Infection Control Updates

California Healthcare Best Practices Conference

November 3, 2025

Indian Health Service

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Disclosures

- I do not have any financial arrangements or affiliations with any corporate organizations that might constitute a conflict of interest in this continuing education activity.
- Any products shown are for the purpose of examples only and are not to be considered an endorsement.

Learning Objectives

California Healthcare Best Practices Conference

Upon completion of this course, participants will be able to:

1. Establish and sustain a culture of safety in hand hygiene practices by engaging leadership, promoting supportive accountability, and integrating measurable improvement goals into organizational performance activities.
2. Ensure consistent adherence to safe injection practices through proper aseptic technique, effective vial management, and continuous competency and quality assurance oversight to ensure accreditation compliance.
3. Assess and mitigate infection prevention risks in the environment of care through collaborative leadership engagement, quality assurance reviews, and data-driven safety metrics that support continuous performance improvement.
4. Strengthen infection prevention performance by routinely auditing reprocessing of reusable medical and dental devices, applying evidence-based standards, tracking quality metrics, and engaging both staff and leadership in accountability for safety and regulatory compliance.

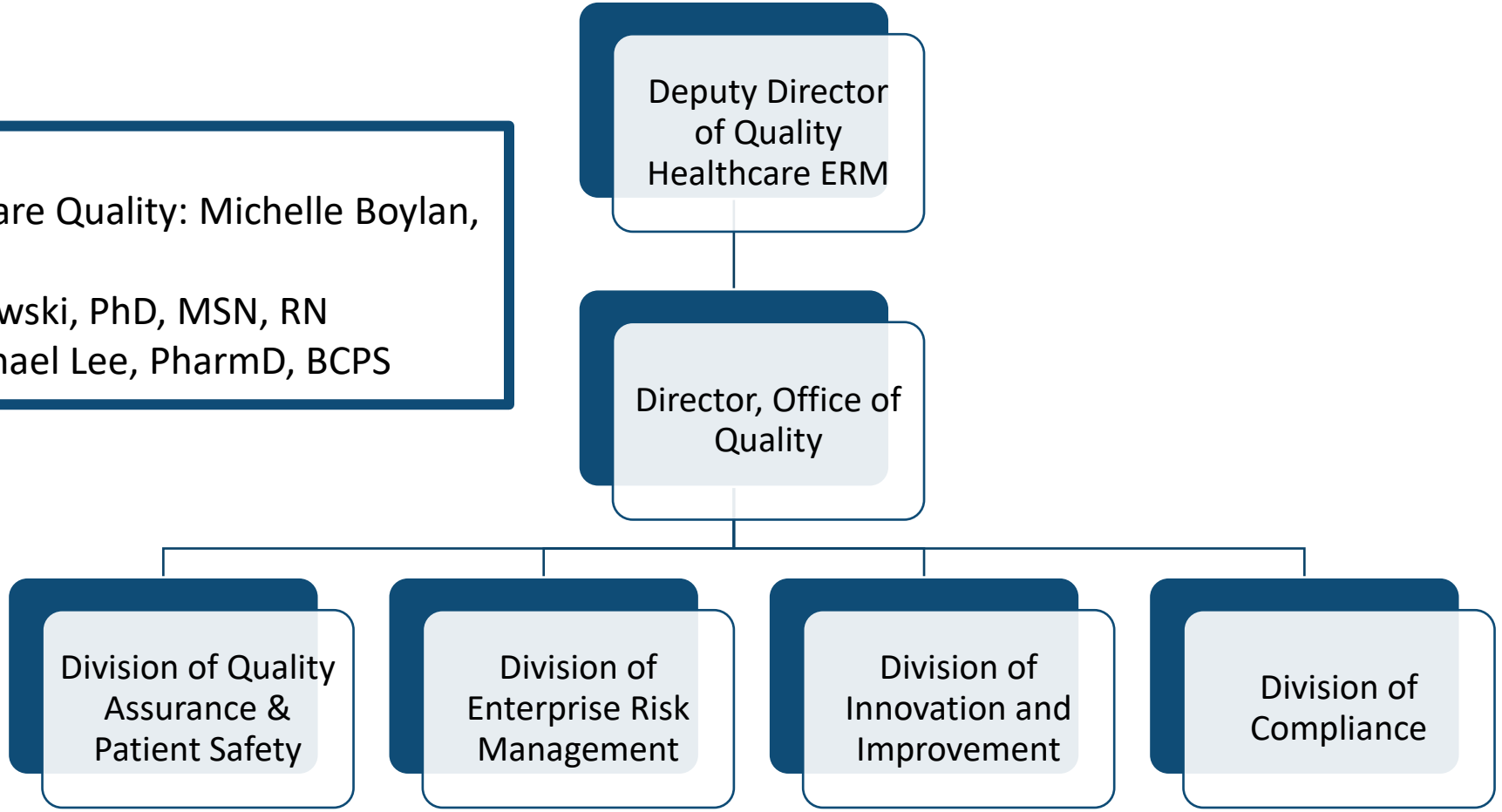
Office of Quality

Division of Quality Assurance and Patient Safety

Office of Quality

Office/Division Leadership:

1. Deputy Director Health Care Quality: Michelle Boylan, RN, MA, MBA, CPHQ
2. Office Director: Lisa Majewski, PhD, MSN, RN
3. Director QAPS: CAPT Michael Lee, PharmD, BCPS



Division of QAPS Programs

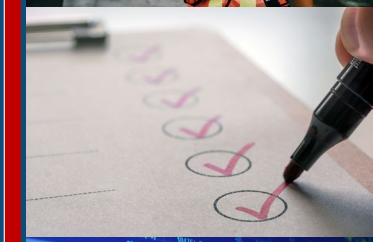
The Office of Quality (OQ) - Quality Assurance and Patient Safety (QAPS) team has programs working on policy development, deploying tools and resources for training and education, providing subject matter expertise and risk analysis.

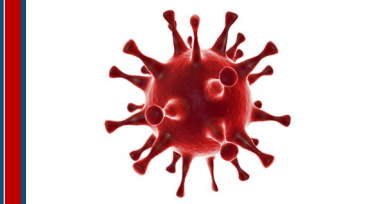
1. Quality Assurance: Lead– Nicole Flom, MSA, BSIS, CHC
2. Credentialing: Lead– CAPT (Ret.) Dione Harjo, MPH, CPCS
3. Patient Safety: Lead– CDR Michelle Livingston, MSN, RN, CNL, CIC, CPPS
4. I-STAR Administrator & Adverse Events Coordinator: Lead– CAPT Jodi Tricinella, PharmD, MHA, BCPS
5. Infection Control: Lead– Kelly Andrews, RN, CIC, CDIPC
6. Life Safety and Environment of Care: Lead– Kenith Franks, CSP, REHS
7. Clinical Risk Management: Lead– Paul Fowler, D.O., J.D. FAAFP, FCLM, FAOCOPM
8. Enterprise Application Coordinator: Lead– Derek Smith

Office of Quality – Division of Quality Assurance and Patient Safety

1) **Develops and implements programs to promote sustained compliance** with relevant federal regulations related to accreditation and professional standards for healthcare facilities;
2) manages and coordinates continuous accreditation compliance programs using **multidisciplinary integration of survey readiness activities**;
3) coordinates healthcare **accreditation resource management**;
4) **tracks healthcare accreditation** and certification survey reports;
5) develops and implements **programs to manage credentialing standards and policy**, acquires and maintains centralized credentialing **software system**, promotes unification of medical staff professionals (MSP), and promotes **standardized training and support** resources for MSP;
6) develops and implements **policies and procedures to promote patient safety, infection control practices, and environment of care and life safety practices**;





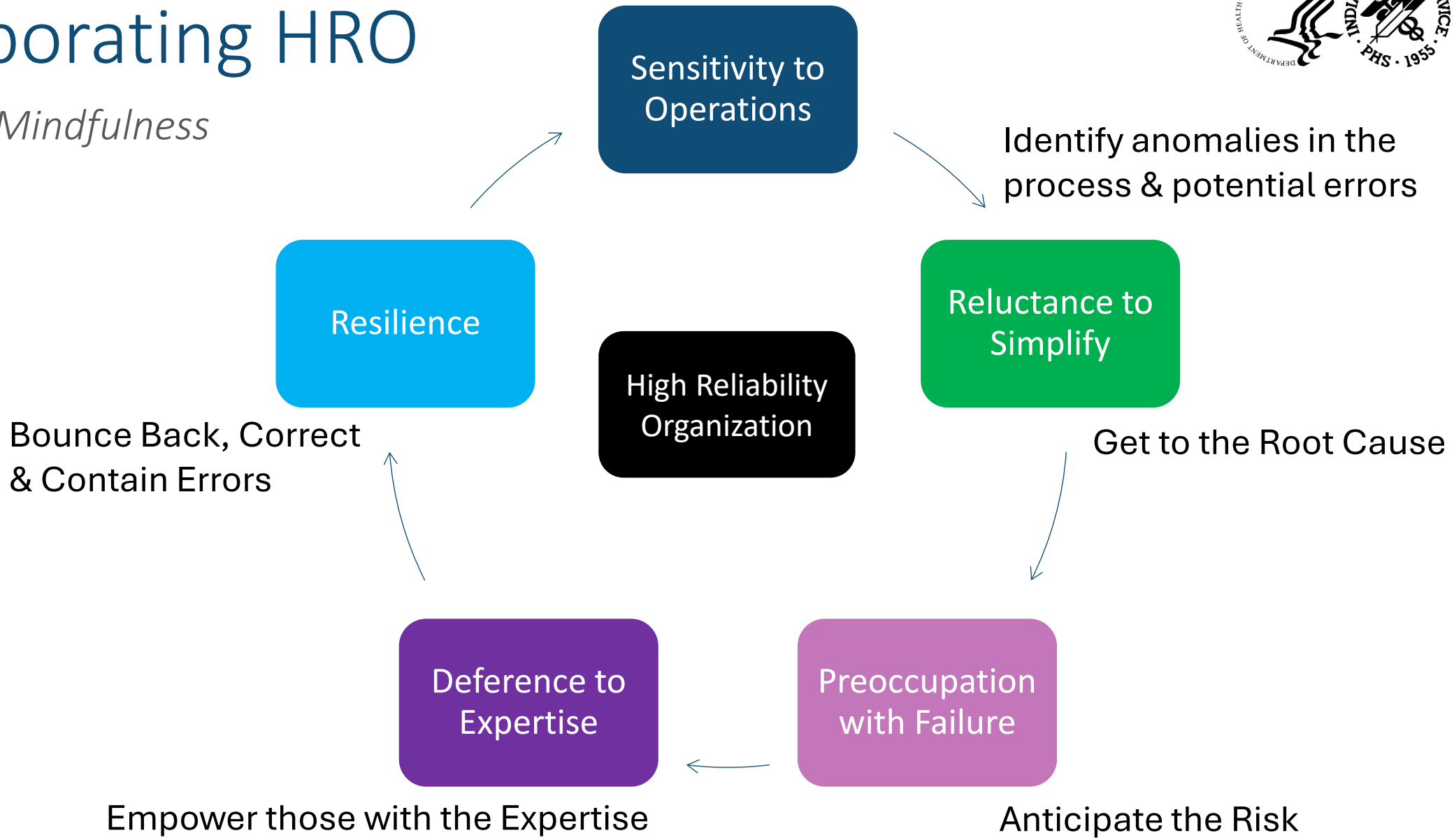



Office of Quality – Division of Quality Assurance and Patient Safety

7) establishes **policies and guidelines to reduce adverse events**;
8) develops **education and training** related to the application of established patient **safety and adverse event reporting systems** and metrics;
9) establishes and maintains oversight mechanisms for incident identification and reporting, adverse events and good catches, comprehensive systemic analysis/root cause analysis process and documentation;
10) implements strategies to **improve patient and workforce safety**;
11) enhances collaborative communication to facilitate the **sharing of best practices** and learning related to **identified risks and mitigation actions** across the agency;
12) identifies IHS and National patient safety trends and investigates positive and negative patient safety outcomes across the agency; and
13) provides patient safety consultation regarding industry standards, best practices, and development of policy, processes, and procedures.

Incorporating HRO

Persistent Mindfulness



Building a Culture of Safety

Leadership Rounds

One IHS – Total System Safety

LEADERSHIP INSIGHTS

Building a Culture of Safety

Key Points:

⇒ Rounding is an opportunity to engage with staff and strengthen the safety culture.

⇒ Make rounding a positive experience.

⇒ Focus on processes and systems to build a just culture and psychological safety.

⇒ Ensure a tracking system is in place to follow-up on issues raised by staff or observed during rounding and provide closed-loop communication with those you engaged.

Leadership Rounds

Leadership rounding is a best practice of leadership in healthcare organizations.

Rounding is an opportunity to engage staff, maintain the visibility of leadership, and contribute to patient safety and staff well-being.

Rounding utilizes the high-reliability principle of deference to expertise to build a strong safety culture. Leaders support a just culture and psychological safety by focusing on process and system weaknesses.

Important concepts to keep in mind:

"Every system is perfectly designed to get the results it gets." W. Edward Deming—*(1900-1993) was a scholar, industrial engineer, management consultant, statistician, and writer.*

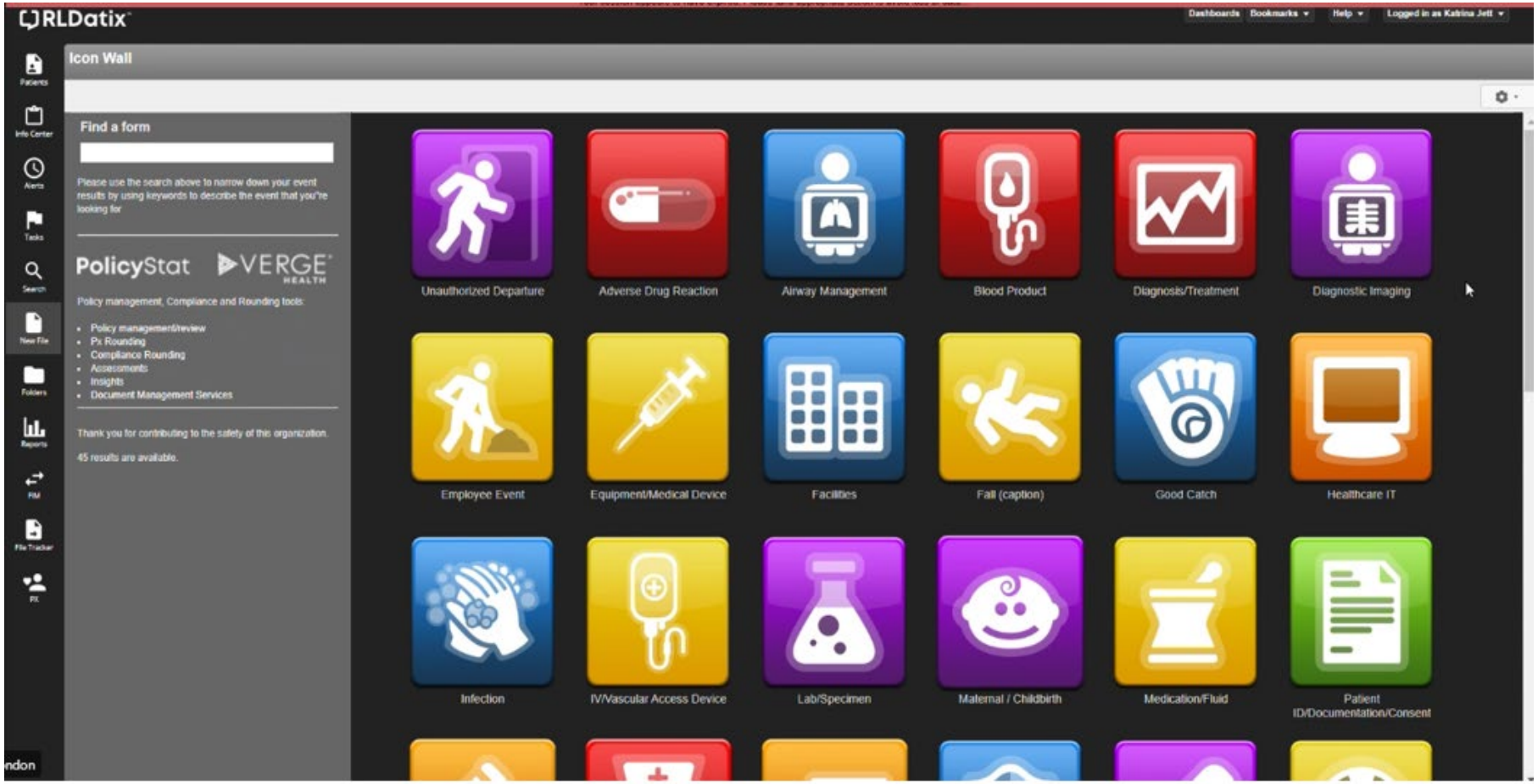
Staff closest to the work have the greatest insight into system weaknesses and safety risks.

Encourage staff to actively identify risks and report them in I-STAR (preoccupation with failure) so they can be effectively tracked, trended, and addressed.

Always closed the loop with staff to inform them how their feedback increased patient and workforce safety.

Building a Culture of Safety

IHS Safety Tracking and Response (I-STAR)



*Not the actual version, but a representation of the icon page (RL6)

Infection Control and Prevention Program

Program Elements

and the Infection Control Committee

CMS Condition of Participation: Infection prevention and control and antibiotic stewardship programs:
eCFR :: 42 CFR 482.42 -- Condition of participation: Infection prevention and control and antibiotic stewardship programs.

Infection Control and Prevention- *The Why*

"On any one given day, 1 in 31 hospitalized patients has at least one healthcare-associated infection."

[Current HAI Progress Report | HAIs | CDC]

ICP Program Leadership

Quality and Leadership

Governing Bodies (GB) must ensure:

- **Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities**, to demonstrate the implementation, success, and sustainability of such activities

ICP Program Leadership

Quality and Leadership

Governing Bodies must ensure:

- **All Healthcare Associated Infections (HAI) and other infectious diseases** identified by the infection control and prevention (ICP) program **are addressed in collaboration with hospital Quality Assurance and Performance Improvement (QAPI) leadership**

ICP Program Leadership

Quality and Leadership

- Facility CEO Roles:
  - Support the development and implementation of an ongoing **risk assessment process** for the safety of patients, visitors, and staff
  - Ensure that issues identified by the ICP program are addressed through the **QAPI and training programs**
  - **Empower and support** the authority of those managing the ICP program

ICP Program Leadership

Quality and Leadership

- Facility CEO Roles:
  - Implement **corrective action plans** for issues identified as requiring improvement
  - Implicit in these responsibilities is **protecting healthcare personnel from the spread of communicable disease**; and
  - Ensure staff have **adequate training and resources** to implement a comprehensive IC program

ICP Program Roles

Quality and Leadership

- The **comprehensive ICP program** must be in accordance with Infection Prevention and Control federal regulations and guidance, accreditation organization standards, professional organization standards, scope and level of services provided, and evidence-based best practices
- The **leadership and management at all levels of the organization should provide support** in the form of staff, facilities, equipment, supplies, time, and training to establish and implement the ICP program

ICP Program Roles

Quality and Leadership

- **Clinical Director & Director of Nursing should provide support** and assistance to the implementation of the ICP program.
- **QAPI Director,** or equivalent, will usually **oversee the implementation of the ICP Program** and provide management, budgetary, and logistical support as appropriate to the local organizational structure.

ICP Program Roles

All Staff have a Role with ICP

- All Employees:
  - All healthcare personnel are responsible for **complying with ICP policies**
  - All are responsible for **identifying potential infection control issues** and taking immediate action, as appropriate to their professional scope, to prevent or correct such issues
  - All are encouraged to **participate in the development, implementation, and evaluation of the ICP program**

Infection Control Nurse/Officer

ICP Officer/Nurse

- The **CEO will identify the ICP Officer**, and any other staff, to whom they confer the authority to implement or intervene in any activity necessary to prevent infections and interrupt the transmission of infectious diseases.
- If the ICP Officer shares information with **leadership** for evaluation and action.
- The **ICP Officers should be qualified through education, training, experience, or certification**, and should maintain their qualifications through ongoing education and training.

