Pennsylvania
Department of Health

INFECTION CONTROL PLAN OUTLINE FOR AMBULATORY SURGICAL FACILITIES

The Medical Care Availability and Reduction of Error (MCARE) Act of March 20, 2002, was amended in 2007 with the addition of Chapter 4 with guidance on reducing and preventing healthcare associated infections (HAI). The amendment includes provisions for Pennsylvania healthcare facilities (i.e., hospitals, ambulatory surgical facilities (ASFs), and long-term care facilities) to develop and implement a facility-specific infection control (IC) plan which must be submitted to and approved by the Pennsylvania Department of Health (PA DOH).

The PA DOH, Healthcare Associated Infection Prevention (HAIP) Division is providing the following *Infection Control Plan Outline For Ambulatory Surgical Facilities* (outline) **to help guide the creation or modification** of an ASF's IC plan. This outline provides topics that should be included in the IC plan. **However, outline content must be edited to address the targeted audience (i.e., facility staff) and provide an overview of IC processes and practices used at your facility.**

Requirements:

1. The IC plan must meet MCARE requirements, specifically detailed in Section 403 and other applicable laws as noted in Section 403 (b).
    a. Applicable laws include but may not be limited to the following:
        i. Pennsylvania Code: Ambulatory Surgical Facilities
        ii. Federal Code: Ambulatory Surgery Centers
        iii. Healthcare Facilities Act of 1979
        iv. OSHA Standards relevant to healthcare (e.g., bloodborne pathogens, personal protective equipment, respiratory protection)
2. The IC plan must align with current nationally recognized guidelines and evidence-based practices **relevant to the facility** (e.g., Association for the Health Care Environment (AHE), American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), Association of periOperative Registered Nurses (AORN), Association for Professionals in Infection Control and Epidemiology (APIC), American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), Centers for Disease Control & Prevention (CDC), Healthcare Sterile Processing Association (HSPA), Infectious Diseases Society of America (IDSA), Society for Healthcare Epidemiology of America (SHEA), World Health Organization (WHO)).
3. A completed, (i.e., scored) facility-specific infection control risk assessment (RA) must be included in the IC plan submission to the HAIP Division as an individual document, an appendix, or a table in the IC plan. The HAIP Division has several RA resources that can be found here.

Key Concepts For Utilizing This Outline:

1. The submitted IC plan and RA should be reflective of facility processes/services and the current fiscal/calendar year that they represent, which is often identified in the header or titling of the document.
2. The IC plan and RA should include a date of infection control committee (ICC) approval or a dating field showing a pending status for post-DOH ICC approval.
3. The IC plan should contain current terminology (e.g., hand hygiene vs. handwashing; standard precautions vs. universal precautions), defined abbreviations, functional links, and a reference section.
4. This outline includes lists of examples. When developing your IC plan, only examples relevant to your facility should be used.
5. This outline includes sample text in *italics* to describe what might be included in an IC plan. If used, sample text must be modified to align with facility processes and operations.
6. **Bold** text is used for emphasis or section headings.
7. Reference to relevant facility policies is applicable in all IC plan sections.

Recommended IC Plan Content/Structure:

1. **Title:**
    a. Include the facility name, document name (i.e., Infection Control Plan), and calendar/fiscal year that the IC plan represents in the header of the document.
    b. Consider including the ICC approval date at the beginning or end of the IC plan.
2. **Introductory Statement / Purpose**
    a. Provide the reason for the IC plan and what it is intended to accomplish. *Sample statements*:
        i. *The infection control (IC) plan contains high-level details of the facility's infection prevention & control program (IPCP), laying out the framework for the detection, prevention, and control of healthcare associated infections (HAI) and disease transmission among patients, visitors, and healthcare personnel (HCP) (e.g., staff, providers, contractors, volunteers, and students).*
        ii. *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.*
3. **Scope**
    a. Describe the scope of the IC plan. *Sample statement:*
        i. *All HCP are responsible for adhering to the IC plan, policies, and processes regardless of their position.*
4. **Facility Properties**
    a. If applicable, describe the facility's affiliation with a network/system, parent hospital, etc.
    b. Describe the patient population(s) served or excluded at the facility.
        i. Examples may include geriatrics, pediatrics, and high-risk populations (e.g., transplant patients, immunocompromised patients).
    c. Describe services provided at the facility including service types.
        i. Examples may include orthopedics, urology, endoscopy, plastics, high-risk procedures (e.g., total joint replacement), robotic use, onsite sterilization, and high-level disinfection reprocessing.
    d. Include building characteristics such as building descriptions, aging utilities, number of operating or procedure rooms, and room types (e.g., patient bays, consult room with closeable door).
5. **Infection Control Risk Assessment**
    a. Include a statement in the IC plan about the performance of an annual IPCP RA that considers potential facility-specific risks that increase the chance of infectious disease development or transmission among patients or HCP.
        i. Examples of risk categories include community, population served, facility infrastructure, staff competency, services offered, staff immunity, IC practice

compliance, invasive medical device use, multidrug-resistant organisms (MDRO) & communicable disease prevalence, and HAI prevalence.

