Department of Health

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Healthcare Quality Reporting Program

HOSPITAL-ACQUIRED INFECTIONS SUBCOMMITTEE

8-9am, October 19, 2015
Healthcentric Advisors, 235 Promenade Street, Suite 500

1. **Welcome & today's meeting objectives** (8am)
   - Meeting chairs: L. Mermel
   - Program staff: E. Cooper, V. Carroll, T. Mota (via phone)
   - Voting members in attendance (6/17): M. Fishman, J. Jefferson, M. Marsella, R. Neale, J. Robinson, N. Vallande
   - Other attendees: L. Martino, A. Mihalakos , R. Reece, J. Reppucci, G. Rocha, P. Winderman

2. **Review of the previous meeting's action items** (8:15am)
   - *Update State HAI Plan based on discussion* – Complete

     Emily stated that the revised HAI Plan has been submitted to the CDC.
   - *Schedule ad hoc meeting for September* – Complete

     Emily noted that an Ad Hoc meeting was held on September 22nd to discuss the creation of a new Hand Hygiene Policy. This policy is being created at the request of Dr. Alexander-Scott with an aim of demonstrating oversight, outlining expectations and acknowledging the work being done in relation to hospital hand hygiene.

3. **HCQP Hand Hygiene Policy** (8:20am)
   - *Review draft policy*

     Dr. Mermel opened the discussion by noting that the proposed policy was not intended to create additional burden on the hospitals, rather it is intended to create a framework for the Hospitals' own policies. This framework includes:
     - Audits
     - Corrective Action Plan
     - Compliance Feedback
     - Education
     - Goals

     Hospitals would be required to attest that their policies meet the standards in the framework and could be asked to submit proof of compliance. Hospitals will also be asked to submit their internal hand hygiene goals and report whether they had met those goals in the intended time-frame. Further, hospitals would be required to inform the program of any deficiencies they may receive from either the Joint Commission or the CDC.

     Concern was expressed regarding the public reporting element. With no standard set for goals, one hospital may be meeting easy goals, while another may not be meeting a more difficult goal. This would create unbalanced reports. The group also wondered whether it was appropriate to publically report hospital deficiencies. The members agreed that it would be

best to report only if an agency was compliant with the policy, and not include the goals or deficiencies in any public reports.

The group then discussed language for the corrective action plan element the policy. After some discussion the group felt adding the term "employed and non-employed health care workers" would better define our expectations.

The group also discussed whether it would be important to review surgical hand hygieneand hand hygiene in procedure-oriented specialty departments (e.g., interventional radiology, interventional cardiology, etc), as one hospital was recently surprised to find lower than expected surgical hand hygiene compliance. After discussion of the differences in surgical hand hygiene practices, the group decided to change the language of the auditing element to include mention of "surgical services and specialty departments".

The discussion turned to who should receive and sign, the policy at the hospital. The committee felt that it would be best to send the policy to both the Chief Executive Officer and the Chief of Medical Staff. Dr. Mermel mentioned that this will be a good opportunity to raise awareness among hospital leadership about hand hygiene and infection prevention work. Emily said that she would ask Dr. Alexander-Scott to send the policy, including a cover letter explaining its purpose.

Emily stated that she will update the draft policy and distribute it with the minutes from this meeting. She will invite further comments from the subcommittee members via email.

4. **Infection Prevention Assessment** (8:35am)
   - *Review tool*

Emily opened by explaining that the original plan for this meeting was to review the existing Hospital Antimicrobial Stewardship Survey in advance of re-administering that survey in the coming weeks. Funding for this survey, for acute-care hospitals, nursing homes and home health agencies had been included in our Ebola supplemental funding from the CDC. However, we have received new guidance from the CDC requiring that we use their Infection Prevention and Control Assessment.

This assessment is meant to be completed onsite and is far more extensive than our original electronic survey. This would be more of a burden for the hospitals and represents a larger level of effort than was considered when we submitted the budget for this grant. Concerns have also been raised that this assessment would be a duplication of the efforts of the QIO, who has been asked to use a similar tool with the hospitals, also developed by the CDC. We are in discussion with the CDC to determine their expectations for this change in scope.

The subcommittee looked at the new tool and felt it would be very useful for the hospitals to use for a risk assessment, with the caveat that there is no documentation needed. It was also noted that the data would be utilized for information gathering purposes; hospitals would not be individually identified when the results are sent to the CDC. Emily offered to send out the PDF of the tool to hospitals to review prior to launching the actual tool. The subcommittee suggested that, if hospitals were given enough time, they could fill it out on their own. A

percentage of hospitals could then be chosen for onsite validation of their responses. This suggestion will be brought to the CDC.

The concern was raised whether this information, once submitted to the Department of Health, would be public domain. Alysia Mihalakos mentioned that the Department of Health is currently exploring a similar concern in relation to the data collected through the Ebola preparedness assessments. Emily asked her to include this additional data collection in her discussions with the legal team at the Department of Health. Gina Rocha also offered to reach out to a colleague in Connecticut to see how they are handling this issue in their state.

With regard to the Hospital Antimicrobial Stewardship Survey, the group felt that this is an informative survey and is not difficult for them to complete. They suggested that this be administered again this year, but asked that the 2014 results be sent at the same time so that they can review their previous answers.

5. **Action Items** (8:55am)
   - Update draft Hand Hygiene Policy (Emily)
   - Ask Dr. Alexander-Scott about Hand Hygiene Policy cover letter (Emily)
   - Send out PDF of Infection Prevent and Control Assessment Tool to hospitals (Emily)
   - Administer 2015 Hospital Antimicrobial Stewardship Survey (Emily)

Next Meeting: December 21, 2015

Infection Prevention and Control Assessment Tool for Acute Care Hospitals

This tool is intended to assist in the assessment of infection control programs and practices in acute care hospitals. If feasible, direct observations of infection control practices are encouraged. To facilitate the assessment, health departments are encouraged to share this tool with hospitals in advance of their visit.

