Hand hygiene in ambulatory surgery centers: The quest for consistency

A standardized system for evidence-based measurement of hand hygiene observations consistently resulted in > 90 percent compliance among ASC healthcare personnel.

By Kathy (KJ) Newman, MSN, MBA, RN, CPHQ, CASC; Mendee Livingston, MPH, MLS (ASCP); Carla Pierle, BSN, RN; Loretta Babbitt, CSCA; Kim Harmon Stevens, BSN, RN; Christine Rebic, MBA, BSN, RN, CNOR
Indiana University Health Ambulatory Surgery Centers; Indianapolis, Indiana, USA

Appropriate hand hygiene is critical to the prevention of healthcare-associated infections (HAIs) within any healthcare facility. However, barriers exist in the healthcare setting that limit healthcare personnel (HCP) compliance with hand hygiene practices:

1. Inadequate knowledge of the five moments for hand hygiene during patient care in the perioperative setting
2. Inadequate understanding of the risk of cross-transmission of pathogens
3. Cost of “secret shoppers” who were removed from their normal duties to allow dedicated time for observations
4. Identified patterns in convenience sampling in which some were observed repeatedly each month while others were rarely observed
5. Staff’s recognition of “secret shoppers”, resulting in higher compliance rates due to the Hawthorne effect during observation periods
6. Inadequate standardization of observation guidelines, resulting in inter-rater reliability issues
7. Methods for measuring compliance

We developed a standardized, budget-neutral method for measuring hand hygiene compliance using the World

Quest for Consistency, continued on page 3
Welcome to the Spring 2012 edition of Preventing Infection in Ambulatory Care, APIC's quarterly e-newsletter providing ambulatory infection preventionists (IPs) with valuable, up-to-date information to help prevent infection in their facilities.

We kick off the spring issue with an article highlighting a pilot study of selected Indiana University Health ambulatory surgery centers (ASCs) within the Indianapolis area to implement consistent hand hygiene practices and observation guidelines. Read more to learn how the standardized system for evidence-based hand hygiene measurement consistently resulted in > 90 percent compliance among ASC healthcare personnel.

The spring issue also features part II of the “Infection Prevention and Control Clinic Survey Tool,” which attempts to bridge the gap between guidelines, standards, and regulations and the actual practice of assessing infection prevention performance in ambulatory settings. This useful tool has been utilized by the author, Judie Brinthurst, RN, MSN, CIC, an acute-care-trained IP, to assess compliance in more than 150 clinics.

In the latest installment of the “AAAHC: The Accreditation Journey” column, Marsha Wallander, RN, assistant director of Accreditation Services, presents readers with five easy steps to creating a risk assessment to create a better Plan (with a capital “P”).

The spring issue also features articles on an Alabama initiative to use technology to monitor hand washing, the new APIC Strategic Plan 2020, the Centers for Disease Control and Prevention’s Vital Signs report on Clostridium difficile and confirmation on safe injection practices, and the 2012 Heroes of Infection Prevention.

Additionally, Nancy Hailpern, APIC’s director of Regulatory Affairs, and Benjamin Rogers, APIC Government Affairs associate, provide a summary of state legislation that affects ambulatory care and surgical centers.

We hope you’ll find these articles 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
Hand hygiene compliance (Graph 2) consistently increased over the 24-month observational time period, especially after the implementation of the 2010 Hand Hygiene Observation Guidelines.

Graph 1

Graph 2

Health Organization’s (WHO) Five Moments of Hand Hygiene and the 16-page surveyor tool that the Center for Medicare & Medicaid Services (CMS) issued to evaluate infection control practices within ambulatory surgery centers (ASCs).1,2,3,4

A pilot study was conducted at four non-randomly selected IU Health ASCs within the Indianapolis area in a quest for consistent hand hygiene practices and observation guidelines. Staff members collected data on hand hygiene observations and compliance during normal work flow of daily activities in the perioperative setting (see page 5 to access the Hand Hygiene Observation Tool used at IU Health ASCs). We compiled base-

line compliance data using the 2009 Hand Hygiene Observation Guidelines until January 2010, when the 2010 Hand Hygiene Observation Guidelines were implemented. Data were submitted electronically for presentation and discussion at monthly Quality Assessment Process Improvement (QAPI) committee meetings. A quality improvement (QI) study was developed using the Accreditation Association for Ambulatory Health Care’s (AAAHC) 10-step process.4

The pilot study was initiated as follows:

1. Core groups of staff in each ASC were designated as hand hygiene experts. The infection preventionists (IPs) provided intensive training in the five moments of hand hygiene by using the WHO and the Centers for Disease Control and Prevention (CDC) guidelines and other resources.2,4

2. Hand hygiene experts from each ASC collaborated with the IPs to develop an observation tool and guidelines using criteria from the CMS surveyor tool for ASCs.

3. An ASC-specific hand hygiene observation tool and guidelines were approved by Infection Prevention committees and leadership at each ASC.

4. Hand hygiene experts developed an ASC-specific education module: PowerPoint presentation of the five moments of hand hygiene and the risks of cross-contamination, video demonstrating good and bad techniques during normal work flow in the perioperative setting, and a quiz.

