COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

This instruction supplements Air Force Policy Directive (AFPD) 44-1, *Medical Operations.* It defines personnel's roles and responsibilities in efforts to mitigate the risks of healthcare-associated infections within all healthcare settings and reduce the spread of infections to patients, visitors, volunteers and personnel. This instruction applies to all Air Force military (Active Component, Reserve, and Air National Guard) and Civil Service personnel and other medical personnel attached to or assigned to a unit with a medical or aeromedical evacuation mission. This AFI may be supplemented at any level, but all supplements that directly implicate this publication must be routed to the Office of Primary Responsibility (OPR) for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the OPR using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of command. The authorities to waive wing/unit level requirements in this publication are identified with a Tier (T-0, T-1, T-2, T-3) number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) Air Force Manual 33-363, *Management of Records*, and disposed of IAW Air Force Records Disposition Schedule located in the Air Force Records Information Management System. The use of the name

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SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include: The elimination of redundancies found throughout the publication; the inclusion of nationally recognized guidelines found in **Attachment 1**; the merging of **Chapter 6** and **Chapter 7** into one chapter; addition of a new chapter on reprocessing reusable medical devices; the deletion of **Attachments 2**, 4, 5, and 6; and the renaming of Chapters 2, 3, 4, 6, and 7.

Chapter 1

OVERVIEW.

1.1. Infection prevention and control (IPC): touches all facets of healthcare. It starts with the basic concept of hand hygiene, to the more complex practice of instrument sterilization and endoscope high level disinfection. IPC demands a basic understanding of the epidemiology of diseases; risk factors that increase patient susceptibility to infection, the practices, procedures and treatments that may result in infections. Support from all levels within the Air Force Medical Service (AFMS) of infection prevention and control programs (IPCP) is necessary to prevent the transmission of communicable diseases and to reduce or eliminate healthcare associated infections in our military treatment facilities (MTF).

1.2. The AFMS is dedicated to: preventing and controlling the transmission of healthcare associated infections to patients, healthcare workers, visitors and others. This publication provides instruction and guidance, to help achieve and maintain an effective IPCP while embracing a culture of "Trusted Care" (the Air Force Medical Service's brand for practicing High Reliability principles).

Chapter 2

GENERAL ROLES AND RESPONSIBILITIES IN ACTIVE COMPONENT MILITARY TREATMENT FACILITIES (MTF).

2.1. Air Force Surgeon General (AF/SG):

2.1.1. Establishes comprehensive IPC instructions, standards of care practices and interdisciplinary core competencies.

2.1.2. Appoints a headquarters-level Infection Preventionist (IP) to oversee the IPCP.

2.1.3. Monitors MTF infection prevention and control improvement action plans.

2.1.4. Reviews and updates current medical service doctrine and training plans to incorporate procedures in the Defense Health Agency Procedural Instruction 6200.01, *Comprehensive Infection Prevention and Control Program, Enclosure 3*.

2.2. Chief, IPC Air Force Medical Operations Agency (AFMOA/SGHQ):

2.2.1. Provides evidence-based clinical consultation on standards of care and practices related to IPC. (T-1)

2.2.2. Liaises with the Defense Health Agency (DHA), military services, and other entities to develop policies, promote leading practices, and facilitate process improvements. (T-1)

2.2.3. Develops, updates, and disseminates Air Force IPC guidance and instructions via print, teleconferences, conferences, and electronic media. (T-1)

2.2.4. Maintains the Management Internal Control Toolset (MICT) and Self-Assessment Communicators (SAC) for this instruction. (T-1)

2.2.5. Collaborates with the DHA, AF/SG1/8 and AFMOA/SGA to coordinate resources and support to military treatment facility IPCPs. (T-1)

2.3. Medical Inspection Directorate, Air Force Inspection Agency (HQ AFIA/SG). Assesses and verifies MTF, Air Force Reserve Command (AFRC) and Air National Guard (ANG) IPCPs, internal inspection processes. In addition, Active Component MTFs are inspected by The Joint Commission.

2.4. Surgeon General, Major Command (MAJCOM/SG). In conjunction with AFMOA, allocates funds, equipment and personnel to MTFs, AFRC and ANG medical units.

2.5. Program Director of Epidemiology, Prevention and Infection Control (EPIC) Courses (Medical Education and Training Campus / 59th Training Group):

2.5.1. Collaborates with AFMOA/SGHQ on development of IPCP guidance and deployment of allocated resources to support the program.

2.5.2. Assists with teleconferences, site visits and consultation requests. (T-1)

2.6. Commander or Director, Military Treatment Facility (MTF/CC).

2.6.1. Enhances the delivery of "Trusted Care"; establishes the Infection Prevention and Control Function (IPCF), which will consist of a multidisciplinary functional area team. (T-1)

2.6.1.1. Commanders at limited-scope MTFs may choose to not have an IPCF. In such cases, the Commander <u>must</u> ensure the IPCP items identified in the Annual Plan are addressed at least quarterly at the Executive Committee of the Medical Staff (ECOMS), or Executive Committee meeting.

2.6.1.2. Appoints in writing a credentialed and privileged provider to serve as the clinical authority and Chairperson of the IPCF (e.g. physician, dentist, nurse practitioner, or physician's assistant). (T-1)

2.6.2. Appoints in writing the IP to manage the IPCP. When the primary IP is not available for periods greater than three months, MTFs will appoint an alternate IP per the qualifications listed in 2.8.1. (T-1)

2.6.3. Publishes an MTF-specific IPCP operating instruction. (T-1)

2.6.4. Provides resources and training to support the IPCP. (T-1)

2.7. Chairperson, Infection Prevention and Control Function.

2.7.1. Executes clinical authority over the IPCP. (T-1)

2.7.2. Oversees the development and implementation of policies governing control of infections and communicable diseases. (T-1)

2.7.3. Attends the EPIC Chairperson course within six months of being assigned to the position. Exception: if board certified in infectious diseases or infection control. (T-1)

2.8. Infection Preventionist.

2.8.1. The IP will be an officer, or a civilian equivalent, who has a minimum of three years of clinical experience in their specialty (e.g., nursing, dental, laboratory, medical) and will remain in position at least two years after attending IP formal training. (T-1)

2.8.2. Reports to the Chief Medical Officer (SGH), or designee, in performing IP duties. (T-3)

2.8.3. Manages day-to-day IPC activities.   (T-1)

NOTE: If IP role is an additional duty, selected member will devote a minimum of eight (8) hours a week to the IPCP. (T-3)

2.8.4. Performs an annual self-inspection using the MICT, SACs, The Joint Commission's *Comprehensive Accreditation Manual*, and other relevant guidance. (T-1)

2.8.5. Conducts a MTF infection control risk assessment (ICRA) annually and when significant change to risk occurs. Risks will be prioritized according to probability and the potential for harm. **Attachment 2**, *Infection Prevention and Control Risk Assessment*, may be used to develop the risk assessment. (T-1)

2.8.6. In collaboration with the Chairperson, develops the IPC Annual Plan and Annual Summary. Uses the ICRA findings to draft the plan and updates as needed. (T-1)

2.8.7. Conducts surveillance as indicated in the Annual Plan or as required by the Air Force Medical Service and the DHA. (T-1)

2.8.7.1. Collects, manages, and analyzes surveillance data using standardized methodology and definitions per the Centers for Disease Control and Prevention's (CDC) guidelines and National Healthcare Safety Network (NHSN). (T-1)

2.8.7.2. Utilizes various information systems for surveillance activities. This includes but is not limited to: Armed Forces Health Longitudinal Technology Application, Composite Healthcare System, NHSN, Surgical Scheduling System, electronic healthcare records, and Defense Medical Logistics Standard Support (DMLSS). (T-1)

2.8.8. Monitors infectious diseases and epidemiologically significant organisms occurring in the community via laboratory and public health reports. (T-1)

2.8.9. Identifies and evaluates clusters of infections and potential outbreaks. (T-1)

2.8.10. Institutes outbreak investigations and control measures as needed. (T-1)

2.8.11. Reviews and updates the MTF's infection prevention and control program operating instruction every two years. (T-1)

2.8.12. Educates and trains personnel on infection prevention and control-related topics and National Patient Safety Goals. (T-1)

2.8.12.1. Ensures IPC newcomers' orientation and annual training is developed and includes all requirements listed in the Occupational Safety and Health Administration (OSHA), Code of Federal Regulations (CFR), Title 29, Standard 1910.1030, *Bloodborne Pathogens (BBP)*, and Standard 1910.134, *Respiratory Protection*. (T-0)

2.8.12.1.1. Annual IPC training must be completed in-person, to allow for interactive questions and answers with the person conducting the training IAW OSHA, CFR, Title 29. (T-0)

2.8.12.1.2. A similar, in-person format for newcomers orientation will be followed if BBP and the MTF Bloodborne Pathogens Exposure Control Plan (ECP) is not briefed by Public Health when the member in-processes to the MTF.