b. Describe how the highest-scoring risks from the RA are used to develop annual IPCP goals (e.g., specific, measurable, achievable, relevant, time-bound goals) and strategies for goal achievement which are documented in the IC plan or other IPCP document (e.g., IPCP goal document, RA, IC plan appendix). *Sample statement:*
    i. *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 IPCP goals that are (insert one of the following: included in [insert title of document] / cataloged below)*
c. **A facility RA is not** a gap analysis, emergency preparedness all-hazard self-assessment, infection control assessment and response (ICAR) tool, or ICRA for construction.
d. Resources for developing a facility's IPCP RA:
    i. PA DOH Infection Control Risk Assessment Resource
    ii. PA-HAI recorded educational event

6. **Infection Prevention & Control Program Structure / Authority**

a. Describe how the facility's leadership supports and empowers the IPCP, ICC, and infection preventionists (IP). *Sample statement*:
    i. *[insert facility name]'s leadership supports the IPCP, infection control committee (ICC), and infection preventionist (IP) and is committed to patient safety, providing quality healthcare services, and preventing the transmission of infectious pathogens, diseases, and/or conditions.*
b. Authority
    i. Describe the governing body or facility leader who has full legal authority and responsibility for facility programs, operations, and services and how authority for IPCP oversight, implementation, and containment strategy duties are delegated.
        1. Include a statement that authority for oversight of the IPCP is given to the multidisciplinary ICC. *Sample statement:*
            a. *The governing body delegates authority for IPCP oversight to the ICC.*
        2. Include a statement that authority for the development, implementation, monitoring, and enforcement of the IPCP is given to the infection preventionist (IP). *Sample statement:*
            a. *The governing body delegates authority for IPCP development, implementation, monitoring, and enforcement to the IP.*
        3. Include a statement regarding the authority to institute precautions and containment strategies needed to respond to an infectious disease threat. *Sample statement:*

a. *The governing body delegates the authority to the IP to institute precautions and/or containment strategies needed to respond to an infectious disease threat.*

c. Describe the IPCP structure, relationship with other committees (e.g., Quality Assurance & Performance Improvement (QAPI), Patient Safety), and how IPCP activities, outcomes, surveillance, and compliance data are disseminated. *Sample statement*:
   i. *IPCP data, activities, and outcomes are discussed at quarterly ICC meetings, reported to the quality assurance and performance improvement (QAPI) committee, and communicated to the governing body.*

d. Describe the affiliation between the facility's IPCP and QAPI program as required by PA and Federal codes. *Sample statement*:
   i. *Infection control is an integral part of the QAPI program at the facility. As applicable, the QAPI program assists with the development and monitoring of IPCP process improvement measures (e.g., action plans, HAI prevention bundles).*

e. Describe the frequency in which the IC plan and RA are updated, reviewed, and approved by the ICC. It is recommended that these documents are updated at least annually and more often if needed, with ICC approval dating reflected in each document.

f. Include a frequency for how often IC policies are updated, reviewed, and approved by the ICC.

g. Infection Preventionist
   i. Describe how the facility meets Federal code requirements in demonstrating that an individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body as the IP(s) responsible for the infection prevention and control program based on the recommendations of medical staff and nursing leadership.
      1. Include IP characteristics such as:
         a. Number of facility IPs
         b. Title(s)
         c. Professional credentials
         d. Infection control training (e.g., AORN, APIC, CDC)
         e. If applicable, Certification in Infection Control (CIC) status or expectations
         f. Employment status (e.g., part-time, full-time); if part-time, number of hours per week dedicated to the IPCP. *Sample statement*:
            i. *The facility has [insert number of IPs] designated full-time IP(s) that has primary professional training in [Select appropriate:*

nursing, medical technology, microbiology, epidemiology, or other related field] and is qualified by completing specialized training in infection prevention and control provided by [insert source of specialized training].

ii. Include IP duties.
    1. Examples may include the development, implementation, monitoring, and enforcement of the IPCP; developing and updating IC plan and policies; ongoing facility-wide surveillance and reporting of HAIs, outbreaks, Pennsylvania reportable diseases, and breaches in IC practices; monitoring emergency preparedness organizations (e.g., CDC, Pennsylvania Health Alert Network (PA-HAN)) for notices of local/state communicable disease threats, emerging pathogens, exposure guidelines; and developing and facilitating IPCP education.

h. Describe the fiscal and human resources allocated to the facility's IPCP. Examples may include:
    i. IP workstation
    ii. Software access (e.g., Microsoft Office, Microsoft Teams)
    iii. Journal access
    iv. Fee and time for initial IP training and continuing education
    v. Membership with professional organizations
    vi. Support for certification
    vii. Administrative or clerical support for the IPCP (e.g., administrative assistant to print and distribute ICC meeting packets, posters, newsletters), if applicable

i. Infection Control Committee (ICC)
    i. Describe how the facility meets MCARE requirements of having a multidisciplinary ICC. Consider including the title/position of each member to drive consistent ICC attendance. Refrain from listing out names of committee members to reduce IC plan editing needs when turnover occurs. The ICC should ideally include frontline HCP in addition to facility leadership, **as applicable to the facility**.
        1. Medical staff: This could include the chief medical officer (CMO), medical director, infectious disease (ID) physician, or surgeon.
        2. Administration: This could include the chief executive officer (CEO), chief financial officer (CFO), chief nursing officer (CNO), director of nursing (DON), facility administrator, comptroller, or other members of the c-suite.
        3. Lab services: This could include the lab director, lab personnel, and lab consultant, if applicable to the facility.
        4. Nursing staff: This could include the DON, nursing manager/supervisor, or staff nurse.

