CMS RULE TOOLKIT
FOR LONG-TERM CARE FACILITIES
(INFECTION CONTROL)

Phase I – by November 28, 2016
Phase II – by November 28, 2017
Phase III – by November 28, 2019

Created June 2017
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**Definitions**

“**Airborne precautions**” refers to actions taken to prevent or minimize the transmission of infectious agents/organisms that remain infectious over long distances when suspended in the air. These particles can remain suspended in the air for prolonged periods of time and can be carried on normal air currents in a room or beyond, to adjacent spaces or areas receiving exhaust air.

“**Alcohol-based hand rub**” (ABHR) refers to a 60-95 percent ethanol or isopropyl- containing preparation base designed for application to the hands to reduce the number of viable microorganisms.

“**Antifungal**” refers to a medication used to treat a fungal infection such as athlete’s foot, ringworm or candidiasis.

“**Anti-infective**” refers to a group of medications used to treat infections.

“**Antiseptic hand wash**” is “washing hands with water and soap or other detergents containing an antiseptic agent.

“**Cohorting**” refers to the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents (cohorting residents). During outbreaks, healthcare personnel may be assigned to a cohort of residents to further limit opportunities for transmission (cohorting staff).

“**Colonization**” refers to the presence of microorganisms on or within body sites without detectable host immune response, cellular damage, or clinical expression.

“**Communicable disease**” (also known as [a.k.a.] “Contagious disease”) refers to an infection transmissible (as from person-to-person) by direct contact with an affected individual or the individual’s body fluids or by indirect means (as by a vector).

“**Community associated infections**” (formerly “Community Acquired Infections”) refers to infections that are present or incubating at the time of admission, or generally develop within 72 hours of admission.

“**Contact precautions**” are measures that are “intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident’s environment.”

“**Droplet precautions**” refers to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.
“Hand hygiene” is a general term that applies to washing hands with water and either plain soap or soap/detergent containing an antiseptic agent; or thoroughly applying an alcohol-based hand rub (ABHR).

“Hand washing” refers to washing hands with plain (i.e., nonantimicrobial) soap and water.

“Health care associated infection [HAI]” (a.k.a. “nosocomial” and “facility-acquired” infection) refers to an infection that generally occurs after 72 hours from the time of admission to a health care facility.

"Hygienically Clean" means being free of pathogens in sufficient numbers to cause human illness.”

“Infection” refers the establishment of an infective agent in or on a suitable host, producing clinical signs and symptoms (e.g., fever, redness, heat, purulent exudates, etc).

“Infection prevention and control program” refers to a program (including surveillance, investigation, prevention, control, and reporting) that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of infection.

“Infection preventionist (IP)” (a.k.a. infection control professional) refers to a person whose primary training is in either nursing, medical technology, microbiology, or epidemiology and who has acquired additional training in infection control.

“Isolation” refers to the practices employed to reduce the spread of an infectious agent and/or minimize the transmission of infection.

“Isolation precautions” see “Transmission-Based Precautions”

“Medical waste” refers to any solid waste that is generated in the diagnosis, treatment, or immunization of human beings or animals, in research pertaining to, or in the production or testing of biologicals (e.g., blood-soaked bandages, sharps).

“Methicillin resistant staphylococcus aureus (MRSA)” refers to Staphylococcus aureus bacteria that are resistant to treatment with semi-synthetic penicillins (e.g., Oxacillin/Nafcillin/Methicillin).

“Multi-Drug resistant organisms (MDROs)” refers to microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent, these pathogens are frequently resistant to most available antimicrobial agents.
“Outbreak” is the occurrence of more cases of a particular infection than is normally expected, the occurrence of an unusual organism, or the occurrence of unusual antibiotic resistance patterns.

“Personal protective equipment” (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury.

“Standard precautions” (formerly “Universal Precautions”) refers to infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions is a combination and expansion of Universal Precautions and Body Substance Isolation (a practice of isolating all body substances such as blood, urine, and feces).

“Surveillance” refers to the ongoing, systematic collection, analysis, interpretation, and dissemination of data to identify infections and infection risks, to try to reduce morbidity and mortality and to improve resident health status.

“Transmission-based precautions” (a.k.a. “Isolation Precautions”) refers to the actions (precautions) implemented, in addition to standard precautions, that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections.

“Vancomycin resistant enterococcus (VRE)” refers to enterococcus that has developed resistance to vancomycin.
Phase I – by November 28, 2016

(a) Infection prevention and control program:
An effective infection prevention and control program is necessary to control the spread of infections and/or outbreaks.

Program Development and Oversight
Program development and oversight emphasize the prevention and management of infections. Program oversight involves establishing goals and priorities for the program, planning, and implementing strategies to achieve the goals, monitoring the implementation of the program (including the interdisciplinary team’s infection control practices), and responding to errors, problems, or other identified issues. Additional activities involved in program development and oversight may include but are not limited to:

- Identifying the staff’s roles and responsibilities for the routine implementation of the program as well as in case of an outbreak of a communicable disease, an episode of infection, or the threat of a bio-hazard attack;
- Developing and implementing appropriate infection control policies and procedures, and training staff on them;
- Monitoring and documenting infections, including tracking and analyzing outbreaks of infection as well as implementing and documenting actions to resolve related problems;
- Defining and managing appropriate resident health initiatives, such as:
  - The immunization program (influenza, pneumonia, etc); and
  - Tuberculosis screening on admission and following the discovery of a new case, and managing active cases consistent with State requirements;
- Providing a nursing home liaison to work with local and State health agencies; and
- Managing food safety, including employee health and hygiene, pest control, investigating potential food-borne illnesses, and waste disposal.

