

# Infection Prevention in Outpatient Surgery Centers

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**Division of Healthcare Quality Promotion  
Centers for Disease Control and Prevention**

*Region 8 Webinar*

*February 22, 2012*

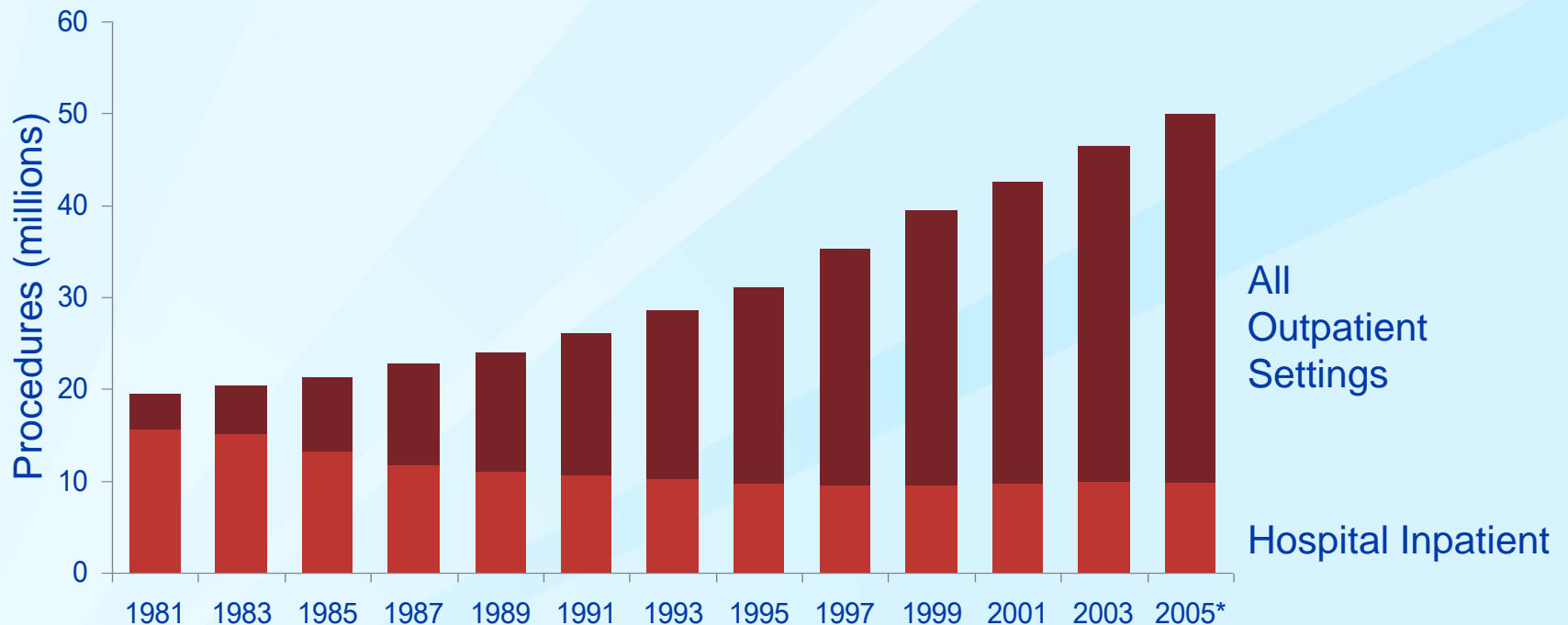
*Nothing to Disclose*

## Objectives

- ❑ **Describe the spectrum of settings where surgery is performed**
- ❑ **Describe infection control lapses being identified in outpatient settings**
- ❑ **Discuss current prevention activities and materials targeting infection prevention needs in outpatient settings**