5. Pharmacy staff: This could include the pharmacy director, clinical pharmacist, or pharmacy consultant, if applicable to the facility.
6. Physical plant staff: This could include the facilities director, maintenance supervisor, heating, ventilation, and air conditioning (HVAC) technician, or physical plant consultant, if applicable to the facility.
7. Patient safety officer
8. Infection control: This should include the facility IP (i.e., not just a consultant). Could also include the ID physician, epidemiologist, and additional IPs.
9. Dietary services: This could include the dietary services director, dietitian, dietary assistant, or dietary technician.
10. Community member: Cannot be an agent, employee, or contractor of the health care facility.

ii. Include ICC characteristics that may include chairmanship, quorum, meeting frequency, meeting minutes, and action items. *Sample statement:*

1. *The [insert title of the ICC chairperson] chairs the ICC. A quorum for ICC meetings shall be [insert # of members required for ICC meeting quorum] inclusive of the facility IP, ICC chair, and an administrative or medical staff member. The ICC meets at least quarterly and more frequently if needs arise. Written meeting minutes with documentation of agenda items, discussions, and actions/recommendations are maintained.*

iii. Include ICC duties.

1. Examples may include reviewing and approving the infection control plan, risk assessment, and policies; reviewing surveillance, HAI, and IC practice compliance data; recommending and carrying out quality improvement activities, addressing issues related to emerging pathogens, and reviewing/approving cleaning, disinfection and sterilization products and practices for use in the facility.

7. **Evidence-Based Strategies to Detect, Prevent, and Control Healthcare-Associated Infections and Disease Transmission**

a. Detection

i. Patient Screening

1. Describe the facility's patient screening process. *Sample statements:*

a. *Trained HCP and screening checklists (e.g., pre-operative assessment, assessment at the time of admission) are used to perform patient screening as a means to identify patients with:*

i. *Current signs or symptoms of infection*

ii. *Current, history of, or recent exposure to a communicable disease (e.g., chickenpox, COVID-19, tuberculosis (TB))*

iii. *Current or history of colonization or infection with multidrug-resistant organisms (MDRO) (e.g., Candida auris (C. auris), Clostridioides difficile (C. diff), carbapenem-resistant Enterobacterales (CRE), extended-spectrum beta-lactamases (ESBL), methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococci (VRE))*

b. **Only for use by ASCs that screen & exclude patients requiring transmission-based precautions (TBP) from having facility services rendered. (Note: If this section is used, a TBP section in the IC plan is not needed):**

i. Include a statement in the IC plan about patients requiring TBP not being candidates for service at the facility. *Sample statement:*

1. *Patients requiring transmission-based precautions are not candidates for service in the facility and are rescheduled once the condition has resolved.*

ii. Include details about instances where a TBP need is not identified until the patient arrives, and measures taken (e.g., isolated, evaluated) until the patient can be rescheduled, discharged, or transferred. *Sample statement:*

1. *Patients who present to the facility with symptoms consistent with a disease requiring TBP will immediately be placed into a private [room/bay] until evaluated by a clinician or rescheduled and safely transferred/discharged.*

iii. Describe how TBP, infection, and MDRO statuses are communicated to internal staff and how external facilities are notified when a patient transfer is necessary. *Sample statements:*

1. *Internal communication:*
   a. *The use of [select methods used such as: TBPs/isolation signage, medical record flag and verbal handoff communication] is used to ensure that HCP are aware of the patient's TBP, infection and/or MDRO status.*
2. *External communication:*
   a. *In the event that a patient with an infection, MDRO or TBP need requires transfer, the following methods are used to alert emergency medical service transfer staff, outside HCP and/or facilities:*
      i. *Verbal report*
      ii. *Written infection control transfer form*

ii. Employee Health

1. Describe the facility's HCP pre-employment health screening process. *Sample statements:*
    a. *Pre-employment health screening of new HCP includes:*
        i. *Evaluation of vaccination or immunity status for CDC-recommended vaccine-preventable diseases for HCP*
        ii. *Vaccination history for COVID-19 and influenza*
        iii. *Assessment for tuberculosis (TB) (i.e., baseline screening and TB risk assessment)*
2. Reference a facility policy or describe sick leave procedures, associated work restrictions/furloughing for ill HCP, and the person responsible for managing these occurrences. *Sample statement:*