The facility identifies personnel responsible for overall program oversight, which may involve collaboration of the administrator, the medical director or his/her designee, the director of nursing, and other appropriate facility staff as needed. This group may define how and when the program is to be routinely monitored and situations that may trigger a focused review of the program. The group communicates the findings from collecting and analyzing data to the facility’s staff and management, and directs changes in practice based on identified trends, government infection control advisories, and other factors.

Components of an Infection Prevention and Control Program
An effective infection prevention and control program incorporates, but is not limited to, the following components:

- Policies, procedures, and practices which promote consistent adherence to evidence-based infection control practices;
• Program oversight including planning, organizing, implementing, operating, monitoring, and maintaining all of the elements of the program and ensuring that the facility’s interdisciplinary team is involved in infection prevention and control;
• Infection preventionist, a person designated to serve as coordinator of the infection prevention and control program;
• Surveillance, including process and outcome surveillance, monitoring, data analysis, documentation and communicable diseases reporting (as required by State and Federal law and regulation);
• Education, including training in infection prevention and control practices, to ensure compliance with facility requirements as well as State and Federal regulation; and
• Antibiotic review including reviewing data to monitor the appropriate use of antibiotics in the resident population.

Examples of activities related to the Infection Prevention and Control Program may include but are not limited to:
• Undertaking process and/or outcome surveillance activities to identify infections that are causing, or have the potential to cause an outbreak;
• Conducting data analysis to help detect unusual or unexpected outcomes and to determine the effectiveness of infection prevention and control practices;
• Documenting observations related to the causes of infection and/or infection trends; and
• Implementing measures to prevent the transmission of infectious agents and to reduce risks for device and procedure-related infections.

(a)(1) System for preventing, identifying, reporting, investigating and controlling infections and communicable diseases and following accepted national standard
National Standard based on CMS State Surveyor Guidance (F441) 42CFR 483.80
Infection Control
Summary:

• §483.80 Infection Control
• §483.80 (a) Infection Prevention and Control Program
• §483.80(b) Infection Preventionist
• §483.65(c) IP Participation on Quality Assessment and Assurance
• §483.65(d) Influenza and Pneumococcal Immunizations
• §483.65(e) Linens
• §483.65(f) Annual Review

• Revision to State Operations Manual (SOM) Appendix PP (as of 3/8/2017)
• Guidelines for Hand Hygiene on Healthcare Settings
• Guidance for the Selection and Use of Personal Protective Equipment (PPE) in Healthcare settings
• Guidelines for Environmental Infection Control in Healthcare Facilities
• Guidelines for Prevention of Catheter-Associated Urinary Tract Infections 2009
• Clostridium difficile Infections (CDI) Prevention Toolkit
• Facility Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE)
• AHRQ Carbapenem-resistant Enterobacteriaceae (CRE) control and prevention toolkit
• Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008
• Nursing Homes and Assisted Living (Long-Term Care Facilities Prevention Tools)

(a)(2) Written standards, policies and procedures for the program

Policies and procedures are the foundation of the facility’s infection prevention and control program. Policies and procedures are reviewed periodically and revised as needed to conform to current standards of practice or to address specific facility concerns.

Written policies establish the program’s expectations and parameters. For example, policies may specify the use of standard precautions facility-wide and use of transmission-based precautions when indicated, define the frequency and nature of surveillance activities, require that staff use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated, or prohibit direct resident contact by an employee who has an infected skin lesion or communicable disease.

Procedures guide the implementation of the policies and performance of specific tasks. Procedures may include, for example, how to identify and communicate information about residents with potentially transmissible infectious agents, how to obtain vital signs for a resident on contact precautions and what to do with the equipment after its use, and essential steps and considerations (including choosing agents) for performing hand hygiene.

i. Surveillance identification before spread

Surveillance is a key component of infection prevention and control, whereby, the Infection Preventionist (IP) collects data on the residents’ clinical condition as it relates to possible infection. In addition to data collection, the IP must make analyze the information gathered and then develop strategies on how to prevent further infection transmission.

Once the data is analyzed and issues are identified, the IP must make rounds in the facility to observe the techniques of the staff and to find the origins of the existing problems. After having identified the root cause of the problem the IP should follow up with appropriate in-services. Education is a key component to an infection control program.

Essential elements of a facility-wide surveillance system include use of standardized definitions and listings of the symptoms of infections, use of surveillance tools such as infection surveys and data collection templates, walking rounds throughout the
facility, identification of segments of the resident populations at risk for infection, identification of the processes or outcomes selected for surveillance, statistical analysis of data that can uncover an outbreak, and feedback of results to the primary caregivers so that they can assess the residents for signs of infection.

Two types of surveillance (process and outcome) can be implemented in facilities.

**Process surveillance** reviews practices directly related to resident care in order to identify whether the practices comply with established prevention and control procedures and policies based on recognized guidelines. Examples of this type of surveillance include monitoring of compliance with transmission based precautions, proper hand hygiene, and the use and disposal of gloves. Process surveillance determines, for example, whether the facility:

- Minimizes exposure to a potential source of infection;
- Uses appropriate hand hygiene prior to and after all procedures;
- Ensures that appropriate sterile techniques are followed; for example, that staff:
  - Use sterile gloves, fluids, and materials, when indicated, depending on the site and the procedure;
  - Avoid contaminating sterile procedures; and
  - Ensure that contaminated/non-sterile items are not placed in a sterile field.
- Uses Personal Protective Equipment (PPE) when indicated;
- Ensures that reusable equipment is appropriately cleaned, disinfected, or reprocessed; and
- Uses single-use medication vials and other single use items appropriately (proper disposal after every single use).

