



Pennsylvania
Department of Health

September 2025

Common Mistakes Identified During Infection Control Plan Review

Bureau of Epidemiology

Healthcare Associated Infection Prevention (HAIP) Division

Infection Control Plan Review Team

Objectives

- **Identify common issues encountered by Pennsylvania Department of Health (DOH) Infection Control (IC) Plan reviewers**
- **Understand solutions to move IC Plans through the approval process in a timely manner**



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TITLE

Infection Control Plan Title Information

Include the document name (e.g., Infection Control Plan).

Avoid using facility nicknames or legal names (if different from the working name).
Example:
Legal Name Smith County Surgery Center, LLC
Working Name Surgery Center at Smith Place

Surgery Center at Smith Place
Infection Control Plan 2025
Infection Control Committee Approval Date: pending

Introductory Statement

The infection control plan (IC plan) contains high-level details of the facility’s infection prevention and control program (IP&C), laying out the framework for the detection, prevention, and control of health care associated infections (HAI), and disease transmission among patients, visitors and health care personnel (HCP) (e.g., staff, providers, contractors, volunteers, and students). The IC plan meets the requirements detailed in the Medical Care Availability and Reduction of Error Act (MCARE) of 2002 (amended in 2007), and other applicable laws in alignment with nationally recognized standards and evidence-based practice guidelines.

Scope

All HCP are responsible for adhering to the IC plan, policies, and processes regardless of their position.

Risk Assessment

The facility performs an annual risk assessment (RA) to assess and identify risks for acquiring and/or transmitting infections, prioritizes them, and then develops strategies to mitigate or eliminate the risks. Prioritized risks are also used to develop specific/measurable annual IP&C goals that are included in the RA.

Include the calendar or fiscal year that the plan represents.

Include the date of Infection Control Committee (ICC) approval for your IC Plan (can be “pending” if ICC has not yet approved).



Find the Goldilocks Zone

There are no length requirements for an IC Plan. However, a review of the length can provide insight into the edits that may be required for approval. The average length of approved IC Plans is 15-25 pages in length.

Too Long

Copied information from infection control policies and procedures, the law, or Pennsylvania code.

Too Short

Missing elements from the [Medical Care Availability and Reduction of Error \(MCARE\) Act](#) and other applicable laws.

Just Right

Utilized the facility specific outline resource from the [DOH Healthcare Professionals Resource website](#).



LENGTH

Too Long

- Copying and pasting information from existing policies or codes is redundant.
 - Creates opportunity for misalignment between policies and the IC plan.
- Summarize your program while still capturing the elements required by MCARE and other applicable laws.



Hand Hygiene

Hand hygiene is the single most important measure for reducing the risk of the spread of infection. Hand hygiene is part of standard precautions and can reduce the transmission of HAIs to patient/ resident and employees. Hand hygiene includes either handwashing with soap and water or the use of alcohol-based hand sanitizer products.

CDC recommends the use of alcohol-based hand sanitizer as the first line of defense in most cases except when hands are visibly soiled, sticky or grossly contaminated and when leaving a *C. difficile* patient/ resident room. Hand sanitizer should contain at least 60% alcohol (ethyl or isopropanol)

Handwashing with soap and water:

- Wet hands and wrists with water
- Apply soap and lather using a rotating motion and friction to adequately clean surfaces including the backs of the hands and fingernails for at least twenty (20) seconds; do not put hands back under water during friction rub
- Rinse hands from wrists to fingers holding hands in a downward position under running water
- Dry hands with a paper towel
- Turn off water with paper towel and without touching the contaminated faucet with hands

Use antimicrobial or non-antimicrobial soap and water:

- When hands are visibly soiled
- After contact with blood or body fluids
- Before and after eating or handling food
- After personal use of the toilet
- Before and after assisting a patient/ resident with toileting
- After contact with a patient/ resident infected with diarrhea including but not limited to infections cause by norovirus, salmonella, shigella, and *C. difficile*
- After performing own personal hygiene
- Before entering and upon leaving isolation precaution settings

Handwashing with soap and water is performed as soon as feasible in cases of gross contamination to adequately flush contaminated material from skin.

Alcohol-Based Hand Sanitizer

Alcohol-based hand sanitizer may be used at the following times (except when hands are visibly soiled or when leaving the room of a patient/ resident who has *C. difficile* or during norovirus outbreak):

- Before having direct contact with patient/ resident
- After having direct contact with patient/ resident
- After having contact with body fluids, wounds or broken skin
- Before entering and exiting a patient/ resident room
- Before and after glove use
- Before inserting invasive devices
- After contact with objects and equipment in patient/ resident immediate vicinity
- After moving from contaminated body site to clean body site during patient/ resident care

Identify ways patient/ resident can communicate and interact with each other, families and friends.