# Increasing numbers of surgical procedures are moving from inpatient to outpatient settings

## Inpatient vs. Outpatient Surgery Volume, 1981-2005



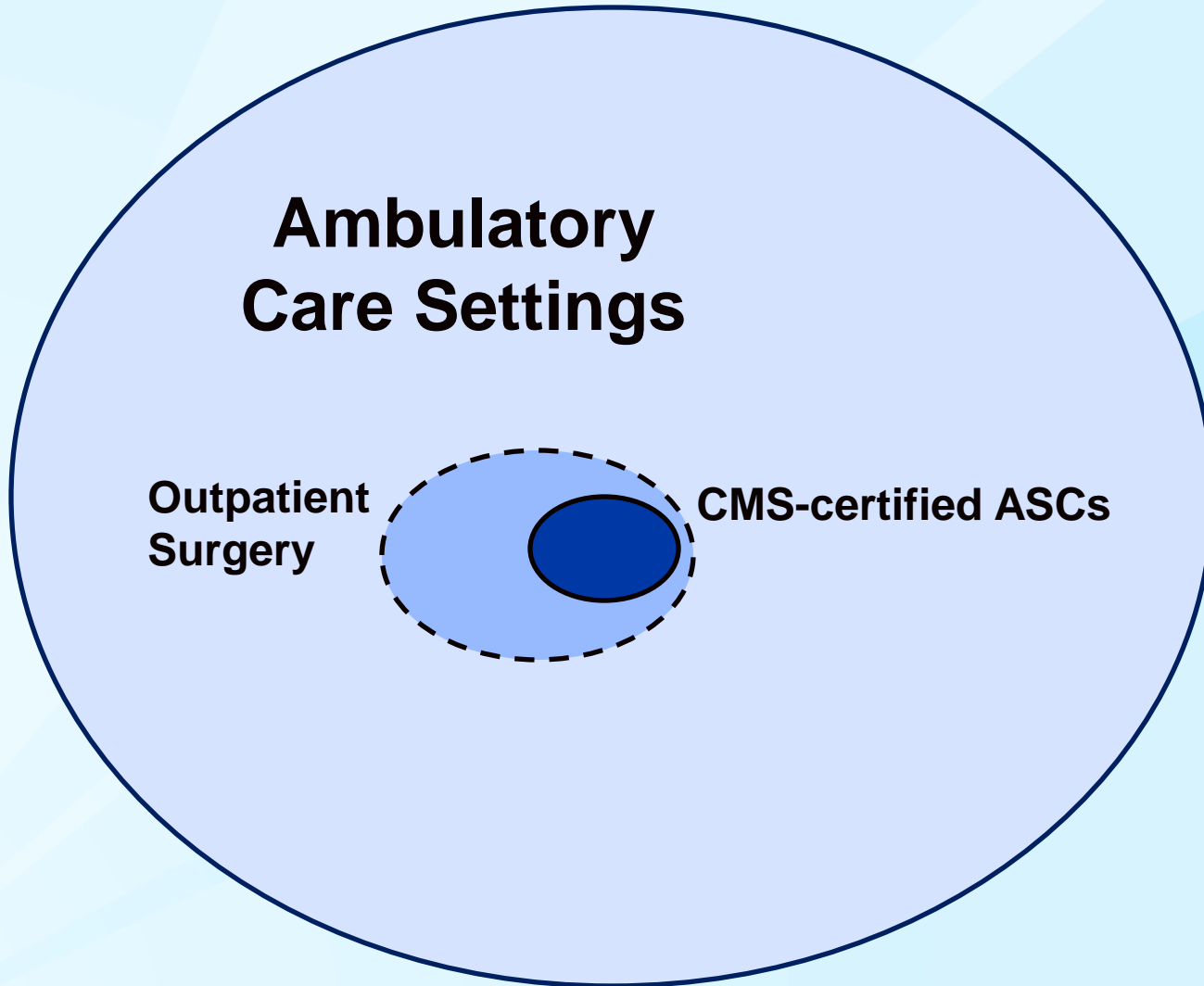
Source data: Avalere Health analysis of Verispan's Diagnostic Imaging Center Profiling Solution, 2004, and American Hospital Association Annual Survey data for community hospitals, 1981-2004. \*2005 values are estimates.

Source: American Hospital Association;  
<http://www.aha.org/research/reports/tw/twjuly2006migration.pdf>

# Ambulatory surgical centers (ASCs)

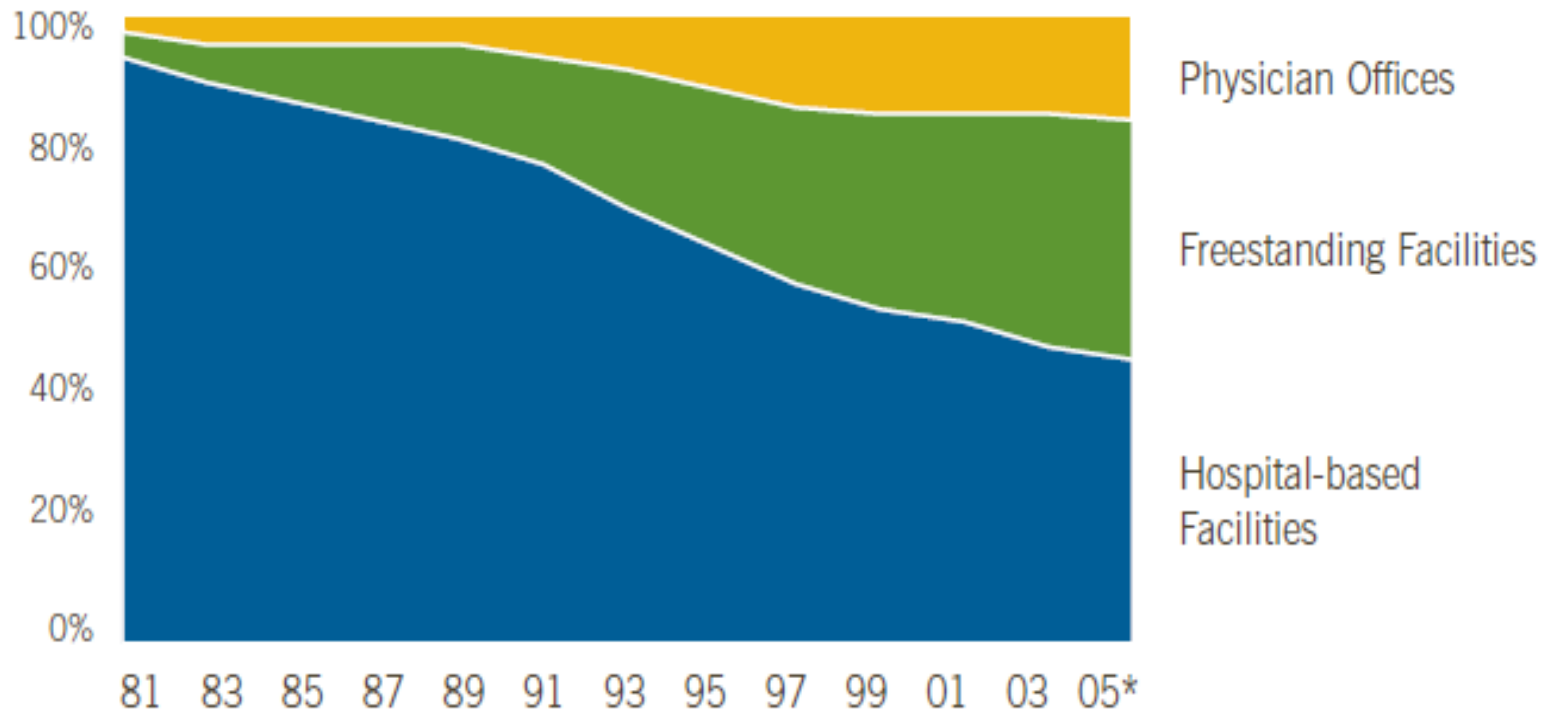
- ❑ **“Distinct entities that operate exclusively to provide surgical services to patients who do not require hospitalization and are not expected to need to stay in a surgical facility > 24 hours”**
- ❑ **Currently, >5,300 ASCs are certified for Medicare participation**
  - >54% increase since 2001
- ❑ **2007: >6 million ASC procedures were paid for by Medicare at a cost of nearly \$3 billion**
  - >70% of claims are for endoscopy or eye procedures (e.g., cataract removal) and spinal / lower back injections

