



WELCOME!

PLEASE MUTE YOUR PHONES!

EQUIP FOR LTC WEBINAR WILL BEGIN AT 10:00 AM PST

**TODAY'S TOPIC IS
"IMPLEMENTING AN INFECTION CONTROL
PROGRAM IN LONG-TERM CARE"
9/27/17**

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER COMMUNITY



HOUSEKEEPING

Please...

Mute your phone if you are not speaking

Do not put the phone line on hold

Use the chat box to ask questions during the presentation



IMPLEMENTING AN INFECTION CONTROL PROGRAM IN LONG-TERM CARE

PATTY MONTGOMERY RN, MPH, CIC



OBJECTIVES

Review importance of having an infection prevention program

Describe essential components of an infection prevention program

Review infection prevention fundamentals

INFECTION CONTROL ASSESSMENT AND RESPONSE PROGRAM (ICAR)

Washington State Department of Health

ICAR uses a consultative and collaborative approach to evaluate the strength of infection prevention in a variety of healthcare settings so that public health can create tools to improve existing capacity.



Public Health + Healthcare = ICAR

Grant funding from the Centers for Disease Control and Prevention (CDC) supports three ICAR infection prevention consultants, one at the Washington State Department of Health and two at the Local Health Jurisdiction level (Clark and Spokane).



Site Specific Assessments

The CDC has provided setting specific assessment tools for acute care hospitals, long-term care facilities, outpatient settings, and dialysis centers. Visits are consultative and provided at no cost.



Going Back to Basics

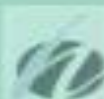
The assessment tool will be sent to the participating facilities ahead of time. Topics covered during the visit will range from hand hygiene to antimicrobial stewardship. Visits will take approximately 1/2 day and may involve observations of staff performing hand hygiene or isolation procedures.



Relationship Building

Public Health will make these visits simple and valuable. Assessing overall infection prevention across the state will no doubt result in a stronger healthcare system.

For questions or to schedule your ICAR assessment, contact the Washington State Department of Health's Healthcare Associated Infections Program at 206-418-5500



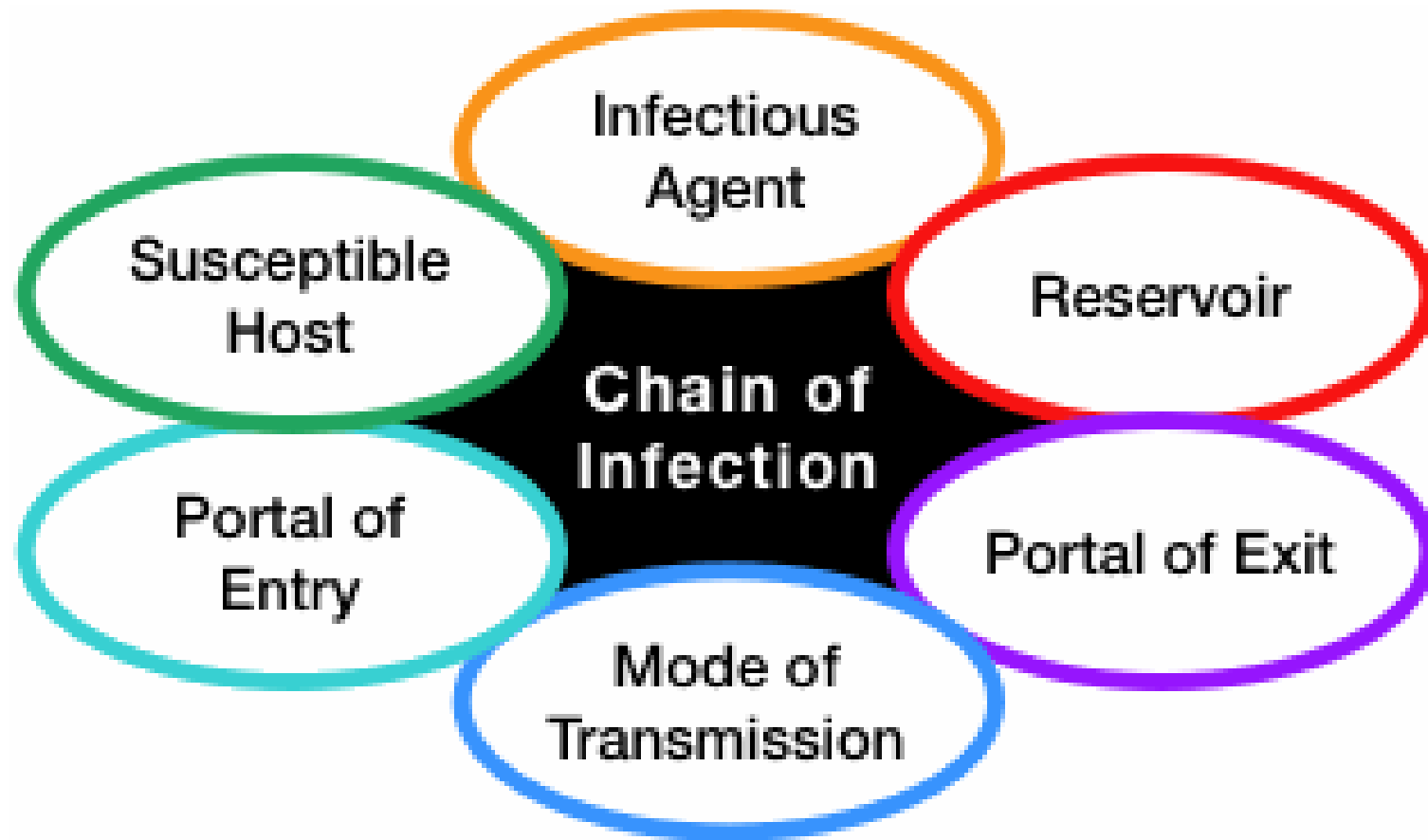
IMPACT OF INFECTIONS IN NURSING HOMES

- 1,600,000 to 3,800,000 infections each year
- ~400,000 deaths
- \$673mil to \$2billion

