National Healthcare Safety Network (NHSN) Annual Training Long-term Care Facility Component July 16-18, 2018

Infection Control Assessment and Response (ICAR)

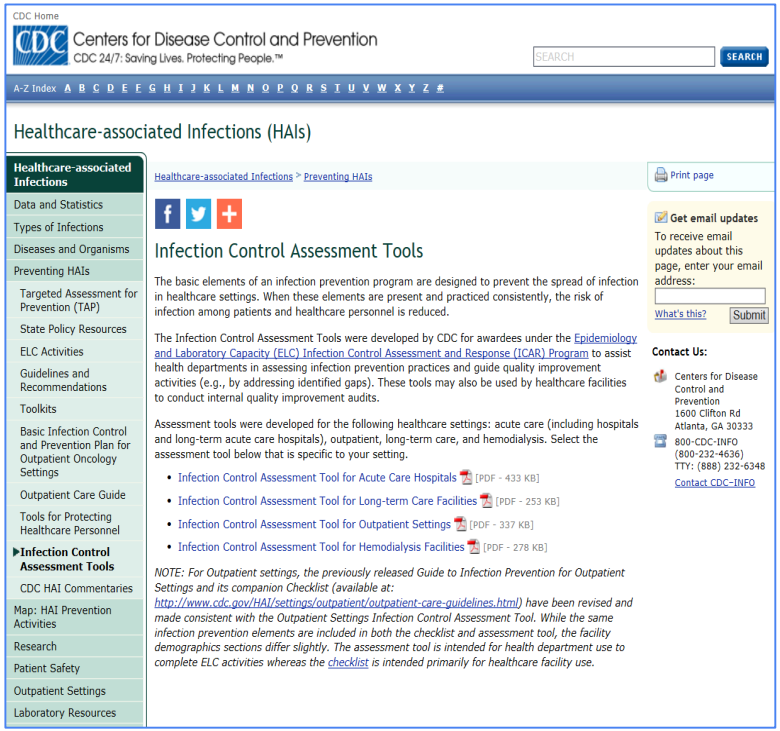
Abimbola (Bola) Ogundimu, DrPH, RN, CIC
Infection Preventionist for LTC
CDC Division of Healthcare Quality Promotion

Session Objectives

- Briefly describe the Infection Control Assessment and Response (ICAR) activity
- Discuss the findings and lessons learned by health departments from this activity in long-term care facilities (LTCFs)
- Highlight examples of educational materials and resources supporting the implementation of infection prevention and antibiotic stewardship activities in LTCFs

CDC Infection Control Assessment and Response (ICAR) Activity, 2015-2018

- CDC funding and technical support to state and local health departments
- Structured approach for assessing current infection prevention and control (IPC) programs
- Opportunity for health departments to expand their outreach to healthcare facilities
- Health departments serve as an IPC resource for healthcare facilities



http://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html

CDC Infection Control Assessment and Response (ICAR) Activity, 2015-2018 (continued)

Elements within each domain regarding the following:

- Policies/procedures
- Staff training and education
- Auditing/monitoring adherence to policies
- Providing feedback on staff adherence
- Availability of supplies

Infection Control Domains for Gap Assessments:

I. Infection Control Program and Infrastructure

II. Healthcare Personnel and Resident Safety

III. Surveillance and Disease Reporting

IV. Hand Hygiene

V. Personal Protective Equipment (PPE)

VI. Respiratory/Cough Etiquette

VII. Antibiotic Stewardship

VIII. Injection Safety and Point of Care Testing

IX. Environmental Cleaning

http://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html

Assessments of Infection Prevention Practices: Hand Hygiene and Gown/Glove Use

OPTIONAL

Hand Hygiene and Contact Precautions Observations

Staff type*	Type of opportunity	HH performed?	Gown or glove indicated?	Gown/glove used?
Click here to enter text.	○ Room entry ○ Room exit ○ Before resident contact ○ After resident contact ○ Before glove ○ After glove ○ Other: Click here to enter text.	○ Alcohol-rub ○ Hand Wash ○ No HH done	○ Gown only ○ Glove only ○ Both ○ No	○ Gown used ○ Glove used ○ Both ○ Neither
Click here to enter text.	○ Room entry ○ Room exit ○ Before resident contact ○ After resident contact ○ Before glove ○ After glove ○ Other: Click here to enter text.	○ Alcohol-rub ○ Hand Wash ○ No HH done	○ Gown only ○ Glove only ○ Both ○ No	○ Gown used ○ Glove used ○ Both ○ Neither
Click here to enter text.	○ Room entry ○ Room exit ○ Before resident contact ○ After resident contact ○ Before glove ○ After glove ○ Other: Click here to enter text.	○ Alcohol-rub ○ Hand Wash ○ No HH done	○ Gown only ○ Glove only ○ Both ○ No	○ Gown used ○ Glove used ○ Both ○ Neither
Click here to enter text.	○ Room entry ○ Room exit ○ Before resident contact ○ After resident contact ○ Before glove ○ After glove ○ Other: Click here to enter text.	○ Alcohol-rub ○ Hand Wash ○ No HH done	○ Gown only ○ Glove only ○ Both ○ No	○ Gown used ○ Glove used ○ Both ○ Neither
Click here to enter text.	○ Room entry ○ Room exit ○ Before resident contact ○ After resident contact ○ Before glove ○ After glove ○ Other: Click here to enter text.	○ Alcohol-rub ○ Hand Wash ○ No HH done	○ Gown only ○ Glove only ○ Both ○ No	○ Gown used ○ Glove used ○ Both ○ Neither

