

Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care

Dr. Melissa Schaefer, CDC, Atlanta
Teleclass broadcast sponsored by Virox Technologies Inc (www.virox.com)

Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care

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(Nothing to Disclose)

Hosted by Paul Webber
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May 31, 2012

Objectives

- Describe the spectrum of care provided in outpatient settings
- Describe infection control lapses being identified in outpatient settings
- Discuss current prevention activities and materials targeting infection prevention needs in outpatient settings

Outpatient settings

- Settings that provide healthcare to patients who do not remain overnight
- Examples include:
 - Physician offices
 - Hospital-based outpatient clinics
 - Urgent care centers
 - Cancer clinics and infusion centers
 - Imaging centers
 - Alternative medicine clinics
 - Ambulatory surgical centers
 - Hemodialysis clinics

<http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html>

Transition of healthcare delivery to settings outside the hospital

- Physician offices
 - 2007: ~1 billion visits to office-based physicians¹
- Hemodialysis
 - 2008: 354,6000 maintenance hemodialysis patients in the U.S.²
- Outpatient procedures represent >3/4 of all operations performed³
 - Ambulatory surgical centers
 - 2011: >5,300 (>54% increase since 2001)⁴
 - 2007: > 6 million procedures performed in ASCs and paid by Medicare (~\$3 billion)
 - 10 states have more ASCs than hospitals⁵
 - MD, DE, WA, NJ, CA, FL, AZ, GA, OR and RI

1. National Ambulatory Medical Care Survey, 2007 Available at: <http://www.cdc.gov/nchs/data/nhr/nhr07.pdf>

2. 2010 USRDS Annual Data Report. Available at: <http://www.usrds.org/pdf/ADR>

3. Balle PS. Infection Control Practices in Ambulatory Surgical Centers. JAMA 2010;303:2295-7

4. MedPac data available at: <http://www.medpac.gov/documents/jun10databookcenterreport.pdf>

5. <http://www.beckersasc.com/asc-transactions-and-valuation-issues/10-states-with-more-surgery-centers-than-hospitals.html>

Outpatient settings

- Provide similar services as hospitals
 - Surgery, injections, infusions (chemotherapy, antimicrobials, contrast)
- Increasingly vulnerable patient populations
 - Age extremes
 - Immunocompromised
- Expansion of services without proportionally expanded infection control infrastructure and oversight

Oversight in outpatient settings

- Outpatient healthcare settings subject to little oversight or regulation
 - Medicare is a Federal insurance program that has oversight of a subset of outpatient settings (e.g., hemodialysis facilities)
 - Medicare-certified facilities are subject to inspections by state survey agencies (or accrediting organizations) to determine compliance with minimum health and safety standards
 - Majority of outpatient settings operate only under the physician's medical license +/- business license unless state laws specify otherwise
 - Not subject to routine survey/inspections (vs. restaurants)
 - Accreditation of outpatient facilities that are not part of hospital systems is uncommon
 - The Joint Commission recently announced accreditation of its 2,000th ambulatory care facility

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HAI Risks in Outpatient Settings

Outbreaks and Patient Notifications in Outpatient Settings

The following table includes examples of recent outbreaks and patient notification events occurring in a variety of outpatient settings including primary care clinics, pediatric offices, ambulatory surgical centers, pain remediation clinics, imaging facilities, oncology clinics, and health fairs. This is not an exhaustive list but it serves as a reminder of the serious consequences that can result when healthcare personnel fail to follow the basic principles of infection control. Such consequences include: infection transmission to patients, notification of thousands of patients of possible exposure to bloodborne pathogens, referral of providers to licensing boards for disciplinary action, and malpractice suits filed by patients.

These events are preventable, yet they continue to occur. Facilities and healthcare personnel are urged to review the *Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care* and its accompanying *Infection Prevention Checklist* to assess the policies and procedures in their facility as well as their own personal practices to assure they are in accordance with evidence-based guidelines and to prevent patient harm.