2.8.12.2. Other training modalities (e.g., Relias Learning) may be used to reinforce learning, but will not be used to substitute IPC newcomers' orientation or annual training. (T-1)

2.8.13. Maintains records IAW regulatory and accrediting agencies and local policy. (T-1)

2.8.14. Develops the IPCF meeting agenda and minutes. (T-3)

2.8.15. Evaluates products, devices, and equipment relating to IPC. (T-1)

2.8.16. Reviews all requests for new products and medical supplies in the DMLSS system, excluding pharmaceutical items and equipment requests IAW AFMAN 41-209, *Medical Logistics Support.* New pharmaceutical items are approved by the Pharmacy and Therapeutics Function IAW AFI 44-102, *Medical Care Management*. (T-1)

2.8.17. Collaborates with other departments to implement strategies to prevent healthcare-associated infections (HAIs), transmission of multidrug-resistant organisms and other epidemiologically important organisms, and to promote antimicrobial stewardship. (T-1)

2.8.18. Monitors and evaluates the efficacy of IPC strategies. (T-1)

2.8.19. Provides consultation on all renovation, construction, repair projects, facility modifications, and relocations. (T-1)

2.8.19.1. Develops a focused construction/renovation ICRA during the construction planning phase. (T-1)

2.8.19.2. Posts an IPC construction permit at the entry way and/or exits of the construction area, to promote safety and awareness of personnel, patients, contractors and visitors. (T-1)

2.8.19.3. Conducts on-site inspections throughout the project and documents observations, to ensure readiness for personnel and patients upon project completion. (T-1)

2.8.20. Reviews and consults on IPC related documents and service contracts. At a minimum, this includes the Hospital Aseptic Management System (HAMS) or an equivalent housekeeping contract, linen, waste management, the Individual Medical Facility Exhibit (IMFE), Housekeeping Contract Adaptive Manual, and Housekeeping Performance Work Statement. (T-1)

2.8.21. Reviews and updates infection prevention and control-related Memorandum of Understanding (MOU) as needed. (T-1)

2.8.22. Provides consultation to Aerospace Medicine in developing the BBP-ECP and Respiratory Protection/Tuberculosis Prevention ECP.

2.8.22.1. Aerospace Medicine reviews and provides updates to the plans at least annually. (T-0) 2.8.22.2. Determines personnel who are at risk for exposure to airborne infectious diseases and notifies Bioenvironmental Engineering (BE) of respiratory protection requirements. (T-1)

2.8.23. Consults with Public Health to determine occupational risk categories for personnel. Ensures the IPC Annual Plan reflects any updates on occupational risk categories, BBP, and medical employee health. (T-1)

2.8.24. Collaborates with Aerospace Medicine and Public Health for the management of an influx of infectious patients. (T-1

2.8.25. Maintains membership in the following committees or their equivalents: (T-1)

2.8.25.1. Environment of Care.

2.8.25.2. Product Evaluation.

2.8.25.3. Patient Safety.

2.8.25.4. Facility Utilization Board.

2.8.25.5. Medical Readiness.

2.8.25.6. Nurse Executive Function.

2.8.25.7. ECOMS.

2.8.26. Reports surveillance data, findings, and analyses to the committees listed above, patient care units, personnel, and external agencies. (T-1)

2.8.27. Collaborates with the Patient Safety Manager on infection prevention and control-related events. Assists with event analyses and development of corrective actions. (T-1)

2.8.28. Consults with AFRC, ANG and Aeromedical Evacuation Units' IPs in developing MOUs, or Host-Tenant Agreements as applicable. (T-1)

2.8.28.1. The agreement will define how the visiting units must comply with the Host MTF's IPCP if providing services to active component beneficiaries. Refer to AFI 25-201, *Intra-Service, Intra-Agency, and Inter-Agency Support Agreements Procedures* for more information. (T-1)

2.8.28.2. Informs the tenant unit's IP on infection prevention and control-related issues within the host MTF. (T-1)

2.8.29. Notifies leadership and other personnel of infection prevention and control-related problems or emergencies. (T-3)

2.8.30. The IP <u>will</u> attend the EPIC course no later than six months of assignment to the position. (T-1)

2.9. Non-Commissioned Officer in Charge of Infection Prevention and Control.

2.9.1. Assists the IP with the development, execution and evaluation of the IPCP. Substitutes for the IP during temporary absences (e.g., three months or less) with oversight from the SGH or designee. (T-3)

2.9.2. Works directly for the IP when performing IPC-related duties. (T-1)

2.9.3. At least eight (8) hours per week will be devoted to IPC duties, if this is an additional duty role. (T-3)

2.9.4. Requirements: must have a minimum of three years of experience in the medical enlisted career field (e.g., nursing, dental, laboratory), complete the EPIC course within six months of assignment, and will remain in the position at least two years after attending the formal training course. (T-1)

2.10. Infection Prevention and Control Assistant (Optional).

2.10.1. Works directly for the IP when performing IPC-related duties; may substitute for the IP during temporary absences. (T-3)

2.10.2. Requirements: active duty officer in a clinical assignment who has an interest in IPC. (T-3)

2.11. Infection Prevention and Control Coordinator (Optional).

2.11.1. Assists the IP and the Unit Manager in the implementation of the IPCP in their assigned clinical area. The coordinator will be appointed by the unit manager in writing and may be an officer, enlisted, or civilian personnel. (T-3)

2.11.2. Assists the IP with surveillance activities and new product evaluation. (T-3)

2.12. Unit Manager/Supervisor/Dental Clinic IPC.

2.12.1. Monitors IPC practices in their area of responsibility. (T-3)

2.12.2. Develops a unit-specific operating instruction, if needed. The unit-specific instruction will be reviewed by the IPCF every two years. (T-3)

2.12.3. Ensures personnel receive initial, annual and ongoing IPC education and training specific to the unit. (T-1)

2.12.4. Validates training documentation per local policy. (T-1)

2.12.5. Assists the IP with unit-specific surveillance. Notifies the IP when a HAI is identified. (T-3)

2.12.6. Ensures personnel with an infectious disease are restricted from duty and notifies Public Health for awareness. Contractor personnel will notify the Contracting Officer's Representative (COR) of their illness. (T-1)

2.12.7. Appoints the unit's IPC coordinator in writing. (T-3)

2.12.8. Informs the IP of any plans to occupy a new space or change existing functional use of a present space. Ensures plans are reviewed by the IPCF during the planning phase, prior to beginning the project. (T-1)

2.12.9. Notifies the IP of any process changes to already established practices which may have IPC implications. (T-1)

2.13. MTF Personnel.

2.13.1. Complies with all IPC policies and MTF-directed training. (T-1)

2.13.2. Reports occupational exposures and injuries IAW local policy. (T-1)

2.13.3. Seeks prompt medical evaluation and treatment of infectious diseases. Notifies the immediate supervisor, IP and Public Health of any duty restrictions or limitations as a result of an infectious disease. (T-1)

2.13.4. Accomplishes periodic health examinations, immunizations, and clinical laboratory studies as deemed necessary by a medical authority or Department of Defense mandate to prevent, detect, or control infections or communicable diseases. (T-1)

2.14. Aerospace Medicine, or local equivalent.

2.14.1. Executes the Occupational and Environmental Health Program IAW AFI 48-145, *Occupational and Environmental Health Program*. (T-1)

2.14.2. Collaborates with the IP in the development of the BBP-ECP and Respiratory Protection-Tuberculosis Prevention ECP. Ensures both are reviewed annually and updated as necessary. (T-3)

2.15. Public Health.

2.15.1. Provides updates on the Medical Employee Health Program (e.g. health status, disease monitoring) to the IPCF, or equivalent.   At limited-scope MTFs, provides updates to the Executive Committee, or equivalent, and per a MOU with a larger MTF. (T-1)

2.15.1.1. Reports on occupational exposures to blood and other potentially infectious materials, and other infectious disease. (T-0)

2.15.1.2. Provides an annual report on medical employee health screening status of personnel. (T-1)

2.15.2. Reports to designated authorities on diseases or conditions that are reportable and relevant to the MTF's IPCP. (T-0)

2.15.3. Consults with the IPCF on the annual ICRA. (T-3)

2.15.4. Collaborates with the IP as necessary when an influx of infectious patients occurs. (T-1)

2.15.5. Collaborates with the IP in developing the ECP, which includes BBP and Respiratory Protection/Tuberculosis Prevention. Reviews and provides updates annually. (T-0)

2.16. Bioenvironmental Engineer (BE).

2.16.1. Conducts respiratory protection fit-testing for medical personnel required to wear N95 particulate respirators or a similar device, while providing patient care IAW AFI 48-137, *Respiratory Protection Program*. (T-1)

2.16.2. Performs ventilation surveys as required by the facility or as requested. Refer to **Chapter 4** for locations and frequency. (T-1)

2.17. Facility Manager.

2.17.1. Provides ventilation survey reports to the IPCF. (T-3)

2.17.2. Notifies the IP and recommends corrective actions, when a ventilation survey fails to meet the criteria in the *Unified Facilities Criteria (UFC), Design: Military Medical Facilities-UFC 4-510-01*. (T-1)

2.17.3. If the facility has not undergone replacement or any extensive repairs/renovations, then the organization must comply with the codes and standards that were established at the time the MTF's construction plans were approved. (T-1)

2.17.4. Consults on issues concerning linen, housekeeping, HAMS, and regulated waste contracts. (T-3)

2.17.5. Coordinates linen, waste management, HAMS or equivalent housekeeping contract changes with the IPCF (T-3)

2.17.6. Coordinates with the IP on facility renovation, clinical services relocation, construction, facility modifications, projects and repairs. (T-3)

2.18. Patient Safety Manager. Collaborates with the IP on IPC related near misses, events, and provides assistance with analyses and corrective actions. (T-3)

Chapter 3

PROGRAM MANAGEMENT.

3.1. Scope. The scope of the infection prevention and control program (IPCP) is based upon the risks and product line services found in each military treatment facility (MTF). The program will comply with applicable external agencies such as The Joint Commission, Occupational Safety and Health Administration (OSHA) and other regulatory bodies. (T-0)

3.1.1. The primary goals of the program are to protect patients, personnel and visitors in the healthcare environment and reduce the risk and occurrence of healthcare associated infections (HAI) across the continuum of care.

3.1.2. Guidelines developed by the Centers for Disease Control and Prevention (CDC), the Society for Healthcare Epidemiology of America, and other professional organizations will be used to implement the program.   (T-1)

3.2. Program Authority.

3.2.1. The Executive Committee of the Medical Staff (ECOMS), or equivalent, oversees the IPCF. (T-3)

3.2.2. MTF leadership will place an emphasis on the healthcare worker's health and safety.

3.2.3. MDG leadership will promote the importance of adhering to IPC principles in all facility settings, to foster a culture of "Trusted Care" and zero harm.

