2025 SNF Symposium on Infection Prevention and Control

Hosted by the Long-Term Care Facilities Team
Part of the Healthcare Outreach Unit
In Acute Communicable Disease Control

County of Los Angeles Public Health

09/22/2025

Association for Professionals in Infection Control and Epidemiology

County of Los Angeles Public Health

Infection Prevention Word Search

L F K U J H E V S R M M W V Q B J N L N
L F K D F G T P E N B I I Z S X O Q O A
O S J B P A I X I K O R C U B I M I C F
R R M U A D M A M D U I R R T B T U B Z
T D F R V J M X I S E V T N O A M R K W
N I F U E Y U L E D E M E U Z B P Z F L
O X N M D G N S X I S V I I A N E K X O
C U N F X G I Q L N E K L O S C U S P Q
N T O Z W H Z L L R B I Q H L Y E M V N
O Q P S W L A J P U R L M K N O Z R V O
I T S X U N T R S E V O L G T V G H P I
T V N Y C C I F T I Z R R L C C L Y O T
C N E E E E O S P A T H O G E N S K U A
E K C W I Y N X O E Y P P A X W C D T N
F S S R M U N N J S Z N E C Q J O M B I
N G S J X V N N A V O L G L J M C G R C
I E R B D I S L N X K Q M J X O T W E C
T G I L Q A D I S I N F E C T I O N A A
R E N E I G Y H D N A H N Z M H Z B K V
C C A C V L N E E H T J F O A L F S Y P

Word Bank

DISINFECTION
EPIDEMIOLOGY
GERMS
GLOVES
HAND HYGIENE
IMMUNIZATION
INFECTION CONTROL
MICROBES
OUTBREAK
PATHOGENS
PRECAUTIONS
PREVENTION
STERILIZATION
SURVEILLANCE
VACCINATION
VIRUSES

Download more games, puzzles, and resources to share with your colleagues!
Visit https://infectionpreventionandyou.org for more resources to promote infection prevention.

Association for Professionals in Infection Control and Epidemiology

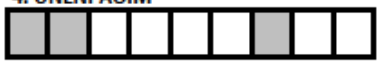
Word Jumble #3

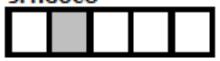
Unscramble the letters to form important words in fighting infections, or things that you hear about when talking about infections. Then use the letters in the shaded areas to find the role we all play.

1. AEBRCTAI 

2. AIISZNET 

3. YENIHEG 

4. UNENPAOIM 

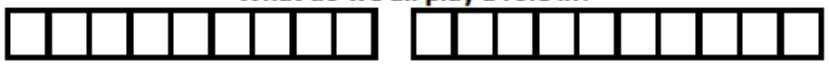
5. HGUCO 

6. VCICNEA 

7. ENNLUAZIF 

8. EUADONCIT 

What do we all play a role in?



Download more games, puzzles, and resources to share with your colleagues!
Visit www.apic.org/infectionpreventionandyou for more resources to promote infection prevention.

Answer Key

1. Bacteria, 2. Sanitize, 3. Hygiene, 4. Pneumonia, 5. Cough, 6. Vaccine, 7. Influenza, 8. Education

Role: Infection Prevention

APIC®

Association for Professionals in Infection Control and Epidemiology

County of Los Angeles Public Health

Germ Matching

Match the answers from the right column with the clues in the left column.

1. This is the best way to prevent the spread of germs.
2. You need to get this vaccination every year.
3. These are the minimum infection prevention practices that should be used in the care of all patients
4. This is a yeast that can lead to invasive infections.
5. This is sometimes referred to as the "stomach flu" even though it isn't a flu.
6. This "ancient" disease has seen a recent comeback.
7. Antibiotics can cause this gut germ to grow out of control.
8. Adults born between 1945 and 1956 should get screened for this disease.
9. Using these improperly may cause superbugs to grow.
10. This vaccine-preventable disease has seen upticks in recent years.

A. Antibiotics

B. *Candida auris*

C. *Clostridium difficile*

D. Hand Hygiene

E. Hepatitis C

F. Influenza

G. Measles

H. Norovirus

I. Standard Precautions

J. Tuberculosis

1. _____ **2.** _____ **3.** _____ **4.** _____ **5.** _____

6. _____ **7.** _____ **8.** _____ **9.** _____ **10.** _____

Download more games, puzzles, and resources to share with your colleagues!
Visit https://infectionpreventionandyou.org for more resources to promote infection prevention.

Answer Key

Welcome!

Moderator:

Chandana Das, MD

AGENDA

Time:	Topic:	Speaker(s):
8:00 AM – 9:00 AM	*Check-In*	
9:00 AM – 9:15 AM	Welcome Remarks	Chandana Das
9:15 AM – 10:45 AM	MDRO Case Studies	Sandeep Bhaurla
10:45 AM – 11:00 AM	*Break*	
11:00 AM- 12:00 PM	CDPH-EVS Collaboration	Zenith Khwaja
12:00 PM – 1:00 PM	*Lunch Break*	
1:00 PM – 2:00 PM	Networking	
2:00 PM – 3:00 PM	HRID Surveys: What to Expect	Michael Lewis & Jessica Jaldon
3:00 PM – 3:15 PM	*Break*	
3:15 PM – 4:30 PM	Unpacking an ICAR	Marco Marquez & Walteena Brooks
4:30 PM – 4:35 PM	Closing Remarks	Chandana Das

Important Announcements

2025-2026 Health Officer Order

- The 2025-2026 Annual Influenza Immunization or Masking Requirement for Healthcare Personnel During Respiratory Virus Season Health Officer Order has been posted.
- In this year's order, the respiratory virus season is defined as November 1, 2025 to March 31, 2026.
- Due to the limited Food and Drug Administration approval of the COVID-19 vaccine and its uncertain availability for this year, it has been removed from the requirements for HCP.
- However, due to the nature of care provided to highly vulnerable populations, the high risk of rapid respiratory virus transmission in SNFs, and low influenza vaccination rates among SNF HCP, all HCP in SNFs must wear a respiratory mask while in contact with residents or working in resident-care areas throughout the respiratory virus season.

1. http://ph.lacounty.gov/media/health-officer-order.htm
2. http://ph.lacounty.gov/acd/docs/HOORespVirusSeason2025.pdf

Antibiotic Stewardship Program Website

- Our Antibiotic Stewardship team has a website with all of the resources you might need for your own antibiotic stewardship initiatives

- One thing to highlight is the new Approach to Evaluation and Monitoring of UTIs in SNF residents

- This can be found in the Programs, Guides, and Toolkits section of the website

1. http://publichealth.lacounty.gov/acd/AntibioticStewardshipProgram/index.htm
2. http://publichealth.lacounty.gov/acd/docs/UTI-Evaluationmonitoring-in-SNFs.pdf

MDRO Case Studies 9:15 am-10:45 am

Novel & Targeted Multidrug-Resistant Organisms (MDROs): How to Detect and Prevent

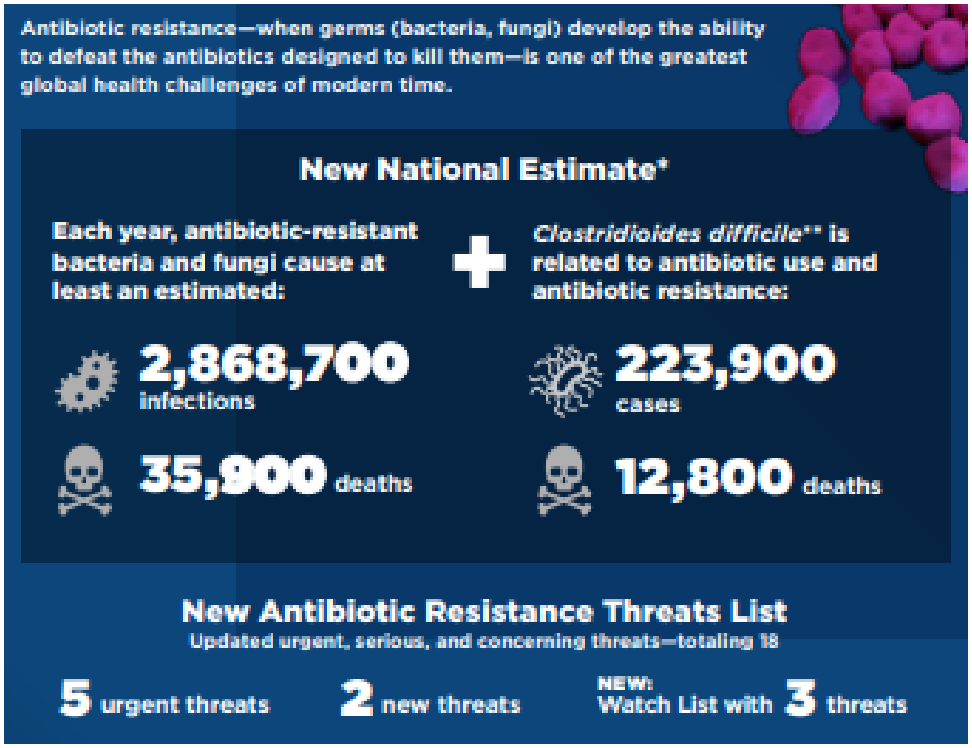
Sandeep K. Bhaurla, MPH, CIC
Epidemiologist
Healthcare Outreach Unit (HOU)
Acute Communicable Disease Control Program (ACDC)
Los Angeles County Department of Public Health

SNF Symposium
September 22nd, 2025

Objectives

- Review novel & targeted multidrug-resistant organisms (MDROs)
- Describe the epidemiology and prevention of these MDROs
- Discuss the role of infection preventionists in detecting, reporting, and containing novel & targeted MDROs
- Share best practices for admitting and cohorting MDRO-positive residents

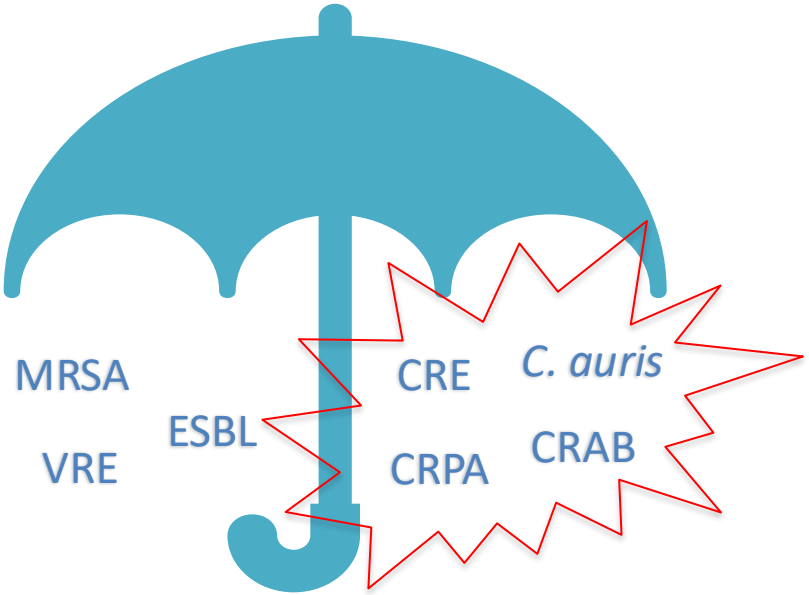
What are MDROs?



1.CDC 2019 AR Threats Report: https://www.cdc.gov/drugresistance/biggest-threats.html
2.COVID-19 Impact on AR: https://www.cdc.gov/drugresistance/pdf/covid19-impact-report-508.pdf

What "Novel" or "Targeted" MDROs Are

- Novel MDROs are:
  - Never/rarely detected in the US
  - Very difficult to treat
- Targeted MDROs are:
  - Pre-endemic
  - Difficult to treat
  - Easy to spread
- Varies by region/jurisdiction



https://www.cdc.gov/hai/pdfs/mdro-guides/Health-Response-Contain-MDRO-H.pdf

see page 4-5 of SNF MDRO guidance

LACDPH MDRO Tier Designation

Tier	Description	Pathogens Included
1	Pathogens/resistance mechanisms never or very rarely detected in Los Angeles County (novel MDROs)	• Novel organism and/or resistance mechanism • Pan-resistant gram-negative organism[1]
2	Pathogens/resistance mechanisms not commonly detected in Los Angeles County (targeted MDROs)	• Concerning *C. auris*[2] • Uncommon carbapenemase-producing *Acinetobacter* spp.[3] • Uncommon carbapenemase-producing Enterobacterales[4]
3	Pathogens/resistance mechanisms commonly detected in Los Angeles County but not endemic	• Carbapenemase-producing *Pseudomonas* spp.[5] • NDM-producing Enterobacterales
4	Pathogens/resistance mechanisms endemic in Los Angeles County and/ or less epidemiologically concerning	• KPC-producing Enterobacterales • *C. auris* • OXA-23-like-producing *Acinetobacter* spp. • Vancomycin-resistant *Staphylococcus aureus* • Other MDROs not previously listed

Increasing DPH follow-up

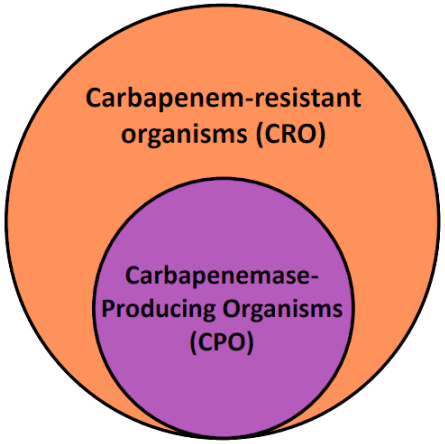
1.Resistant (R) to all drugs tested at public health laboratories (including CDC)
2.Including echinocandin- or pan-resistant C. auris
3.Incldng NDM-, IMP-, VIM-, and KPC-producing Acinetobacter *spp.*
4.Including IMP-, VIM-, and OXA-like producing Enterobacterales
5.Including VIM-, IMP-, NDM-, KPC-, and OXA-like producing Pseudomonas *spp.*

http://publichealth.lacounty.gov/acd/docs/LACDPH_MDRO_Tiers_ExternalGuidance.pdf

CPO vs Carbapenem-resistant Organisms (CROs)

- **CRO= carbapenem-resistant organism**
  - Organism that is resistant (R) to carbapenem antibiotics
    - Meropenem, doripenem, ertapenem, imipenem
  - Includes carbapenem-resistant (CR)-
    - Enterobacterales (CRE)
    - *Acinetobacter baumanii* (CRAB)
    - *Pseudomonas aeruginosa* (CRPA)
  - Regardless of having a carbapenemase or not

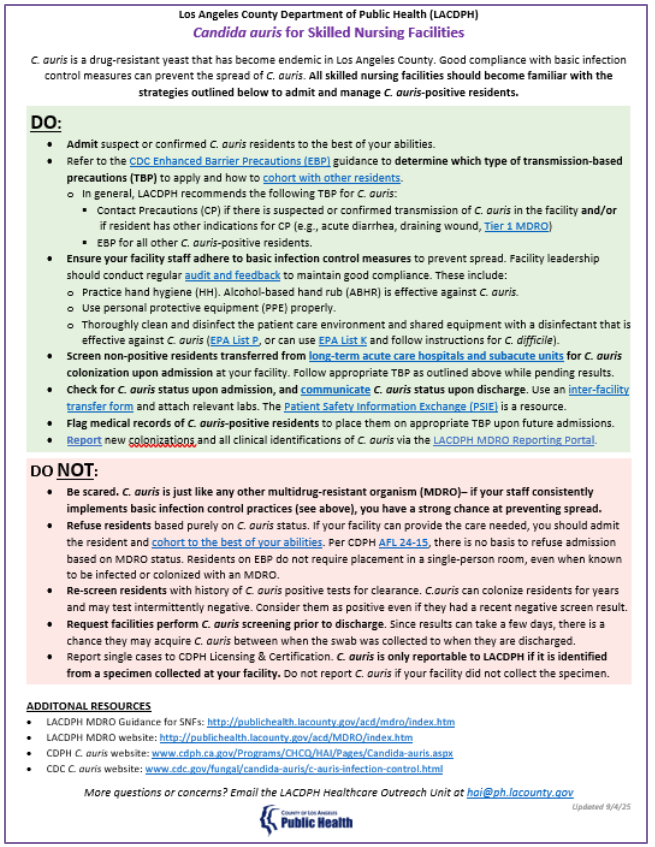
- **CPO= carbapenemase-producing organism**
  - Organism that produces a carbapenemase enzyme
    - KPC, IMP, NDM, OXA, VIM
  - This is one way organisms become CR
  - *Examples: KPC-producing CRE, VIM-producing CRPA*



http://publichealth.lacounty.gov/acd/docs/CDCMidAtlanticWebinarSimplifyingCROs.pdf

Candida auris

- Drug-resistant yeast
  - SoCal strain very treatable
- Can survive on surfaces for longer periods of time
  - Must use appropriate disinfectant
- Can cause outbreaks **if** basic IPC not met
  - Outbreaks in SNFs are rare



Los Angeles County Department of Public Health (LACDPH)

Candida auris for Skilled Nursing Facilities

C. auris is a drug-resistant yeast that has become endemic in Los Angeles County. Good compliance with basic infection control measures can prevent the spread of *C. auris*. **All skilled nursing facilities should become familiar with the strategies outlined below to admit and manage *C. auris*-positive residents.**

DO:

- **Admit** suspect or confirmed *C. auris* residents to the best of your abilities.
- Refer to the CDC Enhanced Barrier Precautions (EBP) guidance to **determine which type of transmission-based precautions (TBP)** to apply and how to cohort with other residents.
  - In general, LACDPH recommends the following TBP for *C. auris*:
    - Contact Precautions (CP) if there is suspected or confirmed transmission of *C. auris* in the facility **and/or** if resident has other indications for CP (e.g., acute diarrhea, draining wound, Tier 1 MDRO)
    - EBP for all other *C. auris*-positive residents.
- **Ensure your facility staff adhere to basic infection control measures** to prevent spread. Facility leadership should conduct regular audit and feedback to maintain good compliance. These include:
  - Practice hand hygiene (HH). Alcohol-based hand rub (ABHR) is effective against *C. auris*.
  - Use personal protective equipment (PPE) properly.
  - Thoroughly clean and disinfect the patient care environment and shared equipment with a disinfectant that is effective against *C. auris* (EPA List P, or can use EPA List K and follow instructions for *C. difficile*).
- **Screen non-positive residents transferred from long-term acute care hospitals and subacute units for *C. auris* colonization upon admission** at your facility. Follow appropriate TBP as outlined above while pending results.
- **Check for *C. auris* status upon admission, and communicate *C. auris* status upon discharge.** Use an inter-facility transfer form and attach relevant labs. The Patient Safety Information Exchange (PSIE) is a resource.
- **Flag medical records of *C. auris*-positive residents** to place them on appropriate TBP upon future admissions.
- Report new colonizations and all clinical identifications of *C. auris* via the LACDPH MDRO Reporting Portal.

DO NOT:

- **Be scared. *C. auris* is just like any other multidrug-resistant organism (MDRO)– if your staff consistently implements basic infection control practices (see above), you have a strong chance at preventing spread.**
- **Refuse residents** based purely on *C. auris* status. If your facility can provide the care needed, you should admit the resident and cohort to the best of your abilities. Per CDPH AFL 24-15, there is no basis to refuse admission based on MDRO status. Residents on EBP do not require placement in a single-person room, even when known to be infected or colonized with an MDRO.
- **Re-screen residents** with history of *C. auris* positive tests for clearance. *C.auris* can colonize residents for years and may test intermittently negative. Consider them as positive even if they had a recent negative screen result.
- **Request facilities perform *C. auris* screening prior to discharge**. Since results can take a few days, there is a chance they may acquire *C. auris* between when the swab was collected to when they are discharged.
- Report single cases to CDPH Licensing & Certification. ***C. auris* is only reportable to LACDPH if it is identified from a specimen collected at your facility.** Do not report *C. auris* if your facility did not collect the specimen.

ADDITONAL RESOURCES

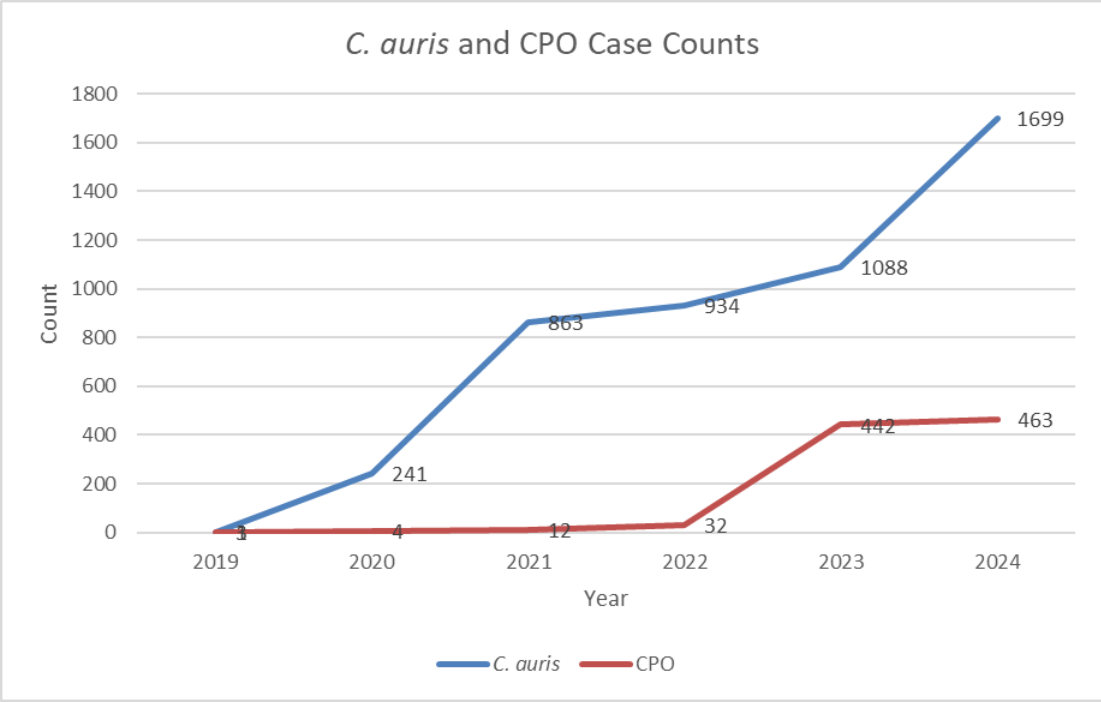
- LACDPH MDRO Guidance for SNFs: http://publichealth.lacounty.gov/acd/mdro/index.htm
- LACDPH MDRO website: http://publichealth.lacounty.gov/acd/MDRO/index.htm
- CDPH *C. auris* website: www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/Candida-auris.aspx
- CDC *C. auris* website: www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html

More questions or concerns? Email the LACDPH Healthcare Outreach Unit at hai@ph.lacounty.gov

Updated 9/4/25

Public Health

MDROs in LA County, 2019-2024



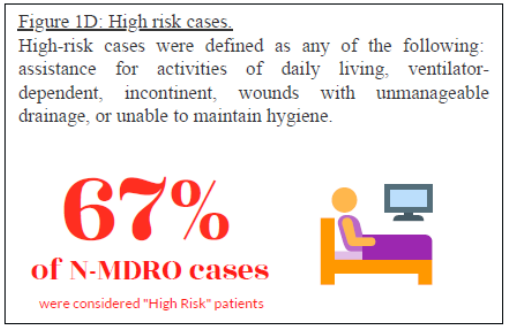
http://publichealth.lacounty.gov/NMDROReportDashboard.htm

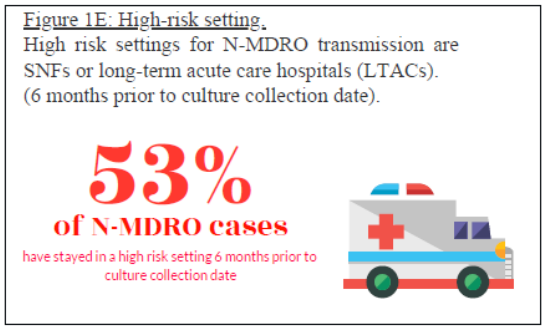
How are MDROs transmitted?

- Person-to-person **contact** with infected or colonized people
  - contact with wounds or stool
- Contact can occur with contaminated surfaces, such as via
  - hands of healthcare staff who did not perform hand hygiene
  - medical equipment that have not been correctly cleaned
  - Some (CROs) via contaminated water sources or products
- Does not change by specimen source
  - E.g., patient with MDRO in sputum does not transmit via droplet

Who is at risk for acquiring MDROs?

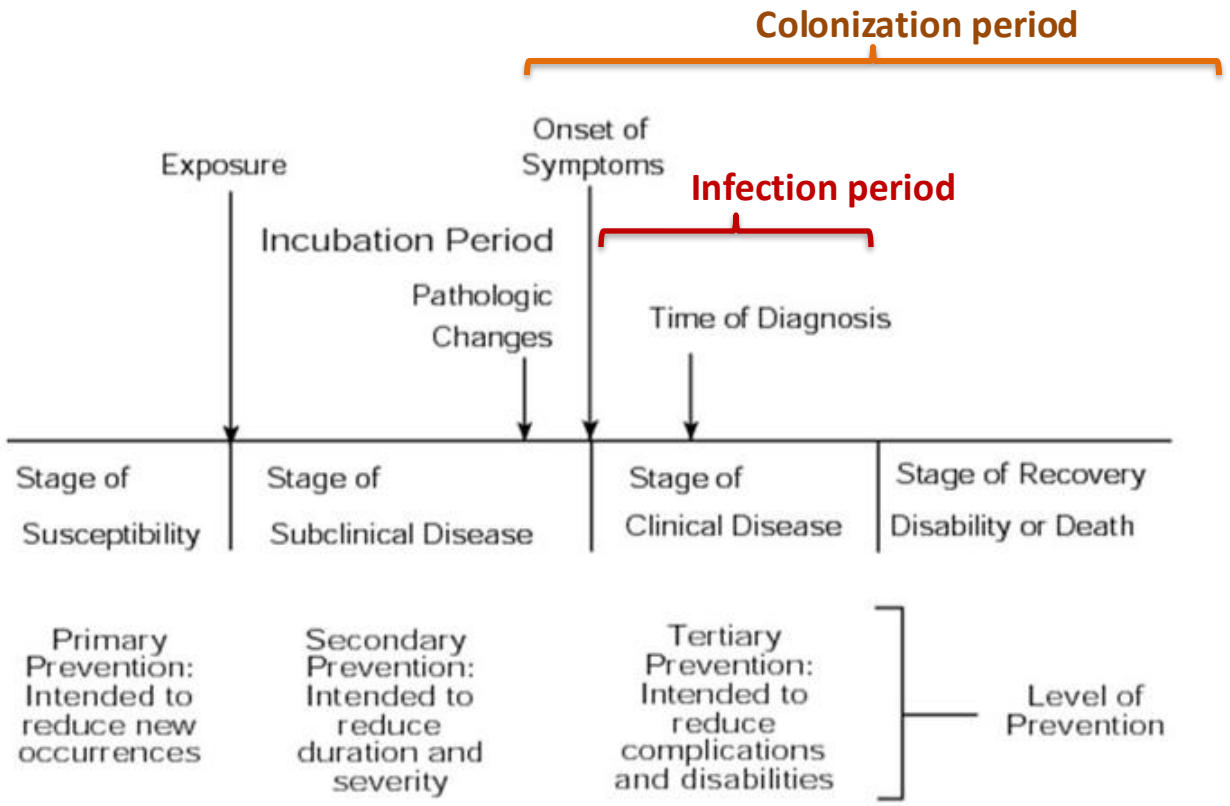
- Patients/residents at highest risk, especially those with
  - One or more devices (e.g., ventilators, catheters)
  - Long courses of antibiotics
  - Weakened immune systems
  - History of healthcare received outside the United States
  - Frequent or long-term exposure to healthcare facilities



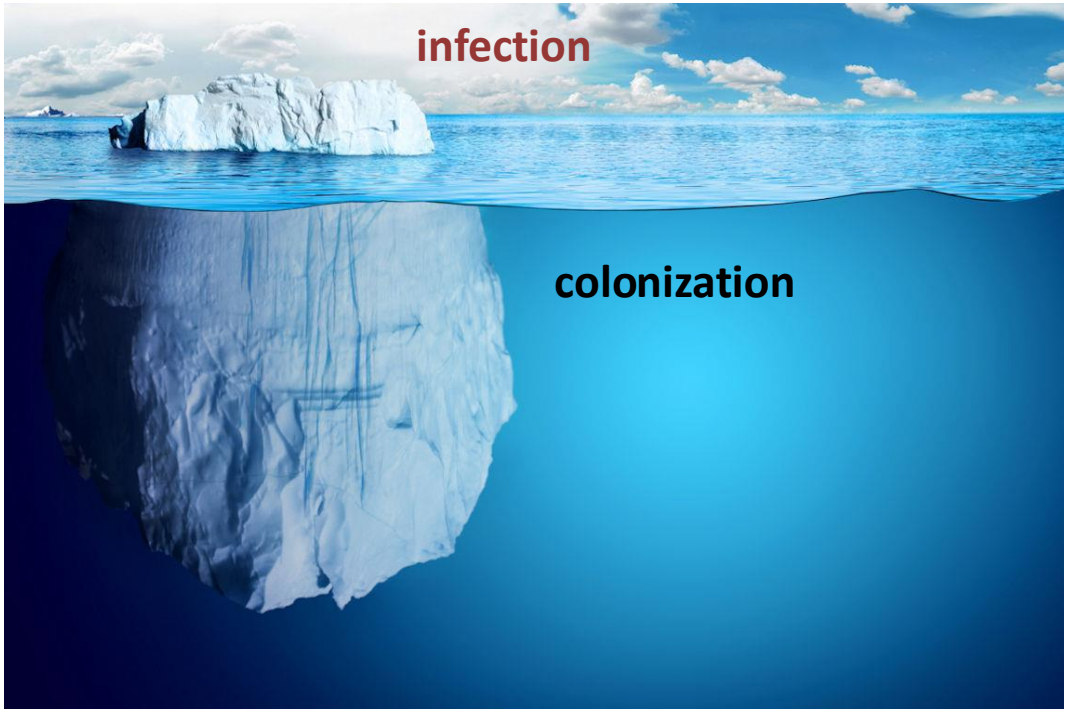


http://publichealth.lacounty.gov/Acd/docs/NMDRONewsletter_Issue1.pdf

Timeline of disease progression for MDROs



Clinical cases are only the tip of the MDRO iceberg



If you only screen patients with signs/symptoms of an infection, you will miss additional cases

What's the difference?

