CMS Infection Control Worksheet

- CMS has three final worksheets
- Addresses discharge planning, infection control (IC), and QAPI (performance improvement)
- Final ones issued November 26, 2014
- Has a section on safe injection practices and antibiotic stewardship
- Every hospital should review this and be familiar with its content and use as a self assessment tool
Hospitals should be familiar with the three worksheets and IC one is 49 pages

Will use whenever a validation survey or certification survey is done at a hospital by CMS

CMS says worksheets are used by State and federal surveyors on all survey activity in assessing compliance with any of the three CoPs

Hospitals are encouraged by CMS to use the worksheet as part of their self-assessment tools which can help promote quality and patient safety
And of course completing the forms helps the hospital to comply with those three CoPs.

Citation instructions are provided on each of the worksheets.

The surveyors will follow standard procedures when non-compliance is identified in hospitals.

This includes documentation on the Form CMS 2567.

Not used in CAH but good tool for CAH to use.

Questions to: hospitalscg@cms.hhs.gov
- Some of the questions asked might not be apparent from a reading of the CoPs
- So the worksheets are a good communication device
- It helps to clearly communicate to hospitals what is going to be asked in these 3 important areas
- Hospitals might want to consider putting together a team to review the 3 worksheets and complete the form in advance as a self assessment
- Hospitals should consider attaching the documentation and P&P to the worksheet

- This would impress the surveyor when they came to the hospital
- The worksheet is used in new hospitals undergoing an initial review and hospitals that are not accredited who are suppose to have a CMS survey every three or so years
  - The Joint Commission (TJC), American Osteopathic Association (AOA) Healthcare Facility Accreditation Program, CIHQ, (Center for Improvement in Healthcare Quality) or DNV Healthcare are the 4 AOs with deemed status
- It would also be used for hospitals undergoing a validation survey by CMS
First part of infection control worksheet includes identification information

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

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

- It will ask for the name hospital, CCN number, and date of survey

Is 49 pages long

- Asks for demographics as discussed previously such as hospital name, address, CCN number, etc.

- Starts out with a list of elements that need to be assessed with a yes, no, or N/A box

- Section one discusses the infection control (IC) prevention program and IC resources

- Does the hospital have an infection preventionist (IP)?

- Is there evidence IP is qualified?
Module 1, the first section addresses the hospital’s infection control program and resources

Does the hospital have an infection preventionist (IP)? (Tag 748)

- Must show evidence that the IP is qualified through education, training, experience or certification
- Many hospitals prefer IP to be CIC or certified in infection control
- Can the IP provide evidence that IC P&P are based on nationally recognized guidelines and consistent with state or federal law
### Module 1: Infection Prevention Program

#### Section 1.A. Infection Prevention Program and Resources

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.A.1 The hospital has designated one or more individual(s) as its Infection Control Officer(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.A.2 The hospital has evidence that demonstrates the Infection Control Officer(s) is qualified and maintain(s) qualifications through education, training, experience or certification related to infection control consistent with hospital policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.A.3 The Infection Control Officer(s) can provide evidence that the hospital has developed general infection control policies and procedures that are based on nationally recognized guidelines and applicable state and federal law.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no to any of 1.A.1 through 1.A.3, (Re at 42 CFR 483.82[e]) (Tag A-798)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.A.4 The Infection Control Officer can provide an updated list of diseases reportable to the local and/or state public health authorities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.A.5 The Infection Control Officer can provide evidence that hospital complies with the reportable diseases requirements of the local health authority.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No citation risk for questions 1.A.4 and 1.A.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.A.6 The hospital has infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, including the requirement for an infection control</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Competency in infection prevention: A conceptual approach to guide current and future practice**

Professional competency has traditionally been divided into 3 essential components: knowledge and skill, more recent definitions have recommended additional components such as communication, values, reasoning, and teamwork. A coherent, viable acceptable comprehensive definition remains an elusive goal. The elements of professional competency are often described as the 6 P’s of professional education, which does not have reference to the importance of these factors. The Association for Professionals in Infection Control and Epidemiology, Inc. made a strategic commitment to develop a conceptual model of IP competency that could be applicable in all practice settings. The new model is being developed in collaboration with the Association for Professionals in Infection Control and Epidemiology, Inc. model will complement similar competency efforts across the country.