5. All ASC staff members were trained in the five moments of hand hygiene using the ASC-specific education module.

6. Each ASC staff member was required to conduct two hand hygiene observations per day during normal work flow.

Continued next page
Results

The use of a standardized system for evidence-based measurement of hand hygiene observations consistently resulted in > 90 percent compliance, thus reducing the potential for HAIs.

Hand hygiene observation numbers (Graph 1) increased steadily over the 24-month observation period, especially after the implementation of the 2010 Hand Hygiene Observation Guidelines.

Discussion

1. Increased numbers of hand hygiene observations were conducted during daily activities by staff members who understood normal work flow.

2. Staff members were continually observed by colleagues using consistent guidelines based on the five moments of hand hygiene.

3. Compliance with hand hygiene improved when staff conducting the observations had detailed guidelines for observing the five moments of hand hygiene and variation was decreased.

4. The Hawthorne effect was effectively used to increase hand hygiene compliance because HCP were aware that anyone could be watching anytime.

Conclusion

The success achieved through the IU Health ASC Hand Hygiene Program was the result of collaboration among the IPs, leadership, physicians, and frontline staff.

References


Hand Hygiene Observation Form

| Facility: ________________________________ | Name(s) of healthcare personnel (HCP) who were: |
| Area of service: __________________________ | Non-compliant: ________________________________ |
| Observer: ________________________________ | Excellent: ________________________________ |
| Date: ________________________________ | |

<table>
<thead>
<tr>
<th>Before patient contact</th>
<th>Before aseptic task</th>
<th>After body fluid exposure risk</th>
<th>After patient contact</th>
<th>After contact with patient surroundings</th>
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<tr>
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<td>Name:</td>
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<tr>
<td>Hand hygiene (HH)</td>
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</table>

Please turn form into your infection control facility coordinator ________________________________

**HCP codes:**
- ANCP: ancillary position
- TECH: surgical technologist
- ANES: anesthesiologist
- NC: non-clinical
- SURG: surgeon
- RN: registered nurse

**Area of service codes:**
- ASMT: assessment
- NC: non-clinical
- OR: operating room
- PA: procedural area
- PA: post-anesthesia care unit
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In the winter edition of Preventing Infection in Ambulatory Care, we presented the first part of a three-part series on assessing infection prevention performance and compliance in your ambulatory setting. Here we present the second part of that series.

It’s challenging for acute-care-trained infection preventionists (IPs) to know where to begin when assessing their ambulatory care facilities, including physician practices, specialty clinics, and ambulatory surgical centers. Guiding, accrediting, and regulatory agencies recognize the potential infection threats to patients in ambulatory care facilities and have recently provided guidelines. However, a gap exists between these guidelines, standards, and regulations and the actual practice of assessing infection prevention performance in these facilities. Some have commented that this gift of guidelines is akin to giving one a car without teaching one how to drive.

The Infection Prevention and Control Clinic Survey Tool (see page 9) attempts to bridge this
This month, sections eight through 15 of the 15-section tool are presented. The tool assumes the user is trained in infection prevention; thus, it is not a training tool. Nor is it a guideline, standard, or regulation. Rather, it compresses guidelines, standards, and regulations into a usable, comprehensive instrument that IPs should keep handy when assessing their ambulatory care facilities. This resource is an example of how one institution assesses their ambulatory care facilities and, as such, reflects that institution’s practice. It assesses process measures, as failure to adhere to process measures has been responsible for adverse patient outcomes.

Generally, in acute care settings, IPs have the benefit of having sterile processing departments guide instrument processing activities. In physician practices and specialty clinics, the IP often serves as the instrument processing expert. Sections nine, 10, 11, and 12 of the survey tool assess instrument processing activities. While none of these sections apply to facilities that do not process instruments, some sections apply to facilities that decontaminate instruments and send them out for sterilization (sections nine and 12), and some sections apply to facilities that perform only high level disinfection (HLD) activities (sections nine, 10, and 12). For facilities that perform HLD and sterilization activities, all four of these sections apply (sections nine, 10,11, and 12).

The summer issue will provide a self-scoring spreadsheet based on the tool, which can be used to quantify compliance in the readers’ facilities. Over the past six years, and in evolving iterations, this tool has been utilized by the author, an acute-care-trained IP, to assess compliance in more than 150 clinics within the Duke University Health System in Durham, North Carolina. It has facilitated data gathering, analysis, and improvement of process measures in these clinics – a critical activity in ambulatory facilities because traditional surveillance (i.e., hospital surveillance) of clinic-associated infections remains a challenge.

