Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC)

Information provided by ECRI is not intended to be viewed as required by ECRI or the Health Resources and Services Administration, nor should these materials be viewed as reflecting the legal standard of care. Further, these materials should not be construed as dictating an exclusive course of treatment or procedure. Practice by providers varies, for reasons including the needs of the individual patient and limitations unique to the institution or type of practice. Best practice recommendations change over time. All organizations should consult with their clinical staff or other experts for specific guidance and with their legal counsel, as circumstances warrant.

- Refer to the "Guidance and Resources" section at the end of the document for pertinent references and resources.

Objective	Yes/No	Comments/Supportive Documentation
A. Leadership and Accountability		--
IPC plans, policies, and procedures include non-clinical and clinical services (e.g., medical, dental, obstetrical, optometry, podiatry, chiropractic services).	NO	-- No Infection Prevention Control (IPC) Policy can be found, so one needs to be developed, including all elements that pertain to this risk assessment. NEED TO DEVELOP AN FQHC POLICY/SOP FOR INFECTION PREVENTION AND CONTROL (IPC).
As a best practice, the organization designates an individual (at least one) who is trained in IPC and who is responsible for overall IPC management and compliance.	NO	-- No IPC Officer has been officially delegated. NEED TO HAVE LEADERSHIP DECIDE WHO SHOULD BE RESPONSIBLE FOR IPC MANAGEMENT AND COMPLIANCE AND ENSURE PROVISION OF TRAINING AN IPC CERTIFICATION.
As a best practice, the person designated as responsible for overall IPC management and compliance obtains a certificate in IPC.	NO	-- No IPC Certification is currently required for a clinical supervisor. NEED TO HAVE LEADERSHIP DECIDE WHO SHOULD BE RESPONSIBLE FOR IPC MANAGEMENT AND COMPLIANCE AND ENSURE PROVISION OF TRAINING AN IPC CERTIFICATION.

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Objective	Yes/No	Comments/Supportive Documentation
The organization assesses and provides resources, equipment, and supplies that are appropriate and in sufficient amounts to ensure staff have the tools necessary to adhere to disinfection, sterilization, and IPC policies.	YES	-- SUPPLIES AND EQUIPMENT ARE KEPT IN INVENTORY TO PROPERLY DISINFECT AND STERILIZE ROOMS, EQUIPMENT, AND TOOLS.
The organization incorporates the [Centers for Disease Control and Prevention (CDC)] and [state immunization recommendations] for healthcare workers in the IPC plan.	NO	-- There is no IPC policy, making this item non-compliant.
The organization collects, analyzes, tracks, monitors, and reports the IPC plan and outcomes to leadership and the board.	NO	-- No IPC data or reports are being tracked, analyzed, nor presented to leadership. ALTHOUGH RISK ASSESSMENT, INCIDENT DATA, AND PLANS ARE PRESENTED TO LEADERSIHP, THE QUALITY RISK AND CREDENTIALING COMMITTEE OF THE GOVERNING BOARD, AND TO THE GOVERNING BOARD, THERE IS NOT A SPECIFIC INFECTION PREVENTION CONTROL POLICY FOR THE FQHC YET.
The organization provides and maintains documentation for IPC training and competency testing as a requirement upon hiring, annually, and when new tasks or procedures are started in the health center.	YES	-- IPC TRAINING IS CONDUCTED FOR ALL CLINICAL STAFF ANNUALLY FOR HAND HYGIENE, BLOOD BORNE PATHOGENS, AND SAFE INJECTION PRACTICES. TRAINING IS TRACKED AND UPDATED FOR FTCA COMPLIANCE. COMMUNITY HEALTH NURSE MANAGERS OVERSEE COMPETENCIES, WORKFLOWS, AND PRACTICES.
As a best practice, the organization supports safe injection practices with additional training and competency evaluations for staff who administer injectable medications.	YES	-- SAFE INJECTION TRAINING IS PROVIDED ANNUALLY TO ALL CLINICAL STAFF. COMMUNITY HEALTH NURSE MANAGERS OVERSEE COMPETENCIES, WORKFLOWS, AND PRACTICES.