- Can the IP provide a list of the current diseases reportable to the local or state health department?
  - Can the IP provide evidence that the hospital is complying with the disease reporting requirements? (748)

- The hospital has P&P on:
  - Construction and renovation
  - Maintenance and repair
  - Demolition
  - Must include IC risk assessment to define scope of project
  - Must include need for barrier measures before starting
- Infection control starts when the hospital itself is built or renovated
- APIC has its Infection Prevention Manual for Construction and Renovation 2015
- Offers tips for infection preventionists during construction
  - Has 11 chapters and helps education hospital administration on the importance of infection control during construction
  - APIC does charge a fee for the manual

The next section is about the hospital QAPI system related to Infection Prevention

- The Infection Preventionist can provide evidence that problems identified in the IC program are addressed in QAPI program (286)
  - Was there a corrective action plan?
  - Was there evaluation of the interventions for both success and sustainability?
- Does CEO, MS, and CNO ensure successful corrective plan in problem areas? (756)
- Is risk assessment process used to prioritize quality indicators in IC? (267)
### Section 1.B. Hospital QAPI Systems Related to Infection Prevention

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital infection prevention program is coordinated into the hospital QAPI program as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>1.B.1 The infection control officer(s) can provide evidence that problems identified in the infection control program are addressed in the hospital QAPI program i.e., development and implementation of corrective interventions, and ongoing evaluation of interventions implemented for both success and sustainability.</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1.B.2 Hospital leadership, including the CEO, Medical Staff, and the Director of Nursing Services ensures the hospital implements successful corrective action plans in affected problem area(s).</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1.B.3 The hospital utilizes a risk assessment process to prioritize selection of quality indicators for infection prevention and control.</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

### Infection Control

**RISK ASSESSMENT AND PRIORITIZATION WORKSHEET**

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

**RISK ASSESSMENT AND PRIORITIZATION WORKSHEET**

<table>
<thead>
<tr>
<th>Event</th>
<th>Conditions and Problems</th>
<th>What is the potential impact of this condition/problem on patients, staff, and visitors?</th>
<th>What is the probability of this condition/problem impacting patients and staff?</th>
<th>What is your organization's preparedness to deal with this condition/problem?</th>
<th>Numerical risk level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>High (5)</td>
<td>Med (4)</td>
<td>Low (3)</td>
<td>None (2)</td>
</tr>
<tr>
<td>Latex risk</td>
<td></td>
<td></td>
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<tr>
<td>Indoor air contaminates</td>
<td></td>
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<tr>
<td>Sharps Injury</td>
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<tr>
<td>Flu Vaccine Non-Compliance</td>
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<tr>
<td>Compliance with isolation</td>
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<tr>
<td>Biological Exposure</td>
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<tr>
<td>Gas or vapor exposure</td>
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<td>Radiation Exposure</td>
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<tr>
<td>Asbestos Exposure</td>
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<tr>
<td><strong>ENVIRONMENT:</strong></td>
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<tr>
<td>Major biohazard spill</td>
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<tr>
<td>Improper clearing of environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ineffective pre-construction planning (risk assessment)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Water Intrusion</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Exposure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SUPPLIES/EQUIPMENT:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improper cleaning or disinfection of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IP Tools**

**LOOKING FOR RESOURCES AND A PLACE TO COLLABORATE WITH OTHER IPs?**

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

[join thousands of users](www.infectionpreventiontools.com/) from 53 different countries who are visiting and accessing these tools and resources.

---

[www.infectionpreventiontools.com/](www.infectionpreventiontools.com/)
The next section is on systems to prevent the transmission of MDRO and promote antibiotic (antimicrobial) stewardship (1 C)

- MDRO is multidrug-resistant organisms such as C-diff, MRSA, or VRE
- Hospital has P&P to minimize risk of transmission of a targeted MDRO? (Yes or No boxes) (749)
- Is there a system in place to identify patients with MDRO so staff know and before moving patients?
  - And to notify facilities before patient is transferred out?

