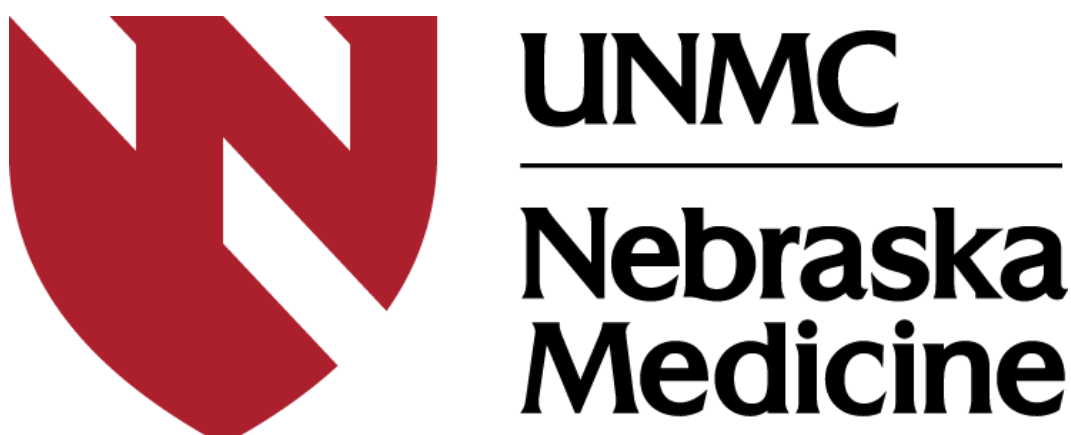


Infection Prevention Program Infrastructure and Implementation of Best Practice Recommendations in Outpatient Healthcare Facilities



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Background

The CDC recommends that outpatient healthcare facilities (OHFs) establish and maintain infection prevention and control (IPC) programs; however, little is known about how these programs are structured.

The Nebraska Infection Control Assessment and Promotion (ICAP) Program † conducted onsite assessments to evaluate implementation of best practice recommendations (BPRs) in these programs.

Methods

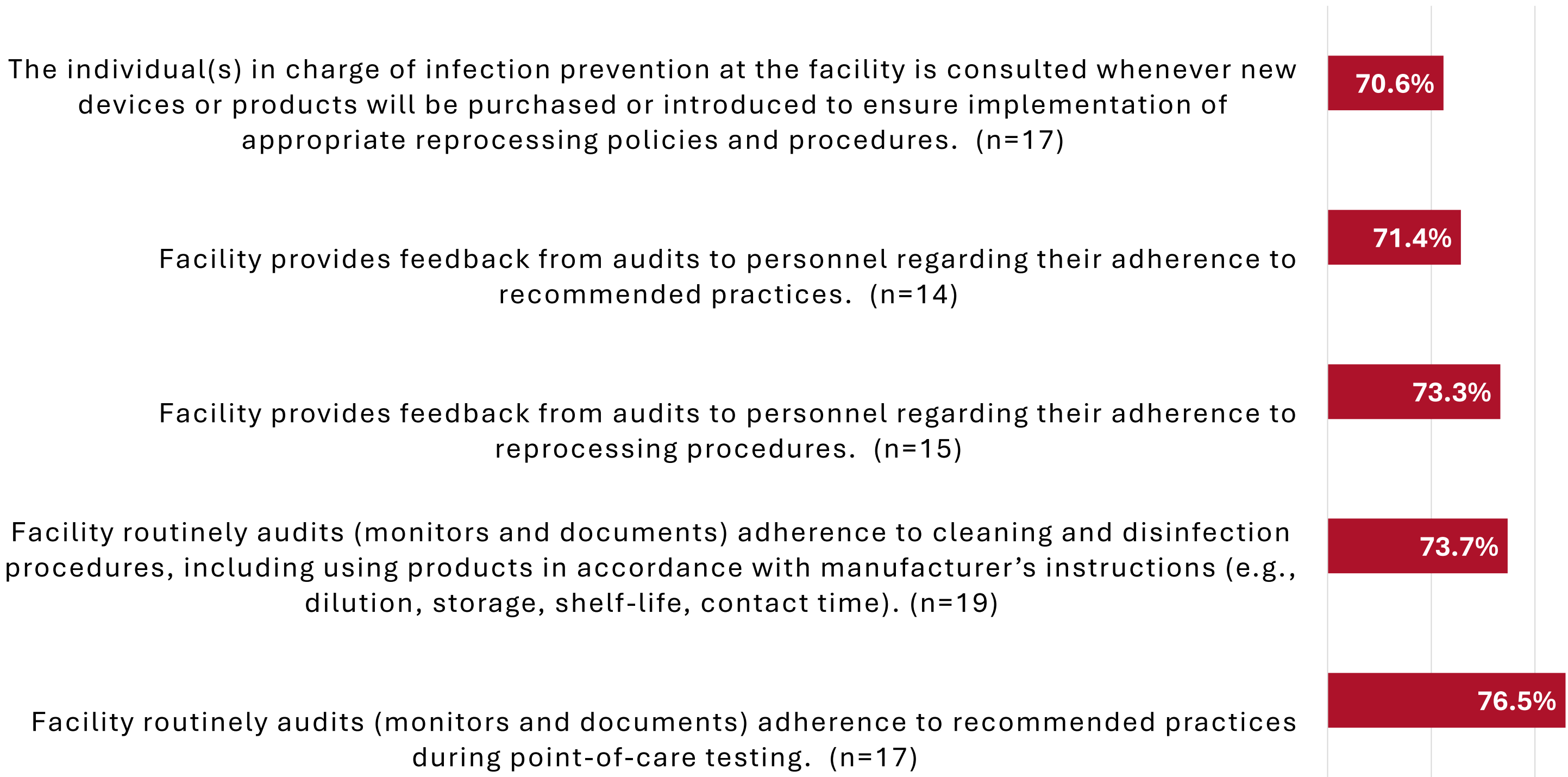
Onsite IPC assessments were conducted in OHFs from January 2020 to February 2024. The assessment questions were based primarily on the CDC 2016 Infection Control Assessment and Response (ICAR) tool, complemented by the CMS Hospital Infection Control Worksheet. Assessments included interviews and onsite observations. A total of 66 BPRs were assessed for implementation.