American Journal of Infection Control
May 2011, Vol. 39, p.263



The Chain of Infection



COMPONENTS OF INFECTION PREVENTION PROGRAM

Surveillance and Reporting

Policy and Procedure Review

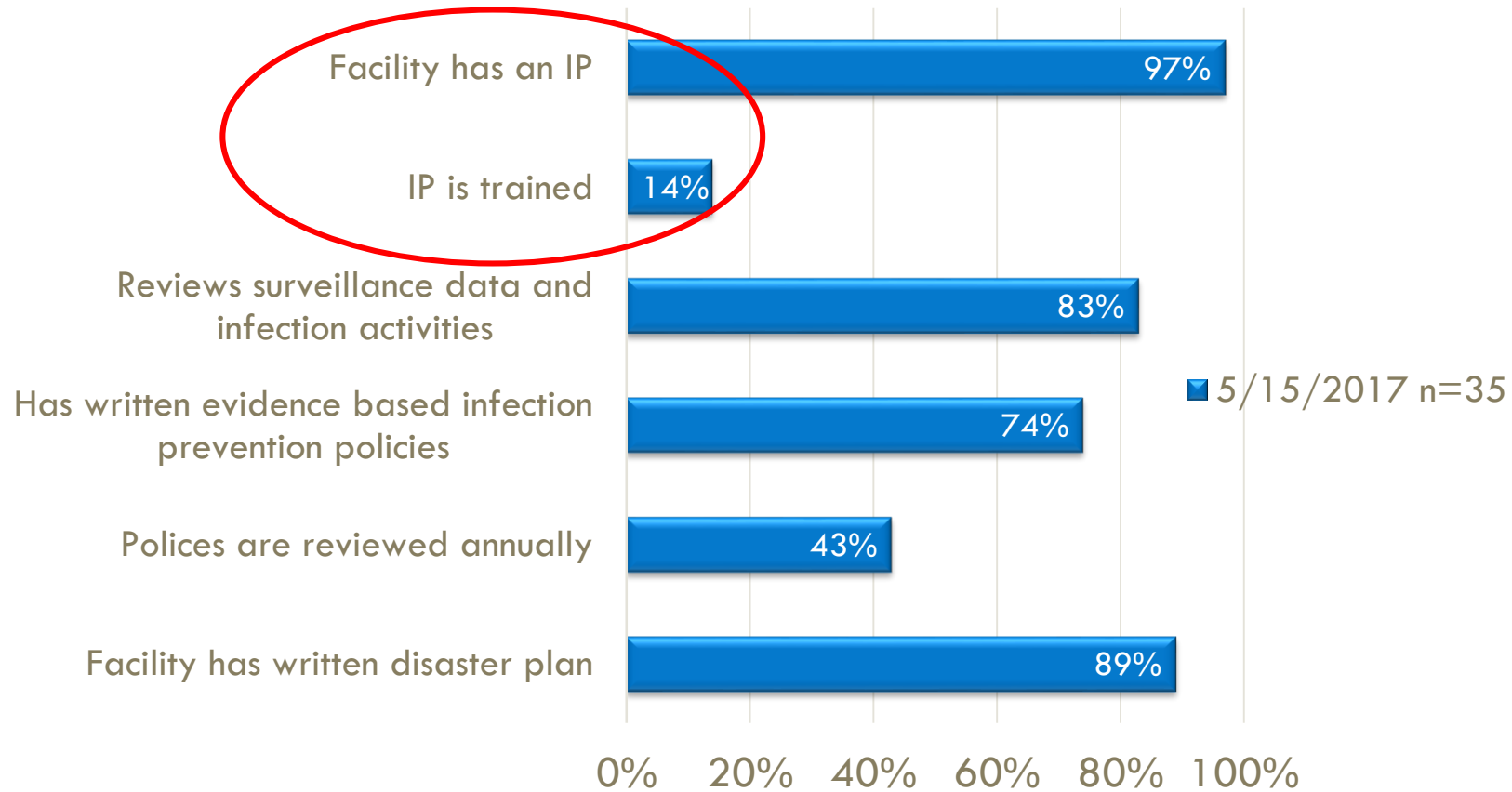
Training and Education

Rounding, Audits and Feedback

Coordination and Communication

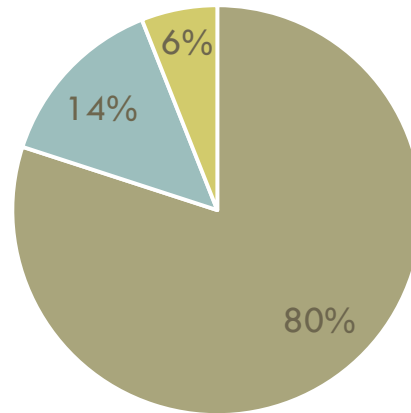
Leadership and accountability

INFECTION CONTROL PROGRAM AND INFRASTRUCTURE LTCF (N=35)



Program Infrastructure

ICAR Assessments by LTC Facility Type (n=35)
Updated 5/30/2017



■ Nursing Home ■ Assisted Living ■ Intermediate Care

	Median	Range
# Beds	100	45-190

	Mean	Median	Range
Hours per week	11	8	2-30

WHO?

Initiative

Flexible

Self-motivated

Approachable

Communication skills



INFECTION PREVENTIONIST

Develop a Job Description

Allocate resources

Provide training

Support development and growth

TRAINING AND EDUCATION

- On-line webinars
- Local Chapter Meetings
- Network
- Equip for Long-Term Care

INFECTION CONTROL ASSESSMENT AND RESPONSE PROGRAM (ICAR)
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OUTREACH

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Education • Quality • Infection Prevention
EQIP for LTC
Training and Professional Development Program



Infection Preventionist's Guide
to Long-Term Care



Association for Professionals in Infection Control (APIC) Training

EPI® in Long-Term Care



Important new opportunity for individuals interested in the LTC Certificate series

EPI® 101 for LTC is offered October 2-3, 2017 at the [Infection Prevention Academy](http://www.apic.org/academy) in San Antonio, TX. Visit www.apic.org/academy for more details and to register.