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Assessments of Infection Prevention Practices: Indwelling Urinary Catheter (IUC) Maintenance * (i.e., foley)

OPTIONAL

Indwelling Urinary Catheter (IUC) Maintenance Observations (i.e., Foley)

Indication assessed regularly [1]	Indication appropriate [2]	HH before handling IUC	Clean gloves donned before handling IUC	Bag < 2/3 full	Bag below bladder	Unobstructed flow	Device secured properly	Bag emptied properly [3]	Specimen collected properly [4]	Gloves Removed after handling IUC	HH after handling IUC
○ Yes ○ No ○ NA*	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
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**NA = Not assessed*

[1] On-going need for IUC is assessed for appropriateness and indication is documented in medical records per facility policy

[2] See: https://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf Table 2A for list of appropriate indications for IUC and more information regarding appropriate maintenance

[3] Clean container is used to catch urine and spigot does not come into contact with container; Additional PPE (e.g., face shields, gown) should be worn per facility policy to prevent body fluid exposure

[4] HH is performed and clean gloves worn to manipulate IUC sample collection port, port is cleaned with alcohol prior to access, specimen is collected using blunt syringe, leur lock syringe, or 10 cc syringe; specimen not obtained from the collection bag

Comments: Click here to enter text.

https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html

Assessments of Infection Prevention Practices: Central Venous Catheter (CVC) Maintenance

OPTIONAL

Central Venous Catheter (CVC) Maintenance Observations

NOTE: May be referred to as Central Line and includes PICC line

Indication appropriate [1]	CVC maintenance performed regularly [2]	Dressing clean, dry and intact	Dressing dated [3]	HH performed before handling CVC	Clean gloves donned before handling CVC	CVC connected and disconnected aseptically	CVC hub scrubbed [4]	CVC hub allowed to dry	Unused CVC ports are capped	CVC accessed with sterile devices only	Gloves removed after handling CVC	HH after handling CVC
○ Yes ○ No ○ NA*	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA

**NA = Not assessed*

[1] *Refer to http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf for recommendations on CVC maintenance (e.g., appropriate indications)*

[2] *Appropriate maintenance should include documentation of the following in the medical record: date and site of insertion, assessment of on-going need for CVC, and frequency of dressing changes and replacement of system components (e.g., catheter tubing, connectors) per facility policy*

[3] *Dressing should be labeled with date changed and be within timeframe for routine dressing changes per facility policy*

[4] *Procedure for "Scrub the Hub": Hub is handled aseptically (i.e., ensuring hub does not touch anything non-sterile) while port cap is removed and discarded; Appropriate antiseptic pad (e.g., 70% alcohol, chlorohexidine) is used to scrub end and sides (threads) of hub thoroughly applying friction for 10 to 15 seconds; Catheter line is disinfected several centimeters toward resident's body using same antiseptic pad to apply friction; Hub is left open "uncapped" shortest time possible. See http://www.cdc.gov/dialysis/PDFs/collaborative/Hemodialysis-Central-Venous-Catheter-STH-Protocol.pdf and http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf for further guidance*

https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html

Assessments of Infection Prevention Practices: Wound Care

OPTIONAL

Wound Dressing Change Observations

All supplies are gathered before dressing change [1]	HH performed before dressing change	Clean gloves donned before dressing change [2]	Multi-dose wound care meds are used appropriately [3]	Dressing change performed in manner to prevent cross-contamination [4]	Gloves removed after dressing change completed	HH performed after dressing change completed	Reusable equipment cleaned and/or disinfected appropriately [5]	Clean, unused supplies discarded or dedicated to one resident	Wound care performed /assessed regularly [6]	Wound care supply cart is clean [7]
○ Yes ○ No ○ NA*	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA
○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA	○ Yes ○ No ○ NA

**NA = Not assessed*

[1] Dedicated wound dressing change supplies and equipment should be gathered and accessible on a clean surface at resident's bedside before starting procedure

[2] Additional PPE (e.g., face mask/face shield, gown) should be worn to prevent body fluids exposure per facility policy