Overview

Section 1: Facility Demographics

Section 2: Infection Control Program and Infrastructure

Section 3: Direct Observation of Facility Practices (optional)

Section 4: Infection Control Guidelines and Other Resources

Infection Control Domains for Gap Assessment

I. Infection Control Program and Infrastructure

II. Infection Control Training, Competency, and Implementation of Policies and Practices

- A. Hand Hygiene
- B. Personal Protective Equipment (PPE)
- C. Catheter-associated Urinary Tract Infection (CAUTI)
- D. Central Line-associated Bloodstream Infection (CLABSI)
- E. Ventilator-associated Event (VAE)
- F. Injection Safety
- G. Surgical Site Infection
- H. *Clostridium difficile* Infection (CDI)
- I. Environmental Cleaning
- J. Equipment Reprocessing

III. Systems to Detect, Prevent, and Respond to Healthcare-Associated Infections and Multidrug-Resistant Organisms (MDROs)

Section 1. Facility Demographics

Facility Name (for health department use only)	
NHSN Facility Organization ID (for health department use only)	
State-assigned Unique ID	
Date of Assessment	_____/_____/_____
Type of Assessment	□ On-site □ Other (specify): _____
Rationale for Assessment (Select all that apply)	□ Outbreak □ Input from accrediting organization or state survey agency □ NHSN data If YES, specify: □ CAUTI □ CLABSI □ SSI □ CDI □ Other (specify: _____) □ Collaborative (specify partner[s]): _____) □ Other (specify): _____
Facility type	□ Acute Care Hospital □ Critical Access Hospital □ Long-term Acute Care Hospital (LTACH) □ Other (specify): _____