Newly published federal regulations will have a significant impact on how long-term care facilities address infection prevention and control. To help prepare these facilities for the change, APIC has launched the "Certificate of Training in Infection Prevention in the Long-Term Care Setting" program as an opportunity for state departments of health to sponsor classes. The objectives of the course are to provide those working in long-term care with a baseline of infection prevention and control (IPC) knowledge, as well as information on handling the infection prevention challenges that are unique to the long-term care (LTC) practice setting.

"With the first revision to the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation for Long-Term Care since 1991, which includes expansion of infection prevention and control conditions, we know that many people will be looking for updated training that helps prepare them for those changes," said Lisa Tomlinson, vice president of Government Affairs at APIC.

The APIC certificate program gathers baseline IPC content in one series and includes the following required components:

<https://apic.org/Education-and-Events/LTC-certificate>



Infectious Disease Society of America (ISDA)

Primer on Healthcare Epidemiology, Infection Control & Antimicrobial Stewardship: Online ID Fellows Course

Introduction:

This online educational course offers any Infectious Diseases practitioner an opportunity to learn the basics of healthcare epidemiology, infection control and antimicrobial stewardship. Written by adult and pediatric experts in the field, case-based information is presented in a dynamic and interactive learning environment intended to highlight the role of the healthcare epidemiologist. Topics covered include pathogen transmission, outbreak management in the healthcare setting, approach to control of bioterrorism agents, advanced occupational health management, implementing antimicrobial stewardship and the prevention and management of multidrug resistant organisms including *Clostridium difficile*, surgical site infections and device-associated infections. This is a product of the membership of the Society of Healthcare Epidemiology of America and is endorsed by Infectious Disease Society of America (IDSA) and Pediatric Infectious Disease Society (PIDS).

Overall Learning Objectives:

At the end of this course, the learner will be able to:

- Describe the role of the healthcare epidemiologist.
- Analyze when to involve the healthcare epidemiologist and infection control experts - specifically during outbreaks, bioterrorism threats and advanced topics in occupational health management.
- Discuss how to implement principles of antimicrobial stewardship.
- Define the epidemiology, surveillance and prevention of healthcare-associated infections including multidrug resistant organisms including *Clostridium difficile*, surgical site infections and device-associated infections.

http://www.idsociety.org/Infect_Control_Course/

IT TAKES A TEAM!



INFECTION CONTROL COMMITTEE

Include staff

Providers

Staff development

Employee Health

Environmental Services

Residents and Family

Consultants Lab/Pharmacy/Wound Care

RISK ASSESSMENT

Cornerstone of any infection prevention program

Facility Specific

Performed annually and reviewed when there are significant changes or challenges

RISK ASSESSMENT

Profile of patients at your facility

Community Infection Risks (Influenza)

