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INFECTION CONTROL PLAN OUTLINE FOR LONG-TERM CARE FACILITIES

The Pennsylvania Department of Health, Healthcare-Associated Infection Prevention (HAI) Division is providing the following outline to guide the creation or modification of a long-term care facility's (LTCF's) infection control (IC) plan. This outline highlights the information that should be included in the IC plan. Content should be used as appropriate, and tailored to be specific to the facility.

1. **Introductory Statement / Purpose:**
    a. The reason for the plan, why it is necessary, and what it is intended to accomplish. Background and importance of an infection control plan, as indicated by the Pennsylvania's Medical Care Availability and Reduction of Error (MCARE) Act of March 20, 2002.
    b. In recognition that LTCFs serve as the residents' functional home, provisions for ongoing socialization (e.g., community activities like community dining) are important. Strategies to mitigate risk while still prioritizing resident quality of life.
2. **Scope:**
    a. The plan applies to the whole infection prevention & control (IP&C) program.
    b. All healthcare personnel (HCP) are responsible for adhering to the plan, policies, and processes regardless of their position.
3. **Facility Introduction / Description:**
    a. Ownership
        i. Whether facility is part of a structure, corporation, etc.
    b. Population(s) served
    c. Characteristics of HCP
    d. Services provided
    e. Geographic area
    f. Building characteristics
        i. If owned or rented
        ii. Building age
        iii. Number of beds
        iv. Room types (e.g., private, semi-private, double, triple, quad), private or shared bathrooms/showers
        v. Availability of airborne infection isolation rooms (or AIIRs)
4. **Infection Prevention & Control Program:**
    a. Leadership support for and empowerment of IP&C program, committee, and IP(s)

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b. Program structure and reporting (e.g., administrative reporting, data reporting)
c. IP Characteristics
    i. Number of IPs at the facility
        1. If the IP is part-time or the person fulfilling the role of IP also has other roles, how many hours per week are devoted to the IP&C program?
    ii. Infection preventionist (IP) title, background, credentials, training (e.g., APIC, CDC), duties
        1. Documentation of training that qualifies them to lead the IP&C program
        2. Certification in Infection Control (CIC)
d. Administrative or clerical support for the program (e.g., administrative assistant to print and distribute ICC meeting packets, posters, newsletters, etc.)
e. Support for provision of denominator data (e.g., business office generates and sends the IP resident days, the minimum data set (MDS) nurse assists with device days)
f. IP cannot also serve as director of nursing (DON) for the facility.
g. IP (or at least one of the individuals, if more than one IP at facility) must be a member of QAPI committee and report on IP&C program regularly.
h. e.g.,e.g.,Other resources allocated to the program:
    i. Software (e.g., Microsoft Office, PointClickCare, Microsoft Teams, etc.)
    ii. Journal access
    iii. Fee and time for initial IP training (e.g., APIC)
    iv. Continuing education
    v. Membership with professional organizations
    vi. Support for certification
i. IC plan is comprehensive document with high-level details about program elements.
    i. No policy and procedure manuals should be submitted.
j. Related IP&C Program Documents: The Risk Assessment, Policies, And Procedures
    i. There are a few companion documents to the IC plan. These are independent documents, which are related to and referenced in the IC plan. They submitted for plan review as individual attachments. They include the risk assessment and IP&C program policies and procedures.
    ii. All documents – *including the plan*:
        1. Must comply with MCARE Law, and federal & state regulations
        2. Must align with the core / basic elements of IP&C
        3. Must have approval, effective, revision dates
        4. Must demonstrate formal approval by facility ICC
        5. Must be signed by ICC signatory/signatories
        6. Should have clear and specific document title names

