Bloodborne Pathogens are diseases that are caused by exposure to the blood or body fluids of another person. These include hepatitis B virus, hepatitis C virus and human immunodeficiency virus (HIV). There are others, but these are the big three that cause the most infections from exposures. The goals of the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard are to prevent exposures of workers to bloodborne pathogens and ensure proper medical management following an exposure.

Avoiding contaminated sharps injuries is a responsibility of every employer. The OSHA Bloodborne Pathogens Standard (29CFR1910.1030) and subsequent updates to it are legal requirements for any work setting in which there is a possibility of on-the-job exposure to blood, bloody body fluids or fluids containing other potentially infectious materials (OPIM). These include cerebrospinal, pericardial, pleural, peritoneal, synovial and amniotic fluids; semen; vaginal secretions; and fluids that cannot be differentiated. OPIM does NOT include tears, sweat, saliva (except in dental settings), urine or stool, as these do not contain bloodborne pathogens unless they are visibly bloody. However, they may contain other pathogens, so protection for ALL body fluids is a must.

**Sharps Injuries**

*Sally is an RN in an ambulatory surgery center (ASC), where she has worked for more than 10 years.*

While starting an IV, as she’s removing the stylet, the patient jerks and Sally sticks herself with the bloody needle.

**What could have helped prevent this exposure?**

A. Use of a safety engineered needle with a finger-activated sheath.

B. Use of a retractable needle.
Welcome to the spring 2011 edition of Preventing Infection in Ambulatory Care, APIC’s quarterly e-newsletter providing ambulatory infection prevention professionals with valuable, up-to-date information to help prevent infection in their facilities.

As the demand for increased infection prevention measures at ambulatory facilities continues to be a priority, our goal is to enhance this newsletter with need-to-know information to help you stay compliant and keep patients safe. As such, we are excited to announce a new column from the Accreditation Association for Ambulatory Health Care (AAAHC). In this issue, Marsha Wallander, RN, AAAHC’s assistant director of Accreditation Services, writes about the “Top 10 Roadblocks to Infection Prevention.” They may not be what you think!

Additionally, sharps safety issues continue to be a problem in ambulatory facilities, even nearly 10 years after the inception of the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard. In the lead article “What Would YOU Do? Sharps Safety in Ambulatory Settings,” Marcia Patrick, RN, MSN, CIC, takes the reader through possible sharps safety scenarios and helps guide the correct prevention efforts to ensure the safety of staff and patients.

Also in this issue:
- Peggy SaBell, BSN, MS, CIC, writes about how to deliver respiratory therapy without spreading “bugs.”
- Sue Barnes, RN, CIC, shares the success of an APIC/Association of periOperative Registered Nurses collaborative to preventing surgical site infections in ambulatory surgery centers in the San Francisco Bay area.
- Nancy Hailpern, APIC’s assistant director of Government Affairs, and Benjamin Rogers, APIC Government Affairs associate, provide an overview of pending legislative bills that apply to infection prevention practices within ambulatory settings.

We hope you’ll find these articles, along with those to come in upcoming issues of Preventing Infection in Ambulatory Care, informative and useful for your practice.

As always, we welcome your comments and encourage you to write to editor@apic.org telling us what you want to read and need to know.

Regards,
Preventing Infection in Ambulatory Care Editors
What Would You Do, continued from page 1

C. Use someone strong to hold the patient still until the procedure was done.

D. Letters A and B.

While some sharps injuries are unavoidable, employers must do everything possible to prevent exposures. This includes implementing the use of **sharps with engineered sharps injury protections**, which are non-needle sharps or needle devices used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident. “I don’t like it” is not a justification for not using safety sharps devices. Some sharps, such as spinal needles, haven’t been available in a safety format; however, these are just beginning to show up with safety features.

The OSHA hierarchy of protection of workers specifies **engineering controls** first. If a device or process can be engineered to be safer, that device or process must be used, **regardless of cost**. This includes safety sharps devices, like blunt needles for internal sewing; retractable needles or those with safety shields built in; Mylar-wrapped capillary tubes; plastic blood specimen tubes instead of glass; needleless IV systems; and safety scalpels. Safety device evaluation must include front-line workers. Devices cannot simply be imposed by management based on cost or other factors.

If a hazard cannot be mitigated through engineering, then workers must be taught **work practice controls**. These are practices that keep workers safe. A very good example of what not to do is to recap needles. Recapping will lead to a sharps injury. It is not a matter of IF someone will be stuck, but WHEN they will be stuck!

