### Infection Prevention and Control Post-Acute Plan Prioritized Risks, Goals, Strategies, and Implementation

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| Nursing Home Name: |  | CCN\*: |  | Date: |  |

Health Services Advisory Group (HSAG) will monitor overall targeted QII performance using the following outcome measure.

*Prevalence of nursing home facility-onset infections:* On a monthly basis, HSAG will use claims data to determine the prevalence of nursing home infections that lead to unanticipated healthcare utilization. The goal is to achieve a significant reduction in the infection rate as determined by the use of statistical process control (SPC) charts. HSAG will continue the intervention until the SPC charts reveal special cause variation in the desired direction (e.g., six or more consecutive improvements in the rate, etc.) the reduction in the infection prevalence (and its associated utilization) will also be used to determine cost savings (e.g., the cost savings associated with averting an infection) and the overall return on investment.

### For each prioritized area of concern, identify goals, strategies, responsible person(s), timeframe, and evaluation of effectiveness.

| **Topic** | **Root Cause** | **Strategies** | **Implementation** | | **Internal Nursing Home Goals** | |
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| **Area of Concern** | **Survey Findings** | **Best Practices by Area of Concern** | **Responsible Person(s)** | **Action** | **Evaluation of Effectiveness via Surveillance** |
| **Hand Hygiene Compliance** | Example:  Lack of hand hygiene education and supplies  Did not provide annual hand hygiene education  Did not follow an established hand hygiene program structure | 1. Complete CMS sponsored COVID-19 training for front line staff members and management: <https://qsep.cms.gov/welcome.aspx> 2. Ensure hand hygiene stations and products are readily accessible to staff members, providers, and residents. 3. Prevent staff/resident exposure and illness. 4. Determine effective means of assuring compliance.  * Observations * Feedback  1. Provide feedback to staff on a monthly basis and as issues are identified. 2. Prioritize hand hygiene across the facility.  * New employee orientation, department meetings, and just-in-time education  1. Provide mandatory education and training annually and as necessary (PRN) when concerns are identified. 2. Change culture starting with administration making hand hygiene a priority. 3. Use *World Health Organization’s Five Moments of Hand Hygiene* as guidance. 4. Modify PRN. | Administration  Infection preventionists (IPs)  Managers  Staff | Implement plan strategies by [date].  Monitor and improve processes PRN.  Accept hand hygiene program and expectations as standard culture. | Ongoing compliance.  Observations with immediate intervention when goal is unmet (See strategies).  Report monthly progress to Quality Assurance & Performance Improvement (QAPI) Committee and Health Services Advisory Group (HSAG). |
| **Isolation and Standard Precautions** |  | 1. Complete CMS sponsored COVID-19 training for front line staff members and management: <https://qsep.cms.gov/welcome.aspx> 2. Ensure personal protective supplies are available for staff use. 3. Follow across the organization the *Centers for Disease Control and Prevention* (*CDC)/Healthcare Infection Control Practices Advisory Committee (HICPAC) Guidelines for Isolation Precautions* and evolving mitigation strategies for COVID-19 based on local, state, and national best-practice recommendations. 4. Provide ongoing education and training to new and existing employees and make information readily and easily accessible to staff members. 5. Prevent staff/resident infection exposure and illness. 6. Determine effective means of assuring compliance.  * Observations  1. Feedback 2. Change culture.  * Maintain high awareness * Implement teamwork—remind each other regardless of disciplines (“Dofficer” program) * Encourage accountability  1. Modify PRN. | IPs  Managers  Staff | Implement plan strategies by [date].  Report monthly to key staff members.  Identify areas of concerns and work with managers and staff to address and improve compliance. | Ongoing compliance.  Observations with immediate intervention when goal is unmet (see strategies).  Report monthly progress to QAPI Committee and HSAG. |
| **Clean/ Disinfect Patient Care Equipment**  **Clean Patient Environments** |  | 1. Complete CMS sponsored COVID-19 training for front line staff members and management: <https://qsep.cms.gov/welcome.aspx> 2. Standardize policy, cleaning products, and expectations.  * Assign accountability and frequency for common (high risk) equipment.  1. Educate pertinent staff annually and at hire regarding product use including the importance of dwell times.  * Update education and training as needed if changes are made to products or guidance is updated (Example: COVID-19).  1. Ensure there is separation between clean and dirty equipment. 2. Ensure cleaning products are readily available to clinical and environmental services staff. 3. Monitor practice and give feedback to managers/staff. 4. Prevent staff/resident infection exposure and illness. 5. Encourage communication between departments so clear accountability of cleaning is understood and applied. 6. Prevent staff/resident infection exposure and illness. 7. Modify PRN. | IPs  Managers  Staff | Implement plan strategies by [date].  Monitor and improve process PRN.  Accept as standard culture. | Ongoing compliance.  Observations with immediate intervention when goal is unmet (see strategies).  Report monthly progress to QAPI Committee and HSAG. |
