

*Employ widespread wisdom while harnessing
the madness otherwise known as*



**Infection Prevention & Control in
the Endoscopy setting**

Infection Prevention & Control

Disclosures:

Director of Infection Prevention
&
Endoscopy
Excellentia Advisory Group




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Objectives:

The learner will be able:

- Identify fundamental elements of infection control
- Apply widespread wisdom and principles to resolve infection prevention and control concerns
- Apply key decision making matrices to assist in the implementation of sound actions through utilization of the infection control risk assessment



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Exhibit 351
Ambulatory Surgical Center (ASC) INFECTION CONTROL SURVEYOR WORKSHEET
(Rev: 142, Issue#: 07-17-15, Effective: 07-17-15, Implementation: 07-17-15)

Name of State Agency or AO (please specify) _____

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the infection control Condition for Coverage. Items are to be assessed primarily by surveyor observation, with interviews used to provide additional confirming evidence of observations. In some cases information gained from interviews may provide sufficient evidence to support a deficiency citation.

The interviews and observations should be performed with the most appropriate staff person(s) for the items of interest (e.g., the staff person responsible for sterilization should answer the sterilization questions). A minimum of one surgical procedure must be observed during the site visit. The surveyor(s) must identify at least one patient and follow that case from registration to discharge to observe pertinent practices. For facilities that perform brief procedures, e.g., colonoscopies, it is preferable to follow at least two cases. When performing interviews and observations, any single instance of a breach in infection control would constitute a breach for that practice.



https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_351.pdf

Infection Prevention & Control

- Hand hygiene
- Safe injection practices
- Environmental cleaning
- Surgical attire
- Safety Data Sheets
- Single use vs re-usable device
- Infection control risk assessment
- Employee Health
- Vaccinations
- Influenza vaccination
- OSHA
- Temps/ Humidities
- Sharps/ BBP exposure
- Curtains
- Chemical strength
- Reprocessing accessories



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Inquiring Minds



Does your facility have a defined hand hygiene program?



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Hand Hygiene

CDC Key moments:

- Before eating
- Before and after having direct contact with patient
- After contact with blood, body fluids, OPIM
- After contact with patient environment
- If hands will be moving from a contaminated-body site to a clean-body site during patient care
- After glove removal
- After using a restroom



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Hand Hygiene

Techniques for performance:

When using alcohol-based hand sanitizer:

- Put product on hands and rub hands together
- Cover all surfaces until hands feel dry
- This should take around 20 seconds



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Hand Hygiene

Techniques for performance with soap and water:

- wet hands with water, apply product recommended by the manufacturer IFU, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.
- Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet.
- Avoid using hot water, to prevent drying of skin.



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Hand Hygiene

When to use Alcohol based hand rub versus soap and water:

Soap and Water:

- 1st wash of day
- Visibly soiled
- After known/ suspected exposure to C. Difficile
- After known/ suspected exposure to pt with infectious diarrhea during *norovirus* outbreak
- Exposure to *Bacillus anthracis*
- Before eating
- After using restroom

Alcohol based hand rub:

- before and after contact
 - Patient
 - Environment



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Hand Hygiene

Surgical Scrub

- Remove rings, watches, and bracelets before beginning
- Remove debris from underneath fingernails using a nail cleaner under running water
- Use antimicrobial soap or an ABHR with persistent activity

Antimicrobial soap:

- scrub hands /forearms for the length of time per manufacturer, usually 2–6”
- Long scrub times (e.g., 10 minutes) are not necessary



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Hand Hygiene

alcohol-based surgical hand-scrub product with persistent activity

- follow the manufacturer’s instructions
- Before applying, prewash hands /forearms with a non-antimicrobial soap and dry hands/forearms completely
- After using ABHR, allow hands/ forearms to dry thoroughly before donning sterile gloves
- Double gloving is advised during invasive procedures, such as surgery, that pose an increased risk of blood exposure



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Hand Hygiene

Why is hand hygiene a primary focus of Regulatory Agencies?