- Provide ongoing monitoring that require infection control practices to be followed.
- Monitor hand hygiene supplies are stocked and available. Monitor proper hand hygiene technique.
- Assure employees are washing their hands:
 - Before and after activities
 - Before and after patient/ resident contact
 - Before and after serving food
 - After one-to-one visits
 - At the beginning and conclusion of a program

Too Short

Infection Control Plan
Last Approved Time: 01/01/1900

Policy:
Facilities shall establish and maintain an infection control program.

Objective:
To minimize and manage infections in our facilities. The following guidelines will be utilized to detect, control and prevent facility acquired infections.

Guidelines:

1. Each facility will establish a multidisciplinary Infection Control Committee that will include if applicable:
 - Medical Staff
 - Administration
 - Nursing Staff
 - Pharmacy Staff
 - Physical Plant Personnel
 - Members from the infection control team
 - Laboratory representative
 - The community
2. Under the program, the facility staff will:
 - a. Investigate, monitor, control, and prevent infections.
 - b. Maintain records of, and corrective actions related to infections.
 - c. Facilitate communication to community care giver/receiving health care facility regarding infections on the use of a transfer form or diagnosis sheet or discharge form.
 - d. Receive mandatory education annually on the facility Infection Control Plan. In addition, the facility Medical Director will be informed of the Infection Control Plan.
 - e. Designate personnel to monitor the facility infection control process.
 - f. Our facilities do not engage in active surveillance cultures of residents. Resident without clinical signs and symptoms of infection should not be cultured.
 - g. The Infection Control Committee has the authority to develop and implement policy within this facility.
 - h. This facility is committed to employing a designated Infection Control Preventionist. Staff will be provided with the most current information needed to maintain the highest level of care for our residents and staff. Educational opportunities regarding standards of practice will be made available. The facility is committed to purchase any needed manuals, periodicals, posters or memberships to ensure the highest level of care.
3. Upon admission to the facility a medical history and physical of the resident will document any knowledge of past Multi Drug Resistant Organism infections. When according to the Infection Control program guidelines, it is determined that a resident requires isolation to prevent the spread of infection, the facility shall isolate the resident only to the extent necessary to isolate the infecting organism and preserve resident dignity.
4. Culture surveillance processes are not mandated for multi drug resistant organisms (MDROs). Clinical symptoms may indicate a need for cultures as directed by the physician.
5. To facilitate appropriate use of antimicrobial agents, documentation of the resident's symptoms should be done prior to obtaining orders for treatment with antimicrobials.
6. The facility will report infections to the Department of Health and other required regulatory agencies as required by individual state regulations. In states that require electronic reporting, the facility will also report electronically to the Department of Health and Patient Safety Authority as directed. Procedures and precautions to deal with an outbreak

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including physical plant operations, maintenance department and housekeeping will be followed as per Exposure Control Plan. Refer to the Outbreak Plan and the Exposure Control Plan in the Infection Control Manual. 7. Employees shall be examined by a licensed physician or designee prior to employment and deemed free from communicable disease in a communicable state.

8. Employees with a communicable disease or infected skin lesions shall be prohibited from direct contact with residents or their food if direct contact will transmit the disease or infection. No surveillance of staff is currently required.

9. Standard precautions shall be always utilized, considering all blood and body fluids to be potentially infectious. The active and aggressive use of appropriate barriers to the transmission of disease is based on the interaction between staff, residents, visitors and the public rather than on a known diagnosis.

10. Hepatitis B vaccine shall be offered to all facility staff as defined by the Center for Disease Control (CDC).

11. Facility staff and residents will be initially screened for tuberculosis, utilizing a two-step process or initially screened by negative chest x-ray (except Maryland which requires two negative chest x-rays twelve months apart). 12. Staff shall be screened annually for tuberculosis using a one step process. Staff with positive reactions shall not be required to have additional chest x-rays unless symptomatic. Fluorogram review may be indicated.

13. Repeat skin tests shall be required for tuberculin negative employees and residents after any suspected exposure to a documented case of active tuberculosis.

14. Residents and staff will be offered the flu vaccine as recommended by the CDC. Education will be provided by the facility to enable residents and staff to make an informed choice regarding whether to receive the flu vaccine. 15. Residents and qualified staff will be offered the pneumococcal vaccine as recommended by the CDC. Education will be provided by the facility to enable residents and staff to make an informed choice regarding whether to receive the flu vaccine.

16. Other immunizations will be provided under the direction of a licensed physician.

17. The Administrator will be responsible for the posting of advisories from the Patient Safety Authority as required by individual state regulations.

18. Also refer to the Surveillance for Infections/Infectious Diseases policy.

19. Also refer to the Surveillance of Healthcare-Associated Infections (HAIs) policy.

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- Lacks the content required to meet the specific details in MCARE and other applicable laws.