Colonization

- Growth of microorganisms on host tissue but without tissue invasion or damage
- No symptoms
- May never resolve
- Other terms:
  - "asymptomatic carrier"
- Example:
  - MRSA in the nares
  - CRE in urine **without** signs or symptoms

Infection

- Growth of organisms in host tissue which do cause damage, may cause a disease
- Usually shows symptoms
- Eventually resolves (e.g., after treatment)
- Other terms:
  - "symptomatic infection"
- Examples
  - MRSA bloodstream infection
  - CRE in urine **with** signs or symptoms

https://ldh.la.gov/assets/oph/Center-PHCH/Center-CH/infectious-epi/HAI/HAIworkshop2017/handoutsD1/ColonizationvInfection2017.pdf

HOW TO DETECT

CPO results can vary – get familiar with your lab!

Preliminary Report
Verified Date/Time: 7/13/2025 08:24 PDT
2+ Acinetobacter baumannii CRO (carbapenem-resistant organism) Carbapenemase producing gene(s) DETECTED NDM Carbapenemase Producing Gene Detected
Sent to LA County Lab for further testing.
Rare Normal upper respiratory flora isolated

Preliminary Report

{	ORGANISM	_ACINETOBACTER_BAUMANNII_COMPL_			06/18/25.1213.RTP.
{	CRE MOLECULAR	__Positive_	A	(NORMAL:Negative)	06/18/25.1213.RTP.
{	IMP	__Negative_		(NORMAL:Negative)	06/18/25.1213.RTP.
{	KPC	__Negative_		(NORMAL:Negative)	06/18/25.1213.RTP.
{	NDM	__Positive_	A	(NORMAL:Negative)	06/18/25.1213.RTP.
{	OXA-48-LIKE	__Negative_		(NORMAL:Negative)	06/18/25.1213.RTP.
{	VIM	__Negative_		(NORMAL:Negative)	06/18/25.1213.RTP.

Specimen Collection Date: Aug 15, 2025@11:33

Test name	Result	units	Ref. range	Site Code
Carba-r Resist Conf PCR	DETECTED		Ref: Not Detected	[691]
Carba-r Resist Imp Gene	Not Detected			[691]
Carba-r Resist Vim Gene	Not Detected			[691]
Carba-r Resist Ndm Gene	Not Detected			[691]
Carba-r Resist Kpc Gene	Not Detected			[691]
Carba-r Resist Oxa48 Gene	DETECTED			[691]

Reportable Tests: Blood Culture Gram Negative Pathogen Panel

See Values: Klebsiella pneumoniae, DNA (A), OXA (CRE resistance gene), DNA (A)

Blood Culture GN Panel, PCR (Final result)

Test Analyte	Result Value
Escherichia coli, DNA	Not Detected
Pseudomonas aeruginosa, DNA	Not Detected
Klebsiella pneumoniae, DNA	Detected (A)
Klebsiella oxytoca, DNA	Not Detected
CTX-M (ESBL resistance gene), DNA	Not Detected
Enterobacter species, DNA	Not Detected
Proteus species, DNA	Not Detected
Acinetobacter species, DNA	Not Detected
Citrobacter species, DNA	Not Detected
OXA (CRE resistance gene), DNA	Detected (A)
IMP (CRE resistance gene), DNA	Not Detected
KPC (CRE resistance gene), DNA	Not Detected
VIM (CRE resistance gene), DNA	Not Detected
NDM (CRE resistance gene), DNA	Not Detected

Concerning *Candida auris*

Almost all *C. auris* in LA County is only resistant to fluconazole – but more resistant, or "concerning" strains, have been identified. This is an example of a concerning *C. auris* resistance profile →

Identification			Candida auris
Analyte/Drug	Value	Units	Results/Interpretation
Amphotericin B (E-Test)	0.5	µg/mL	No CLSI Interpretation
Anidulafungin	4	µg/mL	No CLSI Interpretation
Caspofungin	2	µg/mL	No CLSI Interpretation
Fluconazole	256	µg/mL	No CLSI Interpretation
Isavuconazole	0.12	µg/mL	No CLSI Interpretation
Itraconazole	0.5	µg/mL	No CLSI Interpretation
Micafungin	4	µg/mL	No CLSI Interpretation
Posaconazole	0.12	µg/mL	No CLSI Interpretation
Voriconazole	2	µg/mL	No CLSI Interpretation

Types of MDRO Surveillance Strategies

Active Surveillance

- **What**: Identify colonized individuals with risk factors and/or as part of investigation
- **How**: Screening swabs collected for surveillance testing

- Examples:
  - Screening individuals exposed to MDROs
  - Point prevalence surveys (PPS)
  - Admission screening for carbapenem-resistant Enterobacterales (CRE)

Passive Surveillance

- **What**: Identify/report individuals colonized or infected with important organisms
- **How**: Routine clinical specimens collected for diagnostic testing

- Examples:
  - *C. auris* detected from urine culture
  - CRE detected from blood culture

LACDPH *C. auris* & CPO Active Surveillance Recommendations

CPOs

- Admission screening* for patients:
  - With recent international healthcare exposure
  - Admitted from high-risk facilities[1]
  - Admitted from facilities with outbreaks
- Screening epi-linked contacts of new cases[2]

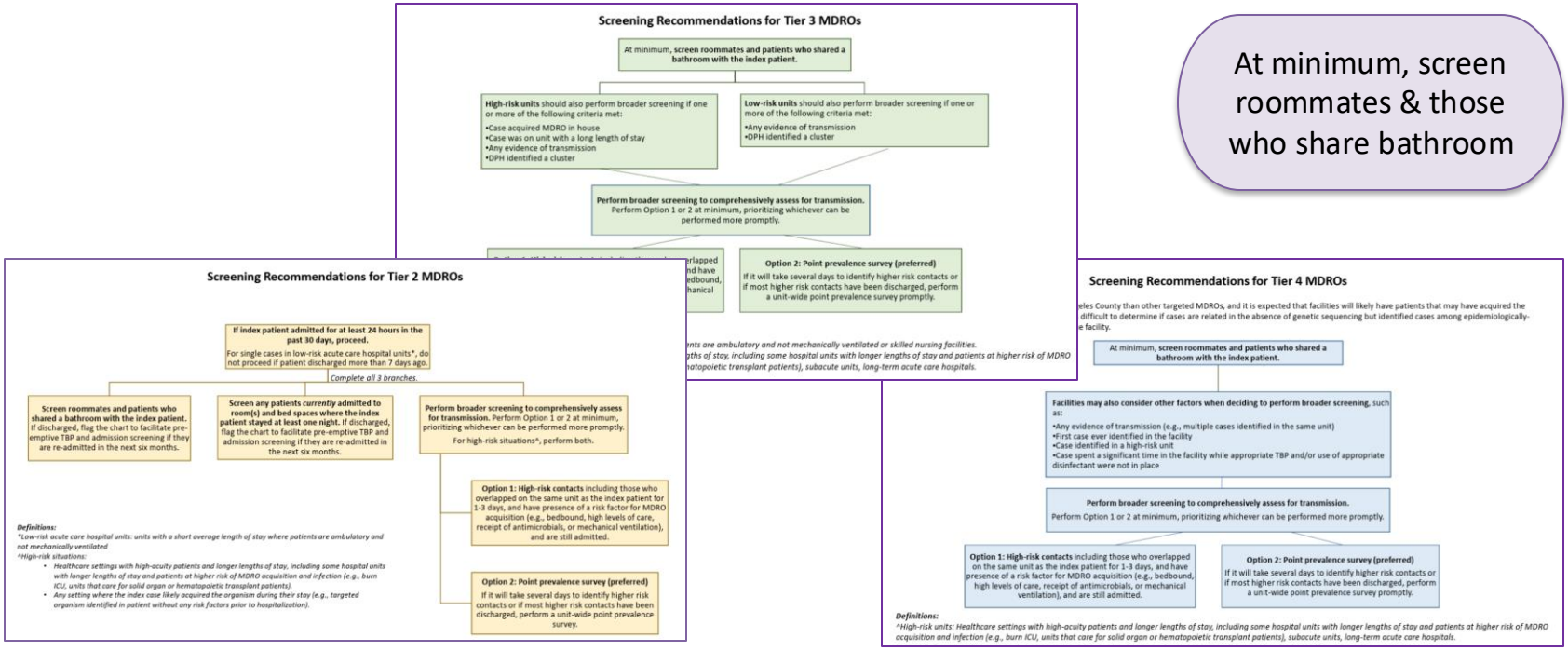
C. auris

- Admission screening* for patients:
  - Admitted from high-risk facilities[1]
  - Admitted from facilities with outbreaks
- Screening epi-linked contacts of new cases[2]

**Avoid requesting screening prior to discharge – patient may acquire before they leave!*

1. http://publichealth.lacounty.gov/acd/LTACvSNF.htm
2. http://publichealth.lacounty.gov/acd/docs/NMDROTierScreeningInterpretation.pdf

Use LACDPH MDRO Screening Algorithm to determine who to screen when new in-house cases identified



At minimum, screen roommates & those who share bathroom

http://publichealth.lacounty.gov/acd/docs/NMDROTierScreeningInterpretation.pdf

C. auris & CPO Screening Resources

CPOs (& CROs)

- Recommended swab: rectal
- List of labs that detect CPO: http://publichealth.lacounty.gov/acd/docs/LaboratorieswithCPOScreening.pdf

C. auris

- Recommended swab: axilla/groin
- List of labs: http://publichealth.lacounty.gov/acd/docs/List_C.aurisLabs.pdf

For both:

- The goal is to identify **colonization** (not infection)
- Most major reference labs offer colonization screening services
- Ideally, perform screen upon admission (not prior to discharge)
- Turnaround time varies by method (PCR faster than culture)
  - Check with lab to confirm correct test and correct swab location

How to request a proactive PPS?

- Goal is to ***prevent an outbreak***

- Complete a PPS Request Form
  - All swabs, shipping supplies, and testing are provided at no cost.
  - Results available within 1-3 weeks.
  - DPH IP support available

- Contact LACDPH HAI team hai@ph.lacounty.gov for consultation and guidance.

- This will meet criteria for the LACDPH SNF Honors Program (Category 4: Preventive Action).

2024-2025 LAC DPH SNF Honors Program

The Los Angeles County (LAC) Department of Public Health (DPH) would like to announce the opening of the 2024-2025 Skilled Nursing Facility (SNF) Honors Program.

The SNF Honors Program is designed to provide special recognition to facilities for outstanding performance in the following categories:

- Public Health Engagement
- Vaccination Coverage
- Infection Prevention Professional Development
- Preventive Action

Activities eligible for program recognition will begin in August 2024 and conclude in May 2025. More information is coming, including a description of program criteria, criteria for each category, the assessment process, and honoree awards. Awarded SNFs will receive certificates and publication on the SNF Honors Program Public Dashboard.

Visit the website: http://publichealth.lacounty.gov/acd/SNFHonorsProgram/index.htm

Contact Us: LACSNF@ph.lacounty.gov

Los Angeles County Department of Public Health
publichealth.lacounty.gov/acd/SNFHonorsProgram/index.htm
2024-2025 SNF Honors Program Flyer, Rev. 8-26-24

http://publichealth.lacounty.gov/acd/SNFHonorsProgram/index.htm

LACDPH *C. auris* & CPO Reporting Requirements

CPOs

- Laboratory reporting only

C. auris

- Provider & Laboratory reporting
  - Use MDRO Reporting Portal: https://dphredcap.ph.lacounty.gov/surveys/?s=CE3RHJD3DF

For both:

- Only report specimens collected at your facility
- IPs should report suspect clusters or outbreaks to ACDC within 1 working day

1. http://publichealth.lacounty.gov/acd/mdro/index.htm#reporting

How to do MDRO surveillance?

- Starting from date of admission, track all MDRO-positive lab reports and maintain a line list to help monitor healthcare-onset (HO) versus community-onset (CO) infections/colonizations

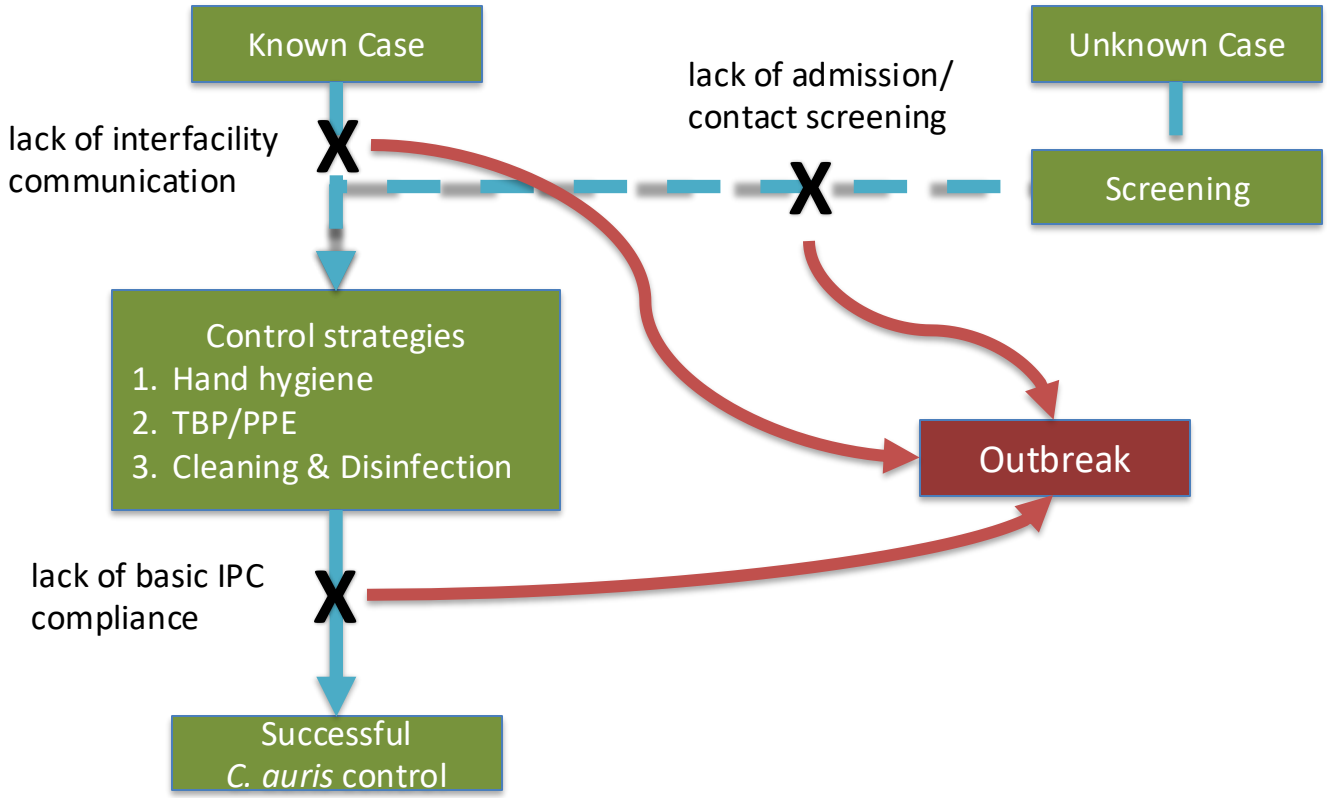
- Regularly review to identify trends that may require intervention
  - E.g., a cluster of a specific organism in a specific unit.
    - *For example: you usually see 1 HO-CRE per month. This past month, you had 4 HO-CRE in the same unit. This should be reported and investigated.*

- See here for an example of an MDRO line list *(downloadable file)*

Date:							Unit:				
RESIDENT NAME/ MR Number	GENDER	ROOM	DATE OF ADMISSION	ADMITTED FROM (latest)	ORGANISM	SITE OF INFECTION/ COLONIZATION	DATE OF CULTURE	DATE OF RESULTS	DATE OF ISOLATION	ISOLATION/ PRECAUTION	Comment
XXX	F	211	6/2/2022	Hospital B	CRE	Sputum	6/6/2022	6/8/2022	6/6/2022	Contact	
XXXX	M	232-A	5/12/2022	SNF B	C.auris	urine	4/12/2021	4/15/2021	5/12/2022	ESP	
XXXXX	M	232-B	5/27/2022	Hospital A	C.auris	Sputum	5/5/2022	5/22/2022	5/27/2022	ESP	

HOW TO PREVENT

Common causes of MDRO outbreaks in LA County healthcare facilities



Basics of MDRO Prevention

Hand Hygiene

- Use of alcohol-based hand rub (ABHR) preferred
- Audit/feedback
- Staff & visitors

Personal Protective Equipment

- Appropriate transmission-based precautions (TBP)
- Audit/feedback
- Staff & visitors

Environmental Cleaning & Disinfection

- Use of EPA- approved disinfectants
- Audit/feedback

Antimicrobial stewardship

- Ensuring judicious use of antimicrobials to prevent future resistance

Inter-facility Communication

- Use of transfer form
- Use of LACDPH PSIE

Surveillance

- Tracking MDRO cases to detect possible clusters
- Screening admissions and epi-linked contacts

Reducing CPO risk from water

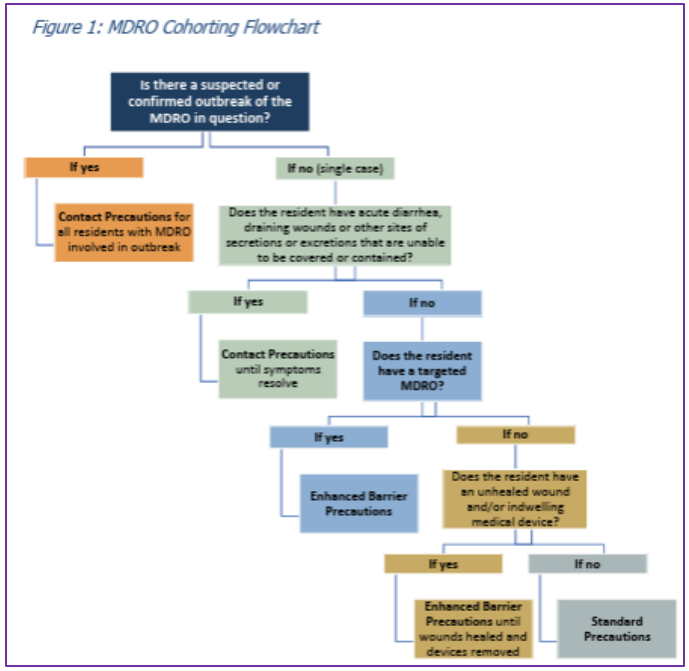
1. Maintain a water management program
2. Conduct a Water Infection Control Risk Assessment (WICRA)
3. Reduce exposure from sinks and drains
4. Select sinks that reduce risk

https://www.cdc.gov/healthcare-associated-infections/php/toolkit/water-management.html

Deciding what type of TBP to apply

- Ask yourself:
  - Is there transmission in the unit/facility?
  - What type of organism is it?
  - Does this patient have any risk factors?

- What should **not** be considered:
  - Current antibiotic use
  - Specimen source



see pages 10-11 of SNF MDRO guidance

Contact Precautions (CP)

Criteria	Duration	PPE use	Can they leave the room?
Resident is positive for a novel MDRO (Tier 1 MDRO).	Residents may be moved to EBP if/when DPH states organism can be de-escalated.	Gloves and gown for any room entry. (Don before room entry, doff before room exit; change before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray)	Yes, only if resident is **c**lean, **c**ontained, and **c**ompliant. If resident has acute diarrhea, draining wounds or other sites of secretions or excretions that are unable to be covered or contained, they cannot leave the room except for medically necessary care.
Unit/facility is experiencing suspected or confirmed transmission of this organism.	Residents may be moved to EBP or SP, as appropriate, once transmission is controlled.		
Resident has acute diarrhea, draining wounds or other sites of secretions or excretions that cannot be covered or contained.	Acute diarrhea resolves; wounds no longer draining, or can be covered/contained.		
Residents with other infections requiring CP (e.g., *C. difficile*, norovirus).	No longer require spore or airborne precautions.		

Enhanced Barrier Precautions (EBP)

Criteria	Duration	PPE use	Can they leave the room?
Resident has one or more of the following high-risk characteristics **AND** criteria for CP do not apply: • Presence of indwelling devices (e.g., catheters or endotracheal tubes). • Wounds or unhealed pressure ulcers.	Resident may be moved to SP if they no longer have indwelling devices and/or open/unhealed wounds.	Gloves and gown prior to high-contact care activity. (Change PPE and perform HH before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray)	Yes, only if resident is **c**lean, **c**ontained, and **c**ompliant.
Resident is positive for a targeted MDRO (Tier 2, 3 or 4 MDRO).	Duration of admission.		

https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/EBP_AdditionalConsiderationsForCA_SNF.pdf

Examples of high-contact resident care activities requiring gown and glove use for EBP

- Dressing
- Bathing/showering
- Transferring
- Providing hygiene
- Changing linens
- Changing briefs or assisting with toileting
- Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator
- Wound care: any skin opening requiring a dressing

EBP should be followed specifically when **anticipating close physical contact** while assisting with transfers and mobility

https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html
https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html
https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/PFL_Module7BathingDressing_FAQ.pdf

Standard Precautions (SP)

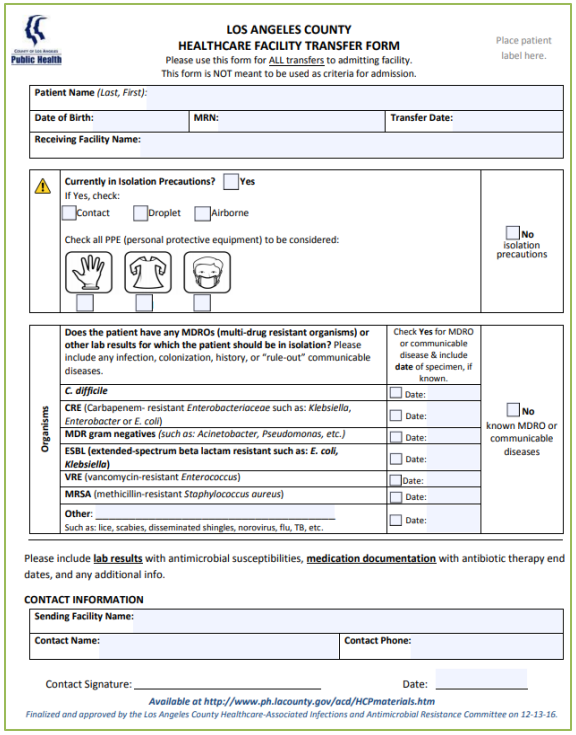
Criteria	Duration	PPE Use	Can they leave the room?
Use only if resident does not meet criteria for EBP or CP, **or** Resides in a community care facility or other non-healthcare facility.	n/a	Depending on anticipated exposure: gloves, gown, or facemask or eye protection. (Change PPE and perform HH before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray)	Yes

How colonization affects TBP

- **Key fact: patients who are colonized can still spread MDROs to other patients**
- Length of precautions
  - MRSA, VRE, ESBL **do** have decolonization methods[1]
  - CROs, CPOs and *C. auris* **do not**
    - CDC and CDPH do not recommend re-testing for "clearance"
- Cohorting
  - You **do not** have to separate people who are "infected" versus "colonized"!

1. https://www.naccho.org/uploads/downloadable-resources/Programs/Community-Health/NACCHO-Decolonization-Implementation-Webinar-March-2023.pdf

Inter-facility Communication is VITAL



LOS ANGELES COUNTY
HEALTHCARE FACILITY TRANSFER FORM

Please use this form for ALL transfers to admitting facility.
This form is NOT meant to be used as criteria for admission.

Place patient label here.

Patient Name *(Last, First):*

Date of Birth: | **MRN:** | **Transfer Date:**

Receiving Facility Name:

Currently in Isolation Precautions? ☐ Yes
If Yes, check:
☐ Contact ☐ Droplet ☐ Airborne

Check all PPE (personal protective equipment) to be considered:

☐ No isolation precautions

Organisms

Does the patient have any MDROs (multi-drug resistant organisms) or other lab results for which the patient should be in isolation? Please include any infection, colonization, history, or "rule-out" communicable diseases.	Check **Yes** for MDRO or communicable disease & include **date** of specimen, if known.
C. difficile	☐ Date:
CRE (Carbapenem- resistant *Enterobacteriaceae* such as: *Klebsiella, Enterobacter* or *E. coli*)	☐ Date:
MDR gram negatives *(such as: Acinetobacter, Pseudomonas, etc.)*	☐ Date:
ESBL (extended-spectrum beta lactam resistant such as: *E. coli, Klebsiella*)	☐ Date:
VRE (vancomycin-resistant *Enterococcus*)	☐ Date:
MRSA (methicillin-resistant *Staphylococcus aureus*)	☐ Date:
Other: _____ Such as: lice, scabies, disseminated shingles, norovirus, flu, TB, etc.	☐ Date:

☐ No known MDRO or communicable diseases

Please include **lab results** with antimicrobial susceptibilities, **medication documentation** with antibiotic therapy end dates, and any additional info.

CONTACT INFORMATION

Sending Facility Name:

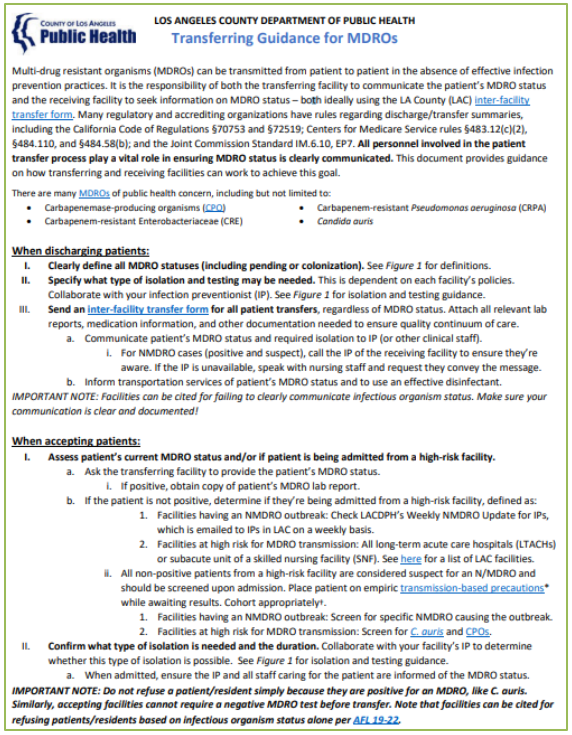
Contact Name: | **Contact Phone:**

Contact Signature: _____ Date: _____

Available at http://www.ph.lacounty.gov/acd/HCPmaterials.htm

Finalized and approved by the Los Angeles County Healthcare-Associated Infections and Antimicrobial Resistance Committee on 12-13-16.

http://publichealth.lacounty.gov/acd/docs/FacilityTransferForm.pdf



LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH

Transferring Guidance for MDROs

Multi-drug resistant organisms (MDROs) can be transmitted from patient to patient in the absence of effective infection prevention practices. It is the responsibility of both the transferring facility to communicate the patient's MDRO status and the receiving facility to seek information on MDRO status – both ideally using the LA County (LAC) inter-facility transfer form. Many regulatory and accrediting organizations have rules regarding discharge/transfer summaries, including the California Code of Regulations §70753 and §72519; Centers for Medicare Service rules §483.12(c)(2), §484.110, and §484.58(b); and the Joint Commission Standard IM.6.10, EP7. **All personnel involved in the patient transfer process play a vital role in ensuring MDRO status is clearly communicated.** This document provides guidance on how transferring and receiving facilities can work to achieve this goal.