**Outcome Surveillance:** In contrast to process surveillance, outcome surveillance is designed to identify and report evidence of an infection. Different types of infections include: respiratory tract infections (RTIs), urinary tract infections (UTIs) (with and indwelling catheter/without an indwelling catheter), skin, soft tissue and mucosal infections, gastrointestinal tract infections (gastroenteritis, norovirus, clostridium difficile infection. The outcome surveillance process consists of collecting/documenting data on individual cases and comparing the collected data to standard written definitions (criteria) of infections. The IP or other designated staff reviews data (including residents with fever or purulent drainage, and cultures or other diagnostic test results consistent with potential infections) to detect clusters and trends. Other sources of relevant data may include antibiotic orders,
laboratory antibiograms (antibiotic susceptibility profiles), medication regimen review reports, and medical record documentation such as physician progress notes and transfer summaries accompanying newly admitted residents. The facility’s program should choose to either track the prevalence of infections (existing/current cases both old and new) at a specific point, or focus on regularly identifying new cases during defined time periods. When conducting outcome surveillance, the facility may choose to use one or more of the automated systems and authoritative resources that are available, and include definitions.

**Documentation**

Facilities may use various approaches to gathering, documenting, and listing surveillance data. The facility’s infection control reports describe the types of infections and are used to identify trends and patterns. Descriptive documentation provides the facility with summaries of the observations of staff practices and/or the investigation of the causes of an infection and/or identification of underlying cause(s) of infection trends. It is important that the infection prevention and control program define how often and by what means surveillance data will be collected, regardless of whether the facility creates its own forms, purchases preprinted forms, or uses automated systems.

**Monitoring**

Monitoring of the implementation of the program, its effectiveness, the condition of any resident with an infection, and the resolution of the infection and/or an outbreak is considered an integral part of nursing home infection surveillance. The facility monitors practices (e.g., dressing changes and transmission-based precaution procedures) to ensure consistent implementation of established infection prevention and control policies and procedures based on current standards of practice. All residents are monitored for current infections and infection risks.

**Data Analysis**

Determining the origin of infections helps the facility identify the number of residents who developed infections within the nursing home. Comparing current infection control surveillance data (including the incidence or prevalence of infections and staff practices) to past data enables detection of unusual or unexpected outcomes, trends, effective practices, and performance issues. The facility can then evaluate whether it needs to change processes or practices to enhance infection prevention and minimize the potential for transmission of infections.
It is important that surveillance reports be shared with appropriate individuals including, but not limited to, the director of nursing and medical director. In addition, it is important that the staff and practitioners receive reports that are relevant to their practices to help them recognize the impact of their care on infection rates and outcome.

Infections can be tracked by several ways:

1. **Revised McGeer Criteria (2012)**
   - Definition of infection for long-term care facilities
   - A consistent way to judge each possible infection event

2. **NHSN**
   - [https://www.cdc.gov/nhsn/ltc/](https://www.cdc.gov/nhsn/ltc/)

3. **National Nursing Home Quality Improvement Campaign**
   - [https://www.nhqualitycampaign.org/goalDetail.aspx?g=inf#tab2](https://www.nhqualitycampaign.org/goalDetail.aspx?g=inf#tab2)

**ii. When and to whom possible incidents of communicable disease or infections should be reported**

It is important for each facility to have processes that enable them to consistently comply with State and Local health department requirements for reporting communicable diseases.

These webpages provide you useful information needed to report communicable disease to the public health

- [Arizona Communicable Disease Reporting-Healthcare Providers](http://www.health.arizona.gov/healthدخولو Paste the URL here)
- [Reportable Disease List](http://www.health.arizona.gov/healthدخولو Paste the URL here)
- [Communicable Disease Report Form](http://www.health.arizona.gov/healthدخولو Paste the URL here)

Report should be sent to local health agency by mail, telephone, or fax.

### Arizona County Contact Information

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<tr>
<th>County</th>
<th>Day Time Hours</th>
<th>After Hours</th>
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<td>Apache</td>
<td>928-337-4364</td>
<td>928-337-4321</td>
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<td>Cochise</td>
<td>520-432-9400</td>
<td>800-423-7271</td>
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<td>County</td>
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<td>Coconino</td>
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<td>520-375-7900</td>
<td>877-202-0586</td>
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<td>Yavapai</td>
<td>928-771-3134</td>
<td>928-442-5262</td>
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<td>Yuma</td>
<td>928-317-4450</td>
<td>928-317-4624</td>
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iii. **Standard and transmission-based precautions to be followed to prevent spread of infections**

A facility’s infection control practices are important to preventing the transmission of infections. Infection control precautions used by the facility include two primary tiers: “Standard Precautions” and “Transmission-Based Precautions.”

**Standard Precautions**

Standard precautions are based upon the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions are intended to be applied to the care of all persons in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. Implementation of standard precautions constitutes the primary strategy for preventing healthcare associated transmission of infectious agents among residents and healthcare personnel. Appropriate infection control measures should be used in each resident interaction.

Standard precautions include but are not limited to hand hygiene, safe injection practices, the proper use of PPE (e.g., gloves, gowns, and masks), resident placement, and care of the environment, textiles, and laundry.

**Transmission-based Precautions**

Transmission-based precautions are used for residents who are known to be, or suspected of being infected or colonized with infectious agents, including
Pathogens that require additional control measures to prevent transmission. In nursing homes, it is appropriate to individualize decisions regarding resident placement (shared or private), balancing infection risks with the need for more than one occupant in a room, the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident.

It is essential both to communicate transmission-based precautions to all health care personnel, and for personnel to comply with requirements. Pertinent signage (i.e., isolation precautions) and verbal reporting between staff can enhance compliance with transmission-based precautions to help minimize the transmission of infections within the facility.

It is important to use the standard approaches, as defined by the CDC for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precaution determines the type of PPE to be used. Communication (e.g., verbal reports, signage) regarding the particular type of precaution to be utilized is important. When transmission-based precautions are in place, PPE should be readily available. Proper hand washing remains a key preventive measure, regardless of the type of transmission-based precaution employed.