7. Must be submitted in acceptable formats (i.e., Word, PDF, Excel, etc.) – no scanned documents
8. Should be organized and structured, with headers
9. Must reference and align with specific nationally recognized guidelines and evidence-based practices (e.g., American Geriatrics Society (AGS), Association for the Health Care Environment (AHE), American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), Association for Professionals in Infection Control and Epidemiology (APIC), American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), Centers for Disease Control & Prevention (CDC), Infectious Diseases Society of America (IDSA), Society for Healthcare Epidemiology of America (SHEA), World Health Organization (WHO), etc.)
10. Must be facility-specific
11. Must be readily accessible to HCP (i.e., location where HCP can find these documents), including but not limited to:
    a. IC plan, risk assessment, and policies & procedures such as:
        i. Bloodborne pathogen (BBP) exposure control plan/policy
        ii. Tuberculosis exposure control plan/policy
        iii. Respiratory protection program plan/policy
        iv. Water management plan/policy
        v. Surveillance plan/policy
    b. Manufacturer instructions for use (IFUs)

iii. IC plan and risk assessment are updated annually or sooner, if needed.

iv. Policies and procedures are updated every two years or sooner, if needed.

v. Infection Prevention & Control Risk Assessment:

1. A risk assessment should be submitted along with the IC plan as an individual document, and there should be high-level details about the risk assessment in the plan.
    a. Should include specific, measurable, achievable, relevant, time-bound, goals that are informed by the risk assessment.
2. Different from a gap analysis, emergency preparedness all-hazard self-assessment, infection control assessment and response (ICAR) tool, ICRA for construction, rounds checklists
3. Responsible persons (e.g., IP with input from infection control committee)
4. Done annually, using:
    a. Healthcare-associated infection (HAI) data
    b. State and national HAI reports
    c. Service registries

d. Data from accreditation bodies
e. Data from similar healthcare facilities
f. Emerging diseases
g. Changes in community risks/problems, population(s), service line(s)
h. Regulatory / legal changes
i. Leadership / quality / regulatory / payor priorities and concerns

5. Process should consider potential risks to the following: :
   a. Community (e.g., geography, rural/urban, weather, natural disasters, etc.)
   b. Population served (e.g., characteristics, behaviors, health statistics, high risk, multi-drug resistant organism (MDRO) prevalence, etc.)
   c. Facility (e.g., environment, structure, surfaces, age of utilities, etc.)
   d. Staff competency (e.g., processes or competency programs for cleaning and disinfection, etc.)
   e. Services offered (e.g., dementia care, hospice care, invasive device utilization, etc.)
   f. Staff immunity (e.g., new hire health screening, communicable diseases immunization status, vaccine programs for influenza/COVID-19, etc.)
   g. Resident care/infection control practice compliance (e.g., hand hygiene, personal protective equipment (PPE), healthcare-associated infection (HAI) prevention bundles, environmental cleaning & disinfection, injection/medication preparation, etc.)
   h. Medical devices (e.g., selection, introduction and training, re-use of single use items, devices with water reservoirs, handling & storage, cleaning & disinfection requirements, etc.)
   i. Facility type (e.g., skilled nursing, independent living, assisted living, etc.)
   j. Resident safety (e.g., healthcare-associated infection trends, etc.)
6. Highest scored risks have associated SMARTIE goals in the plan (updated annually).
7. Inclusion of associated priorities in the IC plan.

vi. Policies and procedures provide a greater amount of detail than the plan. They help to provide evidence of plan implementation by outlining specific organizational rules, methods, strategies, processes, and steps to implement the plan.

5. **Authority:**
   a. Describe the organized governing body (e.g., board of directors of association, corporation, etc.) or designated person (e.g., owner, medical director, nursing home administrator (NHA)), who has authority and responsibility for the program.
   b. Consideration for facility bylaws, as this will determine how authority is delegated (e.g., from the medical executive committee, governing body, administrator, etc.)

c. Authority for oversight of the program should be given to the multidisciplinary infection control committee (ICC).
d. Authority for the development, implementation, monitoring, and enforcement of the program should be given to the infection preventionist (IP).

