



# Long Term Care: Infection Prevention Plan, Risk Assessment and Isolation Recommendations

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# CMS Final Rule Requirements for Long-Term Care Facilities



- Long-Term Care (LTC) Facilities have health and safety standards that facilities must meet in order to participate in the Medicare or Medicaid Programs.

<b>Regulatory Section</b> <b>§483.80</b>	<b>Phase</b>	<b>Implementation Deadline</b>
Infection Prevention and Control (IPCP)	Phase 1	November 28, 2016
Antibiotic Stewardship Program	Phase 2	November 28, 2017
Infection Preventionist (IP)	Phase 3	November 28, 2019
IP participation on QAA committee	Phase 3	November 28, 2019

# The Infection Prevention and Control (IPC) Program


3 It is a comprehensive, effective and supported program that is essential for reducing infection risk and increasing safety.

# Effective IPC Program

- A clinically qualified, well-trained staff to oversee the program
- A risk assessment
- A surveillance program
  - A system for obtaining, managing, and reporting critical data and information
  - Use of surveillance findings in performance assessment and improvement activities

# Effective IPC Program

- A written, risk based plan with goals and measurable objectives, strategies and evaluation methods
- Relevant education and training programs
- Available resources to support the program
- Integration with emergency preparedness systems in the organization and community
- Collaboration with the health department



Minimum  
LTC  
Assessment  
Domains

- Hand hygiene compliance
- Environmental control
- Outbreak control

Prevention of:

- Urinary tract infections (UTI)
- Respiratory tract infections
- Gastrointestinal
- Multidrug-resistant organism infections (MDROs)
- Skin and soft-tissue infections

The Infection Control Plan should contain 4 components:

1. A description of risks
2. A statement of goals
3. A description of strategies to address the risks
4. A description of how the strategies will be evaluated

Creating  
the  
Foundation

# Infection Control Plan Template

## **Administrative**

- Authority statement
- Vision/mission statement
- Program goals and objectives
- Program assessment

## **Personnel Job Description**

- Director/Coordinator/Manager
- Infection Control Practitioner

## **Clinical Infection Control Plan**

- Surveillance strategy
- Environmental monitoring
- Antibiotic utilization studies

## **Investigations**

- Outbreak management
- DOH Liaison

## **General Organizational Policies**

- Occupational health
- Medical waste
- Post-exposure communicable disease management



# The Infection Control Plan

AJIC special communication

## **SHEA/APIC Guideline: Infection prevention and control in the long-term care facility**

Philip W. Smith, MD,<sup>a</sup> Gail Bennett, RN, MSN, CIC,<sup>b</sup> Suzanne Bradley, MD,<sup>c</sup> Paul Drinka, MD,<sup>d</sup> Ebbing Lautenbach, MD,<sup>e</sup>  
James Marx, RN, MS, CIC,<sup>f</sup> Lona Mody, MD,<sup>g</sup> Lindsay Nicolle, MD,<sup>h</sup> and Kurt Stevenson, MD<sup>i</sup>  
July 2008

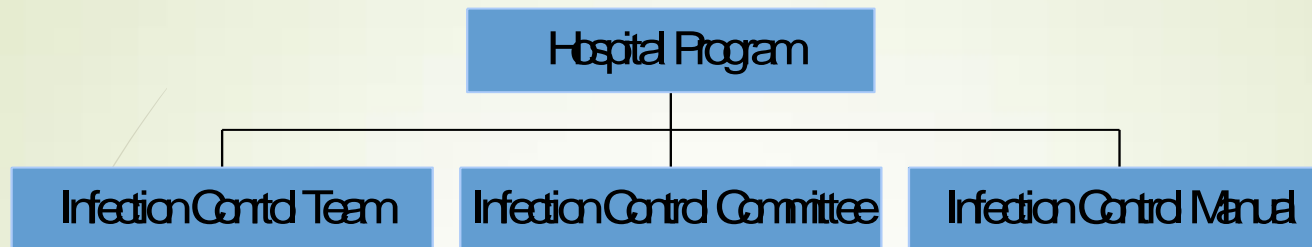


# The Infection Control Plan: Administrative

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# IC Plan: Structure

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Leadership	Expertise/training	Role(s)
<b>Infection Control Committee/Oversight Committee</b>		
Core members	Administration, Nursing Representative, Medical Director, ICP	Identifies areas of risk Establishes priorities
Ad hoc members	Food Service, Maintenance, Housekeeping, Laundry Services, Clinical Services, Resident Activities, Employee Health	Plans strategies to achieve goals Implements plans Develops policies/procedures Allocates resources Assesses program efficacy at least annually
<b>Infection Control Professional</b>		
ICP	Qualification via education, experience, certification	Surveillance Data collection and analysis Implementation of policies, procedures Education Reporting to oversight group/ICC Communication to public health Communication to other agencies Communication to other facilities



# The Infection Control Team

- Has the **authority** to manage an effective control program
- Reports directly with senior administration
- Responsible for day-to-day functions of IC program
- Prepares the yearly plan
- Has expertise in IC
- Creative in their job
- **Remains calm and professional**



# Infection Control Manual

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Every facility should have an infection prevention manual compiling **evidence-based** practices for patient care.

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This manual should be developed and updated in a timely manner by the infection control team.

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It is to be reviewed and accepted by infection control committee.

# Where Is the Evidence?

## Guidelines for Environmental Infection Control in Health-Care Facilities

Recommendations of CDC and  
Infection Control Practices Advisory

## 2007 Guideline for Isolation Precautions Preventing Transmission of Infectious Agents in Healthcare Settings



### GUIDELINE FOR PREVENTION OF CATHETER-ASSOCIATED URINARY TRACT INFECTIONS 2009

Carolyn V. Gould, MD, MSCR<sup>1</sup>; Craig A. Umscheid, MD, MSCE<sup>2</sup>; Rajender K. Agarwal, MD, MPH<sup>3</sup>; Gretchen Krutz, MSN, MSLS<sup>2</sup>; David A. Pegues, MD<sup>4</sup> and the Healthcare Infection Control Practices Advisory Committee (HICPAC)\*

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RN MPH CIC; Marguerite Jackson, PhD;  
Infection Control Practices Advisory

I gratefully acknowledge Dr. Larry Strausbaugh  
in the preparation of this guideline.