MCARE and Other Applicable Laws

Federal Regulations

- [Occupational Safety and Health Administration \(OSHA\)](#)
- [Federal Conditions of Participation for Hospitals](#)
- [Conditions for Coverage for Ambulatory Surgery Centers \(ASCs\)](#)
- [Requirements for States and Long-Term Care Facilities \(LTCFs\)](#)

State Regulations

- [MCARE](#)
- [Health Care Facilities Act \(HCFA\)](#)
- [Pennsylvania Code for Reportable Diseases, Hospitals, ASCs, and LTCFs](#)

Other Regulations

- [County and local public health rules and regulations](#)
- [Current nationally recognized guidelines and evidence-based practices relevant to the facility](#)



Just Right

- Finding the Goldilocks zone is often the result of:
 - Using the IC Plan development resources from the [DOH website](#).
 - Engaging with the IC Plan reviewers via email or by attending Wednesday “office hours” [using the meeting information from the DOH website](#).



Using Available Resources

- If you are using a recently approved IC Plan that's been shared from another facility:
 - Review the entire plan to assure all existing content is revised to reflect services offered and practices used at your facility.
- If you are using the IC Plan development resources from the [DOH website](#):
 - Outlines are provided for each facility type (i.e., ASCs, hospitals, LTCFs), but each requires heavy editing to be facility specific. Review the key concepts at the beginning prior to utilizing this resource.



Attention to Language

The IC Plan should reflect the most current terminology being referenced in the industry.

For example:

- Health care Associated Infections (HAI) *instead of Hospital Acquired Infections*
- Hand Hygiene *instead of handwashing*
- Standard Precautions *instead of Universal Precautions*
- Patient Safety Authority's rolling online journal articles/advisories and annual Patient Safety Journal *instead of Patient Safety Authority Journal*
- Patient Safety Authority's "Training Manual and User's Guide Nursing Home Event Reporting" (adaptation of updated McGeer Criteria and CDC guidelines) *instead of revised McGeer Criteria*



Acronyms

If acronyms are utilized, they should be clearly defined the first time the term is introduced.

For example:

- Health care Associated Infections (HAI)
- Patient Safety Authority (PSA)
- Certification in Infection Control (CIC)
 - This refers to the credential issued by the Certification Board of Infection Control and Epidemiology after passing a standardized (proctored) test.



Correct Language

- Risks should be worded as risks rather than expectations. For example:
 - Inadequate performance of hand hygiene *instead of hand hygiene*
 - Lack of compliance with mandatory education *instead of staff completing education upon hire*
 - Improper transport of linen *instead of adherence to linen policies*
- Risk assessments should include at least 1 HAI-related risk.



Appropriate Scoring

- Probability of occurrence scores should never be zero.
 - If there is zero probability of a risk occurring at your facility, it does not need to be listed on your current risk assessment.
- Risk harm or level of failure scores should never be zero.
 - If an event is truly a risk, the potential for harm always exists. Scores should be based on the level of harm that could occur if the event happened, not the current potential for harm in the facility.



Facility Specific

- No two risk assessments should be alike.
 - There could be duplication in the risk events listed, but scoring should always be facility specific. Once risk levels are totaled, the highest scoring risks should have corresponding goals to show how the facility is attempting to mitigate those risks.
- Resources to assist you in making a facility specific risk assessment include:
 - [DOH Resources](#)
 - [University of North Carolina SPICE resource for LTC](#)



GOALS

Specific, Measurable, Achievable, Relevant, Time-bound (SMART)

- Goals should be SMART, facility specific, and related to the highest priority risks from your risk assessment.
- Goals can be captured in a separate worksheet/tab within the risk assessment, within the IC Plan itself or within an appendix of the IC Plan.



GOALS

Worksheet Format Example

- For this example, assume the risk event listed below had a total risk score that met or exceeded the threshold set by the facility for determining high priority risks.

Risk Event	Measurable Goal	Strategies for Improvement	Responsible Party	Annual Outcome
Lack of annual N95 fit testing	100% of staff will complete fit testing by December 2024	Send weekly reminders regarding fit testing. Offer additional opportunities including during annual influenza clinic. Follow-up with any employees that have incomplete fit testing by requiring completion prior to start of next working shift.	Infection Preventionist and Nurse Educator	

- At the end of the specified timeframe, the goal is reviewed, and any relevant information is captured under annual outcome. If a goal was not achieved and the event still presents a risk in the facility, strategies should be revised and a new timeline set.



Consistency

Choose a single term and/or abbreviation and use it consistently in the document.

Example variations:

- Preventionist – IP, IP professional, ICP, IC officer, IC nurse
- Plan – ICP, IC plan, IP plan, IPCP
- Program – IP, IPCP, IP program, IC program
- Department – IP department, IC department, IPC department
- Committees – IC Committee, ICC, IP&C Committee, QA Committee, QAPI



Summary



Make documents specific to your facility



Use appropriate resources



Be consistent with abbreviations



Align terminology with current industry standards



Support your risk assessment with SMART goals





Pennsylvania
Department of Health

THANK YOU

Contact RA-DHHA1@pa.gov with any
comments or questions.

All weblinks in this document were reviewed and active as of August 28, 2025.