There are many MDROs of public health concern, including but not limited to:

- Carbapenemase-producing organisms (CPO)
- Carbapenem-resistant Enterobacteriaceae (CRE)
- Carbapenem-resistant *Pseudomonas aeruginosa* (CRPA)
- *Candida auris*

When discharging patients:

I. **Clearly define all MDRO statuses (including pending or colonization).** See *Figure 1* for definitions.
II. **Specify what type of isolation and testing may be needed.** This is dependent on each facility's policies. Collaborate with your infection preventionist (IP). See *Figure 1* for isolation and testing guidance.
III. **Send an inter-facility transfer form for all patient transfers**, regardless of MDRO status. Attach all relevant lab reports, medication information, and other documentation needed to ensure quality continuum of care.
   a. Communicate patient's MDRO status and required isolation to IP (or other clinical staff).
      i. For NMDRO cases (positive and suspect), call the IP of the receiving facility to ensure they're aware. If the IP is unavailable, speak with nursing staff and request they convey the message.
   b. Inform transportation services of patient's MDRO status and to use an effective disinfectant.

IMPORTANT NOTE: Facilities can be cited for failing to clearly communicate infectious organism status. Make sure your communication is clear and documented!

When accepting patients:

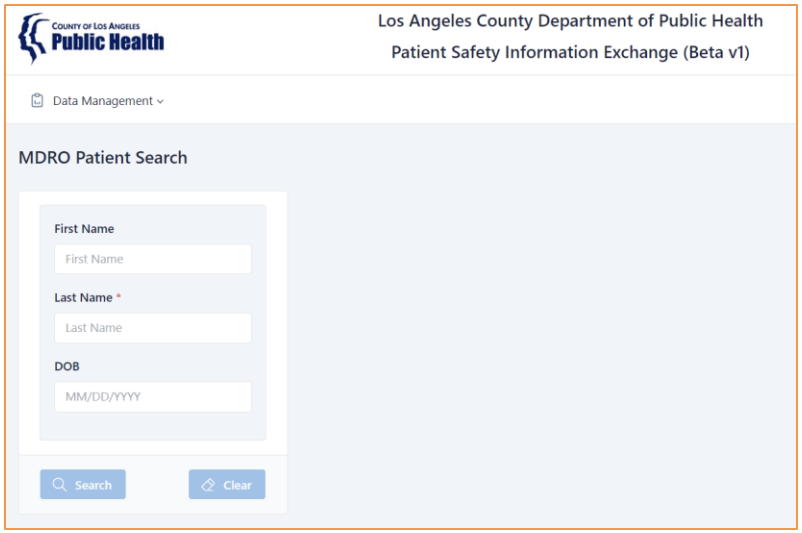
I. **Assess patient's current MDRO status and/or if patient is being admitted from a high-risk facility.**
   a. Ask the transferring facility to provide the patient's MDRO status.
      i. If positive, obtain copy of patient's MDRO lab report.
   b. If the patient is not positive, determine if they're being admitted from a high-risk facility, defined as:
      1. Facilities having an NMDRO outbreak: Check LACDPH's Weekly NMDRO Update for IPs, which is emailed to IPs in LAC on a weekly basis.
      2. Facilities at high risk for MDRO transmission: All long-term acute care hospitals (LTACHs) or subacute unit of a skilled nursing facility (SNF). See here for a list of LAC facilities.
      ii. All non-positive patients from a high-risk facility are considered suspect for an N/MDRO and should be screened upon admission. Place patient on empiric transmission-based precautions* while awaiting results. Cohort appropriately†.
         1. Facilities having an NMDRO outbreak: Screen for specific NMDRO causing the outbreak.
         2. Facilities at high risk for MDRO transmission: Screen for *C. auris* and CPOs.
II. **Confirm what type of isolation is needed and the duration.** Collaborate with your facility's IP to determine whether this type of isolation is possible. See *Figure 1* for isolation and testing guidance.
   a. When admitted, ensure the IP and all staff caring for the patient are informed of the MDRO status.

IMPORTANT NOTE: Do not refuse a patient/resident simply because they are positive for an MDRO, like C. auris. Similarly, accepting facilities cannot require a negative MDRO test before transfer. Note that facilities can be cited for refusing patients/residents based on infectious organism status alone per AFL 19-22.

http://publichealth.lacounty.gov/acd/docs/LACDPH_TransferringGuidanceforMDROs.pdf

Simplifying access to patient MDRO history – LAC Patient Safety Information Exchange (PSIE)

- Easy search for patient MDRO history
  - Includes all confirmed incidents reported to LA County DPH
    - *Candida auris*
    - CPOs
    - CRE
- Can access anytime, anywhere with secure web-based login
- **To start registration for PSIE, email PSIE@ph.lacounty.gov for form links.**



visit
http://publichealth.lacounty.gov/acd/patientsafetyinformationexchange
for more information!

HOW TO MANAGE

A new *C. auris* crisis…

- The problem: More *C. auris* cases, less available beds
- The results:
  - Patients stuck in hospitals
  - Families and patients stressed
  - Hospitals and patients overwhelmed

Example: patient hospitalized for 225 days while awaiting SNF placement (was ready at day 30).

Example: "My dad is so sad, he just wants to go back to his nursing home. We're having to look and travel further just to find a SNF that's willing to accept him."

Example:
Patient care bill: $3.9 million dollars
Amount paid by insurance: $2.49 million
Cost incurred by healthcare institution: $1.41 million

Live survey

- Use a few words to describe your top concerns with C. auris in your facilities

Busting common *C. auris* myths

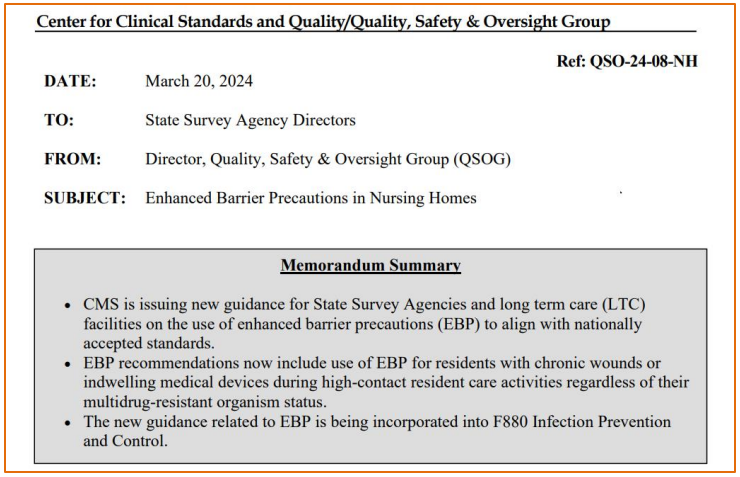
What we will do:

- Provide guidance, resources, sample policies & templates for facilities to incorporate into their own in-house policy
- Be available to answer any questions or concerns
- Investigate clusters of MDROs and reports of novel/targeted MDROs

What we will NOT do:

- Close facilities to admissions
- Conduct point prevalence surveys solely for the reason that you have *C. auris* patients admitted
- Open outbreaks without full investigation to know whether a cluster is above a facility's baseline level

CMS and CDPH Guidance



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-24-08-NH

DATE: March 20, 2024

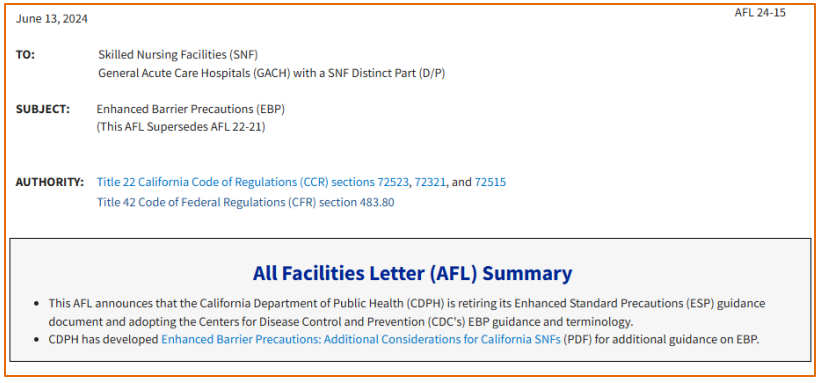
TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Enhanced Barrier Precautions in Nursing Homes

Memorandum Summary

- CMS is issuing new guidance for State Survey Agencies and long term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards.
- EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status.
- The new guidance related to EBP is being incorporated into F880 Infection Prevention and Control.



June 13, 2024

AFL 24-15

TO: Skilled Nursing Facilities (SNF)
General Acute Care Hospitals (GACH) with a SNF Distinct Part (D/P)

SUBJECT: Enhanced Barrier Precautions (EBP)
(This AFL Supersedes AFL 22-21)

AUTHORITY: Title 22 California Code of Regulations (CCR) sections 72523, 72321, and 72515
Title 42 Code of Federal Regulations (CFR) section 483.80

All Facilities Letter (AFL) Summary

- This AFL announces that the California Department of Public Health (CDPH) is retiring its Enhanced Standard Precautions (ESP) guidance document and adopting the Centers for Disease Control and Prevention (CDC's) EBP guidance and terminology.
- CDPH has developed Enhanced Barrier Precautions: Additional Considerations for California SNFs (PDF) for additional guidance on EBP.

"All SNFs in compliance with the CMS's EBP requirement are able to admit and provide care for residents with MDROs.

Thus, **there is no basis for a SNF to refuse admission of a resident based on their need for EBP or MDRO status**.

Residents on EBP do not require placement in a single-person room, even when known to be infected or colonized with an MDRO."

New SNF MDRO Cohorting Guidance

http://publichealth.lacounty.gov/acd/docs/SNFMDROGuidance.pdf

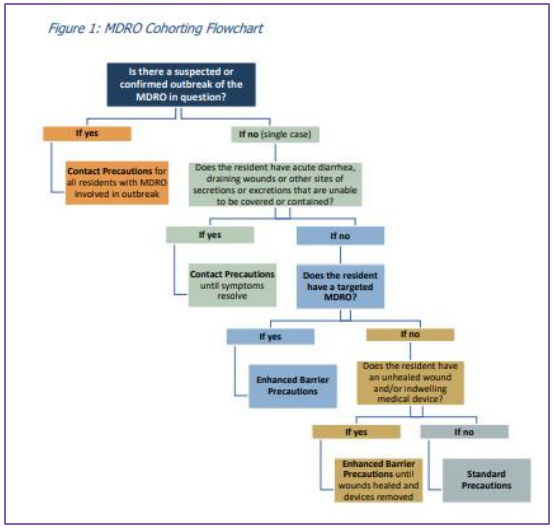
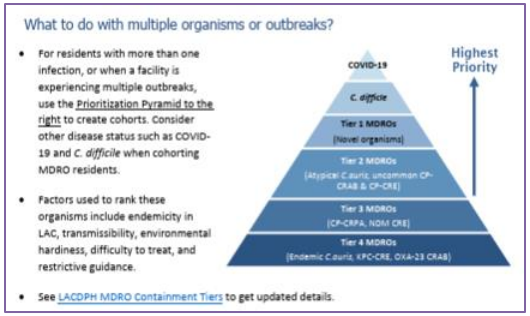


Table 4: TBP and Cohorting Recommendations by MDRO Type

Organism	TBP Type	How to cohort*
MRSA, VRE, ESBL	SP	Cohort with anyone (no need to cohort with another resident with the same organism), unless the facility is experiencing an outbreak for which cohorting needs to be prioritized. See LACDPH Rethinking Contact Precautions for MRSA and VRE for more guidance: http://publichealth.lacounty.gov/acd/RethinkingContactPrecautions/index.htm
CPOs	EBP	Cohort only with other residents with the same carbapenemase gene (KPC, IMP, NDM, OXA, VIM), unless there is an outbreak with a targeted MDRO for which cohorting needs to be prioritized. If a SNF is unable to admit or cohort a new MDRO-positive resident due to a lack of a compatible roommate[a], the new resident can be placed in a room with a non-positive resident with the fewest risk factors for MDRO acquisition.*
CROs	EBP	Cohort only with other residents with the same organism, unless there is an outbreak with a targeted MDRO for which cohorting needs to be prioritized. If a SNF is unable to admit or cohort a new MDRO-positive resident due to a lack of a compatible roommate[a], the new resident can be placed in a room with a non-positive resident with the fewest risk factors for MDRO acquisition.*
C. auris	EBP	Cohort only with other residents with the same organism unless there is an outbreak with a targeted MDRO for which cohorting needs to be prioritized. If a SNF is unable to admit or cohort a new MDRO-positive resident due to a lack of a compatible roommate[a], the new resident can be placed in a room with a non-positive resident with the fewest risk factors for MDRO acquisition.*
VRSA	CP	Cohort only with other residents with the same organism.
Novel MDRO	CP	Cohort only with other residents with the same organism.



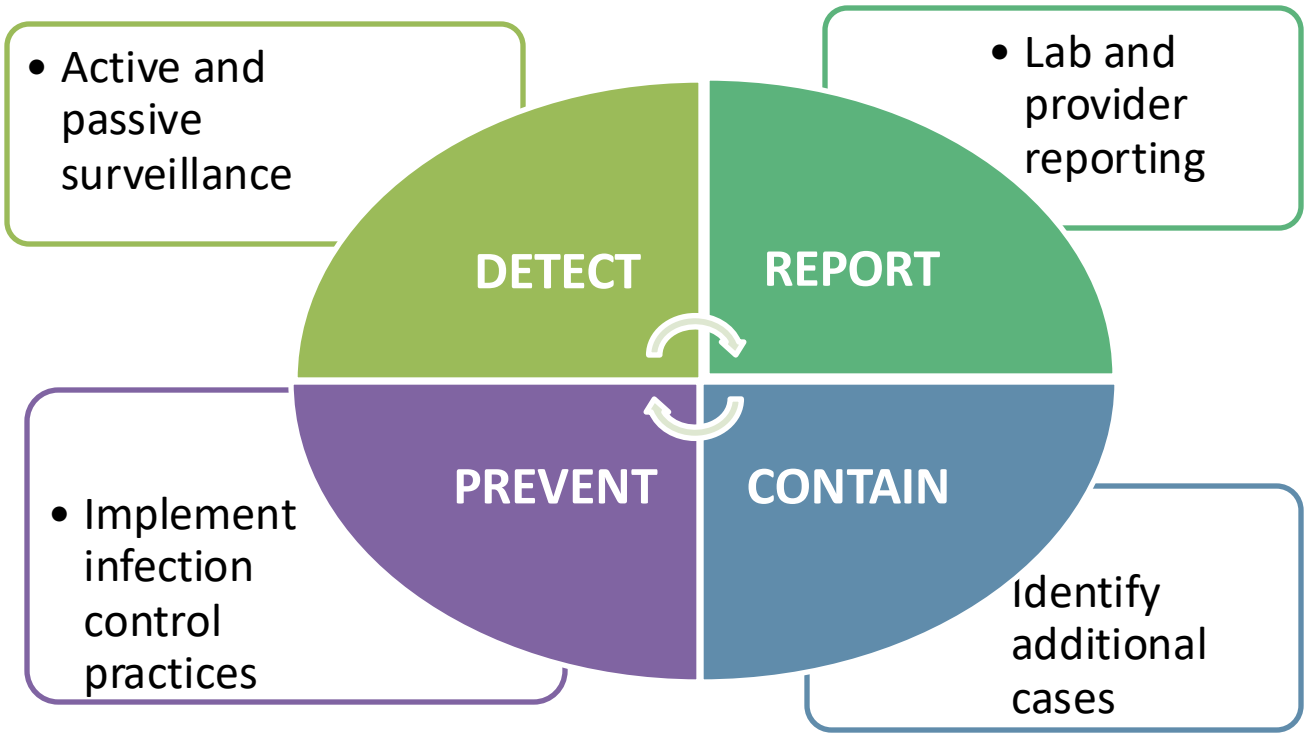
see pages 10-13 of SNF MDRO guidance

Cohorting

- **Ideally cohort "like with like"**
  - Consider other MDROs, COVID-19
  - Prioritize carbapenemase gene
    - *E.g., KPC-E. coli with KPC-E. coli or KPC-K. pneumoniae*
- If capacity doesn't allow, find next best fit
  - **Ok to cohort in a room with a non-positive**
    - As long as steps to minimize transmission are taken
- **Treat each bed as a separate room**
  - Beds at least 3-6 feet apart
  - Staff change PPE and perform HH between residents
- **Avoid multiple room changes as much as possible**
  - Simplify cohorting policies

see page 12 of SNF MDRO guidance

MDRO CONTAINMENT AND PREVENTION



TABLETOP EXERCISE

Instructions

- Create 2-3 groups per table. Get to know each other.
- You will be provided a scenario (1 mins) and then an opportunity to discuss as a group (5 mins).
- Be ready to share your responses with everyone.
- This is an open, no-fault, low-stress learning exercise – use the provided information and your existing knowledge/capabilities to answer questions.
- This exercise scenario is generalized to conduct the activity. Some artificialities/assumptions are necessary to complete the exercise.

STEP 1: RECEIVING AN MDRO+ PATIENT REQUEST

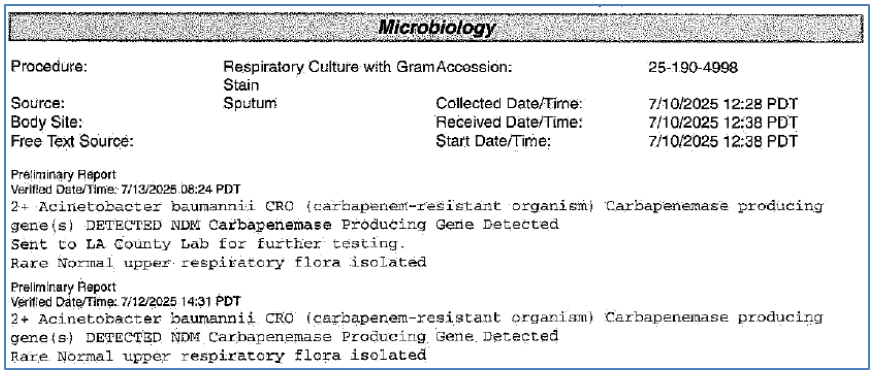
- A hospital reaches out to request a patient transfer:
  - Mr. Homer Simpson
  - 72 years old
  - Hx of diabetes, hypertension
  - Has urinary catheter and wound
  - Positive for NDM-CRAB in urine

QUESTIONS

1. **Is this a concerning MDRO? How do you know?**
   - Refer to LACDPH MDRO guidance
   - NDM-CRAB is a targeted MDRO

2. What kind of information do you need from the hospital?
   - Lab report
   - If on any antibiotics that need to be continued

3. What resources are available to help you get the information you need, including MDRO history?
   - Inter-facility transfer form
   - PSIE
   - IP, case manager, or Admission coordinator



Microbiology

Procedure:	Respiratory Culture with Gram Stain	Accession:	25-190-4998
Source:	Sputum	Collected Date/Time:	7/10/2025 12:28 PDT
Body Site:		Received Date/Time:	7/10/2025 12:38 PDT
Free Text Source:		Start Date/Time:	7/10/2025 12:38 PDT

Preliminary Report
Verified Date/Time: 7/13/2025 08:24 PDT
2+ Acinetobacter baumannii CRO (carbapenem-resistant organism) Carbapenemase producing gene(s) DETECTED NDM Carbapenemase Producing Gene Detected
Sent to LA County Lab for further testing.
Rare Normal upper respiratory flora isolated

Preliminary Report
Verified Date/Time: 7/12/2025 14:31 PDT
2+ Acinetobacter baumannii CRO (carbapenem-resistant organism) Carbapenemase producing gene(s) DETECTED NDM Carbapenemase Producing Gene Detected
Rare Normal upper respiratory flora isolated

see page 5 of SNF MDRO guidance

STEP 2: TRANSFERRING THE RESIDENT

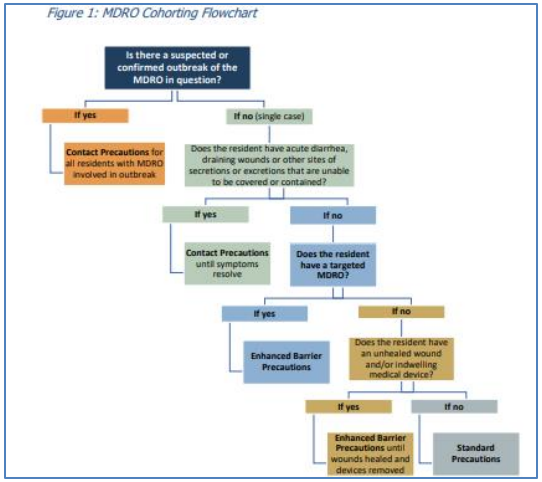
- You are ready to transfer Mr. Simpson.
- There are no single beds available.

QUESTIONS

3. What kind of TBP would you implement?

Answer:

- Enhanced Barrier Precautions.
- Do not have to follow what hospital did.
- Doesn't matter if patient is on antibiotics.



4. How do you cohort them?

Answer:

- Ideally, cohort with another NDM-CRAB-patient.
- If single bed or compatible roommate not available, cohort with resident who has fewest risk factors for transmission **and** in a room that has enough space between beds.

Table 4: TBP and Cohorting Recommendations by MDRO Type

Organism	TBP Type	How to cohort*
MRSA, VRE, ESBL	SP	Cohort with anyone (no need to cohort with another resident with the same organism), unless the facility is experiencing an outbreak for which cohorting needs to be prioritized. See LACDPH Rethinking Contact Precautions for MRSA and VRE for more guidance: http://publichealth.lacounty.gov/acd/RethinkingContactPrecautions/index.htm
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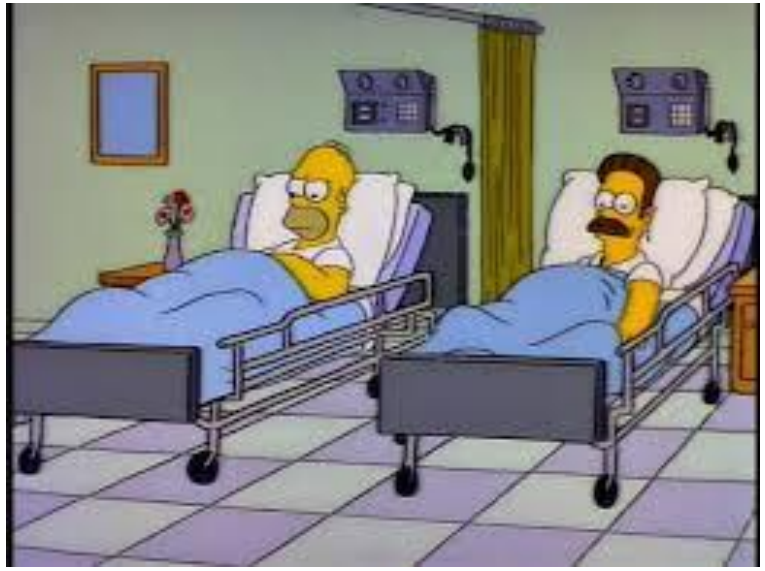
CROs	EBP	Cohort only with other residents with the same organism, unless there is an outbreak with a targeted MDRO for which cohorting needs to be prioritized. If a SNF is unable to admit or cohort a new MDRO-positive resident due to a lack of a compatible roommate*, the new resident can be placed in a room with a non-positive resident with the fewest risk factors for MDRO acquisition.*
C. auris	EBP	Cohort only with other residents with the same organism unless there is an outbreak with a targeted MDRO for which cohorting needs to be prioritized. If a SNF is unable to admit or cohort a new MDRO-positive resident due to a lack of a compatible roommate*, the new resident can be placed in a room with a non-positive resident with the fewest risk factors for MDRO acquisition.*
VRSA	CP	Cohort only with other residents with the same organism.
Novel MDRO	CP	Cohort only with other residents with the same organism.

see pages 8-11 of SNF MDRO guidance

STEP 3: PREVENTING TRANSMISSION

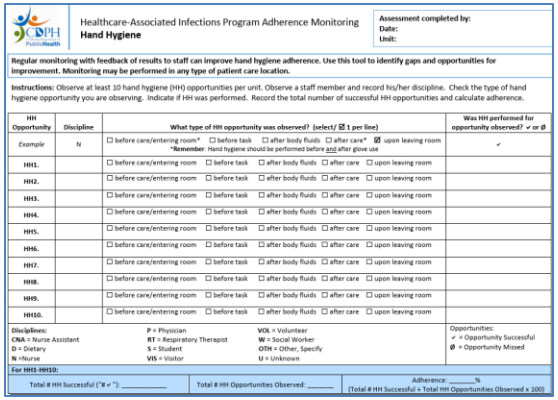
- You placed the resident in a room with another male, who is not positive for NDM-CRAB.
- The patient has been in your facility for 1 month now.



QUESTIONS

5. What actions can you take to assess and improve current IPC practices?

- Answer:
  - Ensure staff treat each bed as a separate space.
  - Increase audits, focusing on key practices like HH, cleaning & disinfection and PPE.



Healthcare-Associated Infections Program Adherence Monitoring
Hand Hygiene

Assessment completed by:
Date:
Unit:

Regular monitoring with feedback of results to staff can improve hand hygiene adherence. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

Instructions: Observe at least 10 hand hygiene (HH) opportunities per unit. Observe a staff member and record his/her discipline. Check the type of hand hygiene opportunity you are observing. Indicate if HH was performed. Record the total number of successful HH opportunities and calculate adherence.

HH Opportunity	Discipline	What type of HH opportunity was observed? (select/ ☑ 1 per line)	Was HH performed for opportunity observed? ✓ or Ø
Example	N	☐ before care/entering room* ☐ before task ☐ after body fluids ☐ after care* ☑ upon leaving room *Remember: Hand hygiene should be performed before and after glove use	✓
HH1.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH2.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH3.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH4.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH5.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH6.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH7.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH8.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH9.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH10.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	

Disciplines:
CNA = Nurse Assistant
D = Dietary
N =Nurse
P = Physician
RT = Respiratory Therapist
S = Student
VIS = Visitor
VOL = Volunteer
W = Social Worker
OTH = Other, Specify
U = Unknown

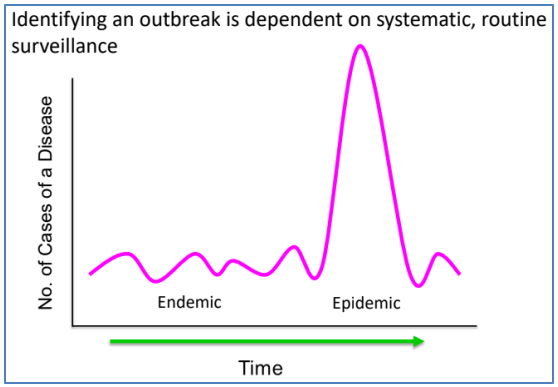
Opportunities:
✓ = Opportunity Successful
Ø = Opportunity Missed

For HH1-HH10:
Total # HH Successful ("✓"): _____
Total # HH Opportunities Observed: _____
Adherence: _____%
(Total # HH Successful ÷ Total HH Opportunities Observed x 100)

see page 12 of SNF MDRO guidance

6. How can you determine if there's additional cases? What happens if additional cases found?

- Answer:
  - Test roommates when new cases identified (at min.)
  - Perform in-house surveillance.
  - Report clusters to DPH for further investigation.



	C. difficile	*C. auris*	CROs/CPOs	COVID-19
Good HH (ABHR preferred)	X (soap & water preferred, esp. during outbreaks)	X	X	X
Appropriate TBP	Contact Precautions	Enhanced Barrier Precautions	Enhanced Barrier Precautions	Contact Precautions + respirator + eye protection
Cohort appropriately	Single room, if possible	X	X	X
Environmental cleaning & disinfection	X (use List K agent)	X (use List P agent)	X	X (use List N agent)
Lab surveillance	X	X	X	X
Screen high-risk contacts	-	X	X	X
Antimicrobial stewardship	X	X	X	-
Interfacility communication	X	X	X	X

Need for a Coordinated Approach to Slow Spread

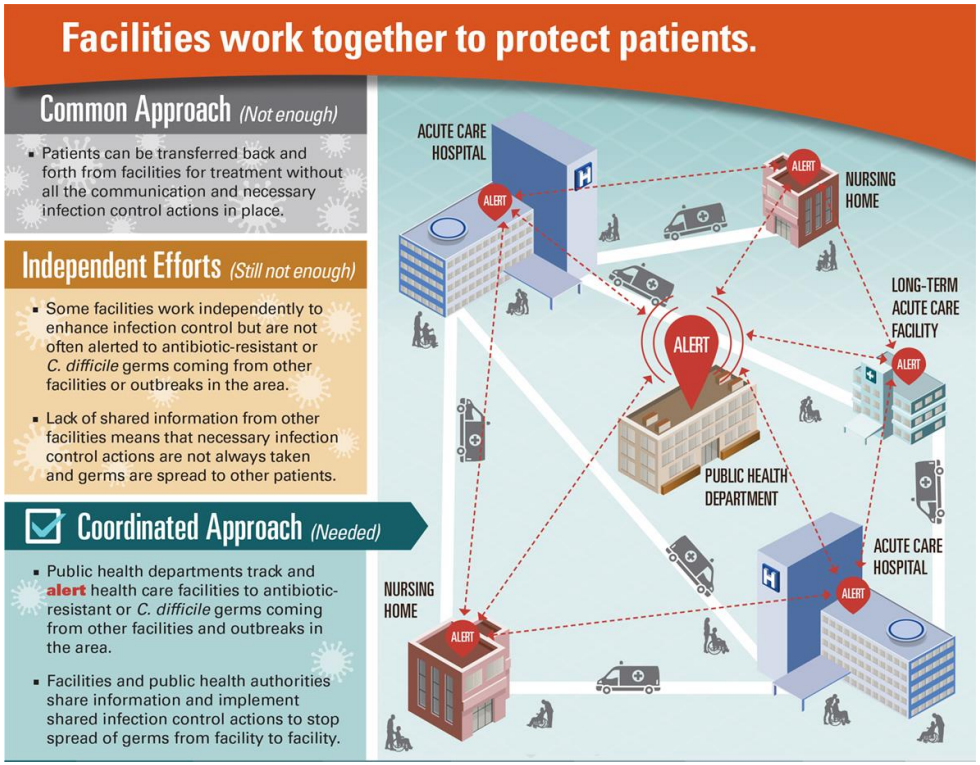


Photo credit: CDC

https://www.cdc.gov/vitalsigns/stop-spread/infographic.html#infographic1

Remember…

- **When in doubt, always contact us!**
  - HOU Email: hai@ph.lacounty.gov
  - HOU website: publichealth.lacounty.gov/acd/HOU/index.htm

- **Additional Resources:**
  - LACDPH MDRO Website: http://publichealth.lacounty.gov/acd/Diseases/MDRO.htm
  - CDPH Antimicrobial Resistance Website: https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AntimicrobialResistanceLandingPage.aspx
  - CDC *C. auris* Infection Control Website: https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html
  - CDC CRE website: https://www.cdc.gov/hai/organisms/cre/index.html
  - CDC HAIs: Consideration for Reducing Risk: Water in Healthcare Facilities https://www.cdc.gov/healthcare-associated-infections/php/toolkit/water-management.html

Questions?