6. **Multidisciplinary / Infection Control Committee:**
    a. Relationship with other committees (e.g., quality assurance & performance improvement (QAPI), patient safety, etc.)
    b. Identification of chair (and co-chair, where applicable) and their qualifications
    c. Membership: Consider including the title / position of the member, and not their name. Should ideally include frontline HCP, in addition to leadership.
        i. Medical staff: Could include the chief medical officer (CMO), medical director, infectious disease physician, geriatrician, or internist.
        ii. Administration: Could include the chief executive officer (CEO), chief financial officer (CFO), chief nursing officer (CNO), director of nursing (DON), nursing home administrator, comptroller, or other members of the c-suite.
        iii. Lab services: Could include the lab director, lab personnel, lab consultant (e.g., contracted lab director, supervisor, or microbiologist).
        iv. Nursing staff: Could include the director of nursing (DON) if not filling the role of administration, charge nurse, nursing manager/supervisor, or staff nurse.
        v. Pharmacy staff: could include the pharmacy director, clinical pharmacist, or pharmacy consultant (e.g., contracted pharmacist, pharmacy tech, or director of pharmacy).
        vi. Physical plant staff: Could include the facilities director, maintenance supervisor, heating, ventilation, and air conditioning (HVAC) technician, or physical plant consultant.
        vii. Infection control: Should include the designated IP. Could include the infectious disease (ID) physician, epidemiologist, or infection control consultant.
        viii. Community member
            1. Cannot be an agent, employee, or contractor of the health care facility
    d. What constitutes a quorum?
    e. Meeting frequency (must be at least quarterly)
    f. Duties of the committee (e.g., approving the infection control plan, risk assessment, policies; reviewing HAI and process surveillance; recommending and carrying out quality improvement activities and establishing subcommittees – for example, to evaluate new medical devices/supplies, hand hygiene compliance, etc.)

7. **Evidence-Based Strategies to Detect, Control, and Prevent Healthcare-Associated Infections:**
    a. Consider breaking out into sections devoted to detection, control, and prevention (understanding that there can be some overlap)

b. Detection:
   i. Resident screening:
      1. Use of screening checklists and written scripts by trained persons with screening duties.
      2. A means to identify (e.g., assessment at time of admission) residents with:
         a. Current signs or symptoms of infection
         b. Current, history of, or recent exposure to a communicable disease, infection (e.g., COVID-19, TB, varicella)
         c. Current or history of colonization or infection with MDRO (e.g., *Candida auris* (*C. auris*), *Clostridioides difficile* (*C. diff*), carbapenem-resistant Enterobacterales (CRE), extended-spectrum beta-lactamases (ESBL), methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant Enterococci (VRE), etc.).
         d. Other infection control risks (e.g., transfer from another skilled nursing facility (SNF) or hospital; recent prolonged hospital or intensive care unit (ICU) stay; transplant, dialysis, or immunocompromised resident; travel or healthcare received outside of the US; history of incarceration; intravenous (IV) drug use, vaccination status (e.g., flu shot) etc.).
            i. If identified, what is the mechanism for communicating this to other HCP (e.g., flag in an electronic medical record or paper chart, verbal report, etc.)?
            ii. If identified, any other triggers that occur (e.g., order generated for a MRSA swab, order for Transmission-Based Precautions, etc.)
         e. Communication of lab results requiring initiation of Transmission-Based Precautions (TBPs)
   ii. Screening of healthcare personnel (HCP):
      1. Employee Health
         a. Screening of new HCP
            i. Immunity status (e.g., hepatitis B; measles, mumps, rubella (MMR); tetanus, diphtheria, and pertussis (Tdap); varicella titers, etc.)
            ii. Vaccination history (e.g., coronavirus disease 2019 (COVID-19), influenza, etc.)
            iii. Risk assessment for tuberculosis (TB)
            iv. Assessment, exposure to other communicable diseases
         b. Annual TB screening questionnaire
      2. A means to identify and notify HCP (e.g., staff, providers, contractors, students, volunteers) with current or recent exposure to a communicable

disease (e.g., when receive a significant positive micro result, such as TB or *Neisseria meningitidis*)