Surveillance, Policies, & Procedures

Documentation of Activities

Competency Based Training & Education

Prevention & Control of HAI

Auditing of Staff Adherence

Communication and Collaboration w/All Staff and QAPI

ICP Nurse/Officer

A Day in the Life

Patient Safety

Infection Control Committee

Dental & Medical

Audits & Tracers

Resource Availability

IC Office Hours

ICRA/ PCRA & WICRA

Accreditation

Training & Competency

TB & BBP Exposure Control Plans

IFUs Resources

New IP Education

High-risk processes

EOC

Reporting

IP Nurse/ Officer

Quality Assurance & Performance Improvement

NHSN & Tracers

HAI & Outbreak Surveillance

ICP Program Plan & Risk Assessment

ICP Program Elements

Goal: Prevent Healthcare-Associated Infections (HAI)

Reporting

Training and Education

Surveillance & Monitoring Activities

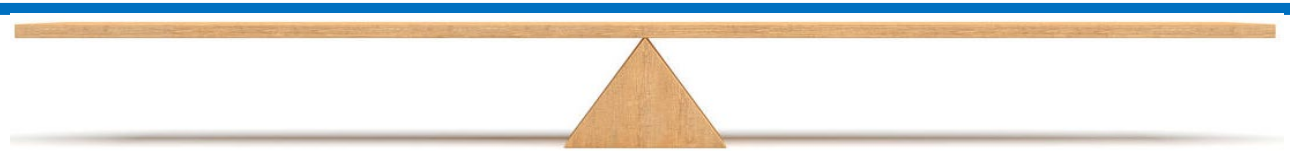
Program Oversight

ICP Program Elements

Goal: Prevent Healthcare-Associated Infections (HAI)

Program Oversight:

- Infection Control and Prevention (ICP) Officer
- Infection Control Committee (ICC)
- Program integrated in Quality Assurance/Performance Improvement Program
- Program Plan and Annual Risk Assessment with Goals
  - Comprehensive IC Risk Assessment, Pre-Construction Infection Control Risk Assessment (PCRA/ICRA), Tuberculosis, Water Infection Control Risk Assessment

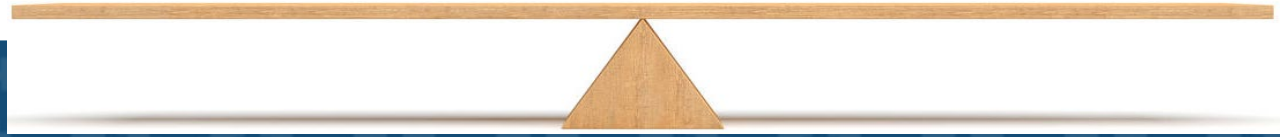


ICP Program Elements

Goal: Prevent Healthcare-Associated Infections (HAI)

Surveillance & Monitoring Activities

- Clinical Surveillance: Healthcare Associated Infections (HAI); Device-associated, SSI; Lab ID Events (MRSA bloodstream, C. diff)
- Surveillance: Infection Control processes in the Physical Environment/Environment of Care
- Investigations
  - Gaps in process, high-risk events (patient/staff actual or potential for harm)
  - Healthcare-Associated Infections
  - Outbreaks



ICP Program Elements

Goal: Prevent Healthcare-Associated Infections (HAI)

Reporting:

- GB, National Healthcare Safety Network (NHSN), Facility, Public Health, Infection Control Committee (ICC)

Training and Education:

- IP Nurse/Officer is trained and qualified
- Staff are trained in ICP
- Evidence-based policies and procedures

Infection Control Committee

Infection Control Committee (ICC)

Infection Control Committee

Multidisciplinary Team

- ICP Officer
- Clinical Director (or Physician designee/ID)
- Quality Manager
- Employee / Occupational Health
- Laboratory Supervisor
- Pharmacy Supervisor
- Nurse Executive
- Environmental Services (Housekeeping)
- Facility Manager
- Safety Officer
- Environmental Health Officer
- Clinical Department Representatives (including Dental)
- Public Health Nursing
- Sterile Processing / Central Sterile
- Leadership / Administration

Ad hoc Members:

- Unit Champions
- Food Services
- Biomedical Engineering
- Specialty Areas (Physical Therapy, Podiatry)
- Emergency Manager

Any others?

Infection Control Committee

Major Functions

- Hold routine Infection Control Committee meetings (Quarterly or Monthly)
- Hold special meetings as needed (e.g., annual risk assessment/annual plan, emergency response to a specific concern)

Infection Control Committee

Major Functions

- **Provide oversight** of program activities
- Ensure **compliance with accreditation standards**
- **Document Infection Control activities**

Infection Control Committee

Major Functions

- Document policy development, training, and surveillance activities
  - **Competency-based training** on policies and procedures, for new staff, new/updated processes
  - Initial training, annual, and when there are new/updated processes
  - Include **hand hygiene, standard precautions, BBP exposure prevention, and high-risk processes (others?)**

Infection Control Committee

Major Functions

- **Conduct Annual Planning Activities** (more frequently if new risks arise):
  - Evaluate the prior year's plan/goals/surveillance data
  - Conduct Risk Assessment
  - Develop a new plan that includes identified risks, measurable goals, and activities/mitigation measures

Annual Evaluation, Risk Assessment, Plan

Considerations:

- Fiscal or Calendar year?
- When was this last done at your facility?
- Have new services been added?
- New locations or clinics?
- New patient population?
- Is your program tailored to your setting?
- How do you accomplish your Annual Eval, Risk Assessment, and creation of a new Annual Plan?

Pointers:

✓ Consider an extra Infection Control Committee meeting (or 2) built into your meeting calendar

✓ Give yourself time- start early (1-2 months before the new year)

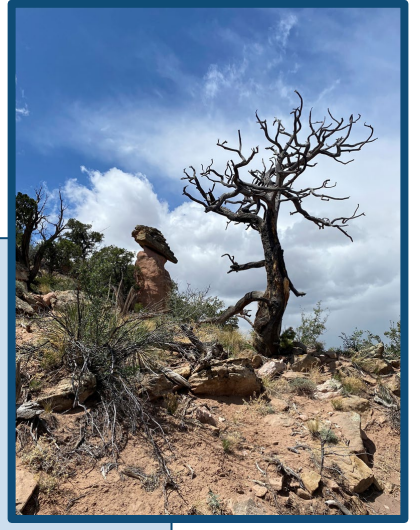
✓ Should you include others aside from your ICC?

Annual Evaluation, Risk Assessment, Plan

Considerations:

- Annual Evaluation
  - This is the end-of-year review of ICP activities and surveillance data
    - Based on the goals developed in the 2025 Annual Plan
    - Data found in ICC meeting minutes
    - Data from tracer activities, other risks and activities identified throughout the year
  - Determine- did you meet the goals you set out to achieve at the beginning of the year?
    - If yes, should they remain for 2026? *Think hand hygiene, high-risk processes/procedures, etc.*
    - If no, should they remain for 2026? *Is it still applicable?*
  - The evaluation is where you can document your successes and challenges, and decisions to include any current plans in the 2026 plans

Annual Evaluation, Risk Assessment, Plan



Considerations:

- Annual Risk Assessment
  - What factors did you include in the Risk Assessment?
    - *Utilize a template, make it applicable to your facility*
    - *Do you need to add anything else based on your services/population*
  - Did you consider the items identified in your Annual Evaluation of 2025 when you completed the Risk Assessment?
  - Did you show that you considered:
    - facility location
    - population
    - services provided
  - Who gives input? *Consider others you may include who are not part of your regular ICC*
  - Does your Risk Assessment clearly identify prioritized risks? *Everything cannot be a priority*

Annual Evaluation, Risk Assessment, Plan

Considerations:

- Annual Plan
  - Are the results of the Risk Assessment used to develop and prioritize the 2026 Annual Program Plan
  - Does your Annual Plan include elements required by accrediting bodies?
  - Have you included all written elements of the Infection Control Program in your program documents?
  - How have you tied your evaluation of the prior year, Risk Assessment, and Goals and Plan together?

Annual Evaluation, Risk Assessment, Plan

Sample Template- APIC

Sample

Cover Page for Risk Assessment Report

Risk Assessment Report for Infection Surveillance, Prevention and Control (ISPC) Program
Year: 20__

Organization Name: _____
Date of Report: _____

Overview

A facility risk assessment for acquiring and transmitting infections should be conducted annually in each healthcare facility. [Note: An annual risk assessment is required for organizations accredited by The Joint Commission and other accreditation organizations.] The risk assessment provides a foundation for the Infection Surveillance, Prevention and Control Program because it is used is used to provide information about where an organization should focus its infection surveillance, prevention and control activities.

This facility risk assessment was conducted by identifying and reviewing potential risk factors for infection related to the care, treatment, and services provided and to the environment of care in a specific healthcare setting. The identified risks of greatest importance and urgency were selected and prioritized and are noted below. Based on these identified risks, facility personnel will develop the organization's Infection Surveillance, Prevention and Control (ISPC) Plan (i.e., an action plan, with goals and measurable objectives.)

The ISPC Plan includes a goal for reducing the risk of infection associated with each of the prioritized risks, a measurable objective for each goal, and evidence based strategies for meeting each of these objectives. The Plan also (1) identifies the personnel responsible for developing the Plan and implementing the ISPC Program strategies and (2) includes mechanisms for evaluating the effectiveness of the meeting the ISPC Program's objectives.

Assessment Tool

An organizational Infection Risk Assessment **tool** (below) was reviewed and adapted for use by (Organization name) by the following personnel:

_____

The Risk Assessment tool was used to identify potential infection risk factors in each of the following categories:

- Community and populations served
- Potential for specific infection
- Treatment and care practices
- Instrument and medical device cleaning, disinfection and handling
- Environment of care
- Emergency management
- Others identified by the organization

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[ASC_Risk_Assessment_Template.docx]

Annual Evaluation, Risk Assessment, Plan

Sample Template- APIC

Sample

Process

The following personnel conducted the risk assessment:

_____

The group identified, assessed and scored each potential risk factor based on the following:

1. **Potential impact** of the event/condition on patients and personnel, determined by evaluating the potential for patient illness, injury, infection, death, need for admission to an inpatient facility; the potential for personnel illness, injury, infection, shortage; potential to impact the organization's ability to function/remain open; and degree of clinical and financial impact.
2. **Probability of the event/condition occurring,** determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.), and health department data, are considered when determining this score.
3. **Organization's preparedness** to deal with the event/condition, determined by considering policies and procedures already in place, staff experience and response to actual situations, and available services and equipment.

Ranking of Scores

After risk scores are assigned in the three assessment groups, the numbers in each group were totaled to provide a numerical risk level for each event/condition. The numerical risk level can range from 0 (lowest vulnerability) to 9 (highest vulnerability). The risk factors (i.e., events/conditions) were then ranked from highest to lowest risk level in the table below. The risks with the highest scores will be used for priority focus for developing the annual ISPC Plan. NOTE: Some events/conditions with a lower score may be selected because they are an accreditation or regulatory requirement, or can be quickly and easily implemented.

Distribution of Risk Assessment

The Risk assessment was shared with others, such as the _____, to solicit comments. The original group evaluated and incorporated the comments, as needed, and finalized this risk assessment. The risk assessment will be taken to the (governing body) _____ and the _____Committee for final approvals before the Infection Surveillance, Prevention and Control Plan is developed. After final approval of the risk assessment findings, the ISPC Plan will be developed by _____with periodic reports back to the _____Committee until the Plan has been fully implemented.

ASC_Risk_Assessment_Template.docx

Annual Evaluation, Risk Assessment, Plan

Sample Template- APIC

Sample

Risk Assessment for the Infection Surveillance, Prevention and Control (ISPC) Program

Year: 20___
Organization Name: _____
Date of Report: _____

Event or Condition	What is potential impact of event/condition on patients and staff?				What is probability of event/condition occurring?				What is organization's preparedness to deal with this event/condition?				Numerical risk level
	High (3)	Med (2)	Low (1)	None (0)	High (3)	Med (2)	Low (1)	None (0)	None (3)	Poor (2)	Fair (1)	Good (0)	Total
COMMUNITY & POPULATIONS SERVED:													
EMERGING INFECTIOUS DISEASE													
POTENTIAL FOR SPECIFIC INFECTION:													

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[ASC_Risk_Assessment_Template.docx]

Annual Evaluation, Risk Assessment, Plan

Sample Template- APIC

GOALS AND OBJECTIVES

RISK EVENT/ CONDITION	GOAL	OBJECTIVE (measurable, includes timeframe for completion)

Page 11 of 12

RISK EVENT/ CONDITION	GOAL	OBJECTIVE (measurable, includes timeframe for completion)	STRATEGIES	IMPLEMENTATION	
				Respon-sible Person(s)	Method for Evaluating Effectiveness

Sample

Page 12 of 12

Annual Evaluation, Risk Assessment, Plan

Sample

NAME OF FACILITY

(Year) Annual Infection Control and Prevention Risk Assessment

Potential for Failure of:	Probability *4 = Expected* *3 = Likely* *2 = Maybe* *1 = Rare* *0 = Not Likely to Occur*	Risk / Impact					Preparedness with Current Systems / Processes					*Relative Risk**
		Possibility of death or permanent injury	*Temporary Physical losses and damages*	*Prolonged Length of Stay*	*Moderate Clinical / Financial*	*Minimal Clinical / Financial*	*NONE No Process / No Policy in Place / No Training Conducted*	*POOR Processes in Place, but Need Improvement / Uncertain Level of Training*	*FAIR Processes in Place and May Need Update / Some Training Done*	*GOOD Processes in Place and May Need Review / Most Trained*	*EXCELLENT Processes in Place and Working / All Trained*	
		5	4	3	2	1	5	4	3	2	1	0 - 100%
Communities and Population Served												
Geographic Location												0%
Patient Population												0%
Community												0%
												0%
Policies and Procedures												
Infection Control Risk reviewed at least anually												0%
Water Management Plan												0%
ICP policies reviewed and approved within 2 years												0%
Exposure Control and Tuberculosis Exposure Control Plans reviewed and updated annually												0%
Mandatory reporting (State Department of												

Page 1

Annual Evaluation, Risk Assessment, Plan

(Year) Infection Cor

Activities (Priority Element/Risk Area)	Measure/Metrics	Expected Outcome and Goal (Measurable)	Actions	Milestone Dates
#1 Improve Hand Hygiene Compliance (HH) (SAMPLE)	HH Compliance = # HH Performed/ # Opportunities to perform HH (SAMPLE)	Increase Hand Hygiene from 70% to 80% (SAMPLE)	1) Evaluate current placement of hand sanitizer 2) Huddle w/each unit and show VCU HH video 3) CEO messaging on focused effort 4) Assign IC unit reps in each unit to assist with collecting HH surveillance monthly 5) Entering HH data in Tracers with AMP 6) Post/announce the unit/department monthly "winner" for most compliant Hand Hygiene (SAMPLE)	1) Evaluate current placement of hand sanitizer (by 1/1/2026) 2) Huddle w/each unit and show HH video (by 1/31/2026) 3) CEO messaging on focused effort (by 2/1/2026) 4) Assign IC unit reps in each unit to assist with collecting HH surveillance monthly (by 3/1/2026); 5) Train IC unit reps on entering data in Tracers with AMP (by 3/31/2026) Go Live on HH surveillance by IC unit reps 4/1 6) Post/announce the unit/department monthly "winner" for most compliant Hand Hygiene (5/1/2026) (SAMPLE)
Priority Element/Risk Area	**Goal (Broad)**	**Objective (Measurable)**	**Actions**	
#1				

Annual Evaluation, Risk Assessment, Plan

ntrol and Prevention Annual Program Plan

Accountable Lead	Identified and Dedicated Resources	Demonstrated Progress (Date & Generate Task beingWorked on)	Transparency	Sustainability (Monitoring)
IP Unit IC Reps CEO	Staff JCR Tracers with AMP Facilities Staff	Update the Action Plan before each ICC Meeting	ICC Meeting minutes get routed to leadership for review and signature Minutes show progress of each Action item	ICC meeting minutes show accomplishments and challenges, which are reviewed by leadership
(SAMPLE)	(SAMPLE)	(SAMPLE)	(SAMPLE)	(SAMPLE)

Annual Evaluation, Risk Assessment, Plan

Sample

End of the Year Objective Evaluation	Met/Not Met (End of Year Evaluation of Program Goal/Plan)
Fill this in at the end of the year End-of-year data. Were each of the actions implemented? What were the successes and challenges? (SAMPLE)	Fill this in at the end of the year. (e.g., Goal Met, will remain a goal for next year) (SAMPLE)
End of the Year Objective Evaluation	Met/Not Met

Sample Agenda Items

ICC Meeting Content

Sample Agenda Items

- ❑ Document meeting, date, time, location, frequency, and ensure meeting minutes are taken
- ❑ Review of prior meeting minutes
- ❑ Old Business (Updates, progress, finalized items)

Sample Agenda Items

ICC Meeting Content

Sample Agenda Items

- ❑ New Business
  - ICP:
    - Report of HAIs: including progress, challenges, corrective actions
    - Report of high-consequence/special pathogens or reportable diseases
    - Updates on Annual Plan activity tracker (surveillance and data from goals implemented)

Sample Agenda Items

ICC Meeting Content

Sample Agenda Items

- Pharmacy:
  - Antimicrobial Stewardship reports
- Employee/Occupational Health
  - Report of Bloodborne Pathogen Exposures
  - Flu vaccination rates
- Facilities Department
  - Construction/Renovations Project Updates
  - Water Management Planning Activities

Sample Agenda Items

ICC Meeting Content

Sample Agenda Items

- Sterile Processing/Central Sterile
  - # of failed loads/# processed instrument loads
  - # of packs with bioburden/# packs processed
  - Process failures, with details, and corrective actions

Sample Agenda Items

ICC Meeting Content

Sample Agenda Items

- Report of Policies/ Activities with other Departments
  - BBP Exposure Control Plan
  - RMW Policy
  - TB Control Plan
  - Annual TB Risk Assessment
  - Sharps Safety Survey updates
  - Special Pathogen response planning

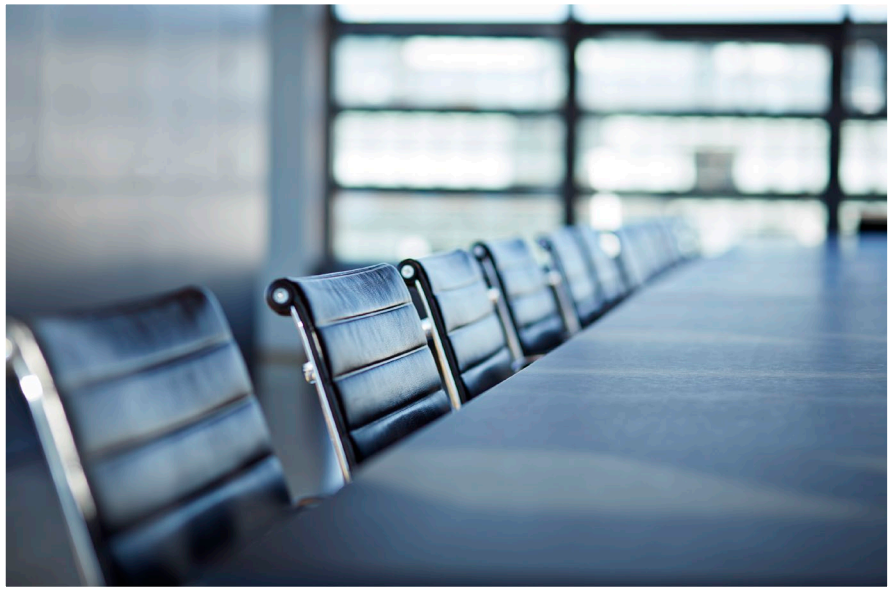
❑ Other Business

❑ Items for leadership awareness or support needed

❑ Next Meeting: Date, time, and location

Committees where ICP plays a role

A seat at the table



- Infection Control Committee
- Environment of Care Committee
- ICRA Team
- Water Management Team
- Quality Review Committee
- Nurse Executive Council
- Medical Executive Council
- Equipment Procurement Committee
- HLD/Sterilization Committee
- Space Utilization Committee
- Input to Service Unit Executive Committee
- Input to Governing Body Meetings
- Emergency Management Team/Committee
- Dental Infection Control

Hand Hygiene

Back to Basics: Hand Hygiene

- Know when to clean your hands:
  - Immediately before touching a patient
  - Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices
  - Before moving from work on a soiled body site to a clean body site on the same patient
  - After touching a patient or patient's surroundings
  - After contact with blood, body fluids, or contaminated surfaces
  - Immediately after glove removal

[Clinical Safety: Hand Hygiene for Healthcare Workers | Clean Hands | CDC]

Hand Hygiene: What to Use

Soap and Water:

- When hands are visibly soiled
- Before eating
- After using the restroom
- During the care of patients with suspected or confirmed infection during outbreaks of *C. difficile* and norovirus

Alcohol-based hand sanitizer (ABHS):

Unless hands are visibly soiled, ABHS is preferred over soap and water in most clinical situations because it:

- Is more effective at killing germs on hands than soap
- Is easier to use when providing care, especially when moving from soiled to clean activities on the same patient or when moving between care of patients in shared rooms
- Results in improved skin condition with less irritation and dryness than soap and water
- Improves hand hygiene adherence

Clinical Safety: Hand Hygiene for Healthcare Workers | Clean Hands | CDC

Back to Basics: "The how"

Soap & Water:

1. Wet hands with water
2. Apply the manufacturer-recommended amount of product to your hands
3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers
4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet
5. Avoid using hot water to prevent drying of the skin

Note: Other entities recommend cleaning hands with soap and water for at least 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times and scrubbing hands and fingers with soap.