Break 10:45 am-11:00 am

CDPH-EVS Collaboration 11:00 am-12:00 pm

CDPH
California Department of Public Health

Infection Prevention and Control Training for Environmental Services (EVS) Staff

Train-the-Trainer Workshop for Skilled Nursing Facility Educators

LA County SNF Symposium 9/22/2025

Implicit Bias

- Describes how our unconscious attitudes or judgements can influence our thoughts, decisions, or actions
- Includes involuntary, unintentional perceptions made without awareness
- Occurs as our brains sort information and perceive data to understand our world
- Affects our decisions, contributing to societal disparities

Self awareness about Implicit bias can promote healthcare diversity and equality. Learn more about your own implicit bias at Project Implicit (implicit.harvard.edu/implicit/)

Objectives

1. Describe the role of environmental services (EVS) staff and managers in infection prevention and control (IPC) and keeping residents safe
2. Demonstrate accessing toolkit curricula through the Project Firstline EVS Training Toolkit and Implementation Guide
3. Demonstrate how to use toolkit materials to train your staff
4. Demonstrate how to implement hands-on activities to enhance EVS staff learning

EVS Staff are part of the IPC Team!

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EVS Staff are Not Just Cleaning - EVS Staff Protect Residents!

- Previous and current outbreaks of multidrug-resistant organisms (MDROs) have been linked to poor adherence to environmental cleaning and disinfection
- MDRO outbreaks can spread quickly within and between resident-sharing networks

Meaning...

- **Environmental Services IPC education and practice protects residents and saves lives**
  - **EVS Managers and Staff Save Lives!**

EVS Curriculum Created in Partnership with EVS Staff and EVS Managers

- We're here to support you!
  - EVS IPC curriculum created specifically for EVS managers to train EVS staff
- EVS staff-specific training that is retainable and accessible
- Tools for educators to provide simple, in-person, hands-on training
- Focus on EVS tasks, not just general IPC
- Adaptable to different learning styles
- Opportunities for additional training and support

A Note About Today's Workshop: Mini-Modules to Demo Toolkit

- We will highlight select slides to review key content
  - The actual slide sets are larger with more information
- We will share sample curriculum files
  - Each module includes complete curriculum slide set, pre/post training questions, an instructor checklist, and suggested hands-on activities
- **Note: All content is available online in both English and Spanish**

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EVS Staff Training Toolkit

- For EVS Managers, facility educators
- Includes sample training schedules

Infection Prevention and Control Training for Environmental Services Staff in Skilled Nursing Facilities: **A Toolkit and Implementation Guide for Skilled Nursing Facilities and Local Public Health Departments**

CDPH HAI Program Project Firstline

PROJECT FIRSTLINE
CDC's National Training Collaborative for Healthcare Infection Prevention & Control

CDPH
California Department of Public Health

Project Firstline is a national collaborative led by the U.S. Centers for Disease Control and Prevention (CDC) to provide infection control training and education to frontline healthcare workers and public health personnel. The California Department of Public Health Healthcare-Associated Infections (HAI) Program is proud to partner with Project Firstline, as supported through Strengthening HAI/AR Program Capacity (SHARP) funding. CDC is an agency within the Department of Health and Human Services (HHS). The contents of this presentation do not necessarily represent the policies of CDC or HHS and should not be considered an endorsement by the Federal Government.

Question #1

As the facility educator, how do you ensure that your EVS staff adhere to IPC practices? Select all that apply.

A. Provide education and training

B. Conduct adherence monitoring (e.g., for hand hygiene, room cleaning & disinfection)

C. Provide feedback to EVS personnel

D. Engage EVS staff to be part of the solution

E. All of the above

F. Other, specify

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Question #2

What are your barriers to implementing training for EVS staff in your facility?

A. Not sure where to start

B. Lack of leadership support for EVS training

C. Not sure what training materials to use

D. Time constraints or staff availability

E. Other, specify

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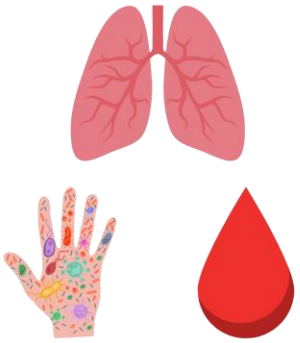
Module 1: Hand Hygiene

- Describe how hand hygiene helps stop the spread of germs
- Demonstrate proper hand hygiene practices
- Adopt proper hand hygiene practices during environmental cleaning and disinfection

Reservoirs: Where Germs Live

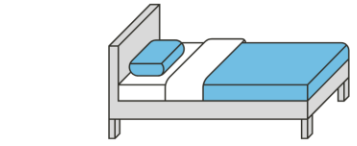
Body Reservoirs

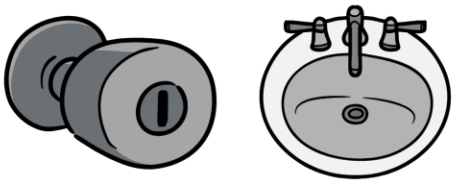
- Skin
- Gastrointestinal system (“the gut”)
- Respiratory system
- Blood



Environmental Reservoirs

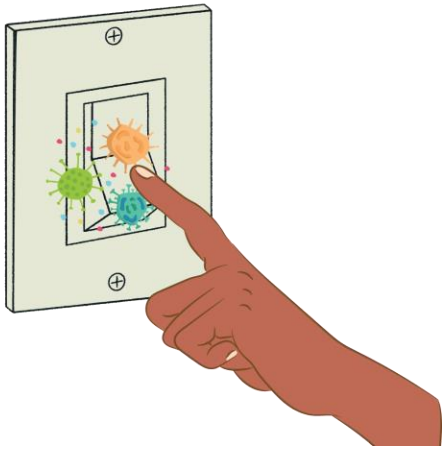
- Sinks/faucets
- Medical devices
- Bed rails
- Door handles
- Curtains



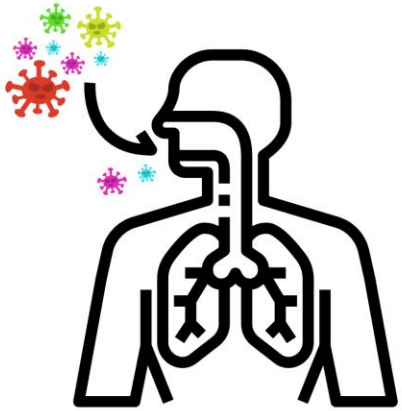


Pathways: How Germs Spread

Touch



Breathed In



Splashes or Sprays

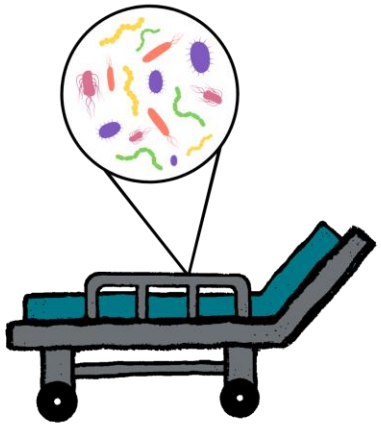
How Germs Make People Sick

- New Person
  - Can be a resident, visitor, or healthcare personnel, etc.

- Germs need to get around the person's natural defenses (e.g., skin, immune system)
- Germs need to survive in the environment
- Implement infection prevention and control practices to help keep germs from spreading

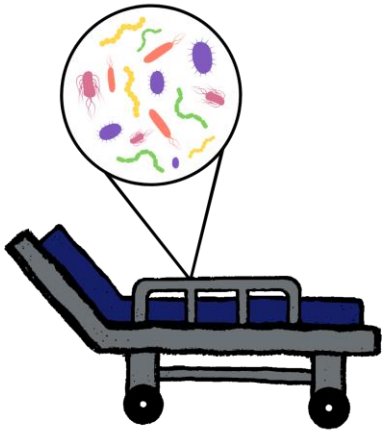
How Germs May Spread: Example

Reservoir



Bedrails contaminated with germs

Pathway



Staff's unwashed hands transmit germs to roommate

Reservoir

Roommate gets sick from germs

Every EVS Moment Matters!

EVS Hand Hygiene Moments

When entering a resident room and before putting on gloves

Upon leaving a resident room and after removing gloves

Between dirty and clean tasks

Before touching clean items on a cart

Between cleaning resident bedspaces

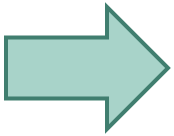
Your 5 Moments for Hand Hygiene | WHO (PDF)
(cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/infection prevention-and-control/your-5-moments-for-hand-hygiene poster.pdf)

Hand Hygiene Scenario Pg. 1

Cleans hands and dons (puts on) gloves

Hand Hygiene Scenario Pg.2

Cleans hands and dons (puts on) gloves



Cleans bedspace 1

Hand Hygiene Scenario Pg. 3

Cleans hands and dons (puts on) gloves

Cleans bedspace 1

Doffs (removes) gloves and dons new gloves

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Hand Hygiene Scenario Pg. 4

Cleans hands and dons (puts on) gloves

Cleans bedspace 1

Doffs (removes) gloves and dons new gloves

Cleans bedspace 2

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Hand Hygiene Scenario Pg. 5

Cleans hands and dons (puts on) gloves

Cleans bedspace 1

Doffs (removes) gloves and dons new gloves

Cleans bedspace 2

Doffs gloves

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Hand Hygiene Scenario Pg. 6

Cleans hands and dons (puts on) gloves

Cleans bedspace 1

Doffs (removes) gloves and dons new gloves

Cleans bedspace 2

Doffs gloves

Cleans hands and exits room

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Hand Hygiene Scenario – What's Missing?

Cleans hands and dons (puts on) gloves

Cleans bedspace 1

Doff gloves, hand hygiene, don new gloves

Cleans bedspace 2

Doffs gloves

Cleans hands and exits room

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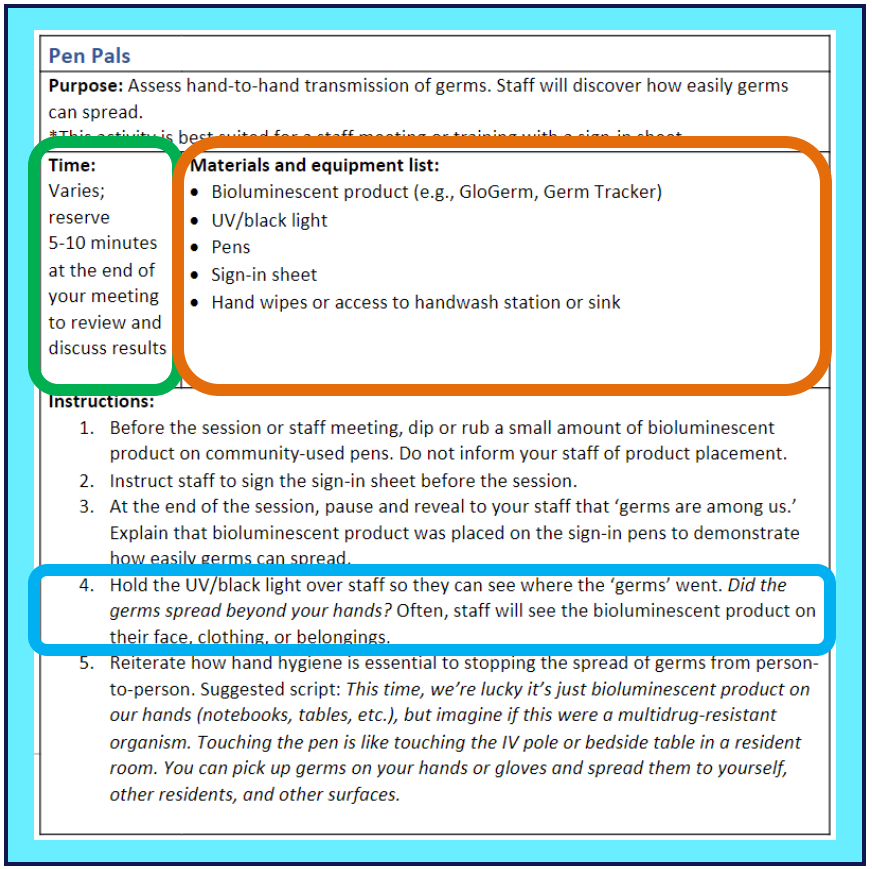
Activity Card Example: Pen Pals



Pen Pals

Purpose: Assess hand-to-hand transmission of germs. Staff will discover how easily germs can spread.

*This activity is best suited for a staff meeting or training with a sign-in sheet.

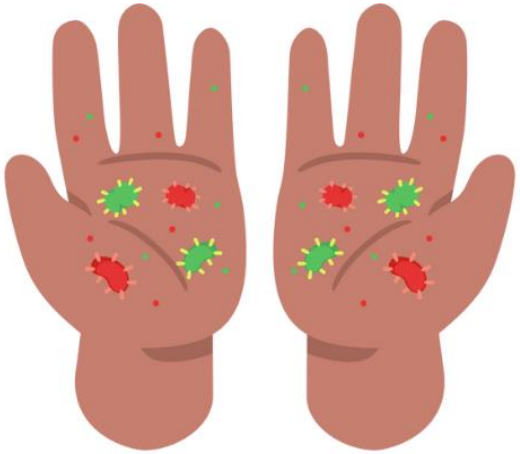
Time:
Varies; reserve 5-10 minutes at the end of your meeting to review and discuss results

Materials and equipment list:
- Bioluminescent product (e.g., GloGerm, Germ Tracker)
- UV/black light
- Pens
- Sign-in sheet
- Hand wipes or access to handwash station or sink

Instructions:

1. Before the session or staff meeting, dip or rub a small amount of bioluminescent product on community-used pens. Do not inform your staff of product placement.
2. Instruct staff to sign the sign-in sheet before the session.
3. At the end of the session, pause and reveal to your staff that 'germs are among us.' Explain that bioluminescent product was placed on the sign-in pens to demonstrate how easily germs can spread.
4. Hold the UV/black light over staff so they can see where the 'germs' went. *Did the germs spread beyond your hands?* Often, staff will see the bioluminescent product on their face, clothing, or belongings.
5. Reiterate how hand hygiene is essential to stopping the spread of germs from person-to-person. Suggested script: *This time, we're lucky it's just bioluminescent product on our hands (notebooks, tables, etc.), but imagine if this were a multidrug-resistant organism. Touching the pen is like touching the IV pole or bedside table in a resident room. You can pick up germs on your hands or gloves and spread them to yourself, other residents, and other surfaces.*

Show your hands!



Activity Recap

- Assesses hand-to-hand transmission of germs
- Demonstrates the importance of hand hygiene
- Would your staff enjoy an activity like this?
- If you've done an activity like this with your staff, please share your experience!

Activity Card Example: Paint with ABHR

Paint with Germs

Purpose: Assess how effectively staff apply alcohol-based hand rub (ABHR). Review how hands can become contaminated when gloves are removed. This activity is similar to "Fluorescent Adventure" but also works well for larger groups.

Preparation time: 5-10 minutes **Activity time:** 10-15 minutes	**Preparation and materials:** • Washable paint (any color)* • Gloves (1 pair per participant) • Timer • Garbage (for glove disposal) • Hand wipes or access to handwash station or sink *Alternative: Use shaving cream for an easier clean up.

Instructions:

Part 1: Application of ABHR

1. Instruct staff to put on their gloves. Ensure proper fit.
2. Have each staff squeeze as much paint into the palm of one glove as you would ABHR (as recommended by your facility's ABHR manufacturer's guidelines). Essentially, pretend the paint *is* ABHR.

Pre-Test – What does your staff know before the training?

Module 2 Pre-Training Test: Understanding Disinfectants

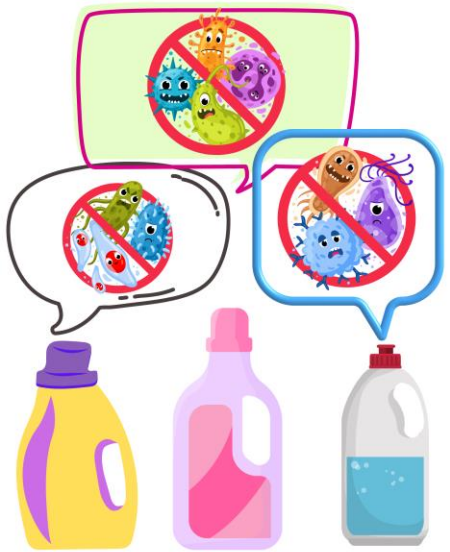
Name:

1. What is a disinfectant?
   a. Chemicals that kill most germs
   b. Soap that removes germs
   c. Gas that kills all germs
   d. All of the above

2. What information you should look for when reading a disinfectant label?
   a. Type of germs the disinfectant can kill
   b. Contact/wet time
   c. Expiration date
   d. All of the above

Module 2: Understanding Disinfectants

- Review the difference between cleaning and disinfection
- Examine types of disinfectants
- Demonstrate how to select a disinfectant
- Identify key components of reading a disinfectant label
- Discuss on the importance of proper disinfectant dilution



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Cleaning Versus Disinfection

Cleaning

Scrubbing surfaces with water and detergent to physically removing dust, dirt, and body fluids

Disinfection

Killing germs on surfaces with chemicals

Disinfectants can't work if cleaning doesn't happen first. Always remember to clean before disinfecting.

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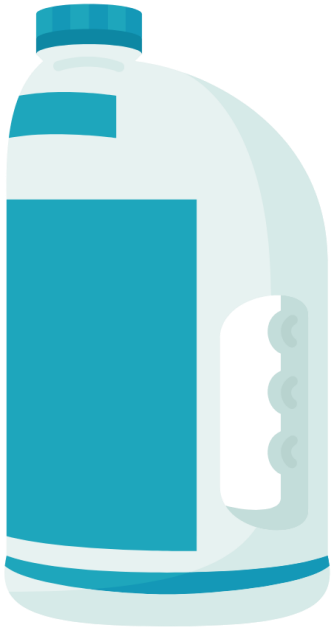
Disinfection and Disinfectants

- Chemicals that kill germs (e.g., quats, bleach, hydrogen peroxide)
- Used on hard, non-porous surfaces such as bedrails and bedside tables
- A one-step detergent-disinfectant product cleans and disinfects at the same time



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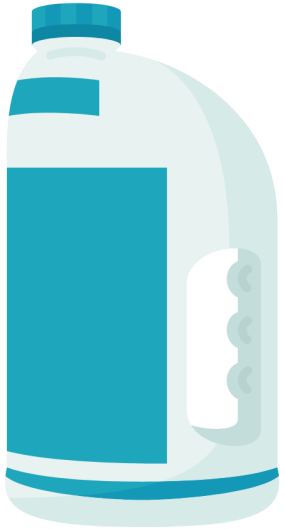
Is the Disinfectant Appropriate for the Task?

- Always check if the disinfectant you are using is appropriate for the task. Ask your EVS manager if unsure.
- Environmental Protection Agency (EPA)-registered, and labeled as “hospital-grade disinfectant”
- Kill claims: Type of germs the disinfectant kills
- Contact/wet time: Time required for the disinfectant to work
- Safety: Know the toxicity, PPE requirements, and appropriate use of disinfectant



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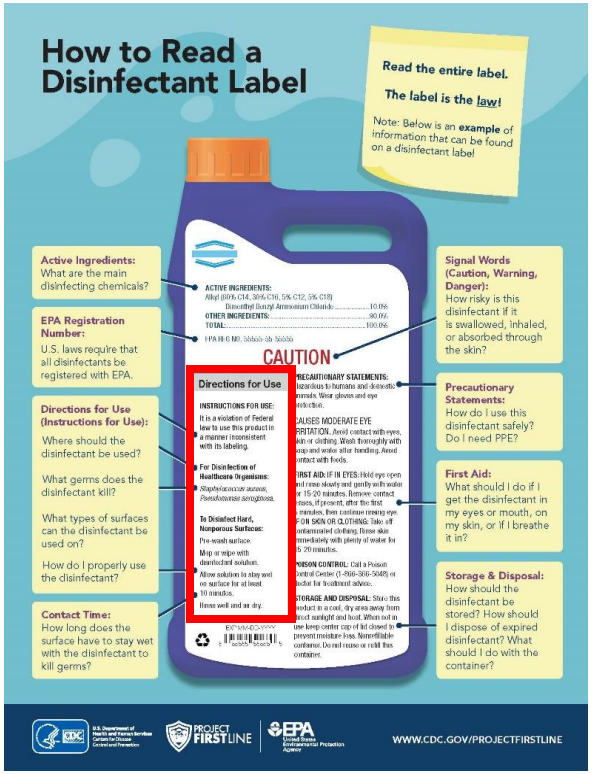
Contact/ Wet Time

- Contact/wet time is the amount of time required for a disinfectant to kill germs on a pre-cleaned surface
- A surface must remain wet long enough to achieve surface disinfection
  - You may have to re-apply to achieve the contact/wet time
- Follow label instructions for the appropriate contact/wet time

How to Read a Disinfectant Label

- Directions for Use
  - Identify (e.g., bacteria, viruses, fungi) the germs it kills
  - Follow directions for use (e.g., how to mix product, how to disinfect)
  - Use recommended amount for the correct duration (contact/wet time)

[How to Read a Disinfectant Label | CDC (PDF)](www.cdc.gov/hai/pdfs/HowToReadALabel-Infographic-508.pdf)
(www.cdc.gov/hai/pdfs/HowToReadALabel-Infographic-508.pdf)



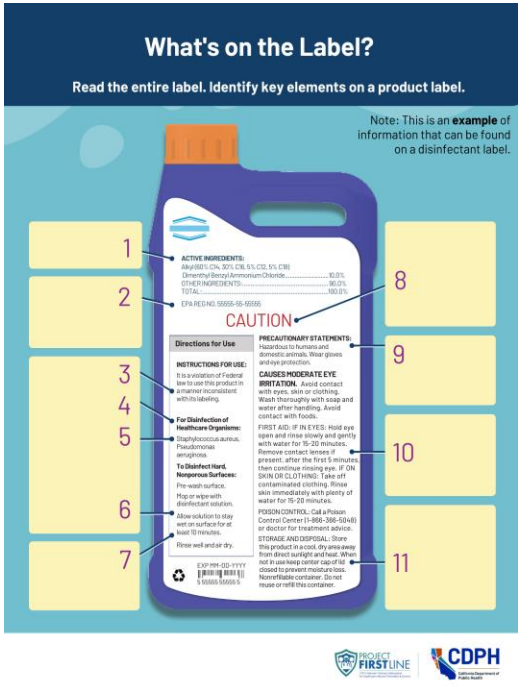
Pre- and Post-Training Answer Key

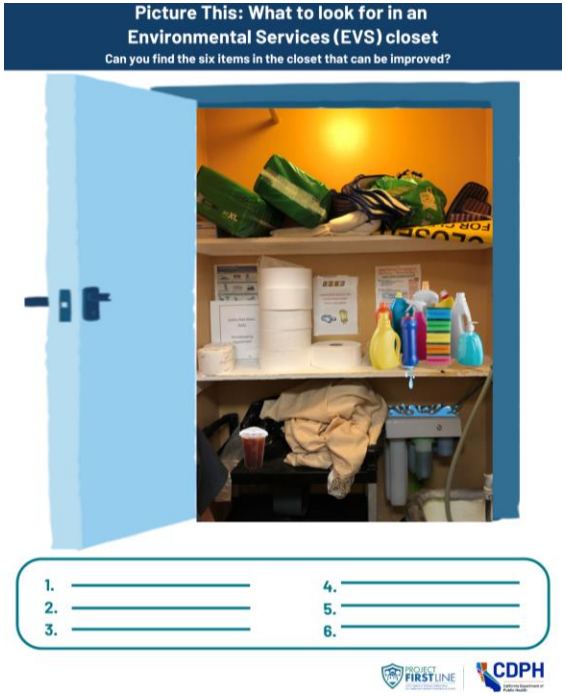
Module 2 Answer Key: Understanding Disinfectants

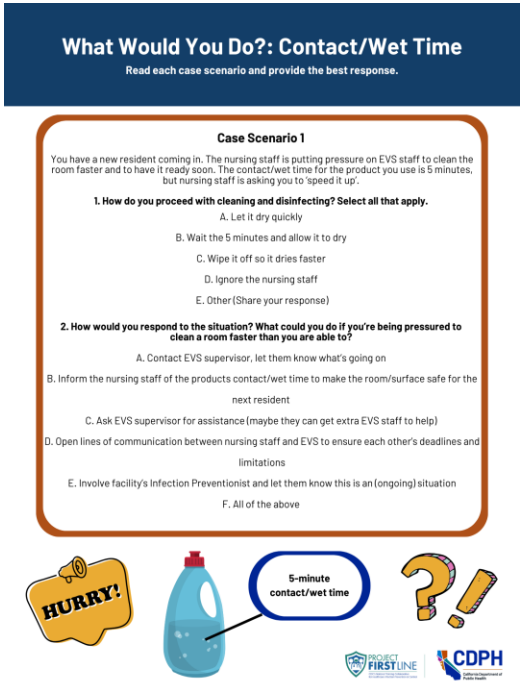
Answers are bolded and marked with an asterisk (*).

1. What is a disinfectant?
   a. **Chemicals that kill most germs***
   b. Soap that removes germs
   c. Gas that kills all germs
   d. All of the above
2. What information should you look for when reading a disinfectant label?
   a. Types of germs the disinfectant can kill
   b. Contact/wet time
   c. Expiration Date
   d. **All of the above***

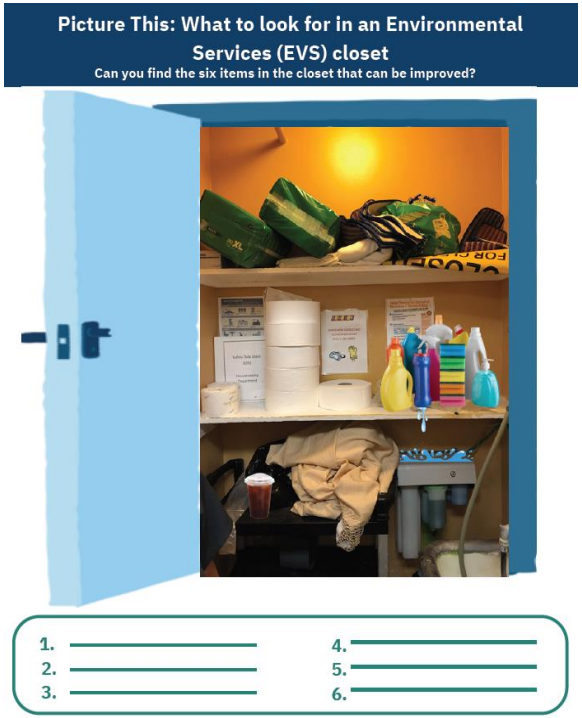
Module 2 Activity Card Worksheets







Activity Card Example - Picture This



Picture This: What to Look for in an EVS Closet

Purpose: Ensure staff know what to look for in an EVS closet – both what *should* and *should not* be stored in an EVS closet. Staff will identify the six aspects in the EVS closet that could be improved and provide rationale.

Preparation time: 10-20 minutes **Activity time:** 10-15 minutes	**Preparation and materials:** • Gather "*Picture This: What to Look for in an EVS Closet*" worksheet (See page 10 or the corresponding slide). Note: If using the worksheet, there is a corresponding answer key on page 10. • Distribute copies to participants or use the image found in the slideset to project on a screen. OR • Obtain images of EVS closets. You may stage and take a picture of a facility EVS closet with unorganized pieces of equipment. OR For more hands-on activity and if timing permits, select and prepare a facility EVS closet to demonstrate both correct and incorrect closet set up. Note this may take an additional 10 minutes to set up.

Instructions:

1. Provide staff with the worksheet/image or take them to the EVS closet.
2. Have staff take turns finding aspects of the closet that could be improved.
3. Ask staff:
   - *What's wrong with or missing from this closet?*
   - *Why is this wrong?*
   - *How would you correct this?*
4. If staff answer correctly or incorrectly, engage in discussion around rationale and refer to training module as needed.