3.3. Infection Prevention and Control Function (IPCF).

3.3.1. The IPCF is a multidisciplinary team that coordinates program activities. If a limited-scope MTF elects to not have an IPCF, the Executive Committee or equivalent <u>will</u> assume this role as previously stated (Refer to **Chapter 3**). (T-1)

3.3.2. Membership includes but is not limited to the following personnel or department: Chairperson, IP, Public Health, Facility Manager, Nursing, Dental, Perioperative, Sterile Processing subject matter expert, Risk Manager, Patient Safety Manager, Housekeeper and other representatives as deemed necessary. (T-3)

3.3.3. Meets at least quarterly and submits minutes to the ECOMS, or equivalent. (T-1)

3.3.4. Agenda items and meeting minutes will reflect all of the components listed in the Annual Plan. (T-1)

3.3.5. Reviews and coordinates approval of the IPC operating instruction, ICRA, Annual Plan and Annual Summary. (T-1)

3.3.6. All documents will be signed and in-place no later than the first day of the reporting period (e.g. calendar year or fiscal year). (T-1)

3.3.7. Reviews and consults on the HAMS contract and IMFE annually. (T-1)

3.4. IP. The IP will coordinate development of the following items with the IPCF, ECOMS, or equivalent: (T-1)

3.4.1. IPC operating instruction.

3.4.2. Infection Control Risk Assessment.

3.4.3. Annual Plan.

3.4.4. Annual Summary.

3.5. MTF Infection Prevention and Control Operating Instruction.

3.5.1. The IPCF, ECOMS or equivalent will review and approve the IPC operating instruction every two years. (T-3)

3.5.1.1. If the instruction contains any aspect of BBP-ECP, or the Tuberculosis Prevention-Respiratory Protection Program, it will be reviewed annually. (T-0)

3.5.1.2. Unit-specific instructions will be reviewed every two years. (T-3)

3.5.2. The MTF's operating instruction will address the following: (T-1)

3.5.2.1. Identify the scope of the program relevant to the MTF's mission.

3.5.2.2. Give authority to isolate infectious patients using transmission-based precautions.

3.5.2.3. Give authority to culture any drainage site.

3.5.2.4. Define policy and procedures for the prevention and control of infection that is consistent throughout the facility (e.g., antimicrobial stewardship, identification of /follow-up on multi-drug resistant organisms, linen, environmental cleaning; medical equipment, devices and supplies; surveillance procedures, and infectious waste disposal).

3.5.2.5. Define public reporting of HAIs through the CDC's NHSN or other databases as required by the DHA.

3.5.2.6. Implement hand hygiene protocol IAW the CDC or the World Health Organization (WHO).

3.5.2.7. Identify the procedures for investigating outbreaks or a sudden influx of infectious patients.

3.6. Infection Control Risk Assessment (ICRA).

3.6.1. The ICRA is a visual tool (**Attachment 2** of this instruction) used to develop program priorities and stratify infection risks based on the following: (T-1)

3.6.1.1. Geographic location, community and population served.

3.6.1.2. Care, treatment, and clinical services provided.

3.6.1.3. Environmental issues and potential disaster situations.

3.6.1.4. Clinically significant microorganisms and multidrug-resistant organisms identified through mandated or planned surveillance.

3.6.1.5. Military mission.

3.6.1.6. Endemic diseases.

3.6.1.7. HAI data and conclusions from the previous year's Annual Plan to address further action and follow-up.

3.6.1.8. Projected construction, renovations or repairs.

3.6.1.9. Potential for sterile processing outages.

3.6.2. The IPCF and the ECOMS or equivalent will review and approve the ICRA annually. (T-1)

3.7. Infection Prevention and Control Annual Plan.

3.7.1. The Annual Plan includes a written description of the activities to minimize, reduce, or eliminate the risk of infection. It will identify the following: (T-1)

3.7.1.1. The MTF's mission and vision statement.

3.7.1.2. Scope of the program which includes: a snapshot of the patient population, type and level of care, treatment and services provided by the community, and environmental risks and issues.

3.7.1.3. Timeframe for which it is written (e.g., calendar year or fiscal year).

3.7.1.4. Surveillance strategies and reporting mechanisms.

3.7.1.5. Process for investigating outbreaks of infectious disease.

3.7.1.6. IPC training.

3.7.1.7. Quality initiatives and process improvement activities.

3.7.1.8. Influenza vaccination rates.

3.7.1.9. Resources required to implement the plan.

3.7.1.10. Contingency plans for sterile processing outages.

3.7.1.11. If applicable, Active Component Host facilities will include how they interface with Aeromedical Evacuation Squadrons, AFRC and ANG medical squadrons and reflect how the unit(s) interface with, and participate in, the MTF's IPCP. (T-1)

3.7.2. The Annual Plan will measure progress in obtaining goals at least quarterly, based on the reporting schedule for each action plan initiative. Document accomplishments, deficiencies and amendments in the IPCF meeting minutes. (T-3)

3.7.3. The Annual Plan may be revised at any time in response to events or changes at the MTF.

3.7.4. The Annual Plan is reviewed and approved each year by the IPCF and the ECOMS or equivalent. (T-1)

3.8. Infection Prevention and Control Annual Summary.

3.8.1. The IPCF and the ECOMS or equivalent will review and approve the IPC summary annually. (T-1)

3.8.2. The Annual Summary will describe all activities included in the Annual Plan. (T-1)

3.8.3. The format of the Annual Summary will include a general discussion of IPC concerns or elements of compliance, recommendations, actions taken, and follow-up actions. Unresolved items will be carried over to the next Annual Plan. (T-1)

3.8.4. MTFs that host an Aeromedical Evacuation Squadron, AFRC or ANG unit may provide a copy of the Annual Summary to the tenant unit.

Chapter 4

INFECTION PREVENTION AND CONTROL GUIDELINES.

4.1. Requirements. A comprehensive list of IPC standards, guidelines and references are listed in **Attachment 1** and on the IPC Kx. These references will be used to guide clinical practices. (T-1)

4.1.2. Blood and other potentially infectious materials will be treated as if infectious. Heightened awareness is required in environments where poor lighting makes visualization difficult (e.g., aircraft, medical transportation buses, austere ground conditions in operational settings). (T-0)

4.1.3. Standard Precautions are used in all healthcare environments. These precautions include: hand hygiene, PPE, respiratory hygiene/cough etiquette, safe injection practices, the wearing of a mask during lumbar puncture procedures, sterile instruments, and cleaned/disinfected environmental surfaces. (T-1)

4.1.3.1. Hand hygiene is performed IAW the Centers for Disease Control and Prevention (CDC) and Healthcare Infection Control Practices Advisory Committee: *Guideline for Hand Hygiene in Health-Care Settings* or the World Health Organization: *Guidelines on Hand Hygiene in Health Care.* (T-1)

4.1.3.2. PPE is worn whenever exposure to blood and other potentially infectious materials is expected, or when there is a potential for such exposure. (T-0)

4.1.3.2.1. PPE includes head cover, face shield, face mask, goggles, impervious gown, gloves, and shoe covers. (T-0)

4.1.3.2.2. Personnel will wear PPE as required for the task to form a barrier of protection for associated exposure risk. (T-0)

NOTE: Powdered surgeon's gloves, powdered patient examination gloves, and absorbable powder for lubricating surgeon's gloves have been banned by the Food and Drug Administration (FDA), and will not be used.

4.1.3.2.3. Gloves will be worn when exposure to blood and other potentially infectious materials is possible or anticipated. Hypoallergenic gloves will be readily accessible to those personnel who are allergic to the gloves normally provided. (T-0)

4.1.3.2.4. Scrub suit attire and cloth surgical hats are not considered PPE. (T-0)

4.1.3.3. Respiratory hygiene/cough etiquette signage and supplies (e.g. masks, tissue and alcohol-based hand hygiene products) will be available to all who enter the healthcare facility. (T-1)

4.1.3.4. Safe Injection Practices. The CDC *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* provides evidence-based recommendations for safe injection practices and reflects the minimum standards that personnel will follow to prevent transmission of infections in healthcare settings. (T-0)

4.1.3.4.1. Use aseptic technique to avoid contamination of sterile injection equipment. (T-0)

4.1.3.4.2. Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space (e.g., during myelograms, lumbar puncture and spinal or epidural anesthesia.) (T-0)

4.1.3.4.3. Irrigation and intravenous fluid bags are considered single-use. Surplus volume from any irrigation or intravenous fluid bag will not be used for more than one patient to avoid the risk of cross-contamination. (T-0)

4.1.3.4.4. Do not administer medications from a single syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulas and syringes are sterile, single-use items; they will not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient. (T-0)

4.1.3.4.5. Use fluid infusion and administration sets (e.g., intravenous bags, tubing and connectors) for one patient only and dispose of them IAW regulatory guidance after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set. (T-0)

4.1.3.4.6. Use single-dose vials for parenteral medications whenever possible. (T-0)

4.1.3.4.7. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use. (T-0)

4.1.3.4.8. If multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial must be sterile. (T-0)

4.1.3.4.9. Label multi-dose medications (e.g., bottles, vials) with the expiration date, which is 28 days after initial entrance. (T-0)

4.1.3.4.9.1. Per AFI 44-102, , the United States Pharmacopeia 797 requires reconstituted multi-dose vials for injection purposes, to be disposed of after 28 days. However, the standard is solely intended for sterile injectable products and does not apply to pre-manufactured topical agents. NOTE: This does not apply to vaccines, which have separate requirements for when multi-dose vials will be discarded. (T-0)

4.1.3.4.9.2. Non-injectable multiple use containers, such as eye drops, rubbing alcohol and hydrogen peroxide, are designed to be administered safely until the manufacturer's expiration dates and will be disposed of when expired or contaminated as noted in the manufacturer's drug insert. (T-0)

4.1.3.4.10. Do not keep multi-dose vials in the immediate patient treatment area and ensure they are stored IAW the manufacturer's recommendations; discard if sterility is compromised or questionable. (T-0)

4.1.3.4.11. Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients. (T-0)

4.1.3.4.12. Do not refill bottles of antiseptic solutions, ultrasound transducer gel, or any other medication unless specifically stated to do so per the manufacturers'

instructions for use (IFU). Use single-use packets or bottles if available for purchase. (T-0)

4.1.4. Transmission-based precautions will be used in all healthcare environments. They include airborne, contact, and droplet precautions. Refer to *CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* for detailed information. (T-0)

4.1.4.1. Protective environment precautions <u>will</u> be used in acute care hospitals that provide care to hematopoietic stem cell transplant patients.