CDC Clean Hands Count Materials: Clean Hands Count Materials | Clean Hands | CDC

Back to Basics: "The how"

Alcohol-Based Hand Sanitizer:

1. Put product on hands and rub hands together
   - The efficacy (effectiveness) of alcohol-based hand sanitizer depends on the volume applied to the hands. Use the right amount of alcohol-based hand sanitizer product to clean your hands.
2. Cover all surfaces and rub until hands feel dry
   - This should take around 20 seconds
3. Pay attention to the areas frequently missed:
   - Thumbs
   - Fingertips
   - Between fingers

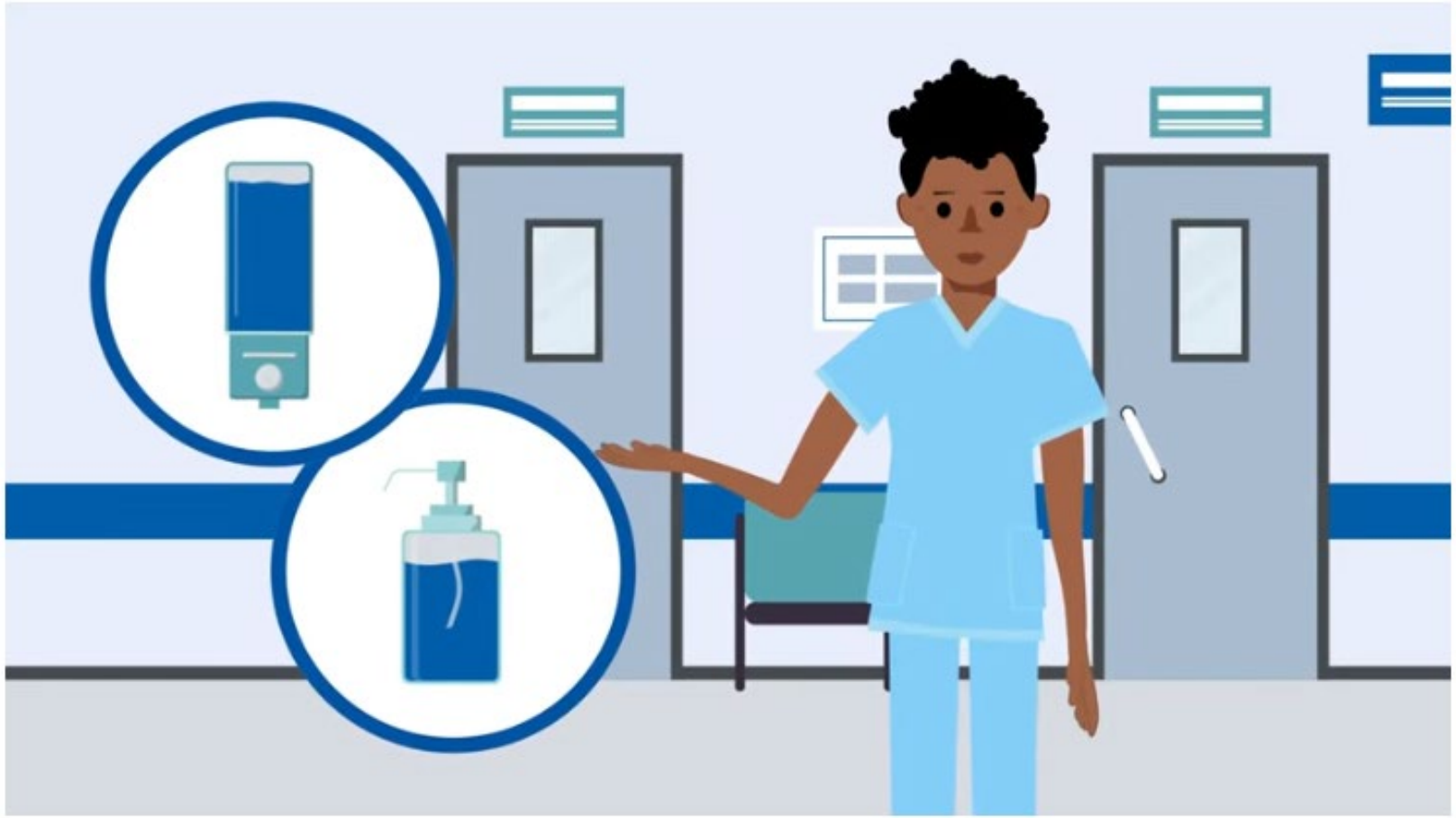
Germ Center

Test your Knowledge

1. What is the preferred method for Hand Hygiene, unless hands are visibly soiled?
   A. Soap and Water
   B. Alcohol-based hand rub
2. During hand hygiene, what areas of the hands are frequently missed?
   A. Thumbs
   B. Palms
   C. Fingers
3. How long should it take hand sanitizer to dry when rubbed on the hands?
   A. Around 15 seconds
   B. Around 20 seconds
   C. Around 2 minutes
4. If gloves are worn properly, hand hygiene is not necessary?
   1. True
   2. False

CDC Hand Hygiene – Engagement of Healthcare Personnel

***Engage**, Educate, Execute, Evaluate*



[Clean Hands in Healthcare Training | Clean Hands | CDC]

Hand Hygiene- Engaging HC Personnel

Clean Hands in Healthcare Training

Availability of Hand Hygiene supplies:

- Alcohol-based handrub should be readily available, visible, and within reach
- One inside the patient room and one outside the room in the hallway
- In common areas or areas with multiple patients, consider one unit for every 2 beds
- Hand washing stations should be present in the workflow, with soap, water, and paper towels

Clean Hands in Healthcare Training | Clean Hands | CDC

Hand Hygiene- Engaging HC Personnel

Clean Hands in Healthcare Training

Help each other remain aware of when to clean hands:

- Common times to ensure hand hygiene: prior to an aseptic task and after removing gloves
- If hand hygiene was missed, what prevented it from happening?

Set Goals:

- Imagine a situation where all limitations are removed
- Goals should focus on outcomes- for example:
  - Supply availability
  - Keeping each other accountable (compliance)

Clean Hands in Healthcare Training | Clean Hands | CDC

Hand Hygiene- Engaging HC Personnel

Clean Hands in Healthcare Training

Set concrete targets:

- Conduct daily or weekly audits to ensure patient areas have accessible and functional supplies
- Create a way to report barriers when help is needed
- Engage leaders in goal setting
- Monitor goals

[Clean Hands in Healthcare Training | Clean Hands | CDC]

Hand Hygiene- Engaging HC Personnel

Clean Hands in Healthcare Training

The program should be based on kind accountability and teamwork:

- Cleaning hands at the right time, training others, and monitoring performance
- Establish accountability: inclusion of hand hygiene program improvement goals in job descriptions and evaluations, ensuring a culture of safety
- Remind coworkers to clean their hands
- Conduct checklist observations during high-risk procedures
- Participating in Performance Improvement (PI) activities

[Clean Hands in Healthcare Training | Clean Hands | CDC]

Hand Hygiene- Engaging HC Personnel

Clean Hands in Healthcare Training

Begin the Quality Improvement Process:

- Determine how engaged personnel are
- Are supplies accessible
- Is hand cleaning included in bundles, such as central line insertion
- Are Hand Hygiene initiatives included in job descriptions
- Are Hand Hygiene goals informed by challenges experienced by personnel in various units

Clean Hands in Healthcare Training | Clean Hands | CDC

Hand Hygiene- Engaging HC Personnel

Clean Hands in Healthcare Training

Build a foundation of excellence by ensuring:

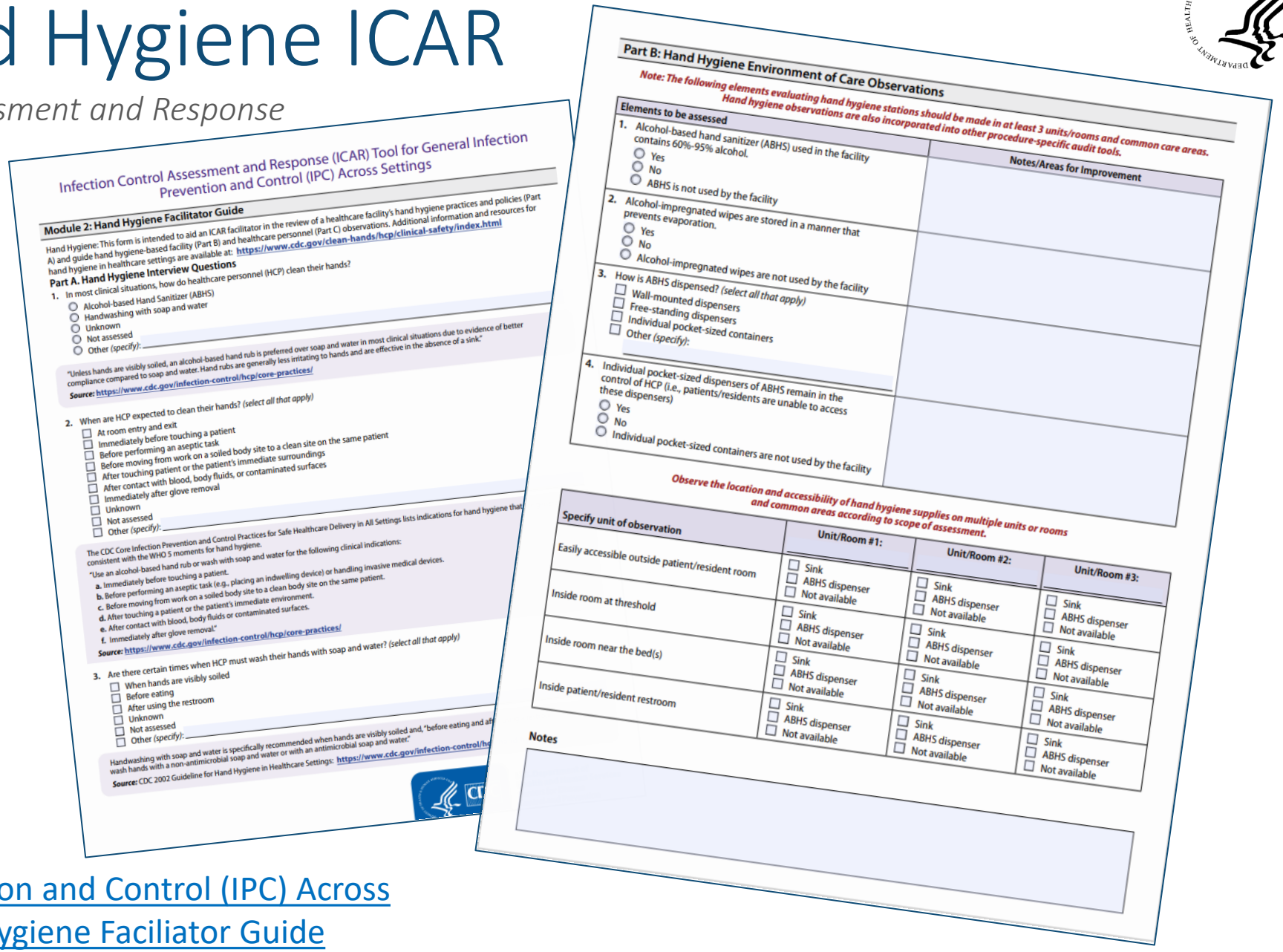
- Access to supplies
- Awareness of when hands should be cleaned
- Setting goals
- Ensuring accountability

~Creating a culture of patient safety will support personnel in caring for the populations they serve~

Clean Hands in Healthcare Training | Clean Hands | CDC

CDC Hand Hygiene ICAR

Infection Control Assessment and Response



Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings

Module 2: Hand Hygiene Facilitator Guide

Hand Hygiene: This form is intended to aid an ICAR facilitator in the review of a healthcare facility's hand hygiene practices and policies (Part A) and guide hand hygiene-based facility (Part B) and healthcare personnel (Part C) observations. Additional information and resources for hand hygiene in healthcare settings are available at: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html

Part A. Hand Hygiene Interview Questions

1. In most clinical situations, how do healthcare personnel (HCP) clean their hands?
   - Alcohol-based Hand Sanitizer (ABHS)
   - Handwashing with soap and water
   - Unknown
   - Not assessed
   - Other (specify):

"Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink."
Source: https://www.cdc.gov/infection-control/hcp/core-practices/

2. When are HCP expected to clean their hands? *(select all that apply)*
   - At room entry and exit
   - Immediately before touching a patient
   - Before performing an aseptic task
   - Before moving from work on a soiled body site to a clean site on the same patient
   - After touching patient or the patient's immediate surroundings
   - After contact with blood, body fluids, or contaminated surfaces
   - Immediately after glove removal
   - Unknown
   - Not assessed
   - Other (specify):

The CDC Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings lists indications for hand hygiene that consistent with the WHO 5 moments for hand hygiene.
"Use an alcohol-based hand rub or wash with soap and water for the following clinical indications:
a. Immediately before touching a patient.
b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices.
c. Before moving from work on a soiled body site to a clean body site on the same patient.
d. After touching a patient or the patient's immediate environment.
e. After contact with blood, body fluids or contaminated surfaces.
f. Immediately after glove removal."
Source: https://www.cdc.gov/infection-control/hcp/core-practices/

3. Are there certain times when HCP must wash their hands with soap and water? *(select all that apply)*
   - When hands are visibly soiled
   - Before eating
   - After using the restroom
   - Unknown
   - Not assessed
   - Other (specify):

Handwashing with soap and water is specifically recommended when hands are visibly soiled and, "before eating and af
wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water."
Source: CDC 2002 Guideline for Hand Hygiene in Healthcare Settings: https://www.cdc.gov/infection-control/h

Part B: Hand Hygiene Environment of Care Observations

Note: The following elements evaluating hand hygiene stations should be made in at least 3 units/rooms and common care areas. Hand hygiene observations are also incorporated into other procedure-specific audit tools.

Elements to be assessed	Notes/Areas for Improvement
1. Alcohol-based hand sanitizer (ABHS) used in the facility contains 60%-95% alcohol. ○ Yes ○ No ○ ABHS is not used by the facility	
2. Alcohol-impregnated wipes are stored in a manner that prevents evaporation. ○ Yes ○ No ○ Alcohol-impregnated wipes are not used by the facility	
3. How is ABHS dispensed? *(select all that apply)* ☐ Wall-mounted dispensers ☐ Free-standing dispensers ☐ Individual pocket-sized containers ☐ Other (specify):	
4. Individual pocket-sized dispensers of ABHS remain in the control of HCP (i.e., patients/residents are unable to access these dispensers) ○ Yes ○ No ○ Individual pocket-sized containers are not used by the facility	

Observe the location and accessibility of hand hygiene supplies on multiple units or rooms and common areas according to scope of assessment.

Specify unit of observation	Unit/Room #1:	Unit/Room #2:	Unit/Room #3:
Easily accessible outside patient/resident room	☐ Sink ☐ ABHS dispenser ☐ Not available	☐ Sink ☐ ABHS dispenser ☐ Not available	☐ Sink ☐ ABHS dispenser ☐ Not available
Inside room at threshold	☐ Sink ☐ ABHS dispenser ☐ Not available	☐ Sink ☐ ABHS dispenser ☐ Not available	☐ Sink ☐ ABHS dispenser ☐ Not available
Inside room near the bed(s)	☐ Sink ☐ ABHS dispenser ☐ Not available	☐ Sink ☐ ABHS dispenser ☐ Not available	☐ Sink ☐ ABHS dispenser ☐ Not available
Inside patient/resident restroom	☐ Sink ☐ ABHS dispenser ☐ Not available	☐ Sink ☐ ABHS dispenser ☐ Not available	☐ Sink ☐ ABHS dispenser ☐ Not available

Notes

[ICAR Tool for General Infection and Control (IPC) Across Settings - Module 2: Hand Hygiene Faciliator Guide]

Back to Basics: Hand Hygiene

- Hand Hygiene Competency Validation
  - Soap & Water
  - Alcohol-based Hand Rub

Policy | Training & Competency | Surveillance

Hand Hygiene

Hand Hygiene Competency Validation

Soap & Water

Alcohol Based Hand Rub (ABHR) (60% - 95% alcohol content)

Type of validation: Return demonstration	☐ Orientation ☐ Annual ☐ Other

Employee Name: _____ Job Title: _____

Hand Hygiene with Soap & Water	Competent YES	Competent NO
1. Checks that sink areas are supplied with soap and paper towels		
2. Turns on faucet and regulates water temperature		
3. Wets hands and applies enough soap to cover all surfaces of hands		
4. Vigorously rubs hands for at least ***15 seconds*** including palms, back of hands, between fingers, and wrists		
5. Rinses thoroughly keeping fingertips pointed down		
6. Dries hands and wrists thoroughly with paper towels		
7. Discards paper towel in wastebasket		
8. Uses paper towel to turn off faucet to prevent contamination to clean hands		
Hand Hygiene with ABHR		
9. Applies enough product to adequately cover all surfaces of hands		
10. Rubs hands including palms, back of hands, between fingers until all surfaces dry		
General Observations		
11. Direct care providers—no artificial nails or enhancements		
12. Natural nails are clean, well groomed, and tips less than ¼ inch long		
13. Skin is intact without open wounds or rashes		

Comments or follow up actions:

_____ _____/_____

Employee Signature Validator Signature Date

CDC at http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf

NC SPICE; 9-2016 1

Hand Hygiene Tools

Data Collection Tools

For those using the Tracers with AMP® 'Hand Hygiene—Comprehensive' tracer, this tool can be used to collect hand hygiene data throughout the month. At the end of the month, enter totals into the JCR Tracers with AMP® portal.

Hand Hygiene Data Collection Tool
Tracer: Hand Hygiene- Comprehensive

Month/Year: ______________________ **Department:** ____________________ **# OBS Due:** _____________

Instructions: *For each observation (OBS), document the staff type from the list provided, and mark Y (yes) or N (no) if the staff were observed performing hand hygiene in accordance with recommendations. Only document OBS that were actually witnessed. There should be at least one OBS per row (there may be more). Collect Data for the full month. At the end of the month, take the totals from the data gathered throughout the month and enter the numerators (# of compliant OBS) and denomintors (# of total OBS) into the Joint Commissions Resources Tracers with AMP ® "Hand Hygiene- Comprehensive" tracer.* Include any notes in the tracer report (see page 2). Share results with staff and include opportunities for improvement.*

OBS	**Staff Type:** Dental Assistant *** Dental Hygienist ***EVS *** Lab/Phlebotomy *** Med Tech/CMA***Nurse/Nurse Assist. Pharmacy *** Provider *** Rad Imaging *** Rehab Svcs *** Respiratory ***Other	Before touching patient	Before aseptic technique	After touching patient/ environment	After contact w/ blood/ fluid/surface	After glove Removal	Soap use when visibly soiled	Soap and water after caring for person w/diarrhea
	Write Staff Type Below (not staff name)	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N
1								
2								
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4								
5								
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17								
18								
19								
20								
Totals from Above (by Staff Type)								
		Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:
		Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:
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		Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:

1/6/2025 Version

Page 1 of 2

Hand Hygiene Data Collection Tool
Tracer: Hand Hygiene- Comprehensive

Totals from Above (by Staff Type)- continued

OBS	**Staff Type:** Dental Assistant *** Dental Hygienist ***EVS *** Lab/Phlebotomy *** Med Tech/CMA***Nurse/Nurse Assist. Pharmacy *** Provider *** Rad Imaging *** Rehab Svcs *** Respiratory ***Other	Before touching patient	Before aseptic technique	After touching patient/ environment	After contact w/ blood/ fluid/surface	After glove Removal	Soap use when visibly soiled	Soap and water after caring for person w/diarrhea
Totals from Above (by Staff Type)								
		Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:	Num: Denom:
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Notes: *Were any barriers to Hand Hygiene identified during the Observations? Include any observed barriers in the "Notes" section of the tracer. Examples include: Soap or Hand Sanitizer dispenser is empty or broken, dispenser not readily available, staff hands full of supplies, staff is distracted, staff didn't use appropriate amount of soap hand sanitizer, staff didn't wash hands for at least 20 seconds.*

1	
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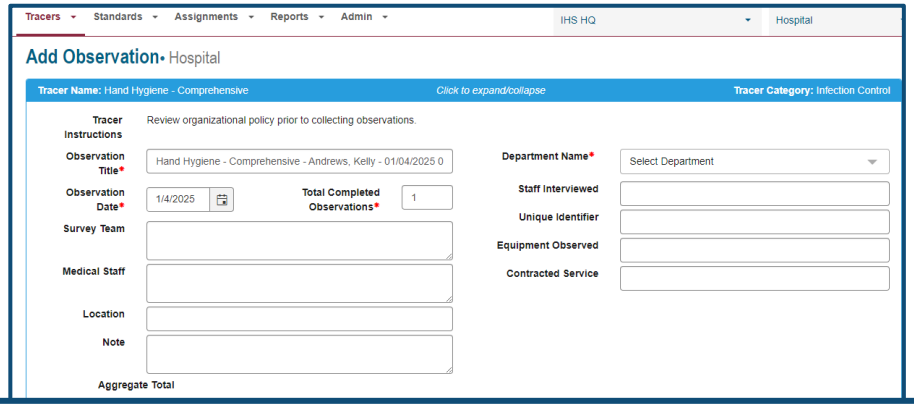
1/6/2025 Version

Page 2 of 2

Back to Basics: Hand Hygiene



JCR Tracers with AMP
Tracer Name:
Hand Hygiene- Comprehensive

Q#	Question Text	Question Type	N/A	Notes & Documents	Action
	1 2 3 4 5 — 20 items per page				1 - 20 of 91 items
	Section: Dental Assistant				
1	Hand hygiene performed immediately before touching a patient	Num 1			Corrective Action / Create Task
2	Hand hygiene performed before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices	Num 1			Corrective Action / Create Task
3	Hand hygiene performed after touching a patient or the patient's immediate environment	Num 1			Corrective Action / Create Task
4	Hand hygiene performed after contact with blood, body fluids or contaminated surfaces	Num 1			Corrective Action / Create Task
5	Hand hygiene performed immediately after glove removal	Num 1			Corrective Action / Create Task
6	Wash with soap and water when hands are visibly soiled	Num 1			Corrective Action / Create Task
7	Wash with soap and water after caring for a person with known or suspected infection or infectious diarrhea or in accordance with policy	Num 1			Corrective Action / Create Task

Staff Types:

Dental Assistant
Dental Hygienist
Environmental Services (EVS)
Laboratory/Phlebotomy
Medical Tech & CMA
Nurse & Nurse Assistant
Nutritional Services
Pharmacy
Provider
Radiology/Imaging
Rehab Services- PT/OT/Speech
Respiratory
Other

Injection Safety

Back to the Basics of ICP- Safe Injection Practices

- Scrub the Hub
- Single vs Multi-dose Vials
- One needle, one syringe, only one time
- Needle and medication- safe storage

Policy | Training & Competency | Surveillance

Safe Injection Practices & RMW

INJECTION SAFETY CHECKLIST

The following Injection Safety checklist items are a subset of items that can be found in the *CDC Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care.*

The checklist, which is appropriate for both inpatient and outpatient settings, should be used to systematically assess adherence of healthcare providers to safe injection practices. Assessment of adherence should be conducted by direct observation of healthcare personnel during the performance of their duties.

