

## **Infection Prevention and Control Plan – FY2023 (for CY 2022)**

### **I. Introduction**

The Infection Prevention and Control (IPC) Plan is a description of the multidisciplinary, systematic, coordinated approach developed by the University of Toledo Medical Center (UTMC) to reduce the risks of acquiring and transmitting infections among patients, employees, physicians and other licensed independent practitioners (LIP), contract employees, volunteers, students, and visitors.

### **II. Mission**

The mission of the UTMC IPC Program is to support UTMC by fostering a culture of patient safety, and by developing and implementing evidence-based strategies that reduce the risk of acquiring and transmitting infections through education, collaboration, and research.

### **III. Authority Statement**

The Infection Control (IC) Committee is a medical staff committee and shall have the authority under the medical staff bylaws to institute appropriate control measures when and if an infectious hazard is identified, or anticipated, that may affect any patient, employee, student, LIP, contract employee, volunteer, faculty, and/or visitor. The chairperson and the Infection Prevention staff shall be notified of the potential issue and shall confer with committee members as necessary to institute appropriate control measures. In their absence, an appropriate director or administrator shall assume responsibility for instituting control measures. The IC committee also has the authority for routine identification and analysis of the incidence and cause of infectious diseases within the hospital and shall develop and implement processes for the surveillance, prevention, and control of infectious disease.

### **IV. Program Goals**

The 2022 overarching goals for the IPC Program are aimed at improving patient safety by eliminating hospital-acquired infections (HAIs):

- a. Eliminate surgical site infections
- b. Eliminate device-related infections
- c. Eliminate transmission of infections
- d. Reducing risks of disease transmission related to SARS-CoV-2

### **V. Plan Components**

Several considerations are made to guide the activities of the program, including internal and external requirements and activities related to healthcare. Careful consideration is made based on internal and external surveillance activities from the preceding year. An IPC Risk Assessment for UTMC is completed at least annually to inform and establish program priorities. The IPC Plan is based upon the most current risk assessment (See attached 2022 Infection Control Plan Risk Assessment).

## **VI. Surveillance Activities**

- A. The activities related to infection prevention surveillance are based on the risk assessment of populations served at UTMC hospital, clinics, and Behavioral Health Services, high risk/high volume indicators, the Centers for Disease Control and Prevention (CDC) definitions of infections, and facility needs based on the annual assessment. County, state, and CDC emerging and reemerging disease reports, as well as reported outbreaks are taken into consideration when planning surveillance activities.
- B. Surveillance and prevention activities are designed to coordinate processes with the related patient care support departments/services (e.g., Family Medicine Clinic, Sterile Processing Department, Environmental Services, Linen and Laundry Services, Microbiology, Nursing Services, Environmental Health and Radiation Safety Department).
- C. Priority-directed, targeted surveillance is utilized and related to the scope of service. High volume and/or high frequency infectious complications, reoccurrence of previous infection prevention and control issues, and issues that have potential for significant adverse patient outcomes are included in the surveillance process.
- D. Utilizing the surveillance data-mining system, the IPC staff obtain laboratory relevant culture information from the microbiology system to assist in determining whether or not an infection has occurred and whether or not the infection was healthcare-acquired. In addition, the daily inpatient census is reviewed for current or potential infection-related issues. Methods for determining presence and classification of infection are based on national guidelines and definitions published by the CDC's National Health Safety Network (NHSN) program. Reports are generated by rate, count and NHSN standardized infection ratio (SIR) using national benchmarks.
- E. The Occupational Health Department uses the Occupational Health Manager system for tracking bloodborne pathogen exposures and employee vaccination status. COVID-19 vaccination status tracking is collected using UToledo Vaccine Registry site.