**Personal protective equipment (PPE)** must be employed when engineering and work practice controls don’t mitigate a hazard. PPE must protect the worker from the hazard identified. An example of appropriate PPE use is donning a moisture-resistant or impervious gown or apron for a large wound irrigation or suturing in order to keep blood and bloody body fluids off clothing. Another example includes wearing impermeable gowns for surgery. Gloves must always be worn to prevent contact with blood and body fluids while starting IVs, drawing blood, and dressing bloody wounds. Gowns that allowed fluids to penetrate to the clothing underneath would not be acceptable protection. Gloves that easily tear are not acceptable. Masks and eye shields must be worn if spraying or splashing the face is anticipated. Moisture-resistant or waterproof booties may be worn in the operating room (OR) to protect feet from irrigation fluids mixed with blood or OPIM.

Most PPE, such as gloves and masks, is single-use disposable and should not be reused. Washable gowns are fine, but must be single patient use only. Goggles and face shields may be either disposable or reusable. If reusable, there must be a written policy for cleaning and disinfection between uses and wearers.

It’s Friday afternoon and you’re working at full speed to clear the last of the patients out of the OR so they can begin recovery and go home. Surgical tech Tom comes out of the OR at the end of a case and tells you he’s been stuck by a contaminated scalpel blade. The surgeon passed it back and nicked Tom’s hand. He stepped away from the table so he wouldn’t bleed into the surgical site, and then washed it with antiseptic soap. Tom now has a dry, sterile bandage on his small, deep puncture wound.

**What needs to happen to protect Tom from bloodborne pathogens?**

A. Nothing. The surgeon assessed the patient for risk of bloodborne pathogens and there was no risk.

B. The source patient must have the following labs drawn – hepatitis B surface antigen, hepatitis C antibody and HIV antibody.

C. Tom must be drawn for hepatitis B surface antibody, hepatitis C and HIV and provided the results of the source patient testing that is also furnished to a provider knowledgeable in bloodborne pathogens exposures who will follow up with Tom for management of this exposure.

D. Letters B and C.
Tom’s employee health record should be examined for what specific piece of information?

A. His hepatitis B vaccine status – Did he have it and did he develop antibodies?
B. His immunizations/immunity to mumps, measles and rubella.
C. His pertussis status.
D. None of the above.

OSHA requires each work setting in which exposure could occur to have a written exposure control plan to prevent exposure and ensure proper evaluation and follow-up of exposed workers. Many ambulatory settings have written agreements with nearby emergency departments, occupational medicine or infectious disease clinics to do this for them. This keeps the employee’s personal health information out of their clinic or ASC and ensures proper follow-up. Labs must be drawn on the source patient and the employee. The source is tested for hepatitis B surface ANTIGEN, hepatitis C and/or HIV in their blood. The exposed worker is tested for ANTIBODIES to hepatitis B from the vaccination or from having the disease, and for hepatitis C and HIV to demonstrate that the employee did not have these diseases at the time of the injury.

The blood samples should be transported to a clinical laboratory as soon as possible to expedite results. Depending on the results, Tom may need immediate treatment to reduce his risk of acquiring hepatitis B or HIV from the puncture. Sadly, at this point, there is no treatment for exposure to hepatitis C other than serial testing to see if infection occurs. It’s good to know ahead of time exactly which tubes to draw, where the specimens will be sent, how quickly results will be available, and to whom they will call the results. This should all be included in the written exposure control plan.

The test results conclude that the patient is HIV positive. The rapid test will have to be confirmed with a Western Blot, but the rapid test is quite reliable. The tests for hepatitis B and hepatitis C will take a bit longer. The surgeon speaks with the patient and learns that she is aware she is HIV positive and is being seen by an infectious disease physician. She didn’t mention it to the surgeon prior to her surgery because she was embarrassed.

So, what needs to be done for Tom?

A. Call an infectious disease physician on Monday and see when an appointment is available.
B. Send him to your Occupational Medicine referral office that has the expertise to manage this high-risk exposure.
C. Start him on antiretroviral medication.
D. Wait until the results of the other two tests are available before doing anything.
E. Letters B and C.

A provider with knowledge and experience in managing HIV exposures should be available 24/7.