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8. Surface disinfection

a. Toys are disinfected per clinic specific policy.
   - All toys should be cleaned daily and (as needed) if they become soiled.
   - Toys must be non-porous and cleanable; plush toys are to be new and given to the individual patient.
   - Reusable toys are to be cleaned with appropriate agent (i.e., an EPA-registered, hospital-grade surface disinfectant).
   - Toys should be rinsed with tap water after cleaning to remove any disinfectant residue.
   - Toys should be restricted to only those that can be easily cleaned.

b. Non-critical items are cleaned per policy.
   - Non-critical items are those that contact intact skin.
   - Some examples of non-critical items are blood pressure cuffs and exam tables. It is strongly recommended that these items be cleaned daily and as needed.
   - Disposable blood pressure cuffs should be changed according to manufacturer’s instructions.

c. Point-of-care devices are cleaned according to policy.
   - Medical equipment that involves blood testing (e.g., glucometers) must be cleaned between every patient with an EPA-registered, hospital-grade surface disinfectant.
# 9. Instrument decontamination/pre-cleaning

- **a.** Items are thoroughly pre-cleaned and decontaminated with enzymatic detergent according to manufacturer’s instructions, national guidelines, and facility policy prior to high level disinfection or sterilization.  
  - Staff can demonstrate understanding of manufacturer’s instructions for use, including precise ratios of detergent to water.

# 10. High level disinfection (HLD)

- **a.** Medical instrument and devices are visually inspected for residual soil and re-cleaned as needed before HLD.

- **b.** HLD equipment is maintained according to manufacturer’s instructions, national guidelines, and facility policy.  
  - Staff should maintain automatic endoscope reprocessors according to manufacturer’s instructions, national guidelines, and facility policy.
  - Maintenance logs must be kept.

- **c.** Chemicals used for HLD are prepared according to manufacturer’s instructions, national guidelines, and facility policy.  
  - Staff must demonstrate understanding of manufacturer’s instructions for use for its specific HLD chemical.

- **d.** Chemicals used for HLD are tested for appropriate concentration (minimum effective concentration = MEC) according to manufacturer instructions, national guidelines, and facility policy and are replaced before they expire.  
  - Staff should keep logs for all HLD processes, including test strip quality control if test strip quality control is indicated by test strip manufacturer.
  - Containers should be covered and labeled with chemical name, hazard information, and expiration date.

- **e.** Chemicals used for HLD are documented to have been prepared and replaced according to manufacturer’s instructions, national guidelines, and facility policy.

- **f.** Equipment is high level disinfected according to manufacturer’s instructions, national guidelines, and facility policy.  
  - Spaulding classification system is used to determine appropriate cleaning requirements of equipment.

- **g.** Items that undergo HLD are dried before re-use.

- **h.** HLD logs are in order.  
  - Logs must be kept on all HLD processes.
i. Test strips are properly dated with “open” and “expiration” dates.

11. Sterilization

| a. Chemical and biological indicators are used appropriately. | Internal chemical indicators must be used in each package to be sterilized; the chemical indicator must be examined before the contents are used. |
| b. Biological indicators run with first load of the day at a minimum and more often if sterilizer manufacturer indicates a more frequent process. | Biological indicators are to be used at least daily and must be used with each load containing implantable devices. |
| c. Sterilization logs accurate and up to date. | Written records of each load should be kept. |
| d. Process is in place for embargo of instruments until biological indicator (BI) is read. | Instruments must not be used until appropriate BI readings are correct. |
| e. Sterile packages are inspected for integrity and compromised packages are reprocessed. | Instruments in torn, wet, or damaged sterilization pouches must be re-processed. |

12. General decontamination/HLD/sterilization

| a. Proper personal protective equipment (PPE) is worn when processing dirty equipment. | Water-proof or water-resistant gown, nitrile disposable gloves, and full face protection must be worn when processing dirty instruments. |
| b. Competencies are maintained for cleaning, disinfection, and sterilization processes. | Records of training must be documented in personnel folder. HLD competency is yearly. |
| c. HLD, decontamination, and/or sterilization is performed in an appropriate environment. | HLD, decontamination, and/or sterilization may not be performed in a patient care area. If using glutaraldehyde, ensure proper ventilation is in place. |
| d. Areas used for cleaning or disinfection flow from dirty to clean. | The area must have a definite work flow from dirty to clean to prevent cross-contamination of equipment. |
| e. There is a procedure in place for identification and recall of inadequately sterilized or high level disinfected instruments. | Variances must be reported to infection prevention. |

continued next page
f. After sterilization or high level disinfection, devices and instruments are stored in a designated clean area to assure sterility is not compromised.

Sterilized and high level disinfected items must not be stored in instrument processing areas.

### 13. Isolation

| a. Staff are able to articulate isolation policies (e.g., TB, chickenpox, “respiratory etiquette”). | ☐ Personnel must be able to articulate isolation policies AND locate policies.  
☐ Use appropriate signage for isolation patients if appropriate. |
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<tbody>
<tr>
<td>b. Staff are able to state how patients who have a known resistant organism would be managed (e.g., MRSA, VRE, <em>C. difficile</em>, draining wound or rash).</td>
<td>Staff is able to locate and articulate facility policy for these patients.</td>
</tr>
<tr>
<td>c. PPE is available.</td>
<td>Clinic must have sufficient stock of gowns, gloves, masks, and eye protection.</td>
</tr>
</tbody>
</table>