3. Education of HCP to report community exposure to communicable conditions as soon as known
4. Means to detect HCPs with conditions such as skin lesions on the hands, which may impact ability to perform hand hygiene, adhere to Standard Precautions, etc.
5. Established criteria for defining what constitutes a communicable disease exposure.
6. Work restrictions / exclusions for HCP who screen positive or meet criteria (e.g., as in an exposure).

iii. Surveillance:

1. Surveillance plan and methodology
    a. Responsible person(s) and training (i.e., PA-Patient Safety Reporting System (PA-PSRS), National Healthcare Safety Network (NHSN) for COVID-19 Module)
        i. Training upon hire and annually on PA-PSRS
        ii. Consistent application of surveillance versus clinical criteria.
            1. IP to determine if event meets surveillance criteria and report events meeting criteria, even if provider disagrees (e.g., since resident is not diagnosed with a clinical infection).
    b. Surveillance technologies and software – electronic surveillance system (e.g., data mining software, video surveillance), if available
        i. Manual data collection, if not
    c. HAI Surveillance
        i. Education of HCPs (e.g., nursing) on the signs and symptoms of infection in the geriatric population, and prompt provider and IP notification
        ii. Process for and means to review data and identify HAIs
            1. Review of surveillance data (e.g., labs, radiology reports).
            2. Monitor for resident changes
            3. Use of revised McGeer Criteria checklist, line listings, reports, etc.
        iii. Continuous monitoring of all HAIs for all services, procedures, infections, etc.
        iv. Data sources
            1. Laboratory tests

2. Kardex / resident profile / temperature logs
3. New-onset fever, hypothermia, confusion in residents
4. Radiology / imaging
5. Antibiotic starts
6. Readmissions
7. Resident (and/or family, guardian, durable POA as appropriate) self-report
8. Reports received from other healthcare facilities
9. Environmental rounds

d. A means to identify clusters of infection, or outbreaks
e. Surveillance related to IC breaches
f. MDRO surveillance
g. Accessibility of the surveillance plan by HCPs (i.e., location, education)

iv. Reporting:

1. Describe the process to ensure that reporting is compliant with MCARE requirements.
   a. All HAIs are deemed serious events, which must be reported within 24 hours of occurrence, discovery, or confirmation.
   b. Residents (and/or family, guardian, durable power of attorney (POA) as appropriate) must receive written notification of serious events within 7 days of occurrence, discovery, or confirmation.
   c. External reporting to the Department of Health (DOH) and PA-PSRS as appropriate
      i. All LCTFs must report all HAIs as serious events into PA-PSRS.
         1. Responsible person(s) and training (i.e., PA-PSRS)
         2. Process / IC breaches in practice resulting in possible BBP exposure must be reported into PSRS and to PA DOH by calling 877-PA-HEALTH (or local health department if applicable).
            a. Drug diversion
            b. Shared glucometers which are not handled, cleaned, or disinfected according to manufacturer IFUs and nationally recognized guidelines
      ii. Reportable diseases are reported into the PA DOH PA National Electronic Disease Surveillance System (PA-NEDSS).
         1. Responsible persons and training (i.e., PA-NEDSS)
         2. Notification of resident(s) (and/or family, guardian, durable POA as appropriate) and DOH

3. Investigation of possible HCP or resident exposures

iii. COVID-19 into NHSN

1. Responsible person(s) and training (i.e., NHSN)

d. Internal reporting

i. Process for IPs to analyze and report data to ICC, up through QAPI, medical executive committee (MEC), and governing body.

ii. Data dissemination to providers, managers, other HCP as needed (along with targets, actions for performance improvement, etc.).