Setting	Year Investigated	Pathogen(s)	Infection(s)	Patient notification performed (# notified)	Infection Control Breaches Reported
Urology Clinic [1]	2011	N/A*	N/A*	Yes (101)	1) Single-use needle guides (for prostate biopsy) used for >1 patient 1) Syringe reuse (i.e.,

<http://www.cdc.gov/HAI/settings/outpatient/outbreaks-patient-notifications.html>


HAI Risks in Outpatient Settings

- ❑ National estimates of number of healthcare-associated infections originating in outpatient settings lacking
- ❑ Rely on information obtained from outbreak investigations and patient notifications
 - >40 recognized outbreaks in outpatient settings resulting from unsafe injection practices during the last 10 years^{1,2}
 - Wide range of infections, many life-threatening
 - >117,000 patients notified they were potentially exposed to unsafe injection practices in outpatient settings²
- ❑ Common theme of outbreaks and notification events
 - Breakdowns and violations in standard procedures
 - Preventable with basic infection control practices
 - Healthcare personnel not aware of their errors

1. Maccarnelli et al. Abstract from SHEA Decennial available at: <http://shes.confex.com/shes/2010/webprogram/Paper2113.html>
2. Guh AY, Thompson ND, Schaefer MK, Patel P, Pez JP. Patient Notification for Bloodborne Pathogen Testing Due to Unsafe Injection Practices in U.S. Healthcare Settings, 2001–2011. *Med Care*. (in press).

The Las Vegas outbreak

May 16, 2008 / Vol. 57 / No. 19



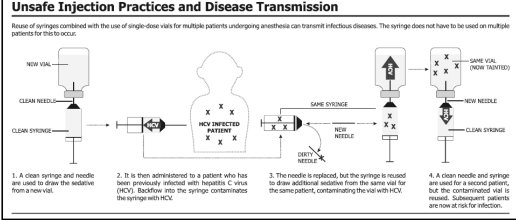
Acute Hepatitis C Virus Infections Attributed to Unsafe Injection Practices at an Endoscopy Clinic — Nevada, 2007

On January 2, 2008, the Nevada State Health Division (NSHD) contacted CDC concerning surveillance reports received by the Southern Nevada Health District (SNHD) regarding two persons recently diagnosed with acute hepatitis C. A third person with acute hepatitis C was reported.

- ❑ Licensed ASC
- ❑ Had not undergone a full inspection by state surveyors in 7 years
- ❑ Serious breaches in injection safety identified during outbreak investigation

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5719a2.htm>

Injection safety breaches



Unsafe Injection Practices and Disease Transmission

Reuse of syringes contaminated with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.

1. A clean syringe and needle are used to draw the medicine from a new vial.
2. It is then administered to a patient who has been previously infected with hepatitis C virus (HCV). Backflow into the syringe contaminates the syringe with HCV.
3. The needle is replaced, but the syringe is reused to draw additional medicine from the same vial for the same patient, contaminating the vial with HCV.
4. A clean needle and syringe are used for a second patient, but the contaminated vial is reused. Subsequent patients are now at risk for infection.

- ❑ Re-entered medication vials with a used syringe
- ❑ Used single-dose vials for more than one patient

Fischer GE et al. Hepatitis C Virus Infection from Unsafe Injection Practices at an Endoscopy Clinic in Las Vegas, Nevada, 2007–2008. *CID* 2010;51:267–273.

Investigation outcomes

- ❑ Clinic immediately advised to stop unsafe practices
 - Business license revoked and clinic was closed
- ❑ Unsafe practices had been commonly used by some staff at the clinic for at least 4 years
 - Health department began notifying >50,000 former patients to recommend testing
- ❑ Transmission clearly identified on 2 separate dates
- ❑ Cost to health department >\$800,000
- ❑ Legal action
 - Physicians and CRNAs at the clinic, Manufacturers of propofol, Insurance companies
- ❑ Led to assessment of remaining ASCs in Nevada using infection control checklist
 - Checklist subsequently adopted by CMS for use in ASC inspections

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Inspection of CMS-certified ASCs

