Preparing for CMS Infection Control Inspections

CMS Interpretive Guidelines and the Revised CMS Infection Control Worksheet

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Speaker

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- Board Member Emergency Medicine Patient Safety Foundation at www.empsf.org
- 614 791-1468
- sdill1@columbus.rr.com
Learning Objectives

- Discuss the infection control policies and procedures required by CMS

- Explain how CMS is using the revised infection control worksheet including why it is so important for staff to know how to utilize it

- Discuss why CMS requires that the national standards of care and practice must be followed such as those from the CDC, SHEA, APIC, OSHA, and AORN,

- List the CMS required infection control officer’s responsibilities in measuring, identifying, preventing and controlling infection
The CDC says there are 1.7 million healthcare infection (HAI) in America every year.

There are 99,000 to 100,000 deaths in American hospitals every year.

CMS gets 50 million dollar grant to enforce infection control standards in 2010 and 2011 and HHS a billion dollars in 2013 so surveyors are more knowledgeable.

Leadership need to make sure there is adequate staffing and resources to prevent and manage infections.

Healthcare-Associated Infections (HAIs) are one of the top ten leading causes of death in the US. 

[www.cdc.gov/ncidod/dhqp/hai.html](http://www.cdc.gov/ncidod/dhqp/hai.html)
The Conditions of Participation (CoPs)

- Regulations first published in 1986
- Revised many times since with IC changes, safe injection practices, insulin pens, humidity in the OR etc.
  - Manual updated August 30, 2013 and 457 pages
- First regulations are published in the Federal Register then CMS publishes the Interpretive Guidelines and some have survey procedures
  - Hospitals should check this website once a month for changes

The Conditions of Participation

- Good way to keep up is sign up for the Federal Register \(^1\)

- Hospitals should check the survey and certification website once a month for changes \(^2\)

- Another good place to check monthly is the transmittal website \(^3\)

- Have one person assigned to check these once a month

\(^1\) www.gpoaccess.gov/fr/index.html
\(^2\) www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp
\(^3\) www.cms.gov/Transmittals/01_overview.asp
Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Select From The Following Options:
- Show all items

Show only (select one or more options):
- Show only items whose is within the past
- Show only items whose Fiscal Year is
- Show only items containing the following word

Show Items

There are 455 items in this list.

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
## Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

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<th>Memo #</th>
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<td><strong>Guidance for Hospitals, Critical Access Hospitals (CAHs) and Ambulatory Surgical Centers (ASCs) Related to Various Rules Reducing Provider/Supplier Burden</strong></td>
<td>13-20-Acute Care</td>
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<td>13-14-ALL</td>
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<td><strong>Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)</strong></td>
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<td><strong>F tag 155—Advance Directives—Revised Advance Copy</strong></td>
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<td><strong>Revised Roll-Out of the New End Stage Renal Disease (ESRD) Core Survey Process</strong></td>
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<td><strong>Information Only: New Dining Standards of Practice Resources are Available Now</strong></td>
<td>13-13-NH</td>
<td>2013-03-01</td>
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</table>
CMS issues memo related to the relative humidity (RH)

AORN use to say temperature maintained between 68-73 degrees and humidity between 30-60% in OR, PACU, cath lab, endoscopy rooms and instrument processing areas

CMS says if no state law can write policy or procedure or process to implement the waiver

Waiver allows RH between 20-60%

In anesthetizing locations- see definition in memo
Humidity in Anesthetizing Areas

Center for Clinical Standards and Quality / Survey & Certification Group

DATE: April 19, 2013
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Relative Humidity (RH): Waiver of Life Safety Code (LSC) Anesthetizing Location Requirements; Discussion of Ambulatory Surgical Center (ASC) Operating Room Requirements

Memorandum Summary

• **RH of ≥20 Percent Permitted in Anesthetizing Locations:** The Centers for Medicare & Medicaid Services (CMS) is issuing a categorical LSC waiver permitting new and existing ventilation systems supplying hospital and critical access hospital (CAH) anesthetizing locations to operate with a RH of ≥20 percent, instead of ≥35 percent. We are also recommending that RH not exceed 60 percent in these locations.

• **This Waiver Does Not Apply:**
  • When more stringent RH control levels are required by State or local laws and regulations, or
  • Where reduction in RH would negatively affect ventilation system performance.

• **Hospitals & CAHs Must Elect to Use the Categorical Waiver:**
  • Individual waiver applications are not required, but facilities are expected to have written documentation that they have elected to use the waiver.
  • At the entrance conference for any survey assessing LSC compliance, a facility that has elected to use this waiver must notify the survey team.

• **Ongoing Requirements:**
  • Facilities must monitor RH in anesthetizing locations and take corrective actions when needed to ensure RH remains at or above 20 percent.

• **ASCs:** ASCs are not subject to all of the same LSC requirements as hospitals, but are required, consistent with 42 CFR 416.44(a)(1), to maintain RH in operating rooms in accordance with nationally accepted guidelines.

• **State Operations Manual (SOM) Appendices A, L, I, & W are being updated accordingly.**
Transmittals

The Centers for Medicare & Medicaid Services uses transmittals to communicate new or changed policies or procedures that we will incorporate into the CMS Online Manual System. The cover or transmittal page summarizes and specifies the changes. The transmittals for 2000 through 2003 have been archived. The archived transmittals can be accessed using the following URLs:

2003 Transmittals


2002 Transmittals


2001 Transmittals


2000 Transmittals

The Conditions of Participation (CoPs)

- The manual is known as the conditions of participation or the CoPs for short
- The CoP sections are called tag numbers
- They go from Tag 0001 to 1164
  - All the sections contain a tag number so it is easy to go back and look up that section if you want to read more about it
- There were changes in the Federal Register went into effect July 16, 2012 and IG issued March 15, 2013 and in the current manual
Location of All of CMS CoPs Manuals

Medicare State Operations Manual
Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.

- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.


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<th>Description</th>
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<tr>
<td>A</td>
<td>Hospitals</td>
<td>2,185 KB</td>
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<tr>
<td>AA</td>
<td>Psychiatric Hospitals</td>
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State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

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(Rev. 84, 06-07-13)

Transmittals for Appendix A

Survey Protocol

Introduction

Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 - Post-Survey Activities
Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module
Hospital Swing-Bed Survey Module

Regulations and Interpretive Guidelines

§482.2 Provision of Emergency Services by Nonparticipating Hospitals
§482.11 Condition of Participation: Compliance with Federal, State and Local Laws
State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

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(Rev. 89, 08-30-13)

Transmittals for Appendix A

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Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module
Hospital Swing-Bed Survey Module

Regulations and Interpretive Guidelines
§482.2 Provision of Emergency Services by Nonparticipating Hospitals
CMS Issues Final Regulation

- CMS publishes 165 page final regulations changing the CMS CoP
- Published in the May 16, 2012 Federal Register
  - CMS publishes to reduce the regulatory burden on hospitals-more than two dozen changes
    - Eliminated the infection control log under Tag 750
    - June 7, 2013 added additions to surveillance
    - June 7, 2013 added IP is infection preventionist
- Available at [www.ofr.gov/inspection.aspx](http://www.ofr.gov/inspection.aspx)
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482 and 485

[CMS–3244–F]

RIN 0938–AQ89

Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services.

ACTION: Final rule.

SUMMARY: This final rule revises the requirements that hospitals and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs. These changes are an integral part of our efforts to reduce procedural burdens on providers. This rule reflects the Centers for Medicare and Medicaid Services’ (CMS) commitment to the general principles of the President’s Executive Order 13563, released January 18, 2011, entitled

www.federalregister.gov/articles/2012/05/16
CMS Updates to Manual

Center for Clinical Standards and Quality / Survey & Certification Group

DATE: March 15, 2013
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group

SUBJECT: Guidance for Hospitals, Critical Access Hospitals (CAHs) and Ambulatory Surgical Centers (ASCs) Related to Various Rules Reducing Provider/Supplier Burden

Memorandum Summary

- Various Burden Reduction Regulations Adopted:
  - On October 24, 2011, the Centers for Medicare & Medicaid Services (CMS) published a final rule revising the ASC Patient Rights regulation at 42 CFR 416.50, effective December 23, 2011 (76 FR 65586).
  - On November 30, 2011, CMS published the Hospital Outpatient Prospective Payment System rule, effective January 1, 2012 (76 FR 74122). The rule included revisions to 42 CFR 489.20(w), governing required notice to patients by hospitals and CAHs that do not have an anesthesiologist anesthesiologist (MD) or doctor of osteopathy (DO) present in the hospital or CAH at all times.
  - On May 16, 2012, CMS published two final rules (77 FR 29002 & 77 FR 29034) which included provisions:
    - For Hospitals: Revisions of the Conditions of Participation (CoPs) concerning governing body, patient’s rights, medical staff, nursing services, medical records, pharmaceutical services, infection control, outpatient services and transplant center organ recovery and receipts.
    - For CAHs: Revisions of the CoPs concerning definitions, personnel qualifications, physical plant and environment, and surgical services.
    - For ASCs: Revision of the Conditions for Coverage (CfC) for environment.
Log of Incidents 750  Deleted 2013

- Must maintain a log related to infections and communicable diseases
  - CMS deleted the log requirement but not for CAH hospitals
  - Log requirements use to require the following;
- Includes information from patients
- Includes employees, contract staff such as agency nurses, and volunteers
- Includes surgical site infections, patients or staff with MDRO, patients who meet isolation requirements
Hospital infection control officers are often referred to as hospital epidemiologists (HEs), infection control professionals (ICPs) or IP

- APIC calls them Infection Preventionist or IP and June 7, 2013 CMS added IP to tag 748

- CDC has defined “infection control professional” as “a person whose primary training is in either nursing, medical technology, microbiology, or epidemiology and who has acquired specialized training in infection control”

- The hospital must designate in writing an individual as its infection control officer
- Mitigate risks associated with
  - Patient infections present upon admission
  - Risks contributing to HAI
- Conduct active surveillance *(revised June 2013)*
  - Includes patients, staff, volunteers, and contract workers
  - Must identify and track infectious and communicable diseases
  - Including HAI selected by IC program bases on targeted surveillance based on nationally recognized guidelines and periodic risk assessment
IC Officer’s Responsibilities  749  2013

- Active surveillance (continued)
  - Culture or patient colonized with MDRO
  - Isolation patients
  - Patients or staff with reportable communicable diseases
  - Staff or patients with signs and symptoms in which local, state, or feds request
  - Staff or patients infected with significant pathogens
  - Recommend use of automated surveillance technology

- Monitoring compliance with all P&Ps, protocols and other infection control program requirements
Changes to Tag 749 Active Surveillance

- **Active surveillance:**
  - The hospital is expected to identify and track infections and communicable diseases in any of the following categories occurring throughout the hospital, whether in patients or staff (patient care staff and non-patient care staff, including employees, contract staff and volunteers). Hospitals are not required to organize their surveillance according to these categories. The categories are:
    - Healthcare-associated infections selected by the hospital’s Infection Prevention and Control Program as part of a targeted surveillance strategy based on nationally recognized guidelines and periodic risk assessment;
    - Patients or staff with identified communicable diseases that local, State, or Federal health agencies require be reported;
    - Patients identified by laboratory culture as colonized or infected with multi-drug-resistant organisms (MDROs), as defined by the hospital’s Infection Prevention and Control Program;
    - Patients who meet CDC criteria for requiring isolation precautions (other than “Standard Precautions” or a protective environment) during their hospitalization;
    - Patients or staff with signs and symptoms that have been requested be reported or
CMS Infection Control Standards

What Hospitals Need to Know.
Infection Control

- There are 12 pages in the interpretive guidelines on infection control
- Updated to reflect changing infectious and communicable disease threats
- Includes current knowledge and best practices
- Must follow national standards of care and practice
- CMS announces unannounced surveys related to infection control in 2014
Infection Control

- Included four major sections
  - Active infection control program
  - Investigations and control of infections
  - Infection control log (no longer mandatory so make sure P&P changed)
  - CEO, CNO, and MS must ensure hospital-wide training program and correction plan for problem areas
- Note that CMS has announced infection control inspections of hospitals so need to do this right
§482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

*Interpretive Guidelines §482.42*

This regulation requires the hospital to develop, implement, and maintain an active, hospital-wide program for the prevention, control, and investigation of infections and communicable diseases. The National Institute of Allergy and Infectious Diseases defines an infectious disease as a change from a state of health to a state in which part or all of a host’s body cannot function normally because of the presence of an infectious agent or its product. An infectious agent is defined by the NIAID as a living or quasi-living organism or particle that causes an infectious disease, and includes bacteria, viruses, fungi, protozoa, helminthes, and prions. NIAID defines a communicable disease as a disease associated with an agent that can be transmitted from one host to another. (NIAID website glossary)
HHS Action Plan

- Estimated that HAIs incur nearly $20 billion in excess healthcare cost each year
  - Many are preventable
- Top priority of HHS now
- Develop HHS Action Plan to Prevent HAIs
- Every infection preventionist (IP) should have a copy of this document
- HHS get a billion dollars to enforce IC and has a video every healthcare practitioner should see
  - Partnering to heal video at [http://www.hhs.gov/partneringtoheal](http://www.hhs.gov/partneringtoheal)

The Cost of Healthcare Associated Infections

www.cdc.gov/HAI/burden.html

Healthcare-associated Infections (HAIs)

The Burden

Healthcare-associated infections (HAIs) are infections that patients acquire during the course of receiving healthcare treatment for other conditions. These infections related to medical care can be devastating and even deadly. As the nation’s health protection agency, CDC is committed to helping all Americans receive the best and safest care when they receive healthcare services.

CDC strives to understand how HAIs happen and to develop appropriate interventions. HAIs are an important public health problem. Approximately 1 out of every 20 hospitalized patients will contract an HAI.

The following documents provide information about the problem of HAIs in the United States.

The Direct Medical Costs of Healthcare-associated Infections in U.S. Hospitals and the Benefits of Prevention [PDF - 835 KB]

This report uses results from the published medical and economic literature to provide a range of estimates for the annual direct medical hospital cost of treating HAIs in the United States.


In 2002, the estimated number of HAIs in U.S. hospitals, adjusted to include federal facilities, was approximately 1.7 million: 33,269 HAIs among newborns in high-risk nurseries; 19,059 among newborns in well-baby nurseries; 417,946 among adults and children in intensive care units (ICUs); and 1,266,851 among adults and children outside of ICUs.

Visit NHSN Data & Statistics for more reports and information.
Watch the Video on Preventing HAI

www.hhs.gov/ash/initiatives/hai/training/
Infection Control  Follow the Money!

- This area is very important now

- Now if you do not do this right it could cost the hospital money

- CMS has hospital acquired conditions (HAC) in which no additional payment is made for Medicare patients and CMS will do this for Medicaid patients

- Many states agree not to bill for some or all of the 29 never events or serious reportable events (revised list in 2011)

- Insurance companies are putting it into their contracts that hospitals will not bill for any of the never events
CMS Hospital Acquired Conditions

- CMS has no additional payment for these HACs or never events
- Studies show huge cost to hospitals
- Vascular catheter-associated infection
- Surgical site infection such as mediastinitis after coronary artery bypass graft surgery
- Catheter-associated urinary tract infections
- Surgical-site infections following certain orthopedic procedures (repair, replacement or fusion of joints)
Hospital-Acquired Conditions

Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

On July 31, 2008, in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision. Payment implications began October 1, 2008, for these Hospital Acquired Conditions. The IPPS FY 2009 Final Rule is available in the Statute/Regulations/Program Instructions section, accessible through the navigation menu at left.