## **VII. Selected IPC Goals and Objective for FY 2022 (CY 2022)**

- A. Eliminate surgical site infections:
  - a. All identified surgical site infections (SSIs) are reviewed for evidence of a hospital-acquired infection and trends. Specific attention is paid to the following, with reporting of these surgical site infections into the NHSN Database:
    - i. Kidney transplant 2022 objective:
      - a) Decrease SIR below 2020 - CDC National Healthcare-associated Infection (HAI) Progress Report of 1.557
        - a. Transplantation of kidney

- ii. Spine surgeries 2022 objective:
    - a) Decrease SIR below 2020 - CDC National HAI Progress Report of 0.986
      - a. Spinal fusion or re-fusions
  - iii. Colon surgeries 2022 objective:
    - a) Maintain SIR below CMS established threshold of 0.717
  - iv. Abdominal Hysterectomy surgeries (including those done by laparoscope) 2022 objective:
    - a) Maintain SIR below CMS established threshold of 0.738
  - v. Knee prosthesis surgeries 2022 objective:
    - a) Decrease SIR below 2020 - CDC National HAI Progress Report of 1.053
  - vi. Hip prosthesis surgeries 2022 objective:
    - a) Decrease SIR below 2020 - CDC National HAI Progress Report of 0.977
  - vii. Other cases classified as clean 2022 objective:
    - a) Decrease rate to less than 2021 - UTMC clean case rate of 0.83/100 procedures
- B. Eliminate Hospital-acquired Device-related Infections
- a. Ventilator-associated events (VAE):
    - i. Definition: deterioration in respiratory status after a period of stability or improvement on the ventilator, evidence of infection or inflammation, and laboratory evidence of respiratory infection
      - a) VAE 2022 objective – decrease SIR below 2020 – CDC National HAI Progress Report comparison with “all locations” of 1.301
      - b) Ventilator-associated condition (VAC) 2022 objective – 10% reduction from 2021
      - c) IVAC Plus: Infection-related ventilator-associated complication (IVAC) and Possible ventilator-associated pneumonia (PVAP) combined 2022 objective – 10% reduction from 2021
        - a. Initiate early mobility program in collaboration with Nursing RT and PT
        - b. Monitor apparent cause analysis (ACA) for IVAC Plus
    - b. Central line-associated blood stream infections (CLABSI) 2022 objective – maintain SIR below CMS established threshold of 0.589
    - c. Catheter-associated urinary tract infections (CAUTI) 2022 objective – maintain SIR below CMS established threshold of 0.650
- C. Eliminate Transmission of Infections
- a. Assist in maintaining UTMC goal for mandatory vaccination of all healthcare workers for the 2021-2022 and 2022-2023 seasons:
    - i. Provide vaccine free-of-charge at various locations and times to 100% of all healthcare workers on the UTMC Health Science Campus. This includes employees, faculty, LIPs, volunteers, contract employees, vendors, and students

- ii. Personnel vaccinated with influenza vaccine will be identifiable by badge stickers
- iii. Personnel that received an approved exemption for current year will be required to wear a surgical mask according to manufacture recommendations while performing patient care and while in patient care areas during the designated flu season
- iv. Exemptions will be allowed, in accordance with the hospital's immunization policy, for those persons with valid medical or religious exemptions as determined by the exemption committee
- v. Record keeping will be tracked through Occupational Health electronic records system. Infection Prevention staff or other designees will report all vaccination data to CDC/NHSN as required
- b. Assist in increasing COVID-19 vaccinations for all UTMC healthcare workers as vaccination criteria expands according to the Ohio Department of Health
  - i. Provide vaccine free-of-charge to 100% of all healthcare workers on the UTMC Health Science Campus. This includes employees, faculty, LIPs, volunteers, contract employees, vendors, and students
  - ii. Exemptions will be allowed, in accordance with the hospital's COVID-19 vaccination and immunization policy, for those persons with valid medical or religious exemptions as determined by the exemption committee
  - iii. Personnel that received an approved exemption will be required to wear a N95 or NK95 mask according to manufacture recommendations while around others within the hospital and clinics
- c. Reduce exposure to sharps injuries in employees in order to assist with elimination of sharps injuries
- d. Prepare for the response to an influx of infectious patients
  - i. Continue enhanced COVID-19 surveillance activities for patients and staff
  - ii. Ensure COVID-19 protocols and policies are updated as standards change in conjunction with the CDC and Toledo-Lucas County Health Department
- e. Improve hand hygiene compliance – 2022 objective – achieve 90% observed compliance:
  - i. Continue to engage ancillary departments with hand hygiene monitoring and education
  - ii. Ensure new services to facility are incorporated with hand hygiene education and monitoring
  - iii. Continue to engage surgical services department with hand hygiene monitoring and education
  - iv. Increase hand hygiene observation to assist with Leapfrog initiatives
- f. Achieve compliance in use of High-level Disinfection (HLD)
  - i. Ensure 100% of competencies are completed annually for employees performing HLD
- g. Achieve compliance with proper point-of-use cleaning and instrument transportation
  - i. Ensure annual training is completed via the online safety test bank for 100% of employees responsible for point-of-use cleaning