4.1.4.2. These precautions are designed to prevent HAIs and consist of engineering and design interventions that decrease the risk of exposure to environmental fungi for severely immunocompromised allogeneic patients. (T-0)

4.1.5. Dental Infection Prevention and Control. Refer to the *USAF Guidelines for Infection Prevention and Control in Dentistry*. (T-1)

4.1.6. Occupational exposure to blood or other potentially infectious materials. Personnel exposed to blood and other potentially infectious materials <u>will</u> be evaluated and managed IAW the *Occupational Health and Safety Administration, 29 CFR, § 1910.1030,* the *CDC, Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Post-exposure Management* and the most current *U.S. Public Health Service, Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Post-exposure Prophylaxis.* (T-0)

4.1.6.1. Injuries involving sharps, blood or other potentially infectious materials exposure will be promptly washed with soap and water. If the eye(s) or a mucous membrane is involved, flush the area with copious amounts of water. (T-0)

4.1.6.2. Report the exposure to the injured person's supervisor. The supervisor will report needle sticks to Public Health for investigation and follow-up IAW AFI 91-204, *Safety Investigations and Reports.* This is also done to ensure compliance with *OSHA 29 CFR, § 1904*. The injured person will seek post-exposure evaluation and treatment from a credentialed and privileged provider per MTF policy. (T-0)

4.1.6.3. The MTF's ECP is used to ensure communication to a medical team trained to triage all exposures and assess the need for post-exposure prophylaxis. If prophylaxis is required, it must be administered as soon as possible, following the exposure incident IAW the *CDC, Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Post-exposure Management* and the most current *U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Post-exposure Prophylaxis, 2013.* (T-0)

4.1.7. The MTF will provide initial and annual in-person training on standard precautions, transmission-based precautions and BBP. This training will be documented per local policy. (T-0)

4.2. Infection Prevention and Control Program Authority Statements.

4.2.1. The IPCF Chair, or Executive Committee Chair for limited scope facilities, institutes surveillance, prevention, and control measures and notifies the Commander of any related problems. (T-1)

4.2.2. The IP, provider, nurse, or technician responsible for the patient has the authority to initiate isolation precautions and to culture suspected infected sites per established clinical protocols. (T-3)

4.2.2.1. Notify the provider when isolation precautions are instituted or when a culture is performed. (T-1)

4.2.2.2. Personnel <u>will</u> be trained in culturing techniques prior to performing any culture. (T-1)   4.2.2.3. Sites that may be cultured include: urine, sputum, wound, stool, peripheral and central venous access sites, and other external drainage. The probing of a deep wound, to include intra-oral surgical sites, will be done by the provider. (T-1)

4.3. Employee Health.

4.3.1. All personnel must in-process through Public Health within 10 duty days of arrival to the MTF/unit or within three Unit Training Assemblies (UTA) after arrival for AFRC or ANG units and prior to patient care duties.(T-1)

4.3.2. Hepatitis B Virus Vaccine and Immunity: refer to *CDC, Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Post-exposure Management,* and *Occupational Health and Safety Administration, 29 CFR, § 1910.1030).* (T-0)

4.3.3. Human Immunodeficiency Virus: refer to AFI 44-178, *Human Immunodeficiency Virus Program.* (T-1)

4.3.4. Other vaccinations or immunity: refer to *CDC, Immunization of Health-Care Personnel, Recommendations of the Advisory Committee on Immunization Practices, 2011.* (T-1)

4.4. Antiseptics.   The MTF's IPC operating instruction will list antiseptics approved by the IPCF, or Executive Committee in limited-scope MTFs. (T-0)

4.4.1. Include antimicrobial hand hygiene agents for use by personnel and antiseptics for use on patients.

4.4.2. All antiseptics must be registered with the FDA.

4.5. Disinfectants. The *CDC, Guideline for Disinfection and Sterilization in Health-care Facilities,* and *Guidelines for Environmental Infection Control in Health-Care Facilities*, <u>will</u> be used as guides for decision making on disinfectant selection. All disinfectants <u>must</u> be registered with the Environmental Protection Agency. (T-1)

4.5.1. The MTF's IPC operating instruction and Annual -Plan must have a list of disinfectants approved by the IPCF, or Executive Committee in limited-scope MTFs. (T-1)

4.5.2. Environmental disinfectants used by housekeeping <u>will</u> be maintained and approved on a separate list, to indicate which products are used by housekeeping and which products are used by healthcare personnel. (T-1)

4.5.2.1. The housekeeping contractor <u>will</u> purchase environmental disinfectants IAW the established contract. (T-1)

4.5.2.2. Supplies acquired through the housekeeping contract (e.g., chemicals, disinfectants, cleaning utensils) will only be used by personnel during an emergency and only when a housekeeper is unavailable for emergency response. (T-1)

4.5.3. Liquid chemical sterilants and high-level disinfectants for processing reusable medical devices (e.g., flexible endoscopes, instruments) will be used according to manufacturers' IFU and will not be used to disinfect environmental surfaces. (T-1)

4.5.4. Bleach (Sodium hypochlorite) <u>will</u> not be used as a primary disinfectant in the healthcare environment; it lacks detergent and may be corrosive to some surfaces. (T-1)

4.5.4.1. Disinfectants containing chlorine compounds may be used as a primary hospital-grade disinfectant.

4.5.4.2. Bleach may be used in Nutritional Medicine as a disinfectant.

4.5.4.3. Bleach may be used as an additional disinfection step if deemed necessary and approved by the IPCF (e.g., due to its highly effective kill of *Enterovirus*, and spore forming bacteria [e.g., *Clostridium difficile, Bacillus anthracis*]).

4.5.4.3.1. Clean surfaces with a detergent or a detergent/disinfectant first and allow to air dry, followed by the bleach disinfecting solution. (T-1)

4.5.4.3.2. Follow the bleach manufacturer's instructions for use for correct dilution ratio. (T-1)

4.5.4.4. Consult the dental unit waterline manufacturer for correct methods and equipment to maintain the quality of dental unit waterlines. (T-1)

4.6. Storage and Transportation of Clean and Sterile Supplies. Storage areas <u>will</u> be kept clean, organized, and in an environment-controlled location. (T-1)

4.6.1. Store similar items together (e.g., sterile with sterile and clean with clean).

4.6.1.1. Store liquids on lower shelves or in containers that <u>will</u> hold the volume of the primary container, in the event it leaks, to prevent compromise to other supplies stored next to or below. (T-1)

4.6.1.2. Sterile and nonsterile patient treatment items may be stored in the same drawers or cabinets as long as there is no possibility of similar nonsterile items being used inadvertently when sterility (e.g., sterile 4x4s and clean 4x4s) is required and the items are kept separated by wipeable dividers or containers.

4.6.2. Supplies <u>will</u> be rotated using a first in, first out plan so that older items are used first, thus preventing waste due to expiration. (T-1)

4.6.3. Storage shelving must be six to eight inches above the floor, and 12 to 18 inches below the ceiling and away from vents, sprinklers and lights, and one to two inches from an outside wall. Open rack systems must have a solid bottom shelf or shelf liner. (T-1)

4.6.4. Do not store supplies on top of plastic covered racks, above cabinets, or in any other manner that is unsafe or impedes cleaning. (T-1)

4.6.5. Sterile supplies will be stored in designated shelving or cabinets. (T-1)

4.6.6. Shipping boxes will be removed from patient care areas promptly after the supplies have been transferred to a clean storage bin. (T-1)

4.6.6.1. Interior boxes (boxes shipped within a shipping box) may be used to store supply items.

4.6.7. Do not use rubber bands to bundle soft packaged items (e.g., paper-plastic packages) together. (T-1)

4.6.8. Do not use towels or absorbent materials (e.g., bed underpad) to line drawers or shelves. (T-1)

4.6.9. Supplies must be checked at the point-of-use for package integrity and expiration dates prior to use on a patient. (T-1)

4.6.10. Personnel will check medical supplies for expiration dates on a monthly basis. Supplies without an expiration date are considered sterile until an event compromises package integrity. (T-1)

4.6.11. Do not store clean supplies in a contaminated area (e.g., decontamination area, soiled utility room). (T-1)

4.6.12. Contaminated devices/instruments must be transported in a puncture-resistant, covered container with leak-proof sides and bottom, or a cart. Transport devices must have a biohazard symbol on the exterior. Refer to **Chapter 8** for additional information on transporting contaminated items. (T-0)

4.6.12.1. Contaminated devices/instruments will be transported as soon as possible following the procedure after pre-cleaning transport solution has been applied. Refer to **Chapter 8** for details on pre-cleaning. (T-1)

4.6.12.2. A government vehicle will be used when transporting clean or contaminated supplies between buildings that are not within walking distance (greater than 0.25 miles). The vehicle will accommodate separation of contaminated items from clean to sterile items. (T-0)

4.6.12.2.1. Follow applicable national and state Department of Transportation laws regarding the transport of biohazardous supplies. (T-0)