    a. *The facility uses established criteria for defining what constitutes an occupational communicable disease exposure (e.g., CDC.) and has sick leave policies to encourage HCP to go or stay home when they develop signs or symptoms of illness.*

iii. Surveillance

1. Describe the facility's surveillance and reporting plan.
    a. Define surveillance. *Sample statement:*
        i. *Surveillance is an ongoing and investigative process to identify MDROs, communicable diseases, outbreaks, IC practice breaches, and potential HAI resulting from or involving any service rendered at the facility*.
    b. Include the responsible person(s) (e.g., IP) for performing ongoing, facility-wide surveillance and surveillance training requirements. Examples of reporting platforms that offer surveillance training include the National Healthcare Safety Network (NHSN), PA-Patient Safety Reporting System (PA-PSRS), and PA National Electronic Disease Surveillance System (PA-NEDSS). *Sample statement:*
        i. *The IP is responsible for performing facility-wide surveillance and has completed initial surveillance and reporting training offered by the National Healthcare Safety Network (NHSN), PA-Patient Safety Reporting System (PA-PSRS), and PA National Electronic Disease Surveillance System (PA-NEDSS).*
    c. Include the facility's surveillance data sources. Examples may include:
        i. Laboratory tests (e.g., manual data collection or data mining software (i.e., qualified electronic surveillance system (QESS))
        ii. Radiology/imaging reports
        iii. Reports received from IPs at other facilities
        iv. Post-discharge calls or surveys

v. Patient self-reporting
vi. Surgeon/Provider letters, attestations, and line lists (e.g., for physicians to report HAIs)
vii. Letters to outpatient surgery cases
viii. Environmental / unit rounds

d. HAI Surveillance
    i. Include the standard HAI surveillance definitions (e.g., NHSN Patient Safety Component (PSC) Manual, NHSN Outpatient Procedure Component (OPC) Manual) used at the facility.
    ii. Describe the consistent application of surveillance definition use for HAI reporting. *Sample statement:*
        1. *Consistent application of surveillance definitions is used by the IP. HAIs meeting NHSN Component Manual surveillance definitions are reported even if a provider disagrees (e.g., in the event that the patient is not diagnosed with a clinical infection).*
e. Consider referencing the facility's surveillance and reporting policy unless most details are included in the IC plan.

2. External surveillance reporting
    a. HAI: Describe the HAI reporting process that aligns with MCARE Section 308.a. requirements and the patient notification process that aligns with MCARE Section 308.b requirements. *Sample statements:*
        i. *All HAIs (e.g., bloodstream infections (BSIs); IV site infections; postoperative pneumonia (PNEU); surgical site infections (SSIs); urinary tract infections (UTIs)) are deemed serious events, which must be reported to PA-PSRS within 24 hours of occurrence, discovery, or confirmation.*
        ii. *Patients (or family, guardian, durable power of attorney (POA), as appropriate) receive written notification of serious events within 7 days of occurrence, discovery, or confirmation.*
    b. Outbreaks: Describe the facility process for reporting outbreaks. *Sample statement:*
        i. *Outbreaks are reported to PA DOH or the local county health department*
    c. Infection Control Practice Breaches: Describe the facility process for reporting infection control practice breaches. *Sample statement:*
        i. *IC practice breaches resulting in possible bloodborne pathogen (BBP) exposure (e.g., shared glucometers that are not cleaned/disinfected according to manufacturer instructions for use (IFUs), use of a syringe for more than one patient) are*

reported to the local health department or the PA DOH (i.e., 1-877-PA-HEALTH) and PA-PSRS

d. PA reportable diseases: Describe the facility process for reporting PA reportable diseases. *Sample statement:*
    i. *PA and county reportable diseases are reported to PA DOH via PA-NEDSS.*

3. Internal surveillance reporting
    a. Describe the process for disseminating surveillance data and outcomes to facility committees inclusive of the ICC.
    b. Describe the process for disseminating relevant surveillance data and outcomes to providers, managers, and other HCP as needed (along with targets, actions for performance improvement, etc.).

b. Prevention
    i. Standard Precautions
        1. Define Standard Precautions. *Sample statement:*
            a. *Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These practices are designed to both protect HCP and prevent HCP from spreading infections among patients.*)
            b. Include a listing of Standard Precautions elements in the IC plan
            c. Reference the facility's Standard Precautions policy.
        2. Hand hygiene
            a. Define hand hygiene. *Sample statement:*
                i. *Hand hygiene includes cleaning hands with alcohol-based hand rub/sanitizer (ABHR), soap and water, or surgical hand antiseptic and is the single most important infection control practice for preventing the transmission of infectious pathogens*.
            b. Note which hand hygiene guidelines (i.e., CDC or WHO) the facility has adopted for use and that *ABHR is the preferred method for performing hand hygiene in most clinical situations*.
            c. Define when soap and water are required to perform hand hygiene. *Sample statement:*
                i. *Hands must be cleaned with soap and water if visibly soiled, before eating/drinking, after toileting, and during the care of patients with suspected or confirmed infection during outbreaks of C. difficile or norovirus.*
            d. Describe the availability of alcohol-based hand rub (ABHR) and hand washing sinks in the facility

e. Reference the facility's hand hygiene policy and if applicable, the facility's surgical antisepsis policy