- h. Participate in Pre-infection Control Risk Assessment (PRCA)/Infection Control Risk Assessment (ICRA) process and monitor compliance of containment of construction and renovation projects
  - i. Ensure IPC staff are involved with each construction project that meets any IC risk groups 1, 2, 3 or 4 while also meeting construction activity risk types A, B, C or D in the LS-08-008 Appendix B - ICRA Construction Permit
- i. Assure air and water quality by:
  - i. Monitoring compliance with air quality measures
    - a) Monitor pharmacy environmental cultures every 6 months
  - ii. Monitoring compliance with Facility water quality testing
    - a) Complete annual Legionella Risk Assessment
  - iii. Monitoring hemodialysis water and dialysate culture results
- j. Monitor blood cultures for contamination rate – 2022 objective- maintain overall contamination rate  $\leq 3.00\%$  for 2022
- k. Healthcare Facility-onset *C. difficile* 2022 objective – maintain SIR below CMS established threshold of 0.520
- l. Healthcare Facility-onset Methicillin-resistant *Staphylococcus aureus* bacteremia 2022 objective – maintain SIR below CMS established threshold of 0.726
- m. Work with staff and Staff Development Department to engage patients and families in isolation and multi-drug resistant organism educational needs
  - i. Collaborate with the EPIC team and use new electronic medical record to assist with education requirements for patients and family
- n. Monitor external regulatory compliance indicators, including, but not limited to, NHSN, CMS, NDNQI, ODH, FDA
- o. Reduce unnecessary device utilization (e.g., Foley catheters, central lines)
- p. Reduce readmissions by the prevention of hospital-acquired infections

## **VIII. Responsibilities for the Infection Control Program**

### **A. Medical Director for Infection Prevention and Control**

The Medical Director for IPC is an Infectious Diseases Physician, designated as Chairperson of the Infection Control (IC) Committee, and also serves on various hospital and medical staff committees as a representative for IPC. The Medical Director is responsible for leading the IC committee and for setting the agenda of the IPC Program.

### **B. Infection Prevention and Control Staff**

#### **a. Core responsibilities:**

- i. Core responsibilities and time allocations are: 30% allocated to surveillance monitoring, 20% allocated to education/prevention activities, 25% allocated to committee/task force-related issues, 20% allocated to management activities, and 5% allocated to policy review/literature research associated activities. This time appropriation fluctuates depending on the needs of the institution and issues affecting

clinical practice, changes in federal legislation, and any suspected outbreak occurrence.

- b. Education and training:
  - i. Employees of the IPC Department are required to have completed Master's level education or have at least 3 years of IPC experience in an acute care setting. It is also a requirement that Certification in Infection Control (CIC) through the Certification Board of Infection Prevention and Control (CBIC) board is obtained within two years of employment within the department.
  - ii. Education to support UTMC's IPC functions is incorporated into the activities of the department.
- c. The IPC Department notifies institutions transferring or receiving patients with infection, using the regional reporting form
- d. The IPC Department is actively engaged in unit rounding several times weekly and participate in environment rounds facilitated by Environmental Health and Radiation Safety department and Joint Commission Compliance officer.
- e. The IPC Department develops and maintains IPC Policies and Procedures that include the Bloodborne Pathogen and Tuberculosis Exposure Control Plans. As a medical staff committee, all policies are reviewed on a three-year cycle or more frequently if federal guidelines or practice indicate needed changes. All policies are based on current published literature. Policy reviews and/or revisions are documented in the IC Committee minutes.
- f. Wellness promotion activities are provided through Occupational Health with recommendations and approval of the IC Committee. Such services include Hepatitis B vaccination, Interferon-gamma release assay (IGRA) blood test, respiratory fit testing (coordinated with the Environmental Health and Safety Department), COVID-19 vaccination and influenza vaccination.

