



**University of Basrah
College of Nursing
Branch of Basic Sciences**

Assessment of Nursing Staff Knowledge about Nosocomial Infection and their role in controlling it.

**A Research project was submitted to the counsel of the nursing college, the
university of Basra as a partial fulfillment of the requirements for the
degree of B.S.C in nursing science**

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بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

لَا يُؤَاخِذُكُمُ اللَّهُ بِاللَّغْوِ فِي أَيْمَانِكُمْ وَلَكِنْ يُؤَاخِذُكُمْ بِمَا كَسَبْتُمْ

قُلُوبِكُمْ وَاللَّهُ غَفُورٌ رَحِيمٌ

صَدَقَ اللَّهُ الْعَلِيِّ الْعَظِيمِ

(البقرة 225)

الاهداء

الى صاحب السيرة العطرة، والفكر المُستنير؛
فلقد كان له الفضل الأول في بلوغي التعليم العالي
(والدي الحبيب)، أطال الله في عُمره.
إلى من وضعتني على طريق الحياة، وجعلتني رابط الجأش،
وراعتني حتى صرت كبيراً
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إلى إخوتي؛ من كان لهم بالغ الأثر في كثير من العقبات والصعاب.
إلى جميع أساتذتي الكرام؛ ممن لم يتوانوا في مد يد العون لي

Supervisor's support

I certify that this project of research
**Assessment of Nursing Staff Knowledge about Nosocomial
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Was prepared under my supervision at the College of
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Abstract

Objectives: To assess hospital infection knowledge and control practices among nursing staff in hospitals of Basrah city.

Methods: A cross-sectional study began on 1 December 2021 targeted 36 nursing staff, where data collection form was used to inquire about their characteristics, general concepts of hospital infection and control, hand hygiene, personal protective equipment, sharp injuries and disposal, and care of health providers were included. Data were collected by questionnaire packets were given to participants to complete at the hospital. The data was then entered and analyzed by using SPSS statistical analysis program.

Results: Knowledge and practices scores in all domains were considerably low, the result of this study assess the nursing staff had weak knowledge 56.91% (n=36) and intermediate level of control practices 60.95% (n=36) . The total assessment among participants was also weak (58.77%) with mean score 25.86. The education level ,experience and course training had an impact on improvement of knowledge and infection control.

Conclusion: The overall knowledge and practices scores for infection control were low especially in the domains of hand hygiene, sharp management, personal protective equipment and isolation precaution reflecting insufficient and ineffective instructions received by nursing staff posing them vulnerable to health facilities related infections

Recommendation : Continuous in-service training programs to update the nursing staff knowledge and practices of infection control , Hospital should provide operating rooms with all supplies and equipment needed

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Chapter one

Introduction

1-1 Introduction

A hospital-acquired infection, also known as a nosocomial infection (from the Greek nosokomeion, meaning "hospital"), is an infection that is acquired in a hospital or other health care facility. To emphasize both hospital and nonhospital settings, it is sometimes instead called a healthcare-associated infection. Such an infection can be acquired in hospital, nursing home, rehabilitation facility, outpatient clinic, diagnostic laboratory or other clinical settings. Infection is spread to the susceptible patient in the clinical setting by various means. Health care staff also spread infection, in addition to contaminated equipment, bed linens, or air droplets. The infection can originate from the outside environment, another infected patient, staff that may be infected, or in some cases, the source of the infection cannot be determined. In some cases the microorganism originates from the patient's own skin microbiota, becoming opportunistic after surgery or other procedures that compromise the protective skin barrier. Though the patient may have contracted the infection from their own skin, the infection is still considered nosocomial since it develops in the health care setting. An easy way to understand the term is that the infection tends to lack evidence that it was incubating, or present when the patient entered the healthcare setting, thus meaning it was acquired post-admission

In the United States, the Centers for Disease Control and Prevention estimated that roughly 1.7 million Healthcare-Associated infections, from all types of microorganisms, including bacteria and fungi combined, cause or contribute to 99,000 deaths each year.[2] In Europe, where hospital surveys have been conducted, the category of gram-negative infections are estimated to account for two-thirds of the 25,000 deaths each year.