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Objective	Yes/No	Comments/Supportive Documentation
The organization arranges for additional training and maintain documentation on competency evaluations for staff assigned to reprocessing medical devices tasks (i.e., high-level disinfection; sterilization of instruments, equipment, and devices).	NO	-- COMPETENCY EVALUATIONS OF STAFF - No evaluation process is established to monitor staff competency.
B. Communication and Documentation		--
The organization has developed communication materials about managing an exposure or breach in IPC (e.g., reporting to state agencies, patient notification, patient testing if indicated).	YES	-- SNCHC IS THE FQHC DIVISION OF THE SOUTHERN NEVADA HEALTH DISTRICT, THE GOVERNING PUBLIC HEALTH AUTHORITY FOR SOUTHERN NEVADA. AS SUCH, INTERNAL PROCESSES HAVE BEEN ESTABLISHED TO COMMUNICATE BREACHES IN INFECTION CONTROL, INCLUDING REPORTING TO PERTINENT AUTHORITIES AND PATIENTS.
The organization retains documentation for routine equipment maintenance, quality test results, and employee trainings.	NO	-- No documentation found the documents routine equipment maintenance, nor quality test results. Third party vendor provides bi-annual inspection, calibration, and repair of all medical equipment, but documentation is not readily available for review. THERE ARE TRACKERS FOR INVENTORY MANAGEMENT, HOWEVER, THERE ARE NOT EQUIPMENT MAINTENANCE, QUALITY TEST RESULT, OR EMPLOYEE TRAINING RECORDS FOR EQUIPMENT.
The organization retains and ensures staff can access manufacturer's instructions for use of instruments, equipment, devices, and cleaning and disinfection products.	NO	-- There is no current process to retain manufacturer's instructions for us of instruments, equipment, devices, and cleaning/disinfection products where staff can access them.

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Objective	Yes/No	Comments/Supportive Documentation
The organization preserves from each sterilizer the logs/records of sterilization cycles and monitoring measures (mechanical, chemical, and biological) according to CDC, state, and local regulations.	NO	-- The logs for each sterilizer of sterilization cycles seems to be monitored, but it is unclear if logs/records are compliant with CDC, State, and local regulations.
C. Patient Safety, Risk, Quality		--
The organization monitors community transmission levels to decide what infection control interventions need to be implemented.	YES	-- SNCHC IS THE FQHC DIVISION OF THE SOUTHERN NEVADA HEALTH DISTRICT, THE GOVERNING PUBLIC HEALTH AUTHORITY FOR SOUTHERN NEVADA. AS SUCH, INTERNAL PROCESSES HAVE BEEN ESTABLISHED TO COMMUNICATE BREACHES IN INFECTION CONTROL, INCLUDING REPORTING TO PERTINENT AUTHORITIES AND PATIENTS.
The organization performs a risk assessment at least annually to help prioritize resources for areas that pose greater risks to patients and staff and to prevent outbreaks.	NO	-- Annual IPC Risk Assessments have not formally been done before. This is the inaugural IPC Risk Assessment, and it will now be conducted annually as a part of FTCA's quarterly risk assessment requirement. INFECTION PREVENTION AND CONTROL RISK ASSESSMENT WILL BE CONDUCTED ANNUALLY FOR FTCA COMPLIANCE AND INCIDENT PREVENTION.
The organization conducts infection control rounds periodically (e.g., quarterly as a best practice, annually) to ensure procedures have been correctly implemented.	NO	-- IPC rounds are not being conducted with intent to monitor IPC. INFECTION PREVENTION AND CONTROL RISK ASSESSMENT WILL BE CONDUCTED ANNUALLY FOR FTCA & POLICY COMPLIANCE AND INCIDENT PREVENTION.

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Objective	Yes/No	Comments/Supportive Documentation
The organization adheres to local, state, and federal requirements for surveillance, disease, and outbreak reporting.	YES	-- SNCHC IS THE FQHC DIVISION OF THE SOUTHERN NEVADA HEALTH DISTRICT, THE GOVERNING PUBLIC HEALTH AUTHORITY FOR SOUTHERN NEVADA. AS SUCH, INTERNAL PROCESSES HAVE BEEN ESTABLISHED TO COMMUNICATE BREACHES IN INFECTION CONTROL, INCLUDING REPORTING TO PERTINENT AUTHORITIES AND PATIENTS.
D. Procedures		--
IPC procedures include, but are not limited to, hand hygiene, choice of personal protective equipment, mask usage, safe injection practices, and sharps handling practices.	YES	-- IPC TRAINING IS CONDUCTED FOR ALL CLINICAL STAFF ANNUALLY FOR HAND HYGIENE, BLOOD BORNE PATHOGENS, AND SAFE INJECTION PRACTICES. TRAINING IS TRACKED AND UPDATED FOR FTCA COMPLIANCE. THERE IS ALSO TRAINING FOR PROPER DONNING, USAGE, AND DOFFING OF PPE.COMMUNITY HEALTH NURSE MANAGERS OVERSEE COMPETENCIES, WORKFLOWS, AND PRACTICES.
The organization utilizes manufacturer's instructions when writing policies for all reusable medical/surgical/dental devices and equipment cleaning, proper solution, and soak/dwell times.	YES	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.