# Surgery not just performed in “ASCs”



# Where is outpatient surgery being performed?

Chart 2: Percent of Outpatient Surgeries by Facility Type, 1981-2005



Source data: Verispan's Diagnostic Imaging Center Profiling Solution, 2004. \*2005 values are estimates

Source: American Hospital Association;  
<http://www.aha.org/research/reports/tw/twjuly2006migration.pdf>

# Oversight in outpatient settings

## □ Variable

- *CMS-certified ASCs are subject to CMS Conditions for Coverage and periodic inspections*
- *Physician-offices operate under the physician's medical license +/- business license unless state laws specify otherwise*

## □ Examples of increasing state requirements

- *NY: Practices that perform office-based surgery required to be accredited<sup>1</sup>*
- *NV: Doctor's offices that provide sedation/anesthesia subject to state inspections<sup>2</sup> + new "injection safety pledge" law<sup>3</sup>*
- *NJ: Outpatient endoscopy and surgical centers required to retain services of a licensed Infection Control Practitioner<sup>4</sup>*

1. [http://www.health.state.ny.us/professionals/office-based\\_surgery/](http://www.health.state.ny.us/professionals/office-based_surgery/) 2. [http://www.leg.state.nv.us/75th2009/Bills/AB/AB123\\_EN.pdf](http://www.leg.state.nv.us/75th2009/Bills/AB/AB123_EN.pdf)  
3. <http://www.oneandonlycampaign.org/partner/nevada>; 4. Maher AC, Hohf BA, Kassai MA, et al. Affiliation of infection prevention professionals: a model for improving infection control in ambulatory care settings. *Am J Infect Control* 2006;34:E144–5.

# **HAI Risks in Outpatient Settings**



# Outbreaks and Patient Notifications in Outpatient Settings

The following table includes examples of recent outbreaks and patient notification events occurring in a variety of outpatient settings including primary care clinics, pediatric offices, ambulatory surgical centers, pain remediation clinics, imaging facilities, oncology clinics, and health fairs. This is not an exhaustive list but it serves as a reminder of the serious consequences that can result when healthcare personnel fail to follow the basic principles of infection control. Such consequences include: infection transmission to patients, notification of thousands of patients of possible exposure to bloodborne pathogens, referral of providers to licensing boards for disciplinary action, and malpractice suits filed by patients.

These events are preventable, yet they continue to occur. Facilities and healthcare personnel are urged to review the [Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care](#) and its accompanying [Infection Prevention Checklist](#) to assess the policies and procedures in their facility as well as their own personal practices to assure they are in accordance with evidence-based guidelines and to prevent patient harm.

Setting	Year Investigated	Pathogen(s)	Infection(s)	Patient notification performed (# notified)	Infection Control Breaches Reported
Urology Clinic [1]	2011	N/A*	N/A*	Yes (101)	1) Single-use needle guides (for prostate biopsy) used for >1 patient
					1) Syringe reuse (i.e.,

# Outbreaks in outpatient settings associated with unsafe injections, United States, 2001-2011

## □ At least 41 outbreaks

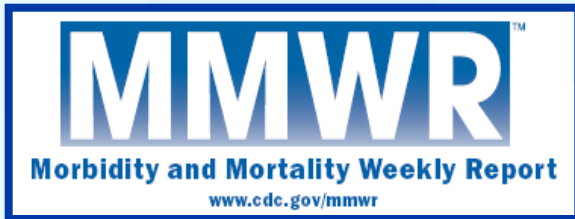
- *18 viral hepatitis (HBV and/or HCV)*
  - *>50% involved administration of anesthetic/analgesic*
- *23 bacterial*
  - *30% in pain remediation clinics*
  - *>50% of case-patients required hospitalization*

## □ Common breaches:

- *Reuse of syringes and/or needles for >1 patient or to reenter medication vials used for >1 patient*
- *Use of single-dose vials or saline bags for >1 patient*
- *Low adherence to hand hygiene and aseptic technique*