| **Pandemic Event  (COVID-19 Preparation)** |  | 1. Complete CMS sponsored COVID-19 training for front line staff members and management: <https://qsep.cms.gov/welcome.aspx>  * Implement CDC COVID-19 control and mitigation strategies. * Educate annually, at hire, and when guidelines change regarding expectations  of care. * Monitor compliance with screening residents/visitors/staff for symptoms. * Reinforce hand hygiene, transmission-based precautions, cohorting, and other best-practice interventions. * Ensure necessary care products are available to staff (personal protective equipment [PPE], cleaning supplies, hand hygiene products, etc.). * Reinforce strategies listed throughout  this plan.  1. Stay informed on current national and international COVID-19 literature and practice. 2. See additional detail in COVID-19 mitigation plan. Available at: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-52-Attachment-01.pdf> | IPs  Managers  Staff | Implement plan strategies by [date].  Monitor and improve processes as needed.  Implement fully and accept as standard culture. | Maintain zero new confirmed COVID-19 cases in 2020 as reported to the CDC National Healthcare Safety Network (NHSN).  Ongoing compliance on COVID-19 mitigation strategies.  Report monthly progress to QAPI Committee and HSAG. |
| **Catheter-Associated Urinary Tract Infections (CAUTIs)** |  | 1. Continue education on urinary tract infection (UTI) prevention, issues, and solutions.  * Monitor for compliance with Foley bundle, follow Foley insertion policy, use perineal cleanser appropriately, and use a latex-free Foley catheter product. * Re-educate on units PRN.  1. Monitor catheter usage according to Foley bundle.  * Criteria for insertion met * Aseptic insertion * Daily perineal care with documentation * Proper securement and positioning * Closed system at all times * Empty bag prior to 2000cc * Justify need daily * Remove as soon as possible  1. Provide timely feedback to staff/clinicians. | IPs  Managers  Staff  Providers | Implement plan strategies by [date].  Monitor and improve process as needed.  Implement fully and accept as standard culture. | Target zero.  Ongoing compliance on CAUTI bundle (See strategies).  Report monthly progress to QAPI Committee and HSAG. |
| ***Clostridioides difficile* Infections (CDIs)** |  | 1. Monitor for positive labs and ensure prompt patient and staff notification of illness. 2. Ensure appropriate PPE and hand hygiene supplies are available for staff/patient/family use. 3. Increase contact isolation compliance by utilizing the isolation/*Clostridioides difficile* (*C. difficile)* bundle algorithm. 4. Assist with the design and implantation of a system-wide cleaning product initiative aimed at improving environmental and patient care equipment cleaning (utilizing a bleach-based cleanser at a 1:10 dilution). 5. Provide recurrent education for staff, patients, and their family members. 6. Provide recurrent education for environmental services staff, if necessary. 7. Involve pharmacy in the management of *C. difficile* patients so that appropriate treatment regimens are selected every time. This is in the form of automatic culture review and physician consultation. 8. Continue to stay informed on current national and international CDI literature and practice. | IPs  Managers  Staff  Providers  Administration | Continue current program with a focus on improvement each quarter [date].  Ensure full implementation of *C. difficile* bundle.  Streamline cleaning, products, and practices.  Hold physician consultation with pharmacy staff to ensure appropriate medication and antibiotic selection. | Target zero.  Ongoing compliance on CDI bundle (See strategies).  Report monthly progress to QAPI and HSAG. |
| **Antibiotic Stewardship** |  | 1. Implement the seven Core Elements of Antibiotic Stewardship in Nursing Homes.  * Collect data on antibiotic use. * Use antibiotic prescribing guidelines or therapeutic formularies. * Restrict use of specific antibiotics. * Communicate antibiotic use information when residents are transferred. * Review cases to assess appropriateness of antibiotic administrations. * Provide feedback to clinicians on antibiotic use and prescribing. * Provide educational resources for improving antibiotic use.  1. Continue to stay informed on current national and international antibiotic prescribing recommendations. 2. See additional detail in full CDC document. Available here: <https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html>. | IPs  Managers  Staff  Providers  Pharmacist  Leadership | Implement plan strategies by [date].  Monitor and improve processes PRN.  Implement fully and accept as standard culture. | Present goal is: Implement the seven Core Elements of Antibiotic Stewardship in Nursing Homes.  Elements 1, 2, and 3 by [target date].  Elements 4 and 5 by [target date].  Elements 6 and 7 by [target date].  Report monthly progress to QAPI Committee and HSAG. |
| **Vaccination** |  | 1. Ensure staff and residents are offered COVID-19, flu, and pneumonia vaccination per local, state, and federal guidelines.  * Assess and document healthcare worker and resident vaccination status * Prevent staff/resident infection exposure and illness. * Educate staff and residents on risks and benefits of vaccination. * Offer vaccination. * Require healthcare worker/resident to provide proof of vaccination or immunity against specific vaccine preventable disease.  1. Stay informed on current national and international vaccination recommendations, especially regarding COVID-19 vaccine development. 2. See additional detail in the full CMS and CDC documents.  Available here:   (CMS) <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/NHQIVaccinationSupplement.pdf>.  (CDC) <https://www.cdc.gov/vaccines/covid-19/toolkits/long-term-care/index.html> | IPs  Managers  Staff  Providers  Pharmacists  Leadership | Implement plan strategies by [date].  Monitor and improve process PRN.  Implement fully and accept as standard culture. | Achieve vaccination for flu/pneumonia/COVID-19 in the resident population of XX%  Achieve vaccination for flu/pneumonia/COVID-19 in the staff population of XX% |

