Top 10 Infection Control Deficiencies

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Mountain-Pacific Quality Health

Top 10 Infection Control Deficiencies According to Your Peers

This information sheet features the top infection control deficiencies identified by infection preventionists and suggestions on how to remediate each issue. Visit www.mpqhf.org/QIO/ to access Mountain-Pacific's nursing home tools and resources.

Need to access the guide on your phone or tablet? Scan the QR code on the right.

Deficiency	Remedy
1. Failure to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations	Health care personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: • Immediately before touching a patient • Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices • Before moving from work on a soiled body site to a clean body site on the same patient • After touching a patient or the patient's immediate environment • After contact with blood, body fluids or contaminated surfaces • Immediately after glove removal Health care facilities should: • Require health care personnel to perform hand hygiene in accordance with CDC recommendations. • Ensure health care personnel perform hand hygiene with soap and water when hands are visibly soiled. • Ensure supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand

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Deficiency	Remedy
	rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands. Read more: https://www.cdc.gov/handwashing/handwashing-healthcare.html
2. Lack proper source control for community transmission level	Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing or coughing. Read more: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
3. Failure to select appropriate personal protective equipment (PPE) for transmission-based precaution	Use PPE whenever there is an expectation of possible exposure to infectious material or pathogen. **Transmission-based precautions** are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Read more: https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html. **COVID-19 PPE** Contact and droplet precaution PPE are recommended for health care workers before entering the room of suspected or confirmed COVID-19 patients. Health care workers should be trained on the correct use of PPE, including how to put it on and remove it. Extended use and re-use of certain PPE items such as masks and gowns can be considered when there are supply shortages. Health care workers should: • Use a medical mask (at least a surgical/medical mask) • Wear eye protection (goggles) or facial protection (face shield) • Wear a clean, non-sterile, long-sleeve gown • Use gloves **Audit PPE Use** Starts with competency-based training and regular audits to monitor adherence to PPE. Audits should include: • Appropriate selection • Donning • Doffing • Hand hygiene • Environmental contamination • Evaluation of appropriate supplies and equipment

Deficiency	Remedy
	• Proximity of supplies to point of use Aggregate data can be provided to identify opportunities for improvement. Sample tools: • LeadingAge: https://leadingage.org/wp-content/uploads/drupal/Audit%20PPE%20COVID19%20donning%20and%20doffing.pdf • Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov/sites/default/files/wysiwyg/nursing-home/materials/observational-audits.pdf • CDC: https://www.cdc.gov/infectioncontrol/pdf/strive/PPE104-508.pdf PPE use in health care settings, CDC: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pd Sequence for donning and removing PPE, CDC: http://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf
4. Failure to disinfect resident's personal devices, such as wheelchairs	Properly handle, clean and disinfect patient care equipment and instruments/devices. Dedicated medical equipment should be used when caring for a patient with a suspected or confirmed COVID-19 infection. Read more: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
5. Failure to adhere to laundry control measures	Determine whether staff handle, store and transport linens appropriately including, but not limited to: • Using standard precautions (e.g., gloves, gowns when sorting and rinsing) and minimal agitation for contaminated linen • Holding contaminated linen and laundry bags away from his/her clothing/body during transport • Bagging/containing contaminated linen where collected, and sorted/rinsed only in the contaminated laundry area (double bagging of linen is only recommended if outside of the bag is visibly contaminated or is observed to be wet on the outside of the bag) • Transporting contaminated and clean linens in separate carts. If this is not possible, the contaminated linen cart should be thoroughly cleaned and disinfected per facility protocol before being used to move clean linens Transport clean linens using methods that ensure cleanliness, (e.g., protected from dust and soil) • Ensuring mattresses, pillows, bedding and linens are maintained in good condition and are clean

Deficiency	Remedy
	• If a laundry chute is in use, laundry bags are closed with no loose items In laundry rooms, determine whether staff: • Maintain/use washing machines/dryers according to the manufacturer's instructions for use • If concerns arise, request evidence of maintenance log/record • Use detergents, rinse aids/additives and follow laundering directions according to the manufacturer's instructions for use Read more: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
6. Failure to prevent cross-contamination during COVID-19 testing	• Designate clean/dirty spaces for COVID-19 testing to prevent surface contamination. • Before engaging with patients, and while wearing a clean set of protective gloves, distribute individual swabs from the bulk container into individual sterile disposable plastic bags. • Use a new pair of gloves each time a specimen is collected from a different person. If specimens are tested in batches, also change gloves before putting a new specimen into a testing device. Doing so will help to avoid cross-contamination. If bulk-packaged swabs cannot be individually packaged: • Use only fresh, clean gloves to retrieve a single new swab from the bulk container. • Close the bulk swab container after each swab removal and leave it closed when not in use to avoid accidental contamination. • Store opened packages in a closed, airtight container to minimize contamination. • Keep all used swabs away from the bulk swab container to avoid contamination. • As with all swabs, only grasp the swab by the distal end of the swab, using gloved hands only. Disinfect surfaces within six feet of the specimen collection and handling area at these times: • Before testing begins each day • Between each specimen collection • At least hourly during testing • When visibly soiled • In the event of a specimen spill or splash • At the end of every testing day • Decontaminate the instrument after each use