These 11 categories of HACs listed below include the new HACs from the IPPS FY 2013 Final Rule which are Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burn
  - Other Injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html
The guidelines include a definition of infectious disease, infectious agent, and communicable diseases.

Hospitals may want to include these definitions in their revised policies and procedures.

Definitions developed by the National Institute of Allergy and Infectious Diseases (NIAID)

**Communicable disease** is defined as a disease associated with an agent that can be transmitted from one host to another.
Definition of Infection

- **Infectious disease** is defined as a change from a state of health to a state in which part or all of a host’s body cannot function normally because of the presence of an infectious agent or its product.

- An **infectious agent** is defined as a living or quasi-living organism or particle that causes an infectious disease, and includes bacteria, viruses, fungi, protozoa, helminths (parasitic worms), and prions.

- Note that APIC now calls them infection preventionist or IPs
  - CMS in 2013 now call them infection preventionist
Infection Control (IC)

- Hospital must have sanitary environment to avoid sources and transmission of infection and communicable diseases
  - Maintain an active IC program for prevention, control, and investigation of infections and communicable diseases
  - Standards apply to all departments of hospitals both on and off campus
- All areas must be clean and sanitary
  - No dried blood on the floor, side of stretchers or on the ceiling tile
Infection Control

- Infection prevention must include monitoring of housekeeping (Environmental Services) and maintenance including construction activities.
- Areas to monitor include food storage preparation, serving and dish rooms, refrigerators, ice machines, air handlers, autoclave rooms, venting systems, inpatient rooms, treatment areas, labs, waste handling, surgical areas, supply storage and equipment cleaning.
Infection Control (IC) A-0747

- Include all standards of care and practice
  - State and federal laws

- Look at national organization recommendations
  - APIC (Association for Professionals in Infection Control and Epidemiology), CDC (Center for Disease Control), SHEA (Society for Healthcare Epidemiology of America), OSHA (Occupational Health and Safety Administration), AORN, IDSA, etc.

- Investigate infections and communicable diseases for **inpatients** and **personnel** working in hospitals including volunteers
APIC’s Targeting Zero Campaign

- Targeting zero is the philosophy that every hospital should be working toward a goal of zero HAIs.
- While not all HAIs are preventable, APIC believes we should strive for the goal of elimination and strive for zero infections.
- Association for Professionals in Infection Control and Epidemiology (APIC) put together many resources to help hospitals to start to meet this goal.
- Prompt investigation of HAIs of greatest concern to the hospital (like MRSA, C-Diff, surgical site infections, catheter associated UTIs).
- Needed because of our declining arsenal of antibiotics to treat infections.
Infection Control

- Maintain active surveillance program
  - So what’s in your IC plan and IC program?
  - Specific measures for infection detection, data collection, analysis monitoring, and evaluations of preventive interventions

- Document surveillance activities

- Must have reliable sampling or other mechanism in place to identify and monitor infections and communicable diseases
### Action Area One: Collaborative Approach: New Ways of Thinking

**Key Issues:** Tackling healthcare associated infections requires commitment from all levels of the organization and an enhanced local and system infrastructure committed to “getting to zero.”

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<th>ACTION REQUIRED</th>
<th>MEASUREMENT OF SUCCESS</th>
<th>LEAD</th>
<th>PRIORITY</th>
<th>COMPLETION DATE</th>
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<tr>
<td>Infrastructure</td>
<td>1. Form a Hospital X-wide multidisciplinary Infection Control and Prevention (ICP) workgroup from inpatient and outpatient services, including Physician, Nursing, Pharmacy, Laboratory, Housekeeping, Facilities, Risk, Quality and Safety departments, etc. to: • Oversee the development and implementation of Hospital X’s Infection Control and Prevention strategies • Monitor performance against the action plan • Review scorecard metrics (including all deaths associated with infections) • Serve as champions to facilitate intervention strategies</td>
<td>Formation of ICP workgroup with quarterly progress reports</td>
<td>VP Clinical Safety, Local Infectious Disease physician to co-chair ICP workgroup</td>
<td>HIGH</td>
<td>January 09</td>
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<td>2. Assess and recommend appropriate local structure to ensure accountability in meeting “getting to zero” goals</td>
<td>Distribution of draft recommendations for local accountability structure</td>
<td>VP Clinical Safety, VP Medical Services, Physician Leadership Council, Nursing Leadership Council</td>
<td>HIGH</td>
<td>February 09</td>
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Infection Control

- Infection control must be integrated in PI
- Surveillance activities should be conducted in accordance with recognized surveillance practices
  - CDC NHSN (National Healthcare Safety Net)
  - NHSN is internet-based surveillance system managed by the CDC
  - Hospitals now using to report ICU and NICU central line infections and selected reporting of CAUTIs
  - Available for hospitals at no charge and great resource
  - Provides multiple options for data analysis and more flexibility for sharing information within and outside the facility
Infection Control

- NHSN replaces the CDCs National Nosocomial Infection Surveillance system (NNIS)
  - Was considered the gold standard for tracking HAI for more than 30 years
  - Designed to help hospitals better manage episodes of HAI such as MRSA and VRE
  - Used by the VA hospitals
  - Hospitals report central line infections in ICUs and NICUs

- Enroll on-line for HAI surveillance and many other resources

The National Healthcare Safety Network (NHSN) is a secure, internet-based surveillance system that integrates and expands legacy patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC. NHSN also includes a new component for hospitals to monitor adverse reactions and incidents associated with receipt of blood and blood products. Enrollment is open to all types of healthcare facilities in the United States, including acute care hospitals, long term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities. For more information, click on the topics below.

**Topics**

- **Join NHSN**
  - Welcome to NHSN, CMS Hospital Inpatient Quality Reporting Program Training...
- **About NHSN**
  - Overview, Purposes, Confidentiality statement, How data are used, External Peer Review report...
- **Enrollment Requirements**
  - Eligibility, Required Training, Reporting & System Requirements, Security, Begin Enrollment...
- **Training**
  - Self study slide sets and corresponding materials for NHSN modules...
- **Forms**
  - Component-specific manuals containing data collection protocols...
- **Patient Safety Component**
  - Overview of the Modules: Device-associated, Procedure-associated.

**Contact NHSN:**

- Centers for Disease Control and Prevention
- National Healthcare Safety Network
- MS- A24
- 1600 Clifton Rd
- Atlanta, GA 30333
- 800-CDC-INFO (800-232-4636)
- TTY: (888) 232-6348
- New Hours of Operation
  - 8am-8pm ET/Monday -Friday

**NHSN Demo**

- Access NHSN Demo Web Site

**Long-term Care Facility Component**

- Click here to enroll

**Dialysis Facilities**

- Enroll here to comply with CMS QIP requirement
National Healthcare Safety Network (NHSN) Training

Our mission is to offer learning opportunities in a variety of formats that enhance the knowledge and skills of NHSN facility- and group-level participants and their partners in order that they may effectively use the data obtained from the surveillance system to improve patient and healthcare personnel safety.

Objectives

- Convey NHSN data collection methods, submission requirements, and analysis options to participants so that they may acquire, submit, and disseminate high quality, actionable data.
- Prepare participants to use the NHSN reporting application accurately and efficiently.
- Enhance participants’ and their partners’ understanding of data quality and the value of adverse event monitoring.
- Encourage collaboration among participants and partners to improve the patient and healthcare personnel safety across the spectrum of care.

NHSN training topics...

- **Course Catalog**
  - Course descriptions for NHSN components, modules and events

- **Patient Safety Component**
  - Self-paced training for specific module & events

- **Enrollment & Setup**
  - Self-paced training for new NHSN enrollment and existing facility set-up

- **Dialysis Event**
  - Self-paced training for outpatient dialysis facilities enrollment &

Case Studies

- Webinars with Case Studies

NHSN Demo

- Access NHSN Demo Web Site

Contact NHSN:

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- TTY: (888) 232-6348
- New Hours of Operation
- 8am-8pm ET/Mondays - Fridays

www.cdc.gov/nhsn/training/
National Healthcare Safety Network (NHSN)

Tracking Infections in Acute Care Hospitals/Facilities

NHSN is the HAI surveillance gold standard. The system (and its predecessors) started years ago helping a few hundred healthcare facilities; today, more than 11,000 healthcare facilities use NHSN as the cornerstone of their HAI elimination strategies. Specifically, facilities use NHSN to:

- Access NHSN enrollment requirements for CMS Hospital Inpatient Quality Reporting Program,
- Obtain baseline HAI rates,
- Compare rates to CDC’s national data,
- Participate in state or national HAI prevention collaboratives,
- Devise and implement HAI elimination strategies,
- Evaluate immediate and long-term results of elimination efforts,
- Refocus efforts as needed, or advance to different areas.

CLABSI - Surveillance for Central Line-associated Bloodstream Infections
- Training
- Protocols
- Forms
- Support Materials
- Analysis Resources
- FAQs

CAUTI - Surveillance for Catheter-associated Urinary Tract Infections
- Training
- Protocols
- Forms
- Support Materials
- Analysis Resources
- FAQs

CLIP - Surveillance for Central Line Insertion Practices Adherence
- Training
- Protocols
- Forms
- Support Materials
- Analysis Resources
- FAQs

SSI - Surveillance for Surgical Site Infections
- Training
- Protocols
- Forms
- Support Materials
- Analysis Resources
- FAQs

MDRO/CDI - Surveillance for C. difficile, MRSA, and Other Drug-Resistant

AUR - Surveillance for Antimicrobial Use and Antimicrobial Resistance Option

Contact NHSN:
Centers for Disease Control and Prevention
National Healthcare Safety Network
MS-A24
1600 Clifton Rd


¹National Institutes of Health, Bethesda, Maryland
²Infusion Nurses Society, Norwood, Massachusetts
³Greenwich Hospital, Greenwich, Connecticut
⁴University of Washington, Seattle, Washington
⁵Wheaton Franciscan Healthcare-St. Joseph, Milwaukee, Wisconsin
⁶University of Massachusetts Medical School, Worcester, Massachusetts
⁷Johns Hopkins University School of Medicine, Baltimore, Maryland
⁸Warren Alpert Medical School of Brown University and Rhode Island Hospital, Providence, Rhode Island
⁹Office of Infectious Diseases, CDC, Atlanta, Georgia
¹⁰MD Anderson Cancer Center, Houston, Texas
¹¹The Children's Hospital, Boston, Massachusetts
¹²University of Nebraska Medical Center, Omaha, Nebraska
¹³Ann Arbor VA Medical Center and University of Michigan, Ann Arbor, Michigan
CMS said there are four special challenges in infection control (just four?)

- Challenge 1: Multidrug-Resistant Organisms
- Challenge 2: Infection Control in Ambulatory Care
- Challenge 3: Communicable Disease Outbreaks
- Challenge 4: Bioterrorism
Multidrug-Resistant Organisms

- Multidrug-resistant organisms (MDROs) are resistant to one or more antimicrobial agents
  - Treatment is more difficult
  - These bad bugs are more dangerous

- Have systems in place to identify and prevent transmission of these organisms.

- The CDC has a special publication on “Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006”

Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006


Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

Acknowledgement:
The authors and HICPAC gratefully acknowledge Dr. Larry Strausbaugh for his many contributions and valued guidance in the preparation of this guideline.
Healthcare-associated Methicillin Resistant \textit{Staphylococcus aureus} (HA-MRSA)

**Overview of Healthcare-associated MRSA**

Methicillin-resistant \textit{Staphylococcus aureus} (MRSA) is a type of staph bacteria that does not react to certain antibiotics and will normally cause skin infections, but MRSA can also cause other infections— including pneumonia. MRSA can be fatal. In 1974, MRSA infections accounted for two percent of the total number of staph infections; in 1995 it was 22%; in 2004 it was 63%. CDC estimated that 94,360 invasive MRSA infections occurred in the United States in 2005; 18,650 of these were associated with death. MRSA is resistant to antibiotics including methicillin, oxacillin, penicillin, and amoxicillin. Since these strong drugs are not effective with MRSA, these infections are sometimes called Multidrug-Resistant Organisms (MDROs). Staph infections, including MRSA, occur most often among people in hospitals and healthcare facilities (such as nursing homes and dialysis centers) who have weakened immune systems. The infection can be spread by skin-to-skin contact, sharing or touching a personal item with someone with infected skin, or touching a surface or item that has been in contact with someone with MRSA.

MRSA infections that occur in otherwise healthy people who have not been recently (within the past year) hospitalized or had a medical procedure (such as dialysis, surgery, catheters) are known as community-associated MRSA infections (CA-MRSA). These infections are usually skin infections such as abscesses, boils, and other pus-filled lesions, but these infections may also lead to more serious illness, such as pneumonia. (See Community-associated MRSA.)
Clinical Practice Guidelines for Clostridium difficile Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA) ·
Author(s): Stuart H. Cohen, MD, Dale N. Gerding, MD, Stuart Johnson, MD, Ciaran P. Kelly, MD, Vivian G. Loo, MD, L. Clifford McDonald, MD, Jacques Pepin, MD, Mark H. Wilcox, MD
Source: Infection Control and Hospital Epidemiology, Vol. 31, No. 5 (May 2010), pp. 431-455
Published by: The University of Chicago Press on behalf of The Society for Healthcare Epidemiology of America
Stable URL: http://www.jstor.org/stable/10.1086/651706
Accessed: 02/08/2011 23:02

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Guide to Preventing Clostridium difficile Infections

www.apic.org/Professional-Practice/Implementation-guides

About APIC
APIC's mission is to create a safer world through prevention of infection. The association's more than 14,000 members direct infection prevention programs that save lives and improve the bottom line for hospitals and other healthcare facilities. APIC advances its mission through patient safety, implementation science, competencies and certification, advocacy, and data standardization.
Infection control in ambulatory care presents special problems

- Patients remain in common areas such as the lobby and ED waiting areas
- Patients are turned around quickly with minimal cleaning
- Infectious patients may not be recognized immediately
- Immuno-compromised patients can receive treatment in rooms with other patients who pose a risk of infection
APIC Resources for Ambulatory Care

APIC, the leading provider of infection prevention and control solutions, has developed a series of resources specific to the ambulatory care setting. With all of the new requirements, regulations, and expectations regarding infection prevention and control in ambulatory care, we know how overwhelming it can be. And we're here to help you find what you need in the most efficient way.