Question

- What do you often see in the EVS closet that shouldn't be there?
- How do you correct for incorrect practices?

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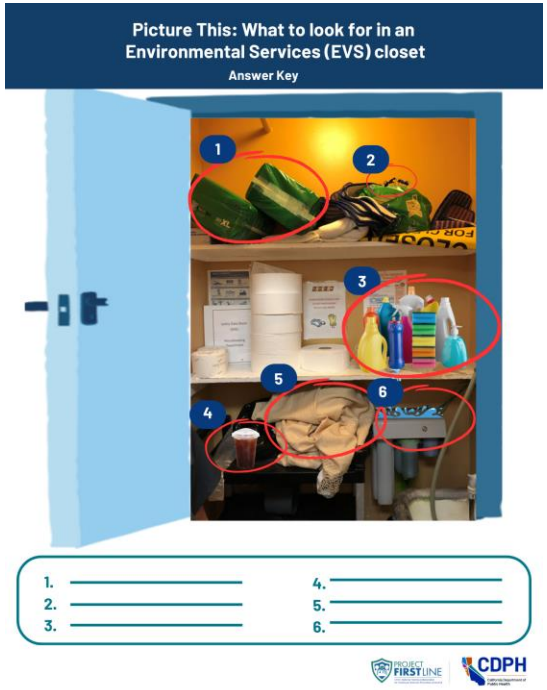
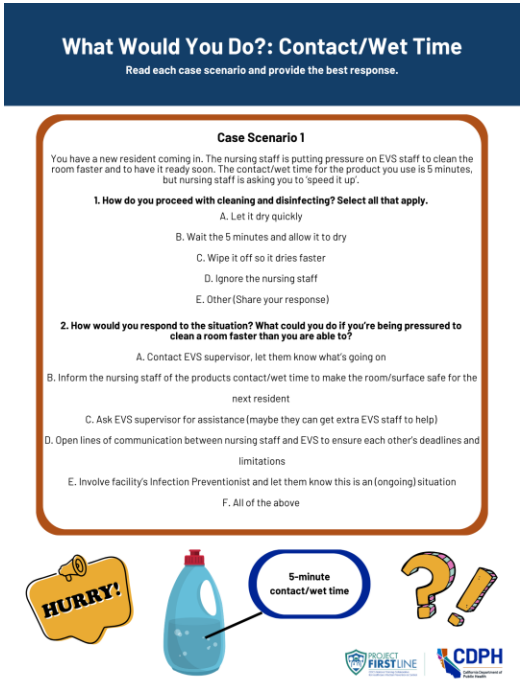
Picture This: Answer Key



Answer Key

#	Item	Rationale
1	Excess Cleaning Items	• Keep closet organized to prevent injuries, spills, or accidental mixing.
2	Insects & Bugs	• EVS closet should be clean and organized. Insects and bugs can lead to contamination of EVS products and equipment.
3	Unlabeled Cleaning and Disinfecting Solutions	• Solutions should be labeled with key dates (manufacturer's expiration date, open date, mix date). • Minimizing the number and types of cleaners will reduce the chance of unintentional mixing and staff confusion about product use.
4	Food & Drink	• Personal belongings can become contaminated with germs.
5	Dirty/Soiled Curtain	• Dirty or soiled curtain not placed in proper area can lead to cross contamination. • Place soiled curtain in dirty container per facility policy.
6	Spills & Leaks	• Ensure proper disinfectant storage to prevent dangerous spills or mixing.

Activity Card Example: What would you do? Contact/Wet Time



What Would You Do?: Contact/Wet Time

Purpose: Ensure staff have a good understanding of contact/wet time.
Staff will answer a series of questions on contact/wet time, individually or in teams. Staff should know how to identify contact/wet time.

Preparation time: 3-5 minutes **Activity time:** 10-15 minutes	**Preparation and materials:** Gather: • Copies of *"What Would You Do?: Contact/Wet Time"* worksheet (See page 8 or the corresponding slide)

Instructions:

1. Distribute the *What Would You Do?: Contact/Wet Time* worksheet (or display slides on screen).
2. You may decide to divide your group into partners or smaller teams for this activity.
3. Review each case scenario as a group. Staff can discuss each case scenario in smaller teams for 1-2 minutes; come back to the larger group and have one or more groups share their responses. In a larger group, you may ask for volunteers to respond to each question.
4. For each case scenario, review correct answers (highlighted in yellow) with the group and provide any additional comment or rationale per facility policy and procedures.

Activity Card Case Scenario #1

You have a new resident coming in. The nursing staff is putting pressure on EVS staff to clean the room faster and to have it ready soon. The contact/wet time for the product you use is 5 minutes, but nursing staff is asking you to 'speed it up'.

How do you proceed with cleaning and disinfecting? Select all that apply.

A. Let it dry quickly
B. Wait the 5 minutes and allow it to dry
C. Wipe it off so it dries faster
D. Ignore the nursing staff
E. Other (Share your response)

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Activity Card Case Scenario #1

Answer

How do you proceed with cleaning and disinfecting? Select all that apply.
Answer is marked with an asterisk.

A. Let it dry quickly
B. Wait the 5 minutes and allow it to dry*
C. Wipe it off so it dries faster
D. Ignore the nursing staff
E. Other (Share your response)*

*E may be a correct response depending on facility policy and procedure.

Answer: B, E

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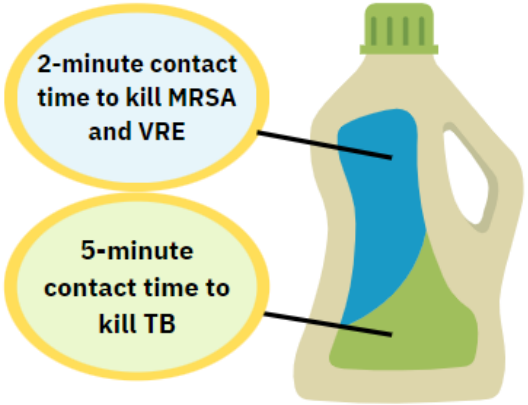
Activity Card Case Scenario #3

You are using a disinfectant product that has different contact/wet times. This disinfectant product has, a 2-minute contact time to kill MRSA & VRE and a 5-minute contact time to kill TB.

Which contact/wet time would you use?

A. The shortest time
B. The longest time
C. The average time
D. The expiry date
E. At midnight



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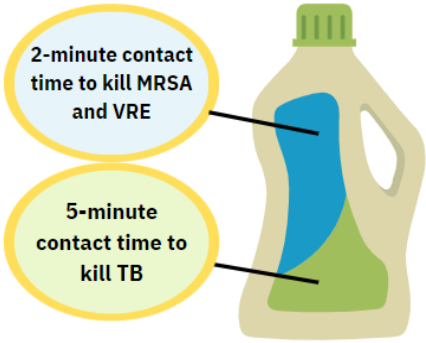
Activity Card Case Scenario #3

Answer

You are using a disinfectant product that has different contact/wet times. This disinfectant product has, a 2-minute contact time to kill MRSA & VRE and a 5-minute contact time to kill TB.

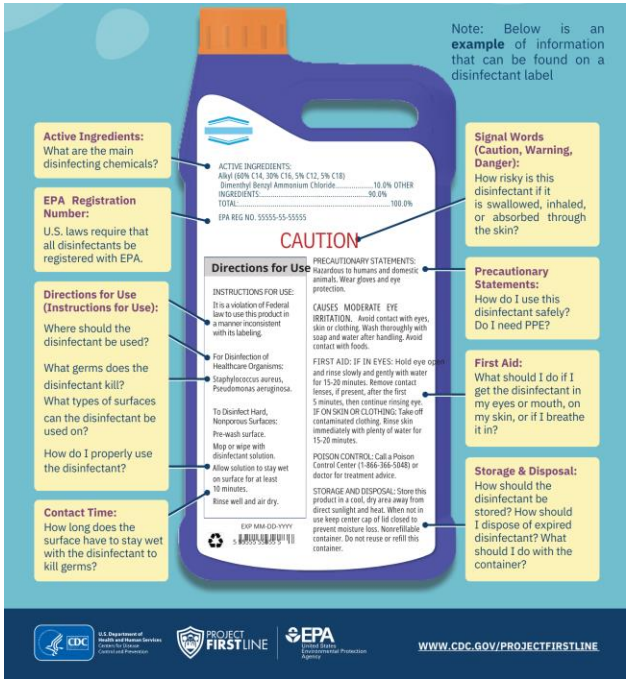
Which contact/wet time would you use?
Answer is marked with an asterisk.

A. The shortest time
B. The longest time*
C. The average time
D. The expiry date
E. At midnight



Answer: B

Activity Card Example: Read a Disinfectant Label



Read a Disinfectant Label	
Purpose: Ensure staff know how to read cleaner/disinfectant labels. Staff will practice identifying where to find key information on a cleaner/disinfectant label (e.g., contact/wet time, required personal protective equipment (PPE), expiry dates).	
Preparation time: 10-15 minutes **Activity time:** 10-15 minutes	**Preparation and materials:** There are variations of this activity below. Select the appropriate activities for your EVS staff. Consider EVS staff knowledge of the product (e.g., is it a new product?), or familiarity with MDS. Are there special notes or product features you need your staff to remember? Gather: • Copies of CDC's "*How to Read a Disinfectant Label*" infographic (See page 4 or the corresponding slide) • Copies of *"What's on the Label"* worksheet (See page 5 below or the corresponding slide) • Copies of facility disinfectant labels (You might ask the manufacturer to provide sample labels, go to manufacturer's website to obtain sample labels, or select unopened product bottles.)
Instructions:	

Module 3: Setting Up a Cart

- List high-touch surfaces at your facility
- Identify the cleaning supplies and equipment used at your facility
- Discuss how to set up a cleaning cart
- Demonstrate how to clean and disinfect equipment after use

Consider Safety, Efficiency, and Convenience When Setting Up Your Cart

- Be familiar with products and tools used
- Identify supply needs
- Save time; be efficient
- Support safety through appropriate use of products

- Note: Clean your hands and put on clean gloves before touch clean items on your cart.

Gathering Supplies and Cart Setup: Top of Cart

- Alcohol-based hand rub (ABHR) and soap refills
- Required PPE
- Resident room supplies
- When setting up your cart, consider safety, convenience, and efficiency

Gathering Supplies and Cart Setup: Inside Cart

- Clean and dry microfiber cleaning cloths
- Cleaning solutions and disinfectants
- Bags or bins for soiled materials
- Do not mix chemicals (this can create toxic gases)
- Do not use spray bottles for cleaning
- Do not keep items on cart you won't use or need
- No food or drinks on cart!
- Lock your cart or store in a secure place

Gathering Supplies and Cart Setup: Front Deck

- Mops with removeable mopheads/floor mops
- Broom/dry mop
- Duster
- Buckets
- Wet floor caution signs
- Soiled linen bag
- Trash bag

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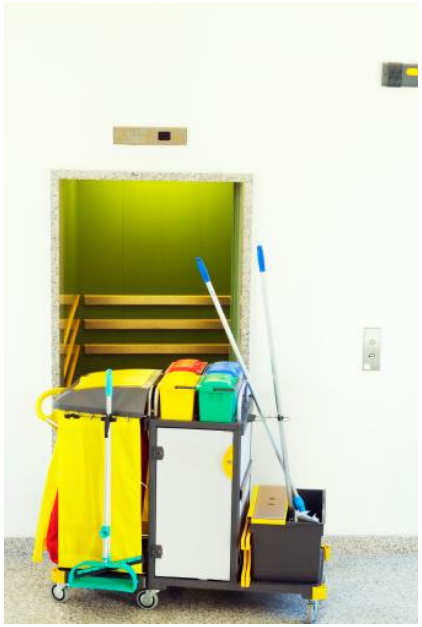
Cleaning of Reusable Equipment and Cart Storage at the End of the Shift

- Remove dirty mop heads and soiled microfiber cleaning cloths
- Ensure cleaning follows manufacturer's instructions
- Follow your facility's policy for cleaning EVS cart and closet



Recommendations for Cleaning Carts

- Stock enough resident room supplies
- Have access to ABHR
- Stock enough microfiber cleaning cloths so they can be changed when soiled
- Use buckets or bins for disinfectant solution
- Use microfiber mops
- Separate clean and soiled items
- Clean and disinfect reusable equipment
- Clean high-touch surfaces at least once per shift
- Keep a reference list of high-touch surfaces on your cart
- Know the required contact/wet times for all disinfectants used
- Have a lockable compartment
- Store in a designated EVS area

Practices to Avoid with Cleaning Carts

- Never mix different chemicals
- Do not refill containers
- Do not mix clean and soiled materials
- Do not use the same cloth for two different resident bedspaces
- Do not use a dirty cloth on a clean area
- Never store personal items, food, or beverages on cart or in EVS closet
- Do not use spray bottles
- Never leave cart unattended

Case Scenario

You observe an EVS staff cleaning a multi-bed occupancy room. You observe the staff move from one resident bedspace to the cart to get more cleaning supplies without removing their gloves and performing hand hygiene.

What's wrong with this situation?

What are your next steps as the manager/educator?

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Case Scenario Answer

What are your next steps as the manager/educator?

- Stop the staff
- Just in time training
- Conduct an in-service using materials from Module 1 of the EVS Toolkit (Hand Hygiene)
- Provide feedback to improve adherence
- Evaluate if the staff has access to the tools needed to perform IPC practices (e.g., ABHR, gloves)
- Other?

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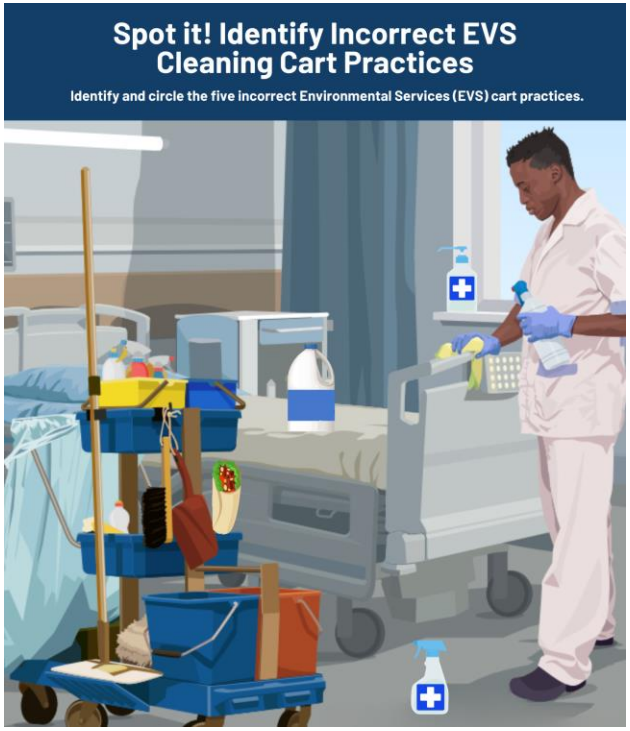
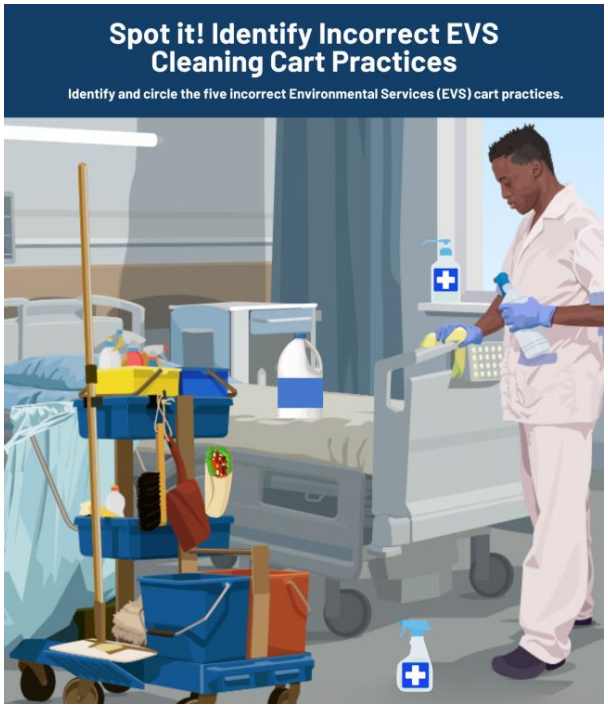
Module 3 Activity Card Worksheets



Activity Card Example: Spot it!



Spot it! Identify Incorrect Environmental Services (EVS) Cart Practices

Purpose: Ensure staff understand correct and incorrect EVS cart practices. Staff will identify five EVS cart practices that could be improved and provide rationale.

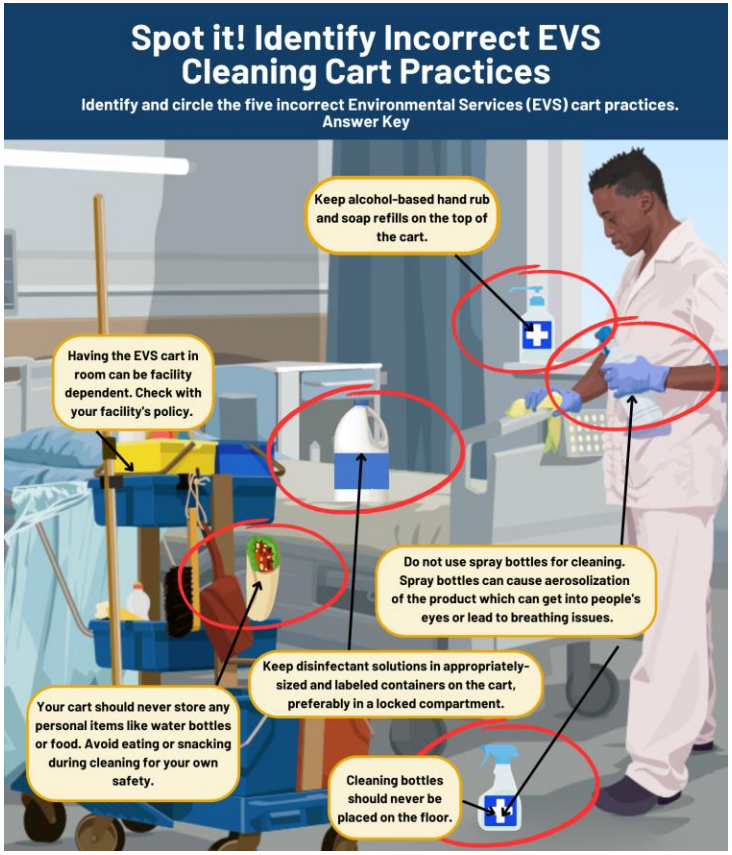
Preparation time: 10-20 minutes **Activity time:** 10-15 minutes	**Preparation and materials:** • Gather copies of *"Spot it! Identify Incorrect EVS Cart Practices"* worksheet (See page 3 below or the corresponding slide). Note: If using the worksheet, there is a corresponding answer key on page 4. • Pens/pencils OR • For more hands-on activity and if timing permits, select and prepare a facility EVS cart and stage incorrect EVS cart practices.

Instructions:

1. Provide staff with the *"Spot it! Identify Incorrect EVS Cart Practices"* worksheet.
2. You may decide to divide your group into partners or smaller teams for this activity.
3. Ask staff to identify and circle five incorrect practices.
4. Review each incorrect practice as a group. Staff can discuss each practice in smaller teams for 1-2 minutes.
5. Come back to the larger group and have one or more groups share their responses. In a larger group, you may ask for volunteers to provide the rationale for reach practice identified.
6. For each incorrect practice, review correct answers with the group and provide any additional comment or discussion.

For hands-on activity:

Spot it!
Answer Key



Activity Card Example: Pin it! What's on the EVS cart

Pin it! Place the Supplies on the Environmental Services (EVS) Cleaning Cart

Purpose: Ensure staff know where to properly place items in an EVS cleaning cart. Staff will identify seven items as correct or incorrect items to place in an EVS cart and identify correct placement on the cart.

Preparation time: 5-10 minutes **Activity time:** 10-15 minutes	**Preparation and materials:** • Gather copies of *"Pin it! Place the Supplies on the EVS Cleaning Cart"* worksheet (see page 6 or the corresponding slide embedded in the Module 3 slides). Note: if using the worksheet, there is a corresponding answer key on pages 7 and 8. • Pens/pencils OR • For more hands-on activities and if timing permits, provide staff with an empty facility cleaning cart and proper and improper facility cleaning cart items.

Instructions:

1. Provide staff with *"Pin it! Place the Supplies on the EVS Cleaning Cart"* worksheet.
2. Review items on the worksheet and have staff identify where they would place each item on the cleaning cart.
3. You may decide to have staff work individually or divide your group into partners or smaller teams for this activity.
4. Give staff 10 minutes to review/fill out the worksheet or engage in small group discussion.
5. Have staff draw an arrow one at a time to "place" items in the appropriate cart area and provide rationale (see answer key for talking points) for why they would

Pin it! Answer Key

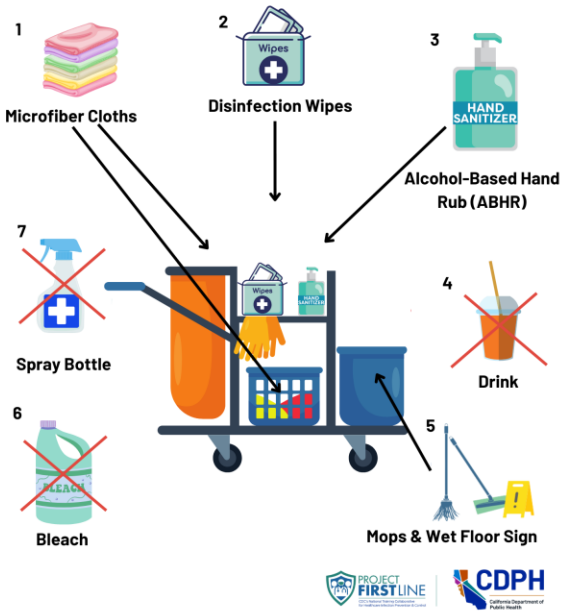
Answer Key

#	Item	Answer	Rationale
1	Microfiber Cloths	Inside or Top of Bin	• Dry microfiber cloths kept inside cart to keep clean and dry. • Microfiber cloths in use should be placed in bin on top of cart saturated in disinfectant.
2	Disinfectant Wipes	Top	• Wipes may be on top or inside cart depending on facility policy. • Convenient access for efficient restocking of resident room supplies.
3	Alcohol-Based Hand Rub (ABHR)	Top	• Accessible ABHR at the top of cart makes performing hand hygiene easier.
4	Food & Drink	Do Not Store	• Never store any personal items like water bottles or food. • Avoid eating or snacking during cleaning for your own safety.
5	Mops & Wet Floor Caution Sign	Front Deck or Outside	• Mops with removable mopheads or floor mops should be switched out between each room or when grossly soiled. • Buckets, wet floor caution signs, and bags for soiled linen and trash stored outside for accessibility and efficiency of use.
6	Cleaning & Disinfecting Solutions	Do Not Store	• Bleach should not be stored in the cart. • Bleach should be premixed & in squirt bottle or in canister.
7	Cleaning & Disinfecting Spray Bottle	Do Not Store	• Do not use spray bottles for cleaning. • Spray bottles can cause aerosolization of the product which can get into people's eyes or lead to breathing issues.

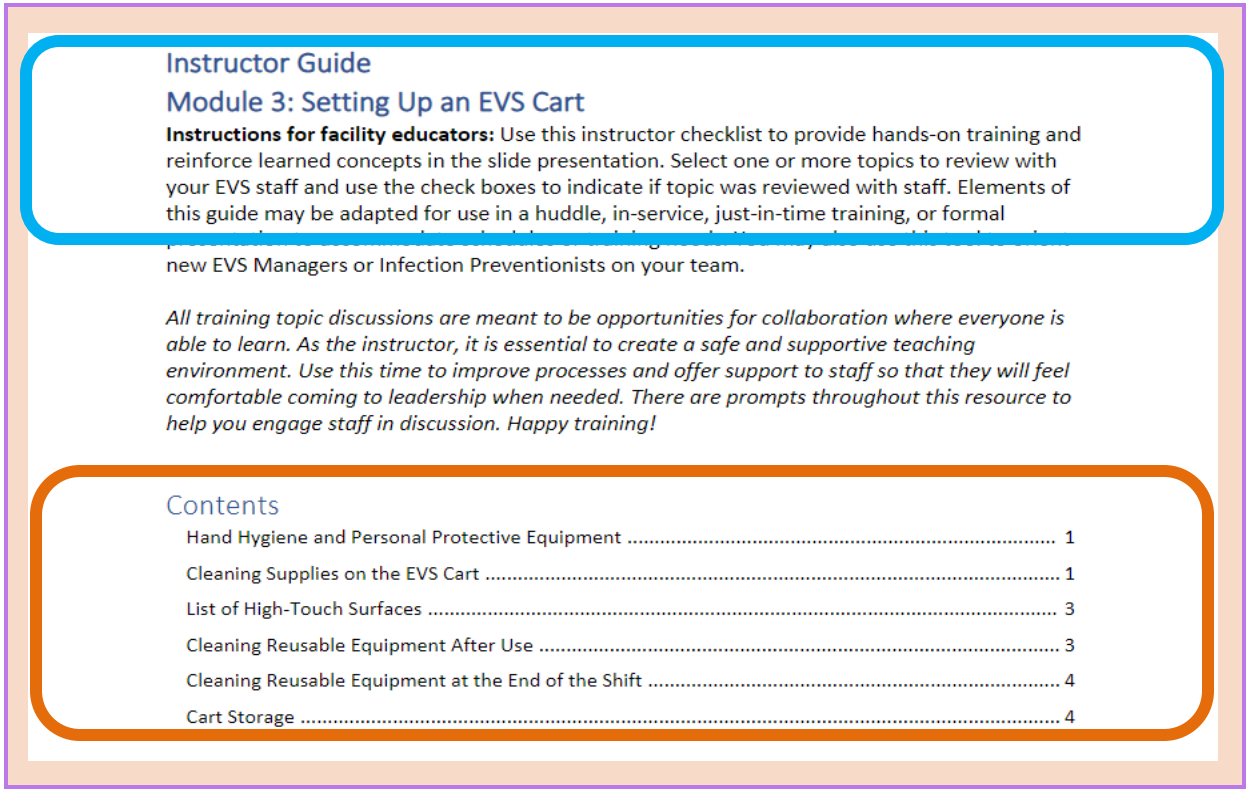
Pin it! Place the Supplies on the Cleaning Cart

Pin the equipment in the Environmental Services (EVS) cart.
Draw arrows connecting the equipment to where it should be placed on the cart. Place an "X" on the image if it does not belong!

Answer Key



Instructor Checklist



Instructor Guide

Module 3: Setting Up an EVS Cart

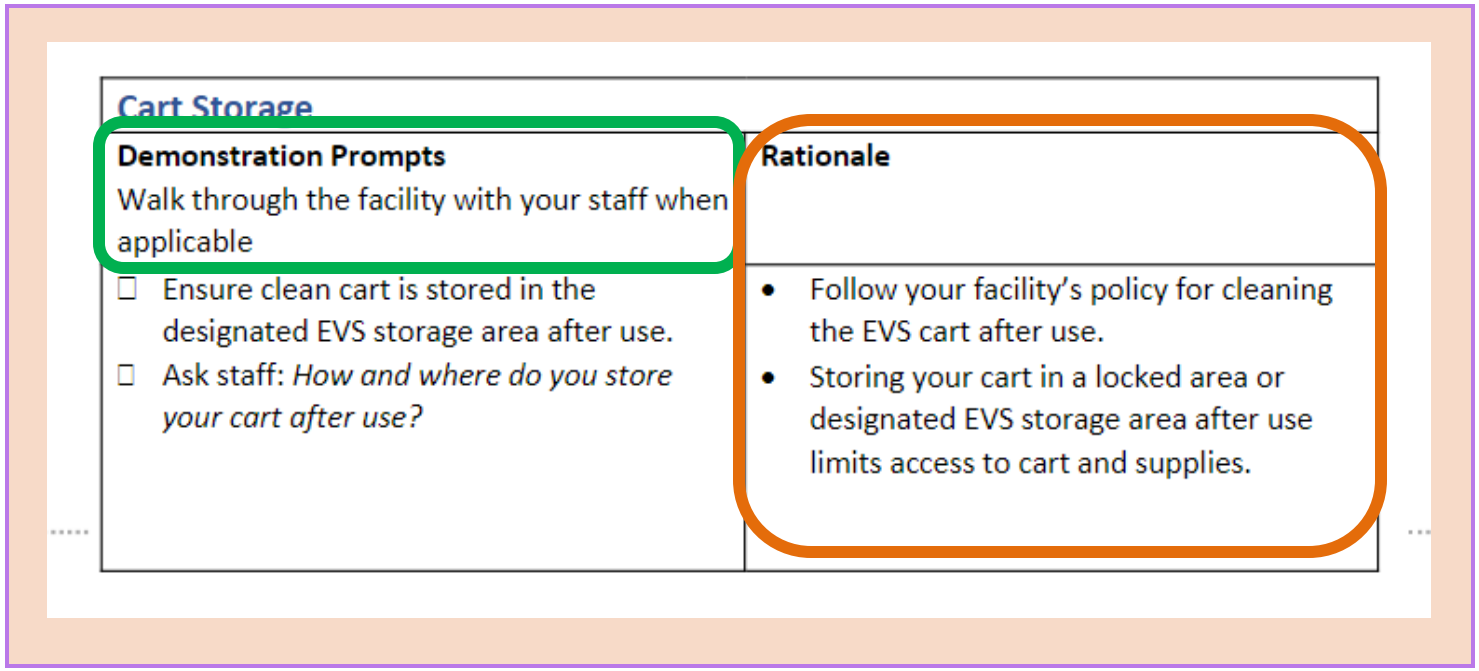
Instructions for facility educators: Use this instructor checklist to provide hands-on training and reinforce learned concepts in the slide presentation. Select one or more topics to review with your EVS staff and use the check boxes to indicate if topic was reviewed with staff. Elements of this guide may be adapted for use in a huddle, in-service, just-in-time training, or formal

new EVS Managers or Infection Preventionists on your team.