- ❑ Prior to 2009, inspections did not require observations of procedures or standardized assessment of infection control
- ❑ After 2009
 - Case-tracer methodology
 - Follow at least 1 patient throughout their entire stay in the ASC while observing practices (e.g., documentation, infection control)
 - Use of standardized checklist
 - Systematic assessment of infection prevention practices
 - www.cms.gov/manuals/downloads/som107_exhibit_351.pdf

Established 2011
Ambulatory Surgical Centers
INFECTION CONTROL SURVEYOR WORKSHEET
(Rev. 08/2010; 11-24-10, R2/09/10; 11-24-10, Implementation; 11-24-10)
CMS
Center for Medicare & Medicaid Services

D. Injection Practices (injectable medications, saline, other infusions)
Observations are to be made of staff who prepare and administer medications and perform injections (e.g., anesthesiologists, certified registered nurse anesthetists, nurses).

Practices to be Assessed	Via Practice Performed?		Number of Confirmation
	Yes	No	
A. Needles are used for only one patient	<input type="radio"/> Yes	<input type="radio"/> Observation	<input type="radio"/> Interview
	<input type="radio"/> No	<input type="radio"/> Both	
	<input type="radio"/> N/A		
B. Syringes are used for only one patient	<input type="radio"/> Yes	<input type="radio"/> Observation	<input type="radio"/> Interview
	<input type="radio"/> No	<input type="radio"/> Both	
	<input type="radio"/> N/A		

Infection control worksheet (ICWS) components

- ❑ Elements from CDC/HICPAC Guidelines
 - Emphasis on Standard Precautions
- ❑ Hand hygiene and glove use
- ❑ Injection safety and medication handling
- ❑ Instrument reprocessing
 - High-level disinfection (e.g., endoscope reprocessing)
 - Sterilization
- ❑ Environmental cleaning
- ❑ Point-of-care devices (e.g., blood glucose meters)

Infection Control Assessment of Ambulatory Surgical Centers

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Context More than 5000 ambulatory surgical centers (ASCs) in the United States participate in the Medicare program. Little is known about infection control practices in ASCs. The Centers for Medicare & Medicaid Services (CMS) piloted an infection control audit tool in a sample of ASC inspections to assess facility adherence to recommended practices.

Objective To describe infection control practices in a sample of ASCs.

Design, Setting, and Participants All State Survey Agencies were invited to participate. Seven states volunteered. 3 were selected based on geographic diversity.

- ❑ 68% of ASCs had at least 1 lapse in infection control
- ❑ 18% had lapses identified in 3 or more of the 5 categories.

Measuring of blood glucose monitoring equipment.

Main Outcome Measures Proportion of facilities with lapses in each infection control category.

Results Overall, 46 of 68 ASCs (67.6%; 95% confidence interval [CI], 55.9%-77.9%) had at least 1 lapse in infection control; 12 of 68 ASCs (17.6%; 95% CI, 9.9%-28.1%) had lapses identified in 3 or more of the 5 infection control categories. Common lapses included using single-dose medication vials for more than 1 patient (18/64, 28.1%; 95% CI, 18.2%-40.0%), failing to adhere to recommended practices regarding reprocessing of equipment (19/62; 29.4%; 95% CI, 18.6%-40.0%), and lapses in handling of blood glucose monitoring equipment (25/54; 46.3%; 95% CI, 33.4%-59.6%).

JAMA
JAMA. 2010;303(22):2273-2279

Overall results of 3-state pilot infection control assessments

Infection Control Category Assessed	Number of Facilities with Lapses Identified
Hand Hygiene and Use of Gloves	12/62 (19%)
Injection Safety and Medication Handling	19/67 (28%)
Equipment Reprocessing	19/67 (28%)
Environmental Cleaning	12/64 (19%)
Handling of Blood Glucose Monitoring Equipment	25/54 (46%)

Schaefer et al. JAMA 2010;303:2273-2279

Recent Outbreaks and Patient Notifications

Injection safety – Patient notification

- ❑ Medical assistant administered flu vaccine from the same syringe to >1 patient
 - Children between age 6 months and 35 months put at risk
- ❑ Patient notification conducted and bloodborne pathogen testing advised