Jackson M, Chiarello L, and the Healthcare Infection  
Control Practices Advisory Committee. 2007.  
[2007.pdf](#)

INFECTION CONTROL AND HOSPITAL EPIDEMIOLOGY SEPTEMBER 2008, VOL. 29, NO. 9

SHEA/APIC GUIDELINE

## SHEA/APIC Guideline: Infection Prevention and Control in the Long-Term Care Facility

July 2008



# MMWR

Morbidity and Mortality Weekly Report

Recommendations and Reports

October 25, 2002 / Vol. 51 / No. RR-16

## Guideline for Hand Hygiene in Health-Care Settings

Recommendations of the Healthcare Infection Control Practices

## Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006

Janis D. Siegel, MD; Emily Riefler, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

**Acknowledgement:**  
The authors and HICPAC gratefully acknowledge Dr. Larry Strausbaugh for his many contributions and valued guidance in the preparation of this guideline.

# IC Plan: Elements Policies and Procedures

## Policies and procedures

- Standard precautions
- Transmission-based precautions
- Specific Infections-MRSA, Scabies, Tinea
- Employee education
- Hand hygiene
- Central line maintenance



# The Infection Control Plan: Clinical

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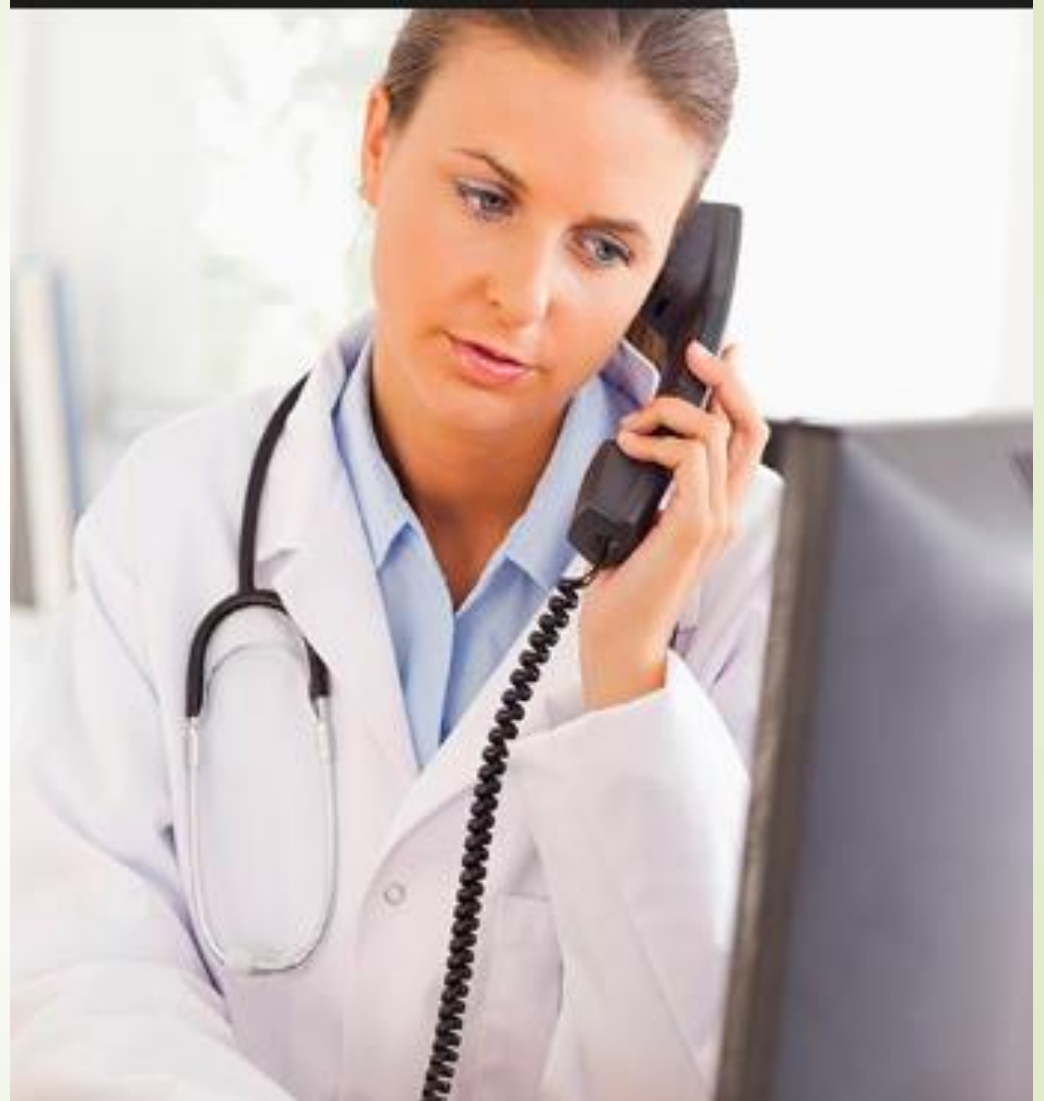
## Surveillance Strategies

- Assessing **your** population (risk assessment)
- Surveillance definitions (McGeer)
- Methods to collect data (EMR, AM report, labs, huddles)
- Outcome measurements (incidence of UTI)
- Performance improvement
- Next year's goals

# IC Plan: Clinical Disease Reporting

Dissemination information to:

- Staff
- Patient and family
- Receiving and transferring institutions
- Public health authorities



# IC Plan: Clinical Antimicrobial Stewardship

- Committee or team
- Leadership support
- De-escalation of antibiotics
- Antibiotic “time-out”
- Standardization of length of treatments
- Work on “low hanging fruit”

# IC Plan: Clinical Health Programs

<b>Residents</b>	<b>Staff</b>
<ul style="list-style-type: none"><li>• TB screening</li><li>• Immunization program</li><li>• Risk assessments</li><li>• Aspiration</li><li>• UTI</li><li>• Skin care</li></ul>	<ul style="list-style-type: none"><li>• TB screening</li><li>• Immunization program</li><li>• Risk assessments</li><li>• Occupational exposures</li></ul>