Section 2: Infection Control Program and Infrastructure

I. Infection Control Program and Infrastructure		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
1. Hospital provides fiscal and human resource support for maintaining the infection prevention and control program.	○ Yes ○ No	
2. The person(s) charged with directing the infection prevention and control program at the hospital is/are qualified and trained in infection control. Verify qualifications, which should include: □ Successful completion of initial and recertification exams developed by the Certification Board for Infection Control & Epidemiology (CIC) <u>AND/OR</u> □ Participation in infection control courses organized by recognized professional societies (e.g., APIC, SHEA)	○ Yes ○ No	
3. Infection prevention and control program performs an annual facility infection risk assessment that evaluates and prioritizes potential risks for infections, contamination, and exposures and the program's preparedness to eliminate or mitigate such risks. *Note: Example of Facility Infection Risk Assessment Report and Plan is available in Section 4.*	○ Yes ○ No	
4. Written infection control policies and procedures are available, current, and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations, or standards. Verify the following: a. Respondent can describe the process for reviewing and updating policies (e.g., policies are dated and reviewed annually and when new guidelines are issued)	○ Yes ○ No a. ○ Yes ○ No	
5. Infection prevention and control program provides infection prevention education to patients, family members, and other caregivers. Verify the following: a. Respondent can describe how this education is provided (e.g., information included in the admission or discharge packet, videos, signage, in-person training)	○ Yes ○ No a. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
A. Hand Hygiene		
1. Hospital has a competency-based training program for hand hygiene. Verify the following: a. Training is provided to all healthcare personnel, including all ancillary personnel not directly involved in patient care but potentially exposed to infectious agents (e.g., food tray handlers, housekeeping, volunteer personnel). b. Training is provided upon hire, prior to provision of care at this hospital. c. Training is provided at least annually. d. Personnel are required to demonstrate competency with hand hygiene following each training. e. Hospital maintains current documentation of hand hygiene competency for all personnel.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No	
2. Hospital regularly audits (monitors and documents) adherence to hand hygiene. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
3. Hospital provides feedback from audits to personnel regarding their hand hygiene performance. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
4. Supplies necessary for adherence to hand hygiene (e.g., soap, water, paper towels, alcohol-based hand rub) are readily accessible in patient care areas.	○ Yes ○ No	
5. Hand hygiene policies promote preferential use of alcohol-based hand rub over soap and water except when hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected *C. difficile* or norovirus.	○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
B. Personal Protective Equipment (PPE)		
1. Hospital has a competency-based training program for use of personal protective equipment (PPE). Verify the following: a. Training is provided to all personnel who use PPE. b. Training is provided upon hire, prior to provision of care at this hospital. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Training includes 1) appropriate indications for specific PPE components, 2) proper donning, doffing, adjustment, and wear of PPE, and 3) proper care, maintenance, useful life, and disposal of PPE. f. Personnel are required to demonstrate competency with selection and use of PPE (i.e., correct technique is observed by trainer) following each training. g. Hospital maintains current documentation of PPE competency for all personnel who use PPE.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No g. ○ Yes ○ No	
2. Hospital regularly audits (monitors and documents) adherence to proper PPE selection and use, including donning and doffing. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
3. Hospital provides feedback from audits to personnel regarding their performance with selection and use of PPE. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
4. Supplies necessary for adherence to personal protective equipment recommendations specified under Standard and Transmission-based Precautions (e.g., gloves, gowns, mouth, eye, nose, and face protection) are available and located near point of use.	○ Yes ○ No	
5. The hospital's respiratory protection program provides annual respiratory fit testing for all personnel who are anticipated to require respiratory protection. Verify the following: a. Hospital maintains supplies of respiratory protection devices (e.g., Powered air purifying respirator) to be used by personnel who cannot be fitted. b. Healthcare personnel are educated about factors that may compromise proper fit and function of respiratory protection devices (e.g., weight gain/loss, facial hair).	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
C. Catheter-associated Urinary Tract Infection (CAUTI)		
1. Hospital has physician and/or nurse champions for CAUTI prevention activities.	○ Yes ○ No	
2. Hospital has a competency-based training program for **insertion** of urinary catheters. Verify the following: a. Training is provided to all personnel who are given responsibility for insertion of urinary catheters. Personnel may include, but are not limited to, nurses, nursing assistants, medical assistants, technicians, and physicians. b. Training is provided upon hire, prior to being allowed to perform urinary catheter insertion. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with insertion (i.e., correct technique is observed by trainer) following each training. f. Hospital maintains current documentation of competency with urinary catheter insertion for all personnel who insert urinary catheters.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No	
3. Hospital regularly audits (monitors and documents) adherence to recommended practices for **insertion** of urinary catheters. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
4. Hospital provides feedback from audits to personnel regarding their performance for **insertion** of urinary catheters. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
C. Catheter-associated Urinary Tract Infection (CAUTI), continued		
5. Hospital has a competency-based training program for **maintenance** of urinary catheters. Verify the following: a. Training is provided to all personnel who are given responsibility for urinary catheter maintenance (e.g., perineal care, emptying the drainage bag aseptically, maintaining the closed drainage system, maintaining unobstructed urine flow). Personnel may include, but are not limited to, nurses, nursing assistants, medical assistants, technicians, and transport personnel. b. Training is provided upon hire, prior to being allowed to perform urinary catheter maintenance. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with catheter maintenance (i.e., correct technique is observed by trainer) following each training. f. Hospital maintains current documentation of competency with urinary catheter maintenance for all personnel who maintain urinary catheters.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No	
6. Hospital regularly audits (monitors and documents) adherence to recommended practices for **maintenance** of urinary catheters. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
7. Hospital provides feedback from audits to personnel regarding their performance for **maintenance** of urinary catheters. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
8. Patients with urinary catheters are assessed, at least daily, for continued need for the catheter. Verify the following: a. Respondent can describe methods used to trigger the daily assessments (e.g., patient safety checklist, daily rounds, nurse directed protocol, reminders or stop orders). b. Hospital routinely audits adherence to daily assessment of urinary catheter need.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
C. Catheter-associated Urinary Tract Infection (CAUTI), continued		
9. Hospital monitors CAUTI data and uses it to direct prevention activities. Verify the following: a. Respondent is familiar with National Healthcare Safety Network (NHSN) CAUTI data. b. Respondent can describe how CAUTI data are used to direct prevention activities.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
10. Hospital provides feedback of CAUTI data to frontline personnel. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
D. Central line-associated Bloodstream Infection (CLABSI)		
1. Hospital has physician and/or nurse champions for CLABSI prevention activities.	○ Yes ○ No	
2. Hospital has a competency-based training program for **insertion** of central venous catheters. Verify the following: a. Training is provided to all personnel who are given responsibility for insertion of central venous catheters. Personnel may include, but are not limited to, physicians, physician assistants, and members of line insertion teams. b. Training is provided upon hire, prior to being allowed to perform central venous catheter insertion. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with insertion (i.e., correct technique is observed by trainer) following each training. f. Hospital maintains current documentation of competency with central venous catheter insertion for all personnel who insert central venous catheters.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No	
3. Hospital regularly audits (monitors and documents) adherence to recommended practices for **insertion** of central venous catheters. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
4. Hospital provides feedback from audits to personnel regarding their performance for **insertion** of central venous catheters. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
D. Central line-associated Bloodstream Infection (CLABSI), continued		
5. Hospital has a competency-based training program for **maintenance** of central venous catheters. Verify the following: a. Training is provided to all personnel who maintain central venous catheters (e.g., scrub the hub, accessing the catheter, dressing changes). Personnel may include, but are not limited to, nurses, nursing assistants, physicians, and physician assistants. b. Training is provided upon hire, prior to being allowed to perform central venous catheter maintenance. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with maintenance (i.e., correct technique is observed by trainer) following each training. f. Hospital maintains current documentation of competency with central venous catheter maintenance for all personnel who maintain central venous catheters.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No	
6. Hospital regularly audits (monitors and documents) adherence to recommended practices for **maintenance** of central venous catheters. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
7. Hospital provides feedback from audits to personnel regarding their performance for **maintenance** of central venous catheters. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
8. Patients with central venous catheters are assessed, at least daily, for continued need for the catheter. Verify the following: a. Respondent can describe methods used to trigger the daily assessments (e.g., patient safety checklist, daily rounds, reminders). b. Hospital routinely audits adherence to daily assessment of central venous catheter need.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
9. Hospital monitors CLABSI data and uses it to direct prevention activities. Verify the following: a. Respondent is familiar with National Healthcare Safety Network (NHSN) CLABSI data. b. Respondent can describe how CLABSI data are used to direct prevention activities.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
D. Central line-associated Bloodstream Infection (CLABSI), continued		
10. Hospital provides feedback of CLABSI data to frontline personnel. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
E. Ventilator-associated Event (VAE)		
1. Hospital has physician and/or nurse champions for VAE prevention activities.	○ Yes ○ No ○ **Check if facility does not provide care to ventilated patients and move to item F. Injection Safety.**	
2. Hospital has a competency-based training program addressing prevention of VAEs. Verify the following: a. Training is provided to all personnel who provide respiratory therapy for ventilated patients (e.g., suctioning, administration of aerosolized medications). Personnel may include, but are not limited to, respiratory therapists and nurses. b. Training is provided upon hire, prior to being allowed to provide respiratory therapy for ventilated patients. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with respiratory therapy practices (i.e., correct technique is observed by trainer) following each training. f. Hospital maintains current documentation of competency with respiratory practices for all personnel who provide respiratory therapy for ventilated patients.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No	
3. Hospital regularly audits (monitors and documents) adherence to recommended practices for management of ventilated patients (e.g., suctioning, administration of aerosolized medications). Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
E. Ventilator-associated Event (VAE), continued		
4. Hospital provides feedback from audits to personnel regarding their performance for management of ventilated patients. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
5. Patients requiring invasive ventilation are assessed, at least daily, for continued need for the ventilator. Verify the following: a. Respondent can describe methods used to trigger the daily assessments (e.g., patient safety checklist, daily rounds, reminders) b. Hospital routinely audits adherence to daily assessment of ventilator need.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
6. Hospital has a program that includes daily spontaneous breathing trials and lightening of sedation in eligible patient.	○ Yes ○ No	
7. Hospital has an oral-hygiene program.	○ Yes ○ No	
8. Hospital monitors VAE data and uses it to direct prevention activities. Verify the following: a. Respondent can describe how VAE data are used to direct prevention activities. If the hospital reports VAE data to NHSN, verify the following: b. Respondent is familiar with NHSN VAE data. If the hospital does not report VAE data to NHSN, verify the following: c. Respondent can describe how VAE data are collected.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No ○ Not Applicable c. ○ Yes ○ No ○ Not Applicable	