#### C. Nursing Directors and Department Heads

- a. Ensure that proper patient care safety practices and product safety are maintained in all patient care areas and departments
- b. Ensure that staff know where to locate the IPC website and online policies
- c. Formulate department-specific policies and procedures in coordination with pre-existing IPC Guidelines
- d. Coordinate, with the IPC Department, educational programs on IPC topics and document attendance
- e. Enforce IPC policies and procedures

#### D. Nursing Staff

- a. Consult, as needed, with the IPC Department concerning patient-related infections
- b. Resolve questions with the IPC Department concerning patient placement, isolation precautions practices, or infection control issues
- c. Assist in revision of IPC policies and procedures
- d. Assist in preparation of educational programs relevant to IPC

- e. Provide the patient with education and materials on infectious diseases and IPC practices
  - f. Attend annual training on IPC topics through the online safety test bank
- E. Medical Staff
- a. Initiate and discontinue isolation precautions in a timely and appropriate manner
  - b. Adhere to IPC policies and procedures
  - c. Attend annual training on required IPC topics through the online safety test bank
- F. Infection Control Committee
- a. A multidisciplinary committee oversees the program for surveillance, prevention and control of infection. Committee membership includes representatives from: medical staff, nursing, Laboratory, Respiratory Therapy, Pharmacy, Environmental Health and Radiation Safety, Facilities Management, Environmental Services, Occupational Health, Surgical Services, hospital administration and persons directly responsible for management of the infection surveillance, prevention, and control program. An up-to-date listing of committee members can be obtained from the Medical Staff Office.
  - b. All direct-care and support departments/services are included in the IPC Program. Patient care support departments/services, such as Family Medicine Clinic, Distribution Services, Environmental Services, Linen and Laundry Services, Laboratory, and Nursing Services are involved in the prevention and control of infections.
  - c. The IC Committee is a committee responsible to the Executive Committee of the Medical Staff. Its purpose is to monitor infection control practices and support the goals of the IPC Program. Additionally, this Committee provides epidemiological direction and consultation to patient-care staff.
  - d. The IC Committee, by virtue of the authority vested in its Chairperson by the Executive Committee of the Medical staff, has the authority to institute appropriate control measures when there is reasonable evidence of a danger to patients and personnel. That authority may be given to the designee of the Chairperson. That designee may be the Infection Control Staff or another physician acting for the Chairperson when the Chairperson is not available. The IC Committee meets at least quarterly as reflected in medical staff [policy 3364-87-13](#).
  - e. Under the direction of the Chairperson of the IC Committee, the Infection Preventionist or designee investigates all suspected outbreaks. This is done in collaboration with appropriate medical and administrative staff. Appropriate corrective actions are made, and findings are documented and reported to the IC Committee.
  - f. The IC Committee strives to reduce infection rates by employing continuous quality improvement activities. Any cluster of infections or suspected outbreaks of a disease or illness above the expected baseline level for inpatients

is brought to the attention of the IPC Department and the Chairperson of the IC Committee by active surveillance methods.