- Bacteria on the hands of surgeons/ Techs can cause wound infections if introduced into the operative field during surgery
- Rapid multiplication of bacteria occurs under surgical gloves if hands are washed with a non-antimicrobial soap
- Bacterial growth is slowed after preoperative scrubbing with an antiseptic agent
- Reducing resident skin flora on the hands of the surgical team for the duration of a procedure reduces the risk of bacteria being released into the surgical field if gloves become punctured or torn during surgery



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Hand Hygiene

Fingernails and Jewelry:

- Germs live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing
- Recommend HCW do not wear artificial fingernails or extensions when having direct contact with patients at high risk
- Keep natural nail tips less than ¼ inch long
- studies show skin underneath rings contain more germs than comparable areas of skin on fingers without rings



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Hand Hygiene

Maintaining Skin Health:

- Lotions and creams prevent /decrease skin dryness
- Use only hand lotions approved by your healthcare facility because they won't interfere with hand sanitizing products



Infection Prevention & Control Hand Hygiene

Quality Control: Hand Hygiene program and monitoring:

- Written P&P
- Set compliance goal and monitor adherence
- Establish corrective actions
 - Post results by discipline of monitoring
 - Auditory and visual reminders for patients/ caregivers
 - education/ re-education
 - competency validation
 - Trial additional product
- Direct counseling of ALL HCW's with persistent deficiencies



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Does your facility have a defined method to monitor safe injection practices?



Infection Prevention & Control Safe Injection Practices

1,300 patients possibly exposed to HIV, hepatitis B and C at Seattle hospital

by: KIRO-TV - Seattle Updated: Mar 16, 2016 - 6:34 AM



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Techniques and Best practices to prevent transmission

- Hand hygiene
- Barrier protection (gloves)
- Minimal manipulation of sharp instruments
- Appropriate segregation and disposal of sharps waste
- Avoid contamination of injectable medications
- Physically separate clean and contaminated equipment and supplies



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A safe injection does not harm the recipient, does not expose the provider to any avoidable risks and does not result in waste that is dangerous for the community



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- CDC - Guideline for Isolation Precautions: Preventing transmission of infectious agents in Healthcare settings 2007 - con't
 - When possible, use a **single – dose vial** (especially when medications will be administered to multiple patients).
 - Dedicate multi-dose vial to single patient
 - After a syringe/ needle has been used to access a patient IV, it is contaminated and should not be used on another patient or enter a medication vial
 - **Do not use medications labeled as “SINGLE DOSE VIALS” for more than 1 patient**



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- Do not use bags of IV solution as common source of fluid supply for more than 1 patient
- Follow proper infection control practices of aseptic technique when preparing and administering medications
- Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space



FACT: injection preparation on surfaces where contaminated substances are handled can lead to the spread of infections

Storage of multi-dose vials and preparation of injections in same area that used needles and syringes were dismantled and discarded



Ref: Samandari et al. ICHE 2005; 26: 745-750
Photo: Don Weiss / NYCDOHMH



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How should I draw up medications?

- Accessed in an aseptic manner
- Use new sterile syringe & sterile needle to draw up medications
 - preventing contact between injection materials and non sterile environment
- Medications should never be transferred to a non sterile container
- Proper **hand hygiene before** handling medications
- Scrub the rubber septum of the medication vial and the IV tubing hub with alcohol prior to piercing



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Maintaining sterility of vials:

- Medications discarded on expiration or any time there are concerns regarding the sterility of the medication
- Leftover parenteral medications should never be pooled for later administration
- A needle should never be left inserted into a medication vial septum for multiple uses
 - This provides a direct route for microorganisms to enter the vial and contaminate the fluid



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 Department of Health and Human Services
 Centers for Disease Control and Prevention
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Infection Control Home » Protecting Patients » Patient Safety »
Injection Safety

Printed medicines are commonly used in healthcare settings for the prevention, diagnosis, and treatment of various illnesses. Injection safety, or safe injection practices are measures taken to perform injections in an optimally safe manner for patients, healthcare providers, and others. A safe injection does not harm the recipient, does not expose the provider to any avoidable risks and does not result in waste that is dangerous to the community. Injection safety includes practices intended to prevent transmission of infectious diseases between one patient and another, or between a patient and healthcare provider, and also to prevent harms such as needless injuries.