Pediatric Clinic

Children told to be tested for HIV after flu vaccines reused

10:08 PM, Apr 12, 2011 | 0 comments

April 12, 2011

- ❑ CDC Recommendations
 - Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens)

<http://www.9news.com/news/article/193134/180/Children-told-to-be-tested-for-HIV-after-flu-vaccines-reused>

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Injection safety – Patient notification

- Diabetes educator used insulin demonstration pens for >1 patient
- 2,345 patients notified and recommended to undergo bloodborne pathogen testing

Outpatient Clinic

Thousands of Wisconsin clinic patients possibly exposed to HIV

August 30, 2011

- CDC Recommendations
 - Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens)

<http://www.newsypipe.com/10766-wisconsin-insulin-pens-hiv/>
<http://www.deancare.com/about-dean/news/2011/important-patient-safety-notification/>

Injection safety – Outbreak and Patient notification

- 16 patients with bloodstream infections
- Clinic closed for “unsafe infection control practices”
- 470 patients notified and advised to undergo bloodborne pathogen testing

JACKSON, Miss. (AP) — A clinic in south Mississippi gave cancer patients less chemotherapy or cheaper drugs than they were told and reused the same needles on multiple people as part of a multimillion-dollar Medicare and Medicaid fraud, a 15-count indictment alleges.

September 9, 2011

- CDC Recommendations
 - Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens)

http://www.entrepreneur-journal.com/news/article_58190090-bbb5-11e0-b99d-001cc4c03286.html
<http://www.chron.com/news/article/3-charged-in-alleged-chemotherapy-fraud-in-Miss-2163084.php>

Injection safety – Outbreak and Patient notification

- “Double dipping” – syringe that has been used to inject IV medication into a patient, reused to enter a medication vial that was used for subsequent patients
- >2000 patients notified and bloodborne pathogen testing recommended

Death may be linked to San Pedro clinic

January 11, 2011

From wire service reports
 Posted: 01/11/2011 08:09:29 AM PST
 Updated: 01/12/2011 08:20:19 AM PST

Pain Clinic

The family of one of about 2,300 patients who were notified that a San Pedro clinic unwittingly used contaminated needles to sedate patients contacted health officials Tuesday to report that the 76-year-old mother of two died from complications of hepatitis C.

- CDC Recommendations
 - Medication vials are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient

<http://www.dailybreeze.com/news/17070130>
<http://www.publichealth.lacounty.gov/acd/hepinfo.htm>

PPE / Injection safety – Outbreak

- Healthcare personnel did not wear facemasks when necessary for spinal injections and used single-dose vials for multiple patients

Post-Myelography Bacterial Meningitis Among Patients at an Outpatient Radiology Facility — Missouri, 2010

AUTHORS: Amit S. Chitnis, I. Benowitz, V. Srinivasan, R. Gertz, Jr, P. Shewmaker, B. Beall, H. O'Connell, J. Noble-Wang, G. Van Beneden, A. Kallen, S. Patrick, C. Turabelidze, A. Guh, P. Patel

- CDC Recommendations
 - HCP wear a surgical mask when placing a catheter or injecting material into the epidural or subdural space (e.g., during myelogram, epidural or spinal anesthesia)
 - Single dose (single-use) medication vials, ampules, and bags or bottles of IV solution are used for only one patient

http://www.cdc.gov/eis/downloads/2011.EIS_Conference.pdf

Injection safety recommendations

- Use aseptic technique when preparing and administering medications
- Never administer medications from the same syringe to multiple patients
- Do not reuse a syringe to enter a medication vial or solution
- Do not administer medications from a single-dose vials or intravenous solution bags to more than one patient
- Limit the use of multi-dose vials and dedicate them to a single patient whenever possible
- Wear a surgical mask for when placing a catheter or injecting material into the epidural or subdural space

<http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>

Equipment reprocessing – Patient notification

- Urology clinic re-used single-use-only endocavitary needle guides during performance of prostate biopsies¹
 - “Needle guides used on average 3-5 times before being discarded after becoming too bloody”²
 - ~100 patients notified

March 15, 2011



Nevada State Health Division Technical Bulletin

Topic: Risk of Transmission of Blood Borne Pathogens from Reuse of Single Use Only Endocavitary Needle Guides
 Section/Program: Bureau of Health Statistics, Planning, Epidemiology, and Response Office of Epidemiology
 Date: March 15, 2011

- CDC Recommendations
 - Single-use devices (SUDs) are discarded after use and not used for more than one patient
 - If the facility elects to reuse SUDs, these devices must be reprocessed prior to reuse by a 3rd-party processor that is registered with the FDA as a 3rd-party reprocessor and cleared by the FDA to reprocess the specific device in question.