APIC offers infection prevention resources directly applicable to ambulatory care.
Guidelines have been developed by the CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) [www.cdc.gov/hicpac/pubs.html](http://www.cdc.gov/hicpac/pubs.html)

- Infection control plan for ambulatory care
- Norovirus gastroenteritis outbreaks 2011
- Guidelines for Disinfection and Sterilization in Healthcare Facilities 2008
- Guidelines for Isolation Precautions 2007
- CDC Intravascular guidelines 2011
- Management of Multidrug-Resistant Organisms 2006
- Influenza Vaccination of Healthcare Personnel 2006
Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings

Taranisia MacCannell, PhD, MSc; Craig A. Umscheid, MD, MSCE; Rajender K. Agarwal, MD, MPH; Ingi Lee, MD, MSCE; Gretchen Kuntz, MSW, MSLIS; Kurt B. Stevenson, MD, MPH and the Healthcare Infection Control Practices Advisory Committee (HICPAC)

1 Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention
Atlanta, GA

2 Center for Evidence-based Practice
University of Pennsylvania Health System
Philadelphia, PA

3 Division of Infectious Diseases
The Ohio State University,
Columbus, OH

www.cdc.gov/hicpac/norovirus/002_norovirus-toc.html
Infection Control in Ambulatory Care

- CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) Guidelines (continued)
  - Guidance on Public Reporting of HAI 2005
  - Guidelines for Preventing Healthcare Associated Pneumonia 2004
  - Guidelines for Environmental Infection Control in Healthcare Facilities 2003, 2002
  - Hand hygiene guidelines, Prevention of Surgical Site Infections and more

- HICPAC is a federal advisory committee made up of 14 external IC experts who provide guidance and advice to the CDC and HHS
  - Members from APIC, SHEA, AORN, CMS, FDA etc.
Preventing Infections in the Outpatient Unit

 2011 CDC has a guide and checklist for preventing infections in the outpatient setting
   The Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care and
   The Infection Prevention Checklist for Outpatient Settings; Minimum Expectations for Safe Care

CDC Guide Infection Control Outpatients

Community-wide outbreaks of communicable diseases present many of the same types of issues as hospital infection disease threats

- Understand the epidemiology
- Know how it is transmitted and the clinical course of the disease in order to manage the outbreak

- Pandemics, or widespread outbreaks of an infection require back up resources
  - Hospitals need to work with state, federal, and local health agencies
Communicable Disease Outbreaks

- There are at a minimum four things that must be addressed:
  - Preventing transmission among patients, healthcare personnel, and visitors
  - Identifying persons who may be infected and exposed
  - Providing treatment or prophylaxis to large numbers of people
  - Logistical issues (staff, medical supplies, resupply, continued operations, and capacity)
I. In addition to implementation of the general Emergency Management Policies, the following issues will be addressed for infectious diseases. Additional information is contained in policies for SARS, Bioterrorism preparedness, pandemic flu preparation.

II. Community Resources: Determine if this is a community-wide event and if other facilities, shelters, hotels, etc., are also accepting the infectious patients. If so, coordinate decision-making with community disaster agencies and local/state public health departments.

III. Type Of Infectious Disease/Mode Of Transmission: Determine what types of infectious disease the patients have and its mode of transmission. If the mode of transmission is any mode that requires precautions beyond standard precautions, make a decision regarding the following:

A. Are rooms needed with negative pressure for isolation?
   1. If yes, does the facility have adequate negative pressure rooms or can rooms be retrofitted for negative pressure?
   2. Can several patients fit into the available negative pressure rooms and thus accommodate the influx?
   3. Can a wing of the building that does not share an air system with the rest of the building be used for the infectious patients?
   4. Does the entire building need to be emptied of patients without the infectious disease so the building can be used for only patients with the infectious disease?
   5. Does an outdoor temporary shelter need to be implemented to house the infectious patients?

B. If negative pressure is not needed but contact or droplet precautions are,
   1. Does the facility have adequate rooms/spaces to cohort the patients with the infectious disease? Move patients to fifth floor if possible to vent out top of
Bioterrorism

- Hospitals should be well versed in emergency preparedness, including bioterrorism
- Terrorists could use bioterrorism
- There is a long list of bioterrorism agents
  - Anthrax, arenaviruses, botulism, brucellosis, cholera, Ebola virus, hemorrhagic fever, E. coli, Lassa fever, plague, ricin toxin, salmonella, and cryptosporidium
- For a comprehensive list go to website

1http://www.emergency.cdc.gov/agent/agentlist.asp
Bioterrorism

Specific Bioterrorism Agents
• A–Z
• List by Category

Info for the General Public
• Overview
• Agent-Specific Fact Sheets

Info for Professionals
• Case Definitions
• Training
• First Responders
• Lab Info

Surveillance
• Preparation & Planning
• Communicating in the First Hours: Initial Communication With the Public During a Potential Bioterrorism Event

More Images
Emergency Preparedness

APIC offers educational and reference materials for infection preventionists, healthcare and public health professionals, and disaster planners related to infection prevention and emergency preparedness enabling members to collaborate with local, state, and federal agencies in areas related to preventing infection transmission during disasters.

You may also visit the Emergency Preparedness Conference Education Library to purchase recordings of emergency preparedness sessions from the 2009 APIC Annual Conference.

**Incident Command Training**
Links to FEMA's Incident Command... [more]

**Pandemics**
Infection prevention information for the novel pathogenic organism... [more]

**Bioterror**
Critical information on bioterrorism agents... [more]

**Surge Capacity**
Addressing infection prevention challenges created by a patient surge... [more]
Bioterrorism

- The hospital must be in compliance with the Occupational Health and Safety Administration’s Bloodborne Pathogens regulation
  - 29 CFR 1910.1030.¹

- The Code of Federal Regulations can be obtained free from the internet

- Regulations address PPE, safer needles, and use of universal precautions to prevent the spread of infection
IP Officer’s Responsibilities

- Many have added these to their job descriptions
- Maintain sanitary hospital environment
  - Ventilation and water controls, construction-make sure safe environment, safe air handling in areas of special ventilations such as the OR and isolation rooms, techniques for food sanitation, cleaning and disinfecting surfaces, carpeting and furniture, how is pest control done, and disposal of trash along with non-regulated waste
A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.

APIC and CMS call these professionals infection preventionists.
Hospital infection control officers are often referred to as hospital epidemiologists (HEs), infection control professionals (ICPs) or IP

- APIC calls them **Infection Preventionist** or IP and June 7, 2013 CMS added IP to tag 748

- CDC has defined “infection control professional” as “a person whose primary training is in either nursing, medical technology, microbiology, or epidemiology and who has acquired specialized training in infection control”

- The hospital must designate in writing an individual as its infection control officer
The person assigned to the job should be educated and competent in that area

- Qualified through education, training, experience, or certification

Certification offered by:

- Certification Board of Infection Control and Epidemiology Inc. (CBIC)

- Specialty boards in adult or pediatric infectious diseases
  - American Board of Internal Medicine (for internists)
  - American Board of Pediatrics (for pediatricians).
Competency in infection prevention: A conceptual approach to guide current and future practice

Denise N. Murphy, RN, MPH, CIC, Marilyn Hanchett, MA, CIC, Russell N. Ohnsted, MPH, CIC, Michele R. Farber, RN, CIC, Terri B. Lee, MSN, CIC, Janet P. Haag, DNSc, CIC, Stephanie A. Reed, MS, CIC

Professional competency has traditionally been divided into 2 essential components: knowledge and skill. More recent definitions have recommended additional components such as communication, values, reasoning, and teamwork. A standard, widely accepted, comprehensive definition remains an elusive goal. For infection preventionists (IPs), the requisite elements of competence are most often embedded in the IF position description, which may or may not reference national standards or guidelines. For this reason, there is widespread variation among these elements and the criteria they include. As the demand for IP expertise continues to rapidly expand, the Association for Professionals in Infection Control and Epidemiology, Inc., made a strategic commitment to develop a conceptual model of IP competent that could be applicable in all practice settings. This conceptual model not only defines essential IP roles and responsibilities, but it also focuses on the knowledge, skills, and attributes that are required to be successfully practiced at each level. 

www.ajicjournal.org/article/S0196-6553(12)00165-4/fulltext
### Examples of competencies demonstrated across the career span

<table>
<thead>
<tr>
<th>Novice IP</th>
<th>Proficient IP (all in column 1 plus)</th>
<th>Expert IP (all in columns 1 and 2 plus)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducts surveillance: standardized, basic case finding methods and application of HAI definitions Is learning to use NHSN</td>
<td>Can apply and expand surveillance principles to diverse populations Skilled at using NHSN and may validate NHSN surveillance conducted by others</td>
<td>Identified as expert in specialty areas such as public health, outpatient settings, research, or consulting Has the ability to confer with the CDC and other stakeholders in ongoing development of NHSN</td>
</tr>
<tr>
<td>Performs manual record/chart review, data abstraction, and data collection</td>
<td>Independently performs electronic surveillance, applies data mining principles, and can integrate both manual and electronic findings for comprehensive reporting</td>
<td>Expert in e-surveillance, use of EMR/other technology Applies principles of information management to emerging technology</td>
</tr>
<tr>
<td>Conducts infection rate calculations and basic statistical analysis (mean, median, rate, ratio)</td>
<td>Uses more advanced statistical tools (SIR, P values, standard deviation, odds ratio) Able to interpret research data and apply findings to current practice</td>
<td>Applies statistical methods in study design and research activities (sampling, power, hypothesis testing)</td>
</tr>
<tr>
<td>Is able to do graphic data display and report generation and dissemination</td>
<td>Understands and/or uses more complex data display tools (control charts, affinity diagrams, scatter plots)</td>
<td>Develops/uses complex data tables; teaches others to refine data display and reporting skills</td>
</tr>
<tr>
<td>Benchmarks/comparisons rates</td>
<td>Possesses understanding of endemic vs epidemic rates, common or special cause variation Uses comparative analysis to support institutional accrediting, regulatory compliance, and others</td>
<td>Integrates comparative analysis into high level, strategic understanding of facility's quality, safety, and risk mitigation programs</td>
</tr>
<tr>
<td>Possesses basic knowledge of epidemiology and outbreak investigation, can assist with investigations but usually does not lead them</td>
<td>Has more advanced knowledge of epidemiology and study design, can conduct basic cluster/epidemic investigations Collaborates with the local/state health department, as needed</td>
<td>Can design and conduct complex studies/investigations, including across institutions Collaborates with CDC on specific events, publishes results</td>
</tr>
<tr>
<td>Uses literature review as an essential tool</td>
<td>Interprets and applies meta-analyses; interprets research findings, identifies study limitations and bias</td>
<td>Adds to the body of published literature Highly skilled at reviewing, interpreting, and applying research finding</td>
</tr>
<tr>
<td>Uses data to identify the need for change and can propose basic intervention/improvement projects Is learning the essential skills of PI and IS</td>
<td>Can design complex interventions, understands and applies principles of PI and IS to both daily operations and special projects</td>
<td>Uses principles of influence, leadership, and change management Effectively negotiates for optimum collaboration and resource allocation for</td>
</tr>
</tbody>
</table>
Infection Control Preventionist (IPs)

- Infection control officers should maintain their qualifications
- This should be done through ongoing education and training
  - APIC has excellent educational conferences
  - This requirement can be demonstrated by participation in infection control courses, or in local and national meetings organized by recognized professional societies, such as APIC and SHEA
- Develop and implement IC measures (hospital staff, contract workers, volunteers)
Mitigate risks associated with

- Patient infections present upon admission
- Risks contributing to HAI

Conduct active surveillance *(revised June 7, 2013)*

- Includes patients, staff, volunteers, and contract workers
- Must identify and track infectious and communicable diseases
- Including HAI selected by IC program bases on targeted surveillance based on nationally recognized guidelines and periodic risk assessment
IC Officer’s Responsibilities 749 2013

- Active surveillance (continued)
  - Culture or patient colonized with MDRO
  - Isolation patients
  - Patients or staff with reportable communicable diseases
  - Staff or patients with signs in which local, state, or feds request
  - Staff or patients infected with significant pathogens
  - Recommend use of automated surveillance technology

- Monitoring compliance with all P&Ps, protocols and other infection control program requirements
IPs Responsibilities

- Evaluate and revise of the program, when indicated
- Coordinate with federal, state, and local emergency preparedness and health authorities to address communicable disease threats, bioterrorism, and outbreaks
  - As required by law
- Comply with the reportable disease requirements of the local health authority
- Integrate IC program into hospital-wide QAPI
Infection Control (IC) A- 749

- Long list of IC policies that hospitals must have

- The 22 policies are now organized under 5 sections

- Maintain a sanitary physical environment

- Hospital staff related measures (evaluate hospital staff immunization status for infectious diseases as per CDC and APIC, how you screen hospital staff for infections likely to cause significant infectious disease to others, policy on when staff are restricted from working)
IC Policies Include:

- New employee orientation (include handwashing)
- How to mitigate risk when patient admitted with infection
  - Must be consistent with the CDC isolation guidelines
  - Staff knowledge of PPE
- Mitigate risk that cause or contribute to HAI
  - SCIP measures, appropriate hair removal, timely antibiotics in OR, DC in 24 hours except 48 hours for cardiac patients, beta blockers during perioperative periods for select cardiac patients, proper sterilization of equipment, etc.
CDC Isolation Guidelines

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

Download the complete PDF version Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007 PDF (3.80 MB / 225 pages)

Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

Acknowledgement: The authors and HICPAC gratefully acknowledge Dr. Larry Strausbaugh for his many contributions and valued guidance in the preparation of this guideline.


Norovirus Guidelines

2011 Guidelines for the Prevention of Intravascular Catheter-Related Infections

2011 Norovirus Guidelines

Table of Contents

- Abbreviations
- Acknowledgements
- Executive Summary
- Summary of Recommendations
- Implementation and Audit
- Recommendations for Further Research
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- Scope and Purpose
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Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, 2011

Download the complete PDF version Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, 2011 [PDF - 676 KB] and Appendices [PDF - 3.48 MB].

www.cdc.gov/hicpac/norovirus/002_norovirus-toc.html
CDC Coronavirus Guidance

- CDC has interim infection prevention and control recommendations

- Recommend standard, contact, and airborne precautions for patients hospitalized with Middle East Respiratory Syndrome Coronavirus (MERS-CoV)
  - Suspect high rate of mortality, limited human to human transmission, unknown mode of transmission

- Similar to coronavirus that caused severe acute respiratory syndrome (SARS)
Interim Infection Prevention and Control Recommendations for Hospitalized Patients with Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

Standard, contact, and airborne precautions are recommended for management of hospitalized patients with known or suspected MERS-CoV infection, based on CDC’s case definition for patient under investigation. These recommendations are consistent with those recommended for the coronavirus that caused severe acute respiratory syndrome (SARS). As information becomes available, these recommendations will be re-evaluated and updated as needed.

These recommendations are based upon available information (as of June 10, 2013) and the following considerations:

- Suspected high rate of morbidity and mortality among infected patients
- Evidence of limited human-to-human transmission
- Poorly characterized clinical signs and symptoms
- Unknown modes of transmission of MERS-CoV
- Lack of a vaccine and chemoprophylaxis
- Absence of confirmed or probable MERS-CoV cases in the United States

Selected Components of Standard, Contact, and Airborne Precautions Recommended for Prevention of MERS-CoV Transmission in Hospitals

For full details of these precautions, see 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting.

<table>
<thead>
<tr>
<th>Component</th>
<th>Recommendation(s)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient placement</td>
<td>• Airborne Infection Room (AIIR)</td>
<td>• If an AIIR is not available, the patient should be transferred as soon as is feasible to a facility where an AIIR is available. Pending transfer, place a facemask on the patient and isolate him/her in a single-patient room with the door closed. The patient should not be placed in any room where...</td>
</tr>
</tbody>
</table>
IC Policies Include:

- **Isolation procedures for:**
  - Highly immuno-suppressed patients (HIV or chemo patients)
  - Trach care, respiratory care, burns, and other similar situations

- **HAI risk mitigation**
  - Promotion of hand hygiene
  - Measures to prevent organisms that are antibiotic resistant such as MRSA and VRE

- **Central line bundle, VAP bundle or sepsis bundle, prompt removal of foley catheter**

- **Use of disinfectants, antiseptics, and germicides in accordance with manufacturers instructions**
IP Tools is a resource for information sharing among Infection Preventionists.

JOIN THE THOUSANDS OF USERS FROM 53 DIFFERENT COUNTRIES WHO ARE VISITING AND ACCESSING THESE TOOLS AND RESOURCES.

What is IP Tools?
IP Tools is devoted to the sharing of information among Infection Preventionists.

The goal is to enable this group of professionals to post documents and files they feel would be useful to others as well as download documents and files that have been posted by others.

Every download is free.

So, if you are ready to share some of your own tools and resources or you are ready to see what others have shared, click Tools and Resources.