c. Prevention:

i. Standard Precautions

1. Not equivalent to Universal Precautions. Combines elements of Universal Precautions and Body Substance Isolation.
2. All elements are referenced in the plan.
3. Hand hygiene
    a. Guidelines are followed (i.e., CDC or WHO).
    b. Moments of hand hygiene / hand hygiene opportunities.
    c. Availability of alcohol-based hand rub (ABHR) and hand washing sinks.
    d. Education of HCP on the elements of hand hygiene upon hire, annually, and if changes / as needed.
    e. While an element of Standard Precautions, this major component should have its own section.
    f. ABHR is the preferred form of hand hygiene for most clinical situations.
        i. Before touching a resident
        ii. Before an aseptic task or procedure (e.g., placing an indwelling device) or when handling an invasive medical device
        iii. Before moving from a soiled to a clean body site on the same resident
        iv. After touching a resident
        v. After touching a resident's immediate environment or surroundings
        vi. After contact with blood, other potentially infectious material (OPIM), or contaminated surfaces
        vii. After removing gloves
    g. Soap & water should be used:
        i. When hands are visibly soiled (e.g., visible contamination with blood or OPIM)

ii. For known or suspected *C. diff* diarrhea or norovirus if determined by a multidisciplinary committee
iii. Before eating, preparing, or handling food
iv. Before and after using the restroom

h. Nail care
   i. Artificial nails not permitted
      1. CDC Guidelines: if caring for residents at high risk
      2. WHO Guidelines: all HCP
   ii. Natural nail tip length:
      1. CDC Guidelines: < ¼"
i. Lotion compatible with hand hygiene products
j. Hand hygiene audits, with responsible persons, training, audit frequency, and immediate feedback given
k. Data reported back to ICC and disseminated to providers, managers, other HCP as needed (along with targets, actions for performance improvement, etc.)

4. PPE:
   a. Availability of PPE
   b. Education of HCP about PPE availability, risk assessment, donning and doffing, etc.
   c. PPE adherence audits, with responsible persons, training, audit frequency, and immediate feedback given
      i. Data reported back to ICC and disseminated to providers, managers, and other HCP as needed (along with targets, actions for performance improvement, etc.).
   d. Respiratory protection plan
      i. Responsible person(s) and training
      ii. Education re: respirator use upon hire, annually, and as needed / if changes
      iii. Medical clearance for respirator use
      iv. Fit testing upon hire, annually, and as needed / if changes
         1. Alternative respirators (e.g., powered air purifying respirators (PAPRs))
      v. Accessibility of the respiratory protection plan (i.e., location)

5. Respiratory hygiene / cough etiquette
   a. Education of residents, HCP, family, visitors
   b. Availability of supplies (e.g., wastebaskets, masks, facial tissues, etc.)

    c. Communication (e.g., signage at entrance, on units/wings, etc.)
6. Sharps safety and safe injection practices
    a. Needles and syringes are used for only one resident.
    b. Rubber septums on medication vials are disinfected with alcohol prior to piercing.
    c. Medications are entered with a new needle and new syringe, even while obtaining additional doses for the same resident.
    d. Medication administration tubing and connectors are used for only one resident.
    e. Multidose vials to be used on more than one resident do not enter the immediate resident treatment area.
    f. Preparation of injections as close as possible to the time of administration to the resident.
7. Use of masks for injections into spinal / epidural spaces and lumbar punctures, if applicable
8. Handling of potentially contaminated equipment
    a. Cleaning and disinfection of resident care items (e.g., blood pressure (BP) cuffs, bedside commodes (BSCs), pumps, glucometers)
        i. Frequency
        ii. Responsible person(s) – who cleans what, and how they know (e.g., cleaning schedule)
        iii. Education of HCP on manufacturer IFUs, use of appropriate hospital- and ICC-approved, US Environmental Protection Agency (EPA)-registered disinfectant (e.g., per EPA list), dwell time, PPE, etc.
        iv. Competencies / validation and monitoring of cleaning practices
    b. Labeling and disposing of regulated medical waste, hazardous materials
    c. Soiled linens
9. Cleaning and disinfection of the environment
    a. High-touch surfaces, congregate areas, etc.
    b. Frequency
    c. Responsible person(s) – who cleans what, and how they know (e.g., cleaning schedule) – and training
        i. Environmental services (EVS)
            1. In-house vs. contract service