¹ <http://www.southernnevadahealthdistrict.org/news11/032111.php>
² <http://medboard.nv.gov/Public%20Filings/2011/Kaplan%20Summary%20Suspension.pdf>
³ http://health.nv.gov/Epidemiology/2011-03_NeedleGuideTechnicalBulletin.pdf

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How often are lapses in reprocessing occurring?

- **January 1, 2007-May 11, 2010 - FDA identified¹:**
 - 80 reports of inadequate reprocessing filed with the Agency
 - 28 reports of infection that may have occurred from inadequate reprocessing
- **ASC 3-state pilot²**
 - 28% with lapse in reprocessing of medical equipment
 - 5.8% inappropriately reprocessed single-use devices
 - 6.7% failed to adequately pre-clean instruments
 - 16.7% did not prepare, test, or replace high-level disinfectant appropriately
- **December 2002-December 2006 - 17 healthcare facilities requested assistance from California Dept Health Services regarding inadequately reprocessed endoscopes³**
 - >9000 patients notified of potential exposure to bloodborne pathogens

1. Statement of Anthony D. Watson to the House Committee on Veteran's Affairs available at: <http://veterans.house.gov/prepared-statement/>
 prepared-statement-anthony-d-watson-bs-ms-mba-director-division-anesthesiology
 2. Schaefer et al. Infection Control Assessment of Ambulatory Surgical Centers. JAMA 2010;303(22):2273-2279.
 3. Rosenberg et al. Inadequate Reprocessing of Endoscopes: The California Experience, 2002-2007. AJIC 2007;35(5):E85-86.

Equipment reprocessing recommendations

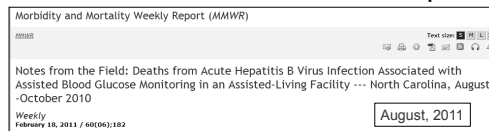
- **Facilities should ensure that reusable medical equipment (e.g., point-of-care devices, surgical instruments, endoscopes) is cleaned and reprocessed appropriately prior to use on another patient**
- **Reusable medical equipment must be cleaned and reprocessed (disinfection or sterilization) and maintained according to the manufacturer's instructions**
 - If the manufacturer does not provide such instructions, the device may not be suitable for multi-patient use
 - Not all equipment is reusable (it must be FDA-approved as such)
 - In ASC pilot, 6% of facilities inappropriately reprocessed/reused single-use devices

Equipment reprocessing recommendations

- **Assign responsibilities for reprocessing of medical equipment to HCP with appropriate training**
 - Maintain copies of the manufacturer's instructions for reprocessing of equipment in use at the facility; post instructions at locations where reprocessing is performed
 - Observe procedures to document competencies of HCP responsible for equipment reprocessing upon assignment of those duties, whenever new equipment is introduced, and on an ongoing periodic basis (e.g., quarterly)
- **Assure HCP have access to and wear appropriate PPE when handling and reprocessing contaminated patient equipment**

Point-of-Care Devices - Outbreak

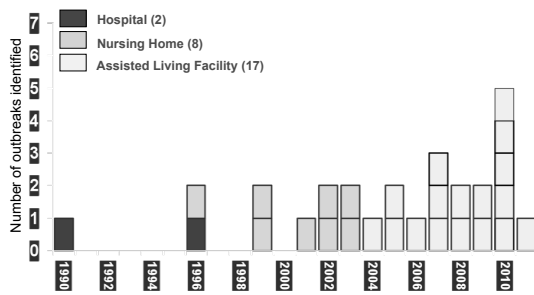
- **HBV outbreak in an assisted-living facility**
 - 8 patients acutely infected with HBV; 6 deaths
- **Fingerstick devices used for >1 patient**
- **Did not clean and disinfect meters between patients**