Additional resources available at: www.publichealthtools.com

We hope you'll help us make a global impact on the Infection Preventionist community!
IC Policies Include:

- Appropriate use of facility and medical equipment (hepa filters, negative pressure room, UV lights and other equipment) to prevent the spread of infectious agents
- Education on infection and communicable diseases for patients, visitors, care givers, and staff
- Active surveillance system, method for getting data to determine if there is a problem
- Policy on getting cultures from patients, etc.
Policies and Organization

- Need IC officer (now called IP or Infection Preventionist) and IC committee
- IC officer must develop and implement policies on control of infection and communicable diseases
- Person must be designated in writing who is qualified through education and experience
- Lists the responsibilities of this person—consider putting into job description
The IP must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel

Applies to both healthcare-associated infections (HAI) and community-acquired infection
The following activities should be based on national guidelines:

- Maintenance of a sanitary hospital environment
- Development and implementation of infection control measures related to hospital personnel (hospital staff, for infection control purposes, includes all hospital staff, contract workers (e.g., agency nurses, housekeeping staff, etc.), and volunteers
- Mitigation of risks associated with patient infections present upon admission and risks contributing to HAI
- Active surveillance
Infection Control Activities

- Monitoring compliance with all policies, procedures, protocols and other infection control program requirements
- Program evaluation and revision of the program, when indicated
- Coordination as required by law with federal, state, and local emergency preparedness and health authorities to address communicable disease threats, bioterrorism, and outbreaks
- Complying with the reportable disease requirements of the local health authority
Must maintain a log related to infections and communicable diseases

- CMS deleted the log requirement effective 7-16-2012
- Log requirements use to require the following;

- Includes information from patients
- Includes employees, contract staff such as agency nurses, and volunteers
- Includes surgical site infections, patients or staff with MDRO, patients who meet isolation requirements
The CEO, DON, and MS must ensure that there is hospital-wide QAPI and training program that address problems identified by IC officer

- QAPI now means Quality Assessment not Assurance

- Implement a successful corrective action plan in affected problem areas

- Train staff in problems identified

- Problems must be reported to nursing, MS, and administration
CMS Worksheets
Infection Control
CMS Hospital Worksheets Third Revision

- October 14, 2011 CMS issues a 137 page memo in the survey and certification section
- Memo discusses surveyor worksheets for hospitals by CMS during a hospital survey
- Addresses discharge planning, infection control, and QAPI
- It was pilot tested in hospitals in 11 states and on May 18, 2012 CMS published a second revised edition
  - Piloted test each of the 3 in every state over summer 2012
- November 9, 2012 CMS issued the third revised worksheet which is now 88 pages
CMS Hospital Worksheets

- Will select hospitals in each state and will complete all 3 worksheets at each hospital
  - From 1-9 hospitals in every state with more in states with larger numbers and will select hospitals with higher than average readmissions for all causes
- This is the third and most likely final pilot and in 2013 will use whenever a validation survey is done at a hospital by CMS
- Third pilot is non-punitive and will not require action plans unless immediate jeopardy is found
- Hospitals should be familiar with the three worksheets
Third Revised Worksheets

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1890

Center for Clinical Standards and Quality/ Survey & Certification Group

DATE: November 9, 2012  
TO: State Survey Agency Directors  
FROM: Director Survey & Certification Group  

SUBJECT: Patient Safety Initiative FY 2013 Pilot Phase — Revised Draft Surveyor Worksheets

REF: S&C: 13-03-Hospital

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Memorandum Summary

• **Patient Safety Initiative:** The Centers for Medicare & Medicaid Services (CMS) is continuing to test revised surveyor worksheets for assessing compliance with three hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. We are focusing on compliance with these CoPs as a means to reduce hospital-acquired conditions (HACs), including healthcare associated infections (HAIs), and preventable readmissions.

• **Draft Worksheets Made Public:** Via this memorandum we are making the revised draft worksheets publicly available. As was the case previously, there may be additional revisions to the worksheets at the end of FY 2013.

Patient Safety Initiative Pilot Phase

The Survey & Certification Group (SCG) Patient Safety Initiative is continuing to pilot test three revised surveyor worksheets designed to help surveyors assess compliance with the hospital CoPs for QAPI, infection control, and discharge planning. In S&C-12-01 released October 14, 2011 and in S&C-12-32 released May 18, 2012, we made available to the public copies of the initial and revised draft surveyor worksheets. These worksheets were used during the pre-test and pilot phases of the SCG initiative, from September 2011 through September 2012.
CMS Hospital Worksheets

- Goal is to reduce hospital acquired conditions (HACs) including healthcare associated infections
- Goal to prevent unnecessary readmission and currently 1 out of every 5 Medicare patients is readmitted within 30 days
- Many hospitals (66%) financially penalized after October 1, 2012 because they had a higher than average rate of readmissions and same in 2013
  - Forfeited 280 million dollars and 2013 is 228 million
- The underlying CoPs on which the worksheet is based did not change
Hierarchical List

**CMS Hospital Worksheets**

- However, some of the questions asked might not be apparent from a reading of the CoPs
- A worksheet is a good communication device
- It will help clearly communicate to hospitals what is going to be asked in these 3 important areas
- Hospitals might want to consider putting together a team to review the 3 worksheets and complete the form in advance as a self assessment
- Hospitals should consider attaching the documentation and P&P to the worksheet
CMS Hospital Worksheets

- This would impress the surveyor when they came to the hospital.
- The worksheet is used in new hospitals undergoing an initial review and hospitals that are not accredited by TJC, DNV, CIHQ, AAHHS, or AOA who have a CMS survey every three or so years.
  - The Joint Commission (TJC), American Osteopathic Association (AOA) Healthcare Facility Accreditation Program, Center for Improvement Healthcare Quality (CIHQ), or DNV Healthcare.
- It would also be used for hospitals undergoing a validation survey by CMS.
The regulations are the basis for any deficiencies that may be cited and not the worksheet per se.

The worksheets are designed to assist the surveyors and the hospital staff to identify when they are in compliance.

Will not affect critical access hospitals (CAHs) but CAH would want to look over the one on PI and especially infection control.

Questions or concerns should be addressed to Mary Ellen Palowitch at PFP.SCG@cms.hhs.gov.
First part of the pilot program draft version included identification information.

Name of the state survey agency which in most states is the department of health under contract by CMS.

- In Kentucky it is the OIG or Office of Inspector General.

- It will ask for the name and address of the hospital, CCN number, number of surveyors, time spent on completing the tool, date of survey etc.
Infection Control

- Is 42 pages long
- Asks for demographics as discussed previously such as hospital name, address, CCN number, etc.
- Starts out with a list of elements that need to be assessed with a yes, no, or N/A box
- Section one discusses the infection control (IC) prevention program and IC resources
- Does the hospital have an infection preventionist (IP)?
- Is there evidence IP is qualified?
Assessing Hospital Compliance with the
Condition of Participation for Infection Control
Pilot Program Draft Version

Name of State Agency: ____________________________

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Infection Control Condition of Participation. Items are to be assessed by a combination of observation, interviews with hospital staff, patients and their family/support persons, review of medical records, and a review of any necessary infection control program documentation. During the survey, observations or concerns may prompt the surveyor to request and review specific facility policies and procedures. Surveyors are expected to use their judgment and review only those documents necessary to investigate their concern(s) or to validate their observations.

The interviews should be performed with the most appropriate staff person(s) for the items of interest, as well as with patients, family members, and support persons.

Citation instructions are provided throughout this instrument, indicating the applicable regulatory provision to be cited on Form CMS-2567 when deficient practices are observed.

### Section 1. Hospital Characteristics

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Hospital name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Address, State, Zip Code:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zipcode</td>
<td></td>
</tr>
<tr>
<td>3. CMS Certification Number (CCN):</td>
<td></td>
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</tr>
</tbody>
</table>
# Module 1: Infection Control/Prevention Program

## Section 1. A. Infection control/prevention program and resources

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A.1 The hospital has designated one or more individual(s) as its Infection Control Officer(s).</td>
<td>☐ Yes ☐ No ☐ N/A 1 2 3 4 5</td>
</tr>
</tbody>
</table>

If no, cite at 42 CFR 482.42(a) (Tag A-0748)

| 1. A.2 The hospital has evidence that demonstrates the Infection Control Officer(s) is qualified and maintain(s) qualifications through education, training, experience or certification related to infection control consistent with hospital policy. | ☐ Yes ☐ No ☐ N/A 1 2 3 4 5                                      |

If no, cite at 42 CFR 482.42(a) (Tag A-0748)

| 1. A.3 The Infection Control Officer(s) can provide evidence that the hospital has developed general infection control policies and procedures that are based on nationally recognized guidelines and applicable state and federal law. | ☐ Yes ☐ No ☐ N/A 1 2 3 4 5                                      |

If no, cite at 482.42(a) (Tag A-0748)

| 1. A.4 The hospital has infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair. An infection control risk assessment (ICRA) to define the scope of the project and need for barrier measures is performed before a project gets underway. | ☐ Yes ☐ No ☐ N/A 1 2 3 4 5                                      |

If no, cite at 42 CFR 482.42(a) (Tag A-0748)

Interview = 1  Observation = 2  Infection Control Document Review = 3  Medical Record Review = 4  Other Document Review = 5
Competency in infection prevention: A conceptual approach to guide current and future practice

Denise N. Murphy, RN, MPH, CIC, Marilyn Hancheck, MA, CIC, Russell N. Ohmsted, MPH, CIC, Michelle R. Farber, RN, CIC, Terri B. Lee, MSN, CIC, Janet P. Haag, DNSc, CIC, Stephanie A. Steed, MS, CIC

Abstract

Professional competency has traditionally been divided into 2 essential components: knowledge and skill. More recent definitions have recommended additional components such as communication, values, reasoning, and teamwork. A standard, widely accepted, comprehensive definition remains an elusive goal. For infection preventionists (IPs), the requisite elements of competence are most often embedded in the IP position description, which may or may not reference national standards or guidelines. For this reason, there is widespread variation among these elements and the criteria they include. As the demand for IP expertise continues to rapidly expand, the Association for Professionals in Infection Control and Epidemiology, Inc., made a strategic commitment to develop a conceptual model of IP competency that could be applicable in all practice settings. The model was designed to be used in combination with organizational training and evaluation tools already in place. Ideally, the Association for Professionals in Infection Control and Epidemiology, Inc., model will complement similar competency efforts undertaken in non-US countries and/or international organizations. This conceptual model not only describes successful IP competency, but also serves as an organizing approach for developing current and future models.
<table>
<thead>
<tr>
<th>Novice IP</th>
<th>Proficient IP (all in column 1 plus)</th>
<th>Expert IP (all in columns 1 and 2 plus)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducts surveillance: standardized, basic case finding methods and application of HAI definitions</td>
<td>Can apply and expand surveillance principles to diverse populations Skilled at using NHSN and may validate NHSN surveillance conducted by others</td>
<td>Identified as expert in specialty areas such as public health, outpatient settings, research, or consulting Has the ability to confer with the CDC and other stakeholders in ongoing development of NHSN</td>
</tr>
<tr>
<td>Performs manual record/chart review, data abstraction, and data collection</td>
<td>Independently performs electronic surveillance, applies data mining principles, and can integrate both manual and electronic findings for comprehensive reporting</td>
<td>Expert in e-surveillance, use of EMR/other technology Applies principles of information management to emerging technology</td>
</tr>
<tr>
<td>Conducts infection rate calculations and basic statistical analysis (mean, median, rate, ratio)</td>
<td>Uses more advanced statistical tools (SIR, $P$ values, standard deviation, odds ratio) Able to interpret research data and apply findings to current practice</td>
<td>Applies statistical methods in study design and research activities (sampling, power, hypothesis testing)</td>
</tr>
<tr>
<td>Is able to do graphic data display and report generation and dissemination</td>
<td>Understands and/or uses more complex data display tools (control charts, affinity diagrams, scatter plots)</td>
<td>Develops/uses complex data tables; teaches others to refine data display and reporting skills</td>
</tr>
<tr>
<td>Benchmarks/comparles rates</td>
<td>Possesses understanding of endemic vs epidemic rates, common or special cause variation Uses comparative analysis to support institutional accrediting, regulatory compliance, and others</td>
<td>Integrates comparative analysis into high level, strategic understanding of facility’s quality, safety, and risk mitigation programs</td>
</tr>
<tr>
<td>Possesses basic knowledge of epidemiology and outbreak investigation, can assist with investigations but usually does not lead them</td>
<td>Has more advanced knowledge of epidemiology and study design, can conduct basic cluster/epidemic investigations Collaborates with the local/state health department, as needed</td>
<td>Can design and conduct complex studies/investigations, including across institutions Collaborates with CDC on specific events, publishes results</td>
</tr>
<tr>
<td>Uses literature review as an essential tool</td>
<td>Interprets and applies meta-analyses; interprets research findings, identifies study limitations and bias</td>
<td>Adds to the body of published literature Highly skilled at reviewing, interpreting, and applying research finding</td>
</tr>
<tr>
<td>Uses data to identify the need for change and can propose basic intervention/improvement projects Is learning the essential skills of PI and IS</td>
<td>Can design complex interventions, understands and applies principles of PI and IS to both daily operations and special projects</td>
<td>Uses principles of influence, leadership, and change management Effectively negotiates for optimum collaboration and resource allocation for</td>
</tr>
</tbody>
</table>
Infection Control Worksheet

- Is there evidence P&P are based on nationally recognized guidelines and state and federal law?
  - CDC guideline on intravascular catheters, CDC on norovirus, CDC on preventing CaUTI, etc

- Is there an IC P&P on construction, renovation, maintenance, demolition, and repair
  - Is there an IC risk assessment (ICRA) to define the scope of the project and barrier measures before project starts?
  - There are appropriate number of air exchanges per hour (6 existing and 12 if new construction)
PI related to Infection Control

- The next section is about the hospital PI system related to IC
- The Infection Preventionist can provide evidence that problems identified in the IC program are addressed in PI
- Is there evidence the hospital has P&P supporting non-punitive approach to staff reporting HAI, AE, and unsafe situations? (tag 756)
- Does CEO, MS, and CNO ensure successful corrective plan in problem areas?
- Is risk assessment process used to prioritize quality indicators in IC?
### Section 1. B. Hospital QAPI systems related to Infection Prevention and Control

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>The hospital infection prevention program is coordinated into the hospital QAPI program as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>1. B.1 The Infection Control Officer(s) can provide evidence that problems identified in the infection control program are addressed in the hospital QAPI program (i.e., development and implementation of corrective interventions, and ongoing evaluation of interventions implemented for both success and sustainability).</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756)

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1. B.2 Is there evidence that the hospital has adopted policies supporting a non-punitive approach to staff reporting of hospital acquired infections, adverse events, and situations they consider unsafe?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If no, cite at 42 CFR 482.21(e)(3) (Tag A-0286)
## Infection Control

**RISK ASSESSMENT AND PRIORITIZATION WORKSHEET**

<table>
<thead>
<tr>
<th>Event / Conditions and Problems</th>
<th>What is the potential impact of this condition/problem on patients, staff, and visitors?</th>
<th>What is the probability of this condition/problem impacting patients and staff?</th>
<th>What is your organization’s preparedness to deal with this condition/problem?</th>
<th>Numerical risk level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High (3)</td>
<td>Med (2)</td>
<td>Low (1)</td>
<td>None (0)</td>
</tr>
<tr>
<td><strong>GEOGRAPHY &amp; COMMUNITY:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation Mass Casualty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB Exposure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hurricanes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-Acquired MRSA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>POTENTIAL INFECTION:</strong></td>
<td></td>
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<tr>
<td>Surgical Site Infection</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Endophthalmitis</td>
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<td></td>
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</tr>
<tr>
<td>Fusarium</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>VRE</td>
<td></td>
<td></td>
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<tr>
<td>MRSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MRSA (hospital acquired)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNICATION:</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Lack of notification of presence of HAI</td>
<td></td>
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<tr>
<td>Lack of notification of employee with illness/disease</td>
<td></td>
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<tr>
<td><strong>EMPLOYEES:</strong></td>
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</table>
# Infection Control