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Objective	Yes/No	Comments/Supportive Documentation
The organization has developed a procedure for checking expiration dates, proper storage, and temperatures for supplies, vaccines, and medications and recording the procedure.	NO	-- There are some practices in place to monitor expiration dates, proper storage, and temperatures for supplies, vaccines, and medications, however, there is not a formal health center policy/procedure that can be identified that sets clear expectations to be followed. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.
The organization has developed a system for early detection and management of potentially infectious persons at initial points of the patient encounter.	NO	-- There are some practices in place for early detection and management of potentially infectious persons at initial points of patient encounter, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.
The organization has trained staff to initiate standard, airborne, contact, and droplet precautions based on policy guidelines.	NO	-- There are some practices in place for initiation of standard, airborne, contact, and droplet precautions, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.

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Objective	Yes/No	Comments/Supportive Documentation
The organization enforces CDC safe injection and sharps safety guidelines.	NO	-- There is no IPC policy, making the requirement to use CDC safe injection and sharps safety guidelines non-compliant. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.
The organization utilizes the special work practices of one-hand scoop technique and removal of burs before disconnecting in dental procedures.[*]	N/A	-- DENTAL SERVICES ARE NOT AVAILABLE AT SNCHC YET BUT WILL LIKELY BECOME AVAILABE IN THE NEXT YEAR.
The organization assesses infection prevention skill and technique by observation and simulation as part of the risk management plan.	N/A	-- IPC IS NOT CURRENTLY A GOAL LISTED ON THE RISK MANAGEMENT PLAN, HOWEVER, IT WILL BECOME A PART OF THE IPC POLICY.
E. Emergency Concerns		
The organization acts promptly when exposures or outbreaks of bacteria, viruses, parasites (e.g., measles, mumps, bed bugs) occur.	NO	-- There is an internal process in SNHD to mitigate and manage exposures or outbreaks of bacteria, viruses, parasites, etc., however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed. SNCHC IS THE FQHC DIVISION OF THE SOUTHERN NEVADA HEALTH DISTRICT, THE GOVERNING PUBLIC HEALTH AUTHORITY FOR SOUTHERN NEVADA. AS SUCH, INTERNAL PROCESSES HAVE BEEN ESTABLISHED TO COMMUNICATE BREACHES IN INFECTION CONTROL, INCLUDING REPORTING TO PERTINENT AUTHORITIES AND PATIENTS.

[*] Items marked with a (*) apply only to dental services.

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Objective	Yes/No	Comments/Supportive Documentation
The organization follows the bloodborne pathogen and exposure control plan directions to ensure time-sensitive actions are promptly initiated.	NO	-- There is annual bloodborne pathogen training for clinical team members conducted annually, however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed.ALTHOUGH THERE IS ANNUAL TRAINING PROVIDED TO THE CLINICAL TEAM REGARDING BLOODBORNE PATHOGEN EXPOSURE AND CONTROL, THERE IS NOT A SPECIFIED PLAN, HOWEVER, IT WILL BECOME A PART OF THE IPC POLICY.
When mechanical, chemical, or biological test results suggest that a sterilizer is not functioning promptly, the organization responds promptly by recalling sterilized devices, removing the sterilizer from service, and conducting repeat testing.	NO	- There are some practices in place that address the response process for when mechanical, chemical, or biological test results suggest that a sterilizer is not functioning promptly, and if the team responds promptly by recalling sterilized devices, removing the sterilizer from service, and conducting repeat testing, however there is still a need for a global formal health center policy/procedure that can be identified that sets clear expectations to be followed. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.
F. Sterilization and Disinfection	--	--
The organization ensures that single-use (disposable) devices are not reprocessed and that they are properly disposed of after one use.	YES	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY. WHEN THE POLICY IS CREATED. Team was observed consistently disposing of single-use disposable devices like gloves, needles, etc.

Objective	Yes/No	Comments/Supportive Documentation
Staff clean and disinfect point-of-care testing devices after every use.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED Autoclave at Decatur is stored and used next to a coffee machine, where people prepare and consume beverages, possibly compromising the sterile environment needed surrounding a piece of equipment designed to sterilize and disinfect.
The organization sterilizes equipment that are classified as critical that penetrate soft tissue or bone (e.g., extraction forceps, scalpel blades, bone chisels, periodontal scalers, surgical scalpels, burs).	NO	-- There are practices in place to sterilize equipment classified as critical that penetrate soft tissue or bone, but there is not a formal health center IPC policy or procedure to govern compliance making this item non-compliant. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED
The organization sterilizes dental instruments that are not intended to penetrate soft tissue or bone (e.g., amalgam condensers, air-water syringes) but that might contact oral tissue and are heat tolerant, although classified as semi-critical. *	N/A	-- DENTAL SERVICES ARE NOT AVAILABLE AT SNCHC YET BUT WILL LIKELY BECOME AVAILABE IN THE NEXT YEAR.
The organization enforces that dental handpieces or intraoral devices are removed for sterilization or have U.S. Food and Drug Administration clearance not to be removed *	N/A	-- DENTAL SERVICES ARE NOT AVAILABLE AT SNCHC YET BUT WILL LIKELY BECOME AVAILABE IN THE NEXT YEAR.