3. Personal Protective Equipment (PPE)
    a. Define PPE and provide examples of PPE types stocked at the facility. *Sample statement:*
        i. *PPE is worn to minimize exposure to blood/body fluid and/or infectious pathogens and includes items such as gowns, gloves, face masks, face shields/goggles, respirators, etc*.
    b. Describe the location/availability of PPE supply in the facility
4. Respiratory hygiene/cough etiquette
    a. Describe the respiratory hygiene/cough etiquette processes in place at the facility. *Sample statement:*
        i. Respiratory hygiene/cough etiquette is used at the facility to prevent the transmission of respiratory infections (e.g., influenza, rhinovirus, COVID-19), and promoted by posting visual alerts (e.g., cover you cough signage) and providing supplies (e.g., facial tissues, face masks, no touch waste receptacles, ABHR) at the facility entrance(s)/waiting room(s)
5. Sharps safety and safe injection practices
    a. Define sharps safety and provide examples of safety devices used at the facility. Examples may include needleless IV systems, self-sheathing needles, safety scalpels, etc. *Sample statement:*
        i. *Sharps with engineered sharp injury protection mechanisms are used at the facility. This includes items such as needleless IV systems, self-sheathing needles, safety scalpels, etc. that contain built-in safety features for preventing injuries such as needlesticks, etc.*
    b. State which safe injection practice guidelines are followed at the facility/ Examples of safe injection practice guidelines include CDC, One and Only Campaign, and WHO.
6. Environmental cleaning and disinfection
    a. Describe who is responsible for performing environmental cleaning and disinfection of the facility (e.g., onsite department, contracted service).
    b. Describe how manufacturer IFUs are followed for all cleaning/disinfection products used at the facility
    c. Reference the facility's environmental cleaning/disinfection policy.
7. Cleaning, disinfection, and sterilization of patient care equipment, devices, and surgical instruments

a. Describe the use of the Spaulding Classification (i.e., non-critical, semi-critical, critical) to determine the type of reprocessing needed for patient care equipment used at the facility.
b. Describe how manufacturer IFUs are accessed by HCP at the facility and used for all reprocessing methods and processes (e.g., patient care equipment, devices, surgical instruments, reprocessing equipment, reprocessing chemicals/disinfectants).
c. Cleaning and disinfection of patient care equipment
    i. Describe who is responsible for, how often, and what is used to clean and disinfect patient care equipment at the facility. *Sample statement:*
        1. *Cleaning and disinfection of patient-care equipment (e.g., blood pressure (BP) cuffs, thermometers, medication pumps, glucometers) is performed by the equipment user with the use of a US Environmental Protection Agency (EPA)-registered disinfectant after every patient use.*
d. High-level disinfection (HLD)
    i. If a HLD reprocessing method is not used at the facility, include a statement in the IC plan that states so and move on to the next section.
    ii. If offsite HLD services are used by the facility, state so in the IC plan and include a policy reference that details the offsite exchange of soiled and reprocessed equipment.
    iii. If HLD services are performed onsite,
        1. Identify equipment used requiring HLD. Examples may include endoscopes; ultrasound probes; laryngoscope blades and handles.
        2. Identify the HLD reprocessing equipment used at the facility. Examples may include an automated endoscope reprocessor (AER), Trophon, TD 100 unit.
        3. Identify the HLD standards used at the facility. Examples may include ANSI/AAMI ST91:2021, AORN, CDC, and the Society of Gastroenterology Nurses and Associates (SGNA).
        4. Provide details of where equipment is stored after it is high-level disinfected
        5. Reference the facility's HLD policy.
e. Sterile Processing (SP)
    i. If SP is not used at the facility, include a statement in the IC plan that states so and move on to the next section

ii. If offsite SP services are used by the facility, state so in the IC plan and include a policy reference that details the offsite exchange of soiled and reprocessed surgical instruments and devices.

iii. If SP is performed onsite,

1. Identify the sterile reprocessing equipment used at the facility. Examples may include a steam sterilizer, dry heat sterilizer, and vaporized hydrogen peroxide.
2. Identify credentialing and/or certification requirements of technicians, or instrument specialists in compliance with Act 80 of 2020 – Central Service Technician and Surgical Technologist Regulation Act)
3. Identify the sterilization standards used at the facility.
    a. Examples may include ANSI/AAMI ST79:2017, CDC, and AORN.
4. Reference the facility's sterilization policy.

f. Immediate-Use Steam Sterilization (IUSS)

i. **If applicable**, include an IUSS policy reference and describe conditions when IUSS is used at the facility. *Sample statement:*

1. *IUSS is reserved for emergent needs only (e.g., dropped surgical instrument needed to finish a procedure). Items undergoing IUSS are not stored or held from one procedure to the next. IUSS frequency and indications for use are reported to the ICC*

g. Storage of Supplies and Equipment

i. Describe the location and identification (e.g., tagged, bagged, placed into clean storage) of where and how clean equipment is stored.

ii. Describe the location of where clean and commercially packaged sterile supplies are stored. *Sample statement:*

1. *Clean and commercially packaged sterile supplies are stored in clean storage rooms using a first-in, first-out shelf rotation.*

iii. **If applicable,** describe the location of where sterile instruments and devices that are reprocessed onsite are stored.