[3] Multi-dose wound care medications (e.g., ointments, creams) should be dedicated to a single resident whenever possible or a small amount of medication should be aliquoted into clean container for single-resident use; Meds should be stored properly in centralized location and never enter a resident treatment area

[4] Gloves should be changed and HH performed when moving from dirty to clean wound care activities (e.g., after removal of soiled dressings, before handling clean supplies); Debridement or irrigation should be performed in a way to minimize cross-contamination of surrounding surfaces from aerosolized irrigation solution; All soiled dressing supplies should be discarded immediately

[5] In addition to reusable medical equipment, any surface in the resident's immediate care area contaminated during a dressing change should be cleaned and disinfected; Any visible blood or body fluid should be removed first with a wet, soapy cloth then disinfected with an EPA-registered disinfectant per manufacturer instructions and facility policy; Surfaces/equipment should be visibly saturated with solution and allowed to dry for proper disinfection before reuse

[6] Wound care documentation should include wound characteristics (e.g., size, stage), dressing assessment (e.g., clean, dry), and date and frequency of dressing changes; Wound care is documented in medical records per facility policy

[7] Wound care supply cart should never enter the resident's immediate care area nor be accessed while wearing gloves or without performing HH first. These are important to preventing cross-contamination of clean supplies and reiterates the importance of collecting all supplies prior to beginning wound care.

https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html

ICAR Assessments (continued)

- **How will your facility benefit from this assessment?**
  - A fresh perspective on your existing program
  - It helps to prepare for regulatory surveys
  - It helps with Infection Control Risk Assessment priorities and planning activities
- **What is the assessment?**
  - It helps to identify your facility's capacity to detect, report and address healthcare acquired infections and/or outbreaks
  - The State/Local Health Departments have been providing a summary report of opportunities and strengths of facility Infection Prevention program, as well as resources
  - The State/Local Health Departments have also partnered with facilities for education, if requested

Long Term Care Facilities (LTCFs) Assessed, as of January/February 2018

- 2206 total facility assessments completed by 44 state/local HDs
  - CMS-certified LTCFs (NHs and ICFs) = 94% of assessments
- Type of assessment:
  - 2143 on-site assessments, with 2078 (97%) in NHs and ICFs
- Long-term care settings assessed:

Nursing Homes (NHs)	Intermediate Care Facilities (ICFs)	Assisted Living Facilities (ALFs)	Other LTCFs
2044	34	46	73

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Infection Control Program and Infrastructure Domain Questions	% YES
A. The facility has specified a person (e.g., staff, consultant) who is responsible for coordinating the IC program.	97%
B. The person responsible for coordinating the infection prevention program has received training in IC	**47%**
C. The facility has a process for reviewing infection surveillance data and infection prevention activities (e.g., presentation at QA committee).	97%
D. Written infection control policies and procedures are available and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations (F-441), or standards.	91%
E. Written infection control policies and procedures are reviewed at least annually or according to state or federal requirements, and updated if appropriate.	79%
F. The facility has a written plan for emergency preparedness (e.g., pandemic influenza or natural disaster).	92%

Overall, only 36% of NHs had ALL elements of the IPC Program Infrastructure domain in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Healthcare Personnel Safety	% YES
A. The facility has work-exclusion policies concerning avoiding contact with residents when personnel have potentially transmissible conditions which do not penalize with loss of wages, benefits, or job status.	83%
B. The facility educates personnel on prompt reporting of signs/symptoms of a potentially transmissible illness to a supervisor	94%
C. The facility conducts baseline Tuberculosis (TB) screening for all new personnel	99%
D. The facility has a policy to assess healthcare personnel risk for TB (based on regional, community data) and requires periodic (at least annual) TB screening if indicated.	83%
E. The facility offers Hepatitis B vaccination to all personnel who may be exposed to blood or body fluids as part of their job duties	97%
F. The facility offers all personnel influenza vaccination annually.	99%
G. The facility maintains written records of personnel influenza vaccination from the most recent influenza season.	98%
H. The facility has an exposure control plan which addresses potential hazards posed by specific services provided by the facility (e.g., blood-borne pathogens).	91%
I. All personnel receive training and competency validation on managing a blood-borne pathogen exposure at the time of employment.	83%
J. All personnel received training and competency validation on managing a potential blood-borne pathogen exposure within the past 12 months.	79%

Overall, only 48% of NHs had ALL elements of the Healthcare Personnel Safety domain in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Resident Safety Questions	% YES
A. The facility currently has a written policy for to assess risk for TB (based on regional, community data) and provide screening to residents on admission.	89%
B. The facility documents resident immunization status for pneumococcal vaccination at time of admission.	98%
C. The facility offers annual influenza vaccination to residents.	100%