A provider with knowledge and experience in managing HIV exposures should be available 24/7. This is especially important if your facility is open after “normal” business hours, evenings, nights or weekends. It is essential for an HIV-exposed employee to start on antiretroviral medications as quickly as possible, within several hours. Waiting until Monday or sending Tom to a provider who isn’t well-versed in this level of exposure management could result in Tom becoming infected with HIV. Some employees have medical conditions that might contraindicate certain antiretrovirals; this needs to be taken into account. Because the source-patient knows that she is HIV-positive and is being treated, a viral load might be available to guide treatment. HIV medications are not benign; many exposed healthcare workers are not able to take them for the full four weeks due to severe side effects.
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Key “take aways”

1. Have a written plan that addresses each element of the OSHA standard.
2. Use safety sharps devices for all sharps products, if available.
3. Teach employees about safety sharps devices, safe work practices, and personal protective equipment. Document education on hire (orientation) annually and if the job changes the exposure risk, enforce standards.
4. Provide hepatitis B vaccine series or have a signed declination on file.
5. Have a solid plan for management of blood and body fluid exposures, including labs and referral provider with expertise in management available during and after work hours.


Financial assistance for the development of APIC ANYWHERE™ has been provided in the form of unrestricted educational grants by the following companies:

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If Tom had received the hepatitis B vaccine and developed antibodies, he would have been protected against hepatitis B. If not, hepatitis B immune globulin and hepatitis B vaccine should be administered in two different sites. The follow-up test for antibodies to hepatitis B should also be done several weeks after the third injection. The immunization record and result should be kept in Tom’s employee health file. These may be maintained on-site or at a contracted provider’s office. They should not be accessible to clinic ownership, only to those involved in Tom’s care.

The onset of the AIDS epidemic in the early 1980s forever changed healthcare workers’ (HCWs) perception of needlestick and other contaminated sharps injuries. Prior to that time, it’s estimated that fewer than 1 in 10 such injuries was reported. That has improved to some degree, but the frequency of reporting is often dependent on what the employee knows—or doesn’t know—about the risks, the type of injury and the history of the patient.

In response to the risks posed to HCWs, OSHA published the first Bloodborne Pathogens Standard in December of 1991 (29CFR1910.1030.) Prior to this standard, OSHA was not very involved in hospitals and healthcare. OSHA’s standards are federal law and apply to everyone in the U.S.

Some states have their own agencies that enforce OSHA standards. The state programs must be as stringent but can be more stringent than the federal OSHA standards. Check with your state’s Department of Occupational Safety and Health to find out which type of program you have.

OSHA, or a State Department of Labor and Industries in states that have their own OSHA programs, can inspect and levy fines for not following the Bloodborne Pathogens Standard. More importantly, following the standard protects our most valuable asset—our staff.

I’ll wager that you’ve had some pretty amazing experiences in your professional life, right? Like you, I’ve had the opportunity to participate in and to witness some truly “ah-ha” moments. It’s important to recall those past experiences as we accept the new and seemingly ever-changing challenges in our current environment. Here are some of the most pressing roadblocks to infection prevention and a few thoughts that might be helpful as you lead your own organization forward. If you’d like to share a proven solution from your own experience, or your own challenge of the moment, send them to editor@apic.org.

1. Apathy within
Lack of senior leader or medical staff involvement in an organization’s infection prevention program is a challenge. Just as problematic is the lack of infection prevention awareness of your own non-clinician staff. Why not work with senior leadership and human resources to review your organization’s job descriptions, its orientation templates and future training schedules to ensure that each role contains the appropriate infection prevention training and involvement to keep your patients and staff safe?

2. Not using your QI program and its results to lobby for your infection prevention needs
Use a quality improvement (QI) study to provide evidence of improvement in care, to demonstrate financial implications and rewards, and to highlight the direct and indirect “costs” of not being fully engaged in infection prevention. Start small – prioritize your known situations and use your QI program to demonstrate a position or success. Plan carefully on how to present your findings; always have the end goal in mind. Not long ago I witnessed a newly-assigned ambulatory care infection preventionist (IP) successfully use his recent past investigation of an adverse incident to demonstrate the need for an extra hour a week dedicated to the organization’s infection prevention program.

3. Lack of knowledge of community, state and federal requirements
There’s a lot to do; recruit some help! Prioritize and when it’s appropriate, delegate to others, such as to those who are currently uninvolved (Hint – see #1 above). For example, the Occupational Health and Safety Administration’s Needlestick Prevention Act is clear in its direction; staff end users should be involved in the annual evaluation of safer devices that might be available. Could a non-clinical staff member assist you in organizing the products to be evaluated that you and your vendor might have identified?