# The Infection Control Plan: Outbreak Management

# Clinical Infection Identification and Outbreak Management

## Case definitions

Example: Respiratory viral infections

- ▶ Fever above 101°F with one of the following:
  - Chills
  - Headache or eye pain
  - Sore throat
  - Muscle ache
  - New or increased cough

## Outbreak Threshold- Noso Outbreak Reporting Application (NORA)

- ▶ One case of influenza
- ▶ Three cases of other respiratory viruses



# The Infection Control Plan: General

# IC Plan: Education

- New Employee orientation programs including students and volunteers
- Re-orientation of new employee and volunteers
- Live programs as needed to address specific issues  
Example: Flu Adenovirus
- One-on-one staff education during isolation rounds/during problem solving activities utilizing verbal and printed material
- Support patient, family and visitor education via:
  - Individual consultation with patients and family
  - Various printed information on infection control related issues



## IC Plan: General Facility Management Issue

- ▶ Food preparation/storage
- ▶ Laundry collection/cleaning
- ▶ Waste collection/disposal
- ▶ Housekeeping/cleaning- who cleans what?
- ▶ Disinfection/sterilization
- ▶ Plumbing/ventilation



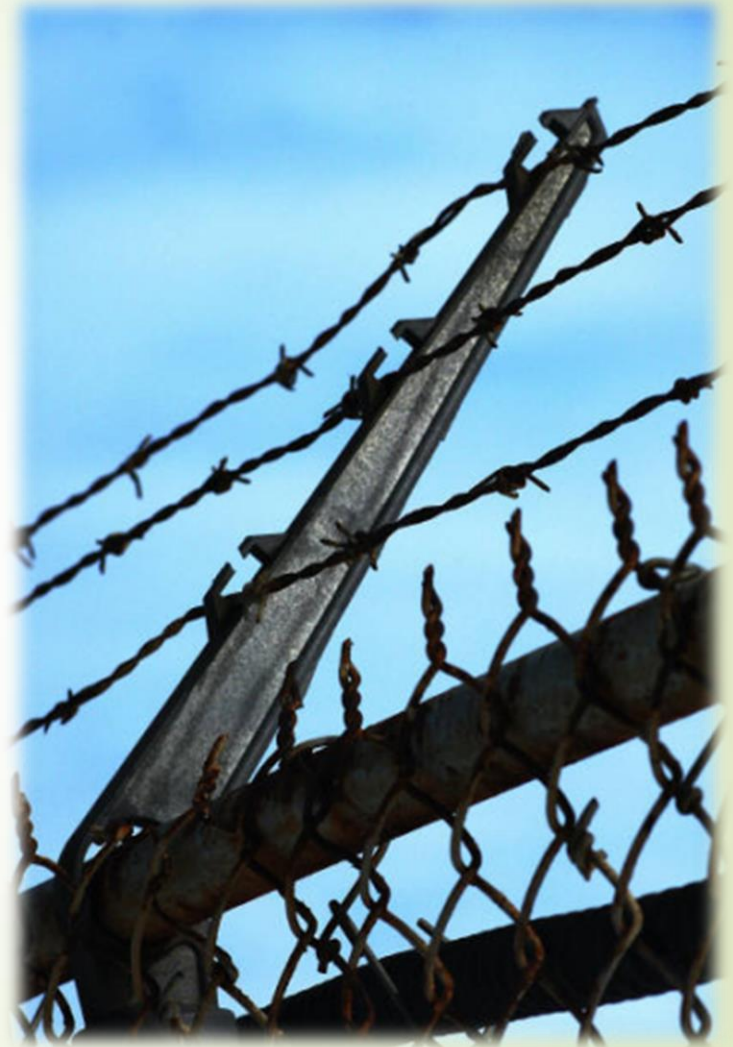
# Facilitators for Success

- Supportive/engaged leaders
- Education, checklists, monitoring
- Multidisciplinary teamwork
- Root-cause analysis for adverse infection events
- Administrative partnership with units
- Accessibility of supplies at point of care
- Sharing process outcome data with staff