1. Describe the facility's event-related sterility approach for storing sterile surgical instruments and devices reprocessed onsite. *Sample statement:*
    a. *Sterile storage of instrument trays and devices is located in a restricted and environmentally*

controlled sterile storage room. An event-related shelf-life practice is used for sterile storage which means that the sterilized product (e.g., wrapped surgical instrument tray, sterile peel pouch) should remain sterile until an event (e.g., tear in packaging, broken seal) causes the item to become contaminated.

ii. Linen Management

a. Describe who is responsible for supplying clean linen and reprocessing soiled linen for the facility (e.g., onsite department, contracted service).

b. If contracted, include the type of accreditation that the healthcare laundry management service maintains. Examples include the Healthcare Laundry Accreditation Council (HLAC), and Hygienically Clean Certification from TRSA.

c. If onsite laundering services are used, include the linen management guidelines used by the facility for processing linen. An example is in CDC.

d. Include a reference to the facility's linen management policy.

c. Education

i. Describe the facility process and topics used for educating patients, family and/or visitors. *Sample statements:*

1. *As applicable, education of patients, family, and visitors on the following* **facility-relevant** topics which **could** include*:*

a. *Disease acquisition and transmission, transmission-based precautions*

b. *Hand hygiene*

c. *Respiratory hygiene/cough etiquette*

d. *Preoperative*

i. *Preoperative bathing – including Chlorhexidine gluconate bathing, if applicable*

ii. *Oral hygiene*

iii. *Glucose control*

iv. *Smoking cessation*

e. *Post-operative care*

i. *Incisional care*

ii. *Device care*

iii. *Signs and symptoms of infection*

ii. Describe the facility process and topics used for mandatory infection control education of new employees, and annual or as needed training. *Sample statements:*

1. *Mandatory IC education for all HCP*
    a. *Upon hire (i.e., prior to performing job duties), annually, and as needed IC education is provided. Educational topics include but may not be limited to:*
        i. *Disease acquisition, chain of infection, and transmission*
        ii. *Standard and transmission-based precautions*
        iii. *PPE use, location, sequence of donning/doffing*
        iv. *Hand hygiene: methods, supplies, monitoring/compliance*
        v. *OSHA Bloodborne Pathogens Exposure Control Plan*
        vi. *Employee Health (e.g., vaccinations, reporting of infection and/or exposure, TB)*
        vii. *TB (e.g., transmission, risk, management, latent vs. infection)*
        viii. *Contents and location of IC plan*
    b. *Competency-based training completed by all HCP upon hire (i.e., prior to performing task independently), annually, and as needed if changes occur, for job-specific IC practices (e.g., insertion of invasive devices, cleaning/disinfection and/or sterilization of equipment and/or surgical instruments/devices, cleaning/disinfection of environmental surfaces)*

d. Control

i. Transmission-Based Precautions **(Note: This topic can be omitted from the IC plan if Section 7.b. on page 8 is used instead.)**

1. Define Transmission-Based Precautions (TBP). *Sample statement:*
    a. *Transmission-based precautions (TBP) are the second tier of basic infection control and are used in addition to standard precautions for patients who may be infected or colonized with certain infectious pathogens for which additional precautions are needed to prevent infection transmission.*
2. **If applicable**, identify who outside of the facility IP has the authority to initiate TBP. Examples may include any HCP as per policy and nursing staff as per protocol.
3. Include the guidelines used for selecting the type and duration of TBP. The primary source used by most healthcare facilities is CDC's Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007).

4. Describe the facility's patient placement practices with the use of private rooms or cohorts in multi-occupancy rooms.
5. If the facility accepts patients requiring TBP but limits their use to certain types or conditions, include the limitations in the IC plan.
6. Include the availability of an airborne infection isolation room (AIIR).
    a. Describe how patients requiring airborne precautions (e.g., for suspected or confirmed chickenpox, TB) are managed if an AIIR is unavailable
    b. If the facility accepts patients with airborne transmission-based precaution needs, or has a respiratory protection program despite not accepting patients with airborne transmission-based precaution needs, reference the title of the facility's Respiratory Protection Plan that details who is responsible (e.g., employee health, IP) for performing medical clearance, fit testing, and training of HCP upon hire and annually for respirator use, and which types of respirators are provided by the facility (e.g., N95, powered air purifying respirator (PAPR)).
7. Describe how the facility communicates TBP, infection, and MDRO statuses internally and externally to HCP and/or receiving facilities.
    a. Examples of internal communication may include the use of medical record flags and/or signage to alert HCP at the facility.
    b. Examples of external communication may include the use of verbal report and/or written notification (e.g., standardized interfacility infection control transfer form, discharge instructions) when transferring a patient to another healthcare facility.
8. Reference the facility's TBP policy.