Invasive lines and devices used

Device associated infection rates and trends

Adherence to hand hygiene

Scope and participation staff and residents with immunization program

Isolation systems

Antibiotic stewardship

Environmental Cleaning and disinfection

Facility readiness to respond to urgent or emergent threats

The Healthcare System

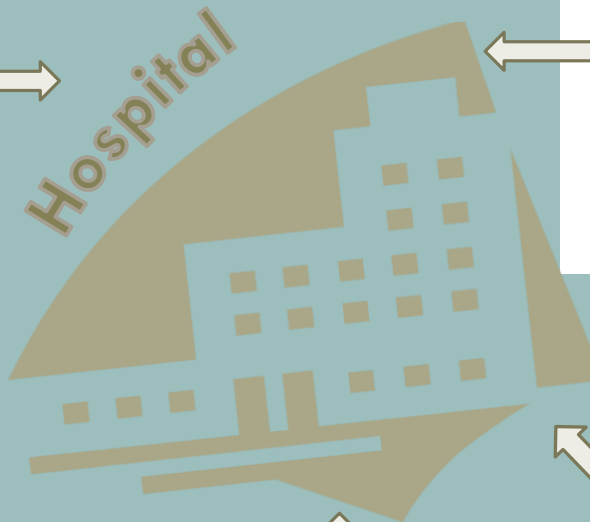


**Assisted
Living**

Home Health



Outpatient Care



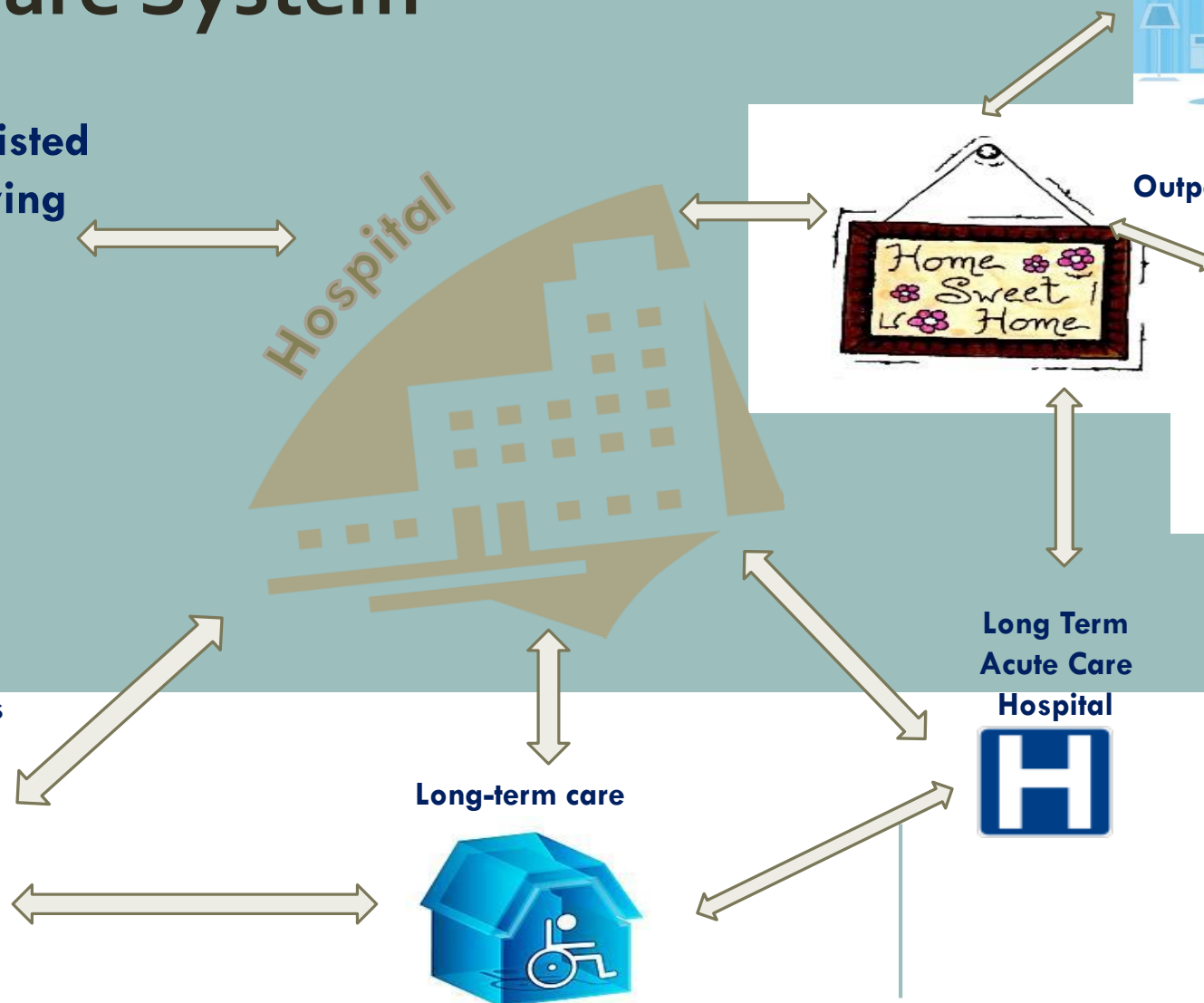
**Long Term
Acute Care
Hospital**



Long-term care



**Critical Access
Hospital**



RISK ASSESSMENT

Date Completed: (date)

Shared with Administrator: (date)

Reviewed by: (insert names)

Potential Risks/Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Facility Preparedness					Score
	Very Likely	Likely	Maybe	Rare	Never	Catastrophic Loss (life/limb/function/financial)	Serious Loss (Function/Financial/Legal)	Risk of Re-Admission or Transfer to High	Moderate Clinical/Financial	Minimal Clinical/Financial	None	Poor	Fair	Good	Very Good	
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
ABX Resistant Organisms																
MRSA																
C Diff																
VRE																
ESBL/other Gram Negative bacteria																
Prevention Activities																
Lack of Hand Hygiene																
Lack of Respiratory Hygiene/ Cough Etiquette																
Improper Glove Use																
Lack of ABX Stewardship Program																
Lack of Resident Influenza Vaccination																
Lack of Resident																

SURVEILLANCE

Identify infections coming into your facility

- Is the resident on antibiotics
- Does the resident have invasive devices
- Is the resident on precautions?
- Does the resident have open wounds?
- Does the resident have symptoms of an acute illness?

INTER-FACILITY TRANSFER FORM

Inter-Facility Infection Prevention and Safety Form

Complete this form and send it with your facility transfer form to the receiving institution.

Attach copies of latest culture reports with susceptibilities, if available.

Sending Facility

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number

Name of Sending Facility	Sending Unit	Sending Facility Phone Number

Is the patient/resident currently in transmission-based precautions? ☐ YES ☐ NO

If yes, check all that apply:

☐ Contact

☐ Contact Enteric

☐ Droplet

☐ Airborne Contact

☐ Airborne Respirator

☐ Special Precautions (Novel):

Does the patient/resident have MDROs or other organisms of infection control significance?

Significant Organisms	Colonization or History <i>Check if YES</i>	Active Infection, on Treatment <i>Check if YES</i>
Acinetobacter, multidrug-resistant	<input type="checkbox"/>	<input type="checkbox"/>
Carbapenem resistant Enterobacteriaceae (CRE)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Has the WA State Lab confirmed that CRE is Carbapenemase-producing?</i>	<input type="checkbox"/>	<input type="checkbox"/>
Clostridium difficile	<input type="checkbox"/>	<input type="checkbox"/>

SURVEILLANCE AND REPORTING

Track infections in your facility

- Is the resident on antibiotics?
- Does the resident have invasive devices?
- Is the resident on precautions?
- Does the resident have open wounds?
- Can the resident come off precautions?
- Is the infection contagious?
- Does anyone else show symptoms?
- Is this reportable?