- g. The IC Committee appoints subcommittees for special project resolution.
  - h. As part of its duties, the IC Committee approves the annual goals and objectives based on the risk assessment. In addition, the following four factors are considered in the selection and design of the surveillance programs:
    - i. The surveillance process selected is continuous, ongoing, and effective
    - ii. Information obtained from surveillance activities improves patient care
    - iii. Assessment rates are evaluated and are epidemiologically valid
    - iv. Data are linked to the hospital-wide performance improvement activities
  - i. Data and recommendations are documented in the IC Committee minutes. Any unusual infections or rates that exceed threshold are reported immediately to the IC Committee Chairperson. The Chairperson/designee documents their findings and forwards them to the appropriate department director for investigation and correction.
  - j. The IC Committee approves the type and scope of surveillance activities. These activities minimally include: annual review of antibiotic susceptibility patterns of microbiology laboratory isolates, the quality indicators for each year, and the methods to collect data on these.
  - k. Definitions of infections are based on those established by CDC/NHSN and Ohio Department of Health. Consultation for unusual patterns or difficult cases will include the Chief of Infectious Disease or designee.
- G. Microbiology Lab
- a. Provides the attending physician or physician in charge of the patient with reports of all identified infectious agents. These reports are maintained in the patient's medical record.
  - b. Generates annual reports on the changes in antibiotic susceptibility patterns of culture isolates.
  - c. Notifies the IPC Department of positive cultures for *Mycobacterium tuberculosis*, Carbapenem resistance (CR) in organisms or other highly transmissible organisms.
  - d. Reports select isolates to the Ohio Department of Health according to state requirements.
- H. Immunology Lab
- a. Reports positive results that are to be reported to the Ohio Department of Health to the IPC Department with the exception of reactive HIV antibody screens. These screens are sent to the HIV Disease Intervention Specialist at the local health department for reporting and follow up.
- I. Quality & Clinical Safety Department
- a. Assists in the collection of data for post-operative surgical wound infections and device-related infections
  - b. Assists in entering findings into the IC software system



- c. Develops reports for review by the IC Committee and other interested committees

J. Occupational Health

- a. Revise policies to meet the recommendations of the CDC
- b. Implement the above-mentioned guidelines
- c. Implement the influenza program
- d. Manage the Exposure Program
- e. Monitor and report to the IC Committee Bloodborne Pathogen Exposure data

K. Environmental Health and Radiation Safety

- a. Monitor and report to the IC Committee Sharps Injury Data
- b. Assist with the Tuberculosis Control Plan and compliance with testing and monitoring
- c. Provide “Just-in-Time” training, testing and monitoring of CAPR/N95 use during a respiratory illness outbreak
- d. Coordinate emergency preparedness activities, planning and drills for max surge events, including those involving infectious disease
- e. Collaborate to conduct and complete mid-level and high-level PPE training for compliance of Infectious Disease Agent and Max Surge Plan for emerging pathogens

L. Home Health Services – Renee’s Survivor Shop

- a. Comply with UTMC’s IC policies and procedures as it relates to services available, including but not limited to:
  - i. Equipment cleaning
  - ii. Employee vaccinations
  - iii. Linen policy
  - iv. Hand hygiene
  - v. Employee work restrictions
  - vi. Bloodborne Pathogens and Tuberculosis Exposure Control Plans
  - vii. Infection Control Precautions
- b. Improve hand hygiene compliance – 2022 objective – achieve 90% observed compliance:
  - i. Ensure home health services (e.g., Renee’s Survivor Shop) is compliant with hand hygiene monitoring and submissions, and maintains a goal for compliance of 95% or greater

**IX. Orientation, Education and Coordination with Departments**

For patient care and employee health activities, mechanisms or processes exist that are designed to reduce the risks of healthcare associated infections. These mechanisms include:

A. Annual Training

Training is accomplished at three levels: at the time of hire, at the department level, and when assigned a position. IPC content is provided at all levels and is required for clinical staff on an annual basis.

#### B. Departmental Coordination

Support departments such as distribution services, environmental services, and linen/laundry services, and coordinate activities to prevent and control infections in consultation with the Infection Prevention Staff.

#### C. Sterile Processing and High-Level Disinfection (HLD) of Equipment

Sterile Processing Department (SPD) is responsible for processing and sterilization of surgical instrumentation and equipment. The Director of Surgical Services is responsible for the program that processes equipment that requires HLD. When HLD is not completed on site, instruments used and stored by the clinics and ancillary departments are sent to endoscopy for reprocessing. All reusable items that require sterilization are sent to SPD after use. All items are transported in facility-approved containers and accompanied by proper documentation. Point-of-use cleaning is completed in the area of instrument use prior to transportation. In instances when HLD processing is done on site, procedures are approved through the Director of Surgical Services and IPC. Departmental procedures address such issues as storage, reprocessing of disposable items by outside contractor, and quality assurance controls. All new reprocessing devices must be approved through the IC Committee and SPD or Director of Surgical Services, if HLD related.