- **CDC Recommendations**
 - A new single-use, auto-disabling lancing device is used for each patient
 - The glucose meter is cleaned and disinfected after every use

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6006a5.htm>

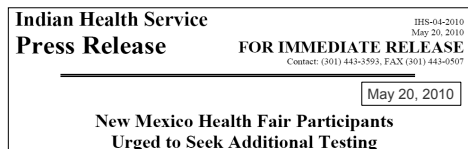
Outbreaks of HBV infection associated with blood glucose monitoring - 1990 to 2011, US



Thompson J Diabetes Sci Technol 2009; 3:283-88. Thompson JDST 2011;5:1396-1402. CDC unpublished data.

Point-of-Care Devices – Patient notification

- **Physician Assistant student trainees used the same multi-lancet fingerstick device for >1 person**
- **~ 50 individuals tested with this device and recommended to undergo bloodborne pathogen testing**



- **CDC Recommendations**
 - A new single-use, auto-disabling lancing device is used for each patient

http://www.ihs.gov/publicaffairs/PressReleases/docs/UNM_Blood_Testing_CDC_final.pdf

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Point-of-Care Devices

- **3-state pilot:**
 - 46% of ASCs at some type of lapse in handling of blood glucose monitoring equipment
 - 32% (17/53) of ASCs failed to clean and disinfect the blood glucose meter between patients
 - 21% (11/53) used the same fingerstick device for >1 patient

Point-of-Care Device Recommendations

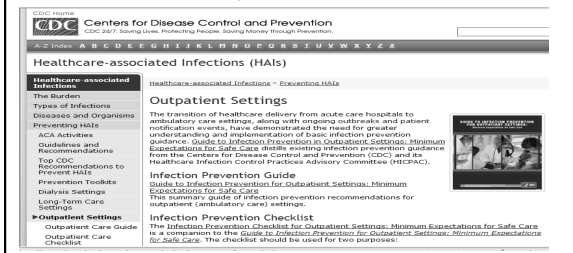
- **New single-use, auto-disabling lancing device is used for each patient**
 - Lancing holder devices are not suitable for multi-patient use
- **If used for >1 patient, the point-of-care testing meter is cleaned and disinfected after every use according to manufacturer's instructions**
 - If the manufacturer does not provide instructions for cleaning and disinfections, then the testing meter should not be used for >1 patient

<http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html>

Infection prevention resources for outpatient surgical settings

- <http://www.cdc.gov/HAI/settings/outpatient/outpatient-settings.html>

- Outpatient Guide
- Outpatient Checklist
- List of outbreaks and patient notification events



CDC Guide to Infection Prevention in Outpatient Settings

- **These recommendations are not new**
 - Summary of existing evidence-based guidelines produced by the CDC and the Healthcare Infection Control Practices Advisory Committee
 - Based primarily upon elements of Standard Precautions
 - Infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting where healthcare is delivered
 - Users should consult the full guidelines for more detailed information and recommendations concerning specialized infection prevention issues (e.g., multi-drug resistant organisms)
 - Does not replace existing detailed guidance for hemodialysis centers or dental practices
- **Represent minimum infection prevention expectations for safe care in ambulatory care settings**

<http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html>

CDC Guide to Infection Prevention in Outpatient Settings

- **Administrative Measures**
 - Assure at least one individual with training in infection prevention is employed by or regularly available to the facility
- **Educate and Train Healthcare Personnel**
- **Monitor and Report Healthcare-associated Infections**
- **Adhere to Standard Precautions**
 - Hand Hygiene
 - Personal Protective Equipment
 - Injection Safety
 - Environmental Cleaning
 - Medical Equipment
 - Respiratory Hygiene/Cough Etiquette

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Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care