Injection Safety for Providers
 Injection Safety Facts
 Safe work practices to prevent HCW exposure to bloodborne pathogens
 Excerpted from [Guidance for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007](#)
 A Patient Safety Threat – Surfactant Reuse

Injection Control Topics
 Infection Control Home
 Healthcare-Associated Infections
 Protecting Patients
 Practical Infection Control Updates
 Infection Control Guidelines
 Infection Control A-Z
 About DHQP

Related Resources
 Guidance for Isolation Precautions in Healthcare Settings



<http://www.cdc.gov/ncidod/dhqp/injectionsafety.html>

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Environmental Cleaning

Fundamental procedure:

- **Cleaning is ALWAYS** the first step
 - Mechanical removal of visible soils/ residue
 - Soil provides medium for microorganism growth
 - Ensures disinfectant will reach surface
 - Cannot decontaminate soiled surfaces
- Cleaning Chemical
 - Surfactant: Wet/ penetrate soil, break soil apart
 - Detergent: emulsify (suspend) oils and soils
 - No antimicrobial claim



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Does your facility utilize staff for environmental cleaning or is that a contracted service?



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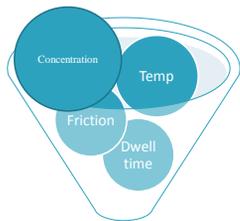
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Does your facility have a defined method to monitor environmental cleaning?



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Effective Cleaning



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Tools for successful cleaning:

- Chemicals
 - EPA registered
 - GM (-) (+)
 - Salmonella choleraesuis
 - Staphylococcus aureus
 - Initial price (acquisition cost)
 - Labor cost to use the item
 - Efficacy of combined tools and chemistry
 - Use or Shelf life
 - Suitable for the task



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Cleaning approach:

- Methodical & repeatable
 - Defined process of who is responsible to clean what
 - Consistent clockwise/counterclockwise
 - Top to bottom
 - Clean to dirty



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5 Key Needs:

- Staff
- Training
- Equipment
- Chemical
 - Quat
 - Phenol
 - Peroxide
- Dwell time



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Surgical attire:

- Mask
- Gloves
- Gown
- Bouffant hat



C diff Barbie



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Single use versus re-usable devices



draft - not for implementation

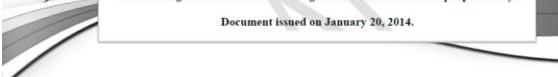
FDA Mitigating the Risk of Cross-Contamination from Valves and Accessories Used for Irrigation through Flexible Gastrointestinal Endoscopes

Draft Guidance for Industry and Food and Drug Administration Staff

DRAFT GUIDANCE

This draft guidance document is being distributed for comment purposes only.

Document issued on January 20, 2014.



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ANSI/AAMI ST91:2015

FDA

AORN Association of periOperative Registered Nurses

SGNA Society of Gastroenterology Nurses and Associates, Inc.



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Valves, ports, connection tubing

- Remove all valves and biopsy port covers, keeping with the scope throughout the process
- Manually actuated Endoscope valves to ensure coverage of all internal parts
- Cleaning brushes single use and disposed or reusable and HLD or sterilized after each use
 - Correct size based on channel size and manufacturer written instructions for use
- Soak, scrub, brush and rinse all reusable and removable parts (valves, buttons, port covers, tubing)



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Objectives and uses of AAMI standards and recommended practices

5.4.2 Manual (dry) leak testing

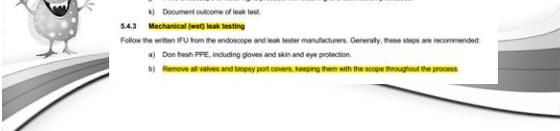
Follow the written IFU from the endoscope and leak tester manufacturers. Generally, these steps are recommended:

- Don fresh PPE, including gloves and skin and eye protection.
- Remove all valves and biopsy port covers, keeping them with the scope throughout the process.**
- Attach the leak tester.
- Pressurize the endoscope to the indicated pressure on the leak tester gauge.
- Place the endoscope in a loose configuration.
- Verify rotate each directional knob and elevator control while watching for changes in the established pressure.
- Message video or remote switches in a circular manner to more readily detect holes in these components.
- Maintain pressure and inspection for a minimum of 30 seconds.
- Release air pressure from the endoscope before removal of the leak testing unit
- If the endoscope is water-tight, proceed with cleaning and disinfection processes.
- Document outcome of leak test.