### 14. General issues

| a. Areas (e.g., fixtures, walls, ceilings, floors) are free of dust, dirt, soil, trash, odors, clutter, and hazards. | ☐ Paint is intact.  
☐ Cabinet doors functioning properly.  
☐ Vinyl upholstery has no rips, holes, or cracks.  
☐ Ceiling tiles are clean and dry. |
| --- | --- |
| b. Areas and furnishings are in good repair. | ☐ Cleaning supplies are in their proper place.  
☐ Only hospital-grade approved disinfectants are to be used for cleaning surfaces in the healthcare environment.  
☐ Surgical and invasive procedure rooms are cleaned after each patient. |
| c. Objects and environmental surfaces that are touched frequently in patient care areas (e.g., stretchers, IV pumps and poles, medication prep areas, procedure tables, toilet surfaces, waiting area surfaces) are disinfected with an EPA-registered, hospital-grade surface disinfectant. | ☐ Cleaning supplies are in their proper place.  
☐ Only hospital-grade approved disinfectants are to be used for cleaning surfaces in the healthcare environment.  
☐ Surgical and invasive procedure rooms are cleaned after each patient. |
| d. For clinics with an IV treatment room or procedure room: IV pumps, chairs, and procedure tables are cleaned between each patient. | ☐ Cleaning supplies are in their proper place.  
☐ Only hospital-grade approved disinfectants are to be used for cleaning surfaces in the healthcare environment.  
☐ Surgical and invasive procedure rooms are cleaned after each patient. |
e. Areas identified as nursing responsibility are cleaned appropriately.

Some examples include: medication storage areas, equipment not covered in cleaning contract (e.g., ultrasound equipment, drawers and cabinets used for supply storage, supply carts, video towers, and thermometers).

f. Staff food and drinks are placed in appropriate areas.

Staff food and drinks should be stored away from patient care areas, some of which include medication areas, treatment areas, supply areas, dirty utility rooms, and intake rooms.

15. Refrigerators, freezers, ice machines, ice chests

a. Refrigerators and freezers are large enough to properly store medications.

Refrigerators and freezers must be large enough to store the year’s largest inventory of medications.

b. Refrigerators and freezers are well maintained and clean.

There should be no expired food or medications in refrigerators and they should be clean. Store patient food, medications, and specimens in separate labeled refrigerators.

c. Medication refrigerator temperature is maintained between 36-46 degrees F (between 2-8 degrees Celsius).

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<thead>
<tr>
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<th>Degrees in F</th>
<th>Degrees in C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food:</strong> Freezer</td>
<td>Below 0°</td>
<td>Below -17°</td>
</tr>
<tr>
<td><strong>Food:</strong> Refrigerator</td>
<td>34° to 40°</td>
<td>1° to 4°</td>
</tr>
<tr>
<td><strong>Medication:</strong> Freezer</td>
<td>5° F or colder</td>
<td>-15° C or colder</td>
</tr>
<tr>
<td><strong>Medication:</strong> Refrigerator</td>
<td>36° to 46°</td>
<td>2° to 8°</td>
</tr>
<tr>
<td><strong>Specimen:</strong> Freezer</td>
<td>5° to -22°</td>
<td>-15° to -30°</td>
</tr>
<tr>
<td><strong>Specimen:</strong> Refrigerator</td>
<td>36° to 42°</td>
<td>2° to 6°</td>
</tr>
</tbody>
</table>

d. Medication freezer is maintained below 5 degrees F (below -15 degrees Celsius).

See table above.

e. An appropriate means to check medication in event of a power outage is in place.

- All sites without emergency back-up power should have external digital temperature devices that monitor minimum and maximum temperatures on all medication refrigerators and freezers.
- Minimum and maximum temperatures shall be routinely checked and action taken for out-of-range temperatures.
| f. Food and medications are stored separately. | Patient nourishments are to be single-serving, individually sealed portions. Patient food refrigerator temperatures must be monitored and documented routinely on the appropriate refrigerator log. |
| g. Food and/or medications are within expiration date. | Expiration date should be visible on all food/medication. |
| h. Specimens and culture media are stored separately from food and medications. | Medications and food must be stored in separate refrigerators with all items within date and not stored with specimens. |
| i. Specimens and lab reagents are stored appropriately. | Laboratory reagents must be stored separately from medication. |
| j. Ice chests and ice machines are maintained according to manufacturer’s instructions for use and facility policy. | 1. DO NOT handle ice directly by hand – use a scoop; wash hands before obtaining ice.  
2. Store the ice scoop on a clean hard surface when not in use. DO NOT store in the ice bin.  
3. Machines that automatically dispense ice are preferred to those that require ice to be removed from bins or chests with a scoop.  
4. Weekly cleaning of ice storage chests, scoops, and ice chute extenders should be performed with fresh soap or detergent solution. After cleaning, rinse all surfaces of the ice storage chest with fresh tap water, wipe dry with clean materials, rinse again with a 10- to 100-ppm bleach solution (1 to 8 ml of sodium hypochlorite household bleach per gallon of water), and allow all surfaces to dry before returning the items to service.  
5. Weekly cleaning as described above should be documented.  
6. Limit access to ice storage chest and keep doors closed.  
7. Follow manufacturer’s instructions for periodic maintenance and cleaning/disinfecting ice machines.  
8. Ice machines that dispense ice automatically are preferred for public access. |

Look for the self-scoring spreadsheet based on the tool, which can be used to quantify compliance, in the summer issue of *Preventing Infection in Ambulatory Care*. 
AAAHC: The Accreditation Journey

Five steps to put the capital “P” in “Plan”

By Marsha Wallander, RN
Assistant Director, Accreditation Services
Accreditation Association for Ambulatory Health Care (AAAHC)

Completing a simple five-step risk assessment and reviewing it on a regular basis helps infection preventionists create a Plan.

