Infection Prevention Program in Ambulatory Surgical Facilities
Patient Safety in the Ambulatory Surgical Setting

Analyzing, Educating and Collaborating for Patient Safety
History and Background of Centers for Medicare and Medicaid Services (CMS) Regulations

• January 2008—cluster of patients with acute hepatitis C infection identified by Southern Nevada Health District.
• 63,000 possible patient exposures between March 2004 and January 2008—all preventable.
• All patients had undergone procedures at the Endoscopy Center of Southern Nevada.
• Unsafe injection practices identified that placed patients at risk for bloodborne pathogens.
• Reuse of syringes to access vials of propofol could have introduced the blood of infected patients, and the multidose vials were reused for subsequent patients.
Where Are We Today?

What are we learning from ongoing state inspections?

Overall, ambulatory surgical facilities (ASFs) across the nation are taking the regulations seriously and making an effort to improve practices.

However, recent studies have revealed that practices are still not where they need to be. In New Jersey, 49 of 91 surgical facilities studied did not meet federal Medicare standards. More than a quarter of the centers studied were cited for violations that put them in "immediate jeopardy," meaning patients were in danger of serious injury, harm, or death.

In a recent report by the Illinois Department of Public Health, two-thirds of the ASFs were cited for lack of best practices.
What are we learning from ongoing state inspections?

- Failure to label open bottles of solution and medication vials appropriately
- Failure to provide medical staff with educational opportunities
- Lack of clarification surrounding staff designated to head the infection prevention program
- Lack of follow-up with possible surgical site infections (SSIs)
- Contamination of the sterile field with used or dirty instruments
- Inadequate sterilization times
- Failure to ensure proper testing of sterilizers
Where Are We Today?

What are we learning from independent on-site visits?

• Cleaning of equipment (particularly high-touch surfaces) between patients is inconsistent and, at times, nonexistent.

• Due to rapid turnover of patients, endoscopy centers are shortcutting cleaning between patients.

• Endoscopy centers are reusing gowns.

• Instrument and scope reprocessing failures are present.

• Reprocessing room is used for cleaning dirty instruments and storing sterile packs.
Where Are We Today?

What are we learning from independent on-site visits?

• Active surveillance systems are inconsistent or nonexistent.
• There is a lack of communication and feedback with staff members.
• Immediate-use sterilization (formerly known as “flashing” or flash sterilization) takes place due to lack of instrument trays in busy centers.
• Blood glucose meters are inadequately cleaned between patients.
• Disposable gowns are reused in the operating room (OR) suites.
Infection Prevention Risk Assessment

Risk Assessment (tool provided)

- Used to develop and review your overall infection prevention program
- Used to evaluate potential risk for infection, contamination, and exposure
- Used to assist you with surveillance efforts—process and outcomes
- Based on the community you serve
- Based on the services you provide
- Each center’s priorities will be different
Leadership and Committee Responsibilities

- Implement and/or maintain a facility-wide infection prevention program that follows nationally recognized guidelines.
- Develop clearly written policies and procedures.
- Designate a clinical staff member qualified to manage the program.
- Provide the designated person with training opportunities.
- Allot time for the trained person to perform infection prevention functions (depends on risk assessment).
- Background and training of medical staff should be obtained from credentialing records.
Leadership and Committee Responsibilities

- Infection prevention should be included in the annual nursing competencies.
- Surveillance, tracking, and documentation of infections with appropriate facility feedback should be implemented.
- Form an infection control committee and stipulate members (department listing versus personnel names); include a community member as per Act 52 of 2007.
- Regular meetings determined by the facility should be conducted (can be incorporated into quality assessment and performance improvement [QAPI] meetings).
- All infection control activities, findings, surveillance data, and incidents should be reported at each meeting.
Education

• Pertains to all staff members, including medical personnel and outside contractual companies (e.g., pharmacy, housekeeping).

• All new personnel will attend an orientation program that addresses general infection control principles and practices.

• Orientation will also include education related to hand hygiene, isolation, Occupational Safety and Health Administration bloodborne pathogens regulations, tuberculosis exposure control plans, multidrug-resistant organisms (MDROs), influenza vaccine, and more.

• All personnel will attend at least one mandatory infection control update per year (e.g., reorientation), which will include any updates in general infection prevention (e.g., MDRO updates, new information pertaining to ASF infection prevention).
Education

• Educational programs, excluding orientation, can be in the form of online training, webinars, and audio conferences.

• Educational programs should be documented, and nurses should receive credit during annual competencies.

• Individual records should be maintained, which document the following:
  - Date and time of training
  - Instructor and qualifications
  - Content outline
Standard Precautions

• Apply to all patients, as all blood, body fluids, excretaions, and secretions (except sweat) are considered potentially infectious

• Designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection

• Used in conjunction with transmission-based precautions if indicated
Standard Precautions

Components include:

- Hand hygiene (addressed in CMS audit tool module)
- Gloves (addressed in CMS audit tool module)
- Gowns
- Masking
- Eyewear (goggles)
- Environmental cleaning
- Practices for special lumbar puncture procedures
- Safe injection practices (addressed in CMS audit tool module)
- Blood glucose monitoring devices (addressed in CMS audit tool module)
Transmission-Based Precautions

Due to the transient nature of the patient’s stay at an ASF, as well as the patient population (in most instances, a healthy, ASA class III or below), the facility’s use of transmission-based isolation precautions is a rare occurrence.