2. Credentialing (e.g., Certified Healthcare Environmental Services Professional (CHESP), Certified Healthcare Environmental Services Technician (CHEST))

d. Cleaning audits: responsible person, audit frequency, subjective / objective (i.e., visual observation vs. objective monitoring – fluorescent gel, adenosine triphosphate (ATP), culture, etc.), and immediate feedback given

   i. Data reported back to ICC and disseminated to EVS, providers, managers, and other HCP as needed (along with targets, actions for performance improvement, etc.)

ii. Storage of Supplies and Equipment

   a. Means to identify

      i. Clean vs. dirty

iii. Disinfection and Sterilization (As Applicable to Facility)

   1. Spaulding Classification (i.e., non-critical, semi-critical, critical)

      a. Non-critical (e.g., BP cuffs, stethoscopes, rehabilitation equipment, walking aids)

         i. Use of a product with a tuberculocidal kill claim or claim against HBV, HIV on items that are visibly contaminated with blood

      b. Semi-critical (e.g., cuticle and nail nippers, respiratory therapy equipment)

      c. Critical (e.g., surgical instruments)

   2. Most LTCFs will not perform onsite high-level disinfection (HLD) or sterilization of reusable resident care equipment.

      a. If performed onsite:

         i. Policies and procedures

         ii. Dedicated space

      b. Consultants (e.g., podiatrists, dentists) that use equipment requiring HLD or sterilization will typically bring equipment and reprocess offsite.

         i. Adequate sink and counter space are provided and appropriate for point of use treatment and onsite cleaning. Process in place for appropriate cleaning and disinfection of spaces after use.

         ii. Process in place for the appropriate containment, removal, and transport of contaminated equipment.

         iii. Verification that consultants have policies and procedures addressing proper instrument reprocessing.

   3. Manufacturer IFUs (e.g., location HCP can access)

iv. Facilities / Physical Plant Operations

1. Policies and processes for monitoring HVAC systems
    a. Monitoring of humidity, temperature, air flow (e.g., pressure differential)
        i. Who is responsible and training
        ii. What to do if out of range (e.g., HCP, manager, facilities, etc.)
    b. HVAC maintenance
2. Policies and processes for monitoring water systems
    a. Must have a water management plan to mitigate waterborne pathogen risk
        i. Risk assessment (potable vs. non-potable), vendor(s) that respond to water emergencies, lab(s) contracted to perform testing
    b. Ice machines, dialysis machines:
        i. Cleaning
        ii. Maintenance
        iii. Testing
        iv. Separate ice machines for potable vs. non-potable (e.g., non-potable: for filling of ice packs)
            1. If not, identify process for ensuring contamination does not occur
    c. Repairs to water utilities should result in testing for downstream systems, equipment.
3. Medication, vaccine, resident nutrition refrigerators and freezers
4. Policies and processes for managing construction
    a. Construction planning, meetings
    b. Infection control risk assessments for construction
    c. Construction rounding
5. Pest control

v. Linen Management
1. In-house vs. contract
2. Use of Healthcare Laundry Accreditation Council (HLAC)-accredited laundry management contractors, if applicable
    a. Validated through review of documentation and visit to the facility
3. Storage and transport of clean, soiled linens
4. Handling of clean, soiled linens

vi. Personnel Practices
1. Attire
2. Jewelry

3. Leave policies for HCP illness

vii. Resident Vaccination (e.g., COVID-19, flu)
  1. Resident (and/or family, guardian, durable POA as appropriate) consent for vaccination