1-2 Name Origin

The term "nosocomial" comes from two Greek words: "nosus" meaning "disease" + "komeion" meaning "to take care of." Hence, "nosocomial" should apply to any disease contracted by a patient while under medical care. However, common usage of the term "nosocomial" is now synonymous with hospital-acquired[3]

1-3 Importance of the project

Nosocomial infections cause significant morbidity and mortality in patients. This means that implementing infection management policies and suitable hygiene measures to keep hospitals and patient areas clean is an absolute imperative. In some cases, replacing reusable products with single-use products helps to keep infection rates down. Our products are always designed with minimal parts and infection prevention in mind – helping you to improve workflow efficiency and reduce the risk of such infections in hospital.

1-4 research aims

- 1) Recognize hospital infection and get acquainted with the history of this type of infection
- 2) Know the reasons that lead to the occurrence and spread of this type of infection
- 3) Identify the appropriate environment for the spread and growth of this type of infection
- 4) Develop appropriate recommendations to prevent the spread of hospital infection.[6]



Chapter Two

Literature Review

2-1 Overview

Nosocomial infection is an infection acquired by the patient after being admitted to the hospital, and he was not infected with it before, due to the spread of bacteria and poor sterilization in the hospital. The most common department in which hospital infections occur is the intensive care unit, where doctors treat critical illnesses.

About 1 in 10 people admitted to hospital develop nosocomial infections, which can cause many deaths. The good news is that hospital infections can be prevented with some simple measures that require disinfection, assessment, and infection control measures, according to the Health Line website.

Nosocomial infections occur in a number of cases:

48 hours after hospitalization - 30 days after surgery - in a health care facility when a person is admitted for reasons other than infection[7]

2-2 History of Hospital infection.

In 1841, Ignaz Semmelweis, a Hungarian obstetrician was working at a Vienna maternity hospital. He was "shocked" by the death rate of women who developed puerperal fever. He documented that mortality was three times higher in the ward where the medical students were delivering babies than in the next ward that was staffed by midwifery students.[8] The medical students were also routinely working with cadavers. He compared the rates of infection

with a similar hospital in Dublin, Ireland and hypothesized that it was the medical students who somehow were infecting the women after labor. He instituted mandatory hand-washing in May 1847 and infection rates dropped dramatically. Louis Pasteur proposed the germ theory of disease and began his work on cholera in 1865 by identifying that it was microorganisms that were associated with disease [8]

2-3 transmission

In-dwelling catheters have recently been identified with hospital acquired infections. To deal with this complication, procedures are used, called intravascular antimicrobial lock therapy that can reduce infections that are unexposed to blood-borne antibiotics. Introducing antibiotics, including ethanol, into the catheter (without flushing it into the bloodstream) reduces the formation of biofilms[9]

Table 1-2 (Main routes of transmission)

Route	Description
Contact transmission	The most important and frequent mode of transmission of nosocomial infections is by direct contact.
Droplet transmission	Transmission occurs when droplets containing microbes from the infected person are propelled a short distance through the air and deposited on the patient's body; droplets are generated from the source person mainly by coughing, sneezing, and talking, and during the performance of certain procedures, such as bronchoscopy.
<u>Airborne</u>	Dissemination can be either airborne droplet nuclei (small-

<u>transmission</u>	particle residue {5 μm or smaller in size} of evaporated droplets containing microorganisms that remain suspended in the air for long periods of time) or dust particles containing the infectious agent. Microorganisms carried in this manner can be dispersed widely by air currents and may become inhaled by a susceptible host within the same room or over a longer distance from the source patient, depending on environmental factors; therefore, special air-handling and ventilation are required to prevent airborne transmission. Microorganisms transmitted by airborne transmission include <u>Legionella</u> , <u>Mycobacterium tuberculosis</u> and the <u>rubeola</u> and <u>varicella</u> viruses.
Common vehicle transmission	This applies to microorganisms transmitted to the host by contaminated items, such as food, water, medications, devices, and equipment.
<u>Vector borne transmission</u>	This occurs when vectors such as mosquitoes, flies, rats, and other vermin transmit microorganisms.