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Objective	Yes/No	Comments/Supportive Documentation
The organization performs high-level disinfection for reusable semi-critical equipment that touches either mucous membranes or nonintact skin, even if probe covers have been used (e.g., vaginal probes, speculums, cryosurgical probes, scopes, respiratory tubing).	NO	-- There are practices in place to govern high-level disinfection for reusable semi-critical equipment that touches either mucous membranes or nonintact skin, even if probe covers have been used, but there is not a formal health center IPC policy or procedure to govern compliance making this item non-compliant. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. OTOSCOPE COVERS, THERMOMETER COVERS, DISPOSABLE SUPPLIES WERE WITNESSED BEING USED ONCE AND DISCARDED.
The organization performs low-level disinfection with a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant for non-critical patient care surfaces and equipment (e.g., blood pressure cuff, thermometer) that touch intact skin.	NO	-- The team uses a U.S. EPA-registered hospital disinfectant for non-critical patient care surfaces and equipment, however there is not a formal health center IPC policy to govern this practice, so it is non-compliant. Team was witnessed inconsistently disinfecting non-critical patient care surfaces and equipment during triage process despite the use of single use covers. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED
G. Environmental Safety		--
The organization consults with a heating, ventilation, and air conditioning (HVAC) professional to ensure that clinical airflow patterns and air exchanges per hour are sufficient to reduce airborne contaminants, including any viruses and bacteria produced from aerosolized procedures.	YES	-- SNHD HAS ITS OWN FACILITIES TEAM THAT HANDLES HVAC ISSUES AND CONSULTING WITH ANY OUTSIDE ORGANIZATIONS NEEDED TO MANAGE HVAC SYSTEMS. THERE IS ALSO A SECTION OF SNHD'S DECATUR LOCATION THAT HAS ITS OWN CLOSED HVAC SYSTEM FOR EVALUATING AND TREATING PATIENTS WHOSE ILLNESSES COULD BE TRASFERRED THROUGH THE AIR.

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Objective	Yes/No	Comments/Supportive Documentation
Aerosol-generating procedures are performed cautiously to reduce spread (e.g., use of airborne infection isolation room, ultrasonic scaler, high-speed dental hand pieces, air/water syringe, nebulizers).	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. THERE IS A SECTION OF SNHD'S DECATUR LOCATION THAT HAS ITS OWN CLOSED HVAC SYSTEM FOR EVALUATING AND TREATING PATIENTS WHOSE ILLNESSES COULD BE TRASFERRED THROUGH THE AIR. However, there is no formal health center IPC policy to govern expectations on how to properly perform or monitor the aerosol-generating procedures.
The organization monitors dental treatment units' water quality to meet EPA standards for drinking, provided by the manufacturer of the unit or waterline treatment product. The organization uses sterile water as a coolant when performing surgery. *	N/A	-- DENTAL SERVICES ARE NOT AVAILABLE AT SNCHC YET BUT WILL LIKELY BECOME AVAILABE IN THE NEXT YEAR.
Staff respond to community boil water notices by following procedures on how to modify care delivery during such notices.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern expectations on how staff should respond to community boil water notices, or how to modify care delivery during such a notice.
Between patients, staff clean and disinfect or provide barrier protection to noncritical clinical contact surfaces that are touched often with gloved hands, that are likely to become contaminated with blood or body substances, and that are difficult to clean with EPA-registered hospital disinfectants (e.g., exam lamps, curing lights, light handles, dental units).	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern expectations on how staff should clean and disinfect or provide barrier protection to noncritical clinical contact surfaces that are touched often with gloved hands, that are likely to become contaminated with blood or body substances, and that are difficult to clean with EPA-registered hospital disinfectants in between patients.

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Objective	Yes/No	Comments/Supportive Documentation
Staff clean surfaces with EPA-registered products (e.g., floors, tabletops) on a regular basis, when spills occur, and when surfaces are visibly soiled.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern expectations on how staff should clean surfaces with EPA-registered products (e.g., floors, tabletops) on a regular basis, when spills occur, and when surfaces are visibly soiled.
Staff dispose of waste (e.g., regular, biohazard, sharps) properly following current state and federal regulations.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern expectations on how staff should dispose of waste (e.g., regular, biohazard, sharps) properly following current state and federal regulations.
H. Equipment and Technology Safety		--
The health center makes certain medical devices and instruments supplied by or on loan from vendors, contracted providers, mobile dental vans, or portable dental equipment meet or exceed infection control and equipment management requirements outlined in health center ICP policies and procedures.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern how the health center staff should monitor that medical devices and instruments meet or exceed infection control and equipment management requirements outlined in health center ICP policies and procedures.