5.4.3 Mechanical (wet) leak testing

Follow the written IFU from the endoscope and leak tester manufacturers. Generally, these steps are recommended:

- Don fresh PPE, including gloves and skin and eye protection.
- Remove all valves and biopsy port covers, keeping them with the scope throughout the process.**



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5.6 Manual rinsing

After cleaning the endoscope, removed components and accessories should be thoroughly rinsed with copious amounts of potable water (see AAMI TRCS) to help ensure all cleaning solutions and loosened debris are removed. Follow the endoscope manufacturer's and cleaning solution manufacturer's written IFU for the amount of water and psi and/or pressure needed to flush through each channel and number of rinses.

Rinsing steps:

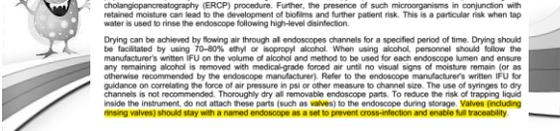
- Using the cleaning adaptors provided by the manufacturer, ensure adequate flow of potable water through each lumen.
- Rinse all exterior endoscope surfaces with freely flowing potable water.
- Purge channels with air using a syringe to evacuate residual rinse water. If compressed air is used, it should be oil-free and used at a pressure not to exceed that recommended by the endoscope manufacturer.
- Rinse all valves and other removable components according to the manufacturer's written IFU.
- Dry the exterior of the endoscope with a lint-free cloth or sponge.

After cleaning, all detachable valves should be kept together with the same endoscope as a unique set.

5.7.4.3 Manual drying

Effective drying of endoscopes can reduce the risk of microbial contamination following high-level disinfection (e.g., recontamination of the endoscope by waterborne microorganisms during rinsing). Certain waterborne microorganisms, such as *Pseudomonas aeruginosa*, can pose an infection risk to a portion of the endoscope patient population, especially those receiving a bronchoscopy procedure or endoscopic retrograde cholangiopancreatography (ERCP) procedure. Further, the presence of such microorganisms in conjunction with retained moisture can lead to the development of biofilms and further patient risk. This is a particular risk when tap water is used to rinse the endoscope following high-level disinfection.

Drying can be achieved by flowing air through all endoscopes channels for a specified period of time. Drying should be facilitated by using 70–80% ethyl or isopropyl alcohol. When using alcohol, personnel should follow the manufacturer's written IFU on the volume of alcohol and method to be used for each endoscope lumen and ensure any remaining alcohol is removed with medical-grade forced air until no visual signs of moisture remain (or as otherwise recommended by the endoscope manufacturer). Refer to the endoscope manufacturer's written IFU for guidance on controlling the force of air pressure in psi or other measure to channel size. The use of syringes to dry channels is not recommended. Thoroughly dry all removable endoscope parts. To reduce the risk of trapping liquid inside the instrument, do not attach these parts (such as valves) to the endoscope during storage. **Valves (including missing valves) should stay with a named endoscope as a set to prevent cross-infection and enable full traceability.**



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9 Processing of endoscope accessories

Processing of certain reusable endoscope components such as air/water and suction valves, biopsy port covers, water bottles, and tubing require the same level of inspection, cleaning, and high-level disinfection or sterilization as the endoscopes themselves.

Reusable endoscopic accessories (e.g., biopsy forceps, other cutting instruments) that break the mucosal barrier should be mechanically cleaned as described previously and then sterilized between each patient use (high-level disinfection is not recommended).