Routes of contact transmission

Route	Description
Direct-contact transmission	This involves a direct body surface-to-body surface contact and physical transfer of microorganisms between a susceptible host and an infected or colonized person, such as when a person turns a patient, gives a patient a bath, or performs other <u>patient-care</u> activities that require direct personal contact. Direct-contact transmission also can occur between two patients, with one serving as the source of the infectious microorganisms and the other as a susceptible host.
Indirect-contact	This involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, such as contaminated instruments, <u>needles</u> , or

transmission

dressings, or contaminated gloves that are not changed between patients. In addition, the improper use of saline flush syringes, vials, and bags has been implicated in disease transmission in the US, even when healthcare workers had access to gloves, disposable needles, intravenous devices, and flushes.

2-4 Prevention

Making Health Care Safer-CDC Vital Signs-March 2012.pdf

Controlling nosocomial infection is to implement QA/QC measures to the health care sectors, and evidence-based management can be a feasible approach. For those with ventilator-associated or hospital-acquired pneumonia, controlling and monitoring hospital indoor air quality needs to be on agenda in management, whereas for nosocomial rotavirus infection, a hand hygiene protocol has to be enforced.[10]

To reduce the number of hospital-acquired infections, the state of Maryland implemented the Maryland Hospital-Acquired Conditions Program that provides financial rewards and penalties for individual hospitals. An adaptation of the Centers for Medicare & Medicaid Services payment policy causes poor-performing hospitals to lose up to 3% of their inpatient revenues, whereas hospitals that are able to decrease hospital-acquired infections can earn up to 3% in rewards. During the program's first two years, complication rates fell by 15.26% across all hospital-acquired conditions tracked by the state (including those not covered by the program), from a risk-adjusted complication rate of 2.38 per 1,000 people in 2009 to a rate of 2.02 in 2011. The 15.26% decline translates into more than \$100 million in cost savings for the health care system in Maryland, with the largest savings coming from avoidance of urinary tract infections, sepsis and other severe infections, and pneumonia and other lung infections. If similar results could be achieved nationwide, the Medicare

program would save an estimated \$1.3 billion over two years, while the US health care system as a whole would save \$5.3 billion.[11]

1-2-4.Sanitation

Hospitals have sanitation protocols regarding uniforms, equipment sterilization, washing, and other preventive measures. Thorough hand washing and/or use of alcohol rubs by all medical personnel before and after each patient contact is one of the most effective ways to combat nosocomial infections.[12] More careful use of antimicrobial agents, such as antibiotics, is also considered vital.[8] As many hospital-acquired infections caused by bacteria such as methicillin-resistant *Staphylococcus aureus*, methicillin-susceptible *Staphylococcus aureus*, and *Clostridium difficile* are caused by a breach of these protocols, it is common that affected patients make medical negligence claims against the hospital in question.

Sanitizing surfaces is part of control measures to reduce nosocomial infections in health care environments. Modern sanitizing methods such as Non-flammable Alcohol Vapor in Carbon Dioxide systems have been effective against gastroenteritis, methicillin-resistant *Staphylococcus aureus*, and influenza agents. Use of hydrogen peroxide vapor has been clinically proven to reduce infection rates and risk of acquisition. Hydrogen peroxide is effective against endospore-forming bacteria, such as *Clostridium difficile*, where alcohol has been shown to be ineffective [non-primary source needed] Ultraviolet cleaning devices may also be used to disinfect the rooms of patients infected with *Clostridium difficile* or methicillin-resistant *Staphylococcus aureus* after discharge [non-primary source needed][12]

Despite sanitation protocol, patients cannot be entirely isolated from infectious agents. Furthermore, patients are often prescribed antibiotics and other antimicrobial drugs to help treat illness; this may increase the selection pressure for the emergence of resistant strains

2-2-4.Sterilization

Sterilization goes further than just sanitizing. It kills all microorganisms on equipment and surfaces through exposure to chemicals, ionizing radiation, dry heat, or steam under pressure.[13]

3-2-4.Isolation

Main article: Isolation (health care)

Isolation is the implementation of isolating precautions designed to prevent transmission of microorganisms by common routes in hospitals. (See Universal precautions and Transmission-based precautions.) Because agent and host factors are more difficult to control, interruption of transfer of microorganisms is directed primarily at transmission for example isolation of infectious cases in special hospitals and isolation of patient with infected wounds in special rooms also isolation of joint transplantation patients on specific rooms.[14]