4. Not using local Department of Health resources
In all likelihood, there are various resources available from your local or county Department of Health (DOH). These public servants have knowledge of the overall health status of your community and have ready access to the most
current references. Make and retain a networking connection within your local DOH and you’ll be better prepared when pertussis or tuberculosis (TB) makes an appearance in your community.

5. Not keeping current on nationally-recognized guidelines and recommended practices

Adopting evidence-based guidelines and recommendations as your organization’s own can inform appropriate patient care practices on a daily basis. Take note that guidelines and recommended practices are subject to change as new evidence is made known. Make certain you have an open information pathway to receive notification when updates are issued. Membership in a professional organization such as APIC has many benefits that include keeping abreast of the most current infection prevention guidelines and best practices.

6. Disregard for orientation and training

Whether by overt choice or through error of oversight, orientation and training sometimes are minimized, shortened, or skimmed through. Sometimes those “more experienced” new staff members seem to demonstrate competence and are easily pressed into early duty or seen as ready for full role responsibilities. Have a formal orientation program in place and use testing and task demonstration to move new members through your organization’s infection prevention program. If your organization is subject to survey by an accrediting body or a state agency, ensure that initial orientation, annual retraining, and other educational and performance documentation is present and well-organized within each employee’s record.

7. Department rounds: Always scheduled or never scheduled?

It’s a good idea to consider doing both scheduled and non-scheduled department/unit visits. Tuesdays at 2 pm is great, but add in some random walkabouts. While you are visiting and observing, turn the time into a teaching moment by engaging those around you in conversation about what you are observing and why. Here’s an interesting tip that was shared with me recently–while performing surveillance activities, an IP used her cell phone camera to gather evidence of overflowing hazardous “red bag” waste and projected that photo image at the following morning’s impromptu staff meeting to gain improved compliance.

8. Absent or incomplete monitoring logs

Ensure the equipment you NEED is the equipment you actually HAVE. This is one part of advance planning for a smooth workday. Preventive maintenance and active monitoring of the use, care and condition of your medical devices is paramount to your effort. Create a simple electronic spreadsheet of your equipment, listed vertically, with the days of the month listed horizontally. Review and update the spreadsheet for equipment retired or added. Then print the list once a month, inserting the responsible staff assigned to the task (per day, week or month) to ensure that the equipment is being monitored and any issues relating to equipment are addressed. Or post or circulate the list and allow your staff to self-assign. Remember to delegate when it’s appropriate; perhaps with appropriate training, your non-clinical staff could assist with monitoring non-critical logs.

9. The policy is in place, but rarely followed

Most high-performing healthcare organizations perform regularly-scheduled drills. Make those drills pertinent to your unique setting. When a policy is present but seldom is required to be followed, the result may be that staff aren’t able to effectively respond when called to action. Consider planning an emergency drill around a scenario that might actually occur. For example, a rare and potentially fatal malignant hyperthermia reaction to a medication unfolds at your ASC. Or a patient arrives with not-yet-diagnosed but now suspected active TB at your community care clinic. In these examples, will your staff know how to respond? Hint—if you previously made that local DOH networking connection (#4), you would know that your communicable disease management policy is current and you would feel confident in helping your staff drill through the scenario of the arrival of that fictitious TB patient.
Delivering Respiratory Care without Spreading “Bugs”

By Peggy SaBell, BSN, MS, CIC
Regional Director of Infection Prevention and Control, Kaiser Permanente, Colorado

Healthcare delivered in the outpatient setting continues to increase in volume and complexity at a dizzying rate. Because of innovations in both diagnostic and therapeutic modalities, respiratory therapy services are being provided in outpatient settings that historically were only provided in the hospital. These settings cover a broad spectrum and can include the physician’s office, the pediatric clinic or the pulmonology department in a medical specialties clinic. Outpatient respiratory therapy ranges from spirometry and nebulization treatments, to home sleep studies and intensive pulmonary rehabilitation. Various healthcare workers may be responsible for different components of this care including medical assistants, certified nursing assistants, licensed practical nurses, registered nurses and respiratory therapists.

Use Precautions for Every Patient
Proper respiratory precautions must be applied with all patients. Even though most respiratory conditions seen in your facility may not be infectious, every clinic and physician’s office should have a plan to minimize and prevent respiratory pathogen spread. Multiple strategies can be employed, including entrance signs that encourage patients to cover their coughs. Masks, tissues, and waterless hand hygiene products should be readily available for patient use. Freestanding hand hygiene and respiratory etiquette stations accompanied by large posters can be posted at entrances to facilities or departments.

