SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	FQHC	**NUMBER(s):**	CHCA-036
PROGRAM:	Division Wide	**VERSION:**	1.00
TITLE:	Infection Prevention and Control Policy	**PAGE:**	1 of 7
		EFFECTIVE DATE: Click or tap here to enter text.	
DESCRIPTION: Guidance for clinical and non-clinical infection prevention and control.		**ORIGINATION DATE:** New	
APPROVED BY: **CHIEF EXECUTIVE OFFICER - FQHC** Randy Smith, MPA Date		**REPLACES:** New	

I. PURPOSE

II. To promote patient, staff, and visitor safety by preventing and mitigating infection risks within Southern Nevada Community Health Center (SNCHC). To align with evidence-based practices, including the Centers for Disease Control (CDC) guidelines, state, and federal regulations, and supports compliance with the Health Resources and Services Administration (HRSA) and Federal Tort Claims Act (FTCA) requirements. This policy guides clinical and non-clinical infection control procedures, ensures resource allocation, and fosters continuous monitoring and improvement in infection prevention efforts.

III. SCOPE

This policy applies to all staff, patients, visitors, contractors, and volunteers within SNCHC facilities, including clinical and non-clinical areas, mobile units, and outreach sites. It encompasses all activities related to infection prevention, including patient care, equipment sterilization, waste management, and environmental cleaning, ensuring compliance with applicable local, state, and federal regulations.

IV. POLICY

A. Roles and Responsibilities

1. Develop, implement, and maintain a comprehensive Infection Prevention and Control (IPC) Policy that outlines procedures, responsibilities, and compliance measures to prevent and control the spread of infections.

2. The Chief Medical Officer (CMO)/Medical Director or a qualified staff member will be designated as the IPC Officer, responsible for overseeing the IPC management, compliance, and staff training.
    a. Assistant IPC Officer may be named for succession planning.
3. The IPC Officer and Assistant IPC Officer will maintain standards through ongoing IPC training, in efforts to support continued excellence in IPC standards, oversight and management.
4. SNCHC ensures that appropriate and sufficient resources, equipment, and supplies are provided to staff in adhering to disinfection, sterilization, and IPC policies effectively.
5. The IPC Officer develops and oversees the implementation of an IPC Plan that encompasses both clinical and non-clinical procedures, ensuring alignment with CDC and state immunization recommendations.
6. The IPC Officer is responsible for overseeing the collection, analysis, tracking, monitoring, and reporting of the IPC plan and outcomes. These findings are regularly reported to the health center's leadership, Quality Improvement (QI) Workgroup, the Quality, Risk Management, & Credentialing (QRMC) Committee and Governing Board in alignment with directives from the FQHC CEO.
    a. The IPC Officer coordinates with the FQHC Risk Manager to monitor and track relevant data, ensuring comprehensive oversight and alignment with organizational risk management efforts.
7. SNCHC ensures that documentation for IPC training and competency testing is maintained, including training upon hire, annually, and whenever new tasks, procedures, or equipment are introduced in the health center.
    a. The training program shall include a clearly defined competency evaluation process to ensure staff proficiency in infection prevention and control practices.
    b. HR Assistant and/or FQHC Administrative Secretary to keep updated training records.
8. SNCHC supports safe injection practices with additional training and competency evaluations for staff who administer injectable medications (Safe Injection Practices Policy).
    a. The training program includes a clearly defined competency evaluation process to ensure staff proficiency in safe injection practices (TRAIN Learning Network).

b. Annual review and assessments are conducted, and certificates of completion are tracked in site specific folders.

9. SNCHC arranges for additional training and maintains documentation of competency evaluations for staff responsible for reprocessing medical devices tasks including tasks such as high-level disinfection, sterilization of instruments, equipment, and devices (Autoclave User Manual).

B. Communication/Documentation

1. SNCHC has developed communication materials to guide the management of exposure breaches in infection prevention and control, in partnership with other health center departments (Workforce Member Incident Reporting Policy).
2. SNCHC retains documentation for equipment maintenance, quality tests, staff training per organizational policies and regulatory requirements. This includes annual calibration by third-party services, maintenance by Facilities staff, and disinfection procedures by staff.
3. Staff are granted access to manufacturers' instruction manuals for instruments, equipment, devices, and cleaning and disinfection products.
4. Logs and records for each sterilizer are maintained in compliance with CDC, State, and local regulations) that include:
   a. Sterilization cycles
      i. Daily, weekly, and monthly sterilization test reports are maintained in the site-specific Autoclave folder.
   b. Monitoring measures (mechanical, chemical, and biological)

C. Patient Safety, Risk, Quality

1. Community transmission levels are monitored to determine and implement appropriate infection control interventions.
2. The Medical Director with the support of the FQHC Administrative Manager conducts an annual IPC Risk Assessment and shares findings with IPC Officer, Leadership, QI Workgroup, QRMC Committee and Governing Board, as required by FTCA compliance regulations.
3. The IPC Officer conducts quarterly infection control rounds to evaluate compliance, track progress, and identify necessary corrections.
   a. Infection prevention skills and techniques are assessed through observation and simulation to ensure competency.
4. Adheres to local, state, and federal requirements for surveillance, disease, and outbreak reporting.

