Ready for an infection control survey?

Infection control in ambulatory surgery centers (ASCs) is under the microscope. The Department of Health and Human Services announced in July 2009 it is funding infection control surveys in more than 125 ASCs in 12 states by September 30, 2009. Additional funds were coming in October.

Surveyors will be armed with detailed new guidelines from the Centers for Medicare and Medicaid Services (CMS). The guidelines are intended to help them assess compliance with the revised ASC Medicare Conditions for Coverage (CfCs) effective in May 2009.

The Accreditation Association for Ambulatory Health Care (AAAHC) is expanding its infection control standards. Proposed revisions for its 2010 accreditation handbook include a dedicated chapter on infection control (www.aaahc.org).

What to expect

The CMS interpretive guidelines include 11 pages of infection control requirements plus a 16-page worksheet for surveyors to use in judging compliance.

In the major requirements, surveyors will check for an organized infection control program based on national guidelines and directed by a trained health care professional (sidebar).

Surveyors will check for compliance primarily by observation. They will also interview staff. In some cases, the guidelines state, the interviews may provide sufficient evidence for citing a deficiency. Surveyors will observe at least 1 surgery during the site visit, unless no procedures are scheduled during that time. If the facility does mostly short procedures, such as colonoscopy, surveyors may observe 2 procedures.

They will also conduct patient tracers like those in accreditation surveys. In a tracer, the surveyor identifies at least one patient and follows the case from admission through discharge to observe practice.

The best way ASCs can prepare is to know the major infection control guidelines. “And make sure you have someone in the role of infection control coordinator who has been trained,” advises Lynn Cromer, RN, MT, CIC, chair of the communications committee for the Association for Professionals in Infection Control and Epidemiology (APIC) and a consultant with the Duke University Infection Control Outreach Network, Durham, North Carolina.

What type of training?

The interpretive guidelines say the person who directs the infection control does not need to be certified in infection control but must have docu-
mented training. The guidelines are not specific about the training. Cromer says surveyors are likely to look for 2 major aspects:

- Has the designated person been specifically trained in infection control?
- Does the person know what an infection control program should include, and is the person implementing that program?

APIC and others offer basic courses. (See Resources.)

How much time the person should devote to infection control depends on the size and complexity of the facility.

“There is no cookie-cutter infection preventionist role,” Cromer says.

Often, smaller ASCs rely on a nurse who also has other responsibilities. A large facility or one with multiple sites may need a full-time infection control director.

**Educating staff**

Managers also need to make sure the staff is educated about the latest infection control guidelines. Staff need to follow the guidelines consistently and be prepared to be questioned by surveyors. Education must include not only nursing staff but also the medical staff, other direct-care staff, sterilization and disinfection personnel, and cleaning staff. Education must be conducted on hire or on granting of privileges and in regular refreshers.

Making sure the staff has the latest information is a challenge because most ASCs can’t afford a dedicated educator, says Bruce Bardall, RN, BSN, MS, CNOR, national director of clinical services for National Surgical Care, an ASC management company based in Dallas.

Internet-based training is a good option, he says, because the staff can complete it as they have time. One source is www.claritynet.com, which has programs that can be customized.

At Lakeshore Surgicare in Chester, Indiana, Donna Tang, RN, BSN, CNOR, the quality improvement coordinator, finds it’s helpful to focus on one infection control topic each month and give contact hours. She’s offered an APIC program on DVD as well as regular “lunch and learn” sessions.

How do you make sure the staff is ready for a survey? Bardall suggests making rounds to observe practice.

“I like to observe every day for breaks in practice,” he says. Any lapses can be addressed immediately and the staff member coached on the spot.

He prefers that approach to having the staff practice tracers because the staff is likely to exhibit model behavior during a practice session rather than what they do every day.

**Monitoring for infections**

An essential element of the infection control program is a system for identifying infections that may be related to the ASC’s procedures. Surveyors will ask:

- how the ASC obtains information on infections
- whether infection tracking is documented
- whether the ASC has a policy and procedure for complying with state notifiable-disease reporting.

There are multiple ways of tracking for infections, Cromer notes. Some ASCs send surgeons a monthly letter listing the patients they have treated in the past 30 days. The letter may have checkboxes to mark Yes or No for any infections and include a self-addressed stamped envelope. Any infections are recorded by the infection control coordinator and investigated.
Other ASCs call patients 30 days after surgery to ask for this information.  
Depending on the facility’s size, Cromer says, surveillance may include all patients or target different groups, for example, focusing on a different procedure or specialty each month.

**The right focus?**

Some ASC managers question whether the focus on infection control surveys is misplaced. They think ASCs should be judged on their outcomes, such as low infection rates, rather than on following every infection control guideline to the letter. They worry changes needed to comply could affect their efficiency and cost-effectiveness. They are also concerned state surveyors might not understand clinical practice.

Said one manager, “We have the evidence to say we don’t have an infection control problem,” noting the center’s rate is less than 0.1%. “But we are starting to feel that this evidence doesn’t matter. We will have to go back to practices we used years ago.”