Injection Safety	Practice Performed?	If answer is No, document plan for remediation
Proper hand hygiene, using alcohol-based hand rub or soap and water, is performed prior to preparing and administering medications.	Yes No	
Injections are prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment.	Yes No	
Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).	Yes No	
The rubber septum on a medication vial is disinfected with alcohol prior to piercing.	Yes No	
Medication vials are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient.	Yes No	
Single-dose or single-use medication vials, ampules, and bags or bottles of intravenous solution are used for only one patient.	Yes No	
Medication administration tubing and connectors are used for only one patient.	Yes No	
Multi-dose vials are dated by healthcare when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Note: This is different from the expiration date printed on the vial.	Yes No	
Multi-dose vials are dedicated to individual patients whenever possible.	Yes No	
Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., operating room, patient room/cubicle). Note: If multi-dose vials enter the immediate patient treatment area, they should be dedicated for single-patient use and discarded immediately after use.	Yes No	

The *One & Only Campaign* is a public health effort to eliminate unsafe medical injections. To learn more about safe injection practices, please visit www.cdc.gov/injectionsafety/1anonly.html.

1 ONE NEEDLE, ONE SYRINGE, ONLY ONE TIME.

CDC

306089-G

Injection Safety

Single-Dose or Multi-Dose
CDC

Basic safe injection practices —

The following safe injection practices are critical for patient safety:

- Always use aseptic technique when preparing and administering injections.
- Use a new sterile syringe and needle for each patient. Once used, the syringe and needle are both contaminated and must be discarded.
- Do not administer medications from the same syringe to more than one patient, even if the needle is changed or you are injecting through an intervening length of IV tubing.
- Do not enter a medication vial, bag, or bottle with a syringe or needle used on another patient.
- Never use medications intended for single use for more than one patient. This includes single-dose vials, ampoules, bags and bottles of intravenous solutions.
- Limit the use of multi-dose vials and dedicate them to a single patient whenever possible. Reused multi-dose vials should be kept and accessed in a designated clean medication preparation area, away from immediate patient treatment areas.
- Always use facemasks when injecting material or inserting a catheter into the epidural or subdural space.

Injection Safety

SAFETY STEPS

FOLLOW THESE INJECTION SAFETY STEPS FOR SUCCESS!

BEFORE THE PROCEDURE

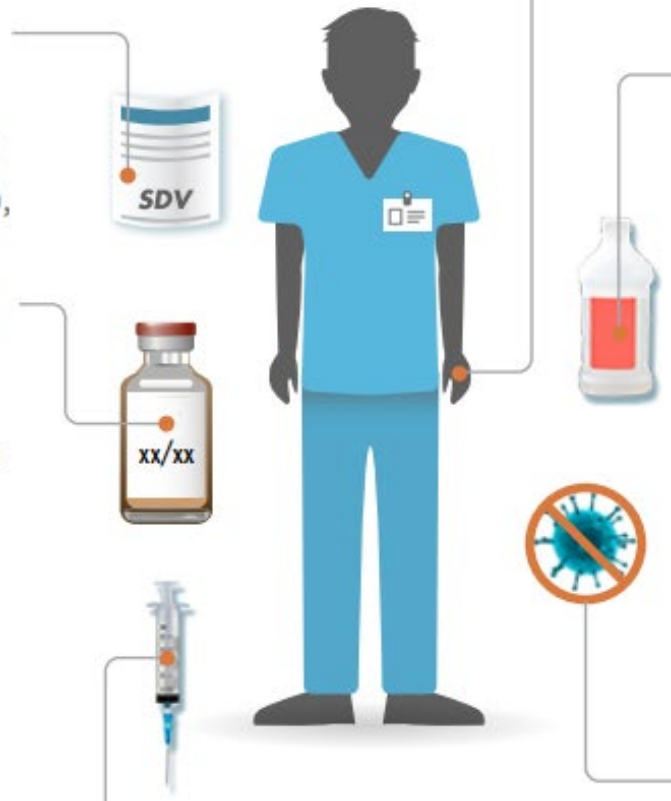
Carefully ***read the label*** of the vial of medication.

- If it says single-dose and it has already been accessed (e.g. needle-punctured), ***throw it away.***
- If it says multiple-dose, ***double-check the expiration date*** and the beyond-use date if it was previously opened, and visually inspect to ensure no visible contamination.
- When in doubt, throw it out.

DURING THE PROCEDURE

Use aseptic technique.

- Use a new needle and syringe for every injection.



- Be sure to clean your hands immediately before handling any medication.
- Disinfect the medication vial by rubbing the diaphragm with alcohol.
- Draw up all medications in a clean medication preparation area.

AFTER THE PROCEDURE

Discard all used needles and syringes and SDVs after the procedure is over.

MDVs should be discarded when:

- the beyond-use date has been reached
- doses are drawn in a patient treatment area
- any time vial sterility is in question

[Single-Dose or Multi-Dose](#)
CDC

Injection Safety

SINGLE-DOSE OR MULTI-DOSE?

NOT ALL VIALS ARE CREATED EQUAL.

Dozens of recent outbreaks have been associated with reuse of single-dose vials and misuse of multiple-dose vials. As a result of these incidents, patients have suffered significant harms, including death. CDC and the One & Only Campaign urge healthcare providers to recognize the differences between single-dose and multiple-dose vials and to understand appropriate use of each container type.

This information can literally save a life.

[Single-Dose or Multi-Dose](#)
CDC

Injection Safety

[Single-Dose or Multi-Dose](#)
CDC

THE MANAGER

INFECTIONS CAN BE COSTLY.

EDUCATE YOUR TEAM!

Make sure your team uses single-dose and multiple-dose vials properly. Misuse of medicine puts your practice and patients at risk.

RISKY BUSINESS

First, do no harm. Improper reuse of SDVs has caused patient infections and deaths.

REALIZE WHAT'S AT STAKE

- A person's life and well-being
- Accreditation status
- Clinic license or certification

HAVE YOU CONSIDERED...?

Do you have enough supplies to ensure safe injections ?

Adequate injection supplies (e.g. syringes, appropriate medications in right-sized vials when possible, personal protective equipment such as gloves and facemasks) should always be available.

Is your medication preparation area separate from the patient care area?

Facilities should have a designated clean medication area where injections are drawn up and labeled immediately before each individual patient. This space should be away from patient care areas and where any used or soiled equipment and materials might be.

Are you purchasing the safest available medication?

Think about safety when you re-supply clinic medications. Request the smallest vials that meet individual patient needs. Use FDA-approved, manufactured medications. Consult with pharmacists and others to learn whether pre-filled syringes or other "ready-to-deliver" unit-dose packaging is available.

Do you arrange infection control training for your healthcare personnel?

In addition to the OSHA-mandated bloodborne pathogen training, job-specific training on infection control, including safe injection practices, should be provided upon hire and at least annually for healthcare personnel.

THE PROVIDER

DO YOU MULTI-DOSE?

A SINGLE-DOSE VIAL (SDV) is approved for use on a **SINGLE** patient for a **SINGLE** procedure or injection.

SDVs typically lack an antimicrobial preservative. Do not save leftover medication from these vials. Harmful bacteria can grow and infect a patient.

DISCARD after every use!

A MULTIPLE-DOSE VIAL (MDV) is recognized by its FDA-approved label.

Although MDVs can be used for more than one patient when aseptic technique is followed, ***ideally even MDVs are used for only one patient.***

MDVs typically contain an antimicrobial preservative to help limit the growth of bacteria. Preservatives have no effect on bloodborne viruses (i.e. hepatitis B, hepatitis C, HIV).

Discard MDVs when the beyond-use date has been reached, when doses are drawn in a patient treatment area, or any time the sterility of the vial is in question!

SIZE DOES NOT MATTER!

SDVs and MDVs can come in any shape and size. ***Do not assume*** that a vial is an SDV or MDV based on size or volume of medication. ***ALWAYS check the label!***

www.cdc.gov/injectionsafety/1anonly.html

[Single-Dose or Multi-Dose](#)
CDC

Key Points

If used for more than one patient, keep and access in a clean medication preparation area away from immediate patient treatment areas.

If a MDV enters an immediate patient treatment area, dedicate it for single patient use, then discard it.

Examples of immediate patient treatment areas are operating and procedure rooms, anesthesia and procedure carts, and patient rooms or bays

Once the MDV is opened, the vial should be dated and discarded within 28 days unless the manufacturer states another date for that opened vial. The beyond-use-date should never exceed the manufacturers original expiration date.

Consult with pharmacy professionals and USP 797 standards if there is a need to subdivide contents of single-dose vials

[Single-Dose or Multi-Dose]
CDC

Injection Safety

[Single & Multidose Vials with the Three Injectioneers]

Discussion:

- ❑ Dating the vial
- ❑ Date Opened or Beyond-use-Date
- ❑ Pharmacy labels

Injection Safety: Test your Knowledge

Discard a multi-dose vial when:

a) Contamination is suspected
b) If the vial is brought into the treatment space
c) If the expiration date is reached
d) All of the above

Injection Safety: Test your Knowledge

If a multi-dose vial is brought into a patient treatment space, it can be used for only that patient, then it must be discarded.

a) True

b) False

Injection Safety: Test your Knowledge

During a procedure, you should:

a) Wash your hands before handling medications
b) Use a new needle and syringe for every injection (even if it is the same patient)
c) Disinfect the hub of the vial before inserting the needle
d) All of the above

Injection Safety: Test your Knowledge

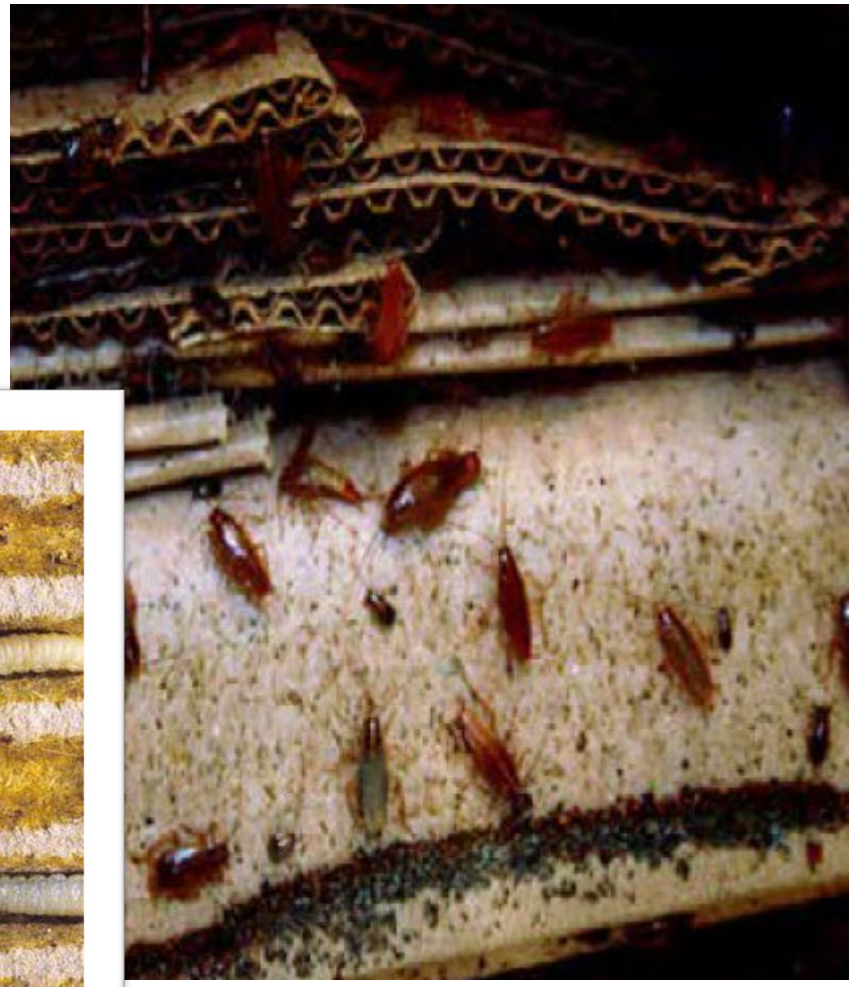
After you have withdrawn a dose of medication from a single-use vial, you label it with the 28-day expiration date and return it to its storage place

a) True
b) False

Physical Environment

Infection Control and Prevention Considerations

Boxes and Shipping Containers: What Lurks Within



Boxes and Shipping Containers

- ❑ Shipping containers are reservoirs for dust, moisture, water, vermin, and bacteria
- ❑ Are boxes permitted anywhere in the facility? What does the policy say?
- ❑ Where are boxes broken down?
- ❑ What if the expiration is on the box? What is the process?

Boxes and Shipping Containers- What does JC say?

"Shipping containers, especially those made of a corrugated material, serve as generators of and reservoirs for dust. Corrugated cardboard boxes are susceptible to moisture, water, vermin and bacteria during warehouse or storeroom storage, as well as transportation environments. Boxes and containers may have been exposed to unknown and potentially high microbial contamination.

When organizations are making a determination as to whether these boxes and containers are appropriate to be located in a certain area, they should consider the potential adverse impact of dust, moisture, bacteria or other contaminants on that area. An organization may determine, for example, that it is - or is not appropriate - for such boxes and containers to be located in food storage (State Food Sanitation Code), a pharmacy (e.g. USP 797) or in sterile storage (e.g. AAMI ST79)."

Boxes and Shipping Containers- What does JC say?

"Other considerations might include, for example, where to load or unload supplies, criteria for content break-down areas, and what level of packaging to keep within the area in question. The process could also address the use of boxes that came out of the shipping container where box labeling is essential to proper use (for example, expiration dates, contents, ingredients, directions for use, etc.).

Once a process for managing cardboard or corrugated boxes and shipping containers is developed, health care organizations should ensure compliance."

Boxes and Shipping Containers

"**AAMI ST 79 5.2.1 General Considerations:**
Clean or sterile items to be transported to central processing and storage areas within the facility should be removed from their external shipping containers before they enter the storage areas of the department. Any instructions for use accompanying the items should be kept with the items.

Fire Safety
Cardboard in storage that has a degree of hazard greater than that normal to the occupancy should be placed in room classified as hazardous areas and protected per LS.02.01.30 and cannot obstruct the means of egress in accordance with standard LS.02.01.20."

- ❑ Remove supplies from boxes before entering the storage room
- ❑ There are fire and Life Safety implications to cardboard boxes

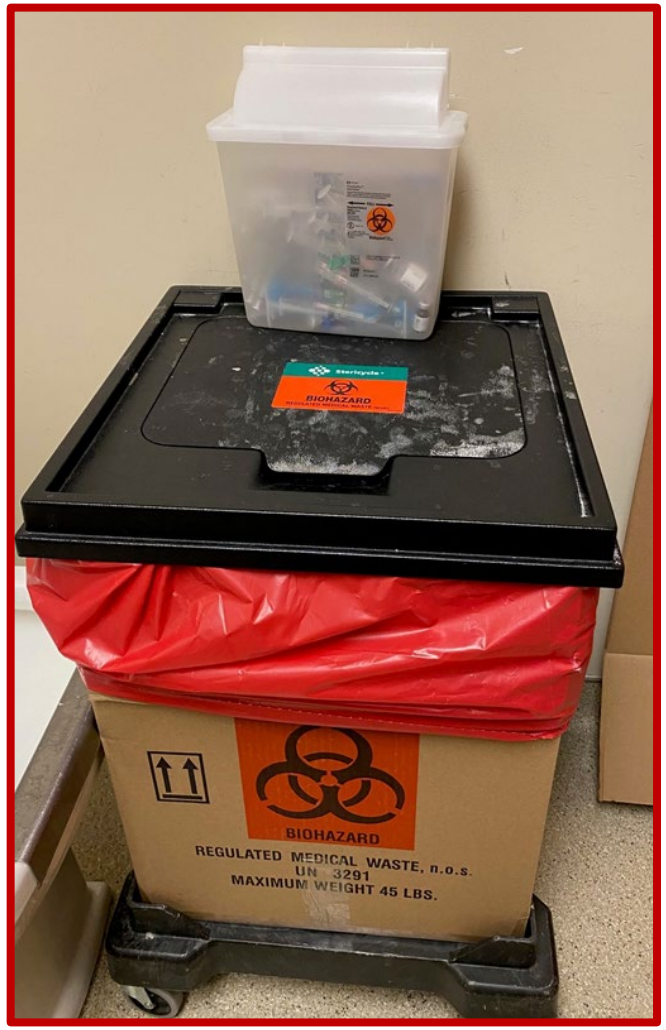
Boxes and Shipping Containers | Hospital and Hospital Clinics | Infection Prevention and Control IC | The Joint Commission

What do you See?

Surveillance of the Physical Environment of Patient Care

Environmental Surveillance Processes

- Regular evaluation and periodic inspection of the environment of patient care should be conducted in accordance with accreditation standards and the assessed levels of risk
- A multi-disciplinary team (e.g., ICP, facility management, safety, facility leadership, and department supervisor) should conduct formal inspection through focused ICP rounds and/or through environmental rounds
- Patient care activities should be undertaken in a clean and/or hygienic environment that facilitates practices related to the prevention and control of HAI



PCRA/ICRA- Considerations

Construction, Renovation, Remediation, Repair, and Demolition

- Multidisciplinary Team- consider proactive measures at the inception
- Educate the team
- Incorporate agreements (e.g., contract or policy) for compliance
- Implement IC measures (considering immunocompromised patient/areas)

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Matrix of Precautions for Construction, Renovation and Operations

Step One:
Using Table 1, Identify the Activity Type (A-D).

Table 1 - Activity Type: _____

Type A	**Inspection and non-invasive activities.** Includes but is not limited to: • Removal of ceiling tile for visual inspection-limited to 1 tile per 50 square feet with limited exposure time. • Limited building system maintenance (e.g., pneumatic tube station, HVAC system, fire suppression system, electrical and carpentry work to include painting without sanding) that does not create dust or debris. • Clean plumbing activity limited in nature.
Type B	**Small-scale, short duration activities that create minimal dust and debris.** Includes but is not limited to: • Work conducted above the ceiling (e.g., prolonged inspection or repair of firewalls and barriers, installation of conduit and/or cabling, and access to mechanical and/or electrical chase spaces). • Fan shutdown/startup. • Installation of electrical devices or new flooring that produces minimal dust and debris. • The removal of drywall where minimal dust and debris is created. • Controlled sanding activities (e.g., wet or dry sanding) that produce minimal dust and debris.
Type C	**Large-scale, longer duration activities that create a moderate amount of dust and debris.** Includes but is not limited to: • Removal of preexisting floor covering, walls, casework or other building components. • New drywall placement. • Renovation work in a single room. • Non-existing cable pathway or invasive electrical work above ceilings. • The removal of drywall where a moderate amount of dust and debris is created. • Dry sanding where a moderate amount of dust and debris is created. • Work creating significant vibration and/or noise. • Any activity that cannot be completed in a single work shift.
Type D	**Major demolition and construction activities.** Includes but is not limited to: • Removal or replacement of building system component(s). • Removal/installation of drywall partitions. • Invasive large-scale new building construction. • Renovation work in two or more rooms.

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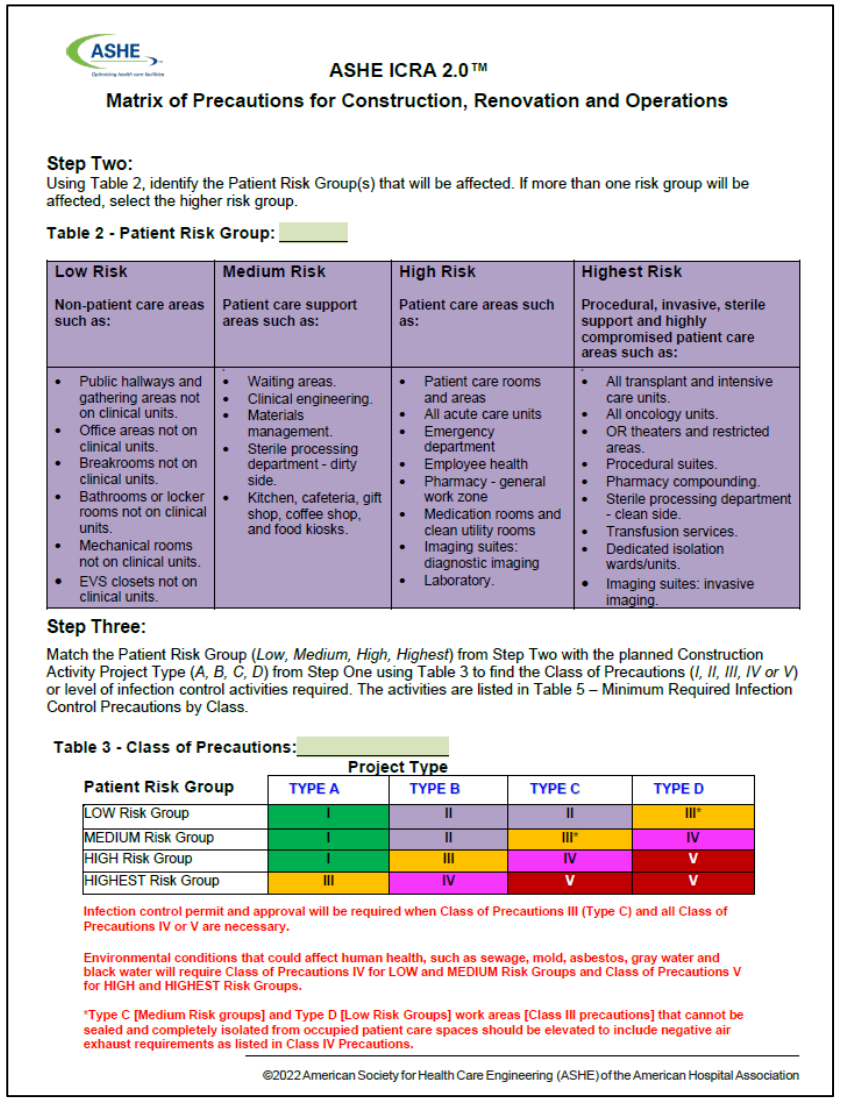
PCRA/ICRA- Considerations

Construction, Renovation, Remediation, Repair, and Demolition

- Perform engineering and work-site IC measures
  - Proper operation of air handling systems
  - Neg air pressure in work zones adjacent to patient care areas (monitor)
  - Monitor barrier seals
  - Traffic flow- identify construction path, stairs/elevator, designated entrances
  - A space (or ante-room) for changing clothes and storing equipment



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Matrix of Precautions for Construction, Renovation and Operations

Step Two:
Using Table 2, identify the Patient Risk Group(s) that will be affected. If more than one risk group will be affected, select the higher risk group.