Transmission-based precautions are maintained for as long as necessary to prevent the transmission of infection. It is appropriate to use the least restrictive approach possible that adequately protects the resident and others. Maintaining isolation longer than necessary may adversely affect psychosocial well-being. The facility should document in the medical record the rationale for the selected transmission-based precautions.

**Airborne Precautions**

Airborne precautions prevent the transmission of organisms that remain infectious when suspended in the air (e.g., varicella zoster (shingles) and M. tuberculosis). Resident health activities related to infection control include tuberculosis (TB) screening and management of active cases, consistent with State requirements. Management of some airborne infections such as active TB requires a single-resident airborne infection isolation room (AIIR) that is equipped with special air handling and ventilation capacity. Although not all residents with airborne infections will require an AIIR, residents with infections...
requiring an AIIR may need to be transported to an acute care setting unless the facility can place the resident in a private AIIR room with the door closed. In cases when AIIR is required it is important for the facility to have a plan in place to effectively manage a situation involving a resident with suspected or active TB while awaiting the resident’s transfer to an acute care setting.

Personnel caring for residents on airborne precautions should wear a mask or respirator that is donned prior to room entry, depending on the disease-specific recommendations. Depending on the condition, staff can use N95 or higher level respirators or wear masks if respirators are not available.

**Contact Precautions**

Contact transmission risk requires the use of contact precautions to prevent infections that are spread by person-to-person contact. Contact precautions require the use of appropriate PPE, including a gown and gloves upon entering the contact precaution room. Prior to leaving the contact precaution room the PPE is removed and hand hygiene is performed.

Depending on the situation, options for residents on contact precautions may include the following: a private room, cohorting, or sharing a room with a roommate with limited risk factors (e.g., without indwelling devices, without pressure ulcers and not immunocompromised).

**Droplet Precautions**

In contrast to contact transmission, respiratory droplets transmit infections directly from the respiratory tract of an infected individual to susceptible mucosal surfaces of the recipient. Since this generally occurs at close proximity, facial protection is necessary. Respiratory droplets are generated when an infected person coughs, sneezes, or talks; or during procedures such as suctioning, endotracheal intubation, cough induction by chest physiotherapy, and cardiopulmonary resuscitation. Studies have shown that respiratory viruses can enter the body via the nasal mucosa, conjunctivae and less frequently the mouth. Examples of droplet-borne organisms that may cause infections include, but are not limited to influenza and mycoplasma.

The maximum distance for droplet transmission is currently unresolved, but the area of defined risk based on epidemiological findings is approximately 3-10 feet. In contrast to airborne pathogens, droplet-borne pathogens are generally
not transmitted through the air over long distances. Masks are to be used within approximately 6 to 10 feet of a resident or upon entry into a resident’s room with respiratory droplet precautions. Residents with droplet precautions are placed in either a private room, cohorted, or share a room with a roommate with limited risk factors.

More information about standard and transmission-based precautions can be found at CDC website

- Precautions to Prevent Transmission of Infectious Agents

iv. **When and how isolation should be used for a resident**

It is important that facility staff clearly identify the type of precautions and the appropriate PPE to be used in the care of the resident. The PPE should be readily available near the entrance to the resident’s room. Signage can be posted on the resident’s door instructing visitors to see the nurse before entering.

It is not always possible to identify prospectively residents needing transmission-based precautions (presumptive precautions). The diagnosis of many infections is based on clinical signs and symptoms, but often requires laboratory confirmation. However, since laboratory tests (especially those that depend on culture techniques) may require two or more days to complete, transmission-based precautions may need to be implemented while test results are pending, based on the clinical presentation and the likely category of pathogens. The use of appropriate transmission-based precautions when a resident develops symptoms or signs of a transmissible infection or arrives at a nursing home with symptoms of an infection (pending laboratory confirmation) reduces transmission opportunities. However, once it is confirmed that the resident is no longer a risk for transmitting the infection, removing transmission-based precautions avoids unnecessary social isolation.

The following document helps to know when and how isolation should be used for a resident.

- **2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings**

v. **The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease**
Facility staff who have direct contact with residents or who handle food must be free of communicable diseases and open skin lesions, if direct contact will transmit the disease. It is important that the facility maintain documentation of how they handle staff with communicable infections or open skin lesions.

It is important that all staff involved in direct resident contact maintain fingernails that are clean, neat, and trimmed. Wearing intact disposable gloves in good condition and that are changed after each use helps reduce the spread of microorganisms. It is important for dietary staff to wear hair restraints (e.g., hairnet, hat, and/or beard restraint) while in the kitchen areas to prevent their hair from contacting exposed food. Since jewelry can harbor microorganisms, it is recommended by the FDA that dietary staff keep jewelry to a minimum and remove or cover hand jewelry when handling food.

The following document provides summary of suggested work restrictions for health care personnel exposed to or infected with infectious diseases of importance in healthcare settings.

- Guideline for infection control in health care personnel, 1998

vi. The hand hygiene procedures to be followed by staff involved in direct resident contact

Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:

- When coming on duty;
- When hands are visibly soiled (hand washing with soap and water); Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);
- Before and after performing any invasive procedure (e.g., fingerstick blood sampling);
- Before and after entering isolation precaution settings;
- Before and after eating or handling food (hand washing with soap and water);
- Before and after assisting a resident with meals;
- Before and after assisting a resident with personal care (e.g., oral care, bathing);
- Before and after handling peripheral vascular catheters and other invasive devices;
- Before and after inserting indwelling catheters;
• Before and after changing a dressing; Upon and after coming in contact with a resident’s intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident);
• After personal use of the toilet (hand washing with soap and water);
• Before and after assisting a resident with toileting;
• After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C. difficile (hand washing with soap and water);
• After blowing or wiping nose;
• After contact with a resident’s mucous membranes and body fluids or excretions;
• After handling soiled or used linens, dressings, bedpans, catheters and urinals;
• After handling soiled equipment or utensils;
• After performing your personal hygiene (hand washing with soap and water);
• After removing gloves or aprons; and
• After completing duty

Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections. It is necessary for staff to have access to proper hand washing facilities with available soap (regular or anti-microbial), warm water, and disposable towels and/or heat/air drying methods. Alcohol based hand rubs (ABHR) cannot be used in place of proper hand washing techniques in a food service setting.