9. Hospital provides feedback of VAE data to frontline personnel. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
F. Injection Safety (This element does not include assessment of pharmacy practices)		
1. Hospital has a competency-based training program for preparation and administration of parenteral medications outside of the pharmacy. Verify the following: a. Training is provided to all personnel who prepare and administer injections and parenteral infusions. b. Training is provided upon hire, prior to being allowed to prepare and administer injections and parenteral infusions. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with preparation and administration of injections and parenteral infusions following each training. f. Hospital maintains current documentation of competency with preparation and administration procedures for all personnel who prepare and administer injections and parenteral infusions.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No	
2. Hospital regularly audits (monitors and documents) adherence to safe injection practices. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
3. Hospital provides feedback from audits to personnel regarding their adherence to safe injection practices. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
4. Hospital has a drug diversion prevention program that includes consultation with the IP program when drug tampering (involving alteration or substitution) is suspected or identified to assess patient safety risks. Verify the following: a. Respondent can describe how the hospital would assess risk to patients if tampering is suspected or identified.	○ Yes ○ No a. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
G. Surgical Site Infections (SSI)		
1. Hospital has a surgical care improvement program. Verify the following: The surgical care improvement program addresses appropriate prophylactic antibiotic use including: a. Preoperative timing of prophylactic antibiotic administration (within 1 hour of incision or 2 hours for vancomycin or fluoroquinolones). b. Appropriate prophylactic antibiotic selection based on procedure type. c. Discontinuation of prophylactic antibiotics within 24 hours (48 hours for cardiovascular surgery) after surgical end time. d. The surgical care improvement program addresses prompt removal of urinary catheter on post-op day 1 or 2, unless there is a documented appropriate reason for continued use.	○ Yes ○ No ○ **Check if facility does not perform surgeries and move to item H. *Clostridium difficile* Infection.** a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No	
2. Hospital regularly audits (monitors and documents) adherence to elements of surgical care improvement program. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
3. Hospital provides feedback from audits to personnel regarding their adherence to elements of the surgical care improvement program. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
G. Surgical Site Infections (SSI), continued		
4. Hospital regularly audits (monitors and documents) adherence to recommended infection control practices for SSI prevention. Verify the following: Auditing includes: a. Adherence to preoperative surgical scrub and hand hygiene b. Appropriate use of surgical attire and drapes c. Adherence to aseptic technique and sterile field d. Proper ventilation requirements e. Minimization of traffic in the operating room f. Adherence to cleaning and disinfection of environmental surfaces g. Respondent can describe process used for audits. h. Respondent can describe frequency of audits. i. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No g. ○ Yes ○ No h. ○ Yes ○ No i. ○ Yes ○ No	
5. Hospital provides feedback from audits to personnel regarding their adherence to surgical infection control practices. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
6. Hospital monitors SSI data and uses it to direct prevention activities. Verify the following: a. Respondent is familiar with NHSN SSI data. b. Respondent can describe how SSI data are used to direct prevention activities.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
7. Hospital provides feedback of SSI data to surgeons and other surgical personnel. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
H. *Clostridium difficile* Infection (CDI)		
1. Hospital has physician and/or nurse champions for CDI prevention activities.	○ Yes ○ No	
2. Hospital regularly audits (monitors and documents) adherence to recommended infection control practices for CDI prevention. Verify the following: Auditing includes: a. Adherence to hand hygiene b. Appropriate use of PPE c. Compliance with Contact Precautions, including use of dedicated or disposable equipment d. Adherence to cleaning and disinfection procedures, including use of sporicidal disinfectants if part of hospital policy e. Respondent can describe process used for audits. f. Respondent can describe frequency of audits. g. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No g. ○ Yes ○ No	
3. Hospital provides feedback from audits to personnel regarding their adherence to recommended infection control practices for CDI prevention. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
4. Hospital has specific antibiotic stewardship strategies in place to reduce CDI. *Note: Please see section III.8 for full assessment of antibiotic stewardship program.* Verify the following: a. Hospital has strategies to reduce unnecessary use of antibiotics that are high-risk for CDI (e.g., fluoroquinolones, 3rd/4th generation cephalosporins). b. Hospital reviews appropriateness of antibiotics prescribed for treatment of other conditions (e.g., urinary tract infection) for patients with new or recent CDI diagnosis. c. Hospital educates providers about the risk of CDI with antibiotics. d. Hospital educates patients and family members about the risk of CDI with antibiotics.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No	
5. Hospital monitors CDI data and uses it to direct prevention activities. Verify the following: a. Respondent is familiar with NHSN CDI data. b. Respondent can describe how CDI data are used to direct prevention activities.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
6. Hospital provides feedback of CDI data to frontline personnel. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
I. Environmental Cleaning		
1. Hospital has a competency-based training program for environmental cleaning. Verify the following: a. Training is provided to all personnel who clean and disinfect patient care areas. Personnel may include, but are not limited to, environmental services staff, nurses, nursing assistants, and technicians. b. Training is provided upon hire, prior to being allowed to perform environmental cleaning. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with environmental cleaning (i.e., correct technique is observed by trainer) following each training. f. Hospital maintains current documentation of competency with environmental cleaning procedures for all personnel who clean and disinfect patient care areas. g. If the hospital contracts environmental services, the contractor has a comparable training program.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No g. ○ Yes ○ No ○ N/A	
2. Hospital has policies that clearly define responsibilities for cleaning and disinfection of non-critical equipment, mobile devices, and other electronics (e.g., ICU monitors, ventilator surfaces, bar code scanners, point-of-care devices, mobile work stations, code carts, airway boxes).	○ Yes ○ No	
3. Hospital has protocols to ensure that healthcare personnel can readily identify equipment that has been properly cleaned and disinfected and is ready for patient use (e.g., tagging system, placement in dedicated clean area).	○ Yes ○ No	
4. Hospital regularly audits (monitors and documents) adherence to cleaning and disinfection procedures, including use of products in accordance with manufacturers' instructions (e.g., dilution, storage, shelf-life, contact time). Verify the following: a. Respondent can describe process used for audits (e.g., monitoring technology, direct observation). b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
5. Hospital provides feedback from audits to personnel regarding their adherence to cleaning and disinfection procedures. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
J. Equipment Reprocessing		
This section refers to all medical devices that may be reused in the hospital. Device categories include: • **Critical items** (e.g., surgical instruments) are objects that enter sterile tissue or the vascular system and must be sterile prior to use. • **Semi-critical items** (e.g., endoscopes for upper endoscopy and colonoscopy, laryngoscope blades) are objects that contact mucous membranes or non-intact skin and require, at a minimum, high-level disinfection prior to reuse. • **Non-critical items** (e.g., blood pressure cuffs, point-of-care devices) are objects that may come in contact with intact skin but not mucous membranes and should undergo cleaning and low- or intermediate-level disinfection depending on the nature and degree of contamination (See Environmental Cleaning Section I. above). **Single-use devices** (SUDs) are labeled by the manufacturer for a single use and do not have reprocessing instructions. They may *not* be reused unless they have been reprocessed for reuse by entities which have complied with FDA regulatory requirements and have received FDA clearance to reprocess specific SUDs.		
1. Hospital has a competency-based training program for reprocessing of **critical** equipment. Verify the following: a. Training is provided to all personnel who reprocess critical equipment. b. Training is provided upon hire, prior to being allowed to reprocess critical equipment. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with equipment reprocessing (i.e., correct technique is observed by trainer) following each training. f. Hospital maintains current documentation of competency with reprocessing procedures for all personnel who reprocess critical equipment. g. If the hospital contracts reprocessing of critical equipment, the contractor has a comparable training program which includes the specific equipment used by the hospital.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No g. ○ Yes ○ No ○ N/A	
2. Hospital regularly audits (monitors and documents) adherence to reprocessing procedures for **critical** equipment. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Audits occur in all locations where critical equipment is reprocessed (e.g., central sterile reprocessing, operating suites), including locations where initial cleaning steps are performed (e.g., point of use). d. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
J. Equipment Reprocessing, continued		
3. Hospital provides feedback from audits to personnel regarding their adherence to reprocessing procedures for **critical** equipment. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
4. Hospital has a competency-based training program for reprocessing of **semi-critical** equipment. Verify the following: a. Training is provided to all personnel who reprocess semi-critical equipment. b. Training is provided upon hire, prior to being allowed to reprocess semi-critical equipment. c. Training is provided at least annually. d. Training is provided when new equipment or protocols are introduced. e. Personnel are required to demonstrate competency with equipment reprocessing (i.e., correct technique is observed by trainer) following each training. f. Hospital maintains current documentation of competency with reprocessing procedures for all personnel who reprocess semi-critical equipment. g. If the hospital contracts reprocessing of semi-critical equipment, the contractor has a comparable training program which includes the specific equipment used by the hospital.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No g. ○ Yes ○ No ○ N/A	
5. Hospital regularly audits (monitors and documents) adherence to reprocessing procedures for **semi-critical** equipment. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Audits occur in all locations where semi-critical equipment is reprocessed (e.g., central sterile reprocessing, endoscopy suites), including locations where initial cleaning steps are performed (e.g., point of use). d. Respondent can describe process for improvement when non-adherence is observed.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No	
6. Hospital provides feedback from audits to personnel regarding their adherence to reprocessing procedures for **semi-critical** equipment. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
J. Equipment Reprocessing, continued		
7. If hospital reuses **single-use devices**, the devices are reprocessed by an FDA-approved entity.	○ Yes ○ No ○ Not applicable (hospital does not reuse single-use devices)	
8. Hospital maintains documentation of reprocessing activities. Verify the following: a. Hospital maintains logs for each sterilizer cycle that include the results from each load. b. Hospital has documentation that the chemicals used for high-level disinfection are routinely tested for appropriate concentration and replaced appropriately. c. Hospital maintains maintenance records for reprocessing equipment (e.g., autoclaves, automated endoscope reprocessors)	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
9. Hospital allows adequate time for reprocessing to ensure adherence to all steps recommended by the device manufacturer, including drying and proper storage. Verify the following: a. Hospital has an adequate supply of instruments for the volume of procedures performed to allow sufficient time for all reprocessing steps. b. Scheduling of procedures allows sufficient time for all reprocessing steps. c. Hospital does not routinely use immediate-use steam sterilization (IUSS).	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
10. IP program is consulted whenever new equipment or products will be purchased or introduced to ensure implementation of appropriate reprocessing policies and procedures.	○ Yes ○ No	
11. Hospital has policies and procedures outlining hospital response (i.e., risk assessment and recall of device) in the event of a reprocessing error or failure. Verify the following: a. The IP can describe how the risk assessment would be performed including how the hospital would identify which patients may have been exposed to an improperly reprocessed instrument.	○ Yes ○ No a. ○ Yes ○ No	