4-2-4.Handwashing

Handwashing frequently is called the single most important measure to reduce the risks of transmitting skin microorganisms from one person to another or from one site to another on the same patient. Washing hands as promptly and thoroughly as possible between patient contacts and after contact with blood,

body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of infection control and isolation precautions. The spread of nosocomial infections, among immunocompromised patients is connected with health care workers' hand contamination in almost 40% of cases, and is a challenging problem in the modern hospitals. The best way for workers to overcome this problem is conducting correct hand-hygiene procedures; this is why the WHO launched in 2005 the GLOBAL Patient Safety Challenge. Two categories of micro-organisms can be present on health care workers' hands: transient flora and resident flora. The first is represented by the micro-organisms taken by workers from the environment, and the bacteria in it are capable of surviving on the human skin and sometimes to grow. The second group is represented by the permanent micro-organisms living on the skin surface (on the stratum corneum or immediately under it). They are capable of surviving on the human skin and to grow freely on it. They have low pathogenicity and infection rate, and they create a kind of protection from the colonization from other more pathogenic bacteria. The skin of workers is colonized by $3.9 \times 10^4 - 4.6 \times 10^6$ cfu/cm². The microbes comprising the resident flora are: *Staphylococcus epidermidis*, *Staphylococcus hominis*, and *Micrococcus*, *Propionibacterium*, *Corynebacterium*, *Dermobacterium*, and *Pitosporum* spp., while transient organisms are *Staphylococcus aureus*, and *Klebsiella pneumoniae*, and *Acinetobacter*, *Enterobacter* and *Candida* spp. The goal of hand hygiene is to eliminate the transient flora with a careful and proper performance of hand washing, using different kinds of soap, (normal and antiseptic), and alcohol-based gels. The main problems found in the practice of hand hygiene is connected with the lack of available sinks and time-consuming performance of hand washing. An easy way to resolve this problem could be the use of alcohol-based hand rubs, because of faster application compared to correct hand-washing.[15]

Improving patient hand washing has also been shown to reduce the rate of nosocomial infection. Patients who are bed-bound often do not have as much access to clean their hands at mealtimes or after touching surfaces or handling waste such as tissues. By reinforcing the importance of handwashing and providing sanitizing gel or wipes within reach of the bed, nurses were directly able to reduce infection rates. A study published in 2017 demonstrated this by improving patient education on both proper hand-washing procedure and important times to use sanitizer and successfully reduced the rate of enterococci and *Staphylococcus aureus*. [16]

All visitors must follow the same procedures as hospital staff to adequately control the spread of infections. Moreover, multidrug-resistant infections can leave the hospital and become part of the community flora if steps are not taken to stop this transmission. [17]

It is unclear whether or not nail polish or rings affected surgical wound infection rates

5-2-4. Gloves

In addition to hand washing, gloves play an important role in reducing the risks of transmission of microorganisms. Gloves are worn for three important reasons in hospitals. First, they are worn to provide a protective barrier for personnel, preventing large scale contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin. In the United States, the Occupational Safety and Health Administration has mandated wearing gloves to reduce the risk of bloodborne pathogen infections. Second, gloves are worn to reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to patients during invasive or other patient-care procedures that involve touching a

patient's mucous membranes and nonintact skin. Third, they are worn to reduce the likelihood that the hands of personnel contaminated with micro-organisms from a patient or a fomite can transmit those micro-organisms to another patient. In this situation, gloves must be changed between patient contacts, and hands should be washed after gloves are removed.[18]