What do the following events have in common?

1. Buying a fixer-upper home
2. Departing on a once-in-a-lifetime vacation
3. Visiting a college campus with your high school son or daughter

Did you guess “money” or “patience”? Those aren’t wrong responses, but neither is the sought-after answer. The answer to which I’m eluding is “a Plan” [and yes, a Plan with a capital “P”]. You’d have a “capital letter P” Plan before signing those mortgage documents, wouldn’t you? Taking a well-deserved and much anticipated trip – down the Amazon River, for example – takes a Plan, and visiting a potential college campus with your ready-to-launch high school graduate likewise takes a Plan. Each of these important life events merit the weighing of the pros and cons, and are worthy of your best thought and effort.

So why is it that those who write the required infection prevention program for an organization jump right into the busy work, or the implementation (of what?)/measurement (again, of what?), and skip the critical risk assessment done prior to creating such a Plan. Without a clear Plan, how is it possible to focus infection prevention resources in a way to receive the biggest return on your investment?

Elements of a risk assessment will vary widely because each ambulatory organization is unique in its services, providers, staff, patient population, and location. Therefore, it wouldn’t serve an organization well to “borrow” a risk assessment from another practice. Fear not, for APIC has well-developed risk assessment tools and resources,* and until you can get your hands onto those APIC tools, read on.

An organization’s risk assessment is an essential planning document that will guide your formal infection prevention program and prioritize your monitoring and surveillance activities. Your risk assessment will fuel your program’s goals and objectives and shape risk reduction strategies. By

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*Assistance provided by the APIC Risk Assessment Task Force.
now you’re probably asking, “How?” or “How do I get started?”

**Step 1**
Collect your internal and external demographics. Internal demographics include the size, type, and scope of services provided, and the volume of visits, surgeries, or procedures. Consider the following:

- Is your organization a single or multi-specialty practice?
- If you’re processing instruments, are you using multiple processes, or are you limited to a single process (e.g., sterilization or high-level disinfection)?
- Is your organization a clean environment of care?

External demographics are more about the community and patient population served. Is your organization:

- Urban or rural?
- Near other similar organizations or is it the only one in a 50-mile radius?
- An office-based cosmetic surgery center?
- A Medicare-certified ambulatory surgery center (ASC)?

**Step 2**
Define your patient population. Are your patients:

- Industrial employees?

<table>
<thead>
<tr>
<th>Table 1</th>
<th>My organization’s information</th>
<th>Factors that increase our risk</th>
<th>Factors that decrease our risk</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal demographics</strong></td>
<td>12 providers, single specialty, high volumes</td>
<td>Tight room turnover times, new sterile processing (SP) tech</td>
<td>Long tenured provider and clinical staff</td>
<td>Review scheduling protocols, strong mentor for SP tech</td>
</tr>
<tr>
<td><strong>External demographics</strong></td>
<td>Lower income area, current high unemployment</td>
<td>Less educated, no insurance coverage</td>
<td>Excellent online and onsite public aid health educator</td>
<td>Written discharge plan of care each visit, follow up wellness calls</td>
</tr>
<tr>
<td><strong>Patients served</strong></td>
<td>High percentage retired, elderly</td>
<td>Older average patient age with chronic illness</td>
<td>Stable existing patient population</td>
<td>Monitor chronic illness status, communication with primary care providers</td>
</tr>
<tr>
<td><strong>Infection prevention-related issues</strong></td>
<td>CA-MRSA on the rise</td>
<td>Known low compliance with hand hygiene (HH) and personal protective equipment (PPE)</td>
<td>Recent alcohol-based hand rub installation, patient hand hygiene awareness campaign</td>
<td>Continue quality improvement studies HH/PPE, increase education patients/staff</td>
</tr>
</tbody>
</table>

- High income or low income?
- Mostly Medicare?
- Predominately young families?

**Step 3**
Define the services you are providing. Does your organization provide:

- Pediatric orthopedics?
- Ophthalmology only?
- General surgery (limited to a single specialty or to multiple specialties)?
- Anesthesia? (What levels?)

**Step 4**
If you had a predecessor, review your facility’s infection control-related data to identify any potential red flags. It is beneficial to have a good working relationship with your local health department staff. For example, if TB or pertussis is on the rise in your area, the local health department will know and can provide vital information pertinent to your unique area and its population.