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Objective	Yes/No	Comments/Supportive Documentation
The health center has a preventive maintenance plan that includes routine and annual inspection, calibration, updates, and repair to ensure proper function.	NO	-- SNCHC USES A MEDICAL EQUIPMENT PREVENTIVE MAINTENANCE VENDOR TO INSPECT, CALIBRATE, UPDATE, AND REPAIR ALL MEDICAL EQUIPMENT AT ALL SITES, BUT DOES NTO HAVE A PREVENTIVE MAINTENANCE PLAN. THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN IT IS CREATED. There is no formal health center IPC policy to govern how the health center staff should have a preventive maintenance plan that includes routine and annual inspection, calibration, updates, and repair to ensure proper function.

Guidance and Resources

Note: Guidance and resources are provided as supplemental information. Consultants are expected to follow the checklist when conducting the assessment and refer to this section when additional clarification or resources/references are needed.

General

Resource Collection: Infection Control: https://www.ecri.org/components/HRSA/Pages/ResourceCollection_InfectionControl.aspx

Resource Collection: COVID-19 Response: https://www.ecri.org/components/HRSA/Pages/ResourceCollection_COVID19Response.aspx

Fundamental Elements of Standard Precautions – 6-part series eLearning course: https://learning.ecri.org/clinicalriskmanagementprogram/content/fundamental-elements-standard-precautions-6-credit-series

CDC. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

CDC. Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care: https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf

Occupational Safety and Health Administration (OSHA). Bloodborne Pathogens and Needlestick Prevention: https://www.osha.gov/bloodborne-pathogens

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CDC. Approach to an infection control breach with potential risk of bloodborne pathogen transmission: https://www.cdc.gov/hai/pdfs/bbp/fig1_ApporachToAnInfectionControlBreach.pdf

CDC. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

CDC. Cleaning & Disinfecting Environmental Surfaces: https://www.cdc.gov/oralhealth/infectioncontrol/faqs/cleaning-disinfecting-environmental-surfaces.html

Joint Commission. Demystifying the Sterilization Process: https://www.jointcommission.org/-/media/tjc/documents/accred-and-cert/ahc/Demystifying_the_Sterilization_Process.pdf

CDC. Steps for Evaluating an Infection Control Breach: https://www.cdc.gov/hai/outbreaks/steps_for_eval_ic_breach.html

Chiropractic

Chiropractic Economics. Hand Hygiene Matters for DCs Too: https://www.chiroeco.com/chiropractic-hand-hygiene/

Dental

Resource Collection: Dental: https://www.ecri.org/components/HRSA/Pages/ResourceCollection_Dental.aspx

CDC. Infection Prevention Checklist for Dental Settings: Basic Expectations for Safe Care (see p. 11–18): https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care-checklist-a.pdf

CDC. Guidelines for Infection Control in Dental Health-Care Settings — 2003: https://www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

CDC. Dental Unit Water Quality: https://www.cdc.gov/oralhealth/infectioncontrol/faqs/dental-unit-water-quality.html

CDC. Outbreaks of Nontuberculous *Mycobacteria* Infections Highlight Importance of Maintaining and Monitoring Dental Waterlines: https://emergency.cdc.gov/han/2022/han00478.asp

Optometry

Indian Journal of Ophthalmology. Chemical disinfectants in ophthalmic practice: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7942131/

Joint Commission. Disinfection of tonometers and other ophthalmology devices: https://www.jointcommission.org/-/media/tjc/documents/resources/hai/quick_safety_disinfection_of_tonometers_final.pdf?db=web&hash=B3EF5D36D17DCD2D7BCFE9CC6B368604&hash=B3EF5D36D17DCD2D7BCFE9CC6B368604

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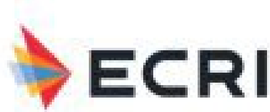

Podiatry

Journal of the American Podiatric Medical Association. Infection Prevention and Control in the Podiatric Medical Setting:

http://www.ndhealth.gov/disease/hai/Docs/Wise%20Infection%20Prevention%20and%20Control%20in%20the%20Podiatric%20Setting%20JAPMA%20201....pdf

CDC. Guide to Infection Prevention for Outpatient Podiatry Settings: https://www.cdc.gov/infectioncontrol/pdf/Podiatry-Guide_508.pdf

DISCLAIMER

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All policies, procedures, and forms published are intended not as models, but rather as samples for illustration purposes only. The content contained does not constitute legal advice. Healthcare laws, standards, and requirements change at a rapid pace, and thus, the sample policies may not meet current requirements. ECRI urges all members to consult with their legal counsel regarding the adequacy of policies, procedures, and forms.