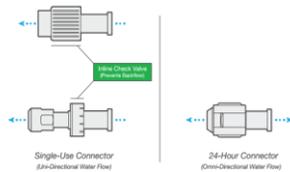
Before manual or mechanical high-level disinfection, remove and clean valves, connectors, and all detachable parts. Disconnect and disassemble endoscope components and completely immerse the endoscope and components in a cleaning solution that is compatible with the accessories, according to the manufacturer's written IFU. **Repeatedly actuate the valves during cleaning to facilitate access to all surfaces. Continue to brush and flush the valves until no visible soils remain. Alternately, consider the use of single-use, disposable valves.**

Valves may then be immersed in a high-level disinfection solution, following the manufacturer's written IFU for disinfectant contact time and rinse requirements. **Repeatedly actuate the valves during disinfection and rinsing to facilitate access to all surfaces. Alternately, valves may be placed in an AER if it has been cleared for the processing of valves and in accordance with the AER manufacturer's written IFU.**



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Auxiliary Water Jet Connectors

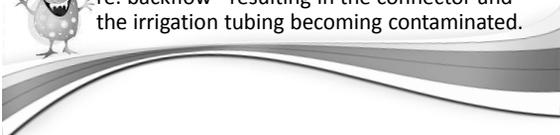


❖Water bottle, irrigation and connecting tubing

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What you should know about 24 Hour Connectors

- A 24 hour connector doesn't have a check valve to prevent back flow.
- 100% reliant on technique (i.e., priming the irrigation channel) to prevent backflow.
- Ongoing studies are looking into concerns re: backflow - resulting in the connector and the irrigation tubing becoming contaminated.



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How does this Differ from a single-use connector ?

- A check valve is present to prevent back flow to the irrigation tubing.
- If back flow occurs up the irrigation channel of the endoscope, only connector is contaminated.
- The connector is removed at the end of the procedure, and the irrigation tubing is safe to reuse for the next procedure if strict adherence to aseptic technique maintained



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Logistics of keeping/ tracing valves with a specific endoscope

Remove all valves and biopsy port covers, keeping with scope throughout process

- Time?
- How? Special container? Mesh bag?
- How will the container/ mesh bag be processed and identified?
- Has the container/ mesh bag been validated for processing? Or will it need to be single use disposable?
- Storage requirements? Adequacy? Temperature/ humidity
- How will container/ bag be labeled for identification in event separated from endoscope?



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Has your facility performed a cost comparison of reusable vs. disposable accessories?

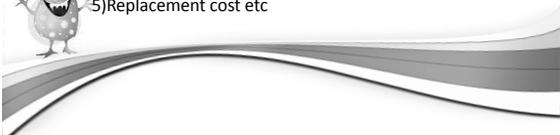


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“Cost is important, but patient safety should be the overriding factor when choosing any type of medical device.”

When determining cost, consider:

- 1)Purchase cost
- 2)Cost per cycle
- 3)Cost for personnel education, training, competency
- 4)Cost for personnel time to perform reprocessing tasks
- 5)Replacement cost etc



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Determining if disposable devices are a fit for your facility

Determine:

- number of “reusable” device on hand
- frequency “reusable” device replaced due to normal wear and tear
- price of replacement “reusable” device
- approximate average number of uses for “reusable” device
- approximate time required for reprocessing “reusable” device
- Are disposable devices available?
- Have disposable devices been
 - FDA approved
 - Compatible with endoscope and endoscope components
- Storage capacity for disposable device
- Availability of disposable device
- Alternatives (backup) in event disposable device on backorder



Sample cost comparison of reusable

Device	Price/reusable	# endoscope components on hand	Min # reusable on hand	# reusable ordered/year (set time frame)	Total # reusable for 1 year	\$ amount on hand	\$ amount ordered/year	Total \$/year	Ave # endo cases/ mo	Ave # endo cases/ year	Cost of reprocessing (time [30 min] + chemicals)/ case	Cost of reprocessing (time [30 min] + chemicals)/ year	approx. cost/ case
Biopsy port	\$2.00	16	18	22	40	\$36.00	\$44.00	\$80.00	250	3000	\$10.00	\$30,000.00	\$11.69
Suction Brunton	\$75.00			7	25	\$1,350.00	\$25.00	\$1,875.00					
Air water Brunton	\$100.00			7	25	\$1,800.00	\$70.00	\$2,500.00					
Water Jet Tubing	\$24.00			7	25	\$432.00	\$168.00	\$600.00					
TOTAL	\$201.00					\$5,818.00	\$1,437.00	\$5,055.00					



All data is for illustration purposes only. Performance of individual cost comparison is required

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Product Evaluation

Product: _____
 Purpose of Product: _____
 Product is compatible with (Olympus), (Pentax), (Fujinon) endoscope _____

Please rate the following characteristics on a scale of 1-5. 1 is worst and 5 is best.