# The Las Vegas outbreak

May 16, 2008 / Vol. 57 / No. 19



## Acute Hepatitis C Virus Infections Attributed to Unsafe Injection Practices at an Endoscopy Clinic — Nevada, 2007

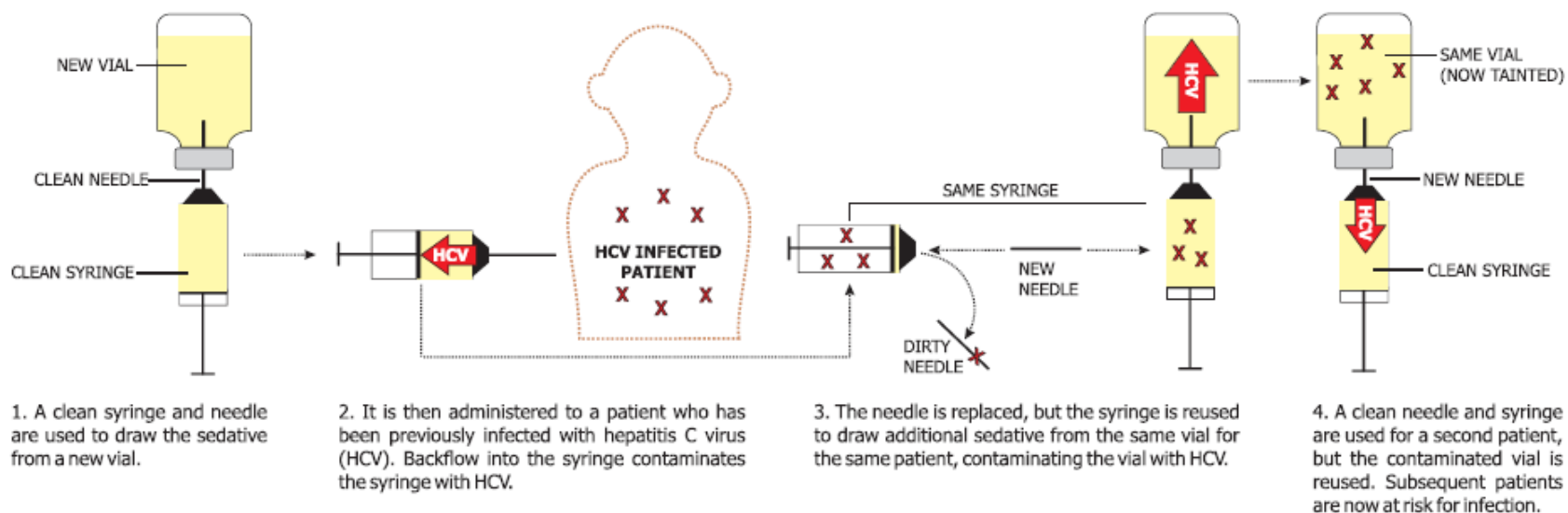
On January 2, 2008, the Nevada State Health Division (NSHD) contacted CDC concerning surveillance reports received by the Southern Nevada Health District (SNHD) regarding two persons recently diagnosed with acute hepatitis C. A third person with acute hepatitis C was reported

- Licensed ASC
- Had not undergone a full inspection by state surveyors in 7 years
- Serious breaches in injection safety identified during outbreak investigation

# Injection safety breaches

## Unsafe Injection Practices and Disease Transmission

Reuse of syringes combined with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.



- ❑ Re-entered medication vials with a used syringe
- ❑ Used single-dose vials for more than one patient

## Investigation outcomes

- ❑ **Clinic immediately advised to stop unsafe practices**
  - *Business license revoked and clinic was closed*
- ❑ **Unsafe practices had been commonly used by some staff at the clinic for at least 4 years**
  - *Health department began notifying >50,000 former patients to recommend testing*
- ❑ **Transmission clearly identified on 2 separate dates**
- ❑ **Cost to health department >\$800,000**
- ❑ **Legal action**
  - *Physicians and CRNAs at the clinic, Manufacturers of propofol, Insurance companies*
- ❑ **Led to assessment of remaining ASCs in Nevada using infection control checklist**
  - *Checklist subsequently adopted by CMS for use in ASC inspections*

# Inspection of CMS-certified ASCs

- ❑ Prior to 2009, inspections did not require observations of procedures or standardized assessment of infection control
- ❑ After 2009
  - Case-tracer methodology
    - Follow at least 1 patient throughout their entire stay in the ASC while observing practices (e.g., documentation, infection control)
  - Use of standardized checklist
    - Systematic assessment of infection prevention practices
    - [www.cms.gov/manuals/downloads/som107\\_exhibit\\_351.pdf](http://www.cms.gov/manuals/downloads/som107_exhibit_351.pdf)

Exhibit 351  
*Ambulatory Surgical Center*  
**INFECTION CONTROL SURVEYOR WORKSHEET**  
 (Rev. 68 Issued: 11-24-10, Effective: 11-24-10, Implementation: 11-24-10)



**II. Injection Practices (injectable medications, saline, other infusates)**  
 Observations are to be made of staff who prepare and administer medications and perform injections (e.g., anesthesiologists, certified registered nurse anesthetists, nurses).

Practices to be Assessed	Was Practice Performed?	Manner of Confirmation
A. Needles are used for only one patient	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Observation <input type="radio"/> Interview <input type="radio"/> Both
B. Syringes are used for only one patient	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	<input type="radio"/> Observation <input type="radio"/> Interview <input type="radio"/> Both

# Infection control worksheet (ICWS) components

- ❑ **Elements from CDC/HICPAC Guidelines**
  - *Emphasis on Standard Precautions*
- ❑ **Hand hygiene and glove use**
- ❑ **Injection safety and medication handling**
- ❑ **Instrument reprocessing**
  - *High-level disinfection (e.g., endoscope reprocessing)*
  - *Sterilization*
- ❑ **Environmental cleaning**
- ❑ **Point-of-care devices (e.g., blood glucose meters)**

# Infection Control Assessment of Ambulatory Surgical Centers

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- ❑ 68% of ASCs had at least 1 lapse in infection control
- ❑ 18% had lapses identified in 3 or more of the 5 categories.