4.6.12.2.2. The government vehicle will be decontaminated between trips and in the event of spills. (T-1)

4.6.12.3. Personnel who transport sterile, clean and/or contaminated supplies/instruments will receive initial and annual training on these responsibilities. (T-1)

4.7. Linen/Laundry.

4.7.1. The IP will:

4.7.1.1. Review the Linen Contract Performance Work Statement (PWS) annually and address problems through the MTF's linen Contracting Officer's Representative (COR). (T-1)

4.7.1.2. Tour and evaluate the linen facility with the linen COR prior to contract award for locally purchased contracts, and annually thereafter. Use the *Inspection of Laundry Facilities Checklist* on the AFMS Knowledge Exchange to assess the linen facility. (T-1)

https://kx2.afms.mil/AFMOA/ClinicalQuality/IP/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2fAFMOA%2fClinicalQuality%2fIP%2fShared%20Documents%2fLINEN%20FACILITY&FolderCTID=0x0120002203EF072EEFC04381B450E5C8524E54

4.7.1.2.1. Personnel will complete a *Customer Complaint Record*, located in the Linen Performance Work Statement Appendices, whenever linen discrepancies are observed. The completed form will be provided to the COR and IPCF. (T-1)

4.7.1.2.2. The COR will validate the customer complaint IAW PWS and collaborate with the contractor to correct the problem(s). (T-1)

4.7.2. Clean linen will be transported and stored in carts used exclusively for this purpose, or in linen carts that were cleaned and disinfected after being used to transport soiled linen. (T-1)

4.7.3. Clean linen will be stored in clean storage areas (e.g., dedicated linen rooms with closing door, covered carts, closed drawers or cabinets). (T-1)

4.7.4. The MTF will treat all used or soiled linen as potentially infectious and also comply with applicable state or host nation requirements. (T-0)

4.7.4.1. Used or soiled linen will be handled in a manner that minimizes dispersal of particles into the air and surrounding area. Extremely soiled or wet linen may be wrapped loosely in clean linen or placed directly in a plastic bag then into the linen hamper. (T-0)

4.7.4.2. Double-bagging of soiled linen is not required unless the first bag has been damaged or is leaking.

4.7.4.3. Do not place soiled linen into biohazard bags unless intended to be disposed of as regulated medical waste. (T-0)

4.7.5. Linen hamper covers may be used for aesthetic purposes in high traffic areas; if used, they must be kept clean. (T-1)

4.7.6. Linen will not be rinsed or sorted in the MTF/healthcare environment. (T-0)

4.7.7. Contaminated laundry shall be bagged or containerized at the location where it was used and will not be sorted or rinsed by MTF personnel. (T-0)

4.8. Regulated Medical Waste. Regulated medical waste will be handled IAW applicable state or host nation laws. If host nation standards are less stringent than what would normally be adhered to in the U.S., personnel will hold to the more stringent standard except as otherwise directed by the Command/Task Force Surgeon's authority in expeditionary operations. Legal advice should be sought before any regulated medical waste is transported internationally. (T-0) Refer to AFI 41-201, *Managing Clinical Engineering Programs*, for more guidance on regulated waste.

4.8.1. Home-generated regulated medical waste.

4.8.1.1. The HAMS contract does not allow for the disposal of home-generated waste (e.g. needles, syringes).

4.8.1.2. Refer patients to state/local regulations and to the safeneedledisposal.org website for more information. (T-3)

4.9. Hospital Aseptic Management System (HAMS)/Clinic Housekeeping Contracts.

4.9.1. HAMS contracts are centrally managed by the Air Force Medical Support Agency (AFMSA) and centrally procured by a single contracting office.

4.9.2. Housekeeping personnel are employees of the civilian contract company. It is the responsibility of the contractor to train their employees on current housekeeping practices and associated regulations.

4.9.3. Housekeepers clean all government-owned property and equipment unless it is attached to a patient. (T-1)

4.9.3.1. The IMFE lists the equipment not to be cleaned by housekeeping personnel and should be reviewed and approved by the IP and MTF leadership. The IPCF will review and consult on the IMFE annually and as indicated with the purchase of new equipment. (T-1)

4.9.3.2. Notify the Housekeeping COR if a specific piece of medical equipment not listed on the IMFE will not be cleaned by Housekeeping. (T-1)

4.9.4. The IPCF will review housekeeping policies, procedures, and cleaning agents annually. (T-1)

4.9.5. Personnel will keep housekeeping personnel informed of any patients with infectious or communicable disease or patients who are placed in Protective Environment Precautions. Isolation precautions signage will be used to aid communication. (T-1)

4.9.6. Facility Management oversees housekeeping functions and serves as the COR of the housekeeping contract. Refer to AFI 41-201 for more information on Facility Management's role in Housekeeping.

4.9.7. Personnel will complete a *Customer Complaint Record*, located in the Housekeeping PWS Appendices, whenever housekeeping discrepancies are observed. The completed form will be provided to the COR and IPCF. (T-1)

4.9.7.1. The COR will validate the customer complaint IAW the PWS and collaborate with the contractor to correct the problem. (T-1)

4.9.8. Emergency Service Response Procedures. Blood or other potentially infectious material spills are an emergency, and Housekeeping will respond promptly to clean the area. If Housekeeping is not immediately available, MTF personnel will clean-up the spill IAW BBP training. If MTF personnel are unable to clean the spill with the spill kit, cordon off the area and wait for Housekeeping to respond. (T-0)

4.10. Ventilation.

4.10.1. Facility Management coordinates the ventilation surveys with BE or a third party contractor to ensure compliance with recommended standards for ventilation pressure and air exchanges.

4.10.2. Ventilation surveys will be performed at least two times per year. More frequent surveys may be needed, based on local conditions. Areas to be tested include, but are not

limited to: Operating Rooms, Delivery Rooms, Instrument Processing Areas, Isolation Rooms, autopsy areas, Procedure Rooms, Cardiac Catheterization Rooms, Interventional Radiology Suites, rooms where high-level disinfection is performed, and any other rooms identified by the IPCF. Refer to the *United Facilities Criteria 4-510-01 Design: Military Medical Facilities* for more information on heating, ventilation, and air conditioning. (T-1)

4.10.3. Surveys will be reported to the IPCF. (T-1)

4.11. Smoke Biohazards.

4.11.1. Surgical smoke (e.g., plume) from hand-held cautery pens, electrosurgical units, lasers, ultrasonic devices and powered instruments may contain blood, cancer cells, viruses (e.g., human immunodeficiency virus, human papilloma virus) and bacteria in addition to toxic compounds (e.g., hydrogen cyanide, toluene, benzene).

4.11.2. Personnel may use a smoke evacuation system IAW smoke generating devices manufacturers' IFU. (T-1)

4.11.3. In addition to smoke evacuation, a fit-tested surgical N95 filtering face piece respirator may be used during higher-risk, aerosol-generating procedures on patients with known or suspected aerosol transmissible diseases (e.g., tuberculosis, varicella, rubeola). (T-1)

4.11.4. Develop safe work practice controls to include education and training on the correct use of equipment and safety hazards associated with smoke generating procedures. Refer to *Association of Perioperative Registered Nurses, Guidelines for Perioperative Practice* for more information on reducing the risks associated with smoke biohazards. (T-1)

4.12. Service animals in healthcare environments.

4.12.1. The use of service animals to assist in patient therapy and research has become more common in all healthcare environments.

4.12.1.1. The risks associated with animals in the healthcare environment include allergy exacerbation, phobias, animal-caused injuries, and zoonoses.

4.12.1.2. Emotional support animals are not covered by the Americans with Disabilities Act.

4.12.2. MTF personnel will use standard IPC measures to prevent animal-to-human transmission, in addition to any state or local requirements. (T-1)

4.12.3. MTFs will establish a written policy regarding the admittance of service animals into the facility. (T-1)

4.12.4. Refer to *Society of Hospital Epidemiology of America, Animals in Healthcare Facilities: Recommendations to Minimize Potential Risks* for more details.

Chapter 5

SURVEILLANCE.

5.1. Definition.   According to the Association for Professionals in Infection Control and Epidemiology (APIC), surveillance is a comprehensive method of measuring outcomes and related processes of care, analyzing the data, and providing information to members of the healthcare team to assist in improving those outcomes.

5.2. Requirements for Inpatient MTFs.

5.2.1. All inpatient MTFs will surveil central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI) and ventilator-associated pneumonias (VAP) and report the data into the CDC's NHSN system. (T-1)

5.2.1.1. Data from all inpatient units (e.g., ICU, Wards) will be included. (T-1)

5.2.1.2. The IP will make data inputs into the NHSN system on a monthly basis no later than the last day of the following month (e.g., January data will be entered no later than 28 February). (T-1)

5.2.2. Surgical site infection (SSI) surveillance will be determined at the MTF-level and targeted on procedures with the highest risk (e.g., colectomy, caesarean section, total joint replacement). (T-1)

5.2.3. Antimicrobial usage data will be surveilled by Pharmacy personnel and provided to the Army Pharmacovigilance Center for input into the NHSN system on a monthly basis or as directed by DHA. (T-1)

5.3. Surveillance Plans for all MTFs.

5.3.1. The ICRA identifies surveillance needs in the facility. Surveillance will be targeted on high-risk, high-volume procedures, such as surgery and organisms of epidemiological significance (e.g. Methicillin-resistant *Staphylococcus aureus*). (T-1)

5.3.2. Surveillance will also be directed by the DHA. (T-1)

5.3.3. A surveillance plan will be defined in the IPCP Annual Plan and will measure outcomes and processes of health care, events of importance to the facility, and applicable National Patient Safety Goals. The plan will include: (T-1)

5.3.3.1. An assessment and definition of the population(s) to be monitored.

5.3.3.2. Events/indicators to be monitored (e.g., outcome, process, and other).

5.3.3.3. Surveillance criteria/case definitions and methodology.

5.3.3.4. Time period for observation and data elements to be collected.

5.3.3.5. Methods for data collection, management, analysis, and reporting.

5.3.3.6. Recipients of surveillance data and reports.

5.3.3.7. Quality assurance/performance improvement activities related to the surveillance.

5.3.3.8. Requirements of federal, state, and accrediting agencies.

5.4. Surveillance Reports.

5.4.1. Surveillance reports will be submitted to the IPCF, or to the Executive Committee or equivalent in limited-scope facilities, and included in the IPCP Annual Summary. (T-1)

5.4.2. Reports will be provided to the ECOMS, Nurse Executive Function and other relevant areas to improve processes and outcomes. (T-1)

5.4.3. If a targeted outcome or process based surveillance has remained stable over an extended period of time (e.g., six months), consider discontinuing the surveillance, or reduce the length of time to survey an item or perform a smaller sample size instead, such as 10%. This will allow resources to be applied to another process or outcome which poses a higher priority. (T-3)

5.4.4. Refer to *Association for Professionals in Infection Control and Epidemiology/Joint Commission Resources Infection Prevention and Control Workbook*, for more details on surveillance. (T-1)

5.5. Outbreak Investigations.

5.5.1. Definition. According to the APIC, an outbreak is an increase over the expected occurrence of an event.

5.5.2. A single case of an unusual disease (e.g., postsurgical group A streptococcus infection, healthcare-associated *Legionella* infection) may constitute an outbreak.