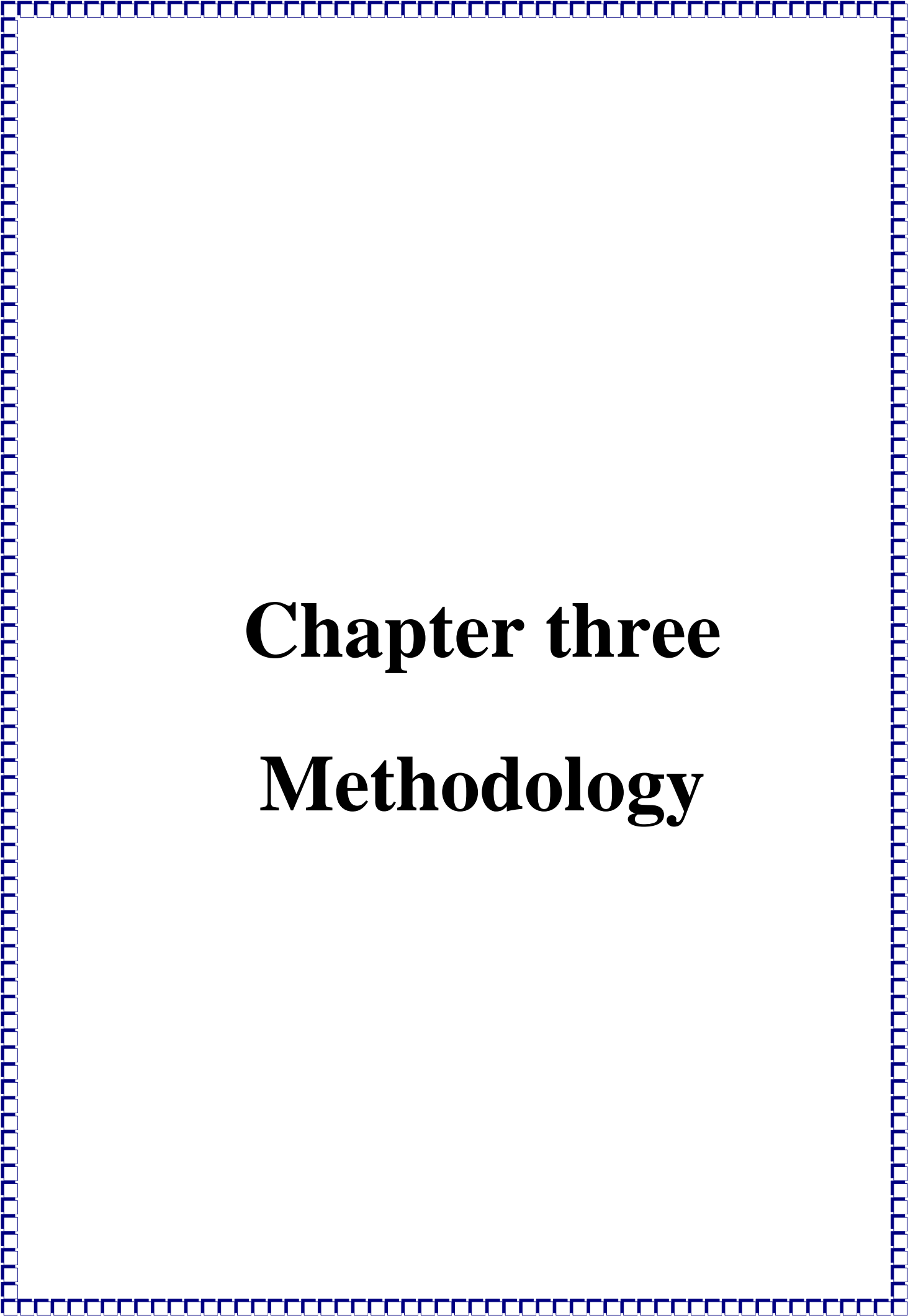
6-2-4. Antimicrobial surfaces

Micro-organisms are known to survive on inanimate 'touch' surfaces for extended periods of time.[10] This can be especially troublesome in hospital environments where immunodeficient patients are at enhanced risk for contracting nosocomial infections. Patients with hospital-acquired infections are predominantly hospitalized in different types of intensive care units (ICUs).[19]

Touch surfaces commonly found in hospital rooms, such as bed rails, call buttons, touch plates, chairs, door handles, light switches, grab rails, intravenous poles, dispensers (alcohol gel, paper towel, soap), dressing trolleys, and counter and table tops are known to be contaminated with *Staphylococcus*, methicillin-resistant *Staphylococcus aureus* (one of the most virulent strains of antibiotic-resistant bacteria) and vancomycin-resistant *Enterococcus*. Objects in closest proximity to patients have the highest levels of methicillin-resistant *Staphylococcus aureus* and vancomycin-resistant *Enterococcus*. This is why touch surfaces in hospital rooms can serve as sources, or reservoirs, for the spread of bacteria from the hands of healthcare workers and visitors to patients.