ii. Bloodborne Pathogens (BBP) Exposure Control Plan (ECP)

1. Include a statement about the existence of a facility BBP ECP that it is updated at least annually and when needs arise to reflect new or modified tasks and procedures that affect occupational exposure to blood, body fluid, or potentially infectious material (OPIM) to comply with OSHA's bloodborne pathogen standard.
2. Reference the facility's BBP ECP.

iii. HCP MDRO Exposure Management

1. Indicate that evidence-based CDC and/or OSHA guidelines are used for the evaluation and management of HCP for unprotected MDRO exposures.

iv. Outbreak Investigation

1. Define an outbreak. *Sample statement:*
    a. *An outbreak refers to an increase in the number of cases of a disease above what is normally expected in a facility, specific community, or*

geographic area. However, a single case of an epidemiological significant pathogen (e.g., Ebola) may be considered an outbreak.

2. Reference the facility's outbreak policy.

v. Compliance Monitoring

1. Include the facility's IC practice compliance monitoring priorities. Examples may include hand hygiene, PPE use, cleaning, disinfection, and sterilization processes.
2. Describe the facility's process for providing immediate feedback/real-time correction when IC practice compliance is observed.
3. Describe the facility's process for enforcing IC practice compliance
4. Describe how compliance outcome data is reported to the ICC and shared/distributed to HCP.

8. **Facilities / Physical Plant Operations**

a. Describe plant operations related to infection control at your facility. Consider including information about the following:

i. Heating, ventilation, and air conditioning (HVAC) system(s)

1. Identify who is responsible for maintaining and performing preventative maintenance of the HVAC system at the facility. Examples may include a maintenance department, building management, and contracted HVAC service provider.
2. Describe the critical areas/locations (e.g., operating room/s, sterile storage, decontamination, endoscope cleaning room, clean workroom) under environmental monitoring for humidity, temperature, and airflow (i.e., pressure differential).
    a. Include the guidelines used for setting pressure, temperature, and humidity parameters for required spaces in the facility. Examples may include ANSI/ASHRAE/ASHE Standard 170, Facility Guidelines Institute (FGI).
    b. Describe the method of daily monitoring of critical space HVAC parameters. Examples may include checked by HCP with manual recording, and continuous electronic system capable of electronic recording and discrepancy alerts.
    c. Identify who is responsible for monitoring, and documenting daily readings and notification/actions taken for out-of-range readings

ii. Medication, bone/tissue, and/or patient nutrition refrigerators and freezers

1. Identify which types of refrigeration/freezers are used at the facility.
2. Identify if there is a manual, continuous electronic, and/or audible alarm temperature monitoring process in place and who is responsible for

documenting daily temperatures and notification/actions taken for out-of-range readings.

iii. Water systems

1. ASFs are not required to have a formal water management plan (WMP).
    a. If the facility has a WMP, include information about the WMP, it's development, review cadence and oversight committee or team. *Sample statements:*
        i. *The facility has a Water Management Plan (WMP) to mitigate waterborne pathogen transmission risks.*
        ii. *A water infection control risk assessment (WICRA) was performed to evaluate facility water sources, modes of transmission, and potential patient exposure risks which was used in developing the facility's water management plan.*
        iii. *The water management plan team meets at least annually to review, update, and approve the WMP.*
        iv. *Reference the facility's WMP.*
    b. If the facility does not have a WMP, include measures used at the facility to mitigate waterborne pathogens in water systems such as one of the following:
        i. Water system outage
            1. Identify if the facility has a stocked supply of bottled water for emergency use during water system outages until service is restored and normal operations are resumed.
        ii. Water filters
            1. Identify when water filters are used for facility equipment (e.g., AERs, ice machines), the frequency in which they are changed (e.g., according to manufacturer's IFUs), and who is responsible for doing so.
        iii. Ice machines
            1. Identify who is responsible for cleaning/disinfecting and preventative maintenance of ice machines in the facility.
            2. Describe that only clean containers (e.g., cups, graduates) are used to collect ice directly out of the ice machine dispenser at the facility.

iv. Construction

1. Discuss the IP's involvement in construction and remediation (e.g., water incursions) planning, meetings, infection control risk assessments (ICRA), and rounding for contractor and maintenance staff adherence to ICRA mitigation strategies/barriers at the facility. *Sample statement:*
    a. *The IP is involved in performing an infection control risk assessment (ICRA) when the facility is planning new construction or renovation and*

monitoring the risk mitigation measures in place (e.g., barriers, negative pressure, HEPA filtration) during construction or remediation to ensure that patient care spaces are not contaminated with dust and infectious pathogens (e.g., Aspergillus).