All training topic discussions are meant to be opportunities for collaboration where everyone is able to learn. As the instructor, it is essential to create a safe and supportive teaching environment. Use this time to improve processes and offer support to staff so that they will feel comfortable coming to leadership when needed. There are prompts throughout this resource to help you engage staff in discussion. Happy training!

Contents

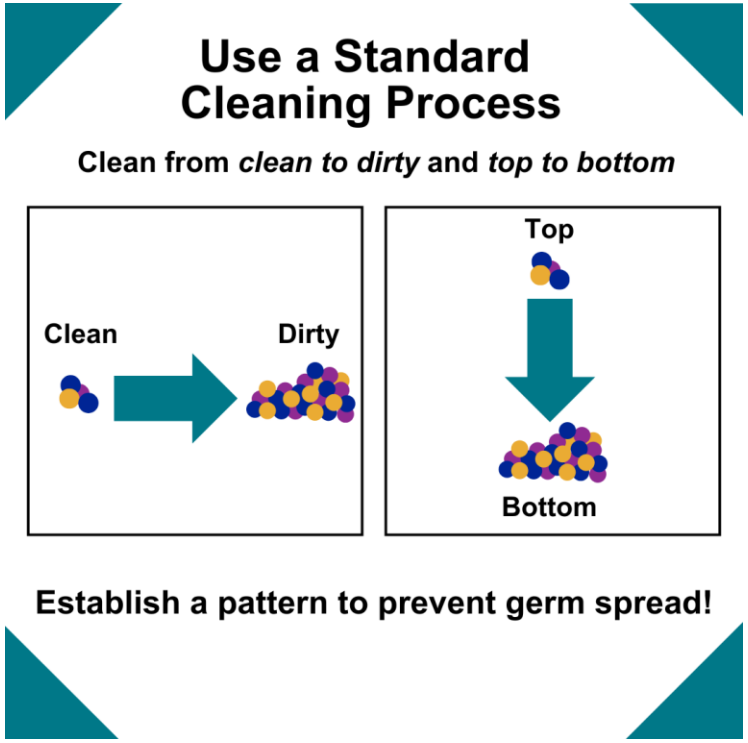
Instructor Checklists Continued



Cart Storage	
Demonstration Prompts Walk through the facility with your staff when applicable	**Rationale**
☐ Ensure clean cart is stored in the designated EVS storage area after use. ☐ Ask staff: *How and where do you store your cart after use?*	• Follow your facility's policy for cleaning the EVS cart after use. • Storing your cart in a locked area or designated EVS storage area after use limits access to cart and supplies.

Module 4: Cleaning and Disinfection Process

- Describe the role of cleaning
- Describe the purpose of disinfection
- Discuss daily and terminal cleaning processes
- Use an environmental cleaning checklist



Where Can You Find the Highest Concentration of Germs in a Resident Room?

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Where Can You Find the Highest Concentration of Germs in a Resident Room?

Answer

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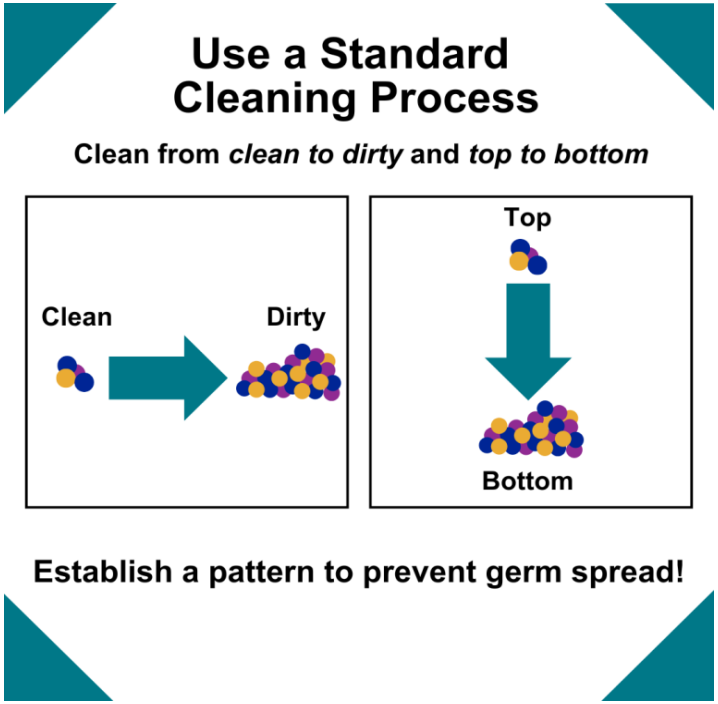
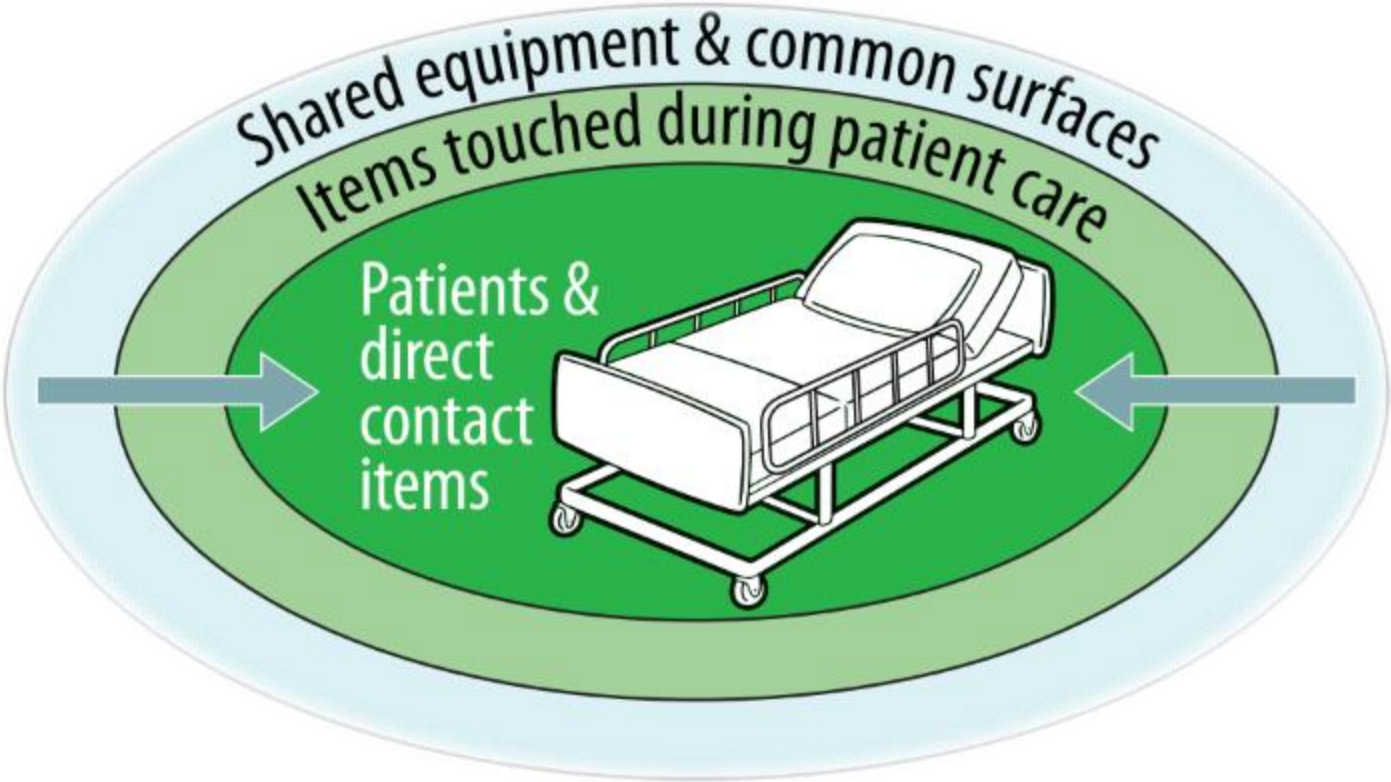
Standard Cleaning Process

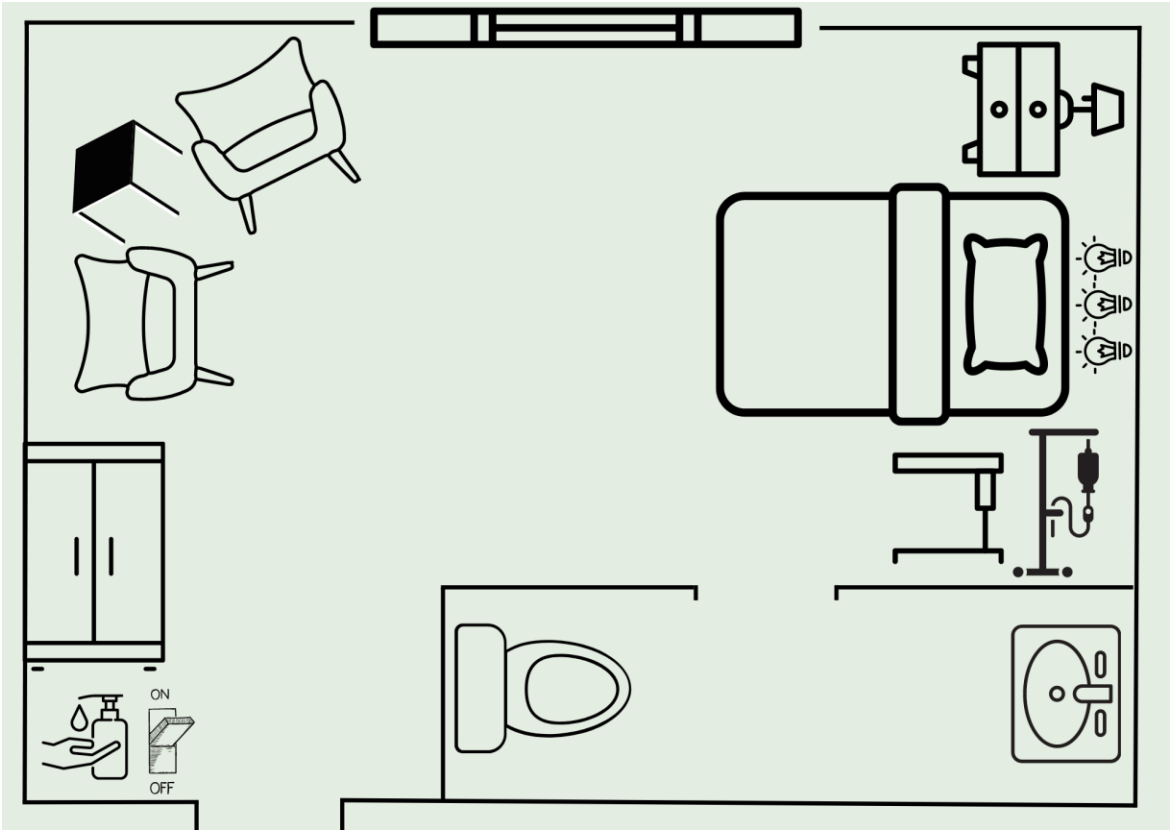
- Clean from clean to dirty
- Clean from top to bottom
- Establish a pattern
- Prevent contamination
- Examples:
  - Begin with common surfaces (e.g., doorknobs) before moving to the resident area
  - Restrooms should be cleaned last
  - Clean bed rails before bed legs



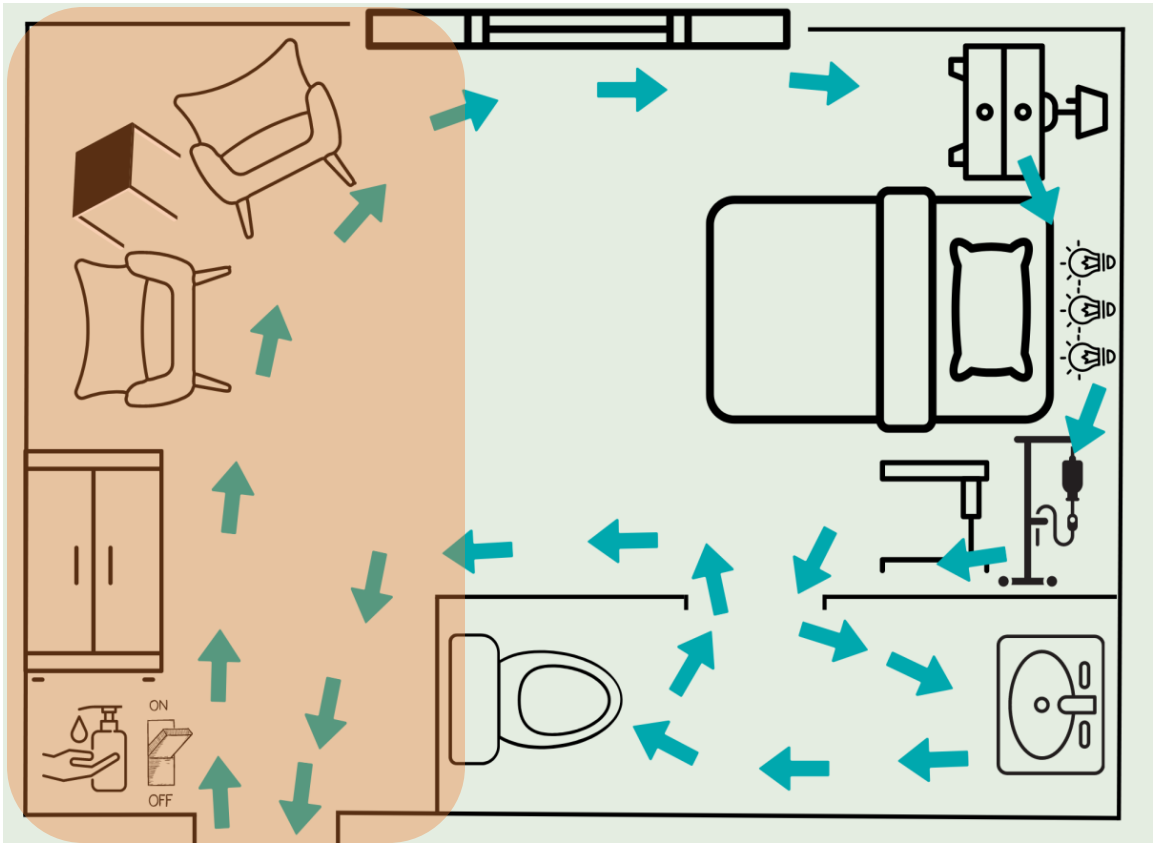
Standard Cleaning Process in a Resident Room



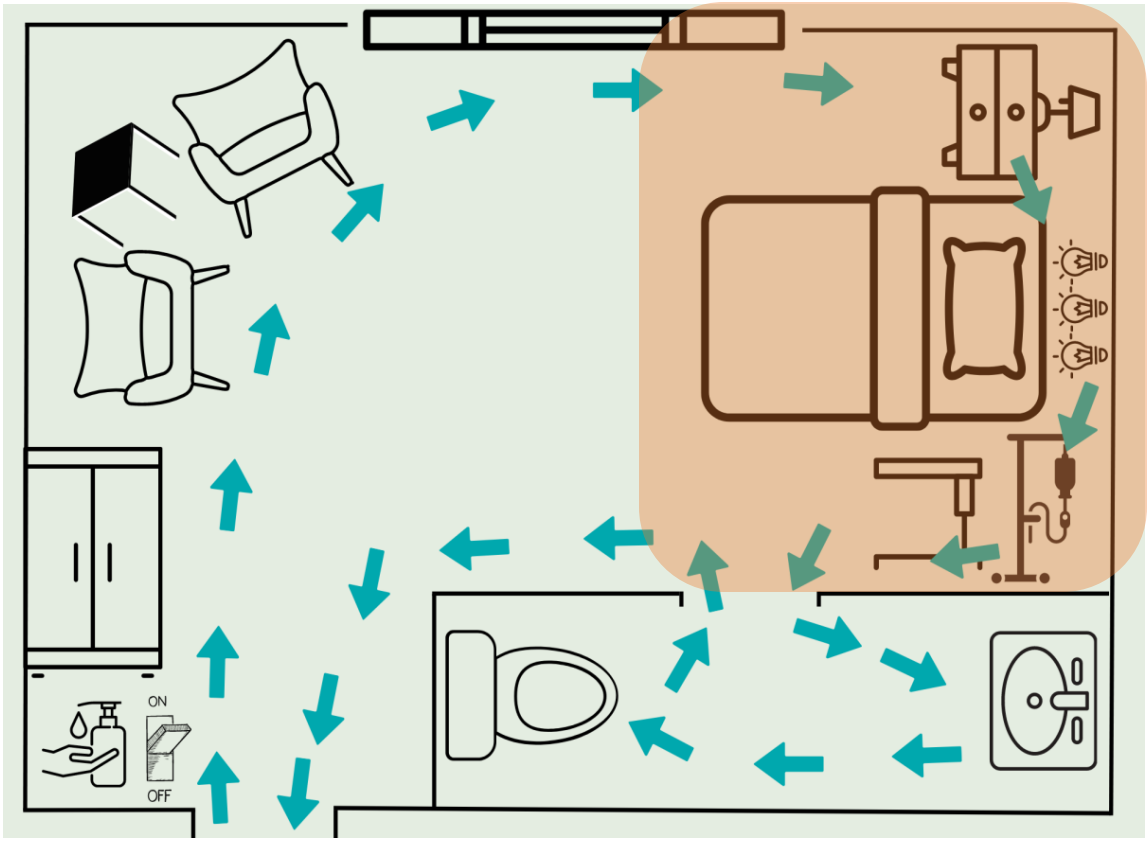
Cleaning a Single-Bed Room



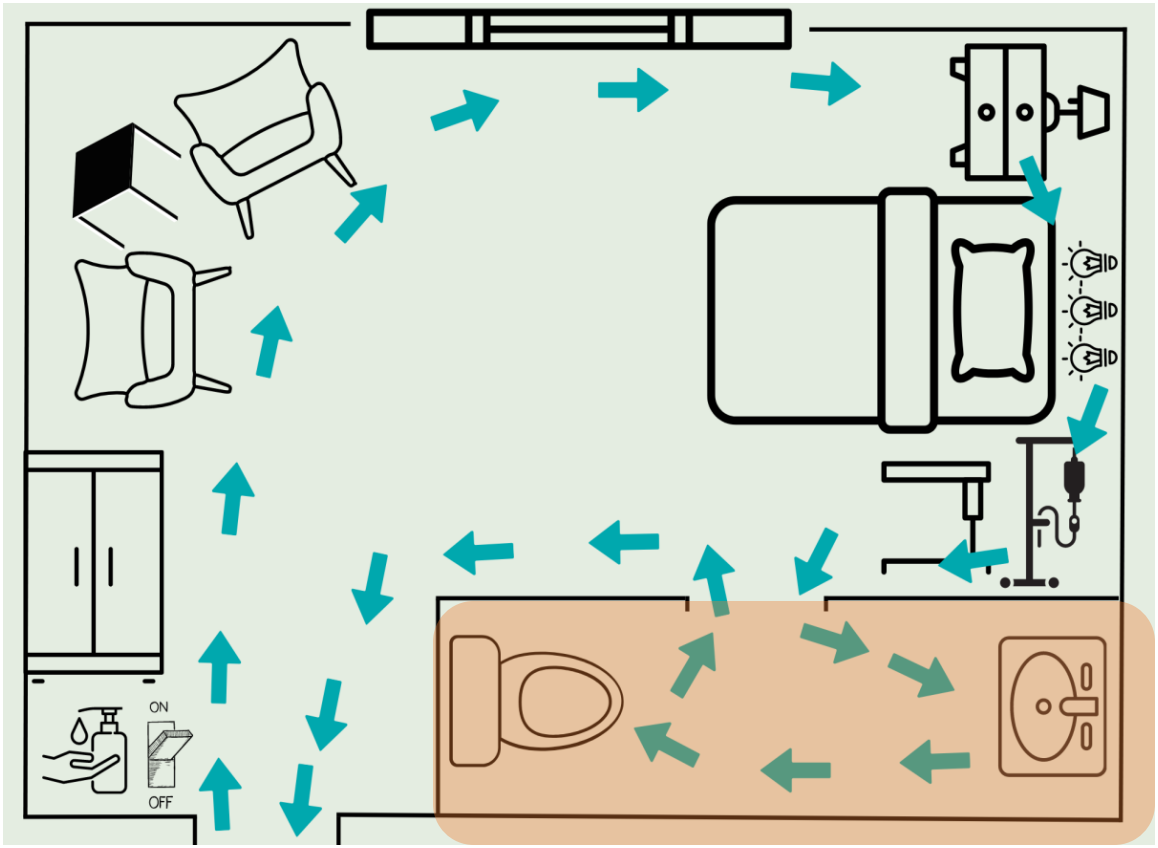
Cleaning a Single-Bed Room: Entry Way/Common Area



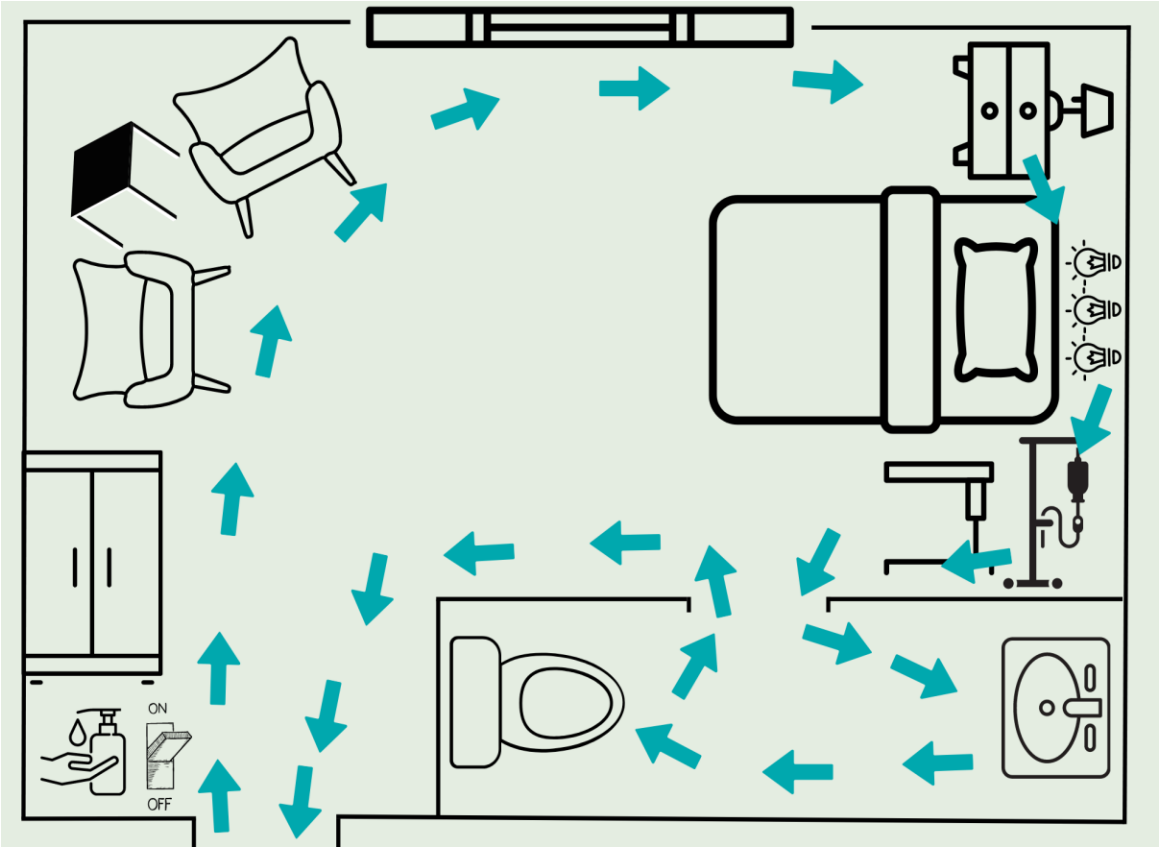
Cleaning a Single-Bed Room: Resident Bed



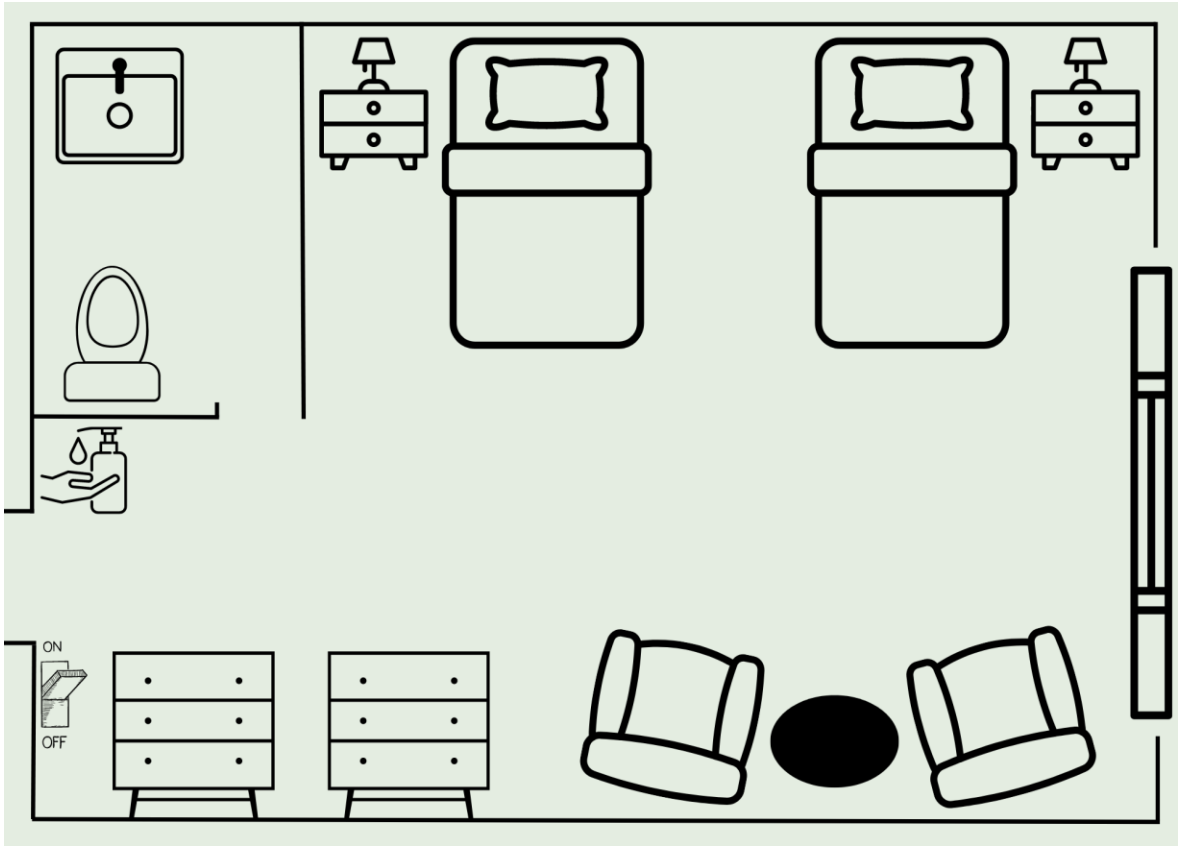
Cleaning a Single-Bed Room: Bathroom



Cleaning a Single-Bed Room: Cleaning Process



Cleaning a Two-Bed Room

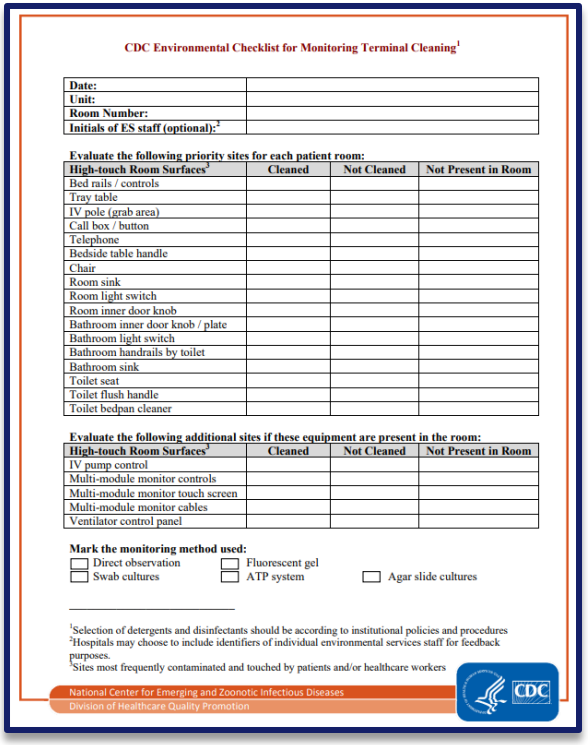


Use an Environmental Cleaning Checklist

- Use an environmental cleaning checklist to ensure all surfaces are cleaned
- Review high-touch room surfaces and denote if they are cleaned, not cleaned, or not present in the room
- Standardize daily and terminal room cleaning processes

CDC Environmental Checklist for Monitoring Terminal Cleaning | CDC (PDF)

(www.cdc.gov/hai/pdfs/toolkits/environmental-cleaning-checklist-10-6-2010.pdf)



CDC Environmental Checklist for Monitoring Terminal Cleaning[1]

Date:	
Unit:	
Room Number:	
Initials of ES staff (optional):[2]	

Evaluate the following priority sites for each patient room:

High-touch Room Surfaces[3]	Cleaned	Not Cleaned	Not Present in Room
Bed rails / controls			
Tray table			
IV pole (grab area)			
Call box / button			
Telephone			
Bedside table handle			
Chair			
Room sink			
Room light switch			
Room inner door knob			
Bathroom inner door knob / plate			
Bathroom light switch			
Bathroom handrails by toilet			
Bathroom sink			
Toilet seat			
Toilet flush handle			
Toilet bedpan cleaner			

Evaluate the following additional sites if these equipment are present in the room:

High-touch Room Surfaces[3]	Cleaned	Not Cleaned	Not Present in Room
IV pump control			
Multi-module monitor controls			
Multi-module monitor touch screen			
Multi-module monitor cables			
Ventilator control panel			

Mark the monitoring method used:

☐ Direct observation ☐ Fluorescent gel ☐ Swab cultures ☐ ATP system ☐ Agar slide cultures

[1]Selection of detergents and disinfectants should be according to institutional policies and procedures
[2]Hospitals may choose to include identifiers of individual environmental services staff for feedback purposes.
[3]Sites most frequently contaminated and touched by patients and/or healthcare workers

National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion

CDC

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Module 4 Activities

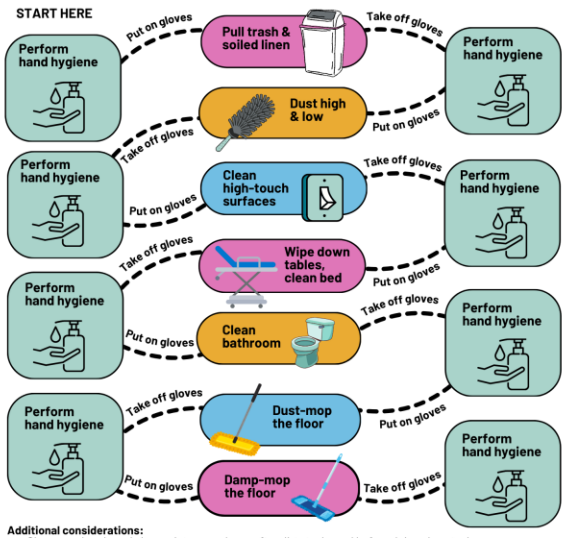
What Would You Do?: Understanding Proper Infection Prevention and Control Practices

Mark if you would ("Yes") or would not ("No") perform each of the cleaning and disinfecting practices prompts. Explain why you would or would not perform each practice.