Overall, only 48% of NHs had ALL elements of the Resident Safety domain in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Surveillance	% YES
A. The facility has written intake procedures to identify potentially infectious persons at the time of admission.	78%
B. The facility has system for notification of infection prevention coordinator when antibiotic-resistant organisms or *C. difficile* are reported by clinical laboratory.	90%
C. The facility has a written surveillance plan outlining the activities for monitoring/tracking infections occurring in residents of the facility.	83%
D. The facility has system to follow-up on clinical information, (e.g., laboratory, procedure results and diagnoses), when residents are transferred to acute care hospitals for management of suspected infections, including sepsis.	80%
Disease Reporting	**% YES**
A. The facility has a written plan for outbreak response which includes a definition, procedures for surveillance and containment, and a list of syndromes or pathogens for which monitoring is performed.	77%
B. The facility has a current list of diseases reportable to public health authorities.	79%
C. The facility can provide point(s) of contact at the local or state health department for assistance with outbreak response.	87%

Overall, only 43% of NHs had ALL elements of these domains in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

	Hand Hygiene	% YES
A.	The facility hand hygiene (HH) policies promote preferential use of alcohol-based hand rub over soap and water except when hands are visibly soiled (e.g., blood, body fluids) or after caring for a resident with known or suspected *C. difficile* or norovirus.	69%
B.	All personnel receive training and competency validation on HH at the time of employment.	78%
C.	All personnel received training and competency validation on HH within the past 12 months.	73%
D.	The facility audits (monitors and documents) adherence to HH	52%
E.	The facility provides feedback to personnel regarding their HH performance.	55%
F.	Supplies necessary for adherence to HH (e.g., soap, water, paper towels, alcohol-based hand rub) are readily accessible in resident care areas (i.e., nursing units, resident rooms, therapy rooms).	88%

Overall, only 27% of NHs had ALL elements of the Hand Hygiene domain in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Personal Protective Equipment		% YES
A.	The facility has a policy on Standard Precautions which includes selection and use of PPE (e.g., indications, donning/doffing procedures).	94%
B.	The facility has a policy on Transmission-based Precautions that includes the clinical conditions for which specific PPE should be used (e.g., *C.diff*, Influenza).	92%
C.	Appropriate personnel receive job-specific training and competency validation on proper use of PPE at the time of employment.	66%
D.	Appropriate personnel received job-specific training and competency validation on proper use of PPE within the past 12 months.	61%
E.	**The facility audits (monitors and documents) adherence to PPE use (e.g., adherence when indicated, donning/doffing).**	**30%**
F.	**The facility provides feedback to personnel regarding their PPE use.**	**40%**
G.	Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms).	92%

Overall, only 21% of NHs had ALL elements of the PPE domain in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Respiratory Hygiene/Cough Etiquette	% YES
A. The facility has signs posted at entrances with instructions to individuals with symptoms of respiratory infection to: cover their mouth/nose when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after contact with respiratory secretions?	63%
B. The facility provides resources for performing hand hygiene near the entrance and in common areas.	85%
C. The facility offers facemasks to coughing residents and other symptomatic persons upon entry to the facility.	71%
D. The facility educates family and visitors to notify staff and take appropriate precautions if they are having symptoms of respiratory infection during their visit?	76%
E. All personnel receive education on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens	92%

Overall, only 46% of NHs had ALL elements of the Respiratory Hygiene/Cough Etiquette domain in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Antibiotic Stewardship		% YES
A.	The facility can demonstrate leadership support for efforts to improve antibiotic use (antibiotic stewardship).	72%
B.	The facility has identified individuals accountable for leading antibiotic stewardship activities	68%
C.	The facility has access to individuals with antibiotic prescribing expertise (e.g. ID trained physician or pharmacist).	79%
D.	**The facility has written policies on antibiotic prescribing.**	**30%**
E.	The facility has implemented practices in place to improve antibiotic use.	59%
F.	The facility has a report summarizing antibiotic use from pharmacy data created within last 6 months.	61%
G.	**The facility has a report summarizing antibiotic resistance (i.e., antibiogram) from the laboratory created within the past 24 months.**	**40%**
H.	**The facility provides clinical prescribers with feedback about their antibiotic prescribing practices.**	**34%**
I.	**The facility has provided training on antibiotic use (stewardship) to all nursing staff within the last 12 months.**	**41%**
J.	**The facility has provided training on antibiotic use (stewardship) to all clinical providers with prescribing privileges within the last 12 months.**	**28%**

Overall, only 8% of NHs had ALL elements of the Antibiotic Stewardship domain in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Injection Safety and Point of Care Testing	% YES
A. The facility has a policy on injection safety which includes protocols for performing finger sticks and point of care testing (e.g., assisted blood glucose monitoring, or AMBG).	87%
B. Personnel who perform point of care testing (e.g., AMBG) receive training and competency validation on injection safety procedures at time of employment.	74%
C. Personnel who perform point of care testing (e.g., AMBG) receive training and competency validation on injection safety procedures within the past 12 months.	61%
D. The facility audits (monitors and documents) adherence to injection safety procedures during point of care testing (e.g., AMBG).	**37%**
E. The facility provides feedback to personnel regarding their adherence to injection safety procedures during point of care testing (e.g., AMBG).	**44%**
F. Supplies necessary for adherence to safe injection practices (e.g., single-use, auto-disabling lancets, sharps containers) are readily accessible in resident care areas (i.e., nursing units).	98%
G. The facility has policies and procedures to track personnel access to controlled substances to prevent narcotics theft/drug diversion.	93%