Over the past decades, health care delivery in the United States has shifted toward the outpatient setting; ambulatory surgery in particular has been an area of immense growth. Ambulatory surgical centers (ASCs) are defined by the Centers for Medicare & Medicaid Services (CMS) as facilities that operate exclusively to pro-

**Context** More than 5000 ambulatory surgical centers (ASCs) in the United States participate in the Medicare program. Little is known about infection control practices in ASCs. The Centers for Medicare & Medicaid Services (CMS) piloted an infection control audit tool in a sample of ASC inspections to assess facility adherence to recommended practices.

**Objective** To describe infection control practices in a sample of ASCs.

**Design, Setting, and Participants** All ambulatory surgical centers (ASCs) were invited to participate in the study. A stratified random sample of ASCs was selected from each state. Sample size was based on the number of inspections each state estimated it could complete between June and October 2008. Sixty-eight ASCs were assessed; 32 in Maryland, 16 in North Carolina, and 20 in Oklahoma. Surveyors from CMS, trained in the use of the audit tool, assessed compliance with specific infection control practices: hand hygiene, medication handling, equipment reprocessing, environmental cleaning, and handling of blood glucose monitoring equipment.

**Main Outcome Measures** Proportion of facilities with lapses in each infection control category.

**Results** Overall, 46 of 68 ASCs (67.6%; 95% confidence interval [CI], 55.9%-77.9%) had at least 1 lapse in infection control; 12 of 68 ASCs (17.6%; 95% CI, 9.9%-28.1%) had lapses identified in 3 or more of the 5 infection control categories. Common lapses included using single-dose medication vials for more than 1 patient (18/64; 28.1%; 95% CI, 18.2%-40.0%), failing to adhere to recommended practices regarding reprocessing of equipment (19/67; 28.4%; 95% CI, 18.6%-40.0%), and lapses in handling of blood glucose monitoring equipment (25/54; 46.3%; 95% CI, 33.4%-59.6%).

**JAMA**<sup>®</sup>



# Overall results of 3-state pilot infection control assessments

<b>Infection Control Category Assessed</b>	<b>Number of Facilities with Lapses Identified</b>
<i>Hand Hygiene and Use of Gloves</i>	12/62 (19%)
<i>Injection Safety and Medication Handling</i>	19/67 (28%)
<i>Equipment Reprocessing</i>	19/67 (28%)
<i>Environmental Cleaning</i>	12/64 (19%)
<i>Handling of Blood Glucose Monitoring Equipment</i>	25/54 (46%)

# **Recent Outbreaks and Patient Notifications**

# Injection safety – Patient notification

- ❑ **Medical assistant administered flu vaccine from the same syringe to >1 patient**
  - *Children between age 6 months and 35 months put at risk*
- ❑ **Patient notification conducted and bloodborne pathogen testing advised**

## Pediatric Clinic

### Children told to be tested for HIV after flu vaccines reused

10:06 PM, Apr 12, 2011 |  comments

*April 12, 2011*

- ❑ **CDC Recommendations**
  - *Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens)*

# Injection safety – Patient notification

- ❑ Diabetes educator used insulin pens for >1 patient
- ❑ 2,345 patients notified and recommended to undergo bloodborne pathogen testing

## Outpatient Clinic

Thousands of Wisconsin clinic patients possibly exposed to  
HIV

August 30, 2011

- ❑ **CDC Recommendations**
  - *Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens)*

# Injection safety – Outbreak and Patient notification

- ❑ 16 patients with bloodstream infections
- ❑ Clinic closed for “unsafe infection control practices”
- ❑ 470 patients notified and advised to undergo bloodborne pathogen testing

JACKSON, Miss. (AP) — A clinic in south Mississippi gave cancer patients less chemotherapy or cheaper drugs than they were told and reused the same needles on multiple people as part of a multimillion-dollar Medicare and Medicaid fraud, a 15-count indictment alleges.

September 9, 2011

## ❑ CDC Recommendations

- *Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens)*

[http://www.enterprise-journal.com/news/article\\_58190090-bbb5-11e0-b99d-001cc4c03286.html](http://www.enterprise-journal.com/news/article_58190090-bbb5-11e0-b99d-001cc4c03286.html)

<http://www.chron.com/news/article/3-charged-in-alleged-chemotherapy-fraud-in-Miss-2163084.php>

# Injection safety – Outbreak and Patient notification

- ❑ “Double dipping” – syringe that has been used to inject IV medication into a patient, reused to enter a medication vial that was used for subsequent patients
- ❑ >2000 patients notified and bloodborne pathogen testing recommended

**Death may be linked to San Pedro clinic** *January 11, 2011*

From wire service reports  
Posted: 01/11/2011 08:09:29 PM PST  
Updated: 01/12/2011 06:50:19 AM PST

**Pain Clinic**

Sign Up to see what your friends recommend. 0 [tweet](#)

The family of one of about 2,300 patients who were notified that a San Pedro clinic unwittingly used contaminated needles to sedate patients contacted health officials Tuesday to report that the 76-year-old mother of two died from complications of hepatitis C.