Findings/areas of highest risk identified:

A. Leadership and Accountability
   1. No Infection Prevention Control (IPC) Policy can be found, so one needs to be developed, including all elements outlined in the IPC Policy Draft attached.
   2. No IPC Officer has been officially delegated.
   3. No IPC Certification is currently required for a clinical supervisor.
   4. There is no IPC policy, making the requirement to use CDC and State immunization recommendations in the policy non-compliant.
   5. No IPC data or reports are being tracked, analyzed, nor presented to leadership.
   6. No evaluation process is established to monitor staff competency.

B. Communication and Documentation
   1. No documentation found the documents routine equipment maintenance, nor quality test results.
      i. Third party vendor provides bi-annual inspection, calibration, and repair of all medical equipment, but documentation is not readily available for review.
   2. There is no current process to retain manufacturer's instructions for us of instruments, equipment, devices, and cleaning/disinfection products where staff can access them.
   3. The logs for each sterilizer of sterilization cycles seems to be monitored, but it is unclear if logs/records are compliant with CDC, State, and local regulations.

C. Patient Safety, Risk, Quality
   1. Annual IPC Risk Assessments have not formally been done before. This is the inaugural IPC Risk Assessment, and it will now be conducted annually as a part of FTCA's quarterly risk assessment requirement.
   2. IPC rounds are not being conducted with intent to monitor IPC.

D. Procedures
   1. There are some practices in place to monitor expiration dates, proper storage, and temperatures for supplies, vaccines, and medications, however, there is not a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   2. There are some practices in place for early detection and management of potentially infectious persons at initial points of patient encounter, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   3. There are some practices in place for initiation of standard, airborne, contact, and droplet precautions, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   4. There is no IPC policy, making the requirement to use CDC safe injection and sharps safety guidelines non-compliant.

E. Emergency Concerns
   1. There is an internal process in SNHD to mitigate and manage exposures or outbreaks of bacteria, viruses, parasites, etc., however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed.
   2. There is annual bloodborne pathogen training for clinical team members conducted annually, however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed.

3. There are some practices in place that address the response process for when mechanical, chemical, or biological test results suggest that a sterilizer is not functioning promptly, and if the team responds promptly by recalling sterilized devices, removing the sterilizer from service, and conducting repeat testing, however there is still a need for a global formal health center policy/procedure that can be identified that sets clear expectations to be followed.

F. Sterilization and Disinfection
   1. The autoclave at Decatur is placed next to a coffee machine where people make and consume beverages. Consider moving either the coffee machine or the autoclave to preserve a sterile environment around the autoclave
   2. There are practices in place to sterilize equipment classified as critical that penetrate soft tissue or bone, but there is not a formal health center IPC policy or procedure to govern compliance making this item non-compliant.
   3. There are practices in place to govern high-level disinfection for reusable semi-critical equipment that touches either mucous membranes or nonintact skin, even if probe covers have been used, but there is not a formal health center IPC policy or procedure to govern compliance making this item non-compliant.
   4. The team uses a U.S. EPA-registered hospital disinfectant for non-critical patient care surfaces and equipment, however there is not a formal health center IPC policy to govern this practice, so it is non-compliant.
      i. Team was witnessed inconsistently disinfecting non-critical patient care surfaces and equipment during triage process despite the use of single use covers.

G. Environmental Safety
   1. There is no formal health center IPC policy to govern expectations on how to properly perform or monitor aerosol-generating procedures.
   2. There is no formal health center IPC policy to govern expectations on how staff should respond to community boil water notices, or how to modify care delivery during such a notice.
   3. There is no formal health center IPC policy to govern expectations on how staff should staff clean and disinfect or provide barrier protection to noncritical clinical contact surfaces that are touched often with gloved hands, that are likely to become contaminated with blood or body substances, and that are difficult to clean with EPA-registered hospital disinfectants in between patients.
   4. There is no formal health center IPC policy to govern expectations on how staff should clean surfaces with EPA-registered products (e.g., floors, tabletops) on a regular basis, when spills occur, and when surfaces are visibly soiled.
   5. There is no formal health center IPC policy to govern expectations on how staff should dispose of waste (e.g., regular, biohazard, sharps) properly following current state and federal regulations.

H. Equipment and Technology Safety
   1. There is no formal health center IPC policy to govern how the health center staff should monitor that medical devices and instruments meet or exceed infection control and equipment management requirements outlined in health center ICP policies and procedures.
   2. There is no formal health center IPC policy to govern how the health center staff should have a preventive maintenance plan that includes routine and annual inspection, calibration, updates, and repair to ensure proper function.