Table 2 - Patient Risk Group: _____

Low Risk Non-patient care areas such as:	Medium Risk Patient care support areas such as:	High Risk Patient care areas such as:	Highest Risk Procedural, invasive, sterile support and highly compromised patient care areas such as:
• Public hallways and gathering areas not on clinical units. • Office areas not on clinical units. • Breakrooms not on clinical units. • Bathrooms or locker rooms not on clinical units. • Mechanical rooms not on clinical units. • EVS closets not on clinical units.	• Waiting areas. • Clinical engineering. • Materials management. • Sterile processing department - dirty side. • Kitchen, cafeteria, gift shop, coffee shop, and food kiosks.	• Patient care rooms and areas • All acute care units • Emergency department • Employee health • Pharmacy - general work zone • Medication rooms and clean utility rooms • Imaging suites: diagnostic imaging • Laboratory.	• All transplant and intensive care units. • All oncology units. • OR theaters and restricted areas. • Procedural suites. • Pharmacy compounding. • Sterile processing department - clean side. • Transfusion services. • Dedicated isolation wards/units. • Imaging suites: invasive imaging.

Step Three:
Match the Patient Risk Group (*Low, Medium, High, Highest*) from Step Two with the planned Construction Activity Project Type (*A, B, C, D*) from Step One using Table 3 to find the Class of Precautions (*I, II, III, IV or V*) or level of infection control activities required. The activities are listed in Table 5 – Minimum Required Infection Control Precautions by Class.

Table 3 - Class of Precautions: _____

Patient Risk Group	Project Type TYPE A	TYPE B	TYPE C	TYPE D
LOW Risk Group	I	II	II	III*
MEDIUM Risk Group	I	II	III*	IV
HIGH Risk Group	I	III	IV	V
HIGHEST Risk Group	III	IV	V	V

Infection control permit and approval will be required when Class of Precautions III (Type C) and all Class of Precautions IV or V are necessary.

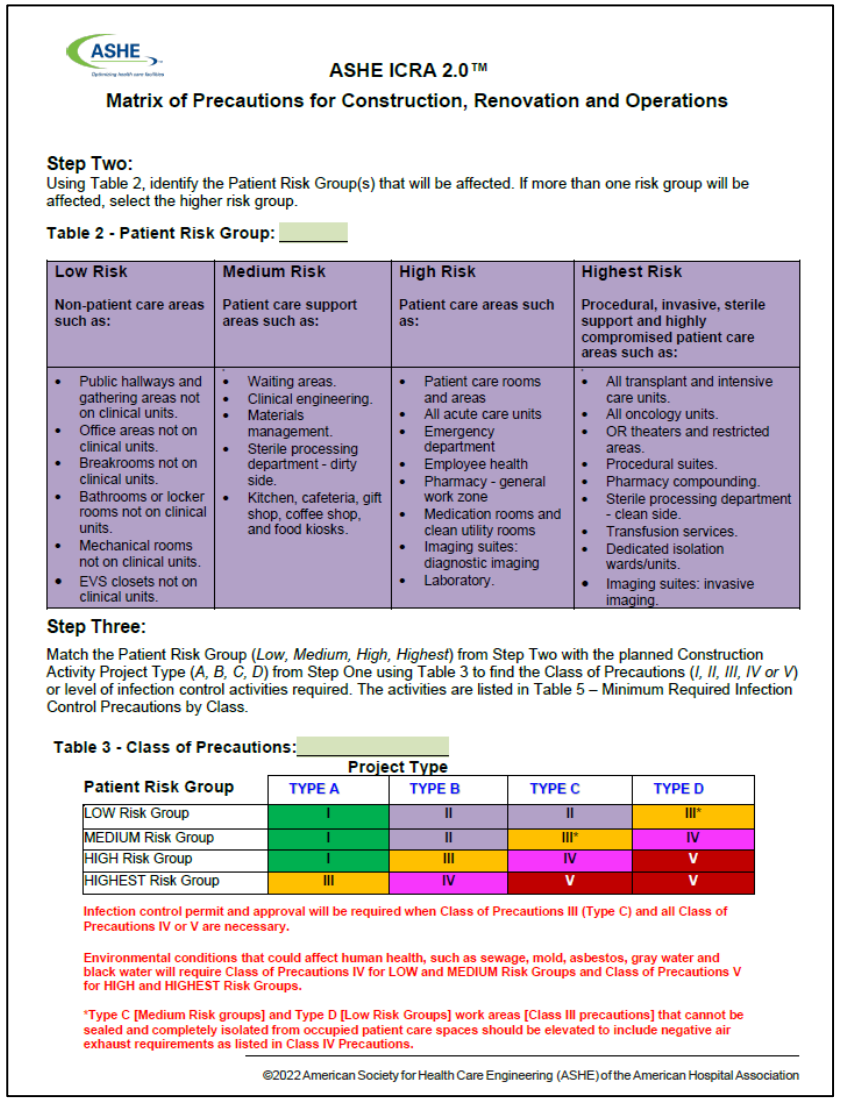
Environmental conditions that could affect human health, such as sewage, mold, asbestos, gray water and black water will require Class of Precautions IV for LOW and MEDIUM Risk Groups and Class of Precautions V for HIGH and HIGHEST Risk Groups.

*Type C [Medium Risk groups] and Type D [Low Risk Groups] work areas [Class III precautions] that cannot be sealed and completely isolated from occupied patient care spaces should be elevated to include negative air exhaust requirements as listed in Class IV Precautions.

PCRA/ICRA- Considerations

Construction, Renovation, Remediation, Repair, and Demolition

- Perform engineering and work-site IC measures
  - Clean work zones/entrances daily (wet-wiping/sticky mats/covering debris before removing from work zone)
  - Ceiling tiles- protection for open ceiling tiles
  - Upon completion- proper cleaning of the work zone according to policy (prior to removal of all barriers)
  - Flush water system of sediment; replace air filters; restore air conditions- pressure, ACH, humidity



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Matrix of Precautions for Construction, Renovation and Operations

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• Public hallways and gathering areas not on clinical units. • Office areas not on clinical units. • Breakrooms not on clinical units. • Bathrooms or locker rooms not on clinical units. • Mechanical rooms not on clinical units. • EVS closets not on clinical units.	• Waiting areas. • Clinical engineering. • Materials management. • Sterile processing department - dirty side. • Kitchen, cafeteria, gift shop, coffee shop, and food kiosks.	• Patient care rooms and areas • All acute care units • Emergency department • Employee health • Pharmacy - general work zone • Medication rooms and clean utility rooms • Imaging suites: diagnostic imaging • Laboratory.	• All transplant and intensive care units. • All oncology units. • OR theaters and restricted areas. • Procedural suites. • Pharmacy compounding. • Sterile processing department - clean side. • Transfusion services. • Dedicated isolation wards/units. • Imaging suites: invasive imaging.

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MEDIUM Risk Group	I	II	III*	IV
HIGH Risk Group	I	III	IV	V
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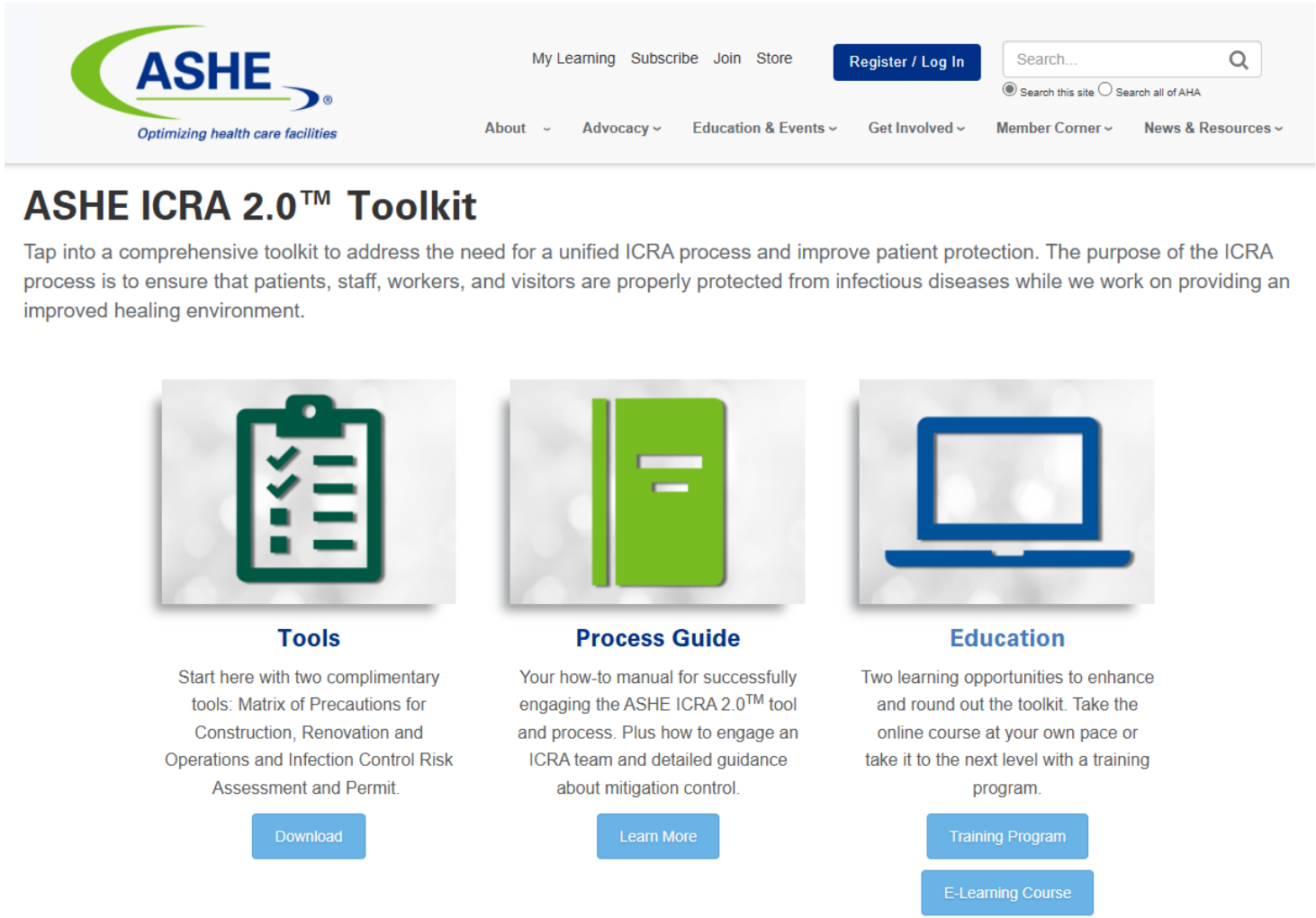
*Type C [Medium Risk groups] and Type D [Low Risk Groups] work areas [Class III precautions] that cannot be sealed and completely isolated from occupied patient care spaces should be elevated to include negative air exhaust requirements as listed in Class IV Precautions.

ICRA Toolkit

ASHE ICRA 2.0™ Toolkit

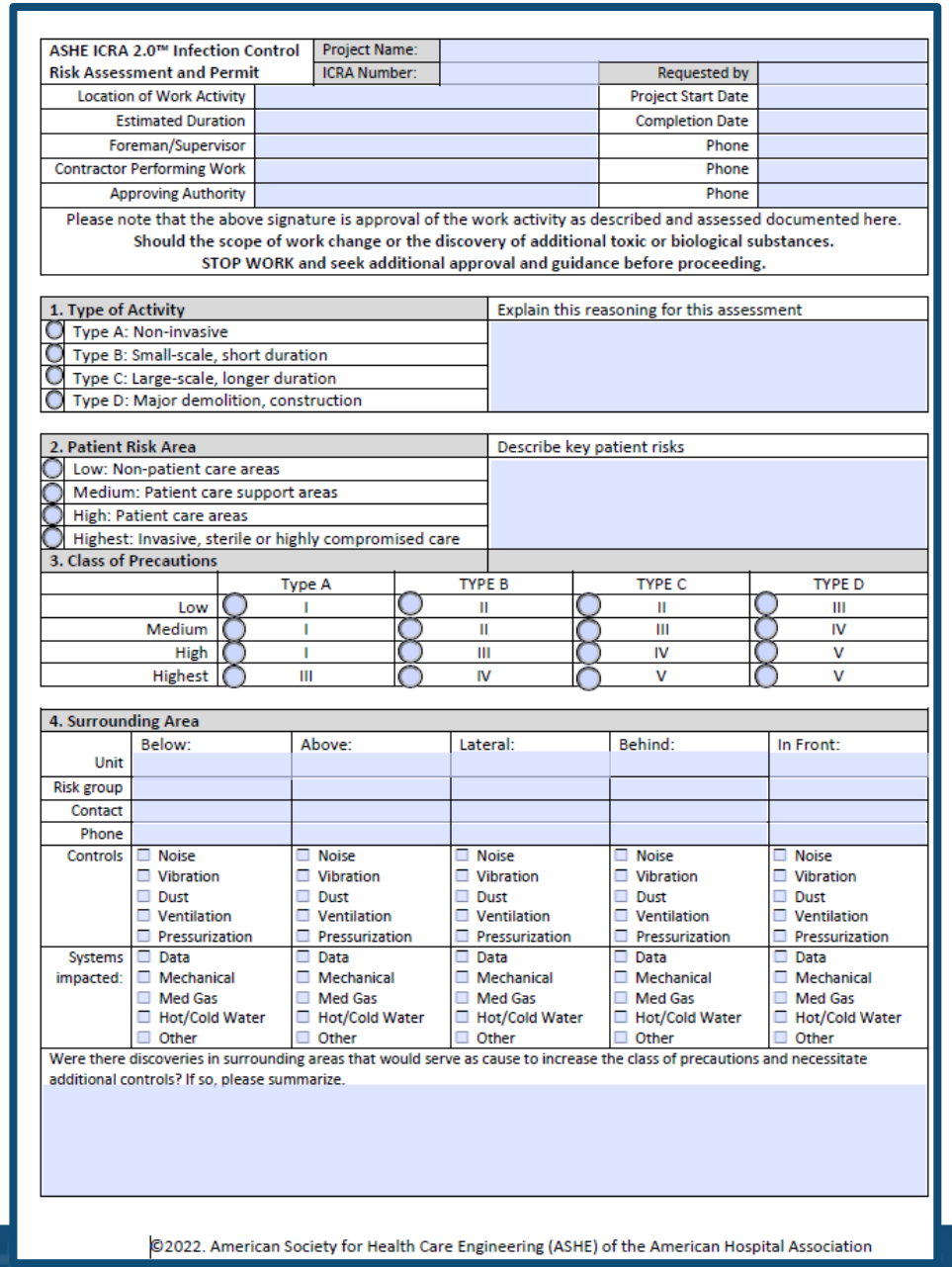
[ASHE ICRA 2.0™ Toolkit | ASHE]

Because of the critical nature of comprehensive infection prevention, ASHE has made its ICRA 2.0 tool and sample permit available to the general public.



ICRA 2.0 ™

ASHE ICRA 2.0™ Toolkit



ASHE ICRA 2.0™ Infection Control Risk Assessment and Permit	Project Name:			
	ICRA Number:		Requested by	
Location of Work Activity			Project Start Date	
Estimated Duration			Completion Date	
Foreman/Supervisor			Phone	
Contractor Performing Work			Phone	
Approving Authority			Phone	

Please note that the above signature is approval of the work activity as described and assessed documented here.
Should the scope of work change or the discovery of additional toxic or biological substances.
STOP WORK and seek additional approval and guidance before proceeding.

1. Type of Activity	Explain this reasoning for this assessment
○ Type A: Non-invasive	
○ Type B: Small-scale, short duration	
○ Type C: Large-scale, longer duration	
○ Type D: Major demolition, construction	

2. Patient Risk Area	Describe key patient risks
○ Low: Non-patient care areas	
○ Medium: Patient care support areas	
○ High: Patient care areas	
○ Highest: Invasive, sterile or highly compromised care	

3. Class of Precautions

	Type A	TYPE B	TYPE C	TYPE D
Low	○ I	○ II	○ II	○ III
Medium	○ I	○ II	○ III	○ IV
High	○ I	○ III	○ IV	○ V
Highest	○ III	○ IV	○ V	○ V

4. Surrounding Area

	Below:	Above:	Lateral:	Behind:	In Front:
Unit					
Risk group					
Contact					
Phone					
Controls	☐ Noise ☐ Vibration ☐ Dust ☐ Ventilation ☐ Pressurization	☐ Noise ☐ Vibration ☐ Dust ☐ Ventilation ☐ Pressurization	☐ Noise ☐ Vibration ☐ Dust ☐ Ventilation ☐ Pressurization	☐ Noise ☐ Vibration ☐ Dust ☐ Ventilation ☐ Pressurization	☐ Noise ☐ Vibration ☐ Dust ☐ Ventilation ☐ Pressurization
Systems impacted:	☐ Data ☐ Mechanical ☐ Med Gas ☐ Hot/Cold Water ☐ Other	☐ Data ☐ Mechanical ☐ Med Gas ☐ Hot/Cold Water ☐ Other	☐ Data ☐ Mechanical ☐ Med Gas ☐ Hot/Cold Water ☐ Other	☐ Data ☐ Mechanical ☐ Med Gas ☐ Hot/Cold Water ☐ Other	☐ Data ☐ Mechanical ☐ Med Gas ☐ Hot/Cold Water ☐ Other

Were there discoveries in surrounding areas that would serve as cause to increase the class of precautions and necessitate additional controls? If so, please summarize.