viii. Education
  1. Education of residents, family, care providers, other visitors
    a. Good resident hygiene practices
      i. Respiratory hygiene / cough etiquette
      ii. Oral care
      iii. Hand hygiene
      iv. Bathing
    b. Wound care
    c. Device care
    d. Signs and symptoms of infection
    e. Disease acquisition and transmission
    f. Transmission-Based Precautions
    g. Enhanced Barrier Precautions
    h. Vaccination
  2. Mandatory education for HCP (including providers, contractors, vendors, students, and volunteers)
    a. Upon hire (i.e., prior to providing resident care), annually, and as needed / if changes
    b. On IP&C topics
      i. Disease acquisition and transmission
      ii. Signs and symptoms of infection in the geriatric population
      iii. Employee health
      iv. Standard Precautions (e.g., hand hygiene, PPE, etc.)
      v. BBPs and TB
      vi. Transmission-Based Precautions (TBPs)
      vii. Enhanced Barrier Precautions
      viii. Cleaning, disinfection, sterilization (if applicable)
      ix. Contents and location of IC plan
    c. Competencies / validation

ix. Antimicrobial Stewardship
  1. Antimicrobial stewardship program
  2. Antimicrobial stewardship committee

3. Leadership commitment
4. Education of HCP
5. Guidelines followed (e.g., specialty-specific)
6. Antibiogram
7. MDRO surveillance (see Section 7 b.iii.1.f)
8. Intravenous (IV) to *per os* (PO) protocols
9. Pharmacy monitoring / auditing of antimicrobial utilization
10. Reporting of antibiotic use and resistance (e.g., to leadership, providers, nursing)

d. Control
   i. Transmission-Based Precautions
      1. Building characteristics (i.e., private or semi-private rooms, availability of AIIRs, etc.)
      2. Immediate resident placement in private location when need identified or until evaluated by IP / DON / physician (e.g., new onset of infectious process, failed COVID-19 screening, etc.)
      3. Cohorting practices when private rooms are not available
      4. Basic information on types (i.e., Airborne, Droplet, Contact)
      5. Indications for TBPs
      6. Authority to initiate, discontinue TBPs
      7. Enhanced Barrier Precautions
         a. A longer-term approach to managing residents who are colonized or infected with novel or targeted MDROs, or at risk for such colonization or infection.
         b. Can be applied (when Contact Precautions do not otherwise apply) to residents with:
            i. Infection or colonization with a novel or targeted MDRO
            ii. Wounds or indwelling medical devices, *regardless of MDRO status*
            iii. Facilities may choose to apply to residents infected or colonized with other epidemiologically-important MDROs
         c. Different from Contact Precautions. Does *not* replace existing guidance regarding use of Contact Precautions for other pathogens (e.g., *C. diff*, scabies, norovirus).
         d. Used for duration of a resident's stay
         e. At a minimum, recommended for the unit or wing where a resident infected or colonized with a novel or targeted MDRO resides

f. Gowns and gloves required when performing high-contact resident care activities associated with MDRO transmission (e.g., dressing, bathing, showering, toileting, transferring, changing linens, etc.)
g. May eliminate the need for a private room.
h. Residents are not restricted to their rooms.

8. Communication (e.g., when transfer within or between facilities) and signage
    a. Use of flags and signage to alert HCP
    b. Verbal report
    c. Written, standardized interfacility infection control transfer forms
9. How residents requiring Airborne Precautions (e.g., for suspected or confirmed disseminated shingles, TB, etc.) are managed if AIIR or private room with door unavailable
10. Education of HCP
11. Auditing of compliance: responsible person(s), training, audit frequency with immediate feedback given
    a. Reporting of data back to ICC
    b. Data dissemination to providers, managers, other HCP as needed (along with targets, actions for performance improvement, etc.)