III. Systems to Detect, Prevent, and Respond to Healthcare-Associated Infections and Multidrug-Resistant Organisms (MDROs)		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
1. Hospital has system in place for early detection and management of potentially infectious persons **at initial points of entry to the hospital**, including rapid isolation as appropriate. Verify the following: a. Travel and occupational history is included as part of triage protocols. b. Hospital has system to identify (flag) patients with targeted MDROs upon readmission so appropriate precautions can be applied. The hospital has a respiratory/hygiene cough etiquette program that includes: c. Posting signs at entrances d. Providing tissues and no-touch receptacles for disposal of tissues e. Providing hand hygiene supplies in or near waiting areas f. Offering facemasks to coughing patients and other symptomatic individuals upon entry to the facility g. Providing space in patient waiting areas (e.g., ED waiting room) and encouraging individuals with symptoms of respiratory infections to sit as far away from others as possible	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No d. ○ Yes ○ No e. ○ Yes ○ No f. ○ Yes ○ No g. ○ Yes ○ No	
2. Hospital has systems in place for early detection and isolation of infectious patients identified **during the hospital stay**, including rapid isolation of patients as appropriate. Verify the following: a. There is a mechanism for prompt notification of the IP by the clinical microbiology laboratory when novel resistance patterns and/or targeted antimicrobial-resistant pathogens are detected.	○ Yes ○ No a. ○ Yes ○ No	
3. Hospital has system in place for **INTER-facility** communication of infectious status and isolation needs of patients **prior to transfer to** other facilities. Verify the following: a. Respondent can describe methods employed to ensure infectious status and isolation needs are communicated with receiving facilities. b. The hospital has system to notify receiving facilities of microbiological tests (e.g., cultures) that are pending at the time of transfer.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