A number of compounds can decrease the risk of bacteria growing on surfaces including: copper, silver, and germicides.[20]

There have been a number of studies evaluating the use of no-touch cleaning systems particularly the use of ultraviolet C devices. One review was inconclusive due to lack of, or of poor quality evidence. Other reviews have found some evidence, and growing evidence of their effectiveness.[21]



Chapter three

Methodology

3.1 Design of the study

Pilot study

3.2 Sample of the study or Project instrument

Nurses

3.3 Methods of work

- 1- work start time (4- 15) April
- 2- The sample included all the nursing staff, which included all the halls
- 3- Designing a paper form organized under the supervision of the supervisor professor
- 4- Distribution of the paper form to the cadres of health institutions (government hospitals) Zubair Hospital and Al-Fayha Hospital
- 5- Collecting forms and arranging statistics to get results

Chapter Four

Results and Discussion

4.1. Rating and scoring of the study of questionnaire

A three-point Likert scale was used statistically to evaluate the questionnaire answers as weak , medium , or good to the study samples , Thus, the weak assessment is in the range (0 – 0.33), the medium in the range (0.34 – 0.67) , and the good in the range (0.68 – 1) as shown in table (4-1).

Table 4-1 : Three Points Likert Scale for Questionnaire Evaluation

Evaluation			
Likert Scale	Interval	Difference	Evaluation
1	0 – 0.33	0.33	Weak
2	0.34 – 0.67	0.33	Medium
3	0.68 – 1	0.33	Good

For both of knowledge control items, a complete correct answer was scored 2, incomplete correct answer was scored 1 and wrong or no answer was scored zero. For each part, the score of the items were summed up and divided by the total of items, giving a mean score of the part. These scores were converted into percent score for each part individually, then for the whole . Nursing staff knowledge and control role was considered adequate if the percent score was 60% or more and inadequate (weak) if less than 60% (Table 4-2).

Table 4-2 : Questionnaire 'score

Questionnaire 'parts	Number of questions	Score of complete answer	Score of incomplete answer	Score of incorrect answer
Knowledge of hospital infection	12	2	1	0
Control of hospital infection	10	2	1	0

4.2. Sample Characteristics

Table 4-3 : descriptive statistics of Demographic Variables

Demographic Variables	Variables Classes	F	Percent
Course training	No	23	64 %
	Yes	13	36 %
	Total	36	100 %
Experience	1 – 5	19	53 %
	5 – 10	10	28 %
	More than 10	7	19 %
	Total	36	100 %
Education level	High school	10	28 %
	Institute	13	36 %
	College	13	36 %
	total	36	100 %

Table (4-3) illustrated some general characteristics of the studied samples, including previous training course, experience, educational level. The table showed that most nursing staff (64%) had never received any course training in nosocomial infection and its control versus 36% who had just entered this training. Also, 53% of nurses had a working experience from 1-5 years compared to 28% had 5-10 years of experience in nursing, and 19% had more than 10 years of career service. The educational level of the participating nurses ranged from primary or high school at 28%, and the institute at 36%, to college at 36% also.

4.3. Questionnaire Item Analysis

Table 4-4: Evaluation of the knowledge and control domain of samples

Domain	Sample No.	Domain score	Mean score	Percentage %	Assessment
knowledge	36	24	13.66	56.91	Weak
Control	36	20	12.19	60.95	Medium
Total	36	44	25.86	58.77%	Weak

The results showed that nurses had weak knowledge (56.91%) ,where the mean score on this domain was 13.66 of a total score 24. In contrast , they had an intermediate assessment (60.95%) on the control domain ,with a mean score 12.19 out of 20 .Finally , the participating nurses had a mean score of 25.86 out of the questionnaire (44), and they all had a weak final assessment of 58.77% (Table 4-4).

Table 4-5: The relationship demographic characteristics and assessment of knowledge and control of nosocomial infection

Education level	Experience	Course training	Percentage	Assessment
Primary school	0-5	0	45.45%	Weak
High school	5-10	0	45.45 - 52.27	Weak
Institute	10-15	0	52.27- 59.09	Weak - medium
College	15-20	1	59.09 - 93.18	Medium - excellent

The table (4-5) shows the relationship between the demographic characteristics of nurses and the level of knowledge about infection in the hospital . The level of knowledge of nurses increased with their educational attainment and their experience through years of nursing service , as well as , the training courses had an impact on the knowledge compared to those who did not take the courses .