Overall, only 27% of NHs had ALL elements of this domain in place

CDC unpublished data, March 2018

Nursing Homes Assessment Findings (n=2044)

Environmental Cleaning		% YES
A.	The facility has written cleaning/disinfection policies which include routine and terminal cleaning and disinfection of resident rooms.	86%
B.	The facility has written cleaning/disinfection policies which include routine and terminal cleaning and disinfection of rooms of residents on contact precautions (e.g., *C. diff*).	82%
C.	The facility has written cleaning/disinfection policies which include cleaning and disinfection of high-touch surfaces in common areas.	77%
D.	The facility cleaning/disinfection policies include handling of equipment shared among residents (e.g., blood pressure cuffs, rehab therapy equipment, etc.).	74%
E.	Facility has policies and procedures to ensure that reusable medical devices (e.g., blood glucose meters, wound care equipment, podiatry equipment, dental equipment) are cleaned and reprocessed appropriately prior to use on another patient.	73%
F.	Appropriate personnel receive job-specific training and competency validation on cleaning and disinfection procedures at the time of employment.	70%
G.	Appropriate personnel received job-specific training and competency validation on cleaning and disinfection procedures within the past 12 months.	56%
H.	**The facility audits (monitors and documents) quality of cleaning and disinfection procedures.**	**50%**
I.	The facility provides feedback to personnel regarding the quality of cleaning and disinfection procedures.	54%
J.	Supplies necessary for appropriate cleaning and disinfection procedures (e.g., EPA-registered, including products labeled as effective against *C.difficile* and Norovirus) are available.	91%

Overall, only 24% of NHs had ALL elements of the Environmental Cleaning domain in place

CDC unpublished data, March 2018

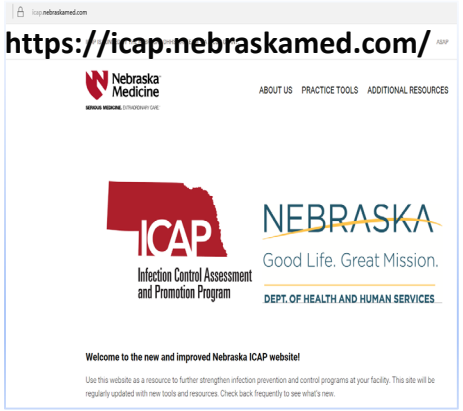
Overall LTC Assessment Experience

- *Common findings and themes*
  - Leadership investment/support for IPC highly variable
  - Staff overseeing IPC programs lacked training and dedicated time
  - Routine auditing of staff adherence to policies and procedures and feedback on staff adherence was not in place (i.e. PPE, injection safety and POCT)
  - Minimal antibiotic stewardship activities in place

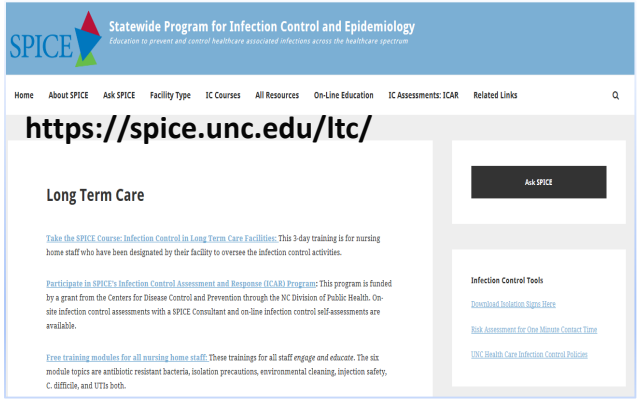
- *Benefits from the activity*
  - New relationships between health dept. and providers
  - Positive learning experience for providers and health dept.
  - Available IPC education and technical assistance available – regulatory requirements
  - Identification of LTC training and resource needs
    - Development of regional LTC training by some health departments