5. Detailed Plan of ICRA Controls for this Work	Class I				
Final Class of Precautions being applied	I	II	III	IV	V
Controls required for this project	Specifications/ Materials			Verification method and frequency	

Exceptions/Additions to this permit
Date and Initials are noted by attached memoranda

Initials		Date	
Permit Request By		Date	
Permit Authorized By		Date	
Approval Signature			

ASHE

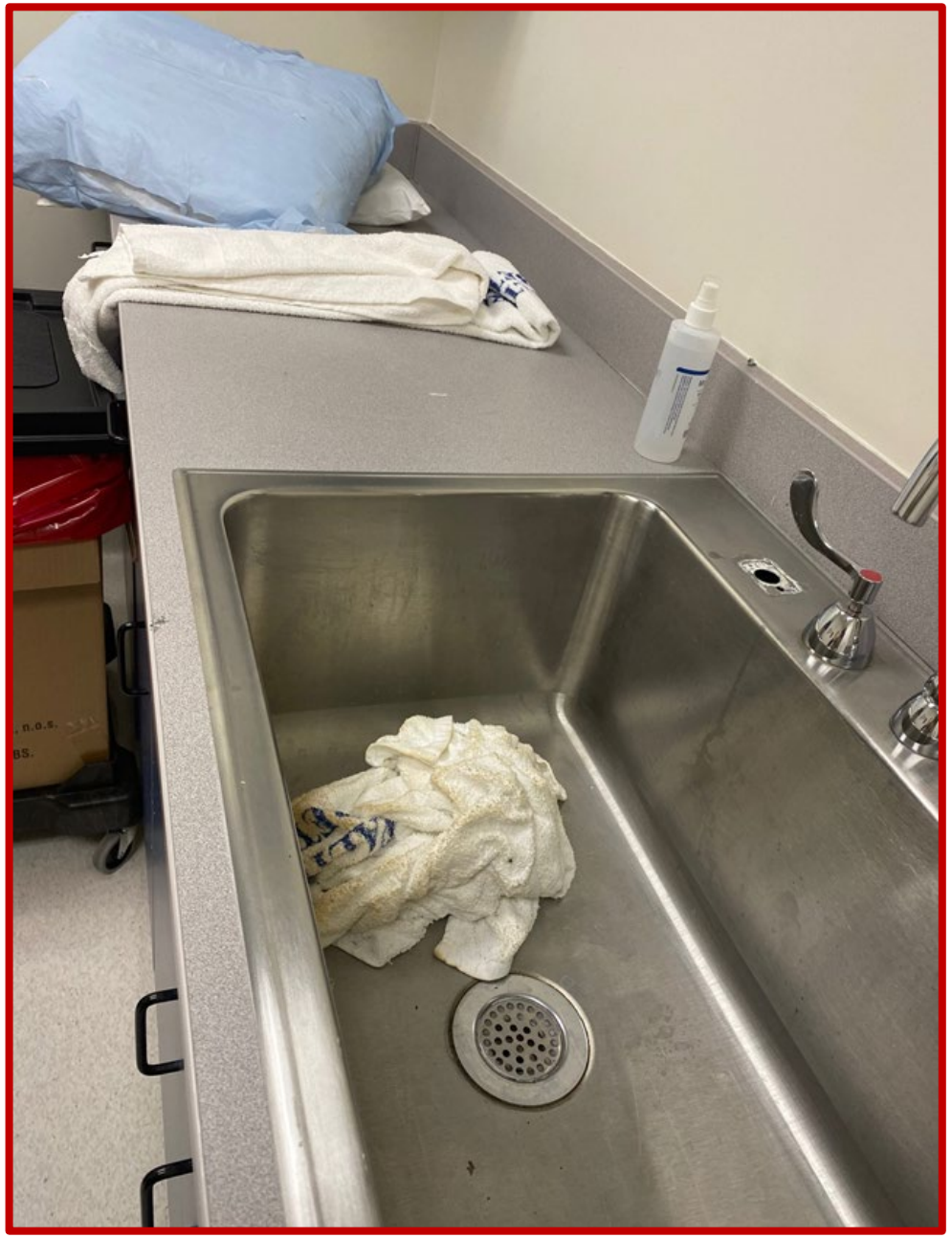
AHA Data & Insights

Surveillance of the Physical Environment of Patient Care

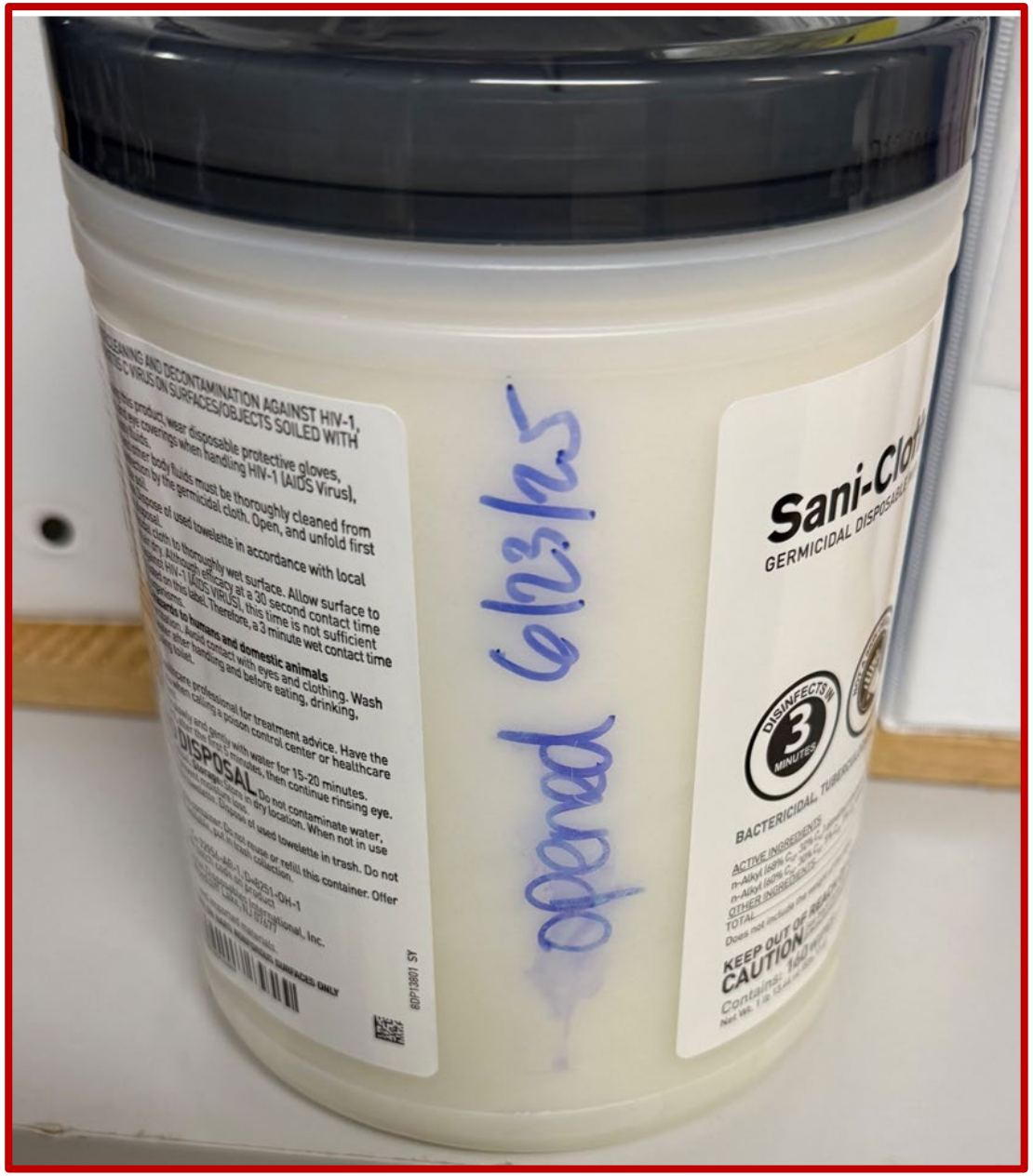
Challenges

What do you See?

What do you See?



What do you See?



What do you See?

What do you See?

Reusable Medical and Dental Devices

Spaulding Classification

Classification of Medical Devices

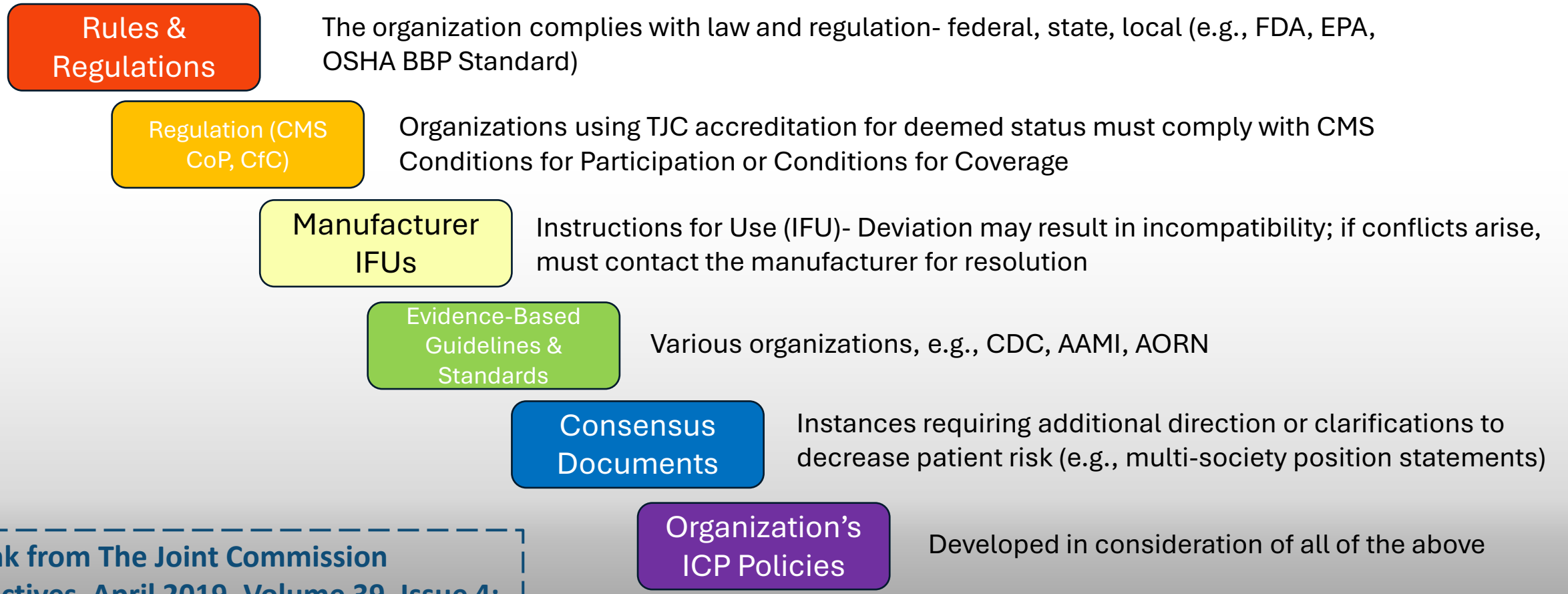
Category	Definition	Method of Decontamination	Level of Microcidal action	Examples of Common Equipment
Critical	Medical devices that enter sterile tissue or the vascular system	**Sterilization** (usually heat if heat-stable, or chemical if not heat-stable)	Kills all microorganisms	Surgical instruments, cardiac and urinary catheters, implants, prostheses and devices, dental instruments
Semi-critical	Medical devices in contact with mucous membranes or non-intact skin	**High-level disinfection** by heat or chemicals (under controlled conditions with minimum toxicity for humans)	Kills all microorganisms, except small numbers of bacterial spores	Respiratory therapy and anesthesia equipment, some endoscopes, endocavity probes
Non-critical	Items in contact with intact skin	**Low level disinfection** (cleaning)	Kills vegetative bacteria, fungi and lipid viruses	Blood pressure cuffs, crutches, bedrails, other environmental surfaces

Adapted from Global Guidelines for the Prevention of Surgical Site Infection, Geneva, World Health Organization, 2018

Important Issues in the Approach to Surgical Site Infection Prevention - Global Guidelines for the Prevention of Surgical Site Infection - NCBI Bookshelf

Hierarchical Method to Address ICP Requirements

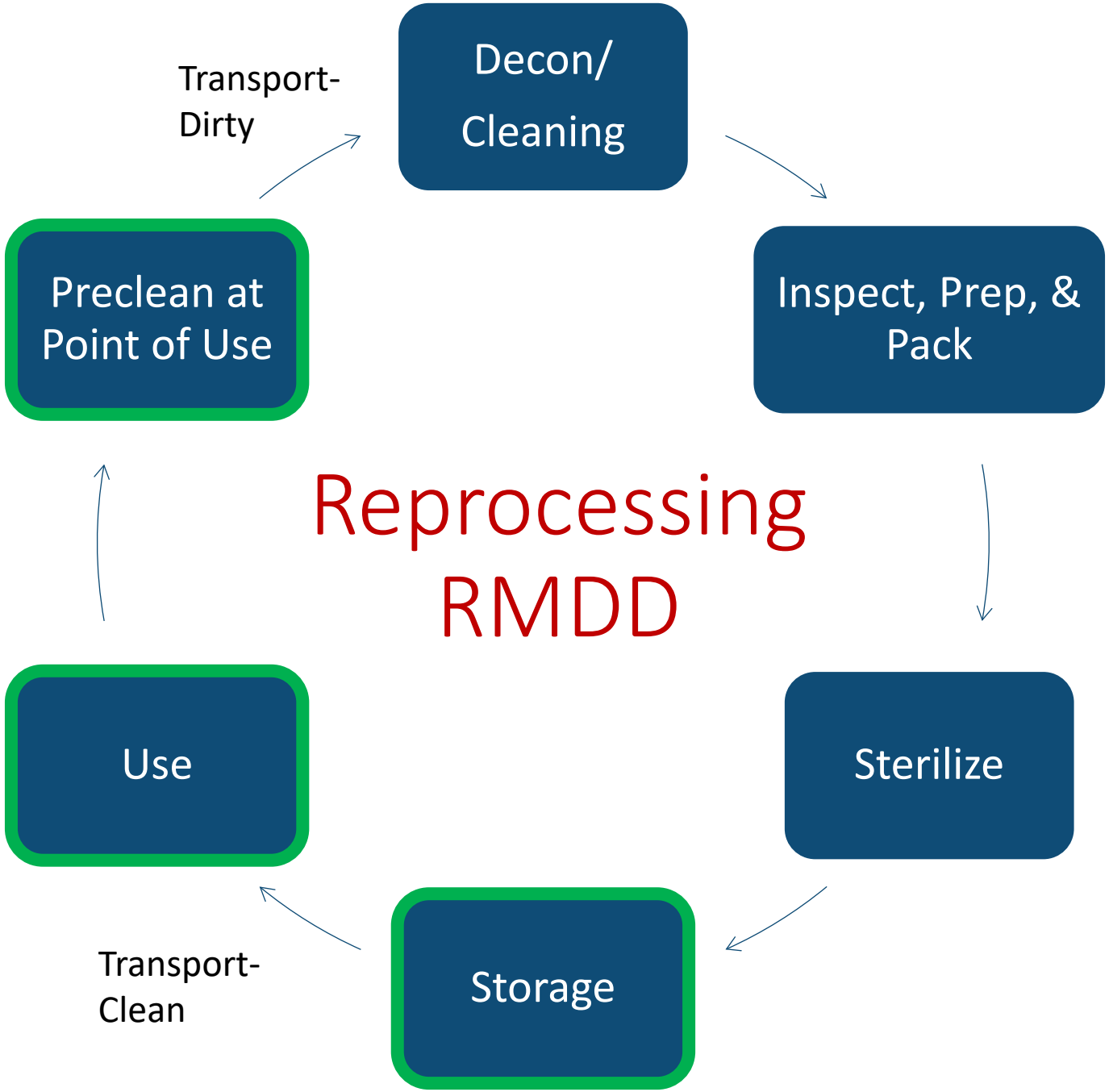
References to use for program, policy, and process development



See Link from The Joint Commission Perspectives, April 2019, Volume 39, Issue 4:
IC_Hierarchy_JCP0419.pdf

Additional Aspects:

- Documentation
- Staff Education, Training, and Competency



Key Abbreviations:
Instructions for Use= IFU
Chemical Indicator= CI
Biological Indicator= BI
Process Challenge Device= PCD

Point of Use Cleaning

This is the same as Pre-Cleaning at the Point of Use

Procedure Room:

- Do not clean instruments in handwashing sinks
- Do not rinse instruments under running water

- Ensure single-use devices are disposed of after use, and not sent to the Sterile Processing Area for reprocessing

Operating room (OR) setting: processes differ from other settings:

- OR setting uses Sterile Water since they rinse instruments throughout the procedure
- OR utilizes a “back table”, where there are basins of sterile water set up and used to facilitate rinsing of instruments and lumens

1. Remove Sharps.

2. Wipe away gross debris with moistened gauze. Do not use saline.

3. Keep instruments moist.

Apply product designed for pretreatment

OR
Place inside a package designed to maintain humid conditions

OR
cover instrument with a mois towel (water, not saline)

What do you See?

4. Transport in approved medical-grade OSHA compliant container/cart.

Container Must Be:

- Medical Grade with IFU to Clean & Disinfect
- Non-porous
- Puncture Resistant
- Labeled Biohazard or color-coded
- Leakproof on the sides and bottom

Considerations:

- Inside or outside
- Within the Department
- Outside the Department
- Path of Travel

Documentation

- **Required documentation for device reprocessing cycles**, including but not limited to
  - Sterilizer cycle logs
  - Chemical and biological testing
  - Results of testing for appropriate concentration for chemicals used in high-level disinfection
- Criteria and process for the use of immediate-use steam sterilization
- Actions to take in the event of a reprocessing error or failure is identified

Sterile Processing Equipment Maintenance Consideration

- What routine user maintenance is required by the manufacturer's IFU?
- What is required at what frequency?
  - ❑ Daily
  - ❑ Weekly
  - ❑ Monthly
  - ❑ Annually (or semi-annually)
- Who performs it?
  - ❑ Equipment Users?
  - ❑ Biomed?
  - ❑ Manufacturer (service contract)?
- Who keeps the maintenance records?
  - ❑ Biomed?
  - ❑ In the Sterile Processing Area?

Maintenance and testing of sterilizers: Joint Commission Environment of Care (EC) Standard EC.02.04.03, EP 4, requires some settings to maintain sterilizers, conduct performance testing on them, and document those activities. The sterilization process, including equipment used to sterilize devices, must work effectively to ensure patient safety. To comply with this standard, your organization must provide documentation showing that your sterilizer performance testing (including physical, chemical, and biological monitoring) and maintenance are performed in accordance with standardized, accepted practices and manufacturer's guidelines.

International organizations must comply with JCI Facility Management and Safety (FMS) Standard FMS.8: The organization establishes a program for inspecting, testing, and maintaining medical equipment and documenting the results. This includes implementing an organizationwide medical equipment program, creating an inventory of all medical equipment, conducting inspections and tests of equipment, staff training, and preventive maintenance.

Joint commission Resources, Digital Learning Center, IC Made Easy, 2nd Edition

Sterile Storage

Storage of Sterile Instruments and Supplies

- Ideally adjacent room to sterilization area
  - Limited- access, enclosed room
- Only sterile and clean products
- No corrugated cardboard shipping boxes
- Storage system: based on environment
  - High traffic: enclosed
  - Limited traffic: open may be acceptable

Sterile Storage

Storage of Sterile Instruments and Supplies

- 8-10” from the floor, 18” below the ceiling or level of the sprinkler head, and 2” from outside walls
- Position so integrity of the item is not compromised
- Solid bottom shelf
- Away from all water sources (e.g., sinks, pipes)
- Shelf-life: inventory should be first in, first out; event-related (verify IFUs for wrap expiry once sterilized)
- Other Considerations:
  - Temperature/humidity controlled & monitored
  - Ventilation
  - Housekeeping/dusting
  - Shelving doesn’t harm the wrap of the packs

Sterile Storage

Storage of Sterile Instruments/Equipment and Supplies

- Airflow/ventilation around packs
- Space considerations
- Store according to IFU

What do you See?

Sterile Storage

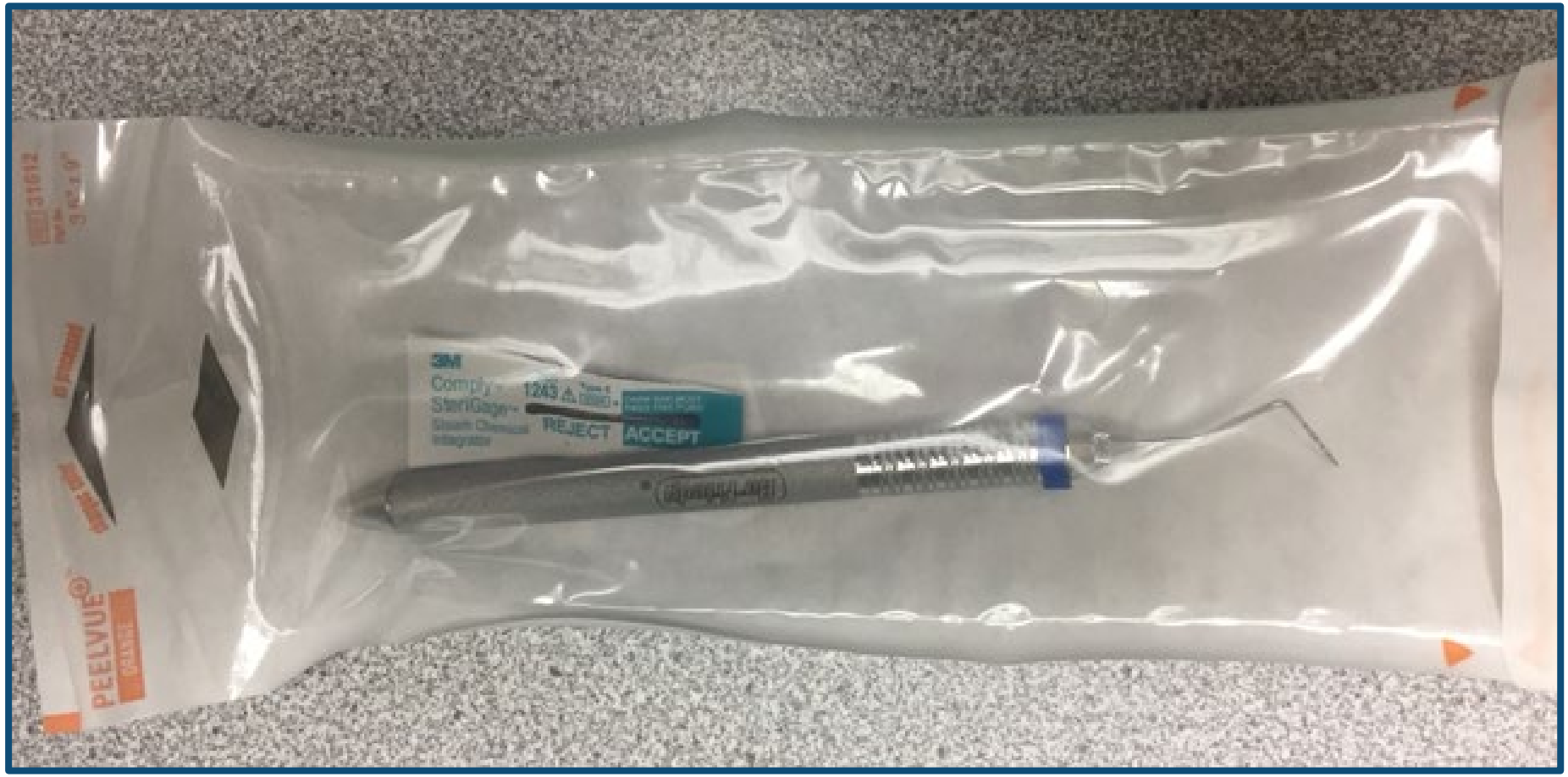
Storage of Sterile Instruments/Equipment and Supplies

How do you Know an Instrument is Safe for Use?