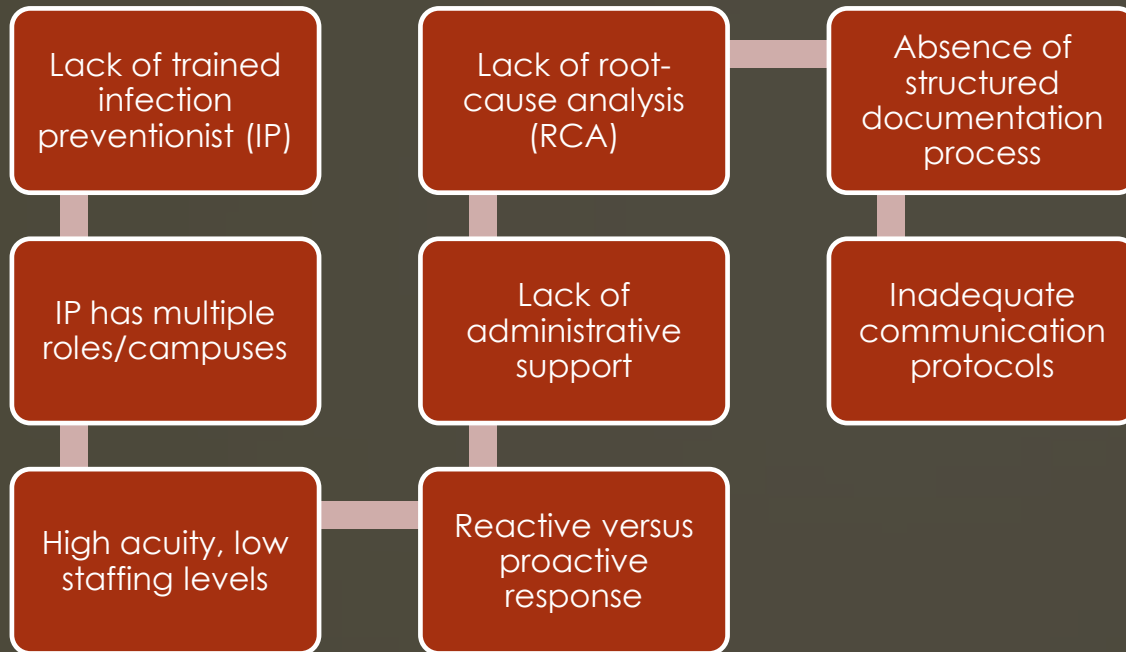


# Practice Barriers Identified

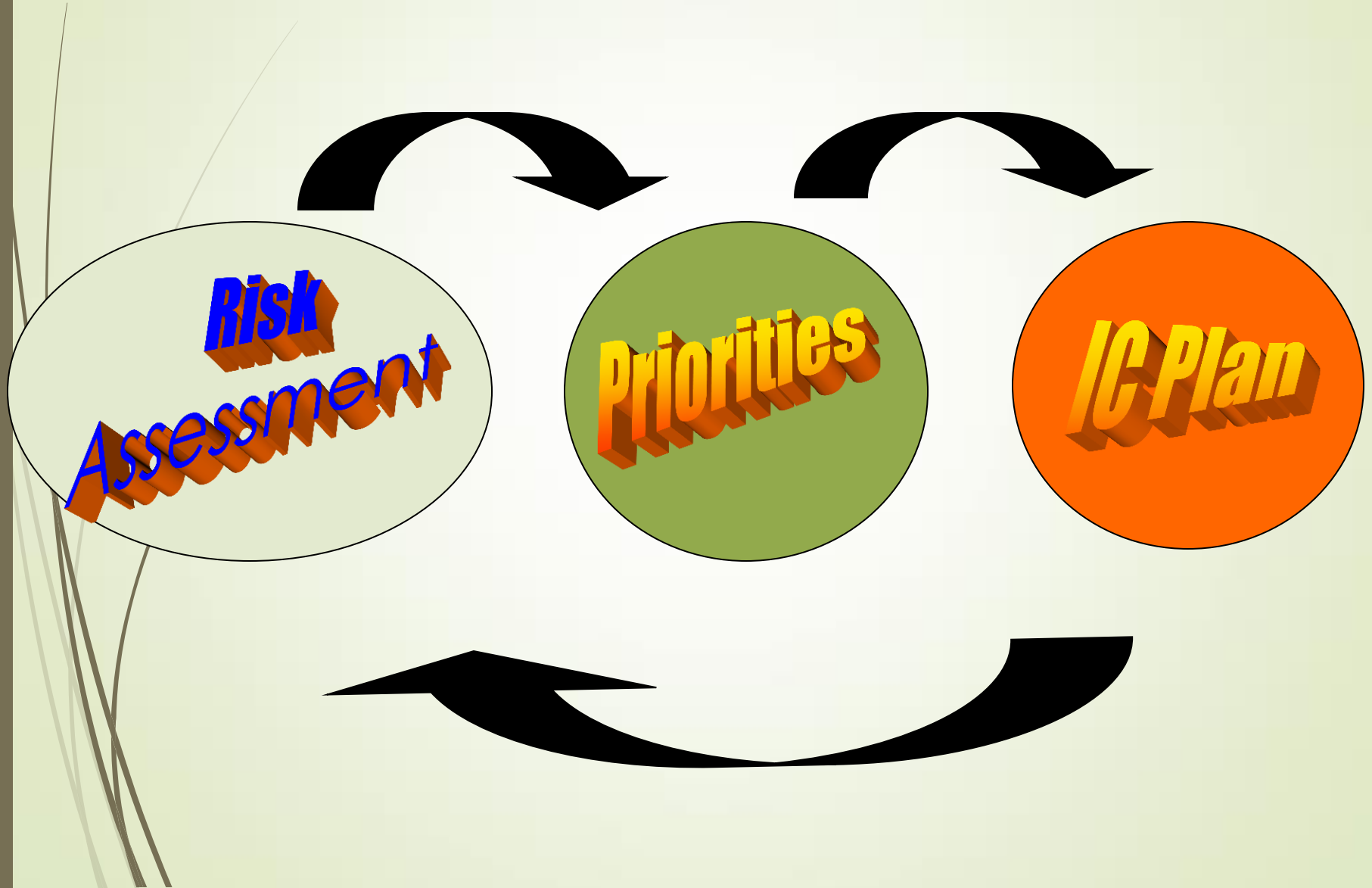
- Unavailability of hand sanitizers
- Inconsistent antimicrobial monitoring
- Lack of prevention strategies
- Physician refusal to remove Foley
- Limited separation of clean/dirty workspace
- Lack of family/resident education



# Organizational Barriers Identified



# From Risks to Priorities to Plan



# Infection Control Program: Risk Assessment



# Risk Assessment

- Risks are reviewed and identified at **least annually** and whenever significant changes occur.
- Risks are assessed with input from, at a minimum, infection control personnel, medical staff, nursing, and leadership.
- Risks that are identified as acquiring and transmitting infections are **prioritized** and documented!
- Objectives, milestones and process measures are developed and implemented to achieve specific **goals** and **decrease risk**.