Chapter Five

Conclusion and Recommendation

5-1. Conclusion

- 1- There is a low level among nursing staff regarding knowledge and control of hospital infection .
- 2- There is a relationship between the level of nurses' knowledge and their educational attainment.
- 3- Experience gained in years of service has an impact on the knowledge level of nurses.
- 4- Training courses are having an impact on increasing nursing staff information in health field.

5-2. Recommendations

- 1- Continuous in-service training programs to update the nursing staff knowledge and practices of infection control.
- 2- The instruction form for infection control measures should be available to all nursing staff.
- 3- Repeat this research for more nursing staff to assess the impact of the implemented health education and training after a few years.
- 4- The attempt to develop the nursing and health staff in terms of this type of infection (personal development) because of its importance to limit the spread of the mentioned infection
- 5- The oversight role of health institutions, represented by the Ministry of Health or the Governorate Health Department, in monitoring their health institutions and their cadres as well
- 6- Holding workshops and periodic training courses for health cadres to prevent, as much as possible, from recovering the health reality to limit the spread of infection

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Appendixes

Appendix [A]

الجزء الاول : محور المعلومات الديموغرافية

- 1- صنف المستشفى التي يعمل بها الممرض : حكومية اهلية
- 2- اختصاص عمل الممرض في المستشفى :
- 3- العنوان الوظيفي :
- 4- عدد سنوات الخدمة :
- 5- الجنس :
- 6- العمر :
- 7- التحصيل الدراسي :
- 8- هل درس مادة الاحياء المجهرية المرضية سابقا
- 9- هل شارك في دورات تعليمية وتثقيفية عن الاحياء المجهرية المرضية الملوثة سابقا. نعم: لا:
- اذا كان الجواب (لا) يذكر السبب :
- 10- عدد الدورات المشاركون فيها :

الجزء الثاني : محور المعرفة بعدوى المستشفيات

- 1- هل البكتريا المسببة للعدوى هي :
* كائنات طبيعية انتهازية في جسم الانسان * ممرضات خارجية عن جسم الانسان.
- 2- هل البكتريا المسببة للعدوى منتجة لسموم :
* خارجية * داخلية * خارجية وداخلية * غير منتجة
- 3- هل البكتريا المسببة للعدوى تمتلك القدرة على الالتصاق بالسطوح او لا تمتلك ؟ نعم لا
- 4- هل البكتريا المسببة للعدوى تمتلك القدرة على الدخول والتكاثر وإتلاف انسجة المضيف ومقاومة مناعته ؟ نعم لا
- 5- يحدث التهاب المعدة والأمعاء لدى الاطفال في المستشفى نتيجة الاصابة ببكتريا الاشريشية القولونية وكذلك تفشي الدزنتريا نتيجة الاصابة ببكتريا الشكيلا سوني . نعم لا
- 6- هل الاشخاص في دور النقاهاة والذين يعانون من نقص المناعة وسوء التغذية اكثر عرضة للاصابة بعدوى المستشفيات ؟ نعم لا

- 7- ماهي الظروف التي تنتهزها البكتريا لاحداث الاصابة والمرض؟
- 8- من هم المرضى الاكثر عرضة للاصابة داخل المستشفيات ؟
- 9- ماهي اكثر انواع البكتيرية المعوية المسببة للعدوى والالتهابات داخل المستشفيات ؟
- 10- ماهي العوامل التي تساعد البكتريا الملوثة على احداث الاصابة داخل المستشفيات ؟
- 11- ماهي مصادر البكتريا المسببة للعدوى داخل المستشفيات ؟ اذكر ثلاث منها
- 12- ماهي اجهزة الجسم الاكثر عرضة لإصابات عدوى المستشفيات ؟