Criteria	1	2	3	4	5	Comments
Ease of use						
Fits snugly						
Produces similar end results as original device						
Feel is similar to original device						
BBP/OPM considerations?						
Special use considerations?						
Product provided to client?						
Special storage conditions?						
Other:						

Comments: _____

I prefer to use:

Criteria	1	2	3	4	5	Comments
Trial product						
Original product						
Something else: List _____						

Evaluated by: _____ Date: _____



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Employee Health

Why Are Employee Health Services Programs Needed?

Many leading causes of death and disability in the U.S. are largely preventable through early detection, intervention and behavior changes.

- Help employees understand their risks for disease
- Help employees obtain preventive health services
- Reduce the risk of premature morbidity, mortality and disability
- Foster healthy lifestyles
- Support a healthy working environment.



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Employee health programs are authorized under 5 U.S.C. §7901.

Basic programs include preventive services:

- immunizations
- physical examinations
- medical screening tests, etc.



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Services which can be provided include:

- Emergency response/ First aid
- Administration of treatments and medications
- Physical examinations
- Environmental health hazards appraisals
- Health education
- Health services/ intervention programs
- Disease screening examinations and immunizations
- Physical fitness programs and facilities



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Emergency response/ First aid

Agency qualified medical staff provide first response and CPR for emergencies as well as assessment and initial treatment/ first aid to employees who are injured, or become ill during work hours.



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Environmental health hazards appraisals

Appraise and report work environment health hazards to department management as an aid in preventing and controlling health risks.



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Immunizations



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- HCP
 - all paid & unpaid persons working in health-care settings
 - potential for exposure to patients, infectious materials, contaminated medical supplies & equipment, contaminated environmental surfaces, or contaminated air.



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- Employers and HCP have a shared responsibility to prevent occupationally acquired infections and avoid causing harm to patients by taking reasonable precautions to prevent transmission of vaccine preventable diseases.
- Vaccination/ Immunization programs are an essential part of infection prevention and control for HCP.



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HICPAC and CDC recommend

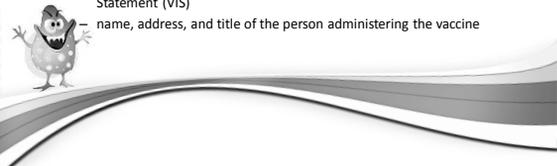
- secure, preferably computerized, systems used to manage vaccination records
- retrieved easily



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Record should reflect immunity status for indicated vaccine-preventable diseases

- (i.e., documented disease, vaccination history, or serology results) as well as vaccinations administered during employment and any documented episodes of adverse events after vaccination
- each vaccine
 - date of vaccine administration
 - vaccine manufacturer and lot number, edition
 - distribution date of the language appropriate Vaccine Information Statement (VIS)
 - name, address, and title of the person administering the vaccine



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- Accurate vaccination records help to rapidly identify susceptible HCP during an outbreak situation
- help reduce costs and disruptions to healthcare operations
- HCP given a copy vaccination records
- keep it with personal health records, readily be made available to future employers



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Respiratory protection controls:

- Implement a respiratory protection program
 - N95
 - PAPR's (powered air purifying respirators)
 - Employee screening by MD
- Train HCW on respiratory protection
 - annually
- Train patients on respiratory hygiene and cough etiquette



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Reporting Employee Infections:

- Policy and Procedure
 - Employee responsible to report to supervisor who will report to IP/ employee health nurse
 - IP/ Employee health nurse responsible for completing and maintaining the employee infection record
 - IP/ Employee health nurse will follow facility/ state policy on work restrictions for communicable disease
 - Physician assessment may be necessary
 - Employee should report to IP/ Employee health nurse on return



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Recommendations and work restrictions for personnel with infectious disease:

<u>Disease</u>	<u>Work restriction</u>	<u>Duration</u>	<u>Category</u>
Conjunctivitis	Restrict from pt/environment contact	Until discharge ceases	II
Diarrhea: Acute stage:	Restrict from pt/ environment/ food handling	Until symptoms resolve	IB
Hepatitis C	No recommendation		Unresolved
Measles	Exclude from duty	Until 7 days after the rash appears	IA



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CRITERIA FOR DETERMINING EXPOSURE TO COMMUNICABLE DISEASE

DISEASE	DEFINITION OF EXPOSURE
AIDS	Parenteral or mucous membrane exposure to blood or body fluids of a patient who is HIV positive or diagnosed as having AIDS.
Hepatitis A	An eligible contact should be a person who has during a period of 15 days before onset of overt symptoms and/or during a few days after the development of jaundice: <ul style="list-style-type: none"> • Lived in the same household with the patient/employee. • Had intimate sexual contact with the patient/employee. • Incurred known exposure to fecal material or vomitus of non-isolated patient or employee if exposed individual has not followed good handwashing technique.
Hepatitis B	Documented percutaneous or per mucosal exposure to infective body fluids.
Herpes (acute glauco-stomatitis)	Direct contact with the saliva of carriers.
Measles	Direct contact with nasal or throat secretions or airborne by droplet spread by personnel who have not had measles or immunization against measles.



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Influenza vaccination

- CMS measure for HCP
 - Evaluate vaccination rates and reason for non participation in immunization program
- Annual education and vaccine campaign
 - Influenza vaccination
 - Non-vaccine control measures (appropriate precautions)
 - Diagnosis, control and potential impact of influenza
- Signed consent/ declination



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Vaccinations

- Hepatitis B Vaccination
 - Offered on hire
 - Signed consent/ declination
 - If decline, can choose to be vaccinated in future
 - Documented in employee file
 - If exposure, follow post exposure algorithm



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Blood borne pathogen exposure:

- Employee provides detailed information re: exposure
- Reports ASAP to supervisor
- See employee health nurse to complete exposure form
- Form used to assist in evaluation of the cause of injury and prevention of future exposure



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Infection Control Risk Assessment

Multidisciplinary method to evaluate risk taking into consideration patient population and current organizational program

- Focuses on risk reduction of infection
- Coordinates and assesses knowledge of infection, disease transmission and environment to anticipate potential impact to patients and HCW
- Directs action to identified gaps



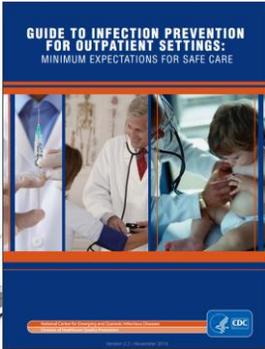
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Infection Control Risk Assessment

- Transmissible disease
 - TB
 - C. diff
- Outbreaks
 - CRE
 - Hepatitis B, Hepatitis C
- Device reprocessing
- Construction



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Updated November 2015

Coordinating ICRA checklist

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

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OSHA

Provide a workplace free from recognized hazards

Comply with OSHA standards and regulations

Be familiar with standards applicable to your workplace and make copies available



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Employee Responsibilities and Rights

Responsibilities include:

- Complying with OSHA standards
- Wearing required PPE
- Reporting hazards to supervisor

Rights Include:

- Reviewing standards
- Receiving training
- Requesting an OSHA investigation
- Reviewing the OSHA 300 Log



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OSHA Standards

29 CFR (Code of Federal Regulations)

- 1910 – General Industry
- 1926- Construction (applies if HCW is exposed)



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OSHA Penalty Adjustments to Take Effect August 2016

In November 2015, Congress enacted legislation requiring Federal agencies to adjust their civil penalties to account for inflation. The Department of Labor is adjusting penalties for its agencies, including the Occupational Safety and Health Administration (OSHA).

OSHA's maximum penalties, which were last adjusted in 1990, will increase by 78%.

The new penalties will take effect after August 1, 2016. Any citations issued by OSHA after that date will be subject to the new penalties. The related inflation occurred after November 2, 2015.