9. **Antibiotic Stewardship**
    a. ASFs are not required to have a formal antibiotic stewardship program (ASP).
        i. If the facility has an ASP:
            1. Define antibiotic stewardship. *Sample statement:*
                a. *Antibiotic stewardship is the effort to optimize (i.e., measure and improve) how antibiotics are prescribed by clinicians and used by patients.*
                b. Describe the facility's ASP activities (e.g., antibiotic utilization, proper antibiotic selection, duration of use, antibiogram) and oversight committee.
                c. Identify the antibiotic stewardship guidelines used at the facility. Examples may include the CDC Core Elements of Outpatient Antibiotic Stewardship and the SHEA/Infectious Disease Society of America (IDSA) Clinical Practice Guidelines for Implementing an Antibiotic Stewardship Program. *Sample statements:*
                    i. *The facility has an antibiotic stewardship program that is led by a clinical pharmacist. Program activity outcomes (e.g., antibiotic utilization, proper antibiotic selection and duration of use) are reported to the ICC.*
                    ii. *The facility utilizes the CDC Core Elements of Outpatient Antibiotic Stewardship for guidelines on antimicrobial tracking/reporting, education, drug expertise, etc.*
        ii. If the facility does not have an ASP but **antibiotics are administered at the facility**, describe measures used to ensure the appropriate use of antibiotics by addressing the following topics:
            1. Identify the surgical prophylaxis or procedural antibiotic guidelines followed at the facility. An example is the "*Clinical Practice Guidelines for Antimicrobial Prophylaxis in Surgery*" developed by the American Society of Health-System Pharmacists (ASHP)/IDSA/ Surgical Infection Society (SIS)/SHEA.
            2. Identify who is responsible for monitoring antibiotic use at the facility. Examples may include the facility IP, pharmacist, and pharmacy consultant.
            3. Identify how antibiotic utilization data is shared with the ICC and HCP, as applicable.

10. **Distribution of PA-HAN Advisories and PA Patient Safety Authority's Patient Safety Journal**
    a. Describe the distribution of PA-HAN advisories to relevant facility HCP.

b. Describe the distribution of PA Patient Safety Authority's rolling online journal articles and the annual Patient Safety Journal to all HCP including the location and method of distribution.
    i. Examples of distribution methods may include email notification, posting in newsletters, posting in key locations (e.g., locker room, time clock), and electronic access on facility computer.

Pennsylvania
Department of Health

References: (Only include facility-relevant references with functional links or citations)

1. AAMI. Association for the Advancement of Medical Instrumentation.
2. ANSI. American National Standards Institute.
3. AORN. Association of periOperative Registered Nurses.
4. AORN. ASC Infection Prevention Online Course.
5. APIC. Association for Professionals in Infection Control and Epidemiology.
6. APIC. Online Learning.
7. ASHE. Infection Control Risk Assessment 2.0 Toolkit for Construction & Renovation.
8. CDC. Core Elements of Outpatient Antibiotic Stewardship.
9. CDC. Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings.
10. CDC. Disinfection and Sterilization.
11. CDC. Environmental Infection Control Guidelines.
12. CDC. Hand Hygiene in Healthcare Settings.
13. CDC. Infection Control
14. CDC. Outbreak Investigations in Healthcare Settings.
15. CDC. Recommended Vaccines for Healthcare Workers.
16. CDC. Standard Precautions for All Patient Care.
17. CDC. Transmission-Based Precautions.
18. Code of Federal Regulations. Title 42, Public Health. Chapter IV, Centers for Medicare & Medicaid Services, Department of Health and Human Services. Subchapter B, Medicare Program. Part 416, Ambulatory Surgical Services. Subchapter C, Specific Conditions for Coverage.
19. Facility Guidelines Institute
20. National Healthcare Safety Network (NHSN). Outpatient Procedure Component.
21. National Healthcare Safety Network (NHSN). Patient Safety Component.
22. OSHA. Occupational Safety and Health Administration.
23. OSHA. Bloodborne Pathogens Standard. Title 29, Labor. Subtitle B, Regulations Relating to Labor. Chapter XVII, Occupational Safety and Health Administration, Department of Labor. Part 1910, Occupational Safety and Health Standards. Subpart Z, Toxic and Hazardous Substances. § 1910.1030 Bloodborne pathogens.
24. Pennsylvania Code. Title 28, Health and Safety. Part IV, Health Facilities. Subpart F. Ambulatory Surgical Facilities.
25. Pennsylvania Code. Title 28, Health and Safety. Chapter 27, Communicable and Noncommunicable Diseases.
26. Pennsylvania DOH. PA Health Alert Network (PA-HAN).
27. Pennsylvania Law. PA Medical Care Availability and Reduction of Error (MCARE) Act 2002 amended 2007.
28. Pennsylvania Patient Safety Authority. Patient Safety Journal.
29. Pennsylvania Patient Safety Reporting System (PA-PSRS). Training Manual and Users' Guide. Using the Pennsylvania Patient Safety Reporting System (PA-PSRS). *User must be logged in under the "Help" dropdown.*

This outline was created by the Pennsylvania Department of Health (Department), Bureau of Epidemiology, Healthcare Associated Infection Prevention (HAIP) Division for PA healthcare facilities to reference as they develop their infection control plans for submission to the Department. The Department respectfully requests that prior to using this document or its content in any manner for other purposes, such as by other entities, that written permission be given by the Department: RA-DHHAI@pa.gov