## Risk Assessment and Prioritization Worksheet

<table>
<thead>
<tr>
<th>Event / Conditions and Problems</th>
<th>What is the potential impact of this condition/problem on patients, staff, and visitors?</th>
<th>What is the probability of this condition/problem impacting patients and staff?</th>
<th>What is your organization’s preparedness to deal with this condition / problem?</th>
<th>Numerical risk level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High (3)</td>
<td>Med (2)</td>
<td>Low (1)</td>
<td>None (0)</td>
</tr>
<tr>
<td>Latex risk</td>
<td></td>
<td></td>
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<tr>
<td>Indoor air contaminates</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sharps Injury</td>
<td></td>
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<tr>
<td>Flu Vaccine Non-Compliance</td>
<td></td>
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<tr>
<td>Compliance with isolation</td>
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<tr>
<td>Biological Exposure</td>
<td></td>
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<tr>
<td>Gas or vapor exposure</td>
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<tr>
<td>Radiation Exposure</td>
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<tr>
<td>Asbestos Exposure</td>
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</tbody>
</table>

**ENVIRONMENT:**

| Major biohazard spill          |                   |                  |                       |                    |                   |                  |                       |                    |                   |                  |                  |                  |       |
| Improper cleaning of environment |                 |                  |                       |                    |                   |                  |                       |                    |                   |                  |                  |                  |       |
| Ineffective pre-construction IC planning (risk assessment) | |                  |                       |                    |                   |                  |                       |                    |                   |                  |                  |                  |       |
| Water Intrusion                |                   |                  |                       |                    |                   |                  |                       |                    |                   |                  |                  |                  |       |
| Chemical Exposure              |                   |                  |                       |                    |                   |                  |                       |                    |                   |                  |                  |                  |       |

**SUPPLIES/EQUIPMENT:**

| Improper cleaning or disinfection of equipment/tools |                   |                  |                       |                    |                   |                  |                       |                    |                   |                  |                  |                  |       |
IP Tools   Excellent Resource

LOOKING FOR RESOURCES AND A PLACE TO COLLABORATE WITH OTHER IPS?

IP TOOLS IS A RESOURCE FOR INFORMATION SHARING AMONG INFECTION PREVENTIONISTS.

www.infectionpreventiontools.com/

Forgot your Username or Password?

JOIN THE THOUSANDS OF USERS FROM 53 DIFFERENT COUNTRIES WHO ARE VISITING AND ACCESSING THESE TOOLS AND RESOURCES.

What is IP Tools? Our Vision Questions?

What is IP Tools?

IP Tools is devoted to the sharing of information among Infection Preventionists.
The next section is on systems to prevent the transmission of MDRO and promote antibiotic stewardship (1 C)

MDRO is multidrug-resistant organisms such as C-diff, MRSA, or VRE

Hospital has P&P to minimize risk of transmission of MDRO?

There are many free toolkits online for MDRO and CDC has tons of excellent resources at www.cdc.gov/nhsn/ such as MDRO modules
1. Is our organization ready for an ASP to reduce *C. difficile*?

Antimicrobial stewardship for reducing *C. difficile* offers a potentially promising path for facilities invested in and committed to the effort. Developing and implementing a successful ASP will involve structural, process, and cultural changes in your organization. To effect the changes needed in clinical practice, organizations require multiple adjustments in roles, responsibilities, workflow, decisionmaking, and communication.

Failure to assess your organization's readiness for the change at multiple levels can lead to unanticipated implementation challenges. Bringing about organizational change of any type is difficult. You will not want to move ahead until you are confident of your organization's readiness. Even then, it will be important to balance the need to proceed thoughtfully with the need to move quickly enough to show progress and maintain momentum.

Consider the following questions as you evaluate your organization's readiness and identify action steps to prepare.

1.1. Do we have the appropriate ASP foundation on which to build?

This toolkit assumes that your hospital already has an ASP or the foundation for an ASP from which to launch the ASP targeted to promote appropriate antibiotic use and potential *C. difficile* reduction.
Multidrug-Resistant Organisms

- Multidrug-resistant organisms (MDROs) are resistant to one or more antimicrobial agents
  - Treatment is more difficult
  - These bad bugs are more dangerous

- Have systems in place to identify and prevent transmission of these organisms.

- The CDC has a special publication on “Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006”

Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006


Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

Acknowledgement:
The authors and HICPAC gratefully acknowledge Dr. Larry Strausbaugh for his many contributions and valued guidance in the preparation of this guideline.
The goal of the National MRSA Education Initiative is to help Americans better recognize and prevent MRSA skin infections.

Why is this important? Recent data show that Americans visit the doctor approximately 12 million times each year to get checked for suspected Staph or MRSA skin infection.

The good news is that a few simple steps can prevent and reduce the spread of MRSA.
Healthcare-associated Methicillin Resistant *Staphylococcus aureus* (HA-MRSA)

**Overview of Healthcare-associated MRSA**

Methicillin-resistant *Staphylococcus aureus* (MRSA) is a type of staph bacteria that does not react to certain antibiotics and will normally cause skin infections, but MRSA can also cause other infections—including pneumonia. MRSA can be fatal. In 1974, MRSA infections accounted for two percent of the total number of staph infections; in 1995 it was 22%; in 2004 it was 63%. CDC estimated that 94,360 invasive MRSA infections occurred in the United States in 2005; 18,650 of these were associated with death. MRSA is resistant to antibiotics including methicillin, oxacillin, penicillin, and amoxicillin. Since these strong drugs are not effective with MRSA, these infections are sometimes called Multidrug-Resistant Organisms (MDROs). Staph infections, including MRSA, occur most often among people in hospitals and healthcare facilities (such as nursing homes and dialysis centers) who have weakened immune systems. The infection can be spread by skin-to-skin contact, sharing or touching a personal item with someone with infected skin, or touching a surface or item that has been in contact with someone with MRSA.

MRSA infections that occur in otherwise healthy people who have not been recently (within the past year) hospitalized or had a medical procedure (such as dialysis, surgery, catheters) are known as community-associated MRSA infections (CA-MRSA). These infections are usually skin infections such as abscesses, boils, and other pus-filled lesions, but these infections may also lead to more serious illness, such as pneumonia. (See [Community-associated MRSA](#) )
Webcast & Slides:

MDRO Infection Surveillance Training

Summary

This session describes the rationale for monitoring multidrug-resistant organisms (MDRO) in NHSN and outlines the protocol, definitions, and procedures used for MDRO Infection Surveillance data collection and reporting.

Audience: This training session is designed for those who will collect and analyze multidrug-resistant organism (MDRO) disease data in the MDRO and CDAD Module of NHSN. This may include: NHSN Facility Administrator, Patient Safety Primary Contact, Infection Preventionist, Epidemiologist, Microbiologist, Professional Nursing Staff, or Trained Support Staff.

Webcast:

- MDRO Infection Surveillance Training Video [WMV - 3.66MB]
  Windows Media Player Required
Guide to Preventing Clostridium difficile Infections

www.apic.org/Professional-Practice/Implementation-guides

About APIC
APIC's mission is to create a safer world through prevention of infection. The association's more than 14,000 members direct infection prevention programs that save lives and improve the bottom line for hospitals and other healthcare facilities. APIC advances its mission through patient safety, implementation science, competencies and certification, advocacy, and data standardization.
Toolkit for Reduction of *Clostridium difficile* Infections Through Antimicrobial Stewardship

The Evaluation and Research on Antimicrobial Stewardship's Effect on *Clostridium difficile* (ERASE *C. difficile*) Project

1. **Is our organization ready for an ASP to reduce *C. difficile***?

Antimicrobial stewardship for reducing *C. difficile* offers a potentially promising path for facilities invested in and committed to the effort. Developing and implementing a successful ASP will involve structural, process, and cultural changes in your organization. To effect the changes needed in clinical practice, organizations require multiple adjustments in roles, responsibilities, workflow, decisionmaking, and communication.

Failure to assess your organization’s readiness for the change at multiple levels can lead to unanticipated implementation challenges. Bringing about organizational change of any type is difficult. You will not want to move ahead until you are confident of your organization’s readiness. Even then, it will be important to balance the need to proceed thoughtfully with the need to move quickly enough to show progress and maintain momentum.

Consider the following questions as you evaluate your organization’s readiness and identify action steps to prepare.

1.1. **Do we have the appropriate ASP foundation on which to build?**

This toolkit assumes that your hospital already has an ASP or the foundation for an ASP from which to launch the ASP targeted to promote appropriate antibiotic use and potential *C. difficile* infection.
The National Healthcare Safety Network (NHSN) is a secure, internet-based surveillance system that integrates and expands legacy patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC. NHSN also includes a new component for hospitals to monitor adverse reactions and incidents associated with receipt of blood and blood products. Enrollment is open to all types of healthcare facilities in the United States, including acute care hospitals, long term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities. For more information, click on the topics below.
System to Prevent MDRO & Antibiotic Use

- Hospital has multidisciplinary process in place to review antimicrobial use, local susceptibility patterns, and antimicrobial agents in the formulary?
- Are patients with MDRO identified?
- Are there P&P to prevent the development and transmission of MDRO?
- Is there a system in place to prompt clinicians to use the right antibiotic?
  - Could include CPOE, susceptibility reports, notifications from pharmacy, comments in microbiology report, evidenced based guidelines, etc.
System to Prevent MDRO & Antibiotic Use

- Is there a mechanism in place to prompt clinicians to review antibiotics use after 72 hours?
- Do antibiotic orders include an indication for use?
- Is there a mechanism in place to identify patients getting IV antibiotics that could be eligible to receive oral antibiotics?
- Is there a system with clinical microbiology lab that ensures prompt notification if there is a novel resistance pattern detected?
- Are patients or healthcare staff who are colonized or infected with MDRO identified and isolated according to the P&P
System to Prevent MDRO & Antibiotic Use

- Is there a system to identify those present on admission (POA) infections in order to control the spread?
- Can the IP provide an updated list of the reportable diseases to the local or state department of health?
- Can the IP provide evidence that all reportable diseases are reported and documented as required (tag 749)
  - Every state has a list of things that must be reported such as HIV, C-diff, hepatitis B, hepatitis C, etc
The next section involves IC education and training.

Do staff receive job specific training on hospital IC P&P, practices in orientation and at regular intervals?

Are staff trained that come into contact with bloodborne pathogens and on the OSHA bloodborne pathogen standard in orientation and when problems are identified?
## Section 1. D Personnel Education System / Infection Control Training

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No □ N/A</td>
</tr>
<tr>
<td>1. D.1 Healthcare personnel receive job-specific training on hospital infection control practices, policies, and procedures upon hire and at regular intervals</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No □ N/A</td>
</tr>
<tr>
<td>1. D.2 The hospital infection control system trains healthcare personnel that are in contact with bloodborne pathogens on the bloodborne pathogen standards upon hire and when problems are identified</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
</tbody>
</table>

Interview = 1    Observation = 2    Infection Control Document Review = 3    Medical Record Review = 4    Other Document Review


¹National Institutes of Health, Bethesda, Maryland
²Infusion Nurses Society, Norwood, Massachusetts
³Greenwich Hospital, Greenwich, Connecticut
IC Personnel Education & Training (1 D)

- IC system address addresses needle stick, sharps injuries, and employee exposure events?
- Is there a post-exposure evaluation and follow-up, including prophylaxis following an exposure event?
- Does the facility ensures healthcare personnel with TB test conversions are provided with appropriate follow-up?
Is there a respiratory protection program that details required worksite-specific procedures and elements for required respirator use?

Does it ensure annual respiratory fit testing at least annually to appropriate staff?

Is there P&P concerning contact of staff with patients with transmissible conditions?

Do these P&P must encourage reporting of illnesses and do not penalize staff with loss of wages, benefits, or job status? (rewritten in 3rd version)
Hospital has well-defined policies concerning contact of personnel with patients when personnel have potentially transmissible conditions. These policies should include:

- Work-exclusion policies that encourage reporting of illnesses and do not penalize with loss of wages, benefits, or job status
- Education of personnel on prompt reporting of illness to supervisor and occupational health
IC Personnel Education & Training

- Are the rates of TB-test conversion periodically reviewed by the IP to determine need for corrective action plans?

- Are staff competent and compliant with IC P&P and ensured through training and when problems are identified?

- If staff exposure does the hospital evaluate the data and corrective actions to reduce the incidence of such events?
IC Personnel Education & Training

- Is Hepatitis B vaccine given to those with occupational exposure including screening after 3rd dose of vaccine is given? (756)

- Are all staff (paid and unpaid) screened for TB upon hire?
  - Then screening is based on the hospital’s risk classification thereafter
  - Those with potential exposure

- Are all staff offered an annual flu shot?
Hand Hygiene

- The next section is on hand hygiene which is very important to both CMS and Joint Commission.

- This is to be followed on all hospitals units including CCU, ED, L&D, radiology, and endoscopy units.