5.5.2.1. In some instances, small outbreaks are referred to as "clusters," but both outbreaks and clusters require prompt investigation. (T-1)

5.5.2.2. The term "pseudo-outbreak" is generally applied to situations in which there is a rise in test results (e.g., positive microbiology cultures) without actual clinical disease.

5.5.3. The process for investigating outbreaks will be described in the MTF's IPCP Annual Plan. (T-1)

Chapter 6

INFECTION PREVENTION AND CONTROL IN OPERATIONAL AND SPECIAL ENVIRONMENTS.

6.1. Purpose. Recommended infection control measures in non-traditional healthcare settings are the same as for hospitals and other ambulatory care settings.

6.1.1. Personnel will follow IPC guidelines and standards to the greatest extent possible in deployed/austere environments.

6.1.2. Personnel will put forth every effort to facilitate as clean an environment as possible to protect patients, personnel and other persons from infection. (T-1)

6.2. Transmission-based Precautions.

6.2.1. Cohorting patients. Patients who are colonized with the same organism may be cohorted (roomed in the same location) when the ability to isolate and/or quarantine is limited due to space constraints and other environmental factors. (T-1)

6.2.1.1. Cohorting the personnel caring for patients infected with the same organism limits further transmission to uninfected patients.

6.2.1.2. Place an isolation sign on the door or privacy curtain and ensure correct PPE is available for each isolated patient. (T-1)

6.2.2. Airborne Precautions. A negative airflow room or Airborne Infection Isolation Room is important in order to vent the airborne particles out of the work area.

6.2.2.1. In the absence of an Airborne Infection Isolation Room, place the patient in a private room with the door closed. (T-1)

6.2.2.2. Personnel caring for airborne precautions patients will wear a N95 particulate respirator or higher level respirators or masks if N95 particulate respirators are not available. The mask will be donned prior to entering the room. (T-1)

6.2.2.3. Provide a surgical mask for the patient if it is not clinically contraindicated. (T-1)

6.2.2.4. Consider the use of temporary portable solutions (e.g., fan) to create a negative pressure environment in the converted area of the facility. Discharge air directly to the outside, away from people and air intakes.

6.2.3. Droplet Precautions. Patient beds will be placed greater than three feet apart (from mattress to mattress). If a three foot separation is not possible, patients will wear a standard surgical mask when in the presence of staff, visitors, patients or during any transport if it is not clinically contraindicated. (T-1)

6.2.4. Contact Precautions. Keep post-operative patients and patients with invasive lines (e.g., IV, drainage tubes, indwelling catheters) separate from those patients who are in contact precautions. (T-1)

6.3. Supplies and Equipment.

6.3.1. Supply deliveries may be inconsistent or infrequent. Personnel will remain vigilant and monitor supply inventories on a daily basis. (T-3)

6.3.2. Store supplies and equipment in a way that protects them from temperature extremes, dust, dirt, vermin, light and moisture. (T-1)

6.3.3. Shipping pallets may be used at shelter entrances to facilitate mud and dirt removal from boots.

6.3.4. Footlocker transport containers may be used as shelves by inverting the box on its lid. Store non-critical items, such as bedpans inside the box. Store sterile and clean items on top of the box.

6.3.5. Lumber may be used as shelving for non-critical items. See **Chapter 8** for the definition of non-critical items.

6.3.6. Plastic wraps and bags can be used as covers and to protect items from dust.

6.4. Environmental Controls.

6.4.1. The goal of cleaning and disinfecting is to decrease the microbial load of the environment. All personnel are responsible for keeping the environment clean.

6.4.2. Workflow pattern will progress from the least soiled areas to the most soiled areas and from the ceiling to the floor. (T-1)

6.4.3. Trash and garbage will be emptied and placed in the designated waste disposal site daily and as needed to prevent accumulation and vermin/infestations. (T-1)

6.4.4. Disposal of biohazardous waste varies depending on location. Contact Civil Engineering for guidance on correct disposal procedures. (T-1)

6.4.5. Wards and vestibules in tents will be swept once a shift and as needed. Mop with a detergent or disinfectant at least daily and as needed. (T-1)

6.4.6. Urinals and bedpans will be rinsed with water following each use, and rinsed with a detergent daily. If a patient has diarrhea, rinse the bedpan with a detergent and water, followed by a bleach 1:100 solution for disinfection. (T-1)

6.5. Detergents and Disinfectants.

6.5.1. Supplies of detergents, disinfectants and other cleaning aids may vary widely. Refer to the manufacturer's IFU before using any product. (T-1)

6.5.2. Bleach (Sodium hypochlorite).

6.5.2.1. Bleach can be used as a disinfectant. However, it does not contain a detergent and cannot "clean" the environment. The soiled area must be cleaned with a detergent then followed with bleach for disinfection to occur. (T-1)

6.5.2.2. Spills containing blood and other potentially infectious materials will be cleaned using a 1:100 dilution of bleach. Follow the bleach manufacturer's instructions for use for dilution instructions. (T-1)

6.5.2.3. Do not mix bleach with other chemicals, detergents or disinfectants; a hazardous reaction might occur. (T-1)

6.5.3. Alcohol (e.g., Ethyl or Isopropyl, 60%-90%).

6.5.3.1. Alcohol is a good disinfectant, but not a good cleaner. Clean the soiled area with a detergent first, then follow with alcohol. (T-1)

6.5.3.2. Alcohol is not recommended for use as a sterilant as it does not destroy bacterial spores.

6.5.3.3. Store alcohol-based products in a cool place. (T-1)

6.5.4. Detergent/Disinfectant (A-33® Dry).

6.5.4.1. A-33 is a quaternary ammonium chloride compound in a premeasured packet which is dissolved in one gallon of warm water. Use this product to clean walls, floors and other nonporous hard surfaces. (T-1)

6.5.4.2. Do not use this product on food preparation surfaces, food handling areas, medical devices or on medical equipment. (T-1)

6.6. Occupational Injuries. Injuries involving blood or other potentially infectious materials will be reported to the injured person's supervisor and Public Health. Public Health will monitor and follow up on all occupational injuries. Follow **Chapter 4** guidance listed in this instruction. (T-0)

Chapter 7

**INFECTION PREVENTION AND CONTROL PROGRAM MANAGEMENT IN
AEROMEDICAL EVACUATION SQUADRONS, AIR FORCE RESERVE COMMAND
AND AIR NATIONAL GUARD MEDICAL UNITS.**

7.1. General.   This chapter provides guidance for management of the IPCP within Aeromedical Evacuation Squadrons and Air Reserve Component Medical Units (AFRC and ANG Medical Units).

7.2. Command Surgeon, Air Force Reserve Command and Office of the Air Surgeon, Air National Guard.   Establishes medical policies/guidance, plans, and programs for their respective units, as required.

7.3. Unit Commander.

7.3.1. Establishes a unit-based IPCP. (T-1)

7.3.2. Appoints an IP in writing to oversee and manage the program. (T-1)

7.3.3. Appoints a credentialed and privileged healthcare provider, in writing, to serve as the clinical authority over the program (e.g., physician, nurse practitioner, dentist, or physician assistant). (T-1)

7.3.3.1. The credentialed and privileged healthcare provider does not attend formal training. (T-3)

7.3.4. Publishes a unit-specific IPC operating instruction and ensures it is reviewed annually and submitted to the Executive Management Committee for approval. (T-1)

7.3.5. Ensures the IP develops an annual ICRA and Annual Plan and submits it to the Executive Management Committee for review and approval. (T-1)

7.3.6. Ensures personnel complete IPC orientation training within three UTAs after arrival to the unit or prior to assignment of duties, whichever comes first. Initial training will be specific to the unit's mission and can be combined with the unit's general orientation program. (T-1)

7.3.7. Ensures personnel receive IPC annual training. Training will be specific to the unit's mission. (T-1)

7.4. Executive Management Committee.

7.4.1. Oversees the IPCP and ensures items identified in the Annual Plan are addressed at least quarterly. (T-1)

7.4.2. Reviews and approves the annual ICRA, Annual Plan and Annual Summary. (T-1)

7.4.3. Reviews Host MTF MOU pertinent to IPC policies annually, if applicable. The Host MTF will provide the ground level support for tenant units located on active duty bases per AFI 25-201,. (T-1)

7.5. IP.

7.5.1. Appointed in writing by the unit commander and is a qualified professional with the grade of captain and one year of experience in the unit. The IP may be any of the following:

nurse, physician, nurse practitioner, physician assistant, dentist, public health or laboratory officer. (T-1)