**Step 5**
Once you have collected all pieces of information, give some thoughtful consideration to issues related to potential increases and decreases in infection risk. For example, the risks to a single specialty procedure-based ASC in a low-income
urban setting may be vastly different from a multi-specialty ASC in a wealthy suburban setting. Further, the risks to a university health center organization would be different from the previous examples. Your one-page risk assessment might look something like this: (see table 1)

By completing this simple five-step risk assessment exercise and reviewing it on a regular basis, you'll be well-enabled to create a “capital-letter P” Plan and assess infection risks. Use the Plan to know your organization’s strengths, prioritize infection prevention program goals, and more efficiently allocate available resources. If the organization’s risk assessment has led you to an important revelation or improved your prevention activities, email editor@apic.org so we can share the knowledge.

*For more ambulatory related infection prevention risk assessment resources, please see inset to the right.

Would you like to learn more about creating an ambulatory risk assessment?

Attend APIC 2012, June 4-6, for educational opportunities tailored to your needs. Educational highlights for ambulatory care include:

- Infection Prevention Risk Assessment – The Starting Place for Your IP Program
- Beyond CMS: Assessing Your Ambulatory Facility


Order the Infection Prevention Manual for Ambulatory Surgery Centers, which provides practical tools and templates to create and implement an infection prevention program. (www.apic.org/store)
Alabama hospitals launch initiative to use technology to monitor hand washing

Twenty-seven hospitals across Alabama are partnering for the “Putting Power into Healthcare Initiative” (PPHI) – the first statewide effort to use a data-backed network to encourage and track employee hand-washing to prevent healthcare-associated infections. According to an announcement from Alabama Power on April 3, the hospitals involved in the project have installed a system in patient rooms (and other places where patient care is provided) that uses active communication units and radio-frequency badges tied to a data and compliance monitoring system. This system measures when and how often badged employees and healthcare professionals wash their hands.

Rich Embrey, MD, chief medical officer of Princeton Baptist Medical Center in Birmingham – a hospital participating in the program – led a team that conducted a seven-month study on the electronic monitoring system and found that infection rates dropped 22 percent in the unit where the system was installed during the study period; this resulted in 159 fewer patient days and an estimated health cost savings of more than $133,000, officials reported.

Learn more about the PPHI initiative.

CDC confirms safe injection practices guidelines

The Centers for Disease Control and Prevention (CDC) issued a position/message paper restating guidelines that call for medications labeled for single-use or single-dose to be used for only one patient. The CDC paper was developed in response to efforts by a coalition of primarily outpatient care organizations who asked the Department of Health and Human Services to relax safe injection practices guidelines in order to avoid drug wastage.

The road ahead: APIC Strategic Plan 2020

Over the next eight years, APIC Strategic Plan 2020 will accelerate progress toward the elimination of healthcare-associated infections (HAIs). Developed by the APIC Board of Directors in collaboration with APIC members and other stakeholders in infection prevention, the plan – published in the March issue of Preventing Infection in AmbulatoryCare.
APIC leaders believe this is the right time to commit to an uncompromising vision and organize the association’s mission and goals around a plan to advance toward healthcare without infection. We propose to advance our mission to create a safer world through prevention of infection and embrace this bold direction through five strategic goals:

**Patient safety goal:** Demonstrate and support effective infection prevention and control as a key component of patient safety.

**Implementation science goal:** Promote and facilitate the development and implementation of scientific research to prevent infection.

**IP competencies and certification goal:** Define, develop, strengthen, and sustain competencies of the IP across the career span and support board certification in infection prevention and control (CIC®) to obtain widespread adoption.

**Advocacy goal:** Influence and facilitate legislative, accreditation, and regulatory agenda for infection prevention with consumers, policy makers, healthcare leaders, and personnel across the care continuum.

APIC is currently developing a Chapter Legislative Representative Toolkit to help guide chapter members and legislative representatives in educating and informing legislators regarding the current diversion of infection prevention resources in many states as the result of public reporting mandates. The toolkit will be available for APIC members in time for International Infection Prevention Week, the third week of October.

**Data standardization goal:** Promote and advocate for standardized, quality, and comparable HAI data.

Access the APIC Strategic Plan 2020 online and in the spring issue of Prevention Strategist. Also, read the May issue of the American Journal of Infection Control (AJIC) to learn more about APIC’s strategic direction. APIC – The Road to 2020 will take a detailed look at two of the five goals described in the strategic plan. First, APIC’s focus on professional development will be explained in a white paper that presents a conceptual model of IP competency – the first of its type ever developed – and includes board certification as a critical component. Second, a discussion of performance improvement and implementation science will examine how both areas are essential to the IP’s – and APIC’s – future success.

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**CDC issues Vital Signs report on C. difficile**

Infections from *Clostridium difficile* (*C. difficile*) have climbed to historic highs over the past decade, according to a new Vital Signs report issued by the CDC. While many healthcare-associated infections, such as bloodstream infections, declined in the past decade, *C. difficile* infection rates and deaths have climbed to historic highs and are now linked to about 14,000 U.S. deaths annually.