Upon initial assessment, if a patient is identified to have a condition or disease that requires transmission-based precautions, the procedure will be rescheduled if possible; however, that may not be feasible, and each case must be separately assessed.
Contact Isolation

- **Direct-contact transmission** involves direct body-surface-to-body-surface contact and physical transfer of microorganisms, often via contaminated hands that are not washed.

- **Indirect-contact transmission** involves contact of a susceptible host with a contaminated intermediate object (fomite), usually inanimate, such as contaminated instruments, needles or dressings, or gloves that are not changed between patient care.
Contact Isolation

• Private room at all times, as per CDC guidelines—patient to be kept out of common areas, including the waiting room.

• Limit the movement and transport of patients.

• Dedicate the use of noncritical patient care equipment and items in areas (e.g., stethoscopes, blood pressure cuffs, electronic thermometers).
Droplet Precautions

Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission.
Droplet Precautions

Infectious agents for which droplet precautions are indicated include *Bordetella pertussis*, influenza virus, adenovirus, rhinovirus, *Neisseria meningitidis*, and group A streptococci (for the first 24 hours of antimicrobial therapy).

It is preferable to reschedule surgery for patients infected with a pathogen that can be spread via the droplet route.
Droplet Precautions

• In the event that surgery is unavoidable, a single-patient room is preferred for patients who require droplet precautions.

• When a single-patient room is not available, spatial separation of >3 feet and drawing the curtain between patient beds is especially important for patients in multibed rooms with infections transmitted by the droplet route.
Droplet Precautions

• Healthcare personnel should wear a mask for close contact with infectious patients, and the mask should be donned upon room entry.

• Patients on droplet precautions who must be transported outside the room should wear a mask if tolerated and follow respiratory hygiene and cough etiquette.

Note: Active tuberculosis (TB) patients require airborne precautions. Unless an ASF is equipped to handle these patients, they should not be admitted to an outpatient setting unless the plant is in compliance with American Institute of Architects/Facility Guidelines Institute (AIA/FGI) standards for an airborne infection isolation room.
Visitors and Ancillary Support Personnel

• Visitors may include those who are in the area to accompany patients (e.g., family member, significant other, guard, interpreter).

• The facility is responsible for advising all visitors of the infection prevention policies that are in place for the purpose of patient and employee safety.

• Observers may include radiology, medical, and nursing students.

• Professionals (e.g., visiting surgeons, residents and interns, ancillary service personnel such as radiology services and sales representatives) may request entrance to the OR suite as part of their work.
Visitors and Ancillary Support Personnel

• Other hospital employees (e.g., biomedical equipment technicians, maintenance or computer support personnel) may need entrance to repair equipment.

POLICY

• Individuals with signs and symptoms of an acute infection such as upper or lower respiratory infection (e.g., cold, sore throat, cough) should not be permitted in the center.

• Professionals and ancillary service personnel who enter the facility should adhere to all policies and procedures of the facility. This includes but is not limited to hand hygiene and use of personal protective equipment.
Visitors and Ancillary Support Personnel

- Hair covers, shoe covers, and freshly laundered clothing intended for OR use should be worn within semirestricted and restricted areas.
- Brief visitors in the OR should be given a one-piece coverall as well as hair and shoe covers, and each situation should be assessed on a case-by-case basis.
- If a child is having surgery, parents accompanying the child to a preoperative preparation or holding area may require wearing cover gowns and hair/shoe covers instead of full garb.
- Delineated traffic flow/patterns and proper attire must be followed by all visitors.
OR Traffic Control

• Traffic control is to deter unauthorized individuals and equipment from entering the restricted area in compliance with established infection control policies and regulatory standards.

• Each facility should incorporate a policy relating to restricted areas and traffic flow in and out of those areas. Generally, restricted areas include the following:
  – All OR suites, hallways outside of OR rooms, OR sterile supply rooms, OR work rooms, scope cleaning rooms, scope storage rooms, equipment storage rooms, decontamination rooms, and instrument processing rooms

• The preoperative and postanesthesia care areas are unrestricted areas with regard to surgical attire (i.e., personal protective equipment), but traffic is restricted and to be kept to a minimum.
Employee Health

• The purpose of an employee health program is to provide guidelines and standards for the prevention and control of infections occurring in the occupational setting.

• All employees will follow the standardized employee health guidelines and standards to prevent and control the transmission of infections to and from employees and patients.
Employee Health

Elements of an employee health program

- A collaborative relationship with the infection prevention program
- Post-offer health screening
- Annual influenza vaccination program
- Annual TB screening program
- Management of occupational exposures
- Maintenance of records and confidentiality
Additional Components

- Infection control risk assessment (ICRA) for construction
- Bloodborne pathogen exposure control plan—OSHA requirement
- TB exposure control plan—OSHA requirement
References


References


References


Resources


Questions and Answers

Q&A

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