#	Question	Yes/No	Rationale
1	Would you clean from clean areas to dirty?		
2	Would you clean from high surfaces to low and top to bottom?		
3	Would you change the curtains in a resident's room daily?		
4	Would you store soiled equipment on the inside of the EVS cart?		

How can you help stop the spread of germs?

We strongly encourage each facility to develop a standardized approach to cleaning and disinfection of resident rooms which incorporates key infection prevention and control practices. The below is an example of how to use a standardized approach.



Additional considerations:

- Clean your hands and change into new gloves after dirty tasks and before doing clean tasks.
- Cleaning high-touch surfaces can be done before or after dusting. This helps prevent germs from spreading.
- Making the bed may be done by other staff.
- In multi-occupancy rooms, each bed space is cleaned and disinfected before the bathroom. Perform hand

High-Touch Surfaces: Identifying Who Cleans What

Circle the high-touch surfaces in your facility. Who cleans each surface?

ABHR dispenser _____
Bathroom _____
Bedrail _____
Call button _____
Charting area _____
Feeding pump _____
Floor _____
Glucometer _____
IV pole _____
IV pump _____
Light switch _____
Medication cart _____
Oxygen tank _____
Patient bed scale _____
Patient lift _____
Patient linen _____
Pill crusher _____
PPE container _____

Privacy curtains _____
Room door handle _____
Room/toilet sink _____
Side table _____
Tray table _____
TV remote _____
Ventilator _____
Vitals machine _____
Wound care cart _____

List other high-touch surfaces and responsible staff:

_____
_____
_____
_____

Activity Card Example: What Would You Do?

What Would You Do?: Understanding Proper Infection Prevention and Control Practices

Mark if you would ("Yes") or would not ("No") perform each of the cleaning and disinfecting practices prompts. Explain why you would or would not perform each practice.

#	Question	Yes/No	Rationale
1	Would you clean from clean areas to dirty?		
2	Would you clean from high surfaces to low and top to bottom?		
3	Would you change the curtains in a resident's room daily?		
4	Would you store soiled equipment on the inside of the EVS cart?		

What Would You Do?: Understanding Proper Infection Prevention and Control (IPC) Practices

Purpose: Ensure staff understand proper cleaning and disinfecting IPC practices. Staff will state whether they would or would not engage in IPC practice statements and provide rationale to demonstrate training understanding

Preparation time: 10 minutes **Activity time:** 15-20 minutes	**Preparation and materials:** • Gather copies of *"What Would you Do?" worksheet* (See page 7 below or use the corresponding slideset embedded in the Module 4 slides). Note: If using the worksheet, there is a corresponding answer key on page 8.

Instructions:

1. Distribute copies of worksheet or present slide set to staff.
2. You may decide to divide your staff into partners or smaller teams for this activity.
3. Ask staff if they *would* or *would not* perform cleaning and disinfecting prompts based on IPC practices learned in the training.
4. Have individual staff or groups compete to see who can raise their hand first to answer the question and provide rationale to their answer.
5. Engage staff in discussion around rationale.

What Would You Do?

Question #1

Would you clean from clean areas to dirty?

CDPH

Question #1

Answer

Would you clean from clean areas to dirty?

- Yes!
- We should always move from clean areas to dirty areas. For example, begin with common surfaces before moving to the resident area, and restrooms should always be cleaned last.

CDPH

Question #2

Would you clean from high surfaces to low and top to bottom?

CDPH

Question #2

Answer

Would you clean from high surfaces to low and top to bottom?

- Yes!
- Clean from high to low surfaces, top to bottom. For example, clean bed rails before bed legs, or high-touch surfaces before floors.

CDPH

Question #3

Would you change the curtains in a resident's room daily?

CDPH

Question #3

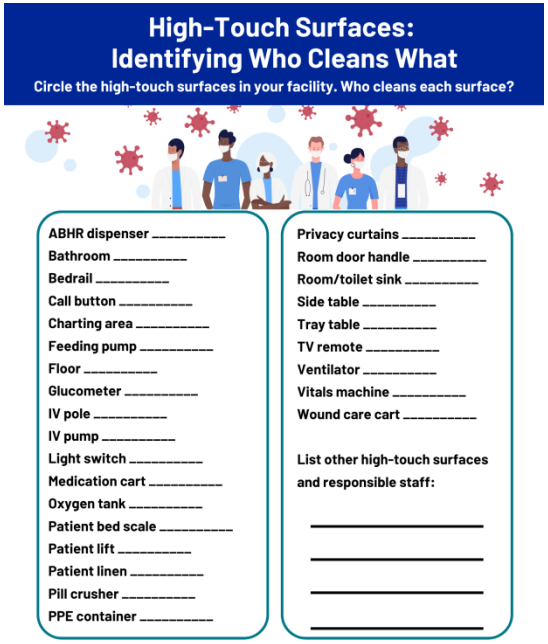
Answer

Would you change the curtains in a resident's room daily?

- No!
- Consider changing curtains when visibly soiled and per a set schedule. Refer to facility policy.

CDPH

Activity Card Example- High-touch Surfaces: Identifying Who Cleans What



High-Touch Surfaces: Identifying Who Cleans What

Purpose: Ensure staff are comfortable identifying high-touch surfaces and who is responsible for cleaning what items.

Preparation time: 5-10 minutes **Activity time:** 15-20 minutes	**Preparation and materials:** • Gather copies of *"High-Touch Surfaces: Identifying Who Cleans What"* worksheet (See page 2 below or the corresponding slide). Note: If using the worksheet, there is a corresponding answer key on page 3. • Pens/pencils

Instructions:

1. Provide staff with the *"High-Touch Surfaces: Identifying Who Cleans What"* worksheet.
2. You may decide to divide your group into partners or smaller teams for this activity.
3. Give staff 8-10 minutes to identify the high-touch surfaces in your facility and list the staff who are responsible for cleaning each item.
4. Review the responses as a group. Ensure staff are familiar with your facility's policy on who cleans what and how frequently each item should be cleaned. You can ask questions like:
    a. *Who cleans the [specific high-touch surface]?*
    b. *How frequently should you clean [specific high-touch surface]?*
    c. *What should you do if you notice an item is not being cleaned as directed?*

Note: Responses for *who cleans what* may include EVS, nursing, physical/occupational therapy, respiratory therapy, and other staff, depending on what high-touch surfaces you wish to focus on. You may also add additional high-touch surfaces beyond what is listed on the worksheet.

Adherence Tool: Who Cleans What?

Healthcare-Associated Infections Program

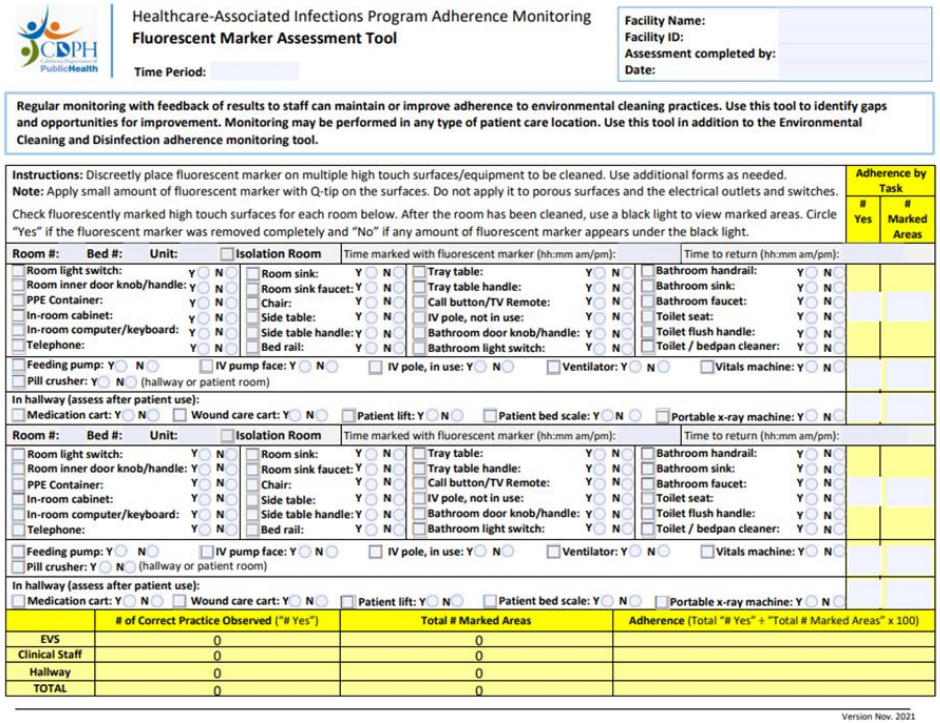
Environmental Cleaning and Disinfection – Who Cleans What?

Everyone is responsible for cleaning and disinfection of the healthcare environment. Keep an updated list of *who cleans what* in your policy. Customize the below template to correspond to your facility policy (e.g., add/delete roles in the top row, add/delete items in the left column). Mark the appropriate columns below with an "X" to designate responsibility, and denote frequency of cleaning (e.g., daily) or when to clean (e.g., before use). Revisit the list on a regular basis to ensure accuracy. Keep this list on cleaning carts, etc., for quick reference.

Date Last Verified:

Who is responsible for cleaning/disinfection of:	Housekeeping	CNA	LVN	RN	RT	PT/OT	Other
ABHR dispenser							
Bathroom							
Bedrail							
Blood pressure machine							
Call button							
Charting area							
Feeding pump							
Floor							
Floor, with large spill							
Glucometer							
In-room computer/keyboard							
IV pole							
IV pump							
Light switch							
Medication cart							
Oxygen tank							
Patient bed scale							
Patient lift							
Patient linen							
Pill crusher							
PPE container							
Privacy curtains							

Adherence Monitoring: GloGerm



Healthcare-Associated Infections Program Adherence Monitoring
Fluorescent Marker Assessment Tool

Time Period:

Facility Name:	
Facility ID:	
Assessment completed by:	
Date:	

Regular monitoring with feedback of results to staff can maintain or improve adherence to environmental cleaning practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location. Use this tool in addition to the Environmental Cleaning and Disinfection adherence monitoring tool.

Instructions: Discreetly place fluorescent marker on multiple high touch surfaces/equipment to be cleaned. Use additional forms as needed.
Note: Apply small amount of fluorescent marker with Q-tip on the surfaces. Do not apply it to porous surfaces and the electrical outlets and switches.

Check fluorescently marked high touch surfaces for each room below. After the room has been cleaned, use a black light to view marked areas. Circle "Yes" if the fluorescent marker was removed completely and "No" if any amount of fluorescent marker appears under the black light.

Adherence by Task

Room #: **Bed #:** **Unit:** ☐ **Isolation Room**	Time marked with fluorescent marker (hh:mm am/pm):	Time to return (hh:mm am/pm):	**# Yes**	**# Marked Areas**
☐ Room light switch: Y ◯ N ◯	☐ Room sink: Y ◯ N ◯	☐ Tray table: Y ◯ N ◯	☐ Bathroom handrail: Y ◯ N ◯		
☐ Room inner door knob/handle: Y ◯ N ◯	☐ Room sink faucet: Y ◯ N ◯	☐ Tray table handle: Y ◯ N ◯	☐ Bathroom sink: Y ◯ N ◯		
☐ PPE Container: Y ◯ N ◯	☐ Chair: Y ◯ N ◯	☐ Call button/TV Remote: Y ◯ N ◯	☐ Bathroom faucet: Y ◯ N ◯		
☐ In-room cabinet: Y ◯ N ◯	☐ Side table: Y ◯ N ◯	☐ IV pole, not in use: Y ◯ N ◯	☐ Toilet seat: Y ◯ N ◯		
☐ In-room computer/keyboard: Y ◯ N ◯	☐ Side table handle: Y ◯ N ◯	☐ Bathroom door knob/handle: Y ◯ N ◯	☐ Toilet flush handle: Y ◯ N ◯		
☐ Telephone: Y ◯ N ◯	☐ Bed rail: Y ◯ N ◯	☐ Bathroom light switch: Y ◯ N ◯	☐ Toilet / bedpan cleaner: Y ◯ N ◯		
☐ Feeding pump: Y ◯ N ◯ ☐ IV pump face: Y ◯ N ◯ ☐ IV pole, in use: Y ◯ N ◯ ☐ Ventilator: Y ◯ N ◯ ☐ Vitals machine: Y ◯ N ◯ ☐ Pill crusher: Y ◯ N ◯ (hallway or patient room)				
In hallway (assess after patient use): ☐ Medication cart: Y ◯ N ◯ ☐ Wound care cart: Y ◯ N ◯ ☐ Patient lift: Y ◯ N ◯ ☐ Patient bed scale: Y ◯ N ◯ ☐ Portable x-ray machine: Y ◯ N ◯				
Room #: **Bed #:** **Unit:** ☐ **Isolation Room**	Time marked with fluorescent marker (hh:mm am/pm):	Time to return (hh:mm am/pm):		
☐ Room light switch: Y ◯ N ◯	☐ Room sink: Y ◯ N ◯	☐ Tray table: Y ◯ N ◯	☐ Bathroom handrail: Y ◯ N ◯		
☐ Room inner door knob/handle: Y ◯ N ◯	☐ Room sink faucet: Y ◯ N ◯	☐ Tray table handle: Y ◯ N ◯	☐ Bathroom sink: Y ◯ N ◯		
☐ PPE Container: Y ◯ N ◯	☐ Chair: Y ◯ N ◯	☐ Call button/TV Remote: Y ◯ N ◯	☐ Bathroom faucet: Y ◯ N ◯		
☐ In-room cabinet: Y ◯ N ◯	☐ Side table: Y ◯ N ◯	☐ IV pole, not in use: Y ◯ N ◯	☐ Toilet seat: Y ◯ N ◯		
☐ In-room computer/keyboard: Y ◯ N ◯	☐ Side table handle: Y ◯ N ◯	☐ Bathroom door knob/handle: Y ◯ N ◯	☐ Toilet flush handle: Y ◯ N ◯		
☐ Telephone: Y ◯ N ◯	☐ Bed rail: Y ◯ N ◯	☐ Bathroom light switch: Y ◯ N ◯	☐ Toilet / bedpan cleaner: Y ◯ N ◯		
☐ Feeding pump: Y ◯ N ◯ ☐ IV pump face: Y ◯ N ◯ ☐ IV pole, in use: Y ◯ N ◯ ☐ Ventilator: Y ◯ N ◯ ☐ Vitals machine: Y ◯ N ◯ ☐ Pill crusher: Y ◯ N ◯ (hallway or patient room)				
In hallway (assess after patient use): ☐ Medication cart: Y ◯ N ◯ ☐ Wound care cart: Y ◯ N ◯ ☐ Patient lift: Y ◯ N ◯ ☐ Patient bed scale: Y ◯ N ◯ ☐ Portable x-ray machine: Y ◯ N ◯				

	# of Correct Practice Observed ("# Yes")	**Total # Marked Areas**	**Adherence** (Total "# Yes" ÷ "Total # Marked Areas" x 100)
EVS	0	0	
Clinical Staff	0	0	
Hallway	0	0	
TOTAL	0	0	

Version Nov. 2021

Addressing IPC Training Barriers

Call-back: Barriers to Providing IPC Training to EVS Staff

- Not sure where to start
- Lack of leadership support
- Not sure what training materials to use
- Time constraints or staff availability
- Other, specify/share

Not Sure Where to Start

- This workshop!
- Enlist other leaders – this is a team effort!
- Start small (e.g., one module at a time)
- Know your audience (e.g., their current level of understanding, learning language preference)

Lack of Leadership Support for Training

- Identify leadership's barriers (e.g., financial)
- Give them an opportunity to be part of the training (e.g., invite them to be trainer, designate an IPC Champion)

Not Sure What Training Materials to Use

- Consider the trainings shared today – Use the EVS Toolkit!

Time Constraints or Staff Availability

- Provide the training over time (e.g., review 1 topic each month)
- Use select slides, instructor checklist items, or activities
- Train as part of new hire/annual orientation
- Train anywhere/anytime (e.g., daily huddle, training day)

Next Steps

EVS Toolkit and Implementation Guide for Facility Educators
(www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ProjectFirstlineToolkit.aspx)

Questions and discussion

Thank You!

Questions?

For more information, contact
HAIProgram@cdph.ca.gov

Visit the California Department of Public Health website.

Lunch 12:00 pm-1:00 pm

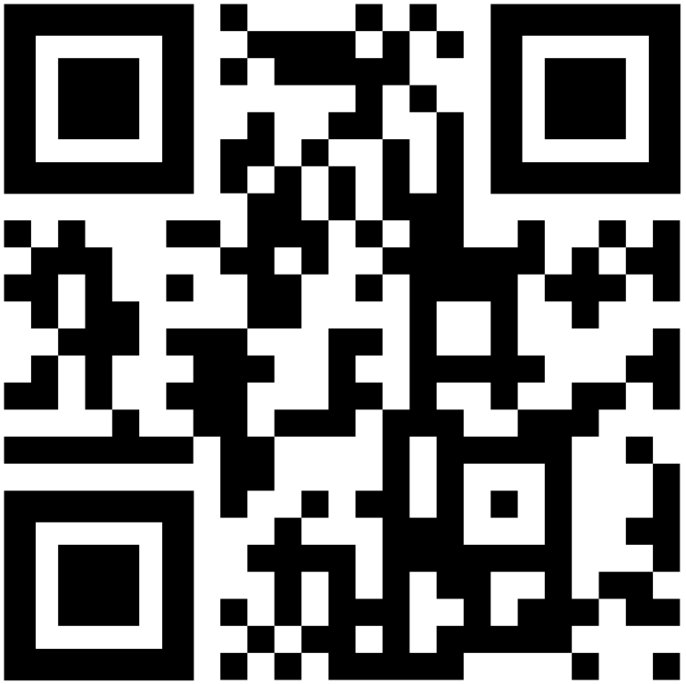
Networking 1:00 pm-2:00 pm

Greater Los Angeles (GLA) APIC SNF Census

CDPH Project Firstline EVS Training Toolkit

Nebraska 90-Day IP Survival Guide

LACDPH Ask an IP Program



LACDPH SNF Honors Program

Sign Up for an ICAR Visit from LACDPH IP Team

LACDPH MDRO Webpage

Sign up for LA Health Alert Network Emails!

HFID Surveys: What to Expect 2:00 pm-3:00 pm

Los Angeles County Health Facilities Inspection Division (HFID)

Michael Lewis, MD, Senior Physician, Consultant Supervisor
Jessica Jaldon, RN, BSN, Supervising Health Facilities Evaluator Nurse

Protecting Public Health Through Quality Care Oversight

About Us

- The **Health Facilities Inspection Division (HFID)** in Los Angeles County has been contracted with the **California Department of Public Health (CDPH)** since **1966**. This partnership allows HFID to act on behalf of CDPH to conduct licensing and certification inspections of healthcare facilities within Los Angeles County.
- This contractual arrangement is unique, as Los Angeles County is the only county in California with this delegated authority, ensuring local oversight and regulation of healthcare facilities in the state's most populous county

Types of Facilities We Inspect

- Acute care hospitals
- Nursing Homes, LTC
- Homes for the developmentally disabled (ICF/IID)
- Hospice Programs
- Ambulatory surgical centers
- Dialysis clinics
- Primary care clinics
- Home Health Agencies
- Congregated Living Facilities (catastrophic and severely disabled, ventilator dependency, terminal illness)

Who Works here?

- Most employees are RNs.
- Employees are called "surveyors" or "evaluators." They conduct routine inspections or "surveys" and investigate complaints. They also make follow-up (re)visits to assure that problems which have been identified are corrected.
- Different titles of surveyors: HFEN (Different levels), HFE, Consultants
- All surveyors have taken and passed the SMQT (federal exam), allowing us to be federal surveyors. Training occurs on the job within the first 6-9 months.
- Chief and Co-chiefs are all RNs

Surveying Staff

- Approximately 270 HFEN (Health Facility Evaluator Nurses)
  - Including supervisors
- Approximately 21 HFE (LSC)
- Consultants (OT, Pharmacists, Dieticians, MDs), 12+1

Workload

- Licensing & Certification: Approve new and existing healthcare facilities.
- Routine Inspections: Conduct compliance checks to ensure regulatory adherence.
- Complaint Investigations: Address public and facility-reported issues.
- Complaint Validations – Similar to above, but for GACHs
- Enforcement: Take corrective actions when facilities violate health and safety standards.
- LSC (Life Safety Code) - state-based regs - Physical environment, fire prevention, and emergency preparedness of the facility.
  - This is not EH

Workload

- HFID inspects approximately 370 nursing homes, representing about 25% of California's total.
- Focused on ensuring compliance and addressing backlog challenges.
- There is a total of 1,964 licensed health facilities in the Los Angeles County area.
  - SNF Recert Surveys Completed: 372
  - LTC Complaints/FRI Completed: 9008
  - NLTC Complaints/FRI Completed: 3060

Where do we cover?

Our Partners

- Federal Partners: Centers for Medicare and Medicaid Services (CMS)
- State Partners: California Department of Public Health
- Local Partners: Los Angeles County Public Health programs
- Community Partners: Residents, patients, and advocacy groups, Ombudsman

Contact Information

- Los Angeles County HFID
- Address: 3400 Aerojet Avenue, #323, El Monte, CA 91731
- Phone: (626) 569-3724 or (800) 228-1019
- Website: publichealth.lacounty.gov

- My email: michael.lewis@cdph.ca.gov

Infection Control and Immunizations

- F-Tags covered in this section:
  - F880, F881, F882, F883, F887

Infection Control and Immunizations

- **F880 – Infection Prevention & Control**
  - Requires facilities to establish and maintain an infection prevention and control program that is designed to provide a safe, sanitary, and comfortable environment. The program must help prevent the development and transmission of communicable diseases and infections through policies, training, surveillance, and appropriate precautions.

- **F881 – Antibiotic Stewardship Program**
  - Facilities must implement an antibiotic stewardship program that includes protocols and systems to monitor the use of antibiotics. The goal is to promote the appropriate use of antibiotics, reduce unnecessary prescribing, and limit the development of antimicrobial resistance, while ensuring safe and effective treatment for residents.

Infection Control and Immunizations

- **F882 – Infection Preventionist**
  - Mandates that each facility designate at least one trained Infection Preventionist (IP), responsible for coordinating the infection prevention and control program. The IP must have specialized training in infection prevention and be involved in quality assessment, data collection, and staff education.

- **F883 – Influenza and Pneumococcal Immunizations**
  - Requires facilities to offer and document influenza and pneumococcal vaccinations for all residents, unless medically contraindicated or refused by the resident. Policies must ensure timely vaccination, education about the benefits and risks, and proper documentation.

Infection Control and Immunizations

- **F887 – COVID-19 Immunization**

  Facilities must develop and implement policies to educate and offer COVID-19 vaccines to all residents and staff when vaccines are available:

  - Education must cover benefits, risks, and side effects, and be provided before offering the vaccine.
  - Vaccines must be offered directly or through outside providers, and re-offered if previously declined.
  - Documentation is required for education, vaccine acceptance/refusal, prior immunization, or contraindications.
  - Staff includes anyone working at the facility at least once a week, including contractors.
  - Adverse events must be reported to VAERS.
  - Residents and staff have the right to refuse without facing discrimination or penalties.

CMS-20054 Infection Prevention, Control and Immunizations Elements

- Standard and transmission-based precautions
- Infection Prevention and Control Program (IPCP) standards, policies, and procedures
- Infection surveillance
- Water management
- Laundry services
- Antibiotic stewardship program
- Infection Preventionist Requirements
- Influenza, pneumococcal, and COVID-19 immunizations

General Standard Precautions

General Standard Precautions:

- Respiratory hygiene/cough etiquette,
- Environmental cleaning and disinfection, and
- Reprocessing of reusable resident medical equipment (e.g., cleaning and disinfection of glucometers per device and disinfectant manufacturer's instructions for use).
- Residents, visitors, and others at the facility wear appropriate source control, in accordance with national standards.

Hand Hygiene

• Appropriate hand hygiene practices (i.e., alcohol-based hand rub (ABHR, must contain 60-95 percent ethanol or isopropyl alcohol) or soap and water) are followed.

• Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected C. difficile infection (CDI) or norovirus during an outbreak, or if endemic rates of CDI are high. Alcohol based hand rub (ABHR) is not appropriate to use under these circumstances

Staff perform hand hygiene (even if gloves are used) in the following situations:

• Before and after contact with the resident;

• After contact with blood, body fluids, or visibly contaminated surfaces;

• After contact with objects and surfaces in the resident's environment;

• After removing personal protective equipment (e.g., gloves, gown, eye protection, facemask); and

• Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care).

Personal Protective Equipment (PPE) Use For Standard Precautions:

• Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin, and removed after contact;

• Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;

• An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions (e.g., changing a resident and their linens when excretions would contaminate staff clothing);

• Appropriate mouth, nose, and eye protection (e.g., facemasks, goggles, face shield) along with isolation gowns are worn for resident care activities or procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions or excretions;

• All staff are following appropriate source control (i.e., facemasks or respirators) in accordance with national standards;

• PPE is appropriately discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national and/or local recommendations), followed by hand hygiene;

• Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (e.g., nursing units, therapy rooms).

Enhanced Barrier Precautions (EBP)

EBP use is evaluated when investigating specific care activities, such as wound care, enteral feeding, urinary catheter care, etc.

EBP are indicated during high contact care activities for residents with infection or colonization with a CDC targeted MDRO (when contact precautions do not apply) or for any resident who has a chronic wound and/or indwelling medical device.