Additionally, the coughing patient should be escorted to an exam room as soon as possible to minimize or eliminate possible infection transmission to others in the waiting area. Be aware that patients with a chronic cough due to a respiratory disease process such as asthma or COPD can have a concurrent transmissible respiratory infection that may not have been identified. “Cover your cough” instructions also apply to these patients.

All healthcare workers should feel comfortable handing either tissues or a mask to their coughing patients. All healthcare workers should also have ready access to masks and hand hygiene supplies, including conveniently-placed dispensers of waterless alcohol-based hand antiseptics. A helpful resource that...
Dealing with Devices

In addition to establishing a robust respiratory etiquette program, the infection preventionist (IP) should focus attention on devices used to deliver the respiratory therapy. The first step to preventing infection via respiratory equipment is consulting the manufacturer’s recommendation for the cleaning and disinfection of every device used for treatment. Many times these instructions have two parts; the first part is guidance for the patient’s at-home use and the second is written for the healthcare worker. If a device only has home-use instructions, the IP should be alerted to the possibility that this is a “single patient use” device and should investigate further. Don’t confuse single patient use devices with single use or disposable devices. The manufacturer usually includes a statement about the appropriate use of the device in the packaging. If the packaging cannot be found, the IP should contact the manufacturer to obtain written guidance.

Single patient use devices must never be used by multiple patients. Even if this is a practice that has occurred in the past, it is not considered safe and puts the patient at risk. Because it is both difficult and impractical to clean and disinfect the interior surfaces of a reusable spirometer between patients, a disposable one-way valve mouthpiece should be used. These mouthpieces allow the patient to only exhale into the device, not inhale. These can only be used for performing exhalatory spirometry and peak flow measurements.

For inhalation and exhalation spirometry, disposable micro-aerosol filters inserted at the end of the spirometer should be used. These filters minimize the risk of contamination of the spirometer from exhalation and the subsequent risk of disease transmission with inhalation. They also protect the internal surfaces of the spirometer from moisture and from cleaning agents and disinfectants. The exterior parts of these devices should be cleaned and disinfected between each patient with a disinfectant wipe. Make sure that all disposable filters comply with the device manufacturer’s guidance.

It’s also important to always stress the importance of performing hand hygiene before and after any type of respiratory therapy. While reusable devices in the hospital setting are commonly sterilized or high-level disinfected – many times through a pasteurization process – this is not always practical or even feasible in the outpatient setting. If a reusable device requires sterilization or high-level disinfection, meticulous cleaning is always required first. If a device can tolerate steam sterilization, this is usually the safest and most cost effective practice. However, if steam sterilization is not recommended, high-level disinfection might be. Remember to follow the manufacturer’s recommendations for the reprocessing of all reusable devices.

However, keep in mind that sometimes the manufacturer – rather than recommending a specific process, i.e. sterilization or high-level disinfection – will recommend a product, such as a specific high-level disinfectant. If this is not a product that is currently used at your facility and would require a significant change, clarify this difference with the manufacturer. It may be that the manufacturer has a very specific and important reason for recommending a specific product. However, if they do not object to a proposed product substitution, request their approval in writing for the substitute product.

Never substitute a lower level process such as intermediate-level disinfection for high-level disinfection. Alternatively, consider substituting a disposable device for one that is reusable, as this might be the more cost effective and the safer approach for the patient and the healthcare worker. Using a dishwasher for these reusable respiratory therapy devices is not considered an acceptable substitute for either sterilization, or pasteurization/high-level disinfection. After disinfection, the device should only be rinsed with sterile water, not tap water because it can harbor microorganisms that could cause pneumonia. Cleaning and disinfecting tubing used in respiratory therapy is difficult in most outpatient settings; most of this tubing is now disposable.

Another common respiratory therapy that occurs in the physician’s office is delivery of medication via a nebulizer, either in-line or hand-held. Aseptic technique should be used for dispensing the medication, which should always be sterile. Using medication in single use-dose vials is a safe and recommended practice. If sterile saline solution is required for this therapy, it should be without preservative or buffering agents. It is best to use sterile saline supplied in single dose plastic “bullets” or “pillows” formulated specifically for respiratory applications. Most outpatient settings use disposable nebulization equipment attached to an oxygen source.