HEALTHCARE ACQUIRED INFECTIONS MONTHLY REPORT									
FOR THE MONTH OF:			SEPTEMBER		2017		TOTAL PATIENT DAYS		
INFECTION SITE			100	200	300	400	Total Facility	Infections Rate Per 1000	Last Months Rate
I.	RESPIRATORY								
	Common Cold								
	Influenza-like Illness								
	Pneumoia								
	Lower Respiratory (Bronchitis)								
II.	URINARY TRAC INFECTION (Symptomatic)								
	Without catheter								
	With cather								
III.	GASTROINTESTINAL								
IV.	SKIN								
	Cellulitius/tissue/wound								
	fungal								
	Herpes Simplex								
	Herpes Zoster (shingles)								
	Scabies								
V.	EYE EAR, NOSE OR MOUTH								
	Conjunctivitis								
	Ear								
	Mouth or peri-oral								
VI.	SYSTEMIC								
	Primary Bloodstream								
	Unexplained Febrile Episode								
VII.	OTHER								
TOTAL INFECTIONS									
INFECTION RATE per 1000 per Unit									

DEVELOPMENT AND REVIEW OF POLICIES AND PROCEDURES

Policies and procedures are written

Evidence based

Available to staff

Reviewed annually

Addresses the needs identified in the risk assessment

TRAINING AND EDUCATION

Hand Hygiene

Standard and Transmission based precautions

PPE

Safe Needle Practices

Antimicrobial Stewardship

Environmental Monitoring

BBP

On hire and annually

WHAT IS COMPETENCY-BASED TRAINING?

The verification of competency through the use of **knowledge-based testing** and **direct observation**

If direct observation is not included, an alternative method to ensure that healthcare personnel possess essential knowledge, skills, and abilities should be used

% Compliance (n=35)

Domain

	Competency based training at hire	Training annually	Audits Practices	Provides Feedback	Supplies Available
Hand Hygiene	71	49	31	66	89
PPE	53	38	20	43	85
Injection Safety	47	38	12	44	88
Environment of Care	65	65	20	50	90

ROUNDING, AUDITING, FEEDBACK

- Unnoticed, visual inspection
- Useful to detect process failures
- Essential to coach rather than criticize
- Include staff in process
- Build engagement
- Report results

Hand Hygiene





"HOLD IT! DON'T COME ANY CLOSER!
WHAT YOU HAVE IS HIGHLY CONTAGIOUS!"

Your 5 moments for HAND HYGIENE



Based on WHO poster 'Your 5 Moments for Hand Hygiene' and reproduced with their kind permission

HAND HYGIENE AUDIT

V.b. Hand hygiene		
Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Supplies necessary for adherence to hand hygiene (e.g., soap, water, paper towels, alcohol-based hand rub) are readily accessible to HCP in patient care areas.	<input type="radio"/> Yes <input checked="" type="radio"/> No	Click here to enter text.
Hand hygiene is performed correctly:		
B. Before contact with the patient	<input type="radio"/> Yes <input type="radio"/> No	Click here to enter text.
C. Before performing an aseptic task (e.g., insertion of IV or preparing an injection, administering eye drops)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable	Click here to enter text.
D. After contact with the patient	<input type="radio"/> Yes <input type="radio"/> No	Click here to enter text.
E. After contact with objects in the immediate vicinity of the patient	<input type="radio"/> Yes <input type="radio"/> No	Click here to enter text.
F. After contact with blood, body fluids or contaminated surfaces	<input type="radio"/> Yes <input type="radio"/> No	Click here to enter text.
G. After removing gloves	<input type="radio"/> Yes <input type="radio"/> No	Click here to enter text.
H. When moving from a contaminated-body site to a clean-body site during patient care	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable	Click here to enter text.

Standard precautions

All Patients

All the time

All healthcare facilities



Major Article

Exploring inappropriate certified nursing assistant glove use in long-term care



Deborah Patterson Burdsall PhD, RN-BC, CIC ^{a,*}, Sue E. Gardner PhD, RN ^a,
Thomas Cox PhD, RN, MSW ^{b,c}, Marin Schweizer PhD ^{b,c}, Kenneth R. Culp PhD, RN ^a,
Victoria M. Steelman PhD, RN, CNOR ^a, Loreen A. Herwaldt MD ^d

^a The University of Iowa College of Nursing, Iowa City, IA

^b Iowa City VA Health Care System, Iowa City, IA

^c Department of Internal Medicine, University of Iowa Carver College of Medicine, Iowa City, IA

^d Department of Epidemiology, University of Iowa College of Public Health, Iowa City, IA

Key Words:

Glove use

Infection prevention and control

Health care-associated infection

Cross-contamination

Background: Certified Nursing Assistants (CNAs) frequently wear gloves when they care for patients in standard precautions. If CNAs use gloves inappropriately, they may spread pathogens to patients and the environment, potentially leading to health care-associated infections (HAIs).

Methods: Using a descriptive structured observational design, we examined the degree of inappropriate health care personnel glove use in a random sample of 74 CNAs performing toileting and perineal care at 1 long-term care facility.

Results: During the 74 patient care events, CNAs wore gloves for 80.2% (1,774/2,213) of the touch points, failing to change gloves at 66.4% (225/339) of glove change points. CNAs changed gloves a median of 2.0 times per patient care event. A median of 1.0 change occurred at a change point. CNAs failed to change their gloves at a glove change point a median of 2.5 times per patient care event. Most (61/74; 82.4%) patient care events had >1 contaminated touch point. Over 44% (782/1,774) of the gloved touch points were defined as contaminated for a median of 8.0 contaminated glove touch points per patient care event. All contaminated touches were with gloved hands ($P < .001$).

Conclusions: Inappropriate glove use was frequently observed in this study. Contaminated gloves may be a significant cause of cross-contamination of pathogens in health care environments. Future research

Do

- ✓ **DO** wear gloves to reduce the risk of contamination or exposure to blood, other body fluids, hazardous materials, and transmission of infection.
- ✓ **DO** clean hands before putting on gloves for a sterile procedure (e.g., insertion of catheter or other invasive device).
- ✓ **DO** clean hands after removing gloves.
- ✓ **DO** clean hands and change gloves between each task (e.g., after contact with a contaminated surface or environment).
- ✓ **DO** make sure that gloves fit you properly before performing any tasks.
- ✓ **DO** ensure the correct type of glove is available if you have skin sensitivity or allergy issues.
- ✓ **DO** wear gloves in hemodialysis settings for any contact with the patient or the patient's equipment.
- ✓ **DO** follow your facility's policy on glove use and remember to consult CDC* and WHO* hand hygiene guidance.