Recommended techniques for washing hands with soap and water include wetting hands first with clean, running warm water, applying the amount of product recommended by the manufacturer to hands, and rubbing hands together vigorously for at least 15 seconds covering all surfaces of the hands and fingers; then rinsing hands with water and drying thoroughly with a disposable towel; and turning off the faucet on the hand sink with the disposable paper towel.

Except for situations where hand washing is specifically required, antimicrobial agents such as ABHR are also appropriate for cleaning hands and can be used for direct resident care. Recommended techniques for performing hand hygiene with an ABHR include applying product to the palm of one hand and rubbing
hands together, covering all surfaces of hands and fingers, until the hands are dry. In addition, gloves or the use of baby wipes are not a substitute for hand hygiene.

Please visit following website for more hand washing resources

- ADHS Hand Hygiene Poster
- Hand Washing: When and How to Wash Hands
- Hand Hygiene in Healthcare Settings
- CDC Hand Hygiene Courses for Healthcare Providers
- Guideline for Hand Hygiene in Health-Care Settings

(a)(4) A system for recording incidents identified under the facility’s IPCP and corrective actions taken by the facility

The facility must have a system for recording incidents identified and corrective actions taken by the facility.

§483.65(d) Influenza and pneumococcal immunizations

The facility must develop policies and procedures to ensure following:

1. Influenza:
   a. Before offering the influenza immunization, each resident of the resident’s representative receives education regarding the benefits and potential side effects of the immunization;
   b. Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
   c. The resident or the resident’s representative has the opportunity to refuse immunization; and
   d. The resident’s medical record includes documentation that indicates, at a minimum, the following:
      i. That the resident or resident’s representative was provided education regarding the benefits and potential side effects of influenza immunization; and
      ii. That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

2. Pneumococcal disease:
   a. Before offering the pneumococcal immunization, each resident or the resident’s representative receives education regarding the benefits and potential side effects of the immunization;
b. Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
c. The resident or the resident’s representative has the opportunity to refuse immunization; and
d. The resident’s medical record includes documentation that indicates, at a minimum, the following:
   i. That the resident or resident’s representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
   ii. That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

Please visit the following website for influenza and pneumococcal immunizations information:

- ADHS Pneumococcal Vaccination Algorithms for Adults
- ADHS Pneumococcal Vaccination for Adults Webinar
- Influenza Toolkit for Long-Term Care Employers
- ACIP Vaccine Recommendations

§483.65(e) Linens
The facility must review organizational practices related to linen handling, storage, process and transport to ensure they are consistent with preventing spread of infection.

It is important that all potentially contaminated linen be handled with appropriate measures to prevent cross transmission (cross contamination). If the facility handles all used linen as potentially contaminated (i.e., using standard precautions), no additional separating or special labeling of the linen is recommended. No special precautions (i.e., double bagging) or categorizing is recommended for linen originating in isolation rooms. Double bagging of linen is only recommended if the outside of the bag is visibly contaminated or is observed to be wet through to the outside of the bag.

Alternatively, leak-resistant bags are recommended for linens contaminated with blood or body substances. If standard precautions for contaminated linens are not used, then some identification with labels, color coding or other alternatives means of communication is important.

For the routine handling of contaminated laundry, minimum agitation is recommended, to avoid the contamination of air, surfaces, and persons. The risk of environmental
contamination may be reduced by having personnel bag or contain contaminated linen at the point of use, and not sorting or pre-rinsing in resident care areas.

It is important that laundry areas have hand washing facilities and products, as well as appropriate PPE (i.e., gloves and gowns) available for workers to wear while sorting linens. Laundry equipment should be used and maintained according to the manufacturer’s instructions to prevent microbial contamination of the system. It is recommended that damp linen is not left in machines overnight. The CDC recommends leaving washing machines open to air when not in use to allow the machine to dry completely and to prevent growth of microorganisms in wet, potentially warm environments.

Detergent and water physically remove many microorganisms from the linen through dilution during the wash cycle. Advances in technology allow modern-day detergents to be much more effective in removing soil and reducing the presence of microbes than those used in the past when much of the research on laundry processing was first conducted. Facilities may use any detergent designated for laundry in laundry processing. Further, laundry detergents used within facilities are not required to have stated anti-microbial claims. Facilities should closely follow manufacturer’s instructions for laundry detergents used. The CMS, in collaboration with the CDC, has determined that ozone cleaning systems are acceptable methods of processing laundry. Ozone cleaning systems also should be used per manufacturer’s instructions.

An effective way to destroy microorganisms in laundry items is through hot water washing at temperatures above 160ºF (71ºC) for 25 minutes. Alternatively, low temperature washing at 71 to 77 degrees F (22-25 degrees C) plus a 125-part-per-million (ppm) chlorine bleach rinse has been found to be effective and comparable to high temperature wash cycles. Laundry washing within facilities typically occurs in a low water temperature environment. Many laundry items are composed of materials that cannot withstand a chlorine bleach rinse and remain intact. A chlorine bleach rinse is not required for all laundry items processed in low temperature washing environments due to the availability of modern laundry detergents that are able to produce hygienically clean laundry without the presence of chlorine bleach. However, a chlorine bleach rinse may still be used for laundry items composed of materials such as cottons.

Facilities are not required to maintain a record of water temperatures during laundry processing cycles. Facilities are required to follow manufacturer’s instructions for all materials involved in laundry processing (e.g., washing machines; dryers; any laundry detergents, rinse aids, or other additives employed during the laundry process). Facilities should also follow manufacturer’s instructions for clothing, linens, and other
laundry items to determine the appropriate methods to use to produce a hygienically clean product. Facilities should also consider a resident’s individual needs (e.g., allergies) when selecting methods for processing laundry.