It is a challenge for the IP to stay current on all respiratory therapy modalities and their attendant devices. Request to be notified when a process is changed or a new piece of equipment or a device is introduced in the department. If there is a product review committee in your organization, participation in this committee usually means that you have input when new respiratory therapy equipment is being considered or introduced. You might very well be the only one in your department or clinic who is asking, “How can we ensure that the use and care of this device will not lead to infection?”

References:


During July 2010, the San Francisco Bay Area (SFBA) APIC chapter discussed the growing need of local ambulatory surgery centers (ASC) for support in preventing surgical site infections (SSIs). This is especially challenging for ASCs because most do not have a dedicated infection preventionist (IP). Centers for Medicare and Medicaid Services (CMS) ASC site visits began in October 2010, focusing in part on SSI prevention efforts and outcomes. IPs within the SFBA chapter who work at hospitals with associated ASCs indicated that they were providing progressively increased levels of consultation and support. The chapter proposed extending an invitation to the local Association of periOperative Registered Nurses (AORN) chapter to partner in developing a method of supporting ASCs in SSI risk reduction. A work group comprised of six IPs was convened and an invitation was extended to two perioperative nurses from the San Francisco/Marin chapter of AORN, who accepted.

**Plan of Action**

First, the work group established a regular meeting day and time for teleconferences through the end of 2011. A work plan was then developed and a timeline was established. The first teleconference was held in August 2010 and monthly teleconferences are conducted each month. The work plan includes:

1. Development of a toolkit/library comprised of documents and website listings designed to support ASCs in preventing SSIs and preparing for or responding to CMS site surveys.
2. Development of a local email ListServ of ASC directors and IPs to facilitate networking.
3. Structured, voluntary site visits for any ASC by voluntary consultative team (one perioperative nurse, one IP).
4. Virtual or face-to-face group meetings for local ASC directors.
In September 2010, as news of our work group spread, AORN contacted the ASC work group with an invitation to present a session on the project during the 2011 AORN congress in Philadelphia. Sue Barnes (an IP) and Kris Anderson (a perioperative nurse) accepted the invitation and co-presented at the conference.

### Toolkit/Library

A collection of documents and websites was compiled and posted on the APIC SFBA website for easy access. The website includes the CMS ASC survey tool, checklists for department assessments relative to infection prevention, and SSI prevention guidelines. The toolkit link is shared with ASC directors when they are each contacted by the work group, and a hard copy is provided during site visits. The toolkit/library contents are posted here: [http://www.aboutinfectioncontrol.com/SubWebs/APIC/MAIN_Toolkits.htm](http://www.aboutinfectioncontrol.com/SubWebs/APIC/MAIN_Toolkits.htm)

### Voluntary Consultative Visits

The first (pilot) site visit was performed on December 14, 2010 at Seton ASC in Daly City, California. The site visit was structured as follows:

1. In-office consultation with local perioperative nurse manager and infection prevention manager
   - Review of toolkit contents

2. Walk through of the ASC and the sterile processing (SP) department. *SP was deferred due to time constraints and is planned for future site visits.*

3. Post-walk through debrief
   - Best practices identified
   - Opportunity areas identified
   - Evaluation of site visit

During the post-site visit evaluation, the ASC director stated that it had been very helpful in preparing for the pending Joint Commission site visit. More importantly, it provided an opportunity for knowledge sharing between the survey team and the onsite team.

The work group continues to respond to requests for site visits by an IP/perioperative team. The site visits provide knowledge sharing opportunities and help refine the process. Best practice tools and documents are added to the dynamic online library. The group plans to continue outreach to ASC directors and will ultimately offer to help establish a regular ASC directors meeting group to facilitate networking.

For more information, please contact Sue Barnes at sue.barnes@kp.org or Kris Anderson at kris94109@gmail.com.
Whereas once infection prevention legislation was perceived as merely a revision to hospital regulations, today, more and more states recognize that preventing infections is a safety measure that should be applied to a broader range of healthcare facilities. As has become APIC’s custom, we provide the table below, which lists pending state legislation that applies to infection prevention practices in ambulatory surgical centers (ASCs). Some of these bills apply specifically to ASCs, and some legislate practices for healthcare facilities, which some states already define as including hospitals, ASCs, and other healthcare settings. For more information on pending legislation which relates to ASCs, or other legislation affecting your state, please contact Nancy Hailpern, assistant director for Government Affairs, at (202) 454-2643 or nhailpern@apic.org, or Benjamin Rogers, Government Affairs associate, at (202) 454-2612 or brogers@apic.org.