Some State Health Department Training Links

https://icap.nebraskamed.com/

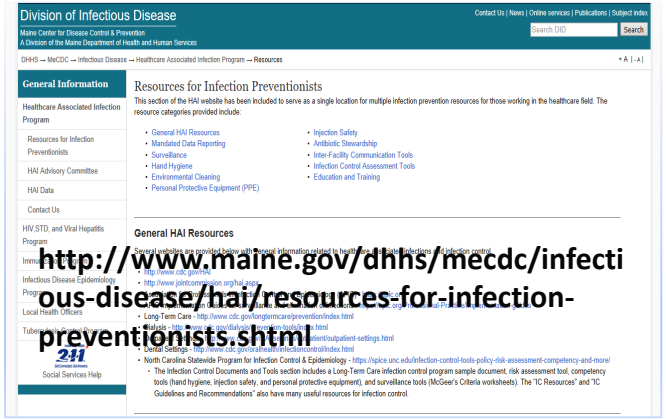


https://spice.unc.edu/ltc/



https://www.colorado.gov/pacific/cdphe/hai-training

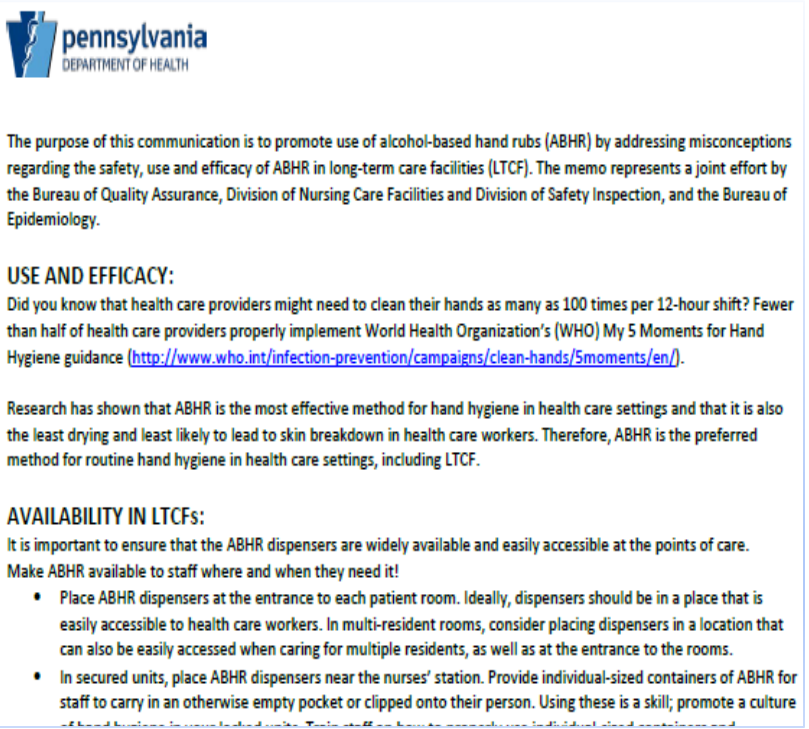
http://www.maine.gov/dhhs/mecdc/infectious-disease/hai/resources-for-infection-preventionists.shtml



https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HAIProgramHome.aspx

Promoting Alcohol-Based Hand Rubs in NHs: PA Example

- Health department recognized concerns about use of alcohol-based hand rubs (ABHR) was a barrier to implementation in NHs
- Worked with state survey agency to craft informational memo to reduce provider concerns and address common misconceptions about ABHR use
- Disseminated memo to all 700+ providers across the state
- Supports efforts to increase access to hand hygiene products within facilities



pennsylvania
DEPARTMENT OF HEALTH

The purpose of this communication is to promote use of alcohol-based hand rubs (ABHR) by addressing misconceptions regarding the safety, use and efficacy of ABHR in long-term care facilities (LTCF). The memo represents a joint effort by the Bureau of Quality Assurance, Division of Nursing Care Facilities and Division of Safety Inspection, and the Bureau of Epidemiology.

USE AND EFFICACY:

Did you know that health care providers might need to clean their hands as many as 100 times per 12-hour shift? Fewer than half of health care providers properly implement World Health Organization's (WHO) My 5 Moments for Hand Hygiene guidance (http://www.who.int/infection-prevention/campaigns/clean-hands/5moments/en/).

Research has shown that ABHR is the most effective method for hand hygiene in health care settings and that it is also the least drying and least likely to lead to skin breakdown in health care workers. Therefore, ABHR is the preferred method for routine hand hygiene in health care settings, including LTCF.

AVAILABILITY IN LTCFs:

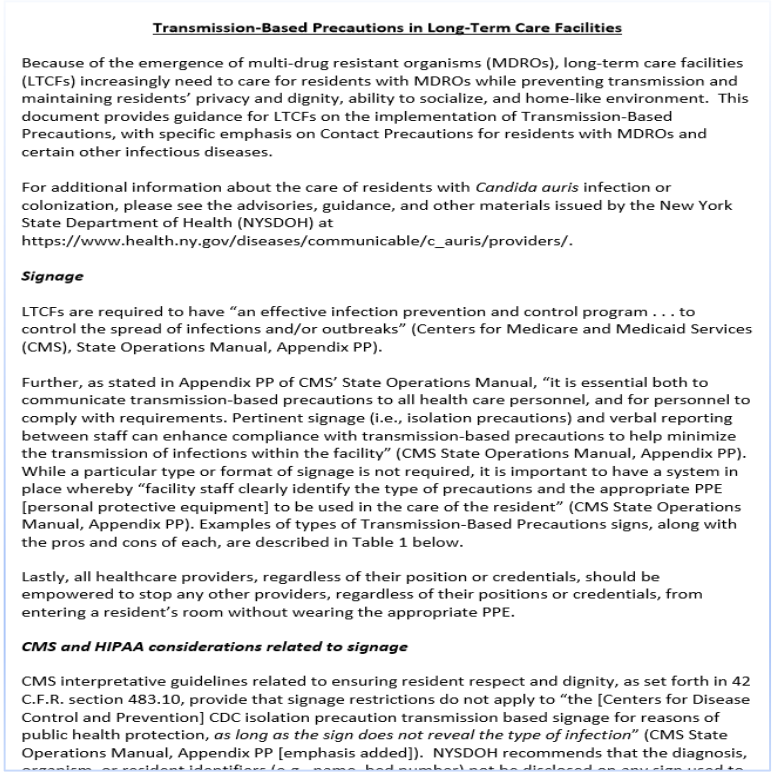
It is important to ensure that the ABHR dispensers are widely available and easily accessible at the points of care. Make ABHR available to staff where and when they need it!

- Place ABHR dispensers at the entrance to each patient room. Ideally, dispensers should be in a place that is easily accessible to health care workers. In multi-resident rooms, consider placing dispensers in a location that can also be easily accessed when caring for multiple residents, as well as at the entrance to the rooms.
- In secured units, place ABHR dispensers near the nurses' station. Provide individual-sized containers of ABHR for staff to carry in an otherwise empty pocket or clipped onto their person. Using these is a skill; promote a culture

http://www.health.pa.gov/facilities/Consumers/Healthcare%20Associated%20Infection%20(HAI)/Documents/ABHRmemo%208%2014%2017%20FINAL%20Approved.pdf

Improving Precautions Signage in NHs: NY Example

- Health department developed guidance to support providers use of signage when residents placed in transmission-based precautions
- Addressed commonly asked questions about HIPPA and privacy questions
- Provided examples of signs which would be appropriate to use as cues to action for staff and visitors
- Discussed with state survey agency to ensure public health recommendations would be supported by regulatory groups



Transmission-Based Precautions in Long-Term Care Facilities

Because of the emergence of multi-drug resistant organisms (MDROs), long-term care facilities (LTCFs) increasingly need to care for residents with MDROs while preventing transmission and maintaining residents' privacy and dignity, ability to socialize, and home-like environment. This document provides guidance for LTCFs on the implementation of Transmission-Based Precautions, with specific emphasis on Contact Precautions for residents with MDROs and certain other infectious diseases.

For additional information about the care of residents with *Candida auris* infection or colonization, please see the advisories, guidance, and other materials issued by the New York State Department of Health (NYSDOH) at https://www.health.ny.gov/diseases/communicable/c_auris/providers/.

Signage

LTCFs are required to have "an effective infection prevention and control program . . . to control the spread of infections and/or outbreaks" (Centers for Medicare and Medicaid Services (CMS), State Operations Manual, Appendix PP).

Further, as stated in Appendix PP of CMS' State Operations Manual, "it is essential both to communicate transmission-based precautions to all health care personnel, and for personnel to comply with requirements. Pertinent signage (i.e., isolation precautions) and verbal reporting between staff can enhance compliance with transmission-based precautions to help minimize the transmission of infections within the facility" (CMS State Operations Manual, Appendix PP). While a particular type or format of signage is not required, it is important to have a system in place whereby "facility staff clearly identify the type of precautions and the appropriate PPE [personal protective equipment] to be used in the care of the resident" (CMS State Operations Manual, Appendix PP). Examples of types of Transmission-Based Precautions signs, along with the pros and cons of each, are described in Table 1 below.

