment

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral to Education</th>
<th>Skills Lab Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Manager Informed</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IMPLEMENTATION, MONITORING COMPLIANCE AND AUDIT

1. Approved clinical guideline will be uploaded to the PPG and communication of updated ‘Aseptic Technique in NICU’ clinical guideline to NICU staff will be via email and message on the HUB.
2. All staff will complete the ‘NICU Standard non-touch Aseptic Technique Competency Assessment Tool’ and recorded on HETI.
3. Incident investigations associated with this Guideline and Procedure will include a review of process.
4. The Guideline and Procedure will be amended in line with the recommendations.
5. The person or leadership team who has approved the Guideline and Procedure is responsible for ensuring timely and effective review of the Guideline and Procedure.
6. Evaluation will include a review of the most current evidence as well as a consideration of the experience of Neonatal staff at JHCH in the implementation of the Guideline and Procedure.

APPENDICES

6. NICU Standard non-touch Aseptic Technique Competency Assessment Tool

FEEDBACK

Any feedback on this document should be sent to the Contact Officer listed on the front page.