- Hand hygiene (HH) must be done in a manner consistent with IC practices and P&Ps to include the following:

  - Soap, water, alcohol based hand rub (ABHR) and sinks are accessible in patient care areas.
Module 2: General Infection Control Elements - to be applied to all locations (e.g., general wards, critical care units, labor and delivery, emergency department, endoscopy suites, radiology)

Section 2. A Hand Hygiene

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene is performed in a manner consistent with hospital infection control practices, policies, and procedures to maximize the prevention of infection and communicable disease including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A1 Soap, water, and a sink are readily accessible in patient care areas including but not limited to direct care areas (such as food and medication preparation areas).</td>
<td>□ Yes □ No □ N/A □ 1 □ 2 □ 3 □ 4 □ 5</td>
<td>□ Yes □ No □ N/A □ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td>2. A2 Alcohol-based hand rub is readily accessible and placed in appropriate locations.</td>
<td>□ Yes □ No □ N/A □ 1 □ 2 □ 3 □ 4 □ 5</td>
<td>□ Yes □ No □ N/A □ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td>2. A3 Healthcare personnel perform hand hygiene:</td>
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</tr>
<tr>
<td>• Before contact with the patient or their immediate care environment (even if gloves are worn)</td>
<td>□ Yes □ No □ N/A □ 1 □ 2 □ 3 □ 4 □ 5</td>
<td>□ Yes □ No □ N/A □ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td>• Before exiting the patient’s care area after touching the patient or the patient’s immediate environment (even if gloves are worn)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Before performing an aseptic task (e.g., insertion of IV or urinary catheter, even if gloves are worn)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• After contact with blood, body fluids or contaminated surfaces (even if gloves are worn)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hand Hygiene Must Be Done

- HH done before contact with patient even if gloves are worn
- Before leaving patient care area after touching patient or immediate environment
- Before performing an aseptic task
  - Such as starting an IV, putting in a foley and even if gloves are worn
  - If patient with C-Diff or Norovirus use soap and water
- After contact with blood or body fluids and even if gloves are worn
- Direct care givers cannot wear artificial nails
CDC Norovirus Guidelines

Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings

Taranisia MacCannell, PhD, MSc; Craig A. Umscheid, MD, MSCE; Rajender K. Agarwal, MD, MPH; Ingi Lee, MD, MSCE; Gretchen Kuntz, MSW, MLSIS; Kurt B. Stevenson, MD, MPH and the Healthcare Infection Control Practices Advisory Committee (HICPAC)

1 Division of Healthcare Quality Promotion
   Centers for Disease Control and Prevention
   Atlanta, GA

2 Center for Evidence-based Practice
   University of Pennsylvania Health System
   Philadelphia, PA

3 Division of Infectious Diseases
   The Ohio State University
   Columbus, OH

www.cdc.gov/hicpac/norovirus/002_norovirus-toc.html
CDC Hand Hygiene Recommendations

- In CDC MMWR Recommendations and Reports, Report available at www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm or go to www.cdc.gov,
- TJC published document in 2009 on Measuring Hand Hygiene Adherence: Overcoming the Challenges and this is an important document,
- Monitored during infection control tracer,
WHO Guidelines on Hand Hygiene in Health Care

First Global Patient Safety Challenge
Clean Care is Safer Care
HAND HYGIENE ADHERENCE: OVERCOMING THE CHALLENGES

This monograph was authored by The Joint Commission in collaboration with the following organizations:

- The Association for Professionals in Infection Control and Epidemiology, Inc.
- The Centers for Disease Control and Prevention
- The Institute for Healthcare Improvement
- The National Foundation for Infectious Diseases
- The Society for Healthcare Epidemiology of America
- The World Health Organization World Alliance for Patient Safety

This monograph was supported in part by an unrestricted educational grant provided by GOJO Industries, Inc., Akron, Ohio
Injection Practices & Sharps Safety

- Next section is on injection practices and sharps safety
- This includes medications, saline, and other infusates
- Injections are given and sharps safety is managed in a manner consistent with IC P&P
- CDC has standards on self injection practices
- Injections are prepared using aseptic technique
- One needle, one syringe for every patient and includes insulin pens (CMS issues memo May 18, 2012)
CMS Memo on Insulin Pens

- CMS issues memo on insulin pens on May 18, 2012
- Insulin pens are intended to be used on one patient only
- CMS notes that some healthcare providers are not aware of this
- Insulin pens were used on more than one patient which is like sharing needles
- Every patient must have their own insulin pen
- Insulin pens must be marked with the patient’s name
Insulin Pen devices: The Centers for Medicare & Medicaid Services (CMS) has recently received reports of use of insulin pens for more than one patient, with at least one 2011 episode resulting in the need for post-exposure patient notification. These reports indicate that some healthcare personnel do not adhere to safe practices and may be unaware of the risks these unsafe practices pose to patients. **Insulin pens are meant for use by a single patient only.** Each patient/resident must have his/her own. Sharing of insulin pens is essentially the same as sharing needles or syringes, and must be cited, consistent with the applicable provider/supplier specific survey guidance, in the same manner as re-use of needles or syringes.
June 15, 2012 CMS issues a 7 page memo on safe injection practices

Discusses the safe use of single dose medication to prevent healthcare associated infections (HAI)

Notes new exception which is important especially in medications shortages

General rule is that single dose vial (SDV) can only be used on one patient

Will allow SDV to be used on multiple patients if prepared by pharmacist under laminar hood following USP 797 guidelines
DATE: June 15, 2012

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Safe Use of Single Dose/Single Use Medications to Prevent Healthcare-associated Infections

Memorandum Summary

- Under certain conditions, it is permissible to repackage single-dose vials or single use vials (collectively referred to in this memorandum as “SDVs”) into smaller doses, each intended for a single patient: The United States Pharmacopeia (USP) has established standards for compounding which, to the extent such practices are also subject to regulation by the Food and Drug Administration (FDA), may also be recognized and enforced under §§501 and 502 of the Federal Food, Drug and Cosmetics Act (FDCA). These USP compounding standards include USP General Chapter 797, Pharmaceutical Compounding - Sterile Preparations (“USP <797”). Under USP <797>, healthcare facilities may repackage SDVs into smaller doses, each intended for use with one patient. Among other things, these standards currently require that:
CMS Memo on Safe Injection Practices

- All entries into a SDV for purposes of repackaging must be completed with 6 hours of the initial puncture in pharmacy following USP guidelines.

- Only exception of when SDV can be used on multiple patients.

- Otherwise using a single dose vial on multiple patients is a violation of CDC standards.

- CMS will cite hospital under the hospital CoP infection control standards since must provide sanitary environment.
  - Also includes ASCs, hospice, LTC, home health, CAH, dialysis, etc.
Bottom line is you cannot use a single dose vial on multiple patients.

CMS requires hospitals to follow nationally recognized standards of care like the CDC guidelines.

SDV typically lack an antimicrobial preservative.

Once the vial is entered, the contents can support the growth of microorganisms.

The vials must have a beyond use date (BUD) and storage conditions on the label.
CMS Memo on Safe Injection Practices

- Make sure pharmacist has a copy of this memo
- If medication is repackaged under an arrangement with an off site vendor or compounding facility ask for evidence they have adhered to 797 standards
- ASHP Foundation has a tool for assessing contractors who provide sterile products
- Go to www.ashpfoundation.org/MainMenuCategories/PracticeTools/SterileProductsTool.aspx
- Click on starting using sterile products outsourcing tool now
Outsourcing Sterile Products Preparation: Contractor Assessment Tool

Developed with support from PharMEDium Services, LLC
Now available!

Preparation of sterile parenteral products is a critical component of health-system pharmacy practice. For departments that choose to outsource the preparation of parenteral medications, this web-based tool can be used to evaluate proposals during the selection of an external organization that would provide parenteral product preparation services.

The assessment tool helps you evaluate each of these areas:

- Regulatory compliance
- Quality and patient safety measures
- Medication administration safety features
- Service excellence

Start using the Sterile Products Outsourcing Tool now!

www.ashpfoundation.org/MainMenuCategories/PracticeTools/SterileProductsTool.aspx
### Section 2. B  Injection Practices and Sharps Safety (Medications, Saline, Other Infusates)

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
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</thead>
<tbody>
<tr>
<td>Injections are given and sharps safety is managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable diseases including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. B.1 Injections are prepared using aseptic technique in an area that has been cleaned and free of visible blood, body fluids, or contaminated equipment.</td>
<td>☐ Yes □ No □ N/A</td>
<td>☐ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td>2. B.2 Needles are used for only one patient.</td>
<td>☐ Yes □ No □ N/A</td>
<td>☐ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td>2. B.3 Syringes are used for only one patient (this includes manufactured prefilled syringes and insulin pens).</td>
<td>☐ Yes □ No □ N/A</td>
<td>☐ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
</tbody>
</table>
Injection Practices & Sharps Safety 2 B

- Injections prepared using aseptic technique in area cleaned and free of blood and bodily fluids
- Is rubber septum disinfected with alcohol before piercing?
- Are single dose vials, IV bags, IV tubing and connectors used on only one patient?
- Are multidose vials dated when opened and discarded in 28 days unless shorter time by manufacturer?
- Make sure expiration date is clear as per P&P
- If multidose vial found in patient care area must be used on only one patient
Safe Injection Practices Patient Safety Brief

By: Sue Dill Calloway RN MSN JD CPHRM
Ruth Carrico PhD RN FSHEA CIC

July 2012

The Centers for Disease Control and Prevention (CDC) says there are 1.7 million healthcare-associated infections in the US every year. Of these, it is estimated that about 99,000 deaths occur as a result. Infection prevention
Injection Practices & Sharps Safety

- Are all sharps disposed of in resistant sharps container?

- Are sharp containers replaced when fill line is reached?
  - Are sharps disposed of in accordance with state medical waste rules

- Hospitals should have a system in place where someone has the responsibility to check these and ensure they are replaced when they are full
2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

Download the complete PDF version Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007 (PDF, 3.80 MB / 225 pages)

Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

Acknowledgement: The authors and HICPAC gratefully acknowledge Dr. Larry Strausbaugh for his many contributions and valued guidance in the preparation of this guideline.


Healthcare Infection Control Practices

The next section is on personal protective equipment (PPE) and standard precautions.

These must be used in accordance with IC P&P.

Are supplies available and near point of use?

- Includes gloves, gowns, face protection etc.

Do healthcare practitioners (HCP) wear gloves, masks, eye wear, and gowns, or when contact with blood or body fluids is anticipated?

- Do they perform HH and change gloves when moving from contaminated body site to clean one?
Personal Protective Equipment

- Appropriate mouth, nose, eye protection is worn for aerosol-generating procedures and/or procedures/activities that are likely to generate splashes or sprays of blood or body fluids.

- Surgical masks are worn by HCP when placing a catheter or injecting materials into the epidural or subdural space.
  - CDC requirement for safe injection practices
  - Includes anesthesia provider inserting epidural or spinal for pain relief
  - Included ED physician who does LP
Bacterial Meningitis After Intrapartum Spinal Anesthesia --- New York and Ohio, 2008--2009

Weekly
January 29, 2010 / 59(03);65-69

In June 2007, the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommended for the first time that surgical masks be worn by spinal procedure operators to prevent infections associated with these procedures (1). HICPAC made the recommendation in response to several reports of meningitis following myelography procedures. In September 2008, three bacterial meningitis cases in postpartum women were reported to the New York State Department of Health (NYSDOH); in May 2009, two similar cases were reported to the Ohio Department of Health. All five women had received intrapartum spinal anesthesia. Four were confirmed to have *Streptococcus salivarius* meningitis, and one woman subsequently died. This report summarizes the investigations of these five cases, which determined that the New York cases were associated with one anesthesiologist and the Ohio cases were associated with a second anesthesiologist. In Ohio, the anesthesiologist did not wear a mask; wearing a mask might have prevented the infections. The findings underscore the need to follow established infection-control recommendations during spinal procedures, including the use of a mask and adherence to aseptic technique.

**Case Reports**

**New York.** In September 2008, a healthy woman aged 24 years (patient A) was admitted in active labor to a New York City hospital. She received combined spinal–epidural anesthesia from anesthesiologist A, and delivered a healthy baby. Approximately 22 hours after receiving anesthesia, patient A experienced headache, back pain, rigors, nausea, vomiting, and disorientation.

Within 1 hour of patient A's admission, a second healthy woman aged 31 years (patient B) was admitted to the same hospital in active labor. Patient B also received combined spinal–epidural anesthesia from anesthesiologist A and delivered a healthy baby.
CDC Clinical Reminder: Spinal Injection Procedures Performed without a Facemask Pose Risk for Bacterial Meningitis

Available for download [Clinical Reminder](https://www.cdc.gov/injectionsafety/SpinalInjection-Meningitis.html) [PDF - 543 KB]

Summary
The Centers for Disease Control and Prevention (CDC) is concerned about the occurrence of bacterial meningitis among patients undergoing spinal injection procedures that require injection of material or insertion of a catheter into epidural or subdural spaces (e.g., myelogram, administration of spinal or epidural anesthesia, or intrathecal chemotherapy). Outbreaks of bacterial meningitis following these spinal injection procedures continue to be identified among patients whose procedures were performed by a healthcare provider who did not wear a facemask (e.g., may be labeled as surgical, medical procedure, or isolation mask).[1] with the most recent occurrence in October 2010 (CDC unpublished data). This notice serves as a reminder that facemasks should always be worn by healthcare providers when performing these spinal injection procedures.[2]
Spinal Injection Procedures Performed without a Facemask Pose Risk for Bacterial Meningitis

Summary:

The Centers for Disease Control and Prevention (CDC) is concerned about the occurrence of bacterial meningitis among patients undergoing spinal injection procedures that require injection of material or insertion of a catheter into epidural or subdural spaces (e.g., myelogram, administration of spinal or epidural anesthesia, or intrathecal chemotherapy). Outbreaks of bacterial meningitis following these spinal injection procedures continue to be identified among patients whose procedures were performed by a healthcare provider who did not wear a facemask (e.g., may be labeled as surgical, medical procedure, or isolation mask), with the most recent occurrence in October 2010 (CDC unpublished data). This notice serves as a reminder that facemasks should always be worn by healthcare providers when performing these spinal injection procedures.

Background:

CDC has investigated multiple outbreaks of bacterial meningitis among patients undergoing spinal injection procedures. Recent outbreaks have occurred among patients in acute care hospitals who received spinal anesthesia or epidural anesthesia, and also among patients at an outpatient imaging facility who underwent myelography.

In each of these outbreak investigations, nearly all spinal injection procedures that resulted in infection were performed by a common healthcare provider who did not wear a facemask. The strain of bacteria isolated from the cerebrospinal fluid of these patients was identical to the strain recovered from the oral flora of the healthcare provider who performed the spinal injection procedure. These findings illustrate the risk of bacterial meningitis associated with droplet transmission of the oral flora from healthcare providers to patients during spinal injection procedures.
The next section is on environmental services (ES)

ES must be provided in manner consistent with hospital IC P&P

Of course all P&P must be consistent with the standard of practices

HCP wear appropriate PPE (gloves, gowns, masks, eye protection) to prevent exposure to infectious agents or chemicals

Objects that touched frequently are cleaned at least daily with EPA registered disinfectant
### Section 2. C Personal Protective Equipment/Standard Precautions

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Personal protective equipment is utilized in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease, including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. C1 Supplies for adherence to Standard and Transmission-based Precautions (e.g., gloves, gowns, mouth, eye, nose, and face protection) are available and located near point of use.</td>
<td>Yes ☐</td>
<td></td>
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<tr>
<td></td>
<td>No ☐</td>
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<td></td>
<td>N/A ☐</td>
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<td>1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐</td>
</tr>
<tr>
<td>2. C2 HCP wear gloves for procedures/activities where contact with blood, body fluids, mucous membranes, or non-intact skin is anticipated.</td>
<td>Yes ☐</td>
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<td></td>
<td>No ☐</td>
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<td></td>
<td>N/A ☐</td>
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<td>1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐</td>
</tr>
<tr>
<td>2. C3 HCP change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.</td>
<td>Yes ☐</td>
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<td></td>
<td>No ☐</td>
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<td></td>
<td>N/A ☐</td>
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<td>1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐</td>
</tr>
<tr>
<td>2. C4 Gowns are worn to prevent contamination of skin and clothing during procedures/activities where contact with blood, body fluids, secretions, or excretions are anticipated.</td>
<td>Yes ☐</td>
<td></td>
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<tr>
<td></td>
<td>No ☐</td>
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<td></td>
<td>N/A ☐</td>
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<td>1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐</td>
</tr>
<tr>
<td>2. C5 Gowns and gloves are removed and hand hygiene is performed immediately before leaving the patient’s environment.</td>
<td>Yes ☐</td>
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<td></td>
<td>No ☐</td>
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<td>1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐</td>
<td>1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐</td>
</tr>
</tbody>
</table>
2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

Part III: Precautions to Prevent Transmission of Infectious Agents

There are two tiers of HICPAC/CDC precautions to prevent transmission of infectious agents, Standard Precautions and Transmission-Based Precautions. Standard Precautions are intended to be applied to the care of all patients in all healthcare settings, regardless of whether suspected or confirmed presence of an infectious agent. Implementation of Standard Precautions constitutes the primary strategy for the prevention of healthcare-associated transmission of infectious agents among patients and healthcare personnel. Transmission-Based Precautions are for patients who are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. Since the infecting agent often is not known at the time of admission to a healthcare facility, Transmission-Based Precautions are used...
### Section 2. D  Environmental Services