The ASC Association reports that the majority of ASCs in its voluntary Outcomes Monitoring Project routinely report infection rates of less than 1%. For the first quarter of 2009, 651 ASCs submitted infection data. There are an estimated 5,000 ASCs in the US.

**Know the guidelines**

An example of a practice that may have to change is using Diprivan (propofol) vials labeled for single use for multiple patients, even though the drug is drawn up aseptically using a sterile needle and syringe for each patient. Another example is spiking IV bags and setting up tubing the night before for the next day’s cases. Both help save minutes and dollars.

Cromer responds: “I understand what ASCs are saying from a cost and efficiency standpoint. But there are cases in the literature for things being done in a certain way.” She added that managers can get more buy-in from the staff and physicians when they share the literature supporting a recommendation and explain the rationale.

Diprivan, for instance, is labeled by its manufacturer, AstraZeneca, for single-patient use. The product insert notes that propofol has no preservatives and can support growth of microorganisms. There have been reports in the literature of postoperative infections. The Centers for Disease Control and Prevention issued its Safe Injection Practices in 2007 after investigating 4 large outbreaks of hepatitis infection in outpatient clinics. The main breaches were reinsertion into multi-dose vials or using a single needle or syringes to give IV medications to multiple patients. A 2008 report cited more than 600 reports of hepatitis C transmission in health care settings over 15 years, most from unsafe injection practices.

Cromer reiterates that knowing the infection control guidelines and their rationale is one of the best ways managers can prepare for surveys. That can help them respond to a surveyor who does not seem to understand clinical practice. It’s also one of the best ways to ensure the ASC’s practice is safe.

—Pat Patterson

The CMS Interpretive Guidelines for Ambulatory Surgical Centers are available at http://ascassociation.org/coverage/
The infection control worksheet is Exhibit 351, located at the end of the guidelines.
References

What’s behind the surveys?
The Government Accountability Office (GAO) recommended in a February 2009 report that HHS develop a plan for random infection control surveys in ASCs. The report outlined several concerns.

First, 43% of surgery in the US is performed in ASCs, yet the GAO noted there is no national infection reporting mechanism for freestanding facilities.

Second, though experts consider infection risks in ASCs to be low, a few widely publicized incidents have occurred, such as reuse of syringes and medication vials in an endoscopy center in Nevada, reported in 2008. Thousands of patients were tested for HIV and hepatitis, with 6 cases identified.

In addition, the GAO says pilot surveys in Maryland, Oklahoma, and North Carolina in 2008 found some “serious lapses,” such as failures to reprocess equipment properly. The findings have not been published.

The ASC Association says the reason surgery centers have not been a focus for government surveys in the past is because they have been considered low-risk.

“We have to keep educating policy makers that the rate of infections in ASCs is extremely low. All of the data from our outcomes monitoring shows that,” the association’s president, Kathy Bryant, said at the group’s annual meeting in the spring. She urged ASCs to demonstrate their quality and safety in the surveys.

Infection control resources

ASC Association
Conditions for Coverage
Compliance Resources

Spiral-bound book with Medicare’s interpretive guidelines, a document highlighting changes in the revised Conditions for Coverage, and more.

$55. Phone 703/836-8808 or download order form at: http://ascassociation.org/Publicationsorderform.pdf

Association for Professionals in Infection Control and Epidemiology (APIC)

- Ambulatory care resources
  — www.apic.org
  Look under Member Services, then Ambulatory Care.
- Training course: Infection Prevention for Ambulatory Care
  November 6-7, 2009, Dallas.
  — www.apic.org
  Look under Education & Certification.
Medicare guidelines: Infection control

Under Medicare’s interpretive guidelines for state surveyors who will review compliance with the ASC Conditions for Coverage, the infection control program must have these elements:

• provide a functional and sanitary environment for surgical services to avoid sources and transmission of infections and communicable diseases
• be based on nationally recognized infection control guidelines
• be directed by a designated health care professional with training in infection control
• be integrated into the ASC’s quality assurance/performance improvement (QAPI) program
• be ongoing
• include actions to prevent, identify, and manage infections and communicable diseases
• include a mechanism to immediately implement corrective actions and preventive measures that improve the control of infection within the ASC.

Infection control guidelines

Surveyors will check that the ASC has considered these nationally recognized guidelines for its infection control program:

• CDC/HICPAC Guidelines:
  —Guideline for Isolation Precautions
  —Hand hygiene
  —Disinfection and Sterilization in Healthcare Facilities
  —Environmental Infection Control in Healthcare Facilities
• AORN: Perioperative Standards and Recommended Practices
• Guidelines from surgical specialty societies and organizations.

Infection control and related practices

The surveyor worksheet includes specific questions in the following areas:

• hand hygiene
• injection practices
• single-use devices, sterilization, and high-level disinfection
• environmental infection control (such as cleaning of ORs, high-touch surfaces, and decontamination of gross spills of blood)
• point-of-care devices (ie, blood glucose meters).

Source: CMS. Interpretive Guidelines for Ambulatory Surgical Centers. The guidelines are available at http://ascassociation.org/coverage/

The CDC guidelines are at www.cdc.gov/ncidod/dhqp/index.html