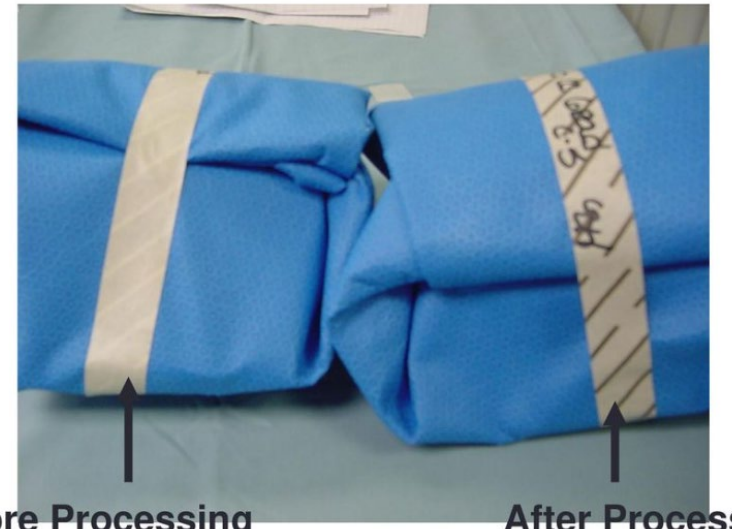
Staff- Prior to Use- Looking at the Pack

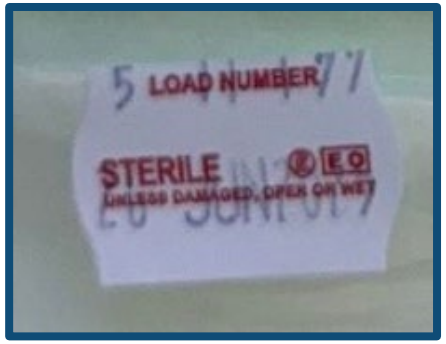
- Is the packaging free of any holes or tears
- Is the packaging free of any marks or signs of moisture
- Have the external chemical indicators passed
- Have the internal chemical indicators passed
- Is the instrument clean, free of debris/soiling
- Is the instrument in good repair/appears functional
- Is any marking (if present) properly applied and intact (e.g., no peeling or flaking instrument tape, no etching)
- If it is a hinged item, was it sterilized open?
- Any compromise to the storage location during the time it was stored
- Is the indicator tape intact?
- Are there any holes in the wrap?
- Did the filter and all indicators change?

What do you See?



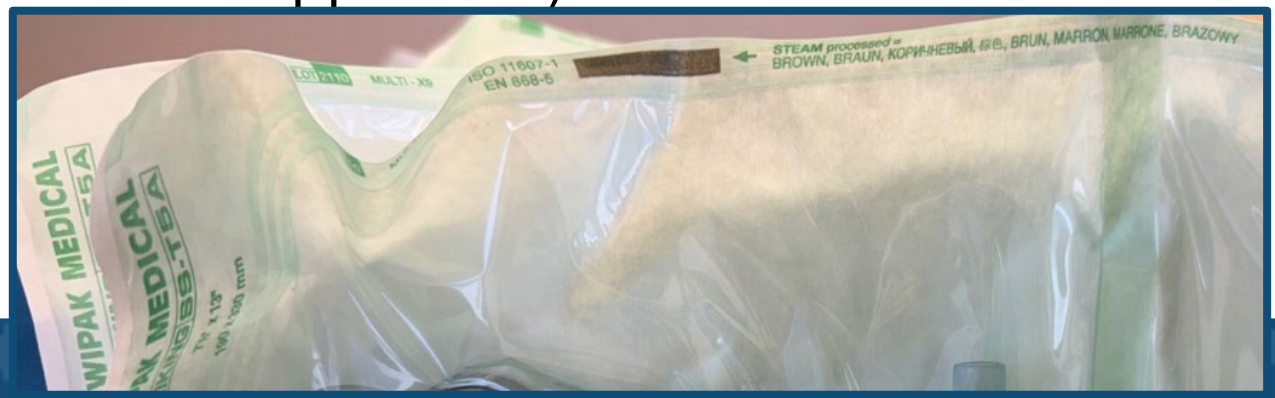
External Chemical Indicator Tape





Label the Pack:

- Sterilizer Identifier
- Cycle/ Load Number
- Date of Sterilization
- Description of Contents
- Person who prepped/packaged
- Expiration Date (only if applicable)



Training and Competency of Staff

Initial, Ongoing (annual), and when new equipment or processes

- Initial orientation covering all tasks performed in sterile processing areas
- Other policies and procedures related to:
  - Infection Control and Prevention
  - Safety
  - Proper attire,
  - Personal hygiene
  - Regulations
- Continuing education- ongoing
- As needed- on new instruments, devices, equipment
- Competency-based training
- Documentation of training

Challenges: Brushes

Key Points

- Know if it is:
  - Single Use
  - Reusable
- Follow the IFU for cleaning/reprocessing reusable brushes
- Discard when worn or damaged
- Ensure the proper length, width, and bristle type of the brush related lumens (following IFU)

Challenges

Damaged or soiled instruments

For reprocessing of reusable instruments and devices:
Careful inspection of critical instruments and devices for soil or damage, including but not limited to bioburden, oxidation, corrosion, pitting, discoloration, cracking, peeling, chipping, lifting or improperly applied identification tape, or etching that leaves rough or frayed edges, is a critical step in protecting patients from potential cross-contamination. *Damaged or soiled instruments should not be released for use as a sterile item.* Soiled instruments cannot be considered sterile because the efficacy of the sterilant or its ability to reach all surfaces may be compromised by soil. All items undergoing reprocessing should also be checked for functionality during the inspection process.

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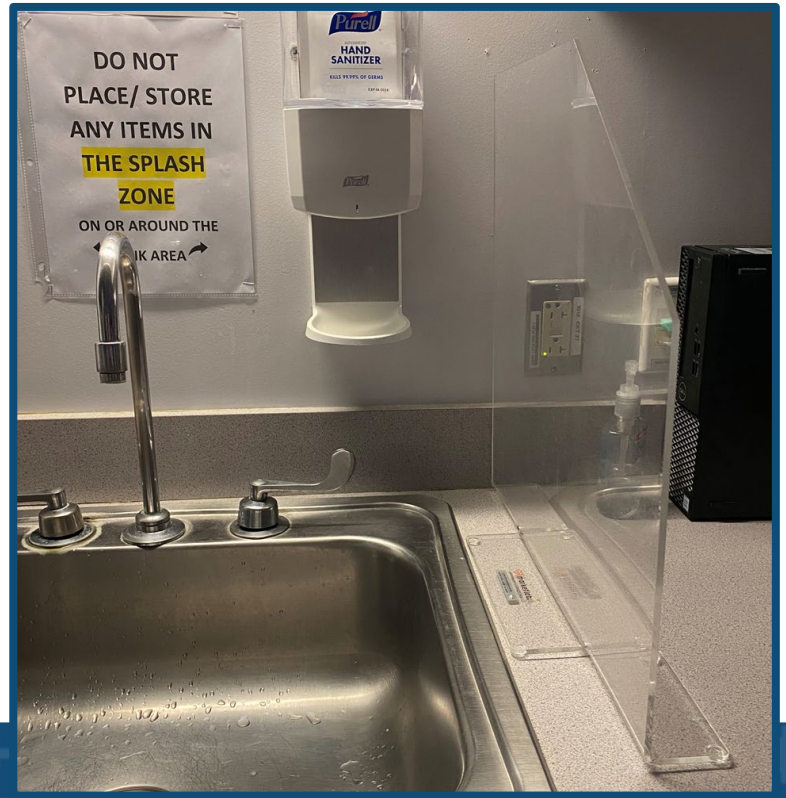
Challenges: Space Considerations

Space Limitations Common Challenge for Ambulatory Clinics, including Dental

In outpatient settings such as medical and dental departments or clinics, it might not be possible to have physically separate rooms/spaces for the decontamination area and the clean work area. If this is not possible:

- Use barrier separation (e.g., splash guards)
- Ensure work practices prevent splashing, the production of aerosols, and the contamination of clean items and work surfaces (e.g., do not have clean processes occurring at the same time as decontamination processes)



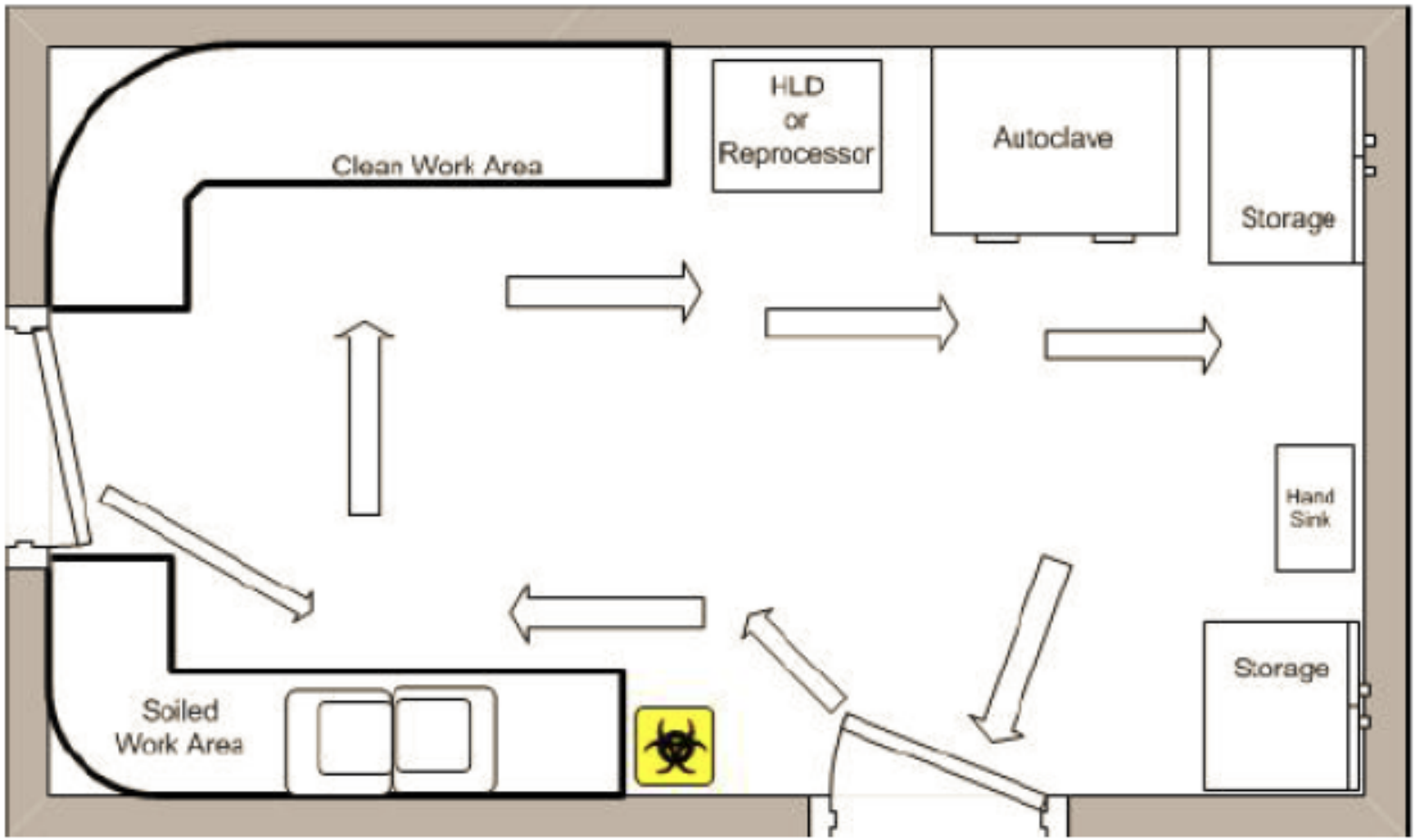
Challenges: Space Considerations

Common Challenge for Ambulatory Clinics, including Dental

- Protect supplies from environmental contamination (e.g., ensure items are inside cabinets)
- Ensure the clean work area/room is cleaned and decontaminated before being used for preparation and assembly tasks
- Ensure staff change PPE when move from decontamination activities to clean activities
- Ensure ventilation and air-handling systems move air from the clean side of the room to the decontamination side of the room (not the reverse)

ANSI/AAMI Workflow Diagram

Office-based (e.g., Dental Clinics, Outpatient Settings)



(b) Workflow in an office-based practice

Figure 2—Workflow


Shield
Protection
Note:Please gently remove
protective film
before using

Tracers with AMP®

Office of Quality (OQ) Priority Tracers

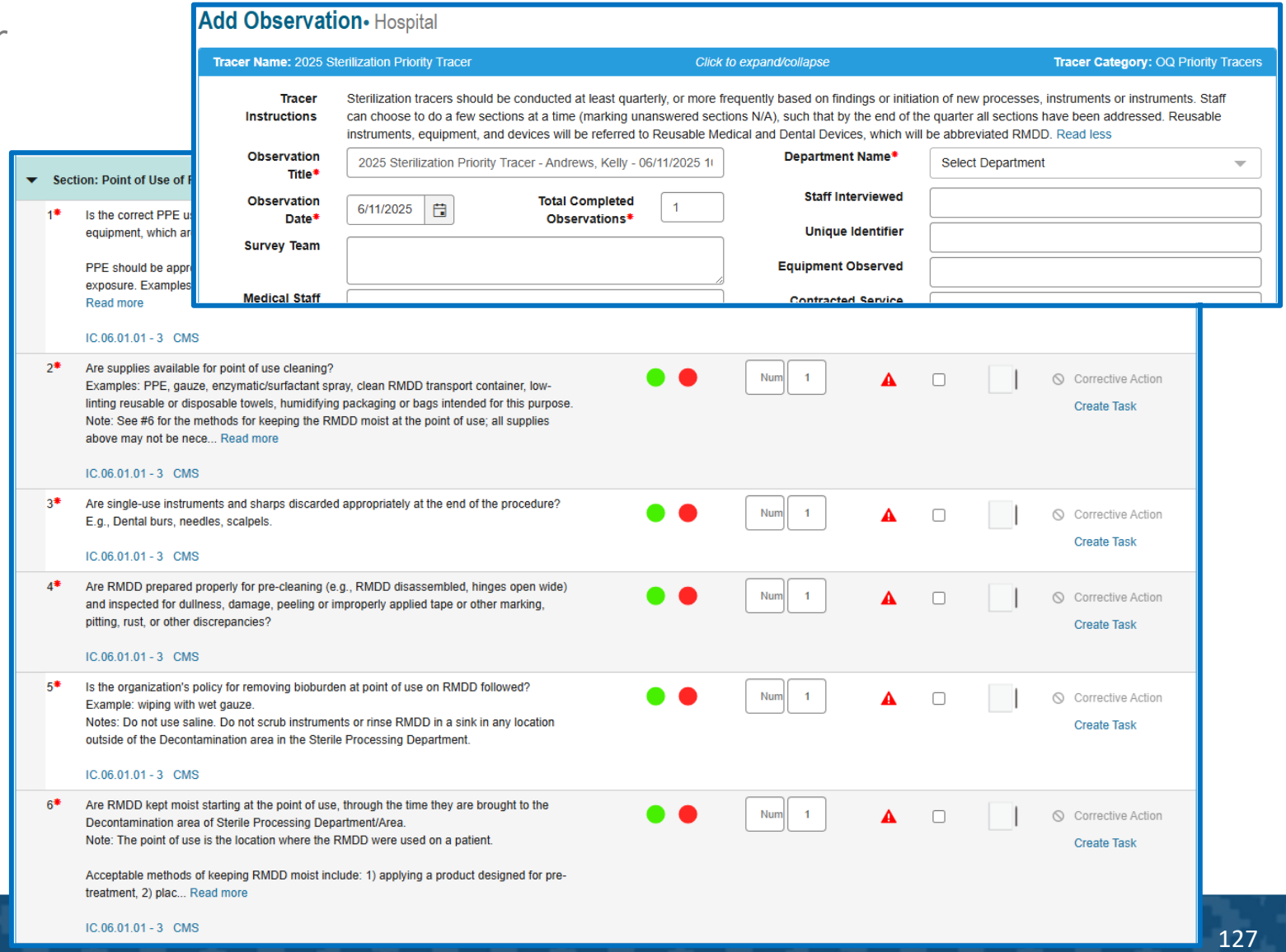
Sections:

- Point of Use
- Storage
- Staff Competency
- Environmental
- Dental Specific
- Cleaning (SPD Process)
- Sterilization (SPD Process)
- Equipment Testing and Preventive Maintenance
- IUSS

Tracers with AMP®

2025 Sterilization Priority Tracer

- Conduct tracer at least quarterly, or more frequently based on findings or initiation of new processes, equipment, or instruments.
- Staff can choose to do a few sections at a time.
- Reusable instruments, equipment, and devices will be referred to Reusable Medical and Dental Devices, which will be abbreviated RMDD.



Resources

Quality Improvement- AAAHC

AAAHC Tools & Study Topic Ideas

Infection Control and Prevention

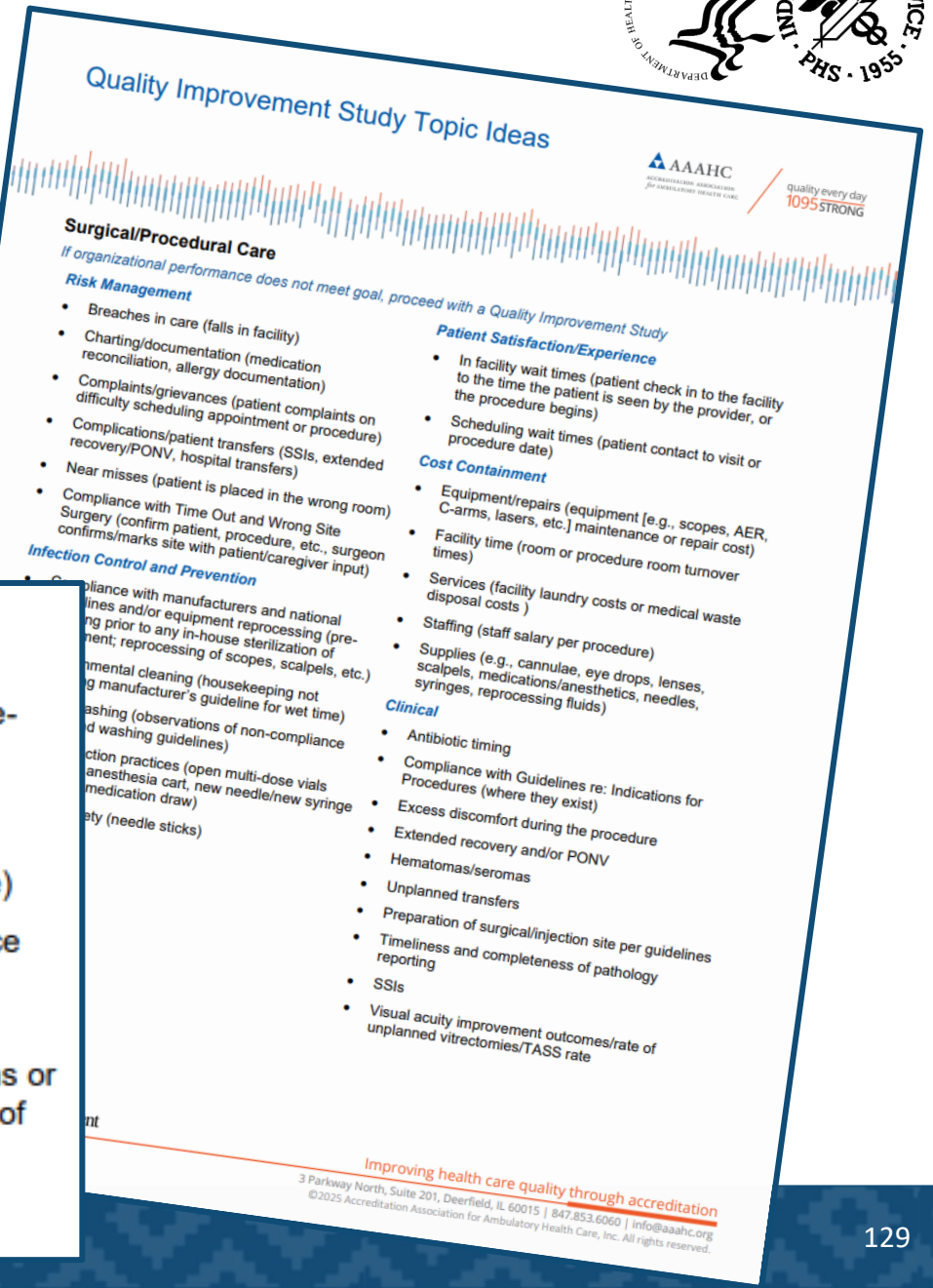
- Compliance with manufacturers and national guidelines and/or equipment reprocessing (pre-cleaning prior to any in-house sterilization of equipment; reprocessing of scopes, scalpels, etc.)
- Environmental cleaning (housekeeping not following manufacturer's guideline for wet time)
- Hand washing (observations of non-compliance with hand washing guidelines)
- Safe injection practices (open multi-dose vials stored in anesthesia cart, new needle/new syrin for every medication draw)
- Sharp safety (needle sticks)