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| **CLABSIs** | |  | 1. Monitor CLABSI Prevention Bundle Compliance:    * Comply with hand hygiene requirements.    * Chlorohexidine bathing daily.    * Scrub the hub prior to access with an approved antiseptic agent.    * Use only sterile devices to access catheters.    * Immediately replace dressings that are wet, soiled, or dislodged.    * Maintain aseptic technique during dressing change.    * Change administration sets for continuous infusions at least every seven days.      + More frequent changes may be necessary following certain infusions (example: blood).    * Document daily justification of central line need. 2. Periodically assess knowledge and adherence to bundle guidelines to ensure the care of central lines are consistent. 3. Ensure supplies are available to staff members caring for residents with central lines. 4. Provide ongoing education regarding facility-specific expectations of central-line care. | IPs  Managers  Staff | Implement plan strategies beginning [date]  Monitor and improve processes as needed.  Implement fully and accept as standard culture. | Target zero.  Ongoing compliance with CLABSI prevention bundle.  Report monthly progress to QAPI Committee and HSAG. |
| **Testing Residents and Healthcare Personnel for COVID-19 Infection** | |  | 1. Complete CMS sponsored COVID-19 training for front line staff members and management: <https://qsep.cms.gov/welcome.aspx> 2. Implement the CDC COVID-19 testing strategies for residents and healthcare personnel. 3. Facilities should have a plan for testing residents for SARS-CoV-2. 4. Testing practices should have a rapid turnaround time in order to facilitate effective interventions. 5. Perform initial baseline testing of each resident in the nursing home to drive infection control interventions and cohorting strategies. 6. Test residents based on daily assessment of COVID-19 signs or symptoms. 7. Test asymptomatic residents with exposure to an individual with COVID-19. 8. Stay informed on current national and international COVID-19 literature and practice. 9. Testing plan should align with state and federal requirements for testing residents and healthcare personnel for SARS-CoV-2. | IPs  Managers  Staff | Implement plan strategies by [date].  Monitor and improve processes as needed.  Implement fully and accept as standard culture. | [Target zero or Decrease] new confirmed nursing home-acquired COVID-19 cases in 2020 as reported to the CDC NHSN by [amount].  Ongoing compliance with COVID-19 testing strategies.  Report monthly progress to QAPI Committee and HSAG. |
| **Cohorting (COVID-19 Preparation)** |  | | 1. Complete CMS sponsored COVID-19 training for front line staff members and management: <https://qsep.cms.gov/welcome.aspx> 2. Implement the CDC COVID-19 control and mitigation strategies. 3. Create a plan to designate units to separate COVID-19 negative residents from COVID-19 positive residents and residents with unknown COVID-19 status. 4. Develop separate staffing teams to cover each separate unit consistently. 5. Educate when guidelines change regarding expectations of care. 6. Reinforce hand hygiene, transmission-based precautions, cohorting, and other best-practice interventions. 7. Ensure necessary care products are available to staff members (PPE, cleaning supplies, hand hygiene products, etc.). 8. Stay informed on current local and state COVID-19 literature and practice. 9. See additional detail in responding to COVID-19. Available at: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-52-Attachment-01.pdf> | IPs  Managers/ Supervisors  Staff | Implement plan strategies by [date].  Monitor and improve processes as needed.  Implement fully and accept as standard culture. | [Target zero or Decrease] new confirmed nursing home-acquired COVID-19 cases in 2020 as reported to the CDC NHSN by [amount].  Ongoing compliance with COVID-19 mitigation strategies. |
| **Safe Transfer  (COVID-19 Preparation)** | |  | 1. Complete CMS sponsored COVID-19 training for front line staff members and management: <https://qsep.cms.gov/welcome.aspx> 2. Implement the CDC COVID-19 control and mitigation strategies. 3. Educate annually, at hire, and when guidelines change regarding expectations of care. 4. Stay informed on current local and state COVID-19 literature and practice. 5. Staff will verbally communicate, especially isolation precautions to emergency medical services (EMS) and receiving facility. 6. Staff will complete an interfacility form. One can be   obtained at: <https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/HealthcareFacilityTransferForm112018.pdf>   1. See additional details in Los Angeles County  COVID-19 Interfacility Transfers & Home Discharge Guidelines. Available at: <http://publichealth.lacounty.gov/acd/NCorona2019/InterfacilityTransferRules.htm> | IPs  Managers  Staff | Implement plan strategies by [date].  Monitor and improve processes as needed.  Implement fully and accept as standard culture. | [Target zero or Decrease] new confirmed nursing home-acquired COVID-19 cases in 2020 as reported to the CDC NHSN by [amount].  Achieve compliance completing interfacility transfer form greater  than x%. |