7.5.2. Liaises with the Host MTF on IPC issues and updates unit personnel on relevant issues (e.g., engineering controls/safety devices, surveillance protocols, BBP-ECP, as applicable). (T-1)

7.5.3. Provides IPC newcomers' orientation and annual training. Training must include information required by the OSHA, CFR, Title 29, Standard 1910.1030, *Bloodborne Pathogens*, and *Standard 1910.134, Respiratory Protection*. (T-0)

> 7.5.3.1. An in-person lecture style format must be used for Annual Infection Prevention and Control training IAW OSHA, CFR, Title 29, Standard 1910.1030, *Bloodborne Pathogens* to provide an opportunity for interactive questions and answers with the person conducting the training. (T-0)

> 7.5.3.2. Other training modalities (e.g., Relias) may be used to reinforce learning, but will not be used to substitute newcomers' orientation and annual training. (T-1)

> 7.5.3.3. Documents and maintains training records IAW unit policy. (T-3)

7.5.4. Assesses unit needs by performing an annual ICRA. Coordinates the assessment with the Executive Management Committee and other unit personnel as required (e.g., immunizations, flight medicine, nursing, public health) and prioritizes according to the level of probability and potential for harm. (T-1)

7.5.5. Uses the ICRA to develop the IPC Annual Plan. Submits the plan to the Executive Management Committee for review and approval. (T-1)

7.5.6. Develops an Annual Summary that includes all activities that occurred during the year. Submits the plan to the Executive Management Committee for review and approval. (T-1)

7.5.7. Performs an annual IPC self-inspection using the MICT, SAC checklists and any other relevant guidance. (T-1)

7.5.8. Attends the EPIC Course, Air Reserve Component, within 12 months of assignment to the IP position. (T-1)

7.5.9. Assists the host MTF's IP in developing a MOU that identifies the responsibilities of the host MTF and the tenant medical unit, as applicable. (T-1)

> 7.5.9.1. If the tenant unit provides services to the host MTF's patient population, the memorandum will define how the tenant unit will comply with the host MTF's IPC Instruction and Annual Plan. The host MTF will provide the ground level support for tenant units located on Active Duty bases per AFI 25-201.   (T-1)

> 7.5.9.2. If the tenant unit uses the host MTF's treatment areas to conduct personnel health assessments (e.g.., the MTF is closed during the UTA), the memorandum will address compliance with waste management, handling of reusable medical devices, and other pertinent concerns. (T-1)

7.5.10. Reports on surveillance and elements of compliance as prioritized in the Annual Plan to the Executive Management Committee as directed, but not less than biannually. (T-1)

7.6. Infection Prevention and Control Non-commissioned Officer in Charge.

7.6.1. The technician must have a minimum of three years clinical experience in the medical enlisted career field. (T-3)

7.6.2. Works directly for the IP when performing related duties and <u>will</u> cover for the IP during temporary absences (e.g., three months or less) with oversight from the Chief Nurse or designee. (T-3)

7.6.3. Assists the IP with program implementation. (T-3)

7.6.4. Attends the EPIC Course, Air Reserve Component, within 12 months of assignment to the position. (T-3)

7.7. Bioenvironmental Engineer.

7.7.1. The host BE office will provide industrial hygiene support and conducts the respiratory protection fit testing for the N95 respirator, if required, IAW AFI 48-137. (T-1)

7.7.2. Units having a BE component (officer or qualified enlisted AFSC) will have delegated authority over the N95 respirator fit-testing program, if applicable. (T-1)

7.8. Unit Personnel.

7.8.1. Comply with all IPC policies and guidelines. (T-1)

7.8.2. Report occupational exposures and injuries IAW the host MTF's policy. (T-0)

7.8.3. Aeromedical Evacuation personnel who experience an occupational exposure (e.g., blood/other potentially infectious materials) or infectious disease exposure (e.g., tuberculosis) incident <u>will</u> follow procedures IAW AFI 48-307, Volume 1, *En Route Care and Aeromedical Evacuation Medical Operations*." (T-0)

7.8.4. Seek prompt medical evaluation and treatment of infectious diseases per unit policy. Notify the immediate supervisor, IP and Public Health of any duty restrictions or limitations as a result of an infectious disease. (T-0)

7.8.5. Accomplish periodic health examinations, immunizations, and clinical laboratory studies as deemed necessary by a medical authority or Department of Defense mandate to prevent, detect, or control infections or communicable diseases. (T-1)

7.8.6. Comply with local IPC policies when assigned to an active component MTF or civilian hospital during annual tours, deployments or when providing direct patient services to active duty beneficiaries during UTAs. (T-1)

7.9. Management of Reusable Medical Devices.

7.9.1. The reprocessing of reusable medical devices is a complex process with inherent risks to the safety of both patients and personnel.

7.9.1.1. All AFRC and ANG medical units that perform dental exams are encouraged to adopt the use of disposable sterilized dental instruments as a viable alternative for dental examinations.

7.9.1.2. Refer to **Chapter 8** of this instruction for details on reprocessing reusable medical devices.

Chapter 8

REPROCESSING REUSABLE MEDICAL DEVICES.

8.1. General. Reusable medical devices (e.g., surgical instruments, dental instruments, endoscopes and other devices) must be reprocessed according to their manufacturer's instructions for use. The steps of reprocessing include: point-of-use pre-cleaning, cleaning, inspecting, packaging, disinfection, sterilization, storage and transport. (T-1)

8.1.1. Sterilization is a complex process that involves multiple disciplines within the AFMS. It requires environmental controls, appropriate equipment, supplies and adequate space. Also critical to this process are qualified competent personnel, who are provided with ongoing training, PPE and monitoring for quality assurance. From both safety and "Trusted Care" perspectives, standardization of these functions and infection prevention involvement is critical.

8.1.2. The Association for the Advancement of Medical Instrumentation (AAMI) guidelines on sterilization in healthcare facilities will be used as the primary reference documents for reprocessing reusable medical devices. (T-1)

8.2. Spaulding Classification. Reusable medical devices are divided into three categories based on the risk of infection from contamination on the item: non-critical, semi-critical, and critical. (T-1)

8.2.1. Non-critical devices include instruments and objects that contact only the intact skin of the patient. Examples in this category include stethoscopes, blood pressure cuffs and patient gurneys. Clean and disinfect non-critical devices IAW the manufacturers' IFUs. (T-1)

8.2.2. Semi-critical devices are instruments and objects that contact intact mucous membranes or non-intact skin of the patient during use, but do not usually penetrate the blood barrier or other normally sterile areas of the body. Examples in this category include dental mirrors, cheek retractors, flexible endoscopes, vaginal ultrasound probes and transesophageal echocardiography probes.

8.2.2.1. If possible, semi-critical devices will be sterilized. (T-1)

8.2.2.2. However, if sterilization is not feasible, the device, at a minimum, will be subjected to a high-level disinfection process that would be expected to destroy all microorganisms except for small numbers of bacterial spores. (T-1)

8.2.3. Critical devices are instruments or devices that are introduced directly into the human body, either into or in contact with the bloodstream or other normally sterile areas of the body. Critical items present a high risk of infection transmission if contaminated and must be sterile at the time of use. (T-1)

8.3. Manufacturers' Instructions for Use (IFUs).

8.3.1. The FDA requires manufacturers to provide customers with instructions for use that includes cleaning, sterilization and preventative maintenance instructions.

8.3.2. When considering purchasing a new device, personnel will review the IFUs before buying the item to verify the required reprocessing equipment is available in the MTF. (T-1)

8.3.3. Include a review from the IP and Biomedical Equipment Technician. (T-1)

8.3.4. Reusable medical devices will be reprocessed IAW their manufacturers' IFUs. (T-1)

8.3.5. Manufacturers' IFUs will be followed for all chemicals, materials and equipment used in reprocessing (e.g., sterilizers, mechanical washers, wrappers, indicators, containers, enzymatic detergents, neutralizers). (T-1)

8.3.6. IFUs will be readily available for the personnel performing reprocessing tasks. (T-1)

8.4. Pre-cleaning.

8.4.1. Reprocessing begins at the point of use (e.g., bedside, chairside [dental] or in other treatment rooms). (T-1)

8.4.2. Remove gross blood and soil as soon as possible following use on the patient to reduce the number of microbes on the instrument. (T-1)

8.4.2.1. Throughout surgical and invasive procedures, use a gauze sponge moistened with sterile water to remove debris from instruments. Instruments having lumen must be flushed with sterile water. (T-1)

8.4.2.2. Do not use saline on reusable instruments. It is highly corrosive and can cause pitting of instruments. (T-1)

8.4.3. Keep soiled instruments moist by covering them with a water-soaked surgical towel or an enzymatic instrument pretreatment solution pre-cleaning spray at the point of use. If spraying the instrument with an enzymatic spray is not feasible, perform this task in a designated soiled utility room. (T-1)

8.4.4. Transport soiled instruments as soon as possible after completion of the procedure to the decontamination area in a closed container that is leak proof, puncture resistant, large enough to contain all contents and labeled as a biohazard. (T-0)

8.4.4.1. Pre-cleaned instruments will not sit longer than six (6) hours before the terminal decontamination process begins. (T-1)

8.4.5. Minimize handling of loose soiled instruments during transport to the instrument processing area. Use work practice controls to minimize exposure potential. (T-0)

8.5. Reprocessing Practices in Instrument Processing Areas.

8.5.1. Instrument processing areas include rooms and designated areas for decontamination, preparation and packaging, high-level disinfection and sterilization.