## ❑ CDC Recommendations

- *Medication vials are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient*

# PPE / Injection safety – Outbreak

- ❑ Healthcare personnel did not wear facemasks when necessary for spinal injections and used single-dose vials for multiple patients

## **Post-Myelography Bacterial Meningitis Among Patients at an Outpatient Radiology Facility – Missouri, 2010**

**AUTHORS:** *Amit S. Chitnis, I. Benowitz, V. Srinivasan, R. Gertz, Jr, P. Shewmaker, B. Beall, H. O’Connell, J. Noble-Wang, C. Van Beneden, A. Kallen, S. Patrick, G. Turabelidze, A. Guh, P. Patel*

- ❑ **CDC Recommendations**
  - *HCP wear a surgical mask when placing a catheter or injecting material into the epidural or subdural space (e.g., during myelogram, epidural or spinal anesthesia)*
  - *Single dose (single-use) medication vials, ampules, and bags or bottles of IV solution are used for only one patient*

## **Injection safety recommendations**

- ❑ Use aseptic technique when preparing and administering medications**
- ❑ Never administer medications from the same syringe to multiple patients**
- ❑ Do not reuse a syringe to enter a medication vial or solution**
- ❑ Do not administer medications from a single-dose vials or intravenous solution bags to more than one patient**
- ❑ Limit the use of multi-dose vials and dedicate them to a single patient whenever possible**
- ❑ Wear a surgical mask for when placing a catheter or injecting material into the epidural or subdural space**



# Equipment reprocessing – Patient notification

- ❑ **Urology clinic re-used single-use-only endocavitary needle guides during performance of prostate biopsies<sup>1</sup>**
  - *“Needle guides used on average 3-5 times before being discarded after becoming too bloody”<sup>2</sup>*
  - *~100 patients notified*

March 15, 2011



## Nevada State Health Division Technical Bulletin



**Topic: Risk of Transmission of Blood Borne Pathogens from Reuse of Single Use Only Endocavity Needle Guides**

**Section/Program: Bureau of Health Statistics, Planning, Epidemiology, and Response/Office of Epidemiology**

**Date: March 15, 2011**

## ❑ **CDC Recommendations**

- *Single-use devices (SUDs) are discarded after use and not used for more than one patient*
  - *If the facility elects to reuse SUDs, these devices must be reprocessed prior to reuse by a 3<sup>rd</sup> –party reprocessor that is registered with the FDA as a 3<sup>rd</sup> –party reprocessor and cleared by the FDA to reprocess the specific device in question.*

1. <http://www.southernnevadahealthdistrict.org/news11/032111.php>

2. [https://nsbme.mylicense.com/Verification/Details.aspx?agency\\_id=1&license\\_id=2457&](https://nsbme.mylicense.com/Verification/Details.aspx?agency_id=1&license_id=2457&)

3. [http://health.nv.gov/Epidemiology/2011-03\\_NeedleGuideTechnicalBulletin.pdf](http://health.nv.gov/Epidemiology/2011-03_NeedleGuideTechnicalBulletin.pdf)

# How often are lapses in reprocessing occurring?

- ❑ **January 1, 2007-May 11, 2010 - FDA identified<sup>1</sup>:**
  - *80 reports of inadequate reprocessing filed with the Agency*
    - *28 reports of infection that may have occurred from inadequate reprocessing*
- ❑ **ASC 3-state pilot<sup>2</sup>**
  - *28% with lapse in reprocessing of medical equipment*
    - *5.8% inappropriately reprocessed single-use devices*
    - *6.7% failed to adequately pre-clean instruments*
    - *16.7% did not prepare, test, or replace high-level disinfectant appropriately*
- ❑ **December 2002-December 2006 - 17 healthcare facilities requested assistance from California Dept Health Services regarding inadequately reprocessed endoscopes<sup>3</sup>**
  - *>9000 patients notified of potential exposure to bloodborne pathogens*

1. Statement of Anthony D. Watson to the House Committee on Veteran's Affairs available at: <http://veterans.house.gov/prepared-statement/prepared-statement-anthony-d-watson-bs-ms-mba-director-division-anesthesiology>

2. Schaefer et al. Infection Control Assessment of Ambulatory Surgical Centers. JAMA 2010;303(22):2273-2279.

3. Rosenberg et al. Inadequate Reprocessing of Endoscopes: The California Experience, 2002-2007. AJIC 2007;35(5):E85-86.

# Equipment reprocessing recommendations

- ❑ **Facilities should ensure that reusable medical equipment (e.g., point-of-care devices, surgical instruments, endoscopes) is cleaned and reprocessed appropriately prior to use on another patient**
- ❑ **Reusable medical equipment must be cleaned and reprocessed (disinfection or sterilization) and maintained according to the manufacturer's instructions**
  - *If the manufacturer does not provide such instructions, the device may not be suitable for multi-patient use*
  - *Not all equipment is reusable (it must be FDA-approved as such)*
    - *In ASC pilot, 6% of facilities inappropriately reprocessed/reused single-use devices*

# Equipment reprocessing recommendations

- ❑ **Assign responsibilities for reprocessing of medical equipment to HCP with appropriate training**
  - *Maintain copies of the manufacturer's instructions for reprocessing of equipment in use at the facility; post instructions at locations where reprocessing is performed*
  - *Observe procedures to document competencies of HCP responsible for equipment reprocessing upon assignment of those duties, whenever new equipment is introduced, and on an ongoing periodic basis (e.g., quarterly)*
  
- ❑ **Assure HCP have access to and wear appropriate PPE when handling and reprocessing contaminated patient equipment**

# Point-of-Care Devices - Outbreak

- ❑ **HBV outbreak in an assisted-living facility**
  - *8 patients acutely infected with HBV; 6 deaths*
- ❑ **Fingerstick devices used for >1 patient**
- ❑ **Did not clean and disinfect meters between patients**

Morbidity and Mortality Weekly Report (MMWR)

[MMWR](#)