# Infection Control Program Risk Assessment

Risk	Probability of Event					Impact (Health, Financial, Legal Regulatory)					Current Preparedness					Score
	Very Likely	Likely	Potential	Rare	Never	Catastrophic Loss (life/limb/function/\$\$\$)	Serious Loss (Fx, \$\$\$, or Legal)	Risk of Re-Admission or Transfer to High Acuity	Mod. Clinical or \$\$\$ Impact	Minimal Clinical of \$\$\$ Impact	None	Poor	Fair	Good	Very Good	
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
Flu	3					3					2					18
CDI	4					3					4					48
UTI	2					2					5					20



# Why Perform An Annual Risk Assessment?

Helps focus our activities on essential tasks to reducing critical infection control risks

Constant changes to:

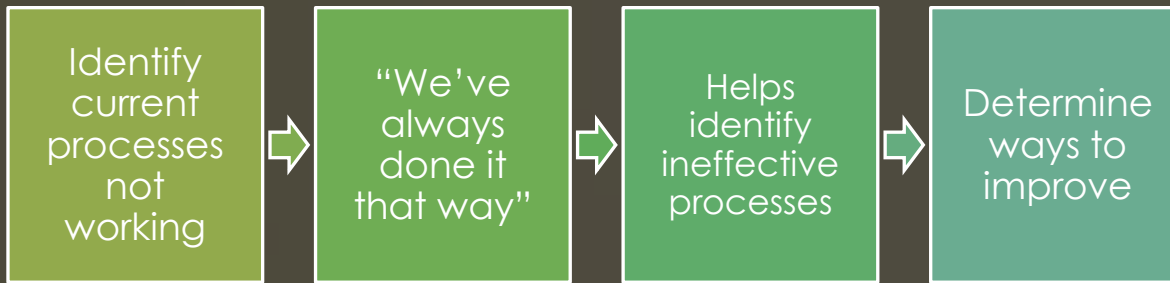
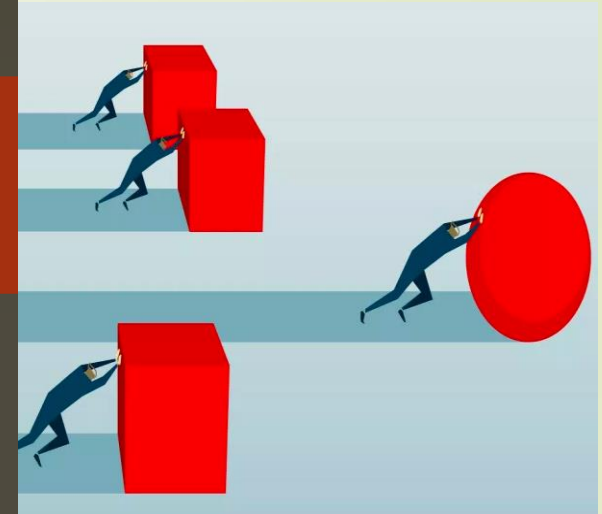
- External guidelines and regulations
- Technologies
- Policies and procedures
- Medications and vaccines
- Populations served
- Services provided



# Why Perform An Annual Risk Assessment?

- Improves patient safety
- Improves staff safety
- Improves efficacy (desired results)
- Identifies training issues
- Personal health habits
- Cultural beliefs regarding disease transmission
- Understanding of disease transmission and prevention
- for implementing new interventions
- Avoids adverse events

# Improves Efficacy



Examples:

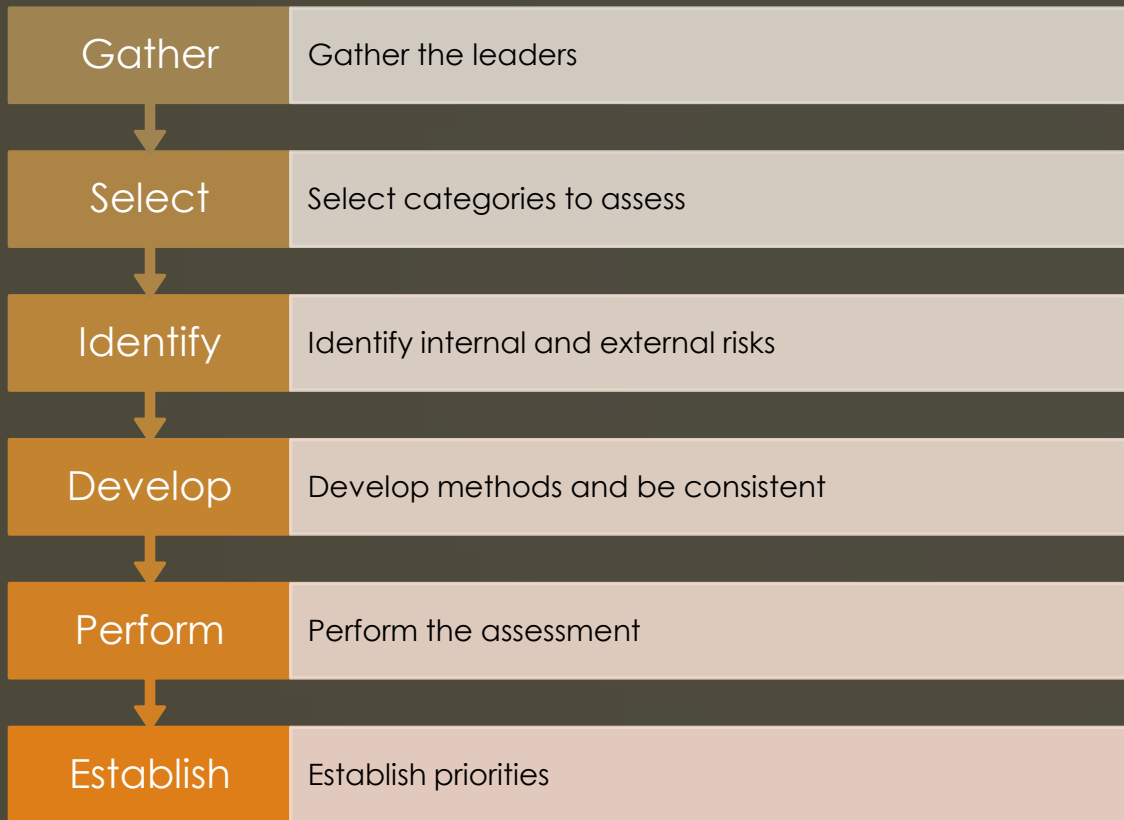
- Staff believes that washing with soap and water is more effective than using an ABHS.
- Staff believes they are required to wash their hands with soap and water after using ABHS ten times

# Justify a Need

- Empower us to approach leadership for increase in resources
- New or increased staffing
- Increased training
- Block beds or increase isolation rooms
- Negative pressure room
- Focuses attention on a need
- Provides a solution to address that need



# Performing the Infection Control Risk Assessment



## Step 1: Gather the Leaders

Include key staff:

- Environmental
- Pharmacy
- Lab
- Nursing
- Medicine
- Quality
- Opinion leaders



# Step 2: Select Categories for Risk Assessment

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<b>Geographic Location</b>	Natural disasters (Probability) Water services Bioterrorism
<b>Community</b>	Community outbreaks Migratory population Incidence of TB
<b>Organizational Programs</b>	Sub acute Rehab LTC
<b>Equipment and Devices</b>	Scopes Instruments- Dental/Podiatry New Devices
<b>Environmental Issues</b>	Construction Isolation rooms
<b>Employee</b>	Needlesticks Vaccinations

## Step 3: External Risks

- ▶ Accidents
  - Mass transit (i.e., airplane, train, bus)
  - Fires involving mass casualties
- ▶ Disasters
  - Tornadoes, Floods, Hurricanes, Earthquakes
  - Breakdown of municipal services ( broken water main, strike by sanitation employees)
- ▶ Intentional Acts
  - Bioterrorism
  - “Dirty Bomb”
  - Contamination of food and water supplies





# Step 3: External Risks

- Community outbreaks of transmissible infectious diseases
  - May be linked to vaccine-preventable illness in unvaccinated population
  - Work with local or county health departments
  - Know local prevalence

NEWS

## Legionnaires' disease in NYC: What to know

People get Legionnaires' disease by breathing in water vapor containing the bacteria.



## Now With 15 Cases of Measles, Rockland Adds Vaccine Clinics

The Health Department offers non-immune residents who are 6 months old through age 60 one dose of MMR vaccine at no cost.

By Lanning Talliaferro, Patch Staff | Oct 23, 2018 5:15 pm ET | Updated Oct 24, 2018 12:48 pm ET



# 7 children dead in virus outbreak at New Jersey facility

By Laura Ly and Susan Scutti, CNN

🕒 Updated 9:13 AM ET, Wed October 24, 2018



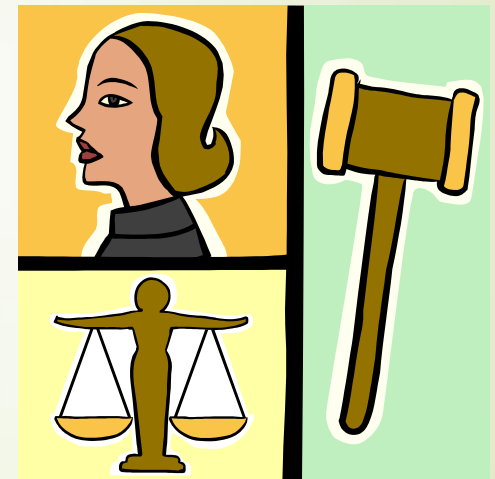
## Important Considerations: Possible but not Probable

- ▶ Threat to life or health
- ▶ Disruption of services
- ▶ Loss of function
- ▶ Loss of community trust
- ▶ Financial impact
- ▶ Legal issues
- ▶ Regulatory impact
- ▶ Standards/requirements

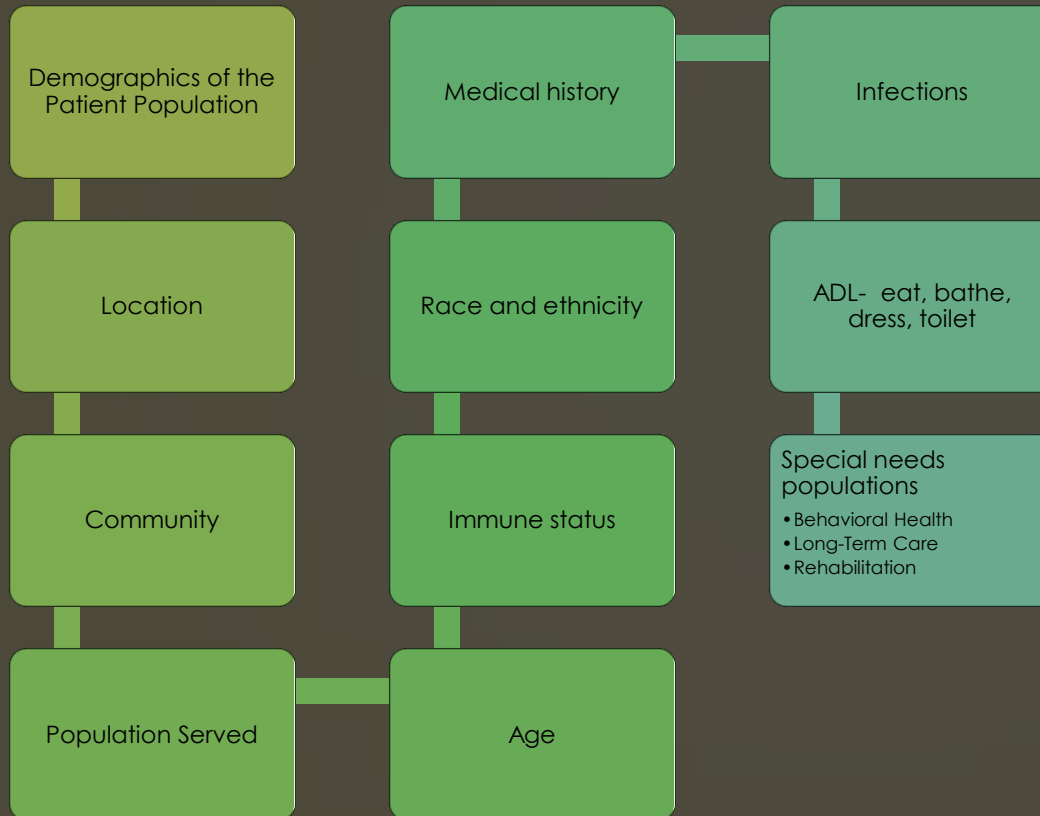


## Step 3: External Risks Regulatory and Accreditation Requirements

Federal	State	Others
Occupational Safety and Health Administration CDC FDA	Department of Health State Education Department Department of Sanitation	TJC APIC, SHEA AHA AORN CLIS