8.5.2. Personnel will follow the AAMI guidelines for reprocessing reusable medical devices, which includes practice recommendations for the following: (T-1)

8.5.2.1. Handling, collection and transport of contaminated items.

8.5.2.2. Cleaning and decontamination.

8.5.2.3. High-level disinfection.

8.5.2.4. Inspecting and packaging.

8.5.2.5. Sterilization.

8.5.2.6. Quality control and sterilization process monitoring.

8.5.3. Sterilizer reports and other pertinent information on reprocessing practices will be submitted to the IPCF at least quarterly. (T-1)

8.5.4. Immediate Use Steam Sterilization (formerly known as "flash sterilization") will only be used in emergency situations when there is no other option. (T-1)

8.5.5. An instrument/device recall policy will be established in all MTFs that reprocess reusable medical devices. (T-1)

8.5.6. A vendor policy will be established in MTFs that utilize vendor services (e.g., loaner instruments, loaner systems). (T-1)

8.5.7. A contingency plan will be in place in the event of a sterile processing outage (e.g., steam line breakage, sterilizer malfunction, plumbing outage).   (T-1)

8.6. Training for Personnel Who Reprocess Reusable Medical Devices.

8.6.1. Personnel who reprocess reusable medical devices, either full-time or part-time, will receive comprehensive training that includes the following: manufacturers' IFUs, point-of-use decontamination, transportation, decontamination, inspection, assembly, packaging/wrapping, sterilization, sterility assurance, and sterile storage. (T-1)

8.6.1.1. Include a hands-on assessment for validation of correct practices. (T-1)

8.6.1.2. Include high-level disinfection training for units/areas that perform those processes. (T-1)

8.6.2. Training will occur at the beginning of employment and annually. (T-1)

8.6.3. In-person training <u>will</u> be provided by qualified personnel (e.g., experienced, competency tested). Training may be supplemented by completing a web-based training course or attending a formal in-person course that has been reviewed and approved by the Air Force Surgeon General's IPC Consultant. A list of approved courses is available on the Knowledge Exchange: **https://kx2.afms.mil/AFMOA/ClinicalQuality/IP/SitePages/IC_Consultants_Corner.aspx**. (T-1)

8.6.4. Instrument processing personnel will receive training prior to using or reprocessing newly acquired instrumentation, devices and equipment. This training will include a review of the manufacturers' instructions for use. (T-1)

8.6.5. Training will be documented _IAW local policy. (T-1)

8.7. Reprocessing Single-Use Devices.

8.7.1. Reprocessing single-use devices is only performed by a FDA-approved reprocessing facility and will not be done in the MTF. (T-0)

8.7.2. Per AFI 41-209, MTFs shall not be obligated to use reprocessed single-use devices. However, MTFs shall have the option of utilizing FDA-approved reprocessed single-use devices. MTFs should contact AFMOA/SGMP, DSN: 343-4164 for more information on the "Go Green" initiative.

DOROTHY A. HOGG,
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

29 Code of Federal Regulations, §1910.1030, *Bloodborne Pathogens.*

29 Code of Federal Regulations, §1910.134, *Respiratory Protection*.

Defense Health Agency, Procedural Instruction 6200.01, *Comprehensive Infection Prevention and Control (IPC) Program,* April 24, 2017

AFI 25-201, *Intra-Service, Intra-Agency, and Inter-Agency Support Agreements Procedures,* 18 October 2013

AFI 33-360, *Publications and Forms Management*, 19 January 2018

AFI 41-201, *Managing Clinical Engineering Programs*, 10 October 2017

AFI 41-209, *Medical Logistics Support*

AFI 44-102, *Medical Care Management*, 17 March 2015

AFI 44-178, *Human Immunodeficiency Virus Program,* 4 March 2014

AFI 48-137, *Respiratory Protection Program,* 15 July 2014

AFI 48-145, *Occupational and Environmental Health Program*, 22 July 2014

AFI 48-307, Volume 1, *En Route Care and Aeromedical Evacuation Medical Operations*, 9 January 2017

AFPD 44-1, *Medical Operations,* 9 June 2016

Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms

AAMI—Association for the Advancement of Medical Instrumentation

AFI—Air Force Instruction

AFIA—Air Force Inspection Agency

AFMOA—-Air Force Medical Operations Agency

AFMS—Air Force Medical Service

AFMSA—-Air Force Medical Support Agency

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

ANG—Air National Guard

APIC—Association for Professionals in Infection Control and Epidemiology

ARC—Air Reserve Component

BE—Bioenvironmental Engineering

BBP—ECP—Bloodborne Pathogen Exposure Control Plan

CAUTI—Catheter-Associated Urinary Tract Infection

CDC—Centers for Disease Control and Prevention

CFR—Code of Federal Regulations

CLABSI—Central Line-Associated Bloodstream Infection

COR—-Contracting Officer Representative

DHA—-Defense Health Agency

DMLSS—Defense Medical Logistics Standard Support

ECOMS—Executive Committee of the Medical Staff

EPIC—Epidemiology Prevention and Infection Control

FDA—Food and Drug Administration

HAI—Healthcare-Associated Infection

HAMS—Hospital Aseptic Management System

ICRA—Infection Prevention and Control Risk Assessment

ICU—Intensive Care Unit

IFU—Information For Use

IMFE—Individual Medical Facility Exhibit

IP—Infection Preventionist

IPC—Infection Prevention and Control

IPCF—Infection Prevention and Control Function

IPCP—Infection Prevention and Control Program

MAJCOM—Major Command

MICT—Management Internal Control Toolset

MOU—Memorandum of Understanding

MTF—Military Medical Treatment Facility

NHSN—National Healthcare Safety Network

OSHA—Occupational Safety and Health Administration

PPE—Personal Protective Equipment

PWS—Performance Work Statement

SAC—Self-Assessment Communicators

SG—Surgeon General

SGH—Chief Medical Officer

SSI—Surgical Site Infection

UTA—Unit Training Assembly

VAP—Ventilator Associated

Terms

Antimicrobial—An agent that kills microorganisms or stops their growth.

Epidemiology—The branch of medicine that deals with the incidence, distribution, and possible control of diseases and other factors relating to health.

The Joint Commission—An independent not-for-profit group in the United States that administers voluntary accreditation programs for hospitals and other healthcare organizations.

Culture—Cultivation of bacteria, tissue cells, in conditions suitable for growth.

Zoonoses—A disease that can be transmitted to humans from animals.

Attachment 2

TABLE A2.1. INFECTION PREVENTION AND CONTROL RISK ASSESSMENT (ICRA).

1 Risk/Event	2 Probability / Risk of occurrence (See Note 2)	3 Impact/Severity (to patients, staff, or facility) (See Note 3)	4 How well is MTF/Unit prepared to prevent or improve listed risk (See Note 4)	5 Score (Add column 2, 3 and 4)	6 Prioritize based on score
HEALTH CONCERNS OF POPULATION					
High-risk Patients (Note 1)					
Diabetes					
Extremes of age					
GEOGRAPHIC CONCERNS					
Location (ex. Proximity to a border, OCONUS)					
Weather					
Vector-borne illness					
EMERGENCY PREPAREDNESS					
Natural / Man-made Disaster					
Managing an Influx of Infectious Patients					
Interruption of Utilities					
POLICIES / PROCEDURES					
Review / Revision of Policies (specify)					
MDGI					
IPC-Specific OI					
Bloodborne Pathogens / Exposure Control Plan					
Tuberculosis / Respiratory Protection Plan					
OUTBREAKS					
Influenza					

Sexually Transmitted Infections					
HEALTHCARE-ASSOCIATED INFECTIONS (HAIs)					
Central Line-Associated Bloodstream Infections					
Catheter-Associated Urinary Tract Infections					
Ventilator-Associated Events / Ventilator-Associated Pneumonia					
Surgical Site Infections					
Outpatient Procedures					
Inadequate surveillance activities					
COMPLIANCE WITH ESTABLISHED POLICIES OR PROCEDURES					
Aseptic Technique					
Disposal / Transport of Regulated Medical Waste					
Hand Hygiene					
Standard Precautions / Transmission-based Precautions					
N95 fit test / PPD skin test					
Sharps injuries / BBP exposure reporting					
REUSABLE MEDICAL DEVICES / STERILE PROCESSING / HIGH-LEVEL DISINFECTION					
Availability of manufacturers' instructions for use					
Competency training (initial and annual)					
Incorrect reprocessing practices					
Sterilizer monitoring / reporting					
Incorrect storage					
ENVIRONMENT					

Construction / Renovation ICRA					
Air handling system (Air exchanges, Temperature, Humidity)					
Housekeeping practices					
Cleaning of patient care equipment					
ANTIBIOTIC / ANTIMICROBIAL RESISTANCE					
Methicillin-resistant *Staphylococcus aureus*					
Vancomycin-resistant *Enterococcus*					
Clostridium difficile					
Extended Spectrum *Enterobacteriaceae*					
Other					
EDUCATION					
Newcomers' Orientation					
Unit-Specific Orientation					
Annual Training					
RESOURCE LIMITATIONS					
Infection Prevention and Control staff					
Nursing staff					
Other clinical support staff					
ORGANIZATION'S SURVEILLANCE DATA					
Historical data (e.g., last year's surveillance data)					

(**Note 1**) Examples only. Insert a separate row for each Risk/Event; more examples are available on the Knowledge Exchange.

(**Note 2**) Score as follows:

0 = Not likely to occur

1 = Low risk (uncommon/rare occurrence)

2 = Medium risk (occasional occurrence)

3 = High risk (frequent occurrence)

(**Note 3**) Score as follows:

1 = Low risk (Minimal clinical impact; less likely to cause disruption of services, minimal legal or financial impact)

2 = Medium risk (moderate severity of disruption of services, damage or failure of equipment or processes, legal or financial impact)

3 = High risk (threat to life or health)

(Note 4) Score as follows:

1 = Low risk (program in place; sound written guidance; evidence of compliance)

2 = Medium risk (program in place, but needs to be reassessed, older written guidance, poor proof of compliance)

3 = High risk (no program in place, no written guidance, no proof of compliance)