III. Systems to Detect, Prevent, and Respond to Healthcare-Associated Infections and Multidrug-Resistant Organisms (MDROs)		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
4. Hospital has system in place for **INTER-facility** communication to identify infectious status and isolation needs of patients **prior to accepting patients from** other facilities. Verify the following: a. Respondent can describe methods employed to ensure infectious status and isolation needs are obtained from transferring facilities. b. The hospital has system to follow-up on microbiological results (e.g., cultures) that are pending at the time of transfer. c. If the hospital identifies an infection that may be related to care provided at another facility (e.g., hospital, nursing home, clinic), the facility is notified.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No c. ○ Yes ○ No	
5. Hospital has system in place for **INTRA-facility** communication to identify infectious status and isolation needs of patients prior to transfer to other units or shared spaces (e.g., radiology, physical therapy, emergency department) within the hospital. Verify the following: a. Respondent can describe methods employed to ensure infectious status and isolation needs are communicated with receiving units.	○ Yes ○ No a. ○ Yes ○ No	
6. Hospital has a surveillance program to monitor incidence of epidemiologically-important organisms (e.g., CRE) and targeted healthcare-associated infections. Verify the following: a. Respondent can describe how the hospital determines which organisms and HAIs to track.	○ Yes ○ No a. ○ Yes ○ No	
7. Hospital uses surveillance data to implement corrective actions rapidly when transmission of epidemiologically-important organisms (e.g., CRE) or increased rates or persistently elevated rates of healthcare-associated infections are detected. Verify the following: a. Data collection method allows for timely response to identified problems.	○ Yes ○ No a. ○ Yes ○ No	

III. Systems to Detect, Prevent, and Respond to Healthcare-Associated Infections and Multidrug-Resistant Organisms (MDROs)		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
8. Hospital has an antibiotic stewardship program that meets the 7 CDC core elements listed below (a – g). *Note: The antibiotic stewardship program should be assessed in consultation with personnel knowledgeable about antibiotic stewardship activities (e.g., physician or pharmacist stewardship lead). Responses can be obtained from or cross-checked with the NHSN Annual Hospital Survey Antibiotic Stewardship Practice questions (Q 23 – 34) if available.*	○ Yes ○ No	
Verify the following: a. Hospital leadership commitment (at least one action below) ○ Hospital has a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship) ○ Hospital provides salary support for dedicated time for antibiotic stewardship activities.	a. ○ Yes ○ No	
b. Program leadership (accountability) ○ There is a leader responsible for outcomes of stewardship activities at the hospital.	b. ○ Yes ○ No	
c. Drug expertise ○ There is at least one pharmacist responsible for improving antibiotic use at the hospital.	c. ○ Yes ○ No	
d. Act (at least one prescribing improvement action below) ○ Hospital has a policy that requires prescribers to document an indication for all antibiotics in the medical record or during order entry. ○ Hospital has hospital-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions. ○ There is a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g., antibiotic time out). ○ Hospital has specified antibiotic agents that need to be approved by a physician or pharmacist prior to dispensing at the hospital. ○ Physician or pharmacist reviews courses of therapy for specified antibiotic agents and communicates results with prescribers.	d. ○ Yes ○ No	
e. Track ○ Hospital monitors antibiotic use (consumption).	e. ○ Yes ○ No	
f. Report ○ Prescribers receive feedback by the stewardship program about how they can improve their antibiotic prescribing.	f. ○ Yes ○ No	
g. Educate ○ Stewardship program provides education to clinicians and other relevant staff on improving antibiotic use.	g. ○ Yes ○ No	