V. PROCEDURE

A. **Core IPC procedures** (Exposure Control Plan):

1. Hand hygiene
2. Selection and use of appropriate personal protective equipment
3. Mask usage
4. Safe injection practices (TRAIN Learning Network)
5. Proper handling and disposal of sharps

B. **Components of IPC procedures:**

1. Adherence to Manufacturer's Instructions (Safety Data Sheets):
   a. Policies for all reusable medical and surgical equipment.
   b. Cleaning protocols, including proper solutions, and soak/dwell times.
2. Expiration Date and Storage Monitoring – Checking expiration dates, storage conditions, and temperatures for:
   a. Supplies
   b. Vaccines
   c. Medications
3. Detection and Management Systems - Early detection and management of potentially infectious persons during initial points of patient encounters.
   a. Initial screening at entry (Appointment Scheduling SOP)
   b. Visual cues (identifying obvious symptoms of illness)
   c. Rapid triage and isolation
4. Precautionary Measures:
   a. Training staff to initiate standard, airborne, contact, and droplet precautions per policy guidelines (Exposure Control Plan)
5. Safe Injections and Sharps Practices:
   a. Enforcing CDC safe injection and sharps safety guidelines.
6. Competency evaluation:
   a. Assessment of infection prevention skill and technique by observation and simulation.

C. **Emergency Response**

1. Prompt action is taken during exposures or outbreaks of bacteria, viruses, parasites (e.g., measles, mumps, bed bugs).
2. SNCHC will follow CDC guidelines and engage with other health district departments to respond appropriately for occupational exposures (Workforce Member Incident Reporting Policy). SNCHC follows the bloodborne pathogen exposure control plan to ensure time-sensitive actions are promptly initiated (Exposure Control Plan).
   a. Post-exposure evaluation is followed for needlestick injuries or exposure to blood or other potentially infectious materials (OPIM).

3. Responding to mechanical, chemical, or biological test results indicating sterilizer malfunction by (SRH Program Clinical Protocol):
    a. Recalling sterilized devices
    b. Removing the sterilizer from service
    c. Conducting repeat testing

D. Sterilization and Disinfection (SRH Program Clinical Protocol):

1. Single-use (disposable) devices are not reprocessed, and they are properly disposed of after one use.
2. Point-of-care testing devices are cleaned and disinfected after each use.
3. Reusable semi-critical equipment that touches either mucous membranes or nonintact skin, undergoes high-level disinfection, even when probe covers are used.
4. Non-critical patient care surfaces and equipment that contact intact skin (e.g., blood pressure cuffs, thermometers) are disinfected using a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant.

E. Environmental Safety

1. Through SNHD's Facility department, SNCHC consults with heating, ventilation, and air conditioning (HVAC) professional to ensure that clinical airflow patterns and air exchange rates meet standards for reducing airborne contaminants, including viruses and bacteria from aerosol-generating procedures.
2. Aerosol-generating procedures are performed with caution to minimize the risk of airborne transmission. Precautions include the use of airborne infection isolation rooms and appropriate equipment such as nebulizers.
3. Staff follow established protocols to modify care delivery during community boil water notices and power outages to ensure patient and staff safety.
4. Noncritical clinical contact surfaces that are frequently touched are cleaned and disinfected or covered with barrier protection between patients using EPA-registered hospital disinfectants.
5. Clinical and non-clinical surfaces (e.g., floors, tabletops) are cleaned using EPA-registered products regularly, after spills, and when visibly soiled.
6. Staff dispose of regular, biohazard, and sharps waste in compliance with current state and federal regulations to ensure safe and proper waste handling.

F. Equipment and Technology Safety

1. SNCHC ensures that all medical devices and instruments, including those supplied by vendors, on loan from contracted providers, or mobile vans meet or exceed infection control and equipment management requirements outlined in the health center's IPC policies and procedures.
2. SNCHC has a robust preventive maintenance program in place to ensure proper functioning of all equipment. This program includes routine and annual inspection, calibration, updates, and repairs with detailed documentation maintained to ensure alignment with IPC standards.

VI. REFERENCES

Appointment Scheduling SOP

Autoclave User Manual

Exposure Control Plan (ECP)

Safe Injection Practices Policy

Safety Data Sheets

Sexual and Reproductive Health (SRH) Program Clinical Protocol

TRAIN Learning Network
(https://www.train.org/main/home)

Workforce Member Incident Reporting Policy

VII. DIRECT RELATED INQUIRIES TO

Chief Medical Officer (CMO)/ Medical Director

FQHC Administrative Manager

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 0		First issuance

VIII. ATTACHMENTS

Not available