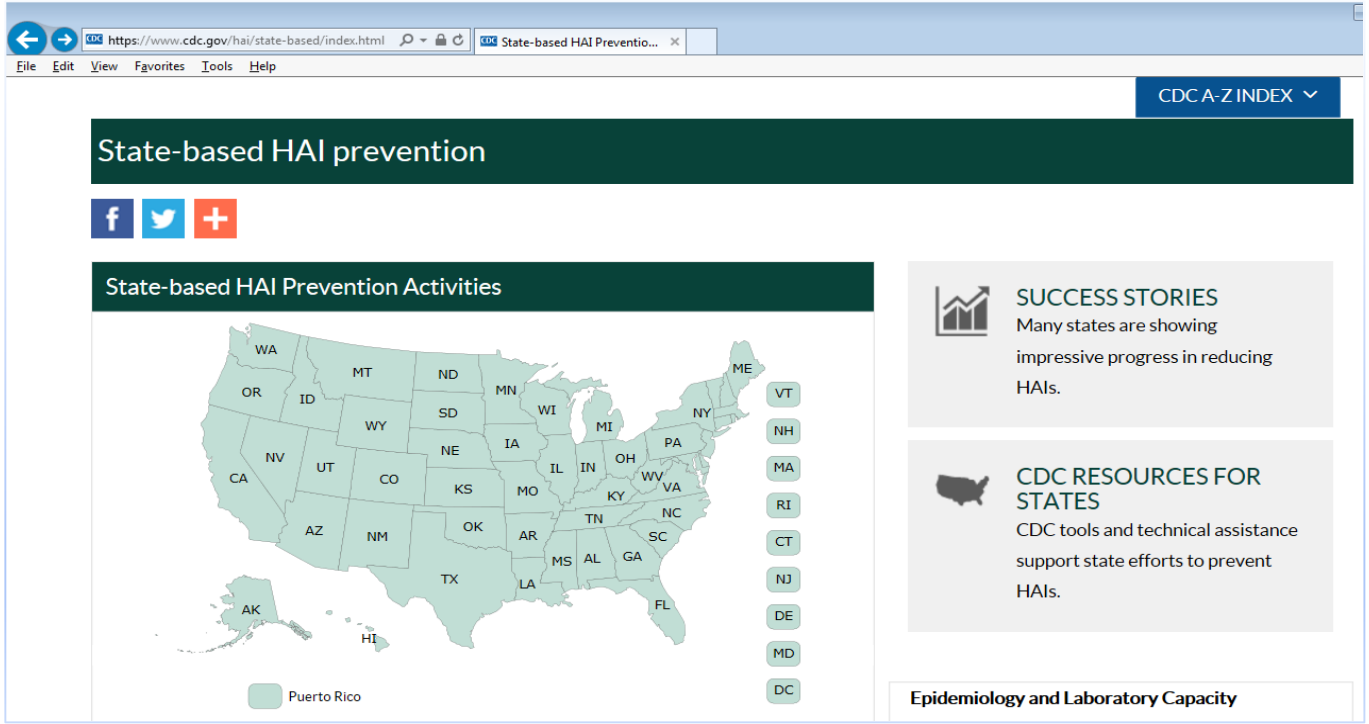
Lastly, all healthcare providers, regardless of their position or credentials, should be empowered to stop any other providers, regardless of their positions or credentials, from entering a resident's room without wearing the appropriate PPE.

CMS and HIPAA considerations related to signage

CMS interpretative guidelines related to ensuring resident respect and dignity, as set forth in 42 C.F.R. section 483.10, provide that signage restrictions do not apply to "the [Centers for Disease Control and Prevention] CDC isolation precaution transmission based signage for reasons of public health protection, *as long as the sign does not reveal the type of infection*" (CMS State Operations Manual, Appendix PP [emphasis added]). NYSDOH recommends that the diagnosis,

https://www.health.ny.gov/diseases/communicable/c_auris/docs/transmission_based_precautions.pdf

Connect with your State Healthcare-Associated Infections (HAI) Program



http://www.cdc.gov/hai/state -based/index.html

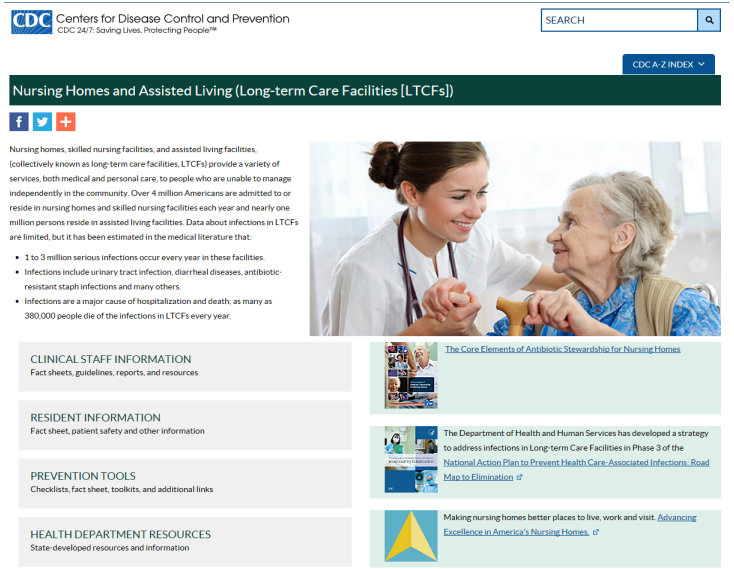
Also, please check out CDC Guidance on IC in Long-Term Care

http://www.cdc.gov/longtermcare

Thank you!!

Questions?

bzo2@cdc.gov



http://www.cdc.gov/longtermcare

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.