- <http://www.cdc.gov/HAI/settings/outpatient/checklist/outpatient-care-checklist.html>
- Checklist should be used:
 - To ensure that the facility has appropriate infection prevention policies and procedures in place and supplies to allow healthcare personnel to provide safe care
 - To systematically assess personnel adherence to correct infection prevention practices

Infection Prevention Checklist		
Section I. Administrative Policies and Facility Practices		
1. Facility Policies	Practices Performed	If answer is No, document plan for remediation
a. Written infection prevention policies and procedures are available, current, and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations, or standards <i>(Note: Policies and procedures should be appropriate for the services provided by the facility and should extend beyond OSMA bloodborne pathogen training)</i>	Yes No	


CMS Inspection Tool for ASCs

- http://www.cms.gov/manuals/downloads/som107_exhibit_351.pdf

II. Injection Practices (injectable medications, saline, other infusates)		
Observations are to be made of staff who prepare and administer medications and perform injections (e.g., anesthesiologists, certified registered nurse anesthetists, nurses).		
Practices to be Assessed	Was Practice Performed?	Manner of Confirmation
A. Needles are used for only one patient	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Observation <input type="radio"/> Interview <input type="radio"/> Both
B. Syringes are used for only one patient	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Observation <input type="radio"/> Interview <input type="radio"/> Both

Outpatient Oncology Settings

- <http://www.cdc.gov/HAI/settings/outpatient/basic-infection-control-prevention-plan-2011/index.html>



Hemodialysis Facilities

- <http://www.cdc.gov/dialysis/collaborative/tool-resources/index.html>
 - Audit tools and protocols for prevention of bloodstream infections

CDC Evidence-based Guidelines

- http://www.cdc.gov/HAI/prevent/prevent_pubs.html
- These include the following:
 - Guideline for Disinfection and Sterilization
 - Guidelines for Environmental Infection Control
 - Guidelines for Hand Hygiene
 - Guideline for Isolation Precautions
 - Standard Precautions
 - Injection Safety

Injection Safety Resources

- <http://www.cdc.gov/injectionsafety/>
 - Guidelines
 - Links to freely accessible publications
 - FAQs
 - Medscape video – Free CME
- <http://www.oneandonlycampaign.org/>
 - Injection safety campaign led by CDC
 - Injection safety training video for healthcare personnel

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Point-of-Care Device resources

- <http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html>
 - Infection prevention recommendations
 - Clinical alerts
 - Fingerstick devices
 - Insulin pens
 - FAQs including
 - "How can Hepatitis B virus be transmitted through the meter?"
 - "What products are acceptable for cleaning and disinfection of blood glucose meters?"

HHS Action Plan for ASCs

- http://www.hhs.gov/ash/initiatives/hai/tier2_ambulatory.html
 - Summarizes HAI prevention issues specific to ASCs and presents key actions needed to assure safe care in these settings
- <http://www.hhs.gov/ash/initiatives/hai/resources/index.html>
 - Infection prevention training for ASCs - **Free CME**

Summary

- **Significant portion of healthcare in the United States provided in outpatient settings**
 - Variable oversight
- **Outbreaks and patient notification events continue to identify infection prevention concerns/opportunities in outpatient settings**
 - Highlight lapses in basic infection control
- **Multiple ongoing activities and resources available to facilities**

Thank you

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.

National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion



05 June (Free Teleclass – Broadcast Live from APIC Conference) **MDR Gram-Negative Infections: Across the Continuum of Care**
Speaker: Prof. Keith Kaye, Wayne State University

06 June (Free WHO Teleclass ... Europe) **Economic Impact of Healthcare-Associated Infections in Low and Middle Income Countries**
Speaker: Dr. A. Nevzat Yalcin, Akdeniz University, Turkey
Sponsored by WHO First Global Patient Safety Challenge – Clean Care is Safer Care

13 June (Free South Pacific Teleclass) **Hand Hygiene Initiatives in Australia**
Speaker: Phil Russo, Hand Hygiene Australia

18 June (Free Teleclass – Broadcast Live from CHICA Conference) **Safety in the Field: Making Decisions About Cleaning, Disinfection, and Sterilization in Long Term Care**
Speaker: Colette Ouellet, Public Health Ontario

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