III. Systems to Detect, Prevent, and Respond to Healthcare-Associated Infections and Multidrug-Resistant Organisms (MDROs)		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
9. Hospital has occupational health program that, in addition to complying with state and federal requirements (e.g., OSHA), has policies regarding contact of personnel with patients when personnel have potentially transmissible conditions. Verify the following: a. The program has work-exclusion policies that encourage reporting of illnesses and do not penalize with loss of wages, benefits or job status. b. Personnel are educated regarding prompt reporting of illness to their supervisor and the occupational health programs.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	
10. Hospital follows recommendations of the Advisory Committee on Immunization Practices (ACIP) for immunization of healthcare personnel, including offering Hepatitis B and influenza vaccination.	○ Yes ○ No	
11. Hospital is compliant with mandatory reporting requirements for notifiable diseases, healthcare-associated infections (as appropriate), and potential outbreaks. Verify the following: a. Hospital can identify point(s) of contact at the local or state health department for HAI concerns.	○ Yes ○ No a. ○ Yes ○ No	
12. Hospital implements infection control measures relevant to construction, renovation, demolition, and repairs including performance of an infection control risk assessment (ICRA) before a project gets underway. Verify the following: a. IP program is consulted anytime construction, renovation, demolition, or repairs will be performed. b. ICRA elements are included in all contracts related to construction, renovation, demolition, and repairs.	○ Yes ○ No a. ○ Yes ○ No b. ○ Yes ○ No	

Section 3: Direct Observation of Facility Practices (optional)

Certain infection control lapses (e.g., reuse of syringes on more than one patient or to access a medication container that is used for subsequent patients; reuse of lancets) can result in bloodborne pathogen transmission and should be halted immediately. Identification of such lapses warrants appropriate notification and testing of potentially affected patients.

Examples of Auditing Tools for Direct Observations:

- ◻ General Infection Control

  Centers for Medicare & Medicaid Services Hospital Infection Control Worksheet: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-1.pdf

  Auditing checklists available for observations of:

  - ◻ Hand hygiene
  - ◻ Injection safety
  - ◻ Personal protective equipment use
  - ◻ Environmental services
  - ◻ Equipment reprocessing (non-critical, semi-critical, critical reusable and single-use devices)
  - ◻ Indwelling urinary catheter insertion and maintenance
  - ◻ Central venous catheter insertion and maintenance
  - ◻ Ventilator/respiratory therapy
  - ◻ Spinal injection procedures
  - ◻ Point of care devices
  - ◻ Transmission-based precautions (Contact, Droplet, Airborne)
  - ◻ Surgical procedures

- ◻ Hand Hygiene Auditing Tools

  - ◻ Measuring Hand Hygiene Adherence: Overcoming the Challenges: http://www.jointcommission.org/assets/1/18/hh_monograph.pdf
  - ◻ iScrub: http://compepi.cs.uiowa.edu/index.php/Research/IScrub

- ◻ Personal Protective Equipment (PPE) Donning and Doffing

  - ◻ CDC Sequence for Donning and Removing Personal Protective Equipment http://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf

- Urinary Catheter Appropriate Use, Insertion, and Maintenance
  - American Nurses Association CAUTI Prevention Tool: http://nursingworld.org/CAUTI-Tool
  - CDC TAP CAUTI Toolkit Implementation Guide: http://www.cdc.gov/hai/prevent/tap/resources.html
- Central Venous Catheter Appropriate Use, Insertion, and Maintenance
  - CDC Checklist for Prevention of Central Line-Associated Blood Stream Infections: http://www.cdc.gov/HAI/pdfs/bsi/checklist-for-CLABSI.pdf
  - AHRQ Tools for Reducing CLABSI: http://www.ahrq.gov/professionals/education/curriculum-tools/clabsitools/index.html
- Safe Injection Practices
  - Injection Safety Checklist: http://www.oneandonlycampaign.org/sites/default/files/upload/pdf/Injection%20Safety%20Checklist-508.pdf
- Environmental Infection Control
  - CDC Environmental Checklist for Monitoring Terminal Cleaning: http://www.cdc.gov/HAI/toolkits/Environmental-Cleaning-Checklist-10-6-2010.pdf
  - CDC Environmental Cleaning Evaluation Worksheet: http://www.cdc.gov/HAI/toolkits/Evaluating-Environmental-Cleaning.html
  - Infection Control Risk Assessment (ICRA) Matrix of Precautions for Construction & Renovation: http://www.ashe.org/advocacy/organizations/CDC/pdfs/assessment_icra.pdf

Section 4: Infection Control Guidelines and Other Resources

- General Infection Prevention
  - CDC/HICPAC Guidelines and recommendations: http://www.cdc.gov/HAI/prevent/prevent_pubs.html
- Facility Infection Risk Assessment
  - Infection Prevention Annual Report and Plan: http://apicchapter26.org/Data%20files/Minutes%202011/IC%20Risk%20Assessment%20guide.pdf
- Hand Hygiene
  - Guideline for Hand Hygiene in Healthcare Settings: http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf
  - Hand Hygiene in Healthcare Settings: http://www.cdc.gov/handhygiene
- Personal Protective Equipment
  - 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: http://www.cdc.gov/hicpac/pdf/isolation2007.pdf
  - Guidance for the Selection and Use of Personal Protective Equipment in Healthcare Settings: http://www.cdc.gov/HAI/prevent/ppe.html
- Catheter-associated Urinary Tract Infection (CAUTI)
  - Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009: http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf
- Central line-associated Bloodstream Infection (CLABSI)
  - Guideline for Prevention of Intravascular Catheter-related Infections, 2011: http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf
- Ventilator-associated Event (VAE)
  - Guidelines for Preventing Healthcare-associated Pneumonia, 2003: http://www.cdc.gov/hicpac/pdf/guidelines/CDCpneumo_guidelines.pdf
- Surgical Site Infection (SSI)
  - Guidelines for the Prevention of Surgical Site Infection, 1999: http://www.cdc.gov/hicpac/pdf/guidelines/SSI_1999.pdf
- Safe Injection Practices
  - 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf
  - CDC Injection Safety Web Materials: http://www.cdc.gov/injectionsafety

- CDC training video and related Safe Injection Practices Campaign materials: http://oneandonlycampaign.org