Type of Violation	Current Maximum Penalty	New Maximum Penalty
General	\$7,000 per violation	\$12,471 per violation
Other than Serious		
Physical Requirements		
Fines for dates	\$7,000 per day beyond the abatement date	\$12,471 per day beyond the abatement date
Willful or Repeated	\$70,000 per violation	\$124,709 per violation



Adjustments to Penalties

To provide guidance to field staff on the implementation of the new penalties, OSHA will issue revisions to its Field Operations Manual by August 1. To address the impact of these penalty increases on smaller businesses, OSHA will continue to provide penalty reductions based on the size of the employer and other factors.

State Plan States

States that operate their own [Occupational Safety and Health Plans](#) are required to adopt maximum penalty levels that are at least as effective as Federal OSHA's.

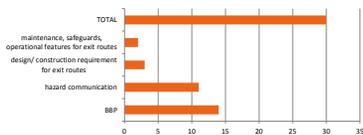


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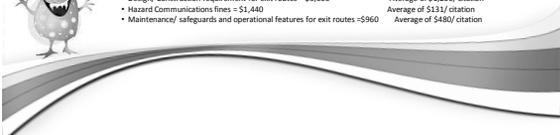
Citations

NAICS Code: 621493 *Freestanding Ambulatory Surgical and Emergency Centers*

Listed below are the standards which were cited by Federal OSHA for the specified NAICS Code during the period October 2013 through September 2014.



- Blood borne pathogen fines = \$4,440 Average \$317/ citation
- Design/ Construction requirement for exit routes = \$3,600 Average of \$1,200/ citation
- Hazard Communications fines = \$1,440 Average of \$133/ citation
- Maintenance/ safeguards and operational features for exit routes = \$960 Average of \$480/ citation



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Inquiring Minds



Questions????



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- *CDC Safe Injection practice frequently asked questions: http://www.cdc.gov/injectionsafety/providers/provider_faqs.html
- *CDC training video: <http://www.oneandonlycampaign.org/>
- *2007 Guidelines for Isolation precautions: Preventing transmission of Infectious Agents in Healthcare Settings <http://www.cdc.gov/hicpac/pdf/isolation/isolation2007.pdf>
- *World Health Organization (WHO): Best practices for injections and related procedures http://www.who.int/injection_safety/sign_toolkit/en/
- CDC Infection control assessment tools. <https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html> accessed July 2016
- *OSHA Hazard Communication https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=10099
- *OSHA Blood Borne Pathogen: http://www.ecfr.gov/cgi-bin/text/id?SID=9a3d4c1b84f659bcb434b5c5c60995c5&mc=true&nkodes=29.6.1910_11030&rgn=div8
- *OSHA eye protection: <https://www.osha.gov/SITC/eyefaceprotection/index.html>
- *OSHA eye and face protection for chemicals: <https://www.osha.gov/SITC/etools/eyeface/ppe/chemicals.html>
- *OSHA FAQ's: https://www.osha.gov/OSHA_FAQs.html
- *CDC recommended immunizations for healthcare workers: <http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html>
- *State immunization laws: <http://www2a.cdc.gov/vaccines/statevac/app/default.asp>

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- Office of Personnel Management: <https://www.opm.gov/policy-data-oversight/worklife/reference-materials/employee-health-services-handbook/#url:Chapter-1>
- CDC: **Guidelines for preventing the transmission of mycobacterium tuberculosis in the health-care settings**, 2005, MMWR 54 (rr-17): pp1-141 <http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf>
- CDC Guideline for infection control in health care personnel, 1998 <http://www.cdc.gov/hicpac/pdf/infectcontrol98.pdf>
- CDC: Vaccine storage and handling toolkit, May 2014, <http://www.cdc.gov/vaccines/recs/storage/toolkit/default.htm>
- Guidelines for environmental infection control in health-care facilities. Centers for Disease Control and Prevention. http://www.cdc.gov/hicpac/pdf/guidelines/enc_in_hcf_03.pdf. Accessed July 2016
- Environmental cleaning toolkit. Association of Perioperative Registered Nurses. <http://www.aorn.org/guidelines/clinical-resources/tool-kits/environmental-cleaning-tool-kit>. Assessed July 2016