If laundry chutes are used, it is recommended that they are properly designed and maintained so as to minimize dispersion of aerosols from contaminated laundry (e.g., no loose items in the chute and bags are closed before tossing into the chute).

If linen is sent off to a professional laundry, the facility should obtain an initial agreement between the laundry service and facility that stipulates the laundry will be hygienically clean and handled to prevent recontamination from dust and dirt during loading and transport. For example, an ozone laundry cleaning system is a method which may require a professional laundry service. The facility will need to obtain such an agreement in this instance. Whether laundry processing is completed within the facility or outside the facility, facilities should have written policies & procedures which should include training for staff who will handle linens and laundry.

Standard mattresses and pillows can become contaminated with body substances during resident care if the integrity of the covers of these items is compromised. A mattress cover is generally a fitted, protective material, the purpose of which is to prevent the mattress from becoming contaminated with body fluids and substances. A linen sheet placed on the mattress is not considered a mattress cover. Patches for tears and holes in mattress covers do not provide an impermeable surface over the mattress. Therefore it is recommended that mattress covers with tears or holes be replaced. It is recommended that moisture resistant mattress covers be cleansed and disinfected between residents with an EPA approved germicidal detergent to help prevent the spread of infections, and fabric mattress covers should be laundered between residents. Pillow covers and washable pillows should be laundered in a hot water laundry cycle between residents or when they become contaminated with body substances. Discarding mattresses if fluids have penetrated into the mattress fabric and washing pillows and pillow covers in a hot-water laundry cycle will also reduce the risk of indirect contact with infectious agents.

- Guidelines for Environmental Infection Control in Healthcare Facilities

§483.65 (f) Annual review
The facility should conduct an annual review of its IPCP and update their program, as necessary.
Preventing spread of illness related to MDROs

The MDROs found in facilities include, but are not limited to MRSA, VRE, and Clostridium difficile (C. difficile). Transmission-based precautions are employed for residents who are actively infected with multidrug resistant organisms. Aggressive infection control measures and strict compliance by healthcare personnel can help minimize the spread of MDROs to other susceptible individuals.

Staphylococcus is a common cause of infections in hospitals and nursing homes, and increasingly in the community. Common sites of MRSA colonization include the rectum, perineum, skin and nares. Colonization may precede or endure beyond an acute infection. MRSA is transmitted person-to-person (skin-to-skin contact), and on inanimate objects.

The MRSA infection is commonly treated with vancomycin, which in turn can lead to increased enterococcus antibiotic resistance. Therefore, preventing infection with MRSA and the limited use of antibiotics for individuals who are only colonized can also help prevent the development of VRE. Enterococcus is an organism that normally occurs in the colorectal tract. VRE infections have been associated with prior antibiotic use.

C. difficile is a bacterial species of the genus clostridium, which are gram-positive, anaerobic, spore-forming rods (bacilli). The organism normally lives benignly in the colon in spore form. When antibiotic use eradicates normal intestinal flora, the organism may become active and produce a toxin that causes symptoms such as diarrhea, abdominal pain, and fever. More severe cases can lead to additional complications such as intestinal damage and severe fluid loss. Treatment options include stopping antibiotics and starting specific antclostridial antibiotics, e.g., metronidazole or oral vancomycin. If a resident has diarrhea due to C. difficile, large numbers of C. difficile organisms will be released from the intestine into the environment and may be transferred to other individuals, causing additional infections.

Contact precautions are instituted for residents with symptomatic C. difficile infection. Thorough hand washing with soap and water after caring for the resident reduces the risk of cross transmission. Another control measure is to give the resident his or her own toilet facilities that will not be shared by other residents.

The C. difficile can survive in the environment (e.g., on floors, bed rails or around toilet seats) in its spore form for up to 6 months. Rigorously cleaning the environment removes C. difficile spores, and can help prevent transmission of the organism. Cleaning equipment used for residents with C. difficile with a 1:10 dilution of sodium hypochlorite
(nine parts water to one part bleach) will also reduce the spread of the organism. Once mixed, the solution is effective for 24 hours.

- Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006

Guidance for controlling C difficile
- ADHS Clostridium difficile Infection (CDI) in Long-Term Care Facilities
- Clostridium difficile Infections (CDI) Prevention Toolkit
- ADHS CDI Letter

Guidance for controlling CRE
- Facility Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE)
- AHRQ Carbapenem-resistant Enterobacteriaceae (CRE) control and prevention toolkit
- ADHS Carbapenem-resistant Enterobacteriacea Infection in Skilled Nursing Facilities

Preventing infections related to the use of specific devices

Intravascular catheters are used widely to provide vascular access, and are increasingly seen in nursing homes. While providing such access, they may increase the risk for local and systemic infections and additional complications such as septic thrombophlebitis.

Central venous catheters (CVCs) have also been associated with infectious complications. Other intravascular catheters such as dialysis catheters and implanted ports may be accessed multiple times per day, such as for hemodynamic measurements, or to obtain samples for laboratory analysis, thus increasing the risk of contamination and subsequent clinical infection. Limiting access to central venous catheters for only the primary purpose may help reduce the risk of infection.

Consistent use of appropriate infection control measures when caring for residents with vascular access catheters reduces the risk for catheter-related infections. Surveillance consistently includes all residents with vascular access, including those with venous access and implanted ports such as peripherally inserted central catheter lines, and midline access catheters. Activities to reduce infection risk includes surveillance such as observation of insertion sites, routine dressing changes, use of appropriate PPE and hand hygiene during the care and treatment of residents with venous catheters, and review of the resident for clinical evidence of infection. It is important that practices reflect the most current CDC guidelines.
Recognizing and containing outbreaks

It is important that facilities know how to recognize and contain infectious outbreaks. Once an outbreak has been identified, it is important that the facility take the appropriate steps to contain it. Plans for containing outbreaks usually include efforts to prevent further transmission of the infection while considering the needs of all residents and staff.

- Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities
- ADHS Norovirus detection and Management: Guidance for Long-Term Care Facilities
- Infectious Disease Outbreak Investigation and Management
- Outbreak threshold guide to providers

It is important that facilities have processes that enable them to consistently comply with State and Local health department requirements for reporting outbreaks. Report should be sent to local health agency by mail, telephone, or fax.
Phase II – by November 28, 2017

(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use
Because of increases in MDROs, review of the use of antibiotics (including comparing prescribed antibiotics with available susceptibility reports) is a vital aspect of the infection prevention and control program. It is the physician’s (or other appropriate authorized practitioner’s) responsibility to prescribe appropriate antibiotics and to establish the indication for use of specific medications. As part of the medication regimen review, the consultant pharmacist can assist with the oversight by identifying antibiotics prescribed for resistant organisms or for situations with questionable indications, and reporting such findings to the director of nursing and the attending physician.

Implement an antibiotic stewardship program
Antimicrobial stewardship is the act of using antibiotics appropriately—that is, using them only when truly needed and using the right antibiotic for each infection. It is called "stewardship" because it protects the effectiveness of the most important tool we have to fight life-threatening bacterial infections: antibiotics.

The Core Elements of Antibiotic Stewardship for Nursing Homes
This document helps to initiate or expand antibiotic stewardship activities in nursing homes. Nursing homes are encouraged to work in a step-wise fashion, implementing one or two activities to start and gradually adding new strategies from each element over time. Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting.

More information about the core elements of antibiotic stewardship for nursing homes are provided in following resources:

- **Core Elements of Antibiotic Stewardship** – Seven core elements of antibiotic stewardship for nursing homes
- **Checklist** – Checklist to review progress in expanding stewardship activities on a regular basis
- **Appendix A: Policy and Practice Actions to Improve Antibiotic Use** – Detailed explanations of policy and practice actions that can be taken by nursing homes as part of their antibiotic stewardship activities
- **Appendix B: Measures of Antibiotic Prescribing, Use and Outcomes** – Detailed explanations of antibiotic use process and outcome measures which
can be tracked by nursing homes to monitor the impact of their antibiotic stewardship activities.

- **Fact Sheets** – Several factsheets for residents, families, medical leaders and administrators that can be used in nursing homes to improve prescribing
- **Infographic** – Infographic showing importance of antibiotic stewardship in nursing homes

**AHRQ Nursing Home Antimicrobial Stewardship Guide/Toolkit**

The Nursing Home Antimicrobial Stewardship Guide provides toolkits to help nursing homes optimize their use of antibiotics. This Guide provides information and tools that nursing homes can use to make antimicrobial stewardship a priority and to select and implement interventions that address the specific needs of their facilities.

- **Entire Toolkits**
- **Implement, Monitor, and Sustain an Antimicrobial Stewardship Program**
  - **Start an Antimicrobial Stewardship Program**
    - Identify champions and gather a team
    - Conduct a readiness assessment
    - Plan for implementation
    - Introduce new policies and procedures to staff
  - **Monitor and Sustain Stewardship**
    - Convene a meeting of the antimicrobial stewardship program team to discuss how and what to monitor.
    - Use the Antibiotic Use Tracking Sheet.
    - Use and evaluate progress through the Monthly Summary Reports
    - Communicate results to prescribing clinicians
    - Review and update guidelines.
- **Determine Whether It Is Necessary To Treat a Potential Infection With Antibiotics**
  - **Suspected UTI SBAR Toolkit**
  - **Common Suspected Infections: Communications and Decision making for Four Infections**
  - **Minimum Criteria for Three Infections Toolkit**
- **Help Prescribing Clinicians Choose the Right Antibiotic**
  - **Working With a Lab To Improve Antibiotic Prescribing**
  - **Using Nursing Home Antibiograms To Choose the Right Antibiotic (Concise Antibiogram Toolkit)**
The Nursing Home Antibiogram Program Toolkit: How To Develop and Implement an Antibiogram Program

Educate and Engage Residents and Family Members

ADHS Antimicrobial Stewardship Subcommittee
The Antimicrobial Stewardship Subcommittee is a group of medical, microbiology and nursing professionals dedicated to providing education on antibiotic use both to providers and the public. This panel of experts provides information, best practices for stewardship, and technical assistance to healthcare facilities. The Antimicrobial Stewardship Subcommittee is currently working on an antimicrobial stewardship toolkit for healthcare providers and a resource list for providers and the public.

- Antimicrobial Stewardship Homepage
- Antimicrobial Stewardship Educational Slide sets
- Business Models to Support Antimicrobial Stewardship Program
- Resources created by the HAI Advisory Committee
- Resources and Reports from other professional organizations
§483.80 (b) Infection preventionist (IP)

The facility must designate one or more individual(s) as the infection preventionist(s) who is responsible for the facility’s IPCP. Responsibilities may include collecting, analyzing, and providing infection data and trends to nursing staff and health care practitioners; consulting on infection risk assessment, prevention, and control strategies; providing education and training; and implementing evidence-based infection control practices, including those mandated by regulatory and licensing agencies, and guidelines from the Centers for Disease Control and Prevention. The IP must

- Have primary professional training in nursing, medical technology, microbiology, epidemiology or other related field
- Is qualified by education, training, experience or certification
- Works at least part time at the facility
- Has completed specialized training in infection prevention and control

Some resources and trainings available are listed below:

CDC

https://www.cdc.gov/longtermcare/


APIC

http://www.apic.org/Resources/Topic-specific-infection-prevention/Long-term-care


SHEA/APIC Guideline: Infection Prevention and control in the long-term care facility