### State Description Bill Bill text and/or related statute Status

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<th>State</th>
<th>Description</th>
<th>Bill Requires HAI Reporting</th>
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<td></td>
<td>Bill would amend current law to require pain management clinics to designate a physician to oversee implementation of infection prevention policies.</td>
<td>No</td>
<td><a href="http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=_h1147__.docx&amp;DocumentType=Bill&amp;BillNumber=1147&amp;Session=2011">Click here for original bill text</a></td>
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<td>Bill would amend current law to require pain management clinics to designate a physician to oversee implementation of infection prevention policies.</td>
<td>No</td>
<td><a href="http://www.flsenate.gov/Session/Bill/2011/0810/BillText/Filed/HTML">Click here for original bill text</a></td>
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<td>Hawaii</td>
<td>HB 889 (Introduced 1/26/2011)</td>
<td>Similar to SB 793</td>
<td>Passed House. Referred to Senate Health Committee and Judiciary and Labor Committee.</td>
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<td>Bill would require ASCs to report information about healthcare-associated infections (HAIs) to the National Healthcare Safety Network (NHSN) and would authorize the U.S. Centers for Disease Control and Prevention (CDC) to allow the state Department of Health to access HAI data reported by providers.</td>
<td>Yes</td>
<td><a href="http://www.capitol.hawaii.gov/session2011/bills/HB889_HD2__HTM">Click here for original bill text</a></td>
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<td>SB 793 (Introduced 1/21/2011)</td>
<td>Bill would require ASCs to report information about HAIs to the NHSN and would authorize CDC to allow the state Department of Health to access HAI data reported by providers.</td>
<td>Yes</td>
<td>Click here for original bill text: <a href="http://www.capitol.hawaii.gov/session2011/bills/SB793_.HTM">http://www.capitol.hawaii.gov/session2011/bills/SB793_.HTM</a></td>
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<td>Bill would require all ASCs to implement an infection prevention program to prevent the spread of multi-drug resistant organisms in areas within facilities where there is a significant HAI risk. Bill would also require the state to make information about facilities’ HAI rates publically available through the NHSN or other data collection method.</td>
<td>No</td>
<td>Click here for original bill text: <a href="http://www.lrc.ky.gov/record/11RS/SB138.htm">http://www.lrc.ky.gov/record/11RS/SB138.htm</a></td>
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<td>Bill would expand the definition of “health facility” to include pain management facilities, and would require infection control regulations specifically for these facilities.</td>
<td>No</td>
<td>Click here for original bill text: <a href="http://www.lrc.ky.gov/record/11RS/SB142.htm">http://www.lrc.ky.gov/record/11RS/SB142.htm</a></td>
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<td>Bill would expand the definition of “health facility” to include pain management facilities and allergy, sinus, and cold management facilities, and would require infection control regulations specifically for these facilities.</td>
<td>No</td>
<td>Click here for original bill text: <a href="http://www.lrc.ky.gov/record/11RS/SB142.htm">http://www.lrc.ky.gov/record/11RS/SB142.htm</a></td>
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<td>Bill would expand the definition of “health facility” to include cold and allergy clinics, and would require infection control regulations specifically for these facilities.</td>
<td>No</td>
<td>Click here for original bill text: <a href="http://www.lrc.ky.gov/record/11RS/SB142.htm">http://www.lrc.ky.gov/record/11RS/SB142.htm</a></td>
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<td>HB 614 (Introduced 1/19/2011)</td>
<td>Yes (MRSA Reporting)</td>
<td>Click here for original bill text: <a href="http://www.malegislature.gov/Bills/BillText/115067/generalCourtId=1">http://www.malegislature.gov/Bills/BillText/115067/generalCourtId=1</a></td>
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<td>Bill would require MRSA screening of high-risk patients admitted to a hospital or ASC. MRSA-colonized or MRSA–infected patients would be isolated. Facilities would be required to report data on MRSA-colonized or MRSA–infected patients to the Department of Public Health.</td>
<td>Yes</td>
<td>Click here for original bill text: <a href="http://www.malegislature.gov/Bills/BillText/106867/generalCourtId=1">http://www.malegislature.gov/Bills/BillText/106867/generalCourtId=1</a></td>
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<td>HB 1519 (Introduced 1/20/2011)</td>
<td>No</td>
<td>Click here for original bill text: <a href="http://www.malegislature.gov/Bills/BillText/106867/generalCourtId=1">http://www.malegislature.gov/Bills/BillText/106867/generalCourtId=1</a></td>
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<tr>
<td>State</td>
<td>Description</td>
<td>Bill Requires HAI Reporting</td>
<td>Bill text and/or related statute</td>
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<td>Bill would require ASCs to collect and provide statistical quarterly reports of certain HAIs.</td>
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<td>Bill would require ASCs to report annually on the number of National Quality Forum-defined serious reportable events.</td>
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<td>Bill would extend to ASCs the current requirement for hospitals to pay a fee to fund implementation of the state HAI reporting law.</td>
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<td>New Jersey</td>
<td>ACR 95 (Introduced 2/8/2010)</td>
<td>No</td>
<td>Click here for original bill text: <a href="http://www.njleg.state.nj.us/2010/Bills/ACR/95_11.HTM">http://www.njleg.state.nj.us/2010/Bills/ACR/95_11.HTM</a></td>
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<td>Resolution would encourage Federally Qualified Health Centers (FQHCs) to satisfy the requirement of having a person with a healthcare background responsible for infection control by having a biannual site review by an infectious disease consultant.</td>
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<td>Bill would require ASCs to obtain informed consent from patients for use of certain reprocessed medical devices.</td>
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<td>Bill would prohibit healthcare coverage plans, including Medicaid, from reimbursing facilities for costs associated with treatment of HAIs that are deemed preventable by the state Health Commissioner.</td>
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<td>State</td>
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<td>AB 5576 (Introduced 2/23/2011)</td>
<td>Bill would amend state law to make it a crime for a healthcare provider, including at an ASC, to reuse a syringe when the action results in the infection of a patient with a communicable disease.</td>
<td>No</td>
<td>Click here for original bill text: <a href="http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB5576&amp;Text=Y">http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB5576&amp;Text=Y</a></td>
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<td>Texas HB 1657 (Introduced 2/22/2011)</td>
<td>Bill would amend the current HAI reporting law to require that ASCs that report their rates of HAIs must indicate cases where an HAI resulted in the death of a patient.</td>
<td>Yes</td>
<td>Click here for original bill text: <a href="http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/HB01657I.pdf">http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/HB01657I.pdf</a></td>
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<td>SB 8 (Introduced 2/16/2011)</td>
<td>Bill would allow the state Health and Human Services Commission to designate the NHSN to receive HAI reports from hospitals and ASCs on behalf of the Department of State Health Services.</td>
<td>Yes</td>
<td>Click here for original bill text: <a href="http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/SB00008I.pdf">http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/SB00008I.pdf</a></td>
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<td>SB 620 (Introduced 2/11/2011)</td>
<td>Bill would amend the current state HAI reporting law to allow reporting of HAIs and preventable adverse events by ASCs to the NHSN, and require the facilities to authorize the state health department to have access to facility-specific data from the NHSN.</td>
<td>Yes</td>
<td>Click here for original bill text: <a href="http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/SB00620I.pdf">http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/SB00620I.pdf</a></td>
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10. Not making your program interesting, challenging or meaningful