# Step 3: Internal Risks The Patient



## Step 3: Internal Risks Employee-Related

- ▶ General health
- ▶ TST conversions
- ▶ Flu vaccination/declination
- ▶ Immunocompromised
- ▶ Pregnancy
- ▶ Presenteeism
- ▶ Personal health habits
- ▶ Cultural beliefs
- ▶ Understanding of disease transmission and prevention





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## Step 3: Internal Risks Equipment/Device- Related

Central lines

Urinary catheters

Radiology  
services

Need for High-  
level disinfection

Laryngoscopes

Vaginal and  
rectal probes

Need for  
sterilization

Podiatry

Dental



## Step 3: Internal Risks Environmental-Related

- ▶ Construction
- ▶ Limited sink/dispensers
- ▶ Limited single rooms
- ▶ Limited housekeeping
- ▶ Confined spaces
- ▶ Joint events:
  - The dining experience
  - The great room
  - Music therapy



# Step 4: Develop Method

## Qualitative Risk Assessment

- Non-numeric scoring system based upon the probability of an event occurring
- Assess risk using **written descriptions**
- Examples: Gap analysis and Strengths, Weakness, Opportunities, Threats (SWOT)

## Quantitative Risk Assessment

- Numeric scoring system based upon probability of event occurring



# Example : Resident with a Multidrug-Resistant Organisms (MDRO)

## ➤ Likelihood

- Likely 66-100%
- Possible 33-66%
- Unlikely 0-33%

## ➤ Consequences

- Minor → can be managed without medical treatment
- Moderate → requires medical treatment
- Major → transfer to hospital or death

# Qualitative Risk Assessment

## Simple Risk Matrix

		Consequences		
		Minor	Moderate	Major
Likelihood	Likely	Yellow	Red	Red
	Possible	Green	Yellow	Red
	Unlikely	Green	Green	Yellow

## Risk Treatment Key

Intolerable Risk Level Immediate action is required
Tolerable Risk Level Risks must be reduced so far as is practicable.
Broadly Accepted Risk Level Monitor andn futher reduce where practicable

# Example 1: Resident with a Multidrug-Resistant Organisms (MDRO)

- Likelihood
  - Likely 66-100%
  - Possible 33-66%
  - Unlikely 0-33%
- Consequences
  - Minor → can be managed without medical treatment
  - Moderate → requires medical treatment
  - Major → transfer to hospital or death

# Qualitative Risk Assessment

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## Simple Risk Matrix

		Consequences		
		Minor	Moderate	Major
Likelihood	Likely			
	Possible		X	
	Unlikely			

## Risk Treatment Key

Intolerable Risk Level Immediate action is required
Tolerable Risk Level Risks must be reduced so far as is practicable.
Broadly Accepted Risk Level Monitor andn futher reduce where practicable

# Quantitative Risk Assessment

Risk	Specific Issues	Probability	Severity	Risk Reduction Initiatives	Preparedness	Risk Score Range
		High = 3	Life threatening; major impact on organization = 3		Poor = 3	Possible 1 - 27
		Moderate = 2	Moderate harm to patient or organization = 2		Fair = 2	
		Low = 1	Minimal impact = 1		Good = 1	Actual 1 - 18
		None = 0	None = 0			

Assign **values** to each risk

- Probability- known risks, historical data, literature
- Impact/severity
- Preparedness- current systems in place

# Quantitative Risk Assessment

## How to Assign Values

- There are no right or wrong answers
- Allow discussion
- Promote consensus
- Each organization's priorities will be different
- Once decided, be consistent



The Infection Prevention Team will revise the risk assessment and the Infection Prevention Committee will review and approve it annually.

### Scoring Process

$$\text{Probability} \times \text{Severity} \times \text{Preparedness} = \text{Risk Score}$$

The probability of occurrence, multiplied by the severity of the risk, multiplied by the organization's preparedness to deal with the risk = the organization's risk level for each item.

RISK	Specific Issues	Probability High = 3 Moderate = 2 Low = 1 None = 0	Severity Life threatening: major impact on organization = 3 Moderate harm to patient or organization = 2 Minimal impact = 1 None = 0	Risk Reduction Initiatives	Preparedness Poor = 3 Fair = 2 Good = 1	RISK SCORE Range: Poss 1- 27 Actual 1-18
Clostridium difficile (C. diff)		3	3	<ul style="list-style-type: none"> <li>➤ Pt equipment labeling protocol (Patient Ready)</li> <li>➤ Equipment Cleaning Grid</li> <li>➤ Participation in community CDI collaborative</li> <li>➤ Dedicated equipment</li> <li>➤ PPE compliance monitoring</li> <li>➤ Hand hygiene compliance audits on selected units &amp; data feedback to units and leadership</li> <li>➤ ATP testing after cleaning, EVS checklist</li> <li>➤ Ultraviolet light machines for surface disinfection</li> <li>➤ C.diff Prevention Plan &amp; Toolkit</li> <li>➤ Antibiotic stewardship</li> <li>➤ Bleach cleaning</li> <li>➤ Early warning communication to prevent clusters</li> <li>➤ Enhanced protocol for cluster settings.</li> <li>➤ Limit use of quinolones to treat C.A. pneumonia</li> </ul>	2	18



## Tips and Reminders

- Include both actual and potential risks
- Clearly identify priority ranking. If numerical: identify how points are allocated
- If qualitative: articulate high, medium, low, etc., (How is this determined?)
- Include data from rounds and observations
- Identify potential risks from the current world threats



The assessment should address 3 questions:

1. What is the probability that a risk event will occur?
2. If it occurs, how severe will it be?
3. What have we done to decrease the risk?