American Health Care Association

https://educate.ahcancal.org/products/infection-preventionist-specialized-training-ipco#tab-product_tab_overview
ADHS

Every year ADHS organizes the annual training event for long term care facilities. For more information about upcoming and past events, please check this webpage


§483.80 (c) IP participation on quality assessment and assurance committee

The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility’s quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
Infection Prevention and Control Program:
A system for preventing, identifying, reporting, investigating, and controlling infection and communicable diseases for all residents, staff volunteers, visitors, and other individuals providing services under a contractual arrangements based upon the facility assessment and following accepted national standards. Written standards, policies, and procedures for the program, must include, but are not limited to:

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<th>Component</th>
<th>Resources</th>
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| System for preventing, identifying, reporting, investigating and controlling infections and communicable diseases and following accepted national standard | Revision to State Operations Manual (SOM) Appendix PP  
Clostridium difficile Infections (CDI) Prevention Toolkit  
Facility Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE)  
AHRQ Carbapenem-resistant Enterobacteriaceae (CRE) control and prevention toolkit  
Nursing Homes and Assisted Living (Long-Term Care Facilities Prevention Tools  
ADHS Injection Safety Toolkit |
| A system of surveillance designed to identify possible communicable diseases or infections before they can spread to others in the facility | Revised McGeer Criteria (2012)  
NHSN Tracking Infections in Long-Term Care Facilities  
National Nursing Home Quality Improvement Campaign |
| When and to whom possible incidents of communicable disease or infections should be reported | Arizona Communicable Disease Reporting-Healthcare Providers  
Reportable Disease List  
Communicable Disease Report Form  
Local Health Agency Contact Information |
| Standard and transmission-based precautions to be followed to prevent spread of infections | Precautions to Prevent Transmission of Infectious Agents |
| When and how isolation should be used for a resident, including but not limited to: | 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings  
Management of multidrug-resistant organisms in healthcare settings, 2006 |
<p>| The circumstances under which the facility must prohibit employees with a communicable disease | Guideline for infection control in health care personnel, 1998 |</p>
<table>
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<tr>
<th>Scenario</th>
<th>Resources</th>
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| or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease | ADHS Hand Hygiene Poster  
Hand Washing: When and How to Wash Hands  
Hand Hygiene in Healthcare Settings  
Guideline for Hand Hygiene in Health-Care Settings |
| The hand hygiene procedures to be followed by staff involved in direct resident contact | The Core Elements for Antibiotic Stewardship in Nursing Homes  
CDC Checklist of Core Elements of Antibiotic Stewardship in Nursing Homes  
CDC Creating a Culture to Improve Antibiotic Stewardship in Nursing Homes  
AHRQ Antimicrobial Stewardship Guide/Toolkit  
ADHS Antimicrobial Stewardship Homepage |
| An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. |                                                                                                                                   |
| A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility. |                                                                                                                                   |
### Infection Preventionist

The facility must designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility’s IPCP. The IP must:

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<tr>
<td>Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field.</td>
<td>CDC <a href="https://www.cdc.gov/longtermcare/">https://www.cdc.gov/longtermcare/</a></td>
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<tr>
<td>Work at least part-time at the facility.</td>
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<td>ADHS Every year ADHS organizes the annual training event for long term care facilities. For more information about upcoming and past events, please check this webpage <a href="http://azdhs.gov/preparedness/epidemiology-disease-control/healthcare-associated-infection/index.php#collaborative-home">http://azdhs.gov/preparedness/epidemiology-disease-control/healthcare-associated-infection/index.php#collaborative-home</a></td>
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### IP Participation on quality assessment and assurance committee

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<td>The individual designated as the IP, must be a member of the facility’s quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.</td>
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### Influenza Immunizations
The facility must develop policies and procedures to ensure that:

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<tr>
<td>Before offering the influenza immunization, each resident or the resident representative receives education regarding the benefits and potential side effects of the immunization</td>
<td>Influenza Toolkit for Long-Term Care Employers Recommended immunization schedule for adults ACIP Vaccine Recommendations</td>
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<td>Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period</td>
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<tr>
<td>The resident or the resident’s representative has the opportunity to refuse immunization</td>
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<tr>
<td>The resident’s medical record includes documentation that indicates, at a minimum:</td>
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<td>- That the resident or resident’s representative was provided education regarding the benefits and potential side effect of influenza immunization.</td>
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<tr>
<td>- That the resident either received the influenza immunization or did not receive the immunization due to medical contraindications or refusal</td>
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| **Pneumococcal immunizations**  
The facility must develop policies and procedures to ensure that: |
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<td><strong>Component</strong></td>
<td><strong>Resources</strong></td>
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| Before offering the pneumococcal immunization, each resident or the resident representative receives education regarding the benefits and potential side effects of the immunization | ADHS Pneumococcal Vaccination Algorithms for Adults  
ADHS Pneumococcal Vaccination for Adults Webinar  
Recommended immunization schedule for adults  
ACIP Vaccine Recommendations |
| Each resident is offered a pneumococcal immunization unless the immunization is medically contraindicated or the resident has already been immunized |  |
| The resident or the resident’s representative has the opportunity to refuse immunization |  |
| The resident’s medical record includes documentation that indicates, at a minimum:  
  - That the resident or resident’s representative was provided education regarding the benefits and potential side effect of pneumococcal immunization.  
  - That the resident either received the pneumococcal immunization or did not receive the immunization due to medical contraindications or refusal. |  |
**Linens**
The facility must review organizational practices related to linen handling, storage, process and transport to ensure they are consistent with preventing spread of infection.

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<tr>
<td>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection</td>
<td>Guidelines for Environmental Infection Control in Healthcare Facilities</td>
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**Annual Review**

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<td>The facility will conduct an annual review of its IPCP program and update their program as necessary</td>
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