Further, the infection is now a patient safety concern in all types of medical facilities, not just hospitals as was traditionally thought. Most at risk are those who take antibiotics and also receive care in any medical setting. According to the report, 94 percent of *C. difficile* infections are related to medical care; about 25 percent first show symptoms in hospital patients; 75 percent in nursing home patients or in people recently cared for in doctor’s offices and clinics. Read the report.
APIC honors its infection prevention heroes

Twelve groups and infection preventionists (IPs) who have improved the health and well-being of patients, healthcare workers, and the public have been selected as Heroes of Infection Prevention by APIC.

Since 2005, when the Heroes of Infection Prevention program was introduced, APIC has recognized more than 60 members and groups for their exceptional work in the infection prevention field. The 2012 Heroes of Infection Prevention are:

Patti Bull, MS, M(ASCP), CIC
Hendrick Medical Center, Abilene, TX

Miguela Caniza, MD, and Don Guimera, BSN, RN, CIC
St. Jude Children's Research Hospital, Memphis, TN

Kim Delahanty, RN, BSN, PHN, MBA/HCM, CIC
University of California, San Diego, CA

Marlene Fishman Wolpert, MPH, CIC
St. Joseph Health Services of RI, Providence, RI

Elaine Flanagan, RN, BSN, MHA, CIC
Detroit Medical Center, Detroit, MI

Catherine Grayson, RN, MSN, CIC
Medical Center of McKinney, McKinney, TX

Namita Jaggi, MD
Artemis Hospital, Gurgaon, India

Katherine Rhodes, RN, BSN, COHN-S, CIC
Texas Health Southwest, Ft. Worth, TX

Beth Ann Rhoton, RN, BSN, MS, CIC
Medical University of South Carolina Medical Center, Summerville, SC

DeAnn Richards, RN, CIC
Agrace HospiceCare, Madison, WI

Wynn Roberts, RN, CIC
Randall Children’s Hospital at Legacy Emanuel, Portland, OR

Judy Warren, RN, MS, CIC, CPHQ
Tawam Hospital, Al Ain, United Arab Emirates

In addition to recognizing the outstanding work of this year’s 12 heroes, APIC is expanding this program by selecting a Heroes Implementation Research Scholar to apply the principles of implementation science to identify success strategies most likely to benefit other infection prevention programs. The scholar will visit the selected facilities, interview staff, summarize findings, and share these success stories with the broader U.S. and international healthcare community.

“Our goal is to improve patient outcomes by advocating for the adoption of best practices in infection prevention,” said Michelle Farber, RN, CIC, APIC 2012 president. “This year’s initiative provides the opportunity to highlight outstanding work by infection preventionists who have been recognized for their dedication to patient safety so that best practices can be replicated in more healthcare settings.”

The 2012-2013 Heroes program is supported by an educational grant from BD (Becton, Dickinson and Company).

Read the full profiles and inspirational stories from each of the 12 heroes in future issues of Prevention Strategist and Preventing Infection in Ambulatory Care.
More effective than iodine-based products at eliminating skin microorganisms.

Period.

ChloraPrep® products have been shown to outperform iodine-based products.¹²

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State legislation affecting ambulatory surgical centers 2012