#### D. Linen

- a. UTMC currently contracts with an off-site source for the processing of linens. Clean linen is delivered in such a way as to minimize microbial contamination from surface contact or airborne deposition. The linen is placed in a clean cart with a plastic liner, and the liner is closed and secured. The vehicle used for transport is cleaned between soiled and clean deliveries. (Refer to [Linen Processes Policy](#))
- b. The laundry service area is organized, equipped, and ventilated with positive pressure air flow to provide hygienically clean linen. The Linen Service Department is responsible for verifying that proper laundry plant practices and procedures are followed (Refer to [Linen Processes](#) policies).
- c. Representatives from Linen Services, Environmental Services, IPC Department or other designated individuals will conduct an annual on-site inspection of the laundry service plant. The inspection covers:
  - i. Laundry layout, separating clean linen processing areas from soiled linen areas
  - ii. Laundry ventilation to assure that there is positive/negative airflow from clean to soiled areas with adequate intake, exchange, and exhaust rate
  - iii. Documentation of laundry equipment, formulas and chemicals used in the washing process

- iv. Availability of adequate hand washing facilities and protective apparel for all laundry personnel
- v. Soiled linen collection process and quality assurance that it is collected in such a manner as to minimize microbial dissemination into the environment

#### E. Regulated Waste

The UT/UTMC Exposure Control Plan addresses the issue of regulated waste management in accordance with the Ohio Revised Code and the Occupational Safety and Health Administration (OSHA) and CDC requirements. The UT/UTMC Environmental Health and Radiation Safety Officer is responsible for the infectious waste stream and management of infectious waste manifests.

#### F. Safety Data Sheets (SDS)

All cleaning agents used by Environmental Services and other individuals are reviewed prior to use. SDSs are reviewed and the Environmental Services supervisors assure education on all new products. SDS are available online through the Environmental Health and Radiation Safety web page.

### **X. Bioterrorism Activity**

#### A. Monitoring

The IPC Department monitors patient admissions and laboratory data for extraordinary findings that may be evidence of biological weapon activities in the community. UTMC provides daily reports on Emergency Department and acute care admissions to the Toledo/Lucas County Department of Health at the online Health Monitoring Systems.

#### B. Response to bioterrorism events

In the event of a community event of a large magnitude, the IPC Department will work with the Environmental Health and Radiation Safety Manager to assure appropriate protective equipment is available to the staff. The IPC Department will communicate with the ED Director, Infectious Disease physician, and state and local health departments as needed, and provide support in monitoring the clinical lab results and reports. The IPC staff will serve as adjunct members of the Emergency Preparedness Committee of UT/UTMC.

#### C. Response to outbreaks

The IPC Department investigates all suspected outbreaks, under the direction of the Chairperson of the IC Committee and in collaboration with appropriate medical and administrative staff. Institutional bylaws authorize the Chairperson or his/her designate to take measures to control an outbreak.

#### D. Additional response information

For additional information, see the [Infectious Disease Agent and Max Surge Plan](#) located on the UTMC Environmental Health and Radiation Safety web page.

## **XI. Resources for Infection Prevention and Control Department**

### **A. Data management**

Management systems provide the healthcare-acquired infection risk reduction process with appropriate data analysis, interpretations, and presentations of findings. The IPC Department interfaces with the Microbiology Laboratory, Occupational Health, and Infectious Disease Physicians on a regular basis. The Safety Committee, Health Information Systems Department, Quality Management Department, and Risk Management Department provide support to the IPC Program. An electronic, web-based surveillance system is used by the IPC Department. In the event the lab computer or hospital computer systems are not functioning, test results will be available by phone as needed and may be faxed to Infection Prevention as needed.