Microorganisms, predominantly bacteria that are resistant to one of more classes of antimicrobial agents

- MRSA - Methicillin-resistant Staphylococcus aureus
- VRE- Vancomycin Resistant Enterococcus
- MDRSP-Multidrug-resistant Streptococcus Pneumoniae
- MDR- GNB- Multidrug-resistant Gram-negative Bacilli
- C-diff- Clostridium difficile
### Section 1.C. Systems to Prevent Transmission of MDROs and Prf Stewardship

#### Elements to be assessed

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.C.1 The hospital has policies and procedures to minimize the risk of development and transmission of multidrug-resistant organisms (MDROs) within the hospital (applicable to all persons in the hospital).</td>
<td>☐ Yes  ☑ No</td>
</tr>
<tr>
<td>1.C.2 Systems are in place to designate patients known to be colonized or infected with a targeted MDRO and to notify receiving units and personnel prior to movement of such patients within the hospital.</td>
<td>☐ Yes  ☑ No</td>
</tr>
<tr>
<td>1.C.3 Systems are in place to designate patients known to be colonized or infected with a targeted MDRO and to notify receiving healthcare facilities and personnel prior to transfer of such patient between facilities.</td>
<td>☐ Yes  ☑ No</td>
</tr>
</tbody>
</table>

---

- Hospital needs to have a list of targeted MDRO for infection control such as MRSA or VRE
- References the CDC’s isolation guidelines except for the Ebola Virus Disease standards in it are superseded by CDC’s new information
  - Which contain 10 safe injection practices
  - Need to justify any important bugs not on their list
  - What criteria was used to determine their list
  - Process to make sure IP is notified if novel resistance pattern is detected
2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

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

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


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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: February 13, 2015
TO: State Survey Agency Directors
FROM: Director, Survey and Certification Group
SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) and Ebola Virus Disease (EVD) – Questions and Answers (Q&A)

Memorandum Summary

EMTALA & Ebola Requirements:
- On November 21, 2014 the Centers for Medicare & Medicaid Services (CMS) Survey & Certification Group released SC 15-10-Hospitals concerning EMTALA Requirements and Implications Related to the EVD.
- The CMS has received follow-up questions regarding EMTALA and Ebola and has produced a Q&A document in response.

The CMS released S&C 15-10 on November 21, 2014 to provide guidance to hospitals and critical access hospitals (CAHs) regarding meeting EMTALA requirements in the case of individuals potentially exposed to Ebola. The memo is available via the following link:
There are many free toolkits online for MDRO and CDC has tons of excellent resources at www.cdc.gov/nhsn/ such as MDRO modules.

AHRQ has a free toolkit for C-diff Infection Through Antimicrobial Stewardship.

APIC has many resources including guide to prevent C-diff which is increasing in hospitals.

The CDC has a special publication on “Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006”¹

Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006


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

Acknowledgement:
The authors and HICPAC gratefully acknowledge Dr. Larry Strausbaugh for his many contributions and valued guidance in the preparation of this guideline.
Multidrug-resistant Organism and Clostridium difficile Infection (MDRO/CDI) Module

MDRO, C. difficile Infection Surveillance and LabID Event Reporting
- Course description
- MDRO and CDI Module Protocol Changes for 2015 [Video - 10 min]
  - YouTube link
  - CDC Streaming Video

Prevention Process and Active Surveillance Testing Outcome Measures
- Course description
- Prevention Process and Active Surveillance Testing Outcome Measures - Video [WMV - 3.57MB]

Guide to Preventing Clostridium difficile Infections


www.apic.org/Professional-Practice/Implementation-guides
Are patients with targeted MDRO identified?
  - Are they placed in contact isolation?

Does the hospital have written P&P to improve antibiotic use (antibiotic stewardship)?

Does the hospital have a leader responsible for program outcomes of antibiotic stewardship activities?
  - Such as a physician or pharmacist
- Is an indication for each antibiotic documented in the medical record along with duration?
- Does hospital have formal procedure to review appropriateness of antibiotics prescribed after 48 hours from the initial orders (antibiotic time out)
- Does the hospital monitor antibiotic use at the unit and hospital level?