Perhaps one of the biggest challenges today is maintaining one's forward momentum. In the delivery of healthcare services to our patients, many assignments arrive in a sudden and unforeseen manner. Because of this, it may be difficult to remain focused on your program's activities, especially if this infection prevention assignment is new to you or to your organization. Commit to scheduled appointments with yourself so that time is set aside for your important infection prevention work. The infection prevention work you do will make a difference!

I’ve enjoyed the opportunity to bring these words directly to your desktop and I hope among them, you’ll find a helpful idea or thought. Now let me know what’s on your infection prevention agenda. Email editor@apic.org.

About AAAHC:

The Accreditation Association for Ambulatory Health Care, also known as AAAHC or the Accreditation Association, is a private, non-profit organization formed in 1979. It is the preeminent leader in developing standards to advance and promote patient safety, quality and value for ambulatory healthcare through peer-based accreditation processes, education and research. Accreditation is awarded to organizations that are found to be in compliance with the Accreditation Association standards.

The Accreditation Association currently accredits nearly 5,000 organizations in a wide variety of ambulatory health care settings, including ambulatory and surgery centers, managed care organizations, as well as Indian and student health centers, among others. With a single focus on the ambulatory care community, the Accreditation Association offers organizations a cost-effective, flexible and collaborative approach to accreditation. Visit www.aaahc.org to learn more.