### **B. Physical and educational support**

UTMC provides sufficient office space and equipment, statistical and computer support, and clinical microbiology and pathology laboratory services to support the infection surveillance, prevention and control program of the institution. Educational support is provided to the IPC Department.

## **XII. Tuberculosis Control Process**

A. Prevention of transmission of tuberculosis is a strong focus of the IPC Program at UTMC. While the risk in Ohio is epidemiologically low, as a major treatment center for HIV care, potential risk of exposure to *Mycobacterium tuberculosis* is a reality. Structural renovation, train-the-trainer fit testing programs, CAPR training and annual targeted IGRA screenings reflect efforts to minimize this risk. Additionally, an exposure control system is in place for possible exposure follow-up and is as follows:

- a. The Microbiology Lab immediately notifies the IPC Department of positive acid-fast bacilli smears
- b. Transmission-based Precautions are rapidly instituted, if needed, after evaluation and coordination by the clinical care team and Infection Prevention staff
- c. Occupational Health in conjunction with department managers and IPC oversee the investigation of possible staff exposure(s) and implement follow-up procedures, as outlined in the Tuberculosis Exposure Control Plan
- d. Communication with the local health department tuberculosis unit is employed on an as needed basis. Reference the UTMC Tuberculosis Control Plan for further details (located on the UTMC Infection Control website at [https://www.utoledo.edu/policies/utmc/infection\\_control/](https://www.utoledo.edu/policies/utmc/infection_control/) )

**XIII. ANNUAL REVIEW PROCESS**

The IPC Plan is updated annually, and as needed, and provides the roadmap for achieving IPC goals and objectives. The IPC Plan is supported by the UTMC Administration and the Board of Trustees.

Original Date: 1/91

Plan Revisions			
2/1992	10/1993	6/1995	5/1996
8/1996	1/1999	4/1999	5/2000
3/2002	10/2003	12/2004	05/2006
12/2007	12/2008	2/2010	2/2011
2/2012	4/2013	3/2014	1/2015
2/2016	2/2017	5/2017	8/2017
2/2018	2/2019	2/2020	2/2021
02/2022			

/s/

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Michael Ellis, M.D.  
Chair, Infection Control Committee

/s/

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Andrew Casabianca, M.D.  
Chief of Staff

/s/

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Michael Ellis, M.D.  
Chief Medical Office

2022 Infection Control Plan Risk Assessment

Potential Risks/ Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expect It	Likely	Maybe	Rare	Never	Catastrophic Loss (Life/ Limb/Function/ Financial)	Serious Loss (Function/ Financial/ Legal)	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
<b>Geography and Community</b>																
Affiliation to UT, Meningitis, Measles, Mumps, Rubella, TB *				1					2				3			6
Community Acquired MRSA		3								1				2		6
Seasonal Influenza			2					3							1	6
SARS CoV2	4						4								1	16
Cryptosporidium				1						1					1	1
Risk of Outbreak in Community*	4							2							1	8
<b>Healthcare Acquired Infections</b>																
Surgical Site Infections (SSI) CABG/CBGB & CABG/CBGC			2				4							2		16
SSI - HPRO/KPRO	4							3					3			36
SSI - FUSN	4							3					3			36
SSI - ABD HYST				1				3						2		6
SSI - COLO			2					3							1	6
SSI - Solid Organ Trans- Kidney		3					4						3			36
SSI - DaVinci Assist				1				3						2		6
PVAP in ICUs		3						3						2		18
CLABSI House wide			2					3							1	6
CAUTI House wide			2						2						1	4
C. diff infection House wide			2					3							1	6
Dialysis Related Infections				1				3						2		6
Fungal Pneumonia				1					2						1	2
Outbreak			2					3							1	6
Sentinel Event				1						1			3			3
Other - HAI				1						1					1	1