2024 Infection Prevention and Control - (IPC) Risk Assessment and Mitigation Tool

Action Plan:

CY24 Goals	CY24 Activities (What, Who, When)	CY24 Performance
		3 & 6 Month Follow Up
Goal #1: Create an Infection Prevention Control Policy that addresses all components required to resolve the deficiencies identified in the HRSA Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC).	• IPC Committee to be formed including, at a minimum, the FQHC CEO, FQHC Risk Manager, QMC, Operations Managers, and Medical Director/IPC Officer • IPC Committee will collaborate on the creation, training, and implementation of an IPC Policy by May 31, 2025. • An IPC Policy Draft has been crafted and attached, in correlation with the IPC Risk Assessment and Mitigation Tool to ensure all findings are addressed and mitigated.	December 2024 – March 2025 – June 2025 –
		3 & 6 Month Follow Up
Goal #2: Name a new IPC Officer and a backup IPC Officer	• FQHC CEO to determine who will serve as the FQHC IPC Officer. • FQHC CEO and IPC Officer will determine who will be the backup/Assistant IPC Officer. • An IPC Certification program/training will be identified and both the IPC Officer and the Assistant IPC Officer will be certified.	December 2024 – March 2025 – June 2025 –
		3 & 6 Month Follow Up

Goal #3: IPC daily procedures to be developed, documented, trained, and implemented with measurable metrics and a process for ongoing IPC monitoring and quality control.	• IPC Committee will determine metrics to be measured and provide quarterly reports to the FQHC Leadership team.
	• IPC Committee will oversee the development, documentation, training, and implementation of
	  ○ day-to-day sanitation, sterilization, and disinfection procedures and practices,
	  ○ day-to-day rounding process to monitor and maintain daily IPC procedures and practices,
	  ○ equipment usage, safety, sterilization, preventive maintenance, and
	  ○ equipment manual adherence, use, and availability
		December 2024 –
		March 2025 –
		June 2025 –

An IPC Policy needs to be developed and approved by the SNCHC Board that must include clinical and non-clinical procedures and practices and incorporate Centers for Disease Control and Prevention (CDC) and state immunization recommendations guidelines. The following components are recommended to coincide with the annual IPC Risk Assessment:

1. Leadership and Accountability
    a. Have an IPC Policy
    b. Medical Director or similar role should be named as IPC Officer, so there is someone on staff who is trained in IPC and who is responsible for overall IPC management and compliance
        a. Consider naming an Assistant IPC Officer for succession planning
    c. Consider requiring the IPC Officer and Asst. IPC Officer needing a certificate in IPC
    d. SNCHC assess and provides resources, equipment and supplies that are appropriate and in sufficient amounts to ensure staff have the tools necessary to adhere to disinfection, sterilization, and IPC policies
    e. IPC Officer creates and manages an IPC Plan that includes clinical and non-clinical procedures and practices and incorporates Centers for Disease Control and Prevention (CDC) and state immunization recommendations guidelines
    f. The IPC Officer oversees the collection, analysis, tracking, monitoring, and reporting of the IPC plan and outcomes to leadership and the Quality, Risk Management, & Credentialing (QRMC) Committee and Governing Board as directed by the FQHC CEO.
        a. Data should be monitored and tracked in coordination with the FQHC Risk Manager
    g. SNCHC provides and maintains documentation for IPC training and competency testing as a requirement upon hiring, annually, and when new tasks or procedures are started in the health center
        a. Training program should also define what the competency evaluation process is
        b. HR Assistant and/or FQHC Administrative Secretary keep updated training records
    h. SNCHC supports safe injection practices with additional training and competency evaluations for staff who administer injectable medications
        a. Training program should also define what the competency evaluation process is
    i. SNCHC arranges for additional training and maintain documentation on competency evaluations for staff assigned to reprocessing medical devices tasks (i.e., high-level disinfection, sterilization of instruments, equipment, and devices)
2. Communication/Documentation
    a. SNCHC has developed communication materials about managing an exposure breach in IPC
        a. e.g., reporting to state agencies, patient notification, patient testing if indicated
    b. Documentation retention for equipment maintenance, quality test results, and trainings.
    c. Staff access to manufacturer's instructions for instruments, equipment, devices and cleaning and disinfection products.
    d. Logs/records from each sterilizer (in accordance with CDC, State, and local regulations) that includes:
        a. sterilization cycles &
        b. monitoring measures (mechanical, chemical, and biological)
3. Patient Safety, Risk, Quality
    a. Monitoring of community transmission levels to decide what infection control interventions need to be implemented