Don't

- ✗ **DON'T** re-use or wash gloves (except for utility gloves after being properly cleaned).
- ✗ **DON'T** substitute glove use for hand hygiene.
- ✗ **DON'T** use non-approved hand lotions.
- ✗ **DON'T** use gloves if they are damaged or visibly soiled.
- ✗ **DON'T** touch your face when wearing gloves.
- ✗ **DON'T** wear the same pair of gloves from one patient to another.
- ✗ **DON'T** wear gloves in the hall; consult your facility's policy for exceptions.
- ✗ **DON'T** forget to remove and dispose of gloves properly.



APIC

Association for Professionals in

PPE

Only YOU
can stop the
spread of
infection!



FRONT

DROPLET PRECAUTIONS

EVERYONE MUST



- Clean hands when entering and leaving room
- Follow Standard Precautions



- Wear mask
- Wear eye protection if splash/spray to eyes likely

DOCTORS AND STAFF MUST



If contact with body fluids likely, use gown, glove, mask and eye protection



BACK

Droplet Precautions

Display sign outside the door. Remove sign after room is cleaned.

Family and other visitors to follow precautions.

Common Conditions:

- Seasonal Influenza
- Bacterial Meningitis (N. meningitidis)
- Pertussis (whooping cough)
- Mumps

Dishes/Utensils:

No special precautions. Kitchenware sanitized in dishwasher.

Equipment and Supplies:

- Use dedicated or disposable equipment when available.
- Clean and disinfect reusable equipment including intravenous pumps, cell phone or pagers (if used in room), other electronics, supplies and other equipment prior to removing from patient's room.
- Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients.
- Only essential supplies in room.

Linen Management:

Bag linen in the patient's room.

Personal Protective Equipment:

Put **ON** in this order:

1. Wash or sanitize hands
2. Gown (if needed)
3. Mask
4. Eye cover
5. Gloves (if needed)

Take **OFF** & dispose in this order:

1. Gloves (if used)
2. Eye cover
3. Gown (if used)
4. Mask
5. Wash or sanitize hands (even if gloves used)

Private Room:

If not available, room with patient that has the same organism but no other infection.

Room Cleaning:

Routine cleaning procedures with the addition of cobble curtain changes if visibly soiled.

Transport:

Essential transport only and place surgical mask on patient. Clean and disinfect transport vehicle. Alert receiving department regarding patient's isolation precaution status.

Discontinue precautions as per hospital policy or Infection Preventionist instructions.

FRONT

CONTACT PRECAUTIONS

(If you have questions, go to Nurse Station)

EVERYONE MUST:



- Clean hands when entering and leaving room
- Follow Standard Precautions



Gown and gloves
when entering room



DOCTORS AND STAFF MUST:



- Use patient dedicated or disposable equipment.
- Clean and disinfect shared equipment.

BACK

Contact Precautions

Display sign outside the door. Remove sign after room is cleaned.

Family and other visitors to follow precautions.

Common Conditions:

- Multidrug-resistant organisms
- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Vancomycin-resistant *Enterococcus* (VRE)
- *Clostridium difficile* infection (diarrhea)
- Scabies
- Wounds or abscesses with uncontained drainage

Dishes/Utensils:

No special precautions. Kitchenware sanitized in dishwasher.

Equipment and Supplies:

- Use dedicated or disposable equipment when available.
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Private Room:

If not available, room with patient that has the same organism but no other infection.

Room Cleaning:

Routine cleaning procedures with the addition of cubicle curtain changes if visibly soiled.

Transport:

Essential transport only. Place patient in clean gown. Clean and disinfect transport vehicle. Alert receiving department regarding patient's isolation precaution status.

Discontinue precautions as per hospital policy or Infection Preventionist instructions.

ENVIRONMENTAL CLEANING



CLEANING

Cleaning products have to match with manufacturer guidelines. Might have to contact manufacturer, often instructions are available online.

Link below is to a table you can use to decide which products work best in your facility.

http://www.education.nh.gov/instruction/school_health/documents/disinfectants.pdf

EPI list of products and their effectiveness against specific microbes and viruses updated January 2017.

<https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants>

Surfaces can remain contaminated for months

Type of bacterium	Duration of persistence (range)
Acinetobacter spp.	3 days to 5 months
Clostridium difficile spores	5 months
E. Coli	1.5 hours to 16 months
VRE	5 days to 4 months
Klebsiella species	2 hours to 30 months
Pseudomonas aeruginosa	6 hours to 16 months; 5 wks on dry floor
Staph aureus including MRSA	7 days to 7 months

Axel Kramer, Ingeborg Schwebke, & Gunter Kampf *How long do nosocomial pathogens persist on inanimate surfaces? A systematic review* BMC Infectious Diseases.

Shared Equipment



SAFE INJECTION PRACTICES

Recommended Practices for Preventing Bloodborne Pathogen Transmission during Blood Glucose Monitoring and Insulin Administration in Healthcare Settings

- **Fingerstick Devices**
 - Restrict use of fingerstick devices to individual persons. They should never be used for more than one person. Select single-use lancets that permanently retract upon puncture. This adds an extra layer of safety for the patient and the provider.
 - Dispose of used lancets at the point of use in an approved sharps container. Never reuse lancets.
- **Blood Glucose Meters**
 - Whenever possible, blood glucose meters should be assigned to an individual person and not be shared.
 - If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared.
- **General**
 - Unused supplies and medications should be maintained in clean areas separate from used supplies and equipment (e.g., glucose meters). Do not carry supplies and medications in pockets.

Insulin Administration

- Insulin pens should be assigned to individual persons and labeled appropriately. They should never be used for more than one person.
- Multiple-dose vials of insulin should be dedicated to a single person whenever possible.
 - If the vial must be used for more than one person it should be stored and prepared in a dedicated medication preparation area outside of the patient care environment and away from potentially contaminated equipment
 - Medication vials should always be entered with a new needle and new syringe

CDC toolkit glucose monitoring

<https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html>

POC devices

https://www.youtube.com/watch?v=dddSV0Tu_AE

INJECTION SAFETY CHECKLIST

The following Injection Safety checklist items are a subset of items that can be found in the CDC Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care.