- The next section involves Infection Prevention education and training
- Do staff receive job specific training on hospital IC P&P, practices in orientation and at regular intervals?
- Are staff trained that come into contact with bloodborne pathogens and on the OSHA bloodborne pathogen standard in orientation and when problems are identified?
### Section 1.D. Infection Prevention Systems, and Training Related to Personnel

<table>
<thead>
<tr>
<th>Elements to be observed</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0.1. Personnel hired, leased or retained by IC personnel to perform activities to prevent transmission of bloodborne pathogens, must be trained in the use of PPE, including gloves, gowns, and face masks.</td>
<td>Yes / No</td>
</tr>
<tr>
<td>1.0.2. The training of individuals likely to be exposed to bloodborne pathogens must include their role in the bloodborne pathogen control program.</td>
<td>Yes / No</td>
</tr>
<tr>
<td>1.0.3. The training of employees is performed on an annual basis and includes topics such as how to recognize and prevent transmission of bloodborne pathogens through the use of PPE.</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

**Notes:**
- An exposure incident refers to a specific exposure, such as a mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of all individual's duties.
- The institution includes in-service training, training sessions, and training materials to ensure that all personnel are aware of the OSHA standard (29 CFR 1910.1030) upon hire, for those with negative results, determine ongoing TB screening criteria, if required.
- Infection control system addresses needle stick, sharps injuries, and employee exposure events?

- Is there a post-exposure evaluation and follow-up, including prophylaxis following an exposure event?

- Does the hospital track staff exposure events and evaluate the information and develop corrective action plans to reduce the incidence?
Post Exposure Prophylaxis (PEP)

Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis

Authors: David T. Kuhar, MD; David K. Henderson, MD; Kimberly A. Struble, PharmD; Wald Heneine, PhD; Vasavi Thomas, RPh, MPH; Laura W. Chesner, MD; So-Mi Ahmed Gomas, MD, ScD; MSPH; Adela I. Panililo, MD and for the US Public Health Service Working Group

Source: Infection Control and Hospital Epidemiology, Vol. 34, No. 9 (September 2013), pp. 875-892

Published by: The University of Chicago Press on behalf of The Society for Healthcare Epidemiology of America

Stable URL: http://www.jstor.org/stable/10.1086/672271

Accessed: 21/12/2014 00:24

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CDC Website Postexposure Prophylaxis

www.cdc.gov/hepatitis/HBV/PEP.htm

www.cdc.gov/hepatitis/HBV/PEP.htm
Are all staff screened for TB upon hire?

- Those with negative then determine ongoing TB screening based on risk classification
- Risk classification needs to be periodically reviewed by IP to determine if any changes need to be made

Does the facility ensure healthcare personnel with TB test conversions are provided with appropriate follow-up
Tuberculosis (TB) is a disease caused by a bacterium called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidneys, heart, brain, or spine. If not treated properly, TB disease can be fatal. TB disease was once the leading cause of death in the United States.

Topics
- Basic TB Facts
- Testing & Diagnosis
- Treatment
- Infection Control & Prevention
- Publications & Products

TB 101 for Healthcare Workers

CDC TB Website and Resources

www.cdc.gov/tb/webcourses/TB101/default.htm

TB 101 for Health Care Workers

This course was developed in partnership with:
- Curry International Tuberculosis Center
- Inghambard National Tuberculosis Center
- New Jersey Medical School Global Tuberculosis Institute
- Southeastern National TB Center

Contact Us:
- Centers for Disease Control and Prevention
- Division of Tuberculosis Elimination (DTBE)
- 1600 Clifton Rd., NE
- Atlanta, GA 30333
- 800-CDC-INFO
- (800) 338-6399
- TTY: (888) 232-5544
- Contact CDC-INFO

TB 101 for Health Care Workers - Continuing Education

The Centers for Disease Control and Prevention is accredited to provide continuing education for various professions. Continuing Education (CE) is offered free of charge.
- Is there a respiratory protection program that details required worksite-specific procedures and elements for required respirator use?
- Does it ensure annual respiratory fit testing at least annually to appropriate staff?
- Is there P&P concerning contact of staff with patients with transmissible conditions?
- Do these P&P provide education or the need for prompt reporting of illnesses to supervisor or occupational health?