Surgical/Procedural Care

Primary Care

Infection Control and Prevention

- Compliance with manufacturers and national guidelines and/or equipment reprocessing (pre-cleaning prior to any in-house sterilization of equipment)
- Environmental cleaning (housekeeping not following manufacturer's guideline for wet time)
- Hand washing (observations of non-compliance with hand washing guidelines)
- Safe injection practices (open multi-dose vials stored in refrigerator with lunches or specimens or in any other patient care area or area not free of contaminants, splitting of single dose vials)
- Sharp safety (needle sticks)


Quality Improvement Study Topic Ideas

AAAHC

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Surgical/Procedural Care

If organizational performance does not meet goal, proceed with a Quality Improvement Study

Risk Management

- Breaches in care (falls in facility)
- Charting/documentation (medication reconciliation, allergy documentation)
- Complaints/grievances (patient complaints on difficulty scheduling appointment or procedure)
- Complications/patient transfers (SSIs, extended recovery/PONV, hospital transfers)
- Near misses (patient is placed in the wrong room)
- Compliance with Time Out and Wrong Site Surgery (confirm patient, procedure, etc., surgeon confirms/marks site with patient/caregiver input)

Infection Control and Prevention

- Compliance with manufacturers and national lines and/or equipment reprocessing (pre- ng prior to any in-house sterilization of nent; reprocessing of scopes, scalpels, etc.)
- mental cleaning (housekeeping not g manufacturer's guideline for wet time)
- ashing (observations of non-compliance d washing guidelines)
- ction practices (open multi-dose vials anesthesia cart, new needle/new syringe medication draw)
- ety (needle sticks)

Patient Satisfaction/Experience

- In facility wait times (patient check in to the facility to the time the patient is seen by the provider, or the procedure begins)
- Scheduling wait times (patient contact to visit or procedure date)

Cost Containment

- Equipment/repairs (equipment [e.g., scopes, AER, C-arms, lasers, etc.] maintenance or repair cost)
- Facility time (room or procedure room turnover times)
- Services (facility laundry costs or medical waste disposal costs)
- Staffing (staff salary per procedure)
- Supplies (e.g., cannulae, eye drops, lenses, scalpels, medications/anesthetics, needles, syringes, reprocessing fluids)

Clinical

- Antibiotic timing
- Compliance with Guidelines re: Indications for Procedures (where they exist)
- Excess discomfort during the procedure
- Extended recovery and/or PONV
- Hematomas/seromas
- Unplanned transfers
- Preparation of surgical/injection site per guidelines
- Timeliness and completeness of pathology reporting
- SSIs
- Visual acuity improvement outcomes/rate of unplanned vitrectomies/TASS rate

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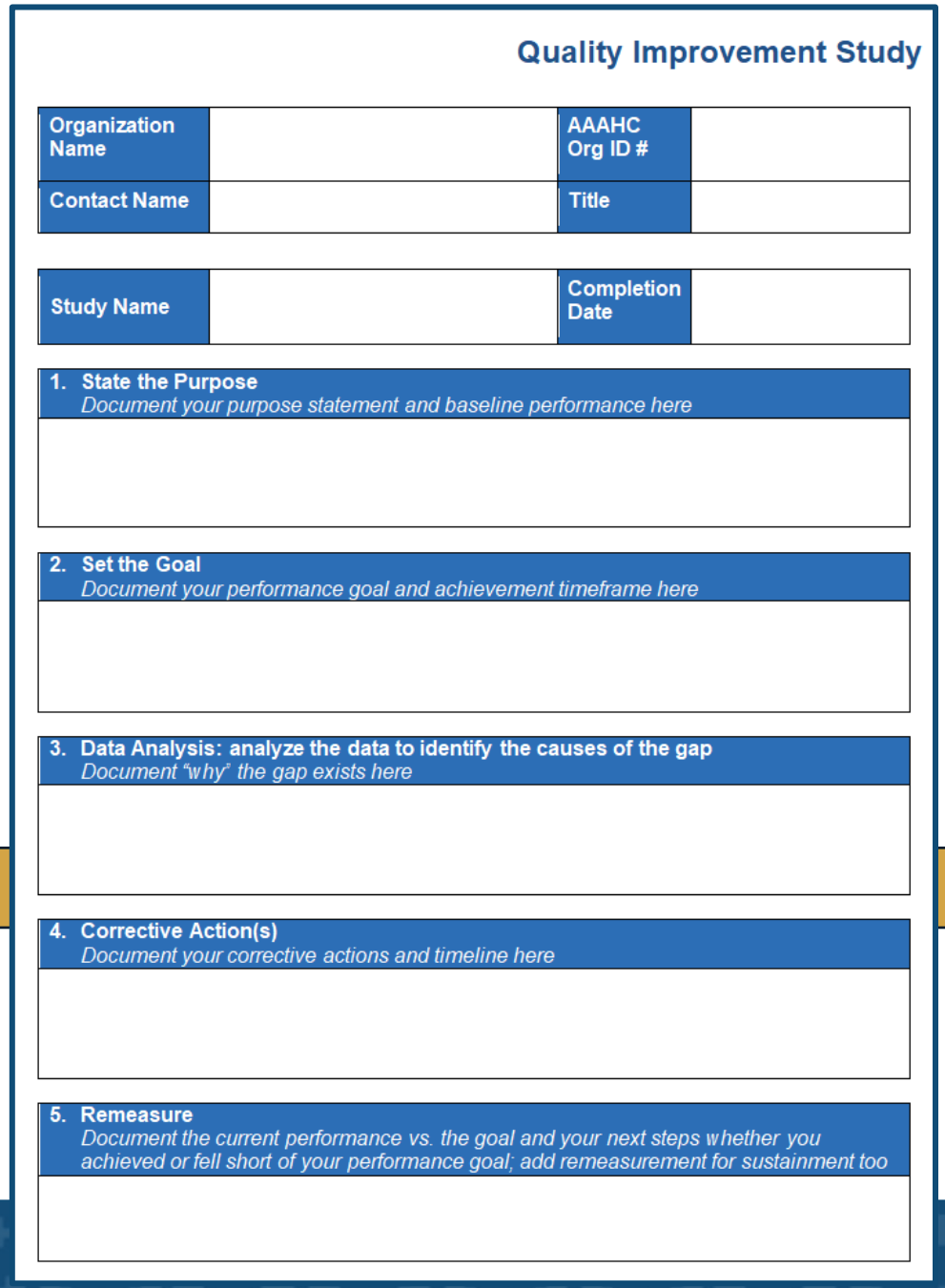
AAAHC Quality Resources

Access quality improvement tools

The AAAHC Institute for Quality Improvement (Quality Institute) offers these resources to aid our clients in complying with AAAHC quality Standards.

- Crosswalk: Aligning PDSA with AAAHC Standards v44
- QI Study Topic Ideas
- Documenting QI Using the 6-Component Criteria
- 6-Component Criteria QI Study Template
- Using Existing Monitoring Activities to Generate a QI Study



Quality Improvement Study

Organization Name		**AAAHC Org ID #**	
Contact Name		**Title**	
Study Name		**Completion Date**	

1. State the Purpose
Document your purpose statement and baseline performance here

2. Set the Goal
Document your performance goal and achievement timeframe here

3. Data Analysis: analyze the data to identify the causes of the gap
Document "why" the gap exists here

4. Corrective Action(s)
Document your corrective actions and timeline here

5. Remeasure
Document the current performance vs. the goal and your next steps whether you achieved or fell short of your performance goal; add remeasurement for sustainment too

AAAHC Quality Resources

Using Existing Monitoring Activities to Generate a Quality Improvement Study

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In the AAAHC Standards, the Quality Category outlines the expectations for organizations to improve the quality of care, while promoting effective and efficient use of facilities and services. In striving to improve clinical quality outcomes, promote effective care delivery, and provide efficient utilization of health care services, organizations maintain a multidimensional, multidisciplinary quality management and improvement program based on comprehensive data analysis of clinical needs, risk levels, and opportunities for interventions and improvements. Quality management and improvement in an organization account for all stakeholders and intersects clinical and service performance indicators with risk management in an organized, systematic manner.

Organizations seeking accreditation are expected to maintain an active, integrated, organized, ongoing, data-driven program of quality management and improvement. The chart below is intended to help you use existing monitoring activities to generate a Quality Improvement (QI) study that will result in meaningful organizational improvement.

The AAAHC does not specify the model or method for monitoring activities that may result in identification of an improvement opportunity. This tool is one of many resources available to facilitate your QI efforts.

Data Collection

Answering "No" to any of the following questions requires you to stop and evaluate your process before moving to the next step.

Are you collecting data?

Refer to your QI Program. Data comes from many areas: patient satisfaction (provider satisfaction, wait times); peer review (patient outcomes, clinical incidents); risk management and safety (breaches, complications, near misses); infection prevention and control (hand hygiene surveillance, safe injection practices); operations (facility time, supplies); and others.

Is your data quantitative?

Is your data in the form of a number, percentage, 20 out of 50, within 1 degree. You cannot manage what you cannot measure.

Based on the data collected, can you identify your current performance level?

What does this data tell you? Check the frequency and consistency of data collection. Identify specific intervals at which you will analyze the results and determine your performance.

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Using Existing Monitoring Activities to Generate a QI Study – **Page 2**

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Compare Performance

Do you have a performance goal?

What is your target? Setting a performance goal helps determine if current performance is acceptable or not.

Did you use a benchmark to determine your goal?

Benchmarking compares your current performance measure to a specific metric. Internal benchmarking is the comparison of performance within an organization, such as an internal metric, e.g., the same measure from last month or year, or the result from another physician or department. External benchmarks compare performance with similar processes outside of the organization. External benchmarking can come from nationally recognized guidelines, federal quality measurements, a professional organization for your medical specialty, a literature review, the AAAHC Institute for Quality Improvement, or other sources.

Solve the Quality Equation

Is your current performance better than or equal to your performance goal?

Yes

Congratulations!
Your performance is better than or equal to your goal. This measure would not qualify for a QI Study because there is no gap requiring improvement. Continue to monitor and celebrate your success!

No

Your monitoring activity indicates a potential for improvement.
Ask yourself: Is this problem or opportunity important enough to warrant an improvement effort by the organization?
Move forward with building a useful QI study.

See "Documenting a Quality Improvement Study Using the AAAHC 6-Component Criteria"

250801 v44

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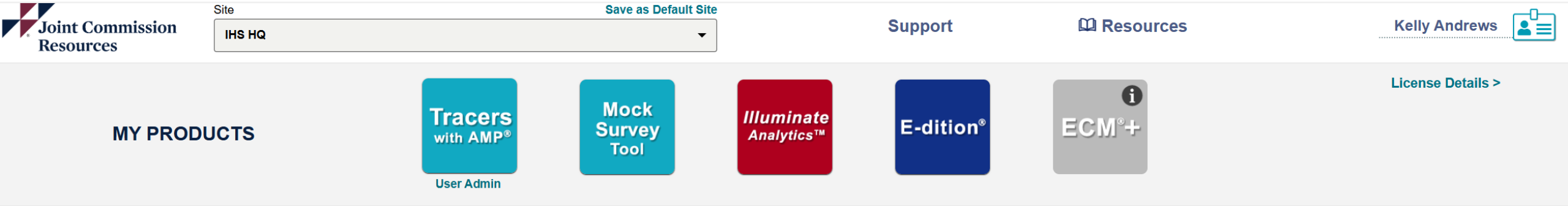
Learn: **Mastering AAAHC v44** Standards, Policies, and Procedures AMB/MDS
[Self-Paced | AAAHC 1095 Learn]

Joint Commission Resources

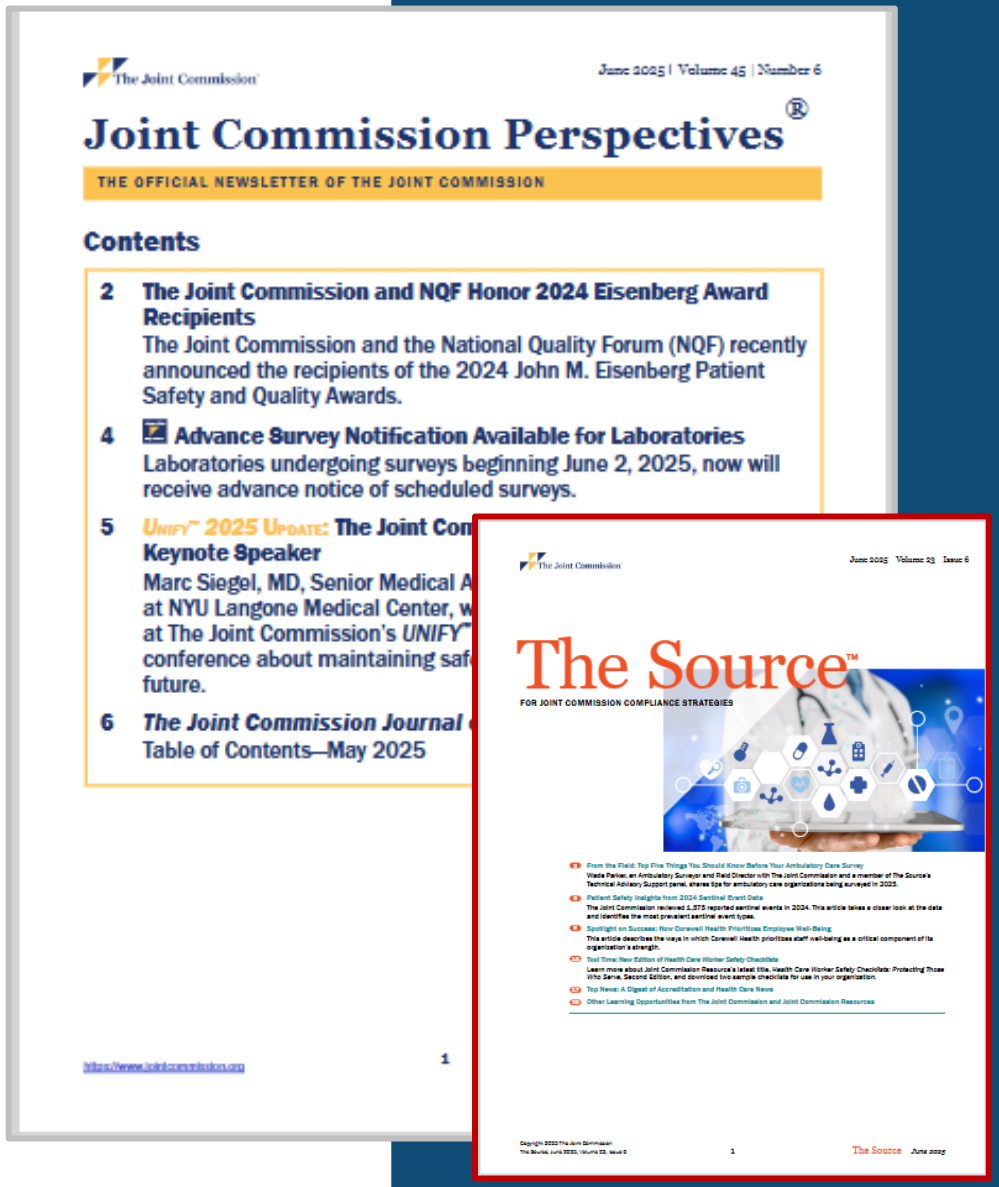
Main Page at Login



Joint Commission Resources

Digital Learning Center- Educational Content

- Annual Breakfast Briefings Webinar Series
- Environment of Care/Life Safety (EC/LS) Webinar Series
- JCR Quality and Safety Network Video Series
- On-demand to premier JCR Conferences
- Exclusive curated content bundles on:
  - CMS
  - EC/LS
  - Infection Prevention and Control
  - Medication Management
  - New Accreditation Manager
- **Continuing Education (CE) credit for all webinars, videos, and live event recordings**

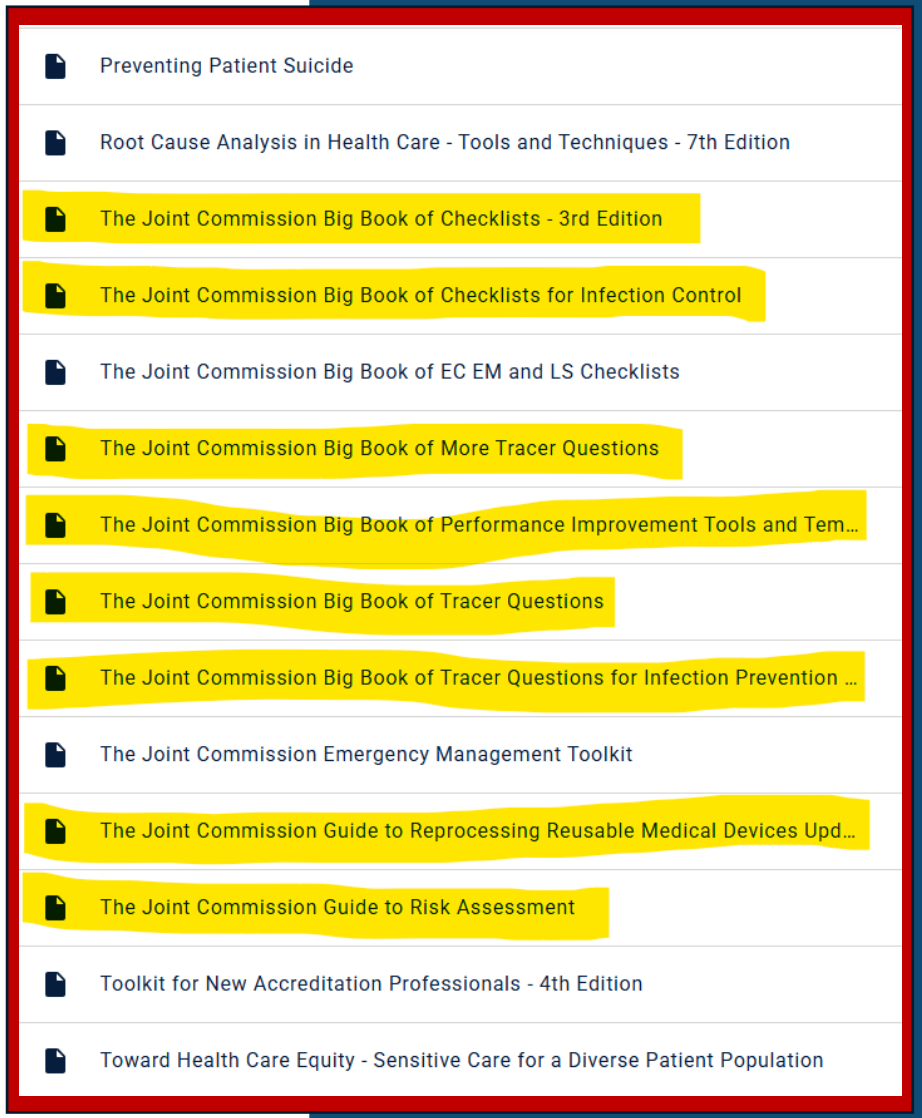


[Digital Learning Center Content]

Joint Commission Resources

Digital Learning Center- Publications Content

- Monthly JCR Newsletters
  - Environment of Care® News
  - The Source
  - Joint Commission Perspectives
  - The Joint Commission Journal on Quality and Patient Safety
- Bi-monthly JCR Newsletter
  - Emergency Management Leader™
- JCR's e-books including checklist books
- Annual standard compliance collections
- Accreditation process and tracer workbooks
- Best sellers on hot topics



Digital Learning Center Content

Resources:

1. High Reliability | PSNet
2. CMS Condition of Participation: Infection prevention and control and antibiotic stewardship programs:
3. eCFR :: 42 CFR 482.42 -- Condition of participation: Infection prevention and control and antibiotic stewardship programs.
4. ASC_Risk_Assessment_Template.docx
5. Clinical Safety: Hand Hygiene for Healthcare Workers | Clean Hands | CDC
6. Germ Center
7. ICAR Tool for General Infection and Control (IPC) Across Settings - Module 2: Hand Hygiene Faciliator Guide
8. NC SPICE
9. CDC Clean Hands Count Materials: Clean Hands Count Materials | Clean Hands | CDC
10. Clean Hands in Healthcare Training | Clean Hands | CDC
11. Single-Dose or Multi-Dose
12. Single & Multidose Vials with the Three Injectioneers
13. The Joint Commission Perspectives, April 2019, Volume 39, Issue 4, Clarifying Infection Control Policy Requirements: April 2019 Perspectives.pdf

Resources:

1. AAMI ST79: Comprehensive guide to steam sterilization and sterility assurance in health care facilities | ANSI/AAMI ST79:2017/(R)2022; Comprehensive guide to steam sterilization and sterility assurance in health care facilities
2. ANSI/AAMI ST91:2021 Flexible and semi-rigid endoscope processing in healthcare facilities: ARRAY | Home
3. ANSI/AAMI ST55: 2015/(R)2023: ARRAY | Search
4. Joint commission Resources, Digital Learning Center, IC Made Easy, 2nd Edition: Joint Commission Resources
5. TJC, Quick Safety Issue 64: Ensuring critical instruments and devices are appropriate for reuse, 2/14/2022: resources news-and-multimedia newsletters newsletters quick-safety quick-safety-issue-64 – jointcommission
6. Guidelines for Environmental Infection Control in Health-Care Facilities
9. ASHE, Infection Control Risk Assessment 2.0, Matrix of Precautions for Construction, Renovation and Operations: ICRA-2.0-FORM-202205 Final.pdf
10. ASHE ICRA 2.0™ Toolkit | ASHE
11. Boxes and Shipping Containers | Hospital and Hospital Clinics | Infection Prevention and Control IC | The Joint Commission
12. resources news-and-multimedia newsletters newsletters quick-safety quick-safety-issue-64 – jointcommission
13. Quality Resources | AAAHC
14. Joint Commission Resources Portal Login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