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply)</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental services are provided in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. D.1 HCP wear appropriate PPE to preclude exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection).</td>
<td>□ Yes  □ No  □ N/A</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td>2. D.2 Objects and environmental surfaces in patient care areas that are touched frequently (e.g., bed rails, side table, call button) are cleaned and then disinfected when visibly contaminated or at least daily with an EPA-registered disinfectant.</td>
<td>□ Yes  □ No  □ N/A</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td>2. D.3 For terminal cleaning (i.e., after patient discharge), all surfaces are thoroughly cleaned and disinfected and towels and bed linens are replaced with clean towels and bed linens.</td>
<td>□ Yes  □ No  □ N/A</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
<tr>
<td>2. D.4 Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturer’s instructions (e.g., dilution, storage, shelf-life, contact time).</td>
<td>□ Yes  □ No  □ N/A</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5</td>
</tr>
</tbody>
</table>
Environmental Services

- Objects touched frequently include things like bed rails, side table, call button, light switches etc.
- Are all surfaces cleaned thoroughly as far as terminal cleaning after patient discharges including replacing all towels and bed linens.
- Are disposable wipes used in accordance with manufacturers instructions including dilution, storage, self life, contact time, etc.?
- Are clean cloths used for each room?
- Are mop heads and cleaning cloths laundered daily?
Environmental Services

- Are spills decontaminated as per P&P?
- Is there a cleaning schedule for equipment such as aerators on faucets, scrub sinks, refrigerators, ice machines, eye wash stations, HVAC equipment?
- Laundry must be processed as according to P&P
- Do HCP handle soiled linens in a manner to ensure it is separate from clean linen and to prevent cross contamination?
  - Clean and dirty laundry separation under negative pressure?
- Is linen bagged at point of collection in leak proof container?
Environmental Services

- Is reprocessing of non-critical items done as per hospital infection P&P?
- Is reusable non-critical patient care devices disinfected on regular basis and if becomes soiled?
- Are manufacturers instructions followed for cleaning medical equipment?
  - BP cuff or pulse ox probe
- Is hydrotherapy equipment drained and cleaned after each use?
  - Hubbard tank, whirlpool, birthing tanks, or spas
Reprocessing of Semi-Critical Equipment

- There is a section on reprocessing of semi-critical equipment and anyone involved in this should read this section.
- High level disinfection must be done of reusable instruments as per hospital P&P.
- Flexible endoscope cleaning is hit hard during survey as well as cleaning of glucometers between use—must be hung in a vertical position after cleaned.
- Are flexible endoscopes inspected for damage and leaks when reprocessing?
Advancing ASC Quality

To support the ASC industry's focus on high quality care, the ASC Quality Collaboration is assembling **ASC Tools for Infection Prevention**, or **ASC TIPS**. Our goal is to make infection prevention resources readily accessible to ASCs by bringing them together in one location.

The following **ASC TIPS** are now available:

- Hand Hygiene Toolkit
- Safe Injection Practices Toolkit
- Point of Care Devices Toolkit
- Environmental Infection Prevention Toolkit
- Single-Use Device Reprocessing Toolkit
- Endoscope Reprocessing Toolkit
- Sterilization and High-Level Disinfection Toolkit

Each toolkit is available in two versions, **BASIC** and **EXPANDED**.
Reprocessing of Semi-Critical Equipment

- Are items pre-cleaned as required by manufacturer instructions?
- Discusses requirements for cleaning brushed and enzymatic cleaners
- Cleaning brushes must be disposed of after each use
- Must follow manufacturers instruction for chemical used in high level disinfections
- Again see the tool for specifics related to cleaning equipment
Immediate Use Sterilization

- CMS issues a memo on flash sterilization which is now called immediate use sterilization
  - Multiple society went together and named immediate use sterilization; AORN, AAMI, APIC, AAAHC, etc.
- CMS instructs hospitals to follow manufactures recommendation
- Not intended to be used to process items used at a later date
- Intended for immediate use so used during a procedure for which it was sterilized and in manner that minimizes exposure to air and other contaminates
CMS Memo on Immediate-Use Steam

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey & Certification Group

Ref: S&C-09-55
(REVISED 10-09-2009)

DATE: September 4, 2009

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Flash Sterilization Clarification - FY 2010 Ambulatory Surgical Center (ASC) Surveys

*****Memo revised to correct regulation citation and contact information*****

Memorandum Summary

Flash Sterilization Clarification: State survey agencies (SAs) using the new survey process in FY 2009, including completing the Infection Control Surveyor Worksheet, have experienced challenges in evaluating use of “flash sterilization” by ASCs. Attachment 1 clarifies what this term means, and how to distinguish appropriate from inappropriate use of flash sterilization.
sterilization cycle is likely to be effective are found in the manufacturer’s instructions for the various devices involved.

Surveyors should utilize the following questions to assess the appropriateness of the ASC’s sterilization practices:

1. Is the sterilizer labeled for this cycle by the manufacturer?
2. What is the sterilizer manufacturer-recommended load for that cycle?
3. Is the containment device used labeled by its manufacturer for use in that cycle?

4. For what load is the containment device recommended by its manufacturer?
5. Is the chemical indicator used labeled for use in this cycle by its manufacturer?
6. If a biological indicator is used is it labeled for use for this cycle by its manufacturer?
7. If the cycle is used frequently, is it checked regularly with a biological indicator?

If an ASC is properly using short sterilization cycles for wrapped/contained loads, then it should not be cited for a violation of the ASC infection control requirements.

Note the emphasis on the manufacturer's instructions for use, which have been validated by the
Now Called Immediate-Use Steam

Multi-society statement endorses process for immediate-use steam sterilization (formerly flash sterilization)

Home > News > Multi-society statement endorses process for immediate-use steam sterilization (formerly flash sterilization)

Multi-society statement endorses process for immediate-use steam sterilization (formerly flash sterilization)

March 29, 2011 Multi-society statement endorses process for immediate-use steam sterilization (formerly flash sterilization)

A new multi-society position statement addressing a common sterilization process for immediate-use steam sterilization (formerly “flash sterilization”) of medical instruments has been released by the Association for the Advancement of Medical Instrumentation (AAMI), following endorsement of the statement by AAMI, AORN and several other organizations. AORN was involved with the development of the statement (Read a news story on this work here.)

As part of the effort to clarify the process for this commonly used method of sterilization, the statement endorses replacing the term “flash sterilization” with “immediate use steam sterilization.” “Flash sterilization’ is an antiquated term that does not fully describe the various steam sterilization cycles now used to process items not intended to be stored for later use,” says the statement, which defines the entire process, from cleaning and sterilization to transporting items for immediate use. Read more about the statement in this March 22 press release from AAMI.

Download a free copy of the statement here.

http://www.aorn.org/News/View/03A1334C-ADE2-CF8F-B329DD5F7E9B71B2
Immediate-Use Steam Sterilization

“Flash sterilization” has traditionally been used to describe steam sterilization cycles where unwrapped medical instruments are subjected to an abbreviated steam exposure time and then used promptly after cycle completion without being stored. This is in contrast to traditional “terminal sterilization” cycles, where instruments are sterilized within containers, wrappers, or primary packaging designed to maintain the instruments’ sterility and allow the devices to be stored for later use. The term “flash” arose out of the abbreviated time of exposure of the unwrapped device.

Today, however, “flash sterilization” is an antiquated term that does not fully describe the various steam sterilization cycles now used to process items not intended to be stored for later use. Current guidelines may require longer exposure times and/or the use of single wrappers or containers designed to allow for aseptic transfer of an item to the point of use. The term “immediate-use steam sterilization” more accurately reflects the current use of these processes. The same critical reprocessing steps (such as cleaning, decontaminating, and transporting sterilized items) must be followed regardless of the specific sterilization cycle employed; a safe process does not include short-cuts or work-arounds.

“Immediate use” is broadly defined as the shortest possible time between a sterilized item’s removal from the sterilizer and its aseptic transfer to the sterile field. Immediacy implies that a sterilized item is used during the procedure for which it was sterilized and in a manner that minimizes its exposure to air and other environmental contaminants. A sterilized item
The Joint Commission has been in discussion with multiple professional and trade organizations in regards to the common and proper use of sterilization using steam in hospital, critical access hospital, ambulatory care, and office-based surgery settings. Recently, some decisions have been made which will have an impact on the interpretation of standards and the survey process, effective immediately. In reviewing this method of sterilization, several issues have emerged including nomenclature, indications, and process issues.

**Flash sterilization** is the most common term used to describe certain types of steam sterilization that do not utilize a full cycle (also known as a terminal cycle). Originally, flash sterilization meant sterilizing unwrapped instruments using steam for 3 minutes, at 270°F at 27 to 28 pounds of pressure. Over the last several decades, a number of improvements have been made to this process, such as longer exposure of the instruments to steam, the use of special trays and packs to hold and protect the instruments, and the routine use of biological indicators. To help sort out confusion about nomenclature, this discussion refers only to steam sterilization as defined (3 minutes at 270°F at 27 to 28 pounds of pressure).

Indication-related issues involve the selection of the sterilization cycle or method. Previously, the selection of a sterilization cycle or method was a primary focus during a survey.
The Joint Commission updated its position on steam sterilization in June 2009. (See The Joint Commission Takes a Second Look at Rapid Cycle Sterilization, page 9, for details.)

National Patient Safety Goal NPSG.07.05.01 requires organizations to implement best practices to prevent surgical site infections (SSI). Sterilization of surgical instruments is a key part of SSI prevention. The most common way to Joint Commission released a statement updating its position on this type of sterilization.

Rapid cycle sterilization involves a process that begins with physical cleaning and decontamination of the instruments. This process removes specifically address steam sterilization, the goal states that organizations should implement policies and practices aimed at reducing the risk of surgical site infections that meet regulatory requirements and are aligned with evidence-based standards, such as Centers for Disease Control and Prevention guidelines, and guidelines of other professional organizations. Other Joint Commission standards address sterilization, such as Standard IC.02.02.01 which requires organizations to reduce the risk of infections associated with medical equipment, devices, supplies; and EC.02.04.03, which requires organizations to conduct performance testing and maintenance for all of its sterilizers.

Organizations should also ensure that the appropriate staff members understand its policies related to surgical site infections, including rapid cycle sterilization of surgical instruments.
Reprocessing of Semi-Critical Equipment

- Medical devices must be stored after sterilization so sterility is maintained
- Sterile packages are inspected for integrity
- If immediate use sterilization is performed then the manufacturers instructions must be followed
  - These must be handled in a way to prevent decontamination
- Does the hospital respond if there is a recall of a device?
- Single use devices discarded after use and not used on more than one patient
IC Patient Tracer

- Hospital has IC P&P to prevent the spread of infections and communicable diseases
- Has a urinary catheter tracer
- Hospital must have guidelines on appropriate indications for urinary catheters
- CDC issued a guideline on preventing catheter associated UTI in December of 2009
- Many excellent toolkits have been developed to help hospitals in this journey
# Urinary Catheter Tracer

## Section 4. A  Urinary Catheter Tracer

<table>
<thead>
<tr>
<th>Manner of Assessment Code</th>
<th>Manner of Assessment Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>(check all that apply) &amp; Surveyor Notes</td>
<td>(check all that apply) &amp; Surveyor Notes</td>
</tr>
</tbody>
</table>

Urinary catheters are inserted, accessed, and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:

### Insertion:

#### 4. A. 1 The hospital has guidelines for appropriate indications for urinary catheters.

- Yes
- No
- N/A

### Hand hygiene performed before and after insertion.

- Yes
- No
- N/A

### Catheter placed using aseptic technique and sterile equipment.

- Yes
- No
- N/A

### Catheter secured properly after insertion.

- Yes
- No
- N/A

---

If no to 4.A.2 through 4.A.4, cite at 42 CFR 482.42a (1) [Tag A-0749]

2009 CAUTI Guidelines (407 KB / 67 pages) and Appendices (4.41 MB / 268 pages) are available for download in PDF format.

Table of Contents
- 2008 Disinfection & Sterilization Guideline
- 2009 CAUTI Guideline
- Executive Summary
- Summary of Recommendations
- Implementation and Audit
- Recommendations for Further Research
- Background
Urinary Catheter Tracer

- The hospital must have guidelines for appropriate indications for urinary catheters
- Remember, guidelines must be consistent with the standard of care
- Must do hand hygiene before and after insertion
- Must use aseptic technique in inserting foley and sterile equipment
- Must secure catheter after insertion
- Must document indication for catheter insertion
Urinary Catheter Tracer

- Must do hand hygiene before manipulating the catheter
- Must use aseptic technique in emptying foley
- Make sure tubing is not disconnected and avoid irrigation
  - Use aseptic technique to obtain urine specimen and small volume can be obtained via needleless port
  - Urine bag must be below level of bladder
- Make sure catheter tubing is free of kinking
- Assess every day to see if can be removed
Prevention & Control of Catheter-Associated Urinary Tract Infections (UTI)

This guideline updates and expands the original Centers for Disease Control and Prevention (CDC) Guideline for Prevention of Catheter-associated Urinary Tract Infections (CAUTI) published in 1981. Several developments necessitated revision of the 1981 guideline, including new research and technological advancements for preventing CAUTI, increasing need to address patients in non-acute care settings and patients requiring long-term urinary catheterization, and greater emphasis on prevention initiatives as well as better defined goals and metrics for outcomes and process measures. In addition to updating the previous guideline, this revised guideline reviews the available evidence on CAUTI prevention for patients requiring chronic indwelling catheters and individuals who can be managed with alternative methods of urinary drainage (e.g., intermittent catheterization).