الجزء الثالث : محور السيطرة على عدوى المستشفيات

- 1- يحدث التهاب المسالك البولية نتيجة استخدام ادوات القسطرة التي يصعب تعقيمها بعد ذلك لذا ينبغي استخدام الادوات ذات الاستخدام الواحد . نعم لا
- 2- يعتبر غسل اليدين والتعقيم بالمعقمات بعد ملامسة المرضى وادوات الجراحة من اهم الطرق لمنع انتقال العدوى داخل المستشفيات . نعم لا
- 3- هل تعتقد ان اخذ كمية كبيرة من المضادات الحيوية يقلل من عدوى المستشفيات ؟ نعم لا
- 4- افضل طريقة لتعقيم ادوات الجراحة لصالوات العمليات هي :
* المعقمات الكيميائية السائلة * الفرن الكهربائي * الاشعة
- 5- ما هي طرق التعقيم التي تستخدم لتعقيم صالات العمليات داخل المستشفى ؟
- 6- اذكر بعض المواد التي تستخدم لتعقيم وتعفير صالات العمليات ورداهات العناية المركزة ؟
- 7- من كم شخص يتكون فريق السيطرة على العدوى داخل المستشفى وما تخصصهم ؟
- 8- ماهي طرق انتقال العدوى التي يصعب السيطرة عليها ؟ اذكر ثلاث منها
- 9- ماهو الاجراء الذي تقوم به مع المرضى المصابين بالامراض الانتقالية ؟
- 10- كيف تتعامل مع المواد الملوثة في الرداهات وصالوات العمليات مثل الدم وسوائل وافرازات الجسم المسببة للرداذا ؟

Appendix [B]

تقييم استبيان بحث

الدكتور / الدكتورة المحترم / المحترمة

نظرا لما تمتلكونه من خبرة علمية واسعة ، نرجوا الاطلاع على استبيان البحث الموسوم :

Assessment of Nursing Staff Knowledge about Nosocomial Infection and their role in controlling it.

وإبداء ملاحظاتكم عليه ، شاكرين لكم حسن تعاونكم .

الملاحظات :

التوقيع :

الدرجة العلمية :

التخصص :

التاريخ :

الخلاصة

الاهداف : تقييم معارف وممارسات مكافحة العدوى في المستشفيات بين طاقم التمريض في مستشفيات مدينة البصرة.

طرق العمل : بدأت الدراسة المقطعية في 1 كانون الاول 2021 واستهدفت 36 من موظفي التمريض ،حيث استخدمت استمارة لجمع البيانات للاستفسار عن خصائصهم الديموغرافية والمفاهيم العامة للعدوى في المستشفيات ومكافحتها والتخلص منها . جمعت المعطيات بواسطة استبيان وزع على المشاركين في المستشفيات ثم تم ادخال البيانات وتحليلها باستخدام برنامج التحليل الاحصائي SPSS .

النتائج : كانت درجات المعرفة وممارسات السيطرة في جميع المجالات منخفضة بشكل كبير حيث ان نتيجة تقييم موظفي التمريض كانت ضعيفة بنسبة 56.91% ومستوى ممارسات السيطرة كان متوسط بنسبة 60.95% ونتيجة التقييم الكلية للمحورين بين الممرضين المشاركين كانت ضعيفة ايضا بنسبة 58.77%. وبمعدل 25.86 من الدرجة الكلية للاستبيان. وكان للمستوى التعليمي وخبرة العمل والدورات التدريبية اثر على تحسين المعرفة ومكافحة العدوى .

الاستنتاج : كانت درجات المعرفة ومكافحة العدوى للممرضين منخفضة وخاصة في مجالات نظافة اليدين ومعدات التطهير والوقاية الشخصية واحتياطات العزل مما يعكس عدم كفاية التعليمات التي يتلقاها طاقم التمريض مما يجعلهم عرضة للعدوى لذلك من الضروري وضع بروتوكولات افضل لمكافحة العدوى وتنفيذ أنشطة في مجال التثقيف والتدريب لضمان ممارسات السلامة .



جامعة البصرة
كلية التمريض
فرع العلوم الاساسية

تقييم معارف الكادر التمريضي حول عدوى المستشفيات ودورهم في السيطرة عليها

مشروع بحث مقدم الى مجلس كلية التمريض جامعة البصرة كجزء من متطلبات نيل درجة
بكالوريوس في علوم التمريض

من قبل الطالبة

علي عبد الرزاق وهيب
محمد طارق طلاب
كرار حسون هاشم

المرحلة الرابعة

المشرف

م.د. عبدالمطلب عبدالله محمد

2021-2022