The checklist, which is appropriate for both inpatient and outpatient settings, should be used to systematically assess adherence of healthcare personnel to safe injection practices. (Assessment of adherence should be conducted by direct observation of healthcare personnel during the performance of their duties.)

Injection Safety	Practice Performed?	If answer is No, document plan for remediation
Injections are prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids or contaminated equipment.	Yes No	
Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).	Yes No	
The rubber septum on a medication vial is disinfected with alcohol prior to piercing	Yes No	
Medication vials are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient.	Yes No	
Single dose (single-use) medication vials, ampules, and bags or bottles of intravenous solution are used for only one patient.	Yes No	
Medication administration tubing and connectors are used for only one patient.	Yes No	
Multi-dose vials are dated by HCP when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. <small>Note: This is different from the expiration date printed on the vial.</small>	Yes No	
Multi-dose vials are dedicated to individual patients whenever possible.	Yes No	
Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., operating room, patient room/cubicle). <small>Note: If multi-dose vials enter the immediate patient treatment area they should be dedicated for single-patient use and discarded immediately after use.</small>	Yes No	

RESOURCES

Checklist: <http://www.cdc.gov/HAI/pdfs/guidelines/ambulatory-care-checklist-07-2011.pdf>

Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care:
<http://www.cdc.gov/HAI/pdfs/guidelines/standards-of-ambulatory-care-7-2011.pdf>