2009 Guidelines

These resources may be of use to healthcare professionals

- Guideline for Prevention of CAUTI 2009 Appendices (4.41 MB / 268 pages)
AHA Guide to Eliminating CaUTIs

Eliminating Catheter-Associated Urinary Tract Infections

July 2013
Additional Resources

- 2011 CDC Guidelines for Prevention of Intravascular Catheter Related Infections,

- CDC Guidelines for the Prevention of catheter-Induced Urinary Tract Infections, December 2009,

- AHRQ toolkit
  - http://www.ahrq.gov/qual/haiflyer.htm
CA-UTI Resources

- Pa Patient Safety has toolkit to prevent CA-UTIs,
  - [http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/cauti/Pages/home.aspx](http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/cauti/Pages/home.aspx)

- APIC guidelines to eliminate catheter-associated UTI

- AORN article Jan 2010 on new SCIP measure regarding urinary catheter removal
  - at
    - [www.aorn.org/News/Managers/November2009Issue/Catheter/](http://www.aorn.org/News/Managers/November2009Issue/Catheter/)
CA-UTI Resources

- IDSA as the “Diagnosis, Prevention, and Treatment of Catheter-Associated Urinary Tract Infections in Adults: 2009 International Clinical Practice Guidelines from the Infectious Disease Society of America
  - http://cid.oxfordjournals.org/content/50/5/625.full

- Iowa Healthcare Collaborative toolkit
  - http://www.ihi.org/IHI/Programs/ImprovementMap/PreventCatheterAssociatedUrinaryTractInfections.htm
Central Venous Catheter Tracer

- Next is the central venous catheter (CVC) tracer
- Must follow hospital IC P&P
- Remember that the CDC has guidelines on intravascular catheters published April 2011 which discussed the evidenced based care
- TJC requires a checklist be used and document its use
- Must do hand hygiene before and after insertion
- Must use maximal barrier precautions (cap, gloves, sterile gown, and full sterile body drape)
### Section 4. B Central Venous Catheter Tracer

Central venous catheters are inserted, accessed and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:

**Insertion:**

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. B.1 Hand Hygiene performed before and after insertion.</td>
<td>□ Yes □ No □ N/A</td>
<td>□ Yes □ No □ N/A</td>
</tr>
<tr>
<td>4. B.2 Maximal barrier precautions used for insertion (includes use of cap, mask, sterile gown, sterile gloves, and a sterile full body drape).</td>
<td>□ Yes □ No □ N/A</td>
<td>□ Yes □ No □ N/A</td>
</tr>
<tr>
<td>4. B.3 &gt;0.5% chlorhexidine with alcohol used for skin antisepsis prior to insertion (if contraindicated, tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives).</td>
<td>□ Yes □ No □ N/A</td>
<td>□ Yes □ No □ N/A</td>
</tr>
<tr>
<td>4. B.4 Sterile gauze or sterile, transparent, semi-permeable dressing used to cover catheter site (may not apply for well-healed tunneled catheters).</td>
<td>□ Yes □ No □ N/A</td>
<td>□ Yes □ No □ N/A</td>
</tr>
</tbody>
</table>

If no to any of the above (4.B.1 through 4.B.4), cite 42 CFR 482.42(a)(1) (Tag A-0749)

4. B.5 Central line insertion and indication documented. | □ Yes □ No | □ Yes □ No |
Hospitals Must Follow CDC Guidelines


Healthcare Infection Control Practices Advisory Committee (HICPAC)

2011 Guidelines for the Prevention of Intravascular Catheter-Related Infections

Download the complete 2011 Guidelines for the Prevention of Intravascular Catheter-Related Infections [PDF - 1.05 MB]


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¹³Ann Arbor VA Medical Center and University of Michigan, Ann Arbor, Michigan
Central Venous Catheter Tracer

- Use chlorahexidine with alcohol to prep skin unless contraindicated (30 seconds)
- Use transparent, semi permeable, or sterile gauze dressing to cover catheter site
- Must document central line insertion
- Must document indication for why it is needed
- Hand hygiene before or after manipulating catheter
- Change wet, soiled or dislodged dressings
Central Venous Catheter Tracer

- Dressing change with aseptic technique using clean or sterile gloves
- Scrub the hub or access port with appropriate antiseptic
  - Chlorhexidine, povidone iodine, or 70% alcohol
- Access catheter only with sterile devices
- Review daily if catheter can be removed
Ventilator/Respiratory Therapy Tracer

- Respiratory procedures must be performed consistent with IC P&P
- Need to prevent VAP (ventilator associated pneumonia)
- Hand hygiene must be performed before and after contact with patient or any respiratory equipment on patient
- Gloves are worn when in contact with respiratory secretions
- Only sterile water is used for nebulization
## Section 4. C Ventilator/Respiratory Therapy Tracer

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General respiratory therapy practices (apply to patients with and without ventilators):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. C1 Hand hygiene is performed before and after contact with patient or any respiratory equipment used on patient.</td>
<td>☐ Yes ☐ No ☐ N/A</td>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
<tr>
<td>4. C2 Gloves are worn when in contact with respiratory secretions and changed before contact with another patient, object, or environmental surface.</td>
<td>☐ Yes ☐ No ☐ N/A</td>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
<tr>
<td>4. C3 Only sterile water is used for nebulization.</td>
<td>☐ Yes ☐ No ☐ N/A</td>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
<tr>
<td>4. C4 Single-dose vials for aerosolized medications are not used for more than one patient.</td>
<td>☐ Yes ☐ No ☐ N/A</td>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
<tr>
<td>4. C5 If multi-dose vials for aerosolized medications are used, manufacturer's instructions for handling, storing, and using the vials are followed.</td>
<td>☐ Yes ☐ No ☐ N/A</td>
<td>☐ Yes ☐ No ☐ N/A</td>
</tr>
</tbody>
</table>
Ventilator/Respiratory Therapy Tracer

- Use single dose vials for aerosolized medications
- If multidose vials are used for aerosolized medications then must follow manufacturers instructions for storage, handling, & dispensing
- If multidose vials above used for more than one patient, they are restricted to centralized medication area
- Nebulizers (mask/mouthpiece, cup) are rinsed with sterile water and dried thoroughly between uses on the same patient (or if tap water used follow by isopropyl alcohol) (removed and undergoing revision)
Ventilator/Respiratory Therapy Tracer

- Need oral hygiene program that includes antiseptic agent (like chlorhexidine)
- HOB is elevated 30-45 degrees unless contraindicated to prevent aspiration
- Ventilators must be used in a manner consistent with hospital IC P&P
- Ventilator circuit is changed if visibly soiled or mechanically malfunctioning
- Sterile water is used to fill bubbling humidifiers
Condensation that collects in the tubing of a mechanical ventilator is periodically drained and discarded.

If single-use open-system suction catheter is employed, a sterile, single-use catheter is used.

Sedation is lightened in eligible patients.

Spontaneous breathing trials are performed daily in eligible patients.
Spinal Injection Procedures  4D

- Spinal injections are performed in accordance with IC P&P
- Hand hygiene before and after the procedure
- The spinal injection procedure is performed using aseptic technique and sterile equipment, including use of sterile gloves
- Masks are worn by HCP putting in the catheter or injecting into epidural or subdural space
Section 4. D Spinal Injection Procedures

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal injection procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. D.1 Hand hygiene performed before and after the procedure.</td>
<td>Yes</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4. D.2 The spinal injection procedure is performed using aseptic technique and sterile equipment, including use of sterile gloves.</td>
<td>Yes</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4. D.3 Surgical masks are worn by HCP when placing a catheter or injecting materials into the epidural or subdural space.</td>
<td>Yes</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

If no to any of the above (4.D.1 through 4.D.3), cite at 42 CFR 482.42(a)(1) (Tag A-0749)
Next section is on point of care devices
  - Glucose meters, INR monitor

Hand hygiene is performed before and after the procedure

Gloves are worn when doing a finger stick

Finger stick devices are not used on more than one person
  - This includes both the lancet and the lancet holding device
### Section 4. E Point of Care Devices (e.g. Blood Glucose Meter, INR Monitor)

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. E.1 Hand hygiene is performed before and after the procedure.</td>
<td>☐ Yes □ No □ N/A</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5 □ Yes □ No □ N/A</td>
</tr>
<tr>
<td>4. E.2 Gloves are worn by healthcare personnel when performing the finger stick procedure to obtain the sample of blood and are removed after the procedure (followed by hand hygiene).</td>
<td>☐ Yes □ No □ N/A</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5 □ Yes □ No □ N/A</td>
</tr>
<tr>
<td>4. E.3 Finger stick devices are not used for more than one patient. Note: This includes both the lancet and the lancet holding device.</td>
<td>☐ Yes □ No □ N/A</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5 □ Yes □ No □ N/A</td>
</tr>
<tr>
<td>4. E.4 If used for more than one patient, the point-of-care device is cleaned and disinfected after every use according to manufacturer’s instructions. Note: If manufacturer does not provide instructions for cleaning and disinfection, then the device should not be used for &gt;1 patient.</td>
<td>☐ Yes □ No □ N/A</td>
<td>□ 1 □ 2 □ 3 □ 4 □ 5 □ Yes □ No □ N/A</td>
</tr>
</tbody>
</table>
Point of Care Devices

- Must be cleaned after each patient use according to manufacturer instructions
- If manufacturer does not provide instructions for cleaning and disinfection, then the device should not be used for more than 1 patient
- Insulin pens are used for only one patient
- Gloves and gowns are available and located near point of use
Isolation Contact Precautions

- Contact precaution signs are clear and visible
  Patients on contact precautions are in private room
- Hand hygiene is performed before entering patient care area
- Soap and water must be used if patient with C-diff or norovirus
- Gloves are put on when going in room
- Upon leaving gloves and gowns are discarded and hand hygiene done
- CDC has isolation guidelines
Section 4. F Isolation: Contact Precautions

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients requiring contact isolation are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. F.1 Gloves and gowns are available and located near point of use.</td>
<td>☐ Yes 1 2 3 4 5</td>
<td>☐ Yes 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>☐ No 1 2 3 4 5</td>
<td>☐ No 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>☐ N/A 1 2 3 4 5</td>
<td>☐ N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>4. F.2 Signs indicating patient is on Contact Precautions are clear and visible.</td>
<td>☐ Yes 1 2 3 4 5</td>
<td>☐ Yes 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>☐ No 1 2 3 4 5</td>
<td>☐ No 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>☐ N/A 1 2 3 4 5</td>
<td>☐ N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>4. F.3 Patients on contact precautions are housed in single-patient rooms when available or cohorted based on a clinical risk assessment.</td>
<td>☐ Yes 1 2 3 4 5</td>
<td>☐ Yes 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>☐ No 1 2 3 4 5</td>
<td>☐ No 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>☐ N/A 1 2 3 4 5</td>
<td>☐ N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>4. F.4 Hand hygiene is performed before entering patient care environment.</td>
<td>☐ Yes 1 2 3 4 5</td>
<td>☐ Yes 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>☐ No 1 2 3 4 5</td>
<td>☐ No 1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>☐ N/A 1 2 3 4 5</td>
<td>☐ N/A 1 2 3 4 5</td>
</tr>
</tbody>
</table>

Note: Soap and water must be used when bare hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected *C. difficile* or norovirus.
Healthcare Infection Control Practices Advisory Committee (HICPAC)

General Guidelines


**Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008** [PDF - 948 KB]

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2007 **Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings** This document is intended for use by infection control staff, healthcare epidemiologists, healthcare administrators, nurses, other healthcare providers, and persons
Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, 2011

Download the complete PDF version Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, 2011 [PDF - 676 KB] and Appendices [PDF - 3.48 MB].

Table of Contents

Abbreviations

Acknowledgements

- Executive Summary
- Summary of Recommendations
- Implementation and Audit
- Recommendations for Further Research
- Background
- Scope and Purpose
- Methods

http://www.cdc.gov/hicpac/norovirus/002_norovirus-toc.html
Isolation Contact Precautions

- Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs) is used.
- Hospital limits movement of patients on Contact Precautions outside of their room to medically necessary purposes.
- If need to leave room then methods followed to communicate that patient’s status and to prevent transmission of infectious disease.
- Frequently touched surfaces are disinfected (bed rails, call button, bedside table, light switch etc.).
Isolation Contact Precautions

- When patient discharged must clean and disinfect and all textiles must be replaced (like curtains and towels)
- Cleaners and disinfectants are labeled and used in accordance with hospital P&P
- Must be in accordance with manufacturer instructions such as dilution, storage, contact time etc.
Isolation Droplet Precautions

- Patients requiring droplet precautions are identified and managed in manner consistent with hospital IC P&P

- Surgical masks are close and put on when entering the room and discarded when leaving

- Droplet precaution signs are clear and visible

- Hand hygiene before and after going in room

- Same consideration as above in cleaning

- Many similarities so see document
Isolation Airborne Precautions

- NIOSH-approved particulate respirators are available and located near point of use
- Airborne precautions signs are clear and visible
- Patients on Airborne Precautions are housed in airborne infection isolation rooms (AIIR)
- Hand hygiene is performed before entering
- HCP wear a NIOSH-approved particulate respirator when entering room and hospital P&P
- Limit movement of patient outside of room unless necessary and patient wears a mask
### Section 4. G Isolation: Droplet Precautions

<table>
<thead>
<tr>
<th>Element to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients requiring Droplet Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease, including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. G.1 Surgical masks are available and located near point of use.</td>
<td>Yes, No, N/A</td>
<td>1, 2, 3, 4, 5</td>
</tr>
<tr>
<td>4. G.2 Signs indicating patient is on Droplet Precautions are clear and visible.</td>
<td>Yes, No, N/A</td>
<td>1, 2, 3, 4, 5</td>
</tr>
<tr>
<td>4. G.3 Patients on Droplet Precautions are housed in single patient rooms when available or cohorted based on a clinical risk assessment.</td>
<td>Yes, No, N/A</td>
<td>1, 2, 3, 4, 5</td>
</tr>
<tr>
<td>4. G.4 Hand hygiene is performed before entering patient care environment.</td>
<td>Yes, No, N/A</td>
<td>1, 2, 3, 4, 5</td>
</tr>
</tbody>
</table>

Interview = 1  Observation = 2  Infection Control Document Review = 3  Medical Record Review = 4  Other Document Review = 5
Surgical Procedure Tracer

- Surgical procedures performed in a manner consistent with hospital IC P&P
- Staff perform surgical scrub on them before putting on sterile gloves for surgical procedures in the OR
- Hands and arms are dried with a sterile towel after the surgical scrub and then sterile gown is put on
- Surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair are worn by all personnel in semi restricted and restricted areas
  - AORN has guidelines on this
## Section 4.1 Surgical Procedure Tracer

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease, including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.1 Healthcare personnel perform a surgical scrub before donning sterile gloves for surgical procedures (in OR) using either an antimicrobial surgical scrub or an FDA-approved alcohol-based antiseptic surgical hand rub.</td>
<td>Yes 1 No 2 N/A 3 4 5</td>
<td>Yes 1 No 2 N/A 3 4 5</td>
</tr>
<tr>
<td>Note: If hands are visibly soiled, they should be prewashed with soap and water before using an alcohol-based surgical scrub.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1.2 After surgical scrub, hands and arms are dried with a sterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.</td>
<td>Yes 1 No 2 N/A 3 4 5</td>
<td>Yes 1 No 2 N/A 3 4 5</td>
</tr>
</tbody>
</table>
Surgical Procedure Tracer

- Restricted area includes ORs, procedure rooms, and the clean core area
- The semi restricted area includes the peripheral support areas of the surgical suite
- Surgical masks are worn by all personnel in restricted areas where open sterile supplies or scrubbed persons are located
  - Masks must be properly tied
- Sterile drapes are used to establish sterile field
Surgical Procedure Tracer

- Traffic in and out of OR is kept to minimum and limited to essential staff
- Surgical masks are removed when leaving the sterile areas and are not reused when returning
- Detailed section about cleaning between cases so environmental services should read this section
- Discusses cleaning of anesthesia machines and reusable noncritical equipment like BP cuffs
- Discusses terminal cleaning and AORN has policies on how to clean including mopping etc.
Sterile Field in the OR

- Sterile field is maintained and monitored constantly to ensure that:
  - Items used within sterile field are sterile
  - Items introduced into sterile field are opened, dispensed, and transferred in a manner to maintain sterility.
  - Sterile field is prepared in the location where it will be used and as close as possible to time of use
  - Movement in or around sterile field is done in a manner to maintain sterility
Bone Marrow Patients

- Last section is on bone marrow patients and ensuring a protective environment
- Anyone working with bone marrow patients needs to read this section
- Includes having positive pressure airflow in room at 12 air exchanges per hour
- Supply air is hepa filtered
- Well sealed room and self closing door
- Make sure ventilation specifications are monitored using visual methods (smoke tubes, flutter strips)
## Module 5: Special Care Environments

### Section 5. A Protective Environment (e.g. Bone Marrow patients)

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients requiring a Protective Environment - the hospital ensures:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. A.1 Positive pressure (air flows out to the corridor)</th>
<th>Yes</th>
<th>1</th>
<th>Yes</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>2</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>3</td>
<td>N/A</td>
<td>3</td>
</tr>
</tbody>
</table>

**Interview = 1  Observation = 2  Infection Control Document Review = 3  Medical Record Review = 4  Other Document Review = 5**
Do you have a question that you would like answered during the Q&A session? Simply follow the instructions below.

If you are listening to the conference via streaming audio through your computer, you must dial in on the telephone at 1-877-776-3544 to ask your question live.

1. To ask a question, please press *1 on your touchtone phone.

2. If you are using a speaker phone, please lift the receiver and then press *1.

3. If you would like to withdraw your question, press *1.

OR

You may enter your question in the chat box in the webinar.
The End! Thank you for attending!

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- Board Member
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