- *Clostridium difficile* Infection (CDI) and Multidrug-Resistant Organisms (MDRO), including antimicrobial stewardship
  - 2012 CRE Toolkit – Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE): http://www.cdc.gov/hai/organisms/cre/cre-toolkit/
  - 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf
  - Management of Multi-Drug Resistant Organisms in Healthcare Settings, 2006: http://www.cdc.gov/hicpac/pdf/guidelines/MDROGuideline2006.pdf
  - SHEA-IDSA Strategies to Prevention *Clostridium difficile* Infections in Acute Care Hospitals: 2014 Update: http://www.jstor.org/stable/10.1086/676023
  - SHEA-IDSA Guideline: http://www.cdc.gov/HAI/pdfs/cdiff/Cohen-IDSA-SHEA-CDI-guidelines-2010.pdf
  - CDC's Core Elements of Hospital Antibiotic Stewardship Program: http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html
  - CDC Implementation Resources for Antibiotic Stewardship: http://www.cdc.gov/getsmart/healthcare/implementation.html
  - EPA Listing of disinfectant products with sporicidal activity against *C. difficile*: http://www.epa.gov/oppad001/list_k_clostridium.pdf

- Environmental Infection Control, including Infection Control Risk Assessment (ICRA)
  - Guidelines for Environmental Infection Control in Healthcare Facilities: http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf
  - 2014 Facility Guidelines Institute (FGI) Guidelines for Hospitals and Outpatient Facilities: http://www.fgiguidelines.org/guidelines2014_HOP.php

- Equipment Reprocessing
  - Guideline for Disinfection and Sterilization in Healthcare Facilities: http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf
  - FDA regulations on reprocessing of single-use devices: http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm071434

- Point-of-Care Testing
  - Infection Prevention during Blood Glucose Monitoring and Insulin Administration: http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html
  - Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration: http://www.cdc.gov/injectionsafety/providers/blood-glucose-monitoring_faqs.html

- Respiratory Hygiene/Cough Etiquette
  - 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf
  - Recommendations for Preventing the Spread of Influenza: http://www.cdc.gov/flu/professionals/infectioncontrol/
- Healthcare Personnel Safety
  - Guideline for Infection Control in Healthcare Personnel: http://www.cdc.gov/hicpac/pdf/InfectControl98.pdf
  - Immunization of Healthcare Personnel: http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html
  - Occupational Safety & Health Administration (OSHA) Bloodborne Pathogen and Needlestick Prevention Standard: https://www.osha.gov/SLTC/bloodbornepathogens/index.html
  - Hospital Respiratory Protection Program Toolkit: http://www.cdc.gov/niosh/docs/2015-117/pdfs/2015-117.pdf
- Resources to assist with evaluation and response to breaches in infection control
  - Patel PR, Srinivasan A, Perz JF. Developing a broader approach to management of infection control breaches in health care settings. Am J Infect Control 2008;36(10):685-90.
  - Steps for Evaluating an Infection Control Breach: http://www.cdc.gov/hai/outbreaks/steps_for_eval_IC_breach.html
  - Patient Notification Toolkit: http://www.cdc.gov/injectionsafety/pntoolkit/index.html

Healthcare Quality Reporting Program

HAND HYGIENE AGREEMENT

2015

Hospital Hand Hygiene Policy Elements

All acute-care hospital hand hygiene policies must meet, at a minimum, the National Patient Safety Goals for hand hygiene as determined by the Joint Commission (NPSG.07.01.01[1]); including following the guidelines of either the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO), setting goals for improving hand hygiene and using those goals to improve hand cleaning. Further, all policies must include:

Audits

Monitoring should be done in multiple locations throughout the hospital, including surgical services and specialty departments, should be done during more than one shift and should include different healthcare worker groups (e.g., nurses, physicians, allied health professionals)

Corrective Action Plan

Hospital hand hygiene policies should include a corrective action plan for individual non-compliance among employed and non-employed healthcare workers

Audit and Feedback

Results of audits should be shared with all healthcare workers, leadership and infection prevention staff

Education

Hand hygiene education should be required for all health care workers on hire, during initial credentialing or at assignment

Goals

All hospitals should have clearly defined goals for improving hand hygiene that are assessed annually and that aim for demonstrating progressive improvement

Joint Commission. They are also required to submit to this program documentation of any mitigation plan developed related to that deficiency. This information will not be publically reported.

[1] Joint Commission, 2015 Hospital National Patient Safety Goals. http://www.jointcommission.org/assets/1/6/2015_HAP_NPSG_ER.pdf Accessed September 30, 2015.

Hospital Reporting Requirements

Policy Elements

Hospitals are required to attest on an annual basis that their policies meet these requirements. These attestations are to be made to the Healthcare Quality Reporting Program. This program maintains the right to require hospitals to submit proof of compliance in the form of up-to-date documentation of hospital policies. This program also reserves the right to publicly report whether hospitals have met these requirements.

Hospital Goals

On an annual basis, hospitals are required to submit documentation of their hand hygiene goal(s) and their plan for meeting their goal(s). At this time hospitals will also be required to attest to whether their goals from the previous year have been met. Hospitals that have not met their stated goal(s) will be required to submit to the Healthcare Quality Reporting Program data related to the stated goal(s) and possible reasons for not meeting the goal(s).

Hospital Deficiencies

Hospitals are required to submit to the Healthcare Quality Reporting Program any deficiencies related to hand hygiene that they have received from either the CDC or The Joint Commission.

Public Reporting

This program reserves the right to publicly report on an annual basis whether hospitals have met the terms of this agreement. The design of this report will be determined by the appropriate committees of the Healthcare Quality Reporting Program.

Hospital Acknowledgement

I, _____, as Chief Executive Officer for

_____ acknowledge the above requirements and agree to support my facility's staff and healthcare workers in meeting these requirements.

_____ _____

Signature Date

I, _____, as Chief of Medical Staff for

_____ acknowledge the above requirements and agree to support my facility's staff and healthcare workers in meeting these requirements.

_____ _____

Signature Date

DRAFT