Deficiency	Remedy
	Read more: https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html
7. Failure to use correct disinfection solution for type of pathogen/infection and contact time, failure to disinfect between patient use for point-of-care devices and failure to apply correct contact time	Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an Environmental Protection Agency [EPA]-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in health care settings, including those patient-care areas in which Aerosol-Generating Procedures (AGPs) are performed. • Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a *difficile* sporicidal agent is recommended to disinfect the rooms of patients with *C. difficile* infection). Read more: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Flong-term-care.html
8. Failure to identify symptoms of COVID-19 and follow prevention strategies	Establish a process to make staff aware of recommended actions to prevent transmission to others if they meet any of the following three criteria: 1) A positive viral test for COVID-19 2) Symptoms of COVID-19 (see below) 3) Close contact with someone with COVID-19 infection (for patients and visitors) or a higher-risk exposure (for health care personnel) Instruct staff to report any of the three above criteria to occupational health or another point of contact designated by the facility so these staff can be properly managed. The clinical presentation of COVID-19 ranges from asymptomatic to severe illness, and COVID-19 symptoms may change over the course of illness. Symptoms can overlap with those of other viral respiratory illnesses. Because symptoms may progress quickly, close follow-up is needed, especially for older adults, people with disabilities, people with immunocompromising conditions and people with medical conditions that place them at greater risk for severe illness or death. People with COVID-19 may be asymptomatic or experience one or more of the following symptoms: • Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigue

Deficiency	Remedy
	• Myalgia (Muscle or body aches) • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea **General Infection Prevention Education** • Infection prevention and control (IPC) education completed upon hire and annually for infection control (chain of infection, hand hygiene, bloodborne pathogens and exposure). • Each facility must have a designated infection control practitioner. Learn more in Centers for Medicare & Medicaid Services (CMS) Memorandum Ref:QSO-19-10-NH: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-10-NH.pdf **CDC Train: Module 1: IPC Program Policies and Procedures: Education & Training** • Education and training provided on hire, at least annually and whenever policies and procedures are revised. • Training should be job-specific and appropriate to the staff's learning style, background and knowledge. • Assessment of competency to verify knowledge, skills and understanding. • Ideally incorporate both knowledge-based testing and direct observation. Read more**:** • CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html • Quality, Safety & Education Portal (QSEP) https://qsep.cms.gov/
9. Failure to achieve infection control performance improvement metrics (policy, audits, healthcare-associated infection rate, antibiotic stewardship)	Regular audits to monitor adherence to PPE should be performed and include: • Appropriate selection • Donning • Doffing • Hand hygiene • Environmental contamination • Evaluation of appropriate supplies and equipment • Proximity of supplies to point of use

Deficiency	Remedy
	Aggregate data can be provided to identify opportunities for improvement. Read more in CMS Memorandum Ref: QSO-21-08-NLT at https://www.cms.gov/files/document/qso-21-08-nltc-revised.pdf, revised 02/04/2022 and 09/26/2022 Resources: • LeadingAge: https://leadingage.org/wp-content/uploads/drupal/Audit%20PPE%20COVID19%20donning%20and%20doffing.pdf • AHRQ: https://www.ahrq.gov/sites/default/files/wysiwyg/nursing-home/materials/observational-audits.pdf • CDC: https://www.cdc.gov/infectioncontrol/pdf/strive/PPE104-508.pdf
10. Failure to provide visitor notification of infection control practices	Ensure everyone is aware of recommended IPC practices in the facility. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can let help ensure people know that they reflect current recommendations. Read more: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Flong-term-care.html Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19 or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent, in-person visitation until they meet CDC criteria for health care settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC health care guidance (e.g., cannot wear source control). Learn more in CMS Memorandum Ref: QSO-20-39-NH at https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf, revised 09/23/2022.