Text size: **S** M L XL



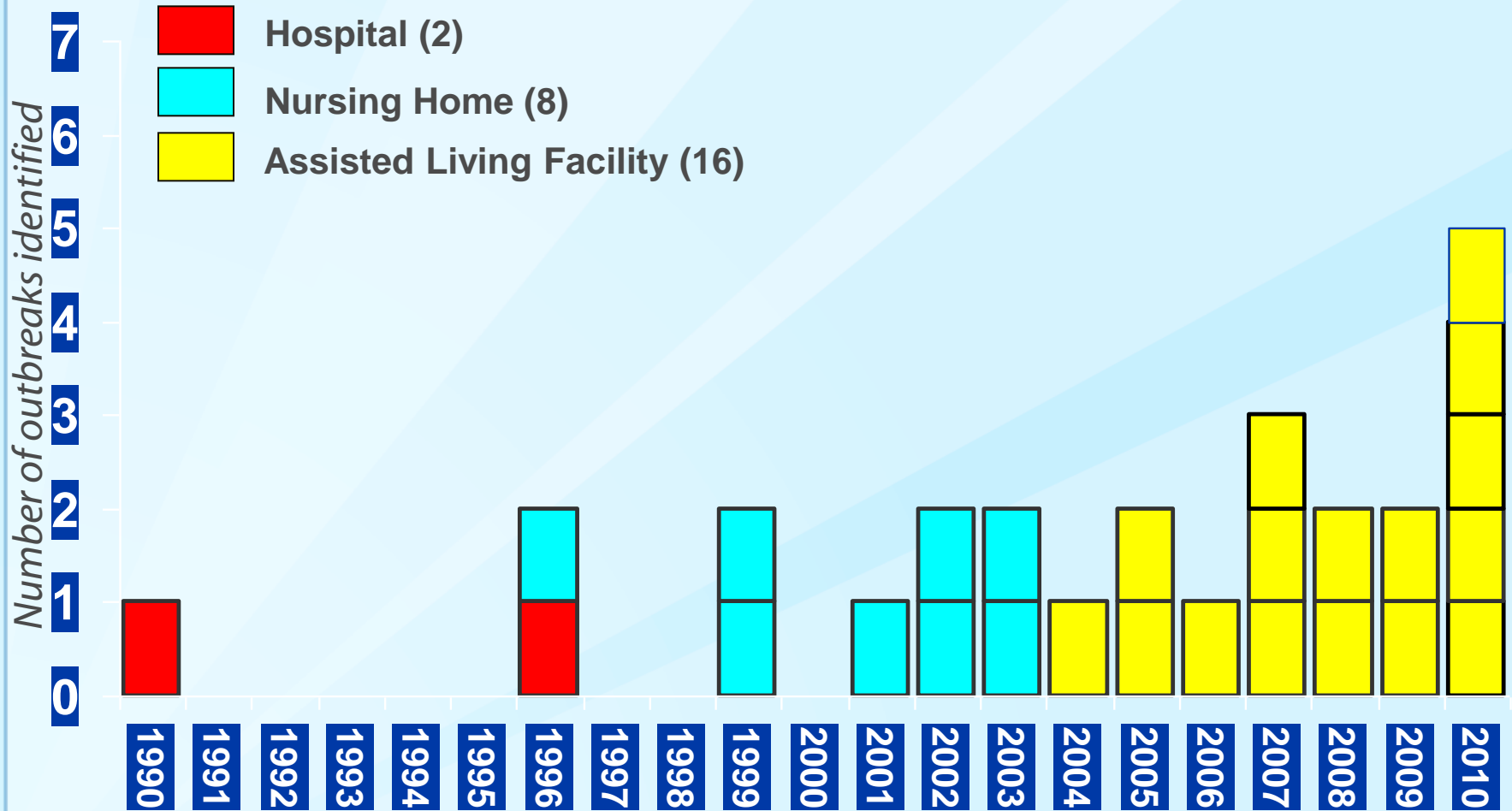
Notes from the Field: Deaths from Acute Hepatitis B Virus Infection Associated with Assisted Blood Glucose Monitoring in an Assisted-Living Facility --- North Carolina, August-October 2010

Weekly  
February 18, 2011 / 60(06);182

August, 2011

- ❑ **CDC Recommendations**
  - *A new single-use, auto-disabling lancing device is used for each patient*
  - *The glucose meter is cleaned and disinfected after every use*

# Outbreaks of HBV infection associated with blood glucose monitoring - 1990 to 2010, US



Thompson *J Diabetes Sci Technol* 2009; 3:283-88. Thompson *JDST* 2011;5:1396-1402. CDC unpublished data.

# Point-of-Care Devices – Patient notification

- ❑ Physician Assistant student trainees used the same multi-lancet fingerstick device for >1 person
- ❑ ~ 50 individuals tested with this device and recommended to undergo bloodborne pathogen testing

## Indian Health Service Press Release

IHS-04-2010  
May 20, 2010

**FOR IMMEDIATE RELEASE**

Contact: (301) 443-3593, FAX (301) 443-0507

May 20, 2010

### **New Mexico Health Fair Participants Urged to Seek Additional Testing**

- ❑ **CDC Recommendations**
  - *A new single-use, auto-disabling lancing device is used for each patient*

# Point-of-Care Devices

## □ 3-state pilot:

- *46% of ASCs at some type of lapse in handling of blood glucose monitoring equipment*
  - *32% (17/53) of ASCs failed to clean and disinfect the blood glucose meter between patients*
  - *21% (11/53) used the same fingerstick device for >1 patient*



## Point-of-Care Device Recommendations

- ❑ **New single-use, auto-disabling lancing device is used for each patient**
  - *Lancet holder devices are not suitable for multi-patient use*
- ❑ **If used for >1 patient, the point-of-care testing meter is cleaned and disinfected after every use according to manufacturer's instructions**
  - *If the manufacturer does not provide instructions for cleaning and disinfections, then the testing meter should not be used for >1 patient*

# **Infection prevention resources for outpatient surgical settings**

# Outpatient Settings

- ❑ <http://www.cdc.gov/HAI/settings/outpatient/outpatient-settings.html>
  - *Outpatient Guide*
  - *Outpatient Checklist*
  - *List of outbreaks and patient notification events*

CDC Home



Centers for Disease Control and Prevention  
CDC 24/7: Saving Lives. Protecting People. Saving Money through Prevention.