Transmission Based Precautions (TBP)

Appropriate transmission-based precautions are implemented, including but not limited to:

• For a resident on contact precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment;

• For a resident on droplet precautions: staff don a facemask and eye protection (goggles or face shield) within six feet of a resident and prior to resident room entry;

• For a resident on airborne precautions: staff don a fit-tested N95 or higher-level respirator prior to room entry of a resident;

• For a resident with an undiagnosed respiratory infection: staff follows standard, contact, and droplet precautions (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires airborne precautions (e.g., tuberculosis);

Transmission Based Precautions (TBP)

- Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then reusable resident medical equipment is cleaned and disinfected according to manufacturers' instructions using an EPA registered disinfectant for healthcare settings and effective against the identified organism (if known) prior to use on another resident.
- Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare settings and effective against the organism identified (if known) at least daily and when visibly soiled.
- Residents on TBP are placed in a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards.
- Before visiting a resident, who is on TBP or quarantine, the facility informs visitors of the potential risk of visiting and precautions necessary when visiting the resident.

Infection Prevention & Control Program (IPCP) Standards, Policies, and Procedures

- The facility has established a facility-wide IPCP including written IPCP standards, policies, and procedures that are current and based on the facility assessment and national standards (e.g., for undiagnosed respiratory illness and COVID-19).
- The facility's policies or procedures include which communicable diseases are reportable to local and/or state public health authorities.
- The facility has a current list of reportable communicable diseases. Staff (e.g., infection preventionist) can identify and describe the communication protocol with local/state public health officials
- The policies and procedures are reviewed at least annually.

Infection Surveillance

- The facility prohibits employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease. Staff are excluded from work according to national standards.
- The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of infections, communicable diseases and outbreaks among residents and staff.
- The plan includes early detection, management of a potentially infectious, symptomatic resident that requires laboratory testing and/or the implementation of appropriate TBP/PPE (the plan may include tracking this information in an infectious disease log).
- The plan uses evidence-based surveillance criteria (e.g., CDC National Healthcare Safety Network (NHSN) for Long-Term Care or an updated McGeer Criteria) to define infections and the use of a data collection tool.

Infection Surveillance

The plan includes ongoing analysis of surveillance data and documentation of follow-up activity.

• The facility has a process for communicating at time of transfer to an acute care hospital or other healthcare provider a resident's diagnosis to include infection or multidrug-resistant organism (MDRO)colonization status, special instructions or precautions for ongoing care such as transmission-based precautions, medications [e.g., antibiotic(s), laboratory and/or radiology test results, treatment, and discharge summary (if discharged).

• The facility has a process for obtaining pertinent notes such as discharge summary, lab results, current diagnoses, treatment, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals.

• The facility conducts testing of staff and residents for communicable diseases (e.g., COVID-19) in accordance with national standards.

• The facility conducts specimen collection and testing in a manner consistent with standards of practice.

Water Management

• Assessment (e.g., description of the building water systems using text and flow diagrams) where Legionella and other opportunistic waterborne pathogens can grow and spread;

• Measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems that is based on nationally accepted standards (e.g., ASHRAE, CDC, U.S. Environmental Protection Agency or EPA).

For example, control measures can include visible inspections, disinfectant, temperature control (that may require mixing valves to prevent scalding);

• A way to monitor the measures they have in place (e.g., testing protocols, acceptable ranges), and established ways to intervene when control limits are not met;

Laundry Services

How does the facility handle, store, and transport linens appropriately including, but not limited to:

- Using standard precautions (e.g., gloves, gowns when sorting and rinsing) and minimal agitation for contaminated linen;
- Holding contaminated linen and laundry bags away from his/her clothing/body during transport;
- Bagging/containing contaminated linen where collected, and sorted/rinsed only in the contaminated laundry area (double bagging of linen is only recommended if the outside of the bag is visibly contaminated or is observed to be wet on the outside of the bag);
- Transporting contaminated and clean linens in separate carts; if this is not possible, the contaminated linen cart should be thoroughly cleaned and disinfected per facility protocol before being used to move clean linens. Clean linens are transported by methods that ensure cleanliness, e.g., protect from dust and soil; and
- If a laundry chute is in use, laundry bags are closed with no loose items.
- Use detergents, rinse aids/additives, and follow laundering directions according to the manufacturer's instructions for use.

Antibiotic Stewardship Program (ASP):

- Written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics;
- Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools or management algorithms are used for one or more infections (e.g., SBAR tool for urinary tract infection (UTI) assessment, Loeb minimum criteria for initiation of antibiotics);
- A process for a periodic review of antibiotic use by prescribing practitioners: for example, review of laboratory and medication orders, progress notes and medication administration records to determine whether or not an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time.
- Protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic; and
- A system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data, and prescribing practices for the prescribing practitioner.

Infection Preventionist (IP)

- The facility designated one or more individual(s) as the infection preventionist(s) who are responsible for the facility's IPCP.
- The Infection Preventionist (s) works at least part-time at the facility and physically work on-site in the facility.
- The Infection Preventionist(s) completed specialized training in infection prevention and control.

IP Requirements

Professional training: There must be one of the following:

- Certificate/diploma or degree in nursing; or
- Bachelor's degree (or higher) in microbiology or epidemiology; or
- Associate's degree or higher in medical technology or clinical laboratory science; or
- Completion of training in another related field such as that for physicians, pharmacists, and physician's assistants.

Specialized training in infection prevention and control:

- Completed prior to assuming the role of the IP; and
- Evidence of completion is available (e.g., certificate).

Influenza, Pneumococcal, and COVID-19 Immunizations for Residents:

Review the records (influenza, pneumococcal, and COVID-19) for documentation of:

- Screening and eligibility to receive the vaccine(s);
- The provision of education related to the influenza, pneumococcal, and COVID-19 vaccines (such as the benefits and potential side effects);
- The administration of vaccines in accordance with national recommendations, which includes doses administered.
- Facilities must follow the CDC and Advisory Committee on Immunization Practices (ACIP) recommendations for vaccines; and
- Allowing a resident or representative to accept or refuse the influenza, pneumococcal, and COVID-19 vaccines. If not provided, documentation as to why the vaccine(s) was not provided.

Influenza, Pneumococcal, and COVID-19 Immunizations for Residents:

• The facility has to demonstrate that: • The vaccine has been ordered and the facility received a confirmation of the order indicating that the vaccine has been shipped or that the product is not available but will be shipped when the supply is available; and

• Plans are developed on how and when the vaccines will be administered when they are available.

Educate and Offer COVID-19 Immunizations for Staff

Review facility documentation for sampled staff for evidence of:

- Screening and eligibility to receive the vaccine(s);
- The provision of education regarding the benefits, risks and potential side effects associated with the vaccine;
- Being offered the vaccine or provided information on obtaining the vaccine;
- The administration of vaccines, if accepted in accordance with national recommendations.

Resources

- State Operations Manual, Appendix PP, revision July 23,2025
- CMS 20054 Critical Element Pathway (CEP)
- Centers for Disease Control and Prevention (CDC). The "Nursing Home Infection Preventionist Training Course" is located on CDC's TRAIN website (https://www.train.org/cdctrain/training_plan/3814
- CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) webpage https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html.

Break 3:00 pm-3:15 pm

Unpacking an ICAR 3:15 pm-4:30 pm

SNF Symposium:
Unpacking ICAR Presentation

Monday September 22nd, 2025

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County of Los Angeles Public Health

Disclosures

There is no commercial support for today's presentation.

Neither the speakers nor planners for today's presentation have disclosed any financial interests related to the content of the meeting

This presentation is meant for healthcare facilities and is off the record.

Objectives

- Understand the purpose and scope of Infection Control Assessment and Response (ICAR)
- How to use ICAR findings and results to create actionable improvement within SNF
- Apply ICAR-related knowledge to real world scenarios

I. Brief Introduction + Review of ICAR

What is an ICAR?

- Infection Control Assessment and Response
- On-site assessment tool used to evaluate Infection Prevention and Control (IPC) practices within your facility
- Goal: to identify strengths and opportunities for improvement in your IPC Program
- Collaborative, not punitive
- Quality improvement and patient safety are key focuses

What is an ICAR?

- We want to identify your facility's capacity to detect and address HAIs and outbreaks
- We want to measure the differences between what is happening with IPC in our facilities and what are the best practices/regulations/requirements
- Identify and bridge the gaps
- At the end of the day this is a gap analysis

What does an ICAR cover?

- IPC Program structure: policies, protocols, risk assessments
- Hand Hygiene: observation of practices, product availability
- Personal Protective Equipment (PPE): Correct use, availability, donning/doffing
- Resident Care: Isolation protocols, device care
- Environmental Cleaning and Disinfection: products, processes, frequency
- High risk procedures: management of wounds, injection safety
- Dietary: food safety and prevention of foodborne illness
- + MORE!

What might an ICAR look like?

- Self Q &A + Staff Q & A
- Direct observations
- Chart/data review
- Feedback from staff

Q & A

Module 8: Respiratory Hygiene, Cough Etiquette and Source Control

The facility requires all personnel who are not immunized against influenza to wear a face mask while on duty during upper respiratory infection season.

- ○ Yes
- ○ No

reset

The facility implements source control in the following situations:

- ☐ Respiratory infection outbreak in the facility
- ☐ Increased respiratory infection activity in the community
- ☐ As ordered by Public Health

Select all that apply

The facility frequently reminds family and visitors that visits should be delayed if they are experiencing symptoms of a respiratory infection (coughing, shortness of breath, fever, sore throat, congestion).

- ○ Yes
- ○ No
- ○ Unknown or unsure

reset

Direct Observations: Adherence Monitoring

CDPH California Department of Public Health

Healthcare-Associated Infections Program Adherence Monitoring
Environmental Cleaning and Disinfection

Assessment completed by:
Date:
Unit:

Regular monitoring with feedback of results to staff can maintain or improve adherence to environmental cleaning practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

Instructions: Observe at least two (2) different environmental services (EVS) staff members. Observe each practice and check a box if adherent ("Yes") or not adherent ("No"). In the right column, record the total number of "Yes" responses for adherent practices observed and the total number of observations ("Yes" + "No"). Calculate adherence percentage in the last row.

	Environmental Cleaning Practices
ES1.	Detergent/disinfectant solution is mixed and stored according to manufacturer's instructions.
ES2.	Solution remains in wet contact with surfaces according to manufacturer's instructions.
ES3.	Cleaning process avoids contamination of solutions and cleaning tools; a clean cloth is used in each patient area, and the cloth is changed when visibly soiled.
ES4.	Standard cleaning protocol is followed to avoid cross-contamination *(e.g. from top to bottom, patient room to bathroom, and clean to dirty)*
ES5.	Environmental Services staff use appropriate personal protective equipment *(e.g. Gowns and gloves are used for patients/residents on contact precautions upon entry to the Contact precautions room.)*
ES6.	Hand hygiene is performed throughout the cleaning process as needed, including before and after glove use.
ES7.	High-touch surfaces* are thoroughly cleaned and disinfected after each patient. *Mark "Yes" if Fluorescent Marker Assessment Tool result is 100%; mark "No" if <100%.*
ES8.	There are no visible tears or damage on environmental surfaces or equipment.
ES9.	The room is clean, dust free, and uncluttered.

***Examples of high touch surfaces:**

Bed rail	Chair	Room light switch	TV remote
Tray table	In-room medical cart	IV pole ("grab area")	Room inner door kno
Side table	Room sink	Call button	In-room cabinet
Side table handle	Room sink faucet	PPE container	In-room computer/k

# of Correct Practice Observed ("# Yes"): _____

Total # Environmental Services Observatic (Up to 27 Total)
If practice could not be observed (i.e. cell is bla

CDPH California Department of Public Health

Healthcare-Associated Infections Program Adherence Monitoring
Hand Hygiene

Assessment completed by:
Date:
Unit:

Regular monitoring with feedback of results to staff can improve hand hygiene adherence. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

Instructions: Observe at least 10 hand hygiene (HH) opportunities per unit. Observe a staff member and record his/her discipline. Check the type of hand hygiene opportunity you are observing. Indicate if HH was performed. Record the total number of successful HH opportunities and calculate adherence.

HH Opportunity	Discipline	What type of HH opportunity was observed? (select/ ☑ 1 per line)	Was HH performed for opportunity observed? ✔ or Ø
Example	N	☐ before care/entering room* ☐ before task ☐ after body fluids ☐ after care* ☑ upon leaving room *Remember: Hand hygiene should be performed before and after glove use	✔
HH1.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH2.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH3.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH4.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH5.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH6.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH7.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH8.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH9.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	
HH10.		☐ before care/entering room ☐ before task ☐ after body fluids ☐ after care ☐ upon leaving room	

Disciplines:
CNA = Nurse Assistant
D = Dietary
N = Nurse
P = Physician
RT = Respiratory Therapist
S = Student
VIS = Visitor
VOL = Volunteer
W = Social Worker
OTH = Other, Specify
U = Unknown

Opportunities:
✔ = Opportunity Successful
Ø = Opportunity Missed

For HH1-HH10:

Total # HH Successful ("# ✔"): _____ | Total # HH Opportunities Observed: _____ | Adherence: _____% (Total # HH Successful ÷ Total HH Opportunities Observed x 100)

Version 2016.10.14

Facility-wide ICAR

- Comprehensive snapshot of your facility's general IPC practices
- Unknown reasons for below standard IPC practices
- Unknown state of IPC practices, not measured or tracked
- Outbreak or increased transmission seen throughout the facility

Focused or Targeted ICAR

- Deeper dive into specific unit, department, or IPC Practices
- Known reasons for below standard IPC practices
- Previous interventions did not yield improvement
- Outbreak or increased transmission seen in specific areas within the facility

When to perform an ICAR?

- On a set schedule, annually
- If HAIs increase
- New staff, or new IP
- Preparation for a regulatory survey

- ICARs can be facility-wide OR you can focus on certain areas of your facility, depending on the need

Who is involved in the ICAR?

- If you are conducting internal ICAR, typically the Infection Preventionist is the lead
- If facility-wide you can recruit other key leadership members or department heads
- If targeted, you can focus on specific leaders for the department or unit you are assessing

- If external, IP Consult, or LAC DPH (we do ICARs too!)

II. ICAR Results/Findings + What to do with them?

What do we do after an ICAR is finished?

- Review and analyze findings
- Prioritize areas for improvement
- Disseminate information, sharing results with staff
- Celebrate Successes
- Take Action! Implement action plans, interventions

Is there a theme that emerges?

- New staff/staff turnover
- Lack of training in a certain role type or overall
- Obstacles in the way of good IPC Practices
- No theme? Needs more information, observation? Nothings presented itself that happens too

- Where is your facility performing well?
- Can those behaviors be bundled or applied ?

Theme continued

- Is there a theme?
  - New staff? → is new hire orientation up to par? Are staff's competencies to IPC practices assessed?
  - Lack of training? → how frequently are staff trained? (asked in the ICAR)
  - Obstacles in the way of good IPC practices? → can PPE or ABHR dispensers be placed in a better location?
  - No theme?
- Which areas is your facility performing well in? → e.g., dietary passes with flying colors
  - Why is this? Ask the staff and leadership; perhaps we can learn something from them

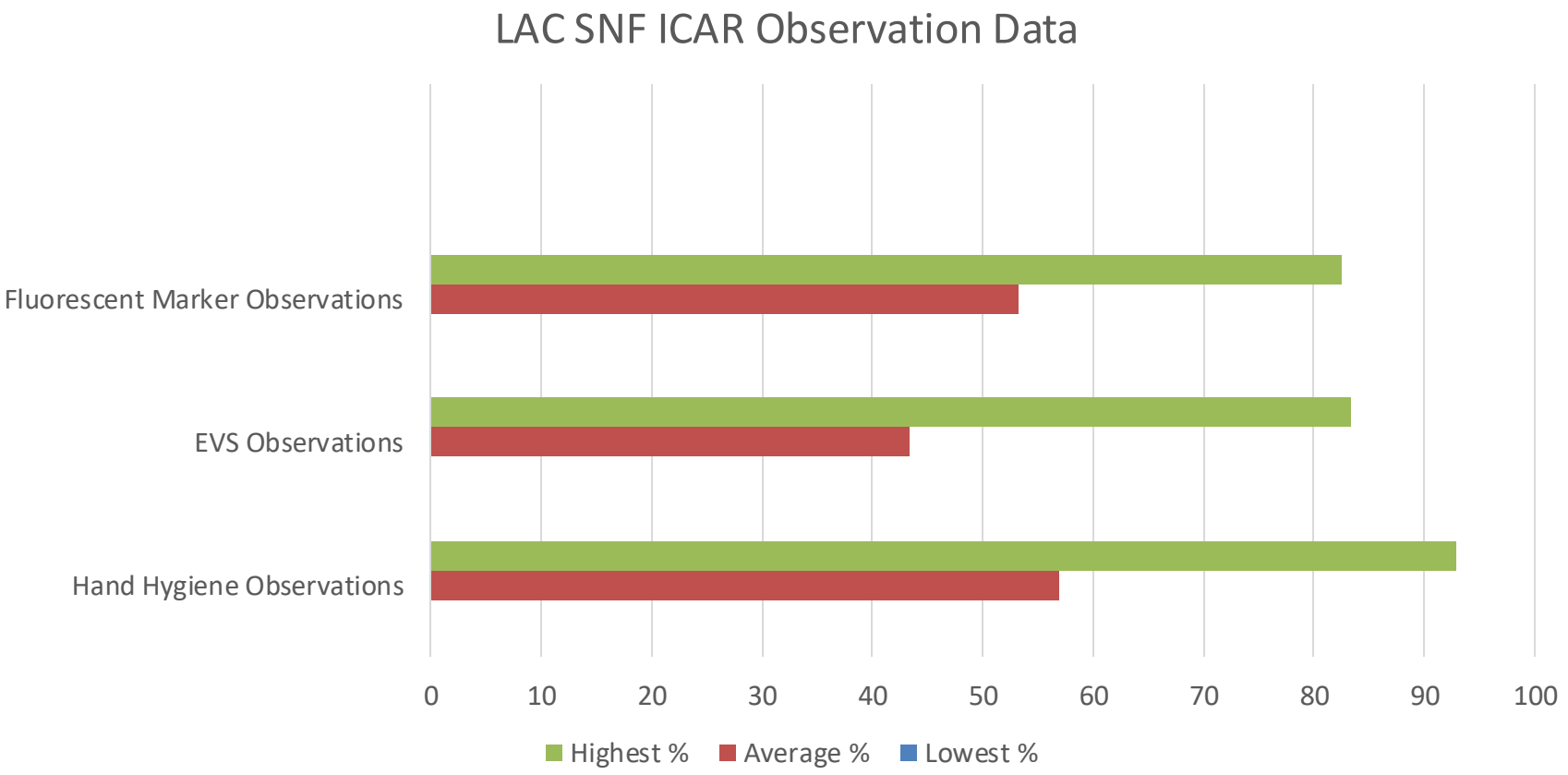
Summarize ICAR results

Example				
Training, Auditing Feedback	Laundry Services	Occupational Health	Hand Hygiene	Standard and Transmission-based precautions
• Environmental Services staff do not receive infection prevention training after onboarding	• One dryer is currently out of service, causing a delay in laundering; piles of linen were found without a tag or sign indicating if the linen is clean or dirty	• Master list of staff who are required to receive annual fit testing is outdated	• The majority of missed opportunities are: after contact with the patient environment • 3 ABHR dispensers were found to be defective	• Multiple rooms with residents on TBP did not have the isolation signage posted at room entry • Several isolation carts were found without the appropriate disinfectant product

Summarize ICAR results

Example							
Training, Auditing Feedback	Laundry Services	Occupational Health	Hand Hygiene	Standard and Transmission-based precautions	Wound Care	Antimicrobial Stewardship	Environmental Services
• Environmental Services staff do not receive infection prevention training after onboarding	• One dryer is currently out of service, causing a delay in laundering; piles of linen were found without a tag or sign indicating if the linen is clean or dirty	• Master list of staff who are required to receive annual fit testing is outdated	• The majority of missed opportunities are: after contact with the patient environment • 3 ABHR dispensers were found to be defective	• Multiple rooms with residents on TBP did not have the isolation signage posted at room entry • Several isolation carts were found without the appropriate disinfectant product	• Few CHG wipes are available to the wound care team	• The committee is set to meet quarterly, but was not able to meet in Q3	• Staff did not know when to change mop water • Microfiber towels are overused, torn, and discolored • 2 staff were found using detergent-based products for disinfecting surfaces

Review Findings: LA County SNF ICAR Data (n=11)



Prioritize

- Breakdown results by module/domain
- What are the major fallouts?
- What is a critical area for improvement, or might need immediate action?

Prioritize

ICAR Module	Fallout	Priority Level
Training, Auditing Feedback	Environmental Services staff do not receive infection prevention training after onboarding	Low
Laundry Services	One dryer is currently out of service, causing a delay in laundering; piles of linen were found without a tag or sign indicating if the linen is clean or dirty	Moderate
Occupational Health	Master list of staff who are required to receive annual fit testing is outdated	Low
Hand Hygiene	The majority of missed opportunities are: after contact with the patient environment	High
Hand Hygiene	3 ABHR dispensers were found to be defective	High
Standard and Transmission-based precautions	Multiple rooms with residents on TBP did not have the isolation signage posted at room entry	High
Standard and Transmission-based precautions	Several isolation carts were found without the appropriate disinfectant product	High
Wound Care	Few CHG wipes are available to the wound care team	High
Antimicrobial Stewardship	The committee is set to meet quarterly, but was not able to meet in Q3	Low
Environmental Services	Staff did not know when to change mop water	Moderate

Disseminate

- What happens after you review findings and prioritize?
- Bring forth this information to leadership and/or staff
  - Structured meeting
  - Daily Huddles
  - QAPI/IPC Committee meetings
  - Summarize findings
  - Ensure that staff/leadership understand information shared with them, including next steps

Disseminate Findings + Recommendations

ICAR Module	Fallout	Priority Level	Recommendation	Reference
Training, Auditing Feedback	Environmental Services staff do not receive infection prevention training after onboarding	Low	EVS to implement regular IP training annually; IP to assist in creating the education	• Facility policy • External regulation • Best practice or guidance

Example: EVS Common Fallouts

- Environmental Cleaning and Disinfection
  - Cross contamination when cleaning
  - PPE related challenges while cleaning
  - Inadequate supplies
  - Need for additional staff training
  - Flow of room cleaning
  - Disorganized EVS Carts
  - Preparation for cleaning a room
  - No cleaning schedule
  - Lack of follow through with high touch surfaces

Examples: Recommendations

- Cleaning from top to bottom
- Educating staff on flow of room cleaning
- Clean to dirty
- Just in time training
- Inventory checks
- Visual step by step cleaning procedures
- Pre-cleaning checklist
- List of high touch surfaces
- Fluorescent marker exercises for learning

Example: HH Fallouts

- Hand Hygiene
  - Missing opportunities for hand hygiene
  - Inadequate supplies for HH
  - Hand hygiene during donning and doffing process
  - Hand hygiene prior to aseptic technique

HH Recommendations

- Direct observation audits
- Real time feedback
- Adequate supply of ABHR
- Daily stock checks
- Hands on training
- Visual reminder for point of care
- Signage in relevant language

Example: Visitor Education

- Visitor Education
  - Visitors who refuse to don PPE
  - Visitors who are unaware of TBP
  - Visitors who do not perform HH
  - Visitors who adjust medical equipment

Visitor Education Recommendations

- Clear signage in relevant languages
- Just in time training
- Education on TBP
- Pre-visit education or educational material sent to visitors
- Staff encouragement or hands on training about donning and doffing PPE

Celebrate Successes

- Acknowledge staff successes not just the pitfalls
- Embrace the patterns and behaviors that are working in certain areas and apply them to others

Take Action!

- QAPI Framework
- Performance Improvement Project
- Adherence Monitoring
- Staff and Visitor Education
- Resource Check

Next Steps: Get into the QAPI Mindset

- ICAR identifies risks, QAPI Framework serves as the vehicle to address these risks
- We don't want to just "band-aid" the solution, we want something sustainable

Performance Improvement Project (PIP)

- Root Cause Analysis (RCA)
- 5 Whys?
- Create SMART Goals

- Example: ICAR Finding: Hand Hygiene is at 50% compliance on Main Unit
  - SMART Goal: increase hand hygiene compliance among nursing staff on the main unit from 50% to 90% within 60 days

Adherence Monitoring: The Key to Sustainability

- Ongoing process, not a one time thing
- Routine Audits
- Data as a tool
- Make it sustainable

Staff and Visitor Education

- Targeted Education
- Hands-on training
- 1:1
- Teach-back
- Keep clear and simple

The Resource Check: Equipping for Success

- Are we equipped?
- Availability
- Access
- Accountability

Another ICAR?

- Time has passed, start the process again, back to the drawing board, sometimes interventions or follow up doesn't stick or maybe was not the best solution, so we try another solutions.
- Something more sustainable.

Scenarios / Interactive

Hand Hygiene Scenario

- During a targeted ICAR focusing on Hand Hygiene:
- 50 hand hygiene opportunities were recorded.
- Staff performed hand hygiene correctly for only 25 of those opportunities (50% compliance).
- Most missed opportunities (20 out of 25) happened when staff exited resident rooms.
- Alcohol-based hand rub and sinks were available, and supplies were fully stocked

Possible Follow Up: Hand Hygiene

- Reinforce that **hand hygiene is required when exiting every resident room**.
- Place **visual reminders** at room exits.
- Conduct **real-time observations with on-the-spot feedback**.
- Track monthly through QAPI until compliance reaches 90% or above.

Hand Hygiene Scenario

- During a targeted ICAR focusing on Hand Hygiene:
- 50 hand hygiene opportunities were recorded.
- Staff performed hand hygiene correctly for only 25 of those opportunities (50% compliance).
- Most missed opportunities (20 out of 25) happened when staff exited resident rooms.
- Alcohol-based hand rub and sinks were available, and supplies were fully stocked

- After interventions were implemented, hand hygiene compliance initially improved for 2 months. However, compliance then dropped below the original baseline levels

Possible Follow Up: Hand Hygiene

- Emphasize that sustainability requires **ongoing monitoring**, not one-time fixes.
- Add hand hygiene as a **standing QAPI agenda item**.
- Use **leadership rounding and peer accountability** to reinforce.

EVS Scenario

- While conducting an environmental cleaning observation for your facility's ICAR, two high-touch surfaces in a common area were missed during daily cleaning.
- Cleaning products and checklists were available

Possible Follow Up: EVS

- Re-educate staff on the importance of **cleaning all high-touch surfaces**.
- Supervisors could **spot check daily** and give immediate coaching/teaching.

- QAPI performance improvement project with 2 weekly observations to confirm sustained improvement

EVS Scenario

- While conducting an environmental cleaning observation for your facility's ICAR, two high-touch surfaces in a common area were missed during daily cleaning.
- Cleaning products and checklists were available

- The facility introduced a cleaning checklist, and compliance improved for about 3 weeks. However, once staff stopped using the checklist, compliance levels dropped again.

Possible Follow Up: EVS

- Incorporate the checklist into **daily workflow** with **supervisor sign-off**.
- Conduct **random fluorescent marker testing** to verify surfaces are cleaned.
- Share audit results in **QAPI meetings** and recognize staff who improve.
- Explore workload or turnover issues as potential barriers.

Fluorescent Marker (High Touch Surface) Scenario

- Fluorescent marker testing showed that after routine cleaning, only 60% of marked high-touch surfaces had been properly cleaned and disinfected.
- The remaining 40% of surfaces still had visible fluorescent marker.

Possible Follow Up: Fluorescent Marker (High Touch Surface)

- Provide **immediate feedback** to EVS staff.
- Reinforce **cleaning technique and attention to all surfaces**.
- Track results through QAPI, with a goal of 90% or higher of cleaned surfaces.
- Share results visually with staff to encourage accountability.

Fluorescent Marker (High Touch Surface) Scenario

- Over a three-month period, fluorescent marker audits were conducted weekly.
- Initial results showed 85% of surfaces were being cleaned effectively.
- However, by the third month, compliance had dropped to 55%.
- When staff were asked, many said they thought audits were ‘temporary’ and had stopped prioritizing the process.

Possible Follow Up: Fluorescent Marker (High Touch Surface)

- Sustainability requires **ongoing and transparent feedback**-share results with staff regularly.
- Incorporate fluorescent marker audits as a **standing QAPI measure** (not a one-time project).
- Engage **EVS supervisors and leadership rounding** to reinforce importance.
- Recognize staff/units for strong compliance to motivate continued performance.

EBP/PPE Scenario

- During Enhanced Barrier Precautions (EBP) observation, staff were not consistently donning gowns and gloves upon entering resident rooms.
- PPE supplies were available at room entry, and signage posted.

Possible Follow Up: EBP/PPE

- Reinforce that **EBP requires gown and gloves for all high-contact resident care activities**.
- Ensure **clear signage** and supplies remain at entry points.
- Provide **just-in-time coaching** when staff are observed noncompliant.
- Monitor PPE adherence in QAPI and celebrate units with high compliance.

EBP/PPE Scenario

- During ICAR follow-up, staff compliance with Enhanced Barrier Precautions (EBP) was observed to be inconsistent.
- While most staff donned gowns/gloves for wound care, they did not consistently do so for high-contact activities such as assisting with bathing or transfers.
- Interviews revealed staff believed PPE was only required for ‘isolation cases’, not under EBP.

Possible Follow Up: EBP/PPE

- Provide **targeted education** clarifying that EBP applies to all residents with MDROs, not just those in isolation.
- Revise signage to highlight **specific high-contact activities** requiring PPE.
- Use **direct observation audits** with just-in-time feedback.
- Track compliance in QAPI: include both **education and monitoring** as action items.

Questions