- Are staff competent and compliant with IC P&P and ensured through training and when problems are identified? (756)
- Is Hepatitis B vaccine given to those with occupational exposure including screening after 3rd dose of vaccine is given? (756)
- Is it documented that all staff have evidence of immunity to measles, mumps, and rubella
• Tdap is given to all staff not previously given?
  • Tdap stands for Tetanus, Diphtheria and acellular Pertussis
  • After Tdap HCP should receive Td for future immunizations
• Is it documented that all staff have immunity to varicella (chicken pox)?
• Are all staff offered an annual flu shot?

• The next section is on hand hygiene which is very important to both CMS and Joint Commission
  • This is to be followed on all hospitals units including CCU, ED, L&D, radiology, and endoscopy units
  • Hand hygiene (HH) must be done in a manner consistent with IC practices and P&Ps to include the following”
  • Soap, water, alcohol based hand rub (ABHR) and sinks are accessible in patient care areas
Module 2: General Infection Prevention Elements - to be applied to all locations providing patient care

Section 2.A. Hand Hygiene

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene is performed in a manner consistent with hospital infection control policies, and procedures to minimize the prevention of communicable disease including the following:</td>
<td>Yes</td>
</tr>
<tr>
<td>Soap, water, and a sink must be accessible in appropriate locations including, but not limited to, patient care areas and food and medication preparation areas.</td>
<td>Yes</td>
</tr>
<tr>
<td>Medications should not be prepared near areas of splashing water (e.g. within 3 feet of a sink). Alternately when space is limited, a splash guard can be mounted beside the sink.</td>
<td>Yes</td>
</tr>
<tr>
<td>Is Alcohol-based hand rub readily accessible and placed in appropriate locations. The locations may include:</td>
<td>Yes</td>
</tr>
<tr>
<td>Entrance to patient rooms,</td>
<td>Yes</td>
</tr>
<tr>
<td>At the bedside,</td>
<td>Yes</td>
</tr>
<tr>
<td>In individual pocket-sized containers carried by healthcare personnel,</td>
<td>Yes</td>
</tr>
<tr>
<td>Staff workstations, and/or</td>
<td>Yes</td>
</tr>
<tr>
<td>Other convenient locations.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal perform hand hygiene:</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before contact with the patient</td>
<td>Yes</td>
</tr>
<tr>
<td>Before removing or putting on personal protective equipment</td>
<td>Yes</td>
</tr>
</tbody>
</table>

- Soap, water, and a sink must be accessible in patient care areas, food, and medication preparation areas
  - Medications should not be prepared within 3 feet of a sink
  - If space is limited then splash guard can be mounted on side of sink
- Is Alcohol-based hand rub readily accessible and in appropriate locations
  - Staff workstations, entrance to patient rooms, at the bedside and in individual pocket sized containers carried by staff
Hand Hygiene (HH) must be done before contact with patient even if gloves are worn (749)

- Before performing an aseptic task (749)
  - Such as starting an IV, putting in a foley and even if gloves are worn
  - If patient with C-Diff or Norovirus use soap and water

- Before leaving patient care area after touching patient or immediate environment

- After contact with blood or body fluids and even if gloves are worn and after removing gloves

- Direct care givers cannot wear artificial nails (749)

Note, that in two places the CMS infection control worksheet states soap and water should be used with patients with C-diff or norovirus

- Not exactly what the CDC and SHEA says

- "Several guidelines recommend the use of gloves and washing with soap and water rather than alcohol bashed hand rubs for mechanical removal of spores from hands in all setting. (contains references) whereas SHEA guidelines advocate hand washing only during outbreaks...."
CDC published guidelines Oct 25, 2002 at www.cdc.gov/handhygiene/

In CDC MMWR Recommendations and Reports,

Report available at www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm or go to www.cdc.gov,

TJC published document in 2009 on Measuring Hand Hygiene Adherence: Overcoming the Challenges and this is an important document,

Monitored during infection control tracer,
WHO Guidelines on Hand Hygiene in Health Care

First Global Patient Safety Challenge
Clean Care is Safer Care

HAND HYGIENE ADHERENCE:
OVERCOMING THE CHALLENGES

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

- The Association for Professionals in Infection Control and Epidemiology, Inc.
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