2022 Infection Control Plan Risk Assessment

Potential Risks/ Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expect It	Likely	Maybe	Rare	Never	Catastrophic Loss (Life/ Limb/Function/ Financial)	Serious Loss (Function/ Financial/ Legal)	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
<b>Antibiotic Resistant Organisms</b>																
MRSA (HA)		3						3						2		18
MRSA Bacteremia (HA)			2					3				3				18
VRE (HA)				1				3					2			6
ESBL			2					3					2			12
OtherABX Resistant Gram Negative bacteria		3						3					2			18
<b>Communication/Education</b>																
Absence of notification of presence of MDRO (internal transfer)			2						1				2			4
Deficit Education of staff, LIP			2						2			3				12
Deficient Education of patients and families		3						3					2			18
<b>Failure of Prevention Activities</b>																
Deficient Hand Hygiene		3							2				2			12
Deficient compliance with IHI Central Line Insertion Guidelines				1				3					2			6
Deficient compliant with IHI VAP bundle			2					3					2			12
Improper Respiratory Hygiene/ Cough Etiquette				1					2					1		2
Deficient Patient Influenza Immunization				1						1			2			2
Deficient Early Recognition of Potential Infections			2							1			2			4
Blood Culture Contamination			2					3					2			12
<b>Isolation Activities</b>																
Deficient Standard Precautions			2						2				2			8
Deficient Transmission Based Precautions			2					3						1		6

2022 Infection Control Plan Risk Assessment

Potential Risks/ Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expect It	Likely	Maybe	Rare	Never	Catastrophic Loss (Life/ Limb/Function/ Financial)	Serious Loss (Function/ Financial/ Legal)	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
<b>Occupational Health</b>																
Deficient Staff Influenza Immunization				1						1					1	1
Exposure to Potential Bloodborne Pathogens		3							2				2			12
Exposure to Tuberculosis				1						1			2			2
Risk of Unknown Level of Communicable Disease Among Employees (e.g., measles,		3							2				2			12
Exposure to Pertussis				1						1					1	1
LIP Screening (lack of)			2						2				2			8
BSL 3 exposure				1			4								1	4
<b>Hospital Environment/ Construction</b>																
Contaminated dialysis water system				1				3							1	3
Legionella Disease				1				3					3			9
Infection from Inadequate Air Handling in the OR		3							2				2			12
Problems with Cleaning/ Disinfection		3							2				2			12
Improper cleaning of environment		3							2				3			18
Improper medication/vaccine storage				1					2						1	2
Contamination/ Infection from Pharmacy Environment					0			3							1	0
Ineffective preconstruction IC planning		3							2				3			18
Infection Related to Construction/ Renovation				1					2				3			6
Water Intrusion	4								2						1	8



**2022 Infection Control Plan Risk Assessment**

Potential Risks/ Problems	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expect It	Likely	Maybe	Rare	Never	Catastrophic Loss (Life/ Limb/Function/ Financial)	Serious Loss (Function/ Financial/ Legal)	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
<b>Supplies and Equipment</b>																
Improper cleaning or disinfection of equipment between patients		3						3						2		18
Improper High Level Disinfection of Equipment/Devices				1					2						1	2
Infection from Inadequate Sterilization			2				4								1	8
<b>Emergency Management</b>																
Emerging Pathogens (e.g. MERS, avian influenza)		3					4								1	12
Mass Casualty			2			5						3				30
Exposure to Bio-terrorism Agents - proximity to airport				1		5									1	5
Exposure to seasonal influenza/ Other Respiratory Infections				1			4								1	4
<b>New Services /Programs</b>																
New Programs	4								2					2		16
New Procedure	4							3							1	12
<b>Renee's Survivor Shop</b>																
MDROs				1						1					1	1
Parasites				1						1					1	1

The Infection Control (IC) Risk assessment grid is a visual tool to develop IC program priorities and stratify infection risks based on our geography, location in the community, our patient population and the review of our previous IC data analysis. The annual IC Plan is developed based on these risks.

The IC Risk assessment is an ongoing, continual process. A more focused review is done on an annual basis after reviewing the quarterly and annual reports with the Infection Control Committee.

Risk Assessment Completed On: 2/8/2022

Present (list names):  
 Ann Keegan                      Melissa Ahrens                      Samantha Eitinear  
 Mark Eckhart                      Heather Lorenz                      Pallavi Yadav  
 Dr. Michael Ellis                      Michelle Mallett                      Arlene Fell  
 Heather Byrd