www.oneandonlycampaign.org



http://www.cdc.gov/injectionsafety/PDF/SIPC_Checklist.pdf

7 CORE ELEMENTS OF AMS FOR NURSING HOMES

Leadership commitment

Accountability

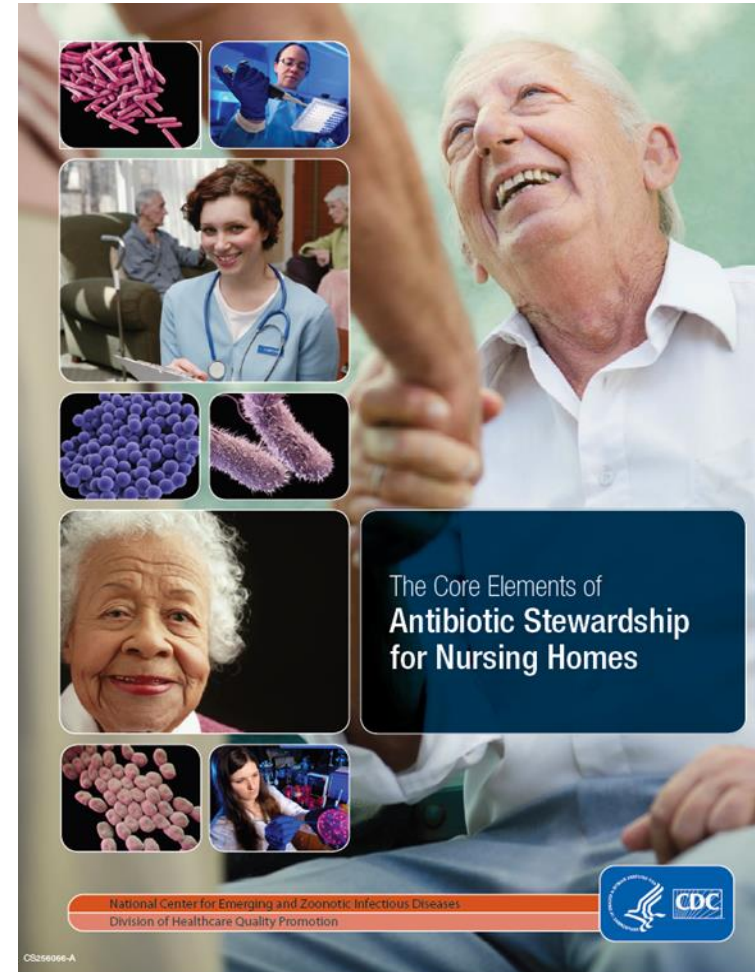
Drug expertise

Action

Tracking

Reporting

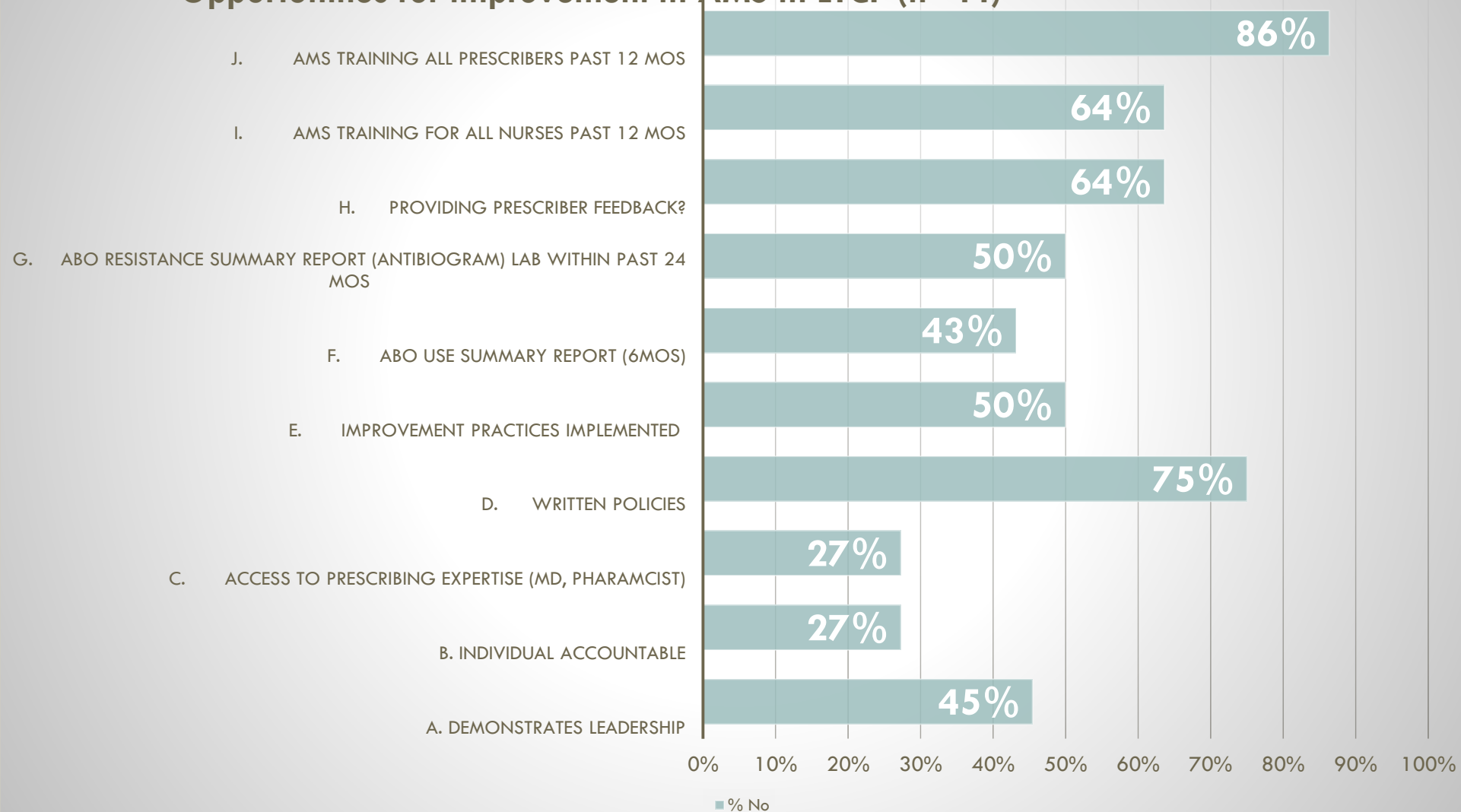
Education



ANTIBIOTIC STEWARDSHIP DOMAIN

VII. Antibiotic Stewardship		
Elements to be assessed	Assessment	Notes/Areas for Improvement
A. The facility can demonstrate leadership support for efforts to improve antibiotic use (antibiotic stewardship).	<input type="radio"/> Yes <input type="radio"/> No	
B. The facility has identified individuals accountable for leading antibiotic stewardship activities	<input type="radio"/> Yes <input type="radio"/> No	
C. The facility has access to individuals with antibiotic prescribing expertise (e.g. ID trained physician or pharmacist).	<input type="radio"/> Yes <input type="radio"/> No	
D. The facility has written policies on antibiotic prescribing.	<input type="radio"/> Yes <input type="radio"/> No	
E. The facility has implemented practices in place to improve antibiotic use.	<input type="radio"/> Yes <input type="radio"/> No	
F. The facility has a report summarizing antibiotic use from pharmacy data created within last 6 months. <i>Note: Report could include number of new starts, types of drugs prescribed, number of days of antibiotic treatment) from the pharmacy on a regular basis</i>	<input type="radio"/> Yes <input type="radio"/> No	
G. The facility has a report summarizing antibiotic resistance (i.e., antibiogram) from the laboratory created within the past 24 months.	<input type="radio"/> Yes <input type="radio"/> No	
H. The facility provides clinical prescribers with feedback about their antibiotic prescribing practices. <i>Note: If yes, facility should provide documentation of feedback reports</i>	<input type="radio"/> Yes <input type="radio"/> No	

Opportunities for improvement in AMS in LTCF (n=44)



RESOURCES

UNC Antimicrobial Stewardship Training Modules for Nurses

<https://nursinghomeinfections.unc.edu/nurses/>

Register for DOH EQuIP for Long-term Care

<https://attendee.gototraining.com/r/4057723852532727554>

EQuIP for Long-term care website

<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HealthcareAssociatedInfections/EQuIP/LTC>

COORDINATION

Facilities Management

Environmental Services

Construction projects

Nutrition Services

Pharmacy

Laboratory

External consultants



COMMUNICATION

- Report back findings to staff
- Engage staff, build a team
- Quality and Safety
- Local Health Jurisdiction
- DSHS
- Resident follow-up



TAKE HOME POINTS

Every staff member has a responsibility to prevent and control infections

Developing and implementing an effective infection prevention and AMS program is a team effort

Measurement is key to evaluating the effectiveness of your interventions to improve care

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"The patient in the next bed is highly infectious. Thank God for these curtains."

RESOURCES AND WORKS CITED

Agency for Healthcare Research and Quality (AHRQ) Nursing Home Antimicrobial Stewardship Guide

<https://www.ahrq.gov/nhguide/index.html>

Centers for Disease Control and Prevention (CDC) Core Elements of Antimicrobial Stewardship for Nursing Homes:

<https://www.cdc.gov/longtermcare/pdfs/core-elements-antibiotic-stewardship.pdf>

Federal Register Reform of Requirements for Long-Term Care Facilities (10/4/16):

<https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

RESOURCES AND WORKS CITED

Qualis Health Infection Prevention resource page:

<http://medicare.qualishealth.org/projects/nursing-home-quality-care-collaborative/selected-resources/infection-prevention>

S. Schweon, D. Burdsall, M. Hanchett, S. Hilley, D. Greene, I. Kenneley, J. Marx, P. Rosenbaum (2013).

The Infection Perfectionist's Guide to Long-Term Care. Association for Professionals in Infection Control (APIC).

Washington State Department of Health (DOH) Education, Quality and Infection Prevention (EQulP)

<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HealthcareAssociatedInfections/EQulP/LTC>

Q & A





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