   b. Risk Manager conducts an annual IPC Risk Assessment & coordinates findings with IPC Officer, Leadership, QRMC Committee and Governing Board, as appropriate and required by FTCA compliance regulations
   c. IPC Officer conducts quarterly infection control rounds to monitor compliance, progress, and corrections
      a. Assessment of infection prevention skill and technique by observation and simulation
   d. Adheres to local, state, and federal requirements for surveillance, disease, and outbreak reporting
4. Procedures
   a. IPC procedures include, but are not limited to,
      a. hand hygiene,
      b. choice of personal protective equipment,
      c. mask usage,
      d. safe injection practices, and
      e. sharps handling practices
   b. Each IPC procedure should include the following components where applicable:
      a. Utilizing manufacturer's instructions when writing policies for
         i. all reusable medical/surgical/dental devices and equipment
         ii. cleaning, proper solution, and
         iii. soak/dwell times.
      b. Checking and recording expiration dates, proper storage, and temperatures for
         i. supplies,
         ii. vaccines,
         iii. medications
      c. A system for early detection and management of potentially infectious persons at initial points of the patient encounter
      d. Trained staff to initiate standard, airborne, contact, and droplet precautions based on policy guidelines
      e. Enforcement of CDC safe injection and sharps safety guidelines.
      f. Utilization of the special work practices of: (Dental Only)
         i. one-hand scoop technique and
         ii. removal of burs before disconnecting in dental procedures
      g. Assessment of infection prevention skill and technique by observation and simulation
5. Emergency Concerns
   a. SNCHC acts promptly when exposures or outbreaks of bacteria, viruses, parasites (e.g., measles, mumps, bed bugs) occur
   b. SNCHC follows the bloodborne pathogen and exposure control plan directions to ensure time-sensitive actions are promptly initiated
   c. When mechanical, chemical, or biological test results suggest that a sterilizer is not functioning promptly, SNCHC responds promptly by recalling sterilized devices, removing the sterilizer from service, and conducting repeat testing
6. Sterilization and Disinfection
   a. SNCHC ensures that single-use (disposable) devices are not reprocessed and that they are properly disposed of after one use.
   b. Staff clean and disinfect point-of-care testing devices after every use

   c. SNCHC sterilizes equipment that are classified as critical that penetrate soft tissue or bone (e.g., extraction forceps, scalpel blades, bone chisels, periodontal scalers, surgical scalpels, burs)
   d. SNCHC sterilizes dental instruments that are not intended to penetrate soft tissue or bone (e.g., amalgam condensers, air-water syringes) but that might contact oral tissue and are heat tolerant, although classified as semi-critical*
   e. The organization enforces that dental handpieces or intraoral devices are removed for sterilization or have U.S. Food and Drug Administration clearance not to be removed *
   f. SNCHC performs high-level disinfection for reusable semi-critical equipment that touches either mucous membranes or nonintact skin, even if probe covers have been used (e.g., vaginal probes, speculums, cryosurgical probes, scopes, respiratory tubing)
   g. SNCHC performs low-level disinfection with a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant for non-critical patient care surfaces and equipment (e.g., blood pressure cuff, thermometer) that touch intact skin
7. Environmental Safety
   a. SNCHC consults with a heating, ventilation, and air conditioning (HVAC) professionals to ensure that clinical airflow patterns and air exchanges per hour are sufficient to reduce airborne contaminants, including any viruses and bacteria produced from aerosolized procedures
   b. Aerosol-generating procedures are performed cautiously to reduce spread (e.g., use of airborne infection isolation room, ultrasonic scaler, high-speed dental hand pieces, air/water syringe, nebulizers)
   c. SNCHC monitors dental treatment units' water quality to meet EPA standards for drinking, provided by the manufacturer of the unit or waterline treatment product. The organization uses sterile water as a coolant when performing surgery *
   d. Staff respond to community boil water notices by following procedures on how to modify care delivery during such notices
   e. Between patients, staff clean and disinfect or provide barrier protection to noncritical clinical contact surfaces that are touched often with gloved hands, that are likely to become contaminated with blood or body substances, and that are difficult to clean with EPA-registered hospital disinfectants (e.g., exam lamps, curing lights, light handles, dental units)
   f. Staff clean surfaces with EPA-registered products (e.g., floors, tabletops) on a regular basis, when spills occur, and when surfaces are visibly soiled
   g. Staff dispose of waste (e.g., regular, biohazard, sharps) properly following current state and federal regulations.
8. Equipment and Technology Safety
   a. SNCHC makes certain medical devices and instruments supplied by or on loan from vendors, contracted providers, mobile dental vans, or portable dental equipment meet or exceed infection control and equipment management requirements outlined in health center ICP policies and procedures
   b. SNCHC has a preventive maintenance plan that includes routine and annual inspection, calibration, updates, and repair to ensure proper function