By Nancy Hailpern
APIC Director of Regulatory Affairs

& Benjamin Rogers
APIC Government Affairs Associate

As public policy efforts at all levels of government continue to focus on improving healthcare quality in all care settings, APIC continues to monitor infection-related legislation. This table focuses on state legislation impacting ambulatory surgical centers (ASCs). In many states, legislative sessions last for two years, and legislation that has not been enacted carries over from the first to the second year of the session. As such, the 2012 state legislation table includes bills that were introduced in 2011 and are still pending. Bills that have been introduced or have had a change in status since the last issue of Preventing Infection in Ambulatory Care are shaded in blue. For more information on legislation impacting ASCs, or other legislation affecting your state, please contact Benjamin Rogers, Government Affairs associate, at 202-454-2612 or brogers@apic.org, or Nancy Hailpern, director of Regulatory Affairs, at 202-454-2643 or nhailpern@apic.org, or visit the legislative map on the APIC website at http://www.apic.org/Advocacy/Legislative-Map.
<table>
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<td>Kentucky</td>
<td><strong>HB 416 (Introduced 2/16/2012)</strong> Bill would require healthcare facilities, including ambulatory care centers, to implement infection prevention programs in high-risk areas, and report to the state health department all HAI and MDRO infections through CDC's National Healthcare Safety Network (NHSN). The health department would be required to make the information publicly available in understandable language that allows for comparisons between facilities. A similar bill was introduced in 2011.</td>
<td>Yes</td>
<td><a href="http://www.lrc.ky.gov/record/12RS/HB416.htm">http://www.lrc.ky.gov/record/12RS/HB416.htm</a></td>
<td>Legislature adjourned without enacting legislation.</td>
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<td>SB 42</td>
<td><strong>(Introduced 1/3/2012)</strong> Bill would require the State Board of Medical Licensure to establish infection control requirements for pain management facilities.</td>
<td>No</td>
<td><a href="http://www.lrc.ky.gov/record/12RS/SB42.htm">http://www.lrc.ky.gov/record/12RS/SB42.htm</a></td>
<td>Legislature adjourned without enacting legislation.</td>
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<tr>
<td>Massachusetts</td>
<td><strong>HB 614 (Introduced 1/19/2011)</strong> Bill would require MRSA screening of high-risk patients admitted to a hospital or ASC. Facilities would be required to report data on MRSA-colonized or MRSA–infected patients to the public health department.</td>
<td>Yes (MRSA Reporting)</td>
<td><a href="http://www.malegislature.gov/Bills/BillText/11506?generalCourtId=1">http://www.malegislature.gov/Bills/BillText/11506?generalCourtId=1</a></td>
<td>Carried over from 2011 session and pending in Joint Committee on Public Health</td>
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<td>HB 1519</td>
<td><strong>(Introduced 1/20/2011)</strong> Provisions of this bill would direct the state health department to develop checklists of care to prevent adverse events and reduce HAI rates, and encourage their implementation in hospitals and ASCs; encourage development of screening and prevention procedures to reduce rates of MDROs; and add MDROs to the definition of HAIs.</td>
<td>No</td>
<td><a href="http://www.malegislature.gov/Bills/BillText/10686?generalCourtId=1">http://www.malegislature.gov/Bills/BillText/10686?generalCourtId=1</a></td>
<td>Referred to Joint Committee on Public Health.</td>
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<td>New Jersey</td>
<td><strong>SB 281 (Introduced 1/1/2012)</strong> Bill would amend current emergency personnel notification law to require infection control officers in healthcare facilities, including ASCs, to inform state public health officials when an individual is transported to the facility who might expose workers to an infectious disease.</td>
<td>No</td>
<td><a href="http://www.gencourt.state.nh.us/legislation/2012/SB0281.html">http://www.gencourt.state.nh.us/legislation/2012/SB0281.html</a></td>
<td>Senate Health and Human Services Committee recommended passage.</td>
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<td>New Jersey</td>
<td><strong>S 1203 (Introduced 1/23/2012)</strong> Bill would prohibit healthcare facilities and personnel from using a reprocessed device without obtaining informed consent of the patient. Similar bills have been introduced in previous years.</td>
<td>No</td>
<td><a href="http://www.njleg.state.nj.us/2012/Bills/S1500/1203_I1.HTM">http://www.njleg.state.nj.us/2012/Bills/S1500/1203_I1.HTM</a></td>
<td>Pending in Senate Health, Human Services and Senior Citizens Committee.</td>
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<td>New York</td>
<td><strong>AB 3963 (Introduced 1/31/2011)</strong> Identical to SB 4023 Bill would require the state health department to develop an HAI prevention/reduction policy for healthcare facilities, including outpatient facilities.</td>
<td>No</td>
<td><a href="http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB3963&amp;Text=Y">http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB3963&amp;Text=Y</a></td>
<td>Carried over from 2011 and pending in Assembly Health Committee.</td>
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<td>New York</td>
<td><strong>AB 4969 (Introduced 2/9/2011)</strong> 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>
<td>No</td>
<td><a href="http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB4969&amp;Text=Y">http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB4969&amp;Text=Y</a></td>
<td>Referred to Assembly Health Committee.</td>
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<td>New York</td>
<td><strong>AB 5576 (Introduced 2/23/2011)</strong> Identical to SB 3430 Bill would amend state law to make it a crime for a healthcare provider in any healthcare setting to reuse a syringe when the action results in the infection of a patient with a communicable disease.</td>
<td>No</td>
<td><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>
<td>Referred to Assembly Committee on Codes.</td>
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<td>New York</td>
<td><strong>SB 3430 (Introduced 2/22/2011)</strong> Identical to AB 5576 Bill would amend state law to make it a crime for a healthcare provider in any healthcare setting to reuse a syringe when the action results in the infection of a patient with a communicable disease.</td>
<td>No</td>
<td><a href="http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+SB3430&amp;Text=Y">http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+SB3430&amp;Text=Y</a></td>
<td>Referred to Senate Committee on Codes.</td>
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<td>New York</td>
<td><strong>SB 4023 (Introduced 3/14/2011)</strong> Identical to AB 3963 Bill would require the state health department to develop an HAI prevention/reduction policy for healthcare facilities, including outpatient facilities.</td>
<td>No</td>
<td><a href="http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+SB4023&amp;Text=Y">http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+SB4023&amp;Text=Y</a></td>
<td>Carried over from 2011 session and pending in Senate Health Committee.</td>
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<td></td>
<td>Bill would require healthcare personnel to provide their employers with evidence of influenza vaccination or a written declination including the reason. Healthcare facilities would be required to report annually to the state health department on employee influenza vaccinations.</td>
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<td>Resolution would call for a comprehensive budgetary analysis of the Pennsylvania Patient Safety Authority and recommend whether or not the authority’s existence should be discontinued. The authority is charged with promoting patient safety in ASCs. Resolutions do not have the force of law.</td>
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<td></td>
<td>Bill would require facilities, including ambulatory surgical facilities, to provide the state with the HAI data those facilities already submit to NHSN.</td>
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