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## Healthcare-associated Infections (HAIs)

### Healthcare-associated Infections

The Burden

Types of Infections

Diseases and Organisms

Preventing HAIs

ACA Activities

Guidelines and Recommendations

Top CDC Recommendations to Prevent HAIs

Prevention Toolkits

Dialysis Settings

Long-Term Care Settings

► **Outpatient Settings**

Outpatient Care Guide

Outpatient Care Checklist

[Healthcare-associated Infections](#) > [Preventing HAIs](#)

## Outpatient Settings

The transition of healthcare delivery from acute care hospitals to ambulatory care settings, along with ongoing **outbreaks and patient notification events**, have demonstrated the need for greater understanding and implementation of basic infection prevention guidance. [Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care](#) distills existing infection prevention guidance from the Centers for Disease Control and Prevention (CDC) and its Healthcare Infection Control Practices Advisory Committee (HICPAC).

### Infection Prevention Guide

[Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care](#)

This summary guide of infection prevention recommendations for outpatient (ambulatory care) settings.

### Infection Prevention Checklist

The [Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care](#) is a companion to the [Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care](#). The checklist should be used for two purposes:



# **CDC Guide to Infection Prevention in Outpatient Settings**

- ❑ **These recommendations are not new**
  - **Summary of existing evidence-based guidelines produced by the CDC and the Healthcare Infection Control Practices Advisory Committee**
  - **Based primarily upon elements of Standard Precautions**
    - **Infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting where healthcare is delivered**
  - **Users should consult the full guidelines for more detailed information and recommendations concerning specialized infection prevention issues (e.g., multi-drug resistant organisms)**
  - **Does not replace existing detailed guidance for hemodialysis centers or dental practices**
  
- ❑ **Represent minimum infection prevention expectations for safe care in ambulatory care settings**

# Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care

- ❑ <http://www.cdc.gov/HAI/settings/outpatient/checklist/outpatient-care-checklist.html>
- ❑ **Checklist should be used:**
  - *To ensure that the facility has appropriate infection prevention policies and procedures in place and supplies to allow healthcare personnel to provide safe care*
  - *To systematically assess personnel adherence to correct infection prevention practices*

Infection Prevention Checklist		
Section I. Administrative Policies and Facility Practices		
1. Facility Policies	Practice Performed	If answer is No, document plan for remediation
a. Written infection prevention policies and procedures are available, current, and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations, or standards <i>(Note: Policies and procedures should be appropriate for the services provided by the facility and should extend beyond OSHA bloodborne pathogen training)</i>	Yes    No	

# CMS Inspection Tool for ASCs

- [http://www.cms.gov/manuals/downloads/som107\\_exhibit\\_351.pdf](http://www.cms.gov/manuals/downloads/som107_exhibit_351.pdf)

## II. Injection Practices (injectable medications, saline, other infusates)

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# CDC Evidence-based Guidelines

- ❑ [http://www.cdc.gov/HAI/prevent/prevent\\_pubs.html](http://www.cdc.gov/HAI/prevent/prevent_pubs.html)
- ❑ **These include the following:**
  - *Guideline for Disinfection and Sterilization*
  - *Guidelines for Environmental Infection Control*
  - *Guidelines for Hand Hygiene*
  - *Guideline for Isolation Precautions*
    - *Standard Precautions*
    - *Injection Safety*

# Injection Safety Resources

- ❑ <http://www.cdc.gov/injectionsafety/>
  - *Guidelines*
  - *Links to freely accessible publications*
  - *FAQs*
  - *Medscape video – Free CME*
- ❑ <http://www.oneandonlycampaign.org/>
  - *Injection safety campaign led by CDC*
  - *Injection safety training video for healthcare personnel*



## Point-of-Care Device resources

- **<http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html>**
  - *Infection prevention recommendations*
  - *Clinical alerts*
    - *Fingerstick devices*
    - *Insulin pens*
  - *FAQs including*
    - *“How can Hepatitis B virus be transmitted through the meter?”*
    - *“What products are acceptable for cleaning and disinfection of blood glucose meters?”*

## HHS Action Plan for ASCs

- [http://www.hhs.gov/ash/initiatives/hai/tier2\\_ambulatory.html](http://www.hhs.gov/ash/initiatives/hai/tier2_ambulatory.html)
  - *Summarizes HAI prevention issues specific to ASCs and presents key actions needed to assure safe care in these settings*
- <http://www.hhs.gov/ash/initiatives/hai/resources/index.html>
  - *Infection prevention training for ASCs - **Free CME***

## Summary

- ❑ **Surgical/Invasive procedures being performed in a variety of outpatient settings**
  - *Variable oversight*
- ❑ **Outbreaks and patient notification events continue to identify infection prevention concerns/opportunities in outpatient settings**
- ❑ **Multiple ongoing activities and resources available to facilities**

# Thank you

*The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.*