Tips and  
Reminders

# Consequences of Not Performing Risk Assessment

Center for Medicare and Medicaid Services violations

Joint Commission accreditation problems

Adverse events for our residents:

More illnesses

Longer hospital stays

Increased antibiotic use

Increased acuity needs

Death





# Isolation Precautions

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# Preparations for Precautions

- Inform resident, family and visitors about PPE and hand hygiene
- Display appropriate signage
- Review the policy and procedure
- Observe and audit for compliance (donning and doffing of PPE, hand hygiene)
- Supplies available and replenished regularly
- Increased environmental services
  - Garbage pick-up
  - High touch area cleaning



# Patient Placement Before Admission

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- Be represented on the Admissions Committee
- Perform an individual risk assessment

Determine isolation needs as to:

1. Medical needs
2. History MDROs
3. Secretions, wounds, devices, immune status, immunization history, personal hygiene
4. Psychological risks of depression, anxiety, fear





## Transmission-based Precautions: Patient Placement

- If *possible*, place resident in a private room.
- If not possible, resident should be cohorted with another resident with the same organism.
- If neither option is possible, the resident should be placed in a room with another resident who is considered at *low risk* for acquisition of a MDRO.

Examples include: no wounds, no invasive devices, not immunocompromised

# Discontinuation of Precautions

## Phase 1

### 483.80 Infection control

When and how isolation should be used for a resident, *including but not limited to:*

- The type and duration of the isolation depending upon the infectious agent or organism involved
- A requirement that the isolation should be the least restrictive possible for the resident under the circumstances

# CDC Guidelines for Isolation Precautions

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Use precautions on a case by case basis in LTCFs

5 C's to assess residents need for addition to Standard Precautions

1. Colonized
2. Cognizant
3. Compliant
4. Catheterized (device)
5. Continent/Wound





**Discontinuation of  
Precautions**

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Transmission-based precautions  
maintained for the duration of illness

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It is not necessary to do a test of cure or  
clearance cultures after treatment  
complete and resident has no S&S

---

S&S resolved, discontinue isolation

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Following resolution of active infection,  
the resident may remain colonized.  
Need to monitor, as colonization  
increases the risk of future infection

# References

- ▶ CDC guidelines for isolation precautions in hospitals 1996, Hospital Infection Control Practices Advisory Committee (HICPAC):  
<http://wonder.cdc.gov/wonder/prevguid/p0000419/p0000419.asp>
- ▶ Principles of Epidemiology in public health practice, 3<sup>rd</sup> edition
- ▶ Sehulster, L.M., Chinn, R.Y.W., Arduino, M.J., Carpenter, J., Donlan, R., Ashford, D., Besser, R., Fields, B., McNeil, M.M., Whitney, C., Wong, S., Juranek, D., and Cleveland, J. (2003).
- ▶ Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Pp.139.  
[http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Enviro\\_guide\\_03.pdf](http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Enviro_guide_03.pdf)
- ▶ Sehulster, L.M., Chinn, R.Y.W., Arduino, M.J., Carpenter, J., Donlan, R., Ashford, D., Besser, R., Fields, B., McNeil, M.M., Whitney, C., Wong, S., Juranek, D., and Cleveland, J. (2003). Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Pp. 139.
- ▶ 102Sehulster, L.M., Chinn, R.Y.W., Arduino, M.J., Carpenter, J., Donlan, R., Ashford, D., Besser, R., Fields, B., McNeil, M.M., Whitney, C., Wong, S., Juranek, D., and Cleveland, J. (2003). Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Pp. 140.

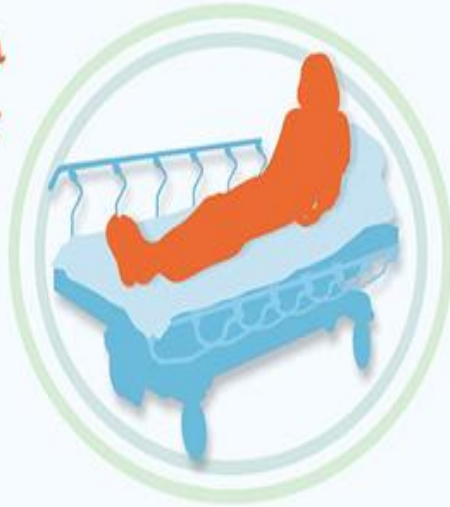
# References

- ▶ Bradley S, Segal P, Finley E. Impact of implementation of evidence-based best practices on nursing home infections. *Pa Patient Saf Advis* [online] 2012 Sep [cited 2013 Apr 24].  
[http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2012/Sep;9\(3\)/Pages/89.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2012/Sep;9(3)/Pages/89.aspx).
- ▶ Castle NG, Wagner LM, Ferguson-Rome JC, et al. Nursing home deficiency citations for infection control. *Am J Infect Control* 2011 May;39(4):263-9.
- ▶ Centers for Disease Control and Prevention (CDC): Guideline for preventing health-care--associated pneumonia, 2003 [online]. [cited 2013 Apr 24].  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm>.
- ▶ Centers for Medicare and Medicaid Services (CMS). Revisions to appendix PP—“Interpretive Guidelines for Long-Term Care Facilities,” Tag F441” [transmittal 55 online]. 2009 Dec 2 [cited 2013 Apr 24].  
<http://www.cms.hhs.gov/transmittals/downloads/R55SOMA.pdf>.
- ▶ Denham CR. Patient safety practices: leaders can turn barriers into accelerators. *J Patient Saf* 2005;1:41-55.
- ▶ 2007 Guideline for isolation precautions: preventing transmission of infectious agents in healthcare settings:  
<http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>
- ▶ CDC guidelines for isolation precautions in hospitals 1996, Hospital Infection Control Practices Advisory Committee (HICPAC):  
<http://wonder.cdc.gov/wonder/prevguid/p0000419/p0000419.asp>

# Questions?

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You are an  
important  
part of  
patient  
safety!



1. Wash or clean your hands before and after you provide care to a patient.
2. Use gloves the right way.
3. Get your shots– including your annual flu shot– and make sure everyone in your family does too.
4. Follow the rules of isolation for the patient's protection, your protection, and everyone else's protection.
5. Follow safe injection practices – remember One needle, One syringe, Only one time.
6. Make patient identification a priority: right drug, right time, right dose.
7. Keep the patient's room and equipment clean.
8. Know when antibiotics are appropriate . . . and when they are NOT.
9. What you wear matters! Make sure your attire does not become a source of infection.
10. Know about the infection preventionist.