ii. BBP Exposure Control Plan

1. Engineering Controls
    a. Sharps safety devices (e.g., safer medical devices, self-sheathing needles)
        i. HCP using sharps safety devices participate in their evaluation and selection
    b. Sharps disposal containers (e.g., labeled, color-coded, leakproof, rigid) availability and replacement when ¾ full
2. Work Practice Controls
    a. No smoking, eating, drinking
    b. No applying cosmetics / lip balm
    c. No handling contact lenses
    d. No food / beverages in refrigerators or other areas where blood or other potentially infectious material (OPIM) are present
    e. No recapping, bending, or breaking of needles
    f. No pipetting
    g. Immediately place used sharps in a sharps disposal container.
3. BBP exposure follow-up protocols
    a. In the event of a BBP exposure

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i. Staffing support
ii. First aid
iii. Who to contact
iv. What to do / steps to take
v. Availability of post-exposure prophylaxis as soon as possible (i.e., within 2 hours), if indicated for the exposure
vi. Testing of source, exposed HCP
vii. Availability of hepatitis B vaccine and hepatitis B immunoglobulin (HBIG), if indicated for the exposure
viii. Additional follow-up, as appropriate
ix. Investigation of cause(s), reeducation as needed, process changes as indicated

4. Cleaning and disinfection of blood spills and OPIM
5. Education of HCP upon hire, annually, and as needed / if changes
6. Accessibility of BBP exposure control plan (i.e., location)
7. Monitoring of sharps injuries, needlesticks
   a. Reporting of data back to ICC
   b. Data usage to assist with product selection, risk mitigation

iii. Outbreak Investigation

1. Policies and procedures describing how HCP will recognize an outbreak
2. Steps taken by HCP in the event that an outbreak is suspected or detected
3. Identification of person(s) who will lead the investigation, verification of diagnosis, case finding, characterization of cases (e.g., person, place, time), hypothesis formulation, testing (e.g., point prevalence)

iv. Breaches in IC Practice

1. Identification of breaches in IC practice
2. Investigation of IC practice breaches
3. Notification of residents (and/or family, guardian, durable POA as appropriate), providers, agencies as appropriate

v. TB Exposure Control Plan

1. Employee health (see Section 7.b.ii.1)
2. Aligns with current CDC recommendations
   a. Treatment of latent TB in new convertors and those never treated in the past
3. Education of HCP upon hire, annually, and as needed / if changes
4. Accessibility of TB exposure control plan (i.e., location)
5. TB monitoring (e.g., TB conversions)

a. Reporting of data back to ICC

vi. Communicable Disease Exposure Management
1. Notification
2. Availability of prophylaxis and process for distribution
3. Process for HCP exposures (see Section 7.b.ii.2)

vii. HCP MDRO Exposure Management
1. Following evidence-based CDC and OSHA guidelines for the evaluation and management of unprotected exposures (if follow-up care or testing is warranted)
2. Emphasis on investigation of causes, documentation, reporting, QI

8. **Compliance Monitoring**
   a. Targeted priorities (e.g., hand hygiene, PPE, TBPs, cleaning, etc.)
   b. Responsible person(s) and training
   c. Enforcement of compliance
      i. Disciplinary process up to and including termination for addressing ongoing noncompliance
   d. Environment of care monitoring
   e. Monitoring of work practice safety
   f. Rounding with immediate feedback given
   g. Data summary and analysis
      i. Data to inform annual risk assessment and quality improvement activities
   h. Reporting of data back to ICC
   i. Data dissemination to providers, managers, other HCP as needed (along with targets, actions for performance improvement, etc.)
9. **Quality Assurance and Performance Improvement (QAPI)**
   a. Assist with development and review of policies, procedures
   b. Review of data summaries and analysis
   c. Creation, implementation, and usage of improvement activities, plans, tools, bundles, etc.
10. **Distribution of DOH Advisories and PA Patient Safety Authority's *Patient Safety* Journal**
   a. Accessibility of advisories and journal to HCP (i.e., location, method of distribution)

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