Descriptive statistics were calculated for assessment responses and demographic information.

BPRs were classified based on hospital affiliation, accreditation status (based on certification by recognized accrediting bodies), and urban-rural designation (based on USDA rural-urban commuting area codes). The chi-square test of independence was performed to assess for statistically significant differences across these categories using a threshold of p < 0.05.

Figure 1

Most Common Opportunities for Improvement



Demographic Features on Compliance with Best Practice Recommendations

Best Practice Recommendation	% All OHC with BPR in place (N=19)	Accreditation (N=8) vs. No Accreditation (N=11) P-value*	Affiliation (N=8) vs. No Affiliation (N=11) P-value*	Urban (N=7) vs. Rural (N=8) vs. Semi-Urban (N=4) P-value*
Facility has policies and procedures outlining facility response (i.e., risk assessment and recall of device) in the event of a reprocessing error or failure.	35%	63% vs 11% (p 0.013)	17% vs 45% (p 0.127)	83% vs 14% vs 0% (p 0.015)
Personnel who clean and disinfect patient care areas (e.g., environmental services, technicians, nurses, contractors) receive training on cleaning procedures annually.	33%	63% vs 10% (p 0.013)	14% vs 45% (p 0.127)	50% vs 13% vs 50% (p 0.303)
HCP are required to demonstrate competency with environmental cleaning procedures following each training.	33%	13% vs 50% (p 0.127)	57% vs 18% (p 0.141)	33% vs 50% vs 0% (p 0.209)
Facility routinely audits (monitors and documents) adherence to hand hygiene.	32%	38% vs 27% (p 0.636)	38% vs 27% (p 0.636)	43% vs 38% vs 0% (p 0.303)
The individual(s) in charge of infection prevention at the facility is consulted whenever new devices or products will be purchased or introduced to ensure implementation of appropriate reprocessing policies and procedures.	31%	57% vs 11% (p 0.046)	0% vs 45% (p 0.026)	83% vs 0% vs 0% (p 0.003)
Facility routinely audits (monitors and documents) adherence to cleaning and disinfection procedures, including using products in accordance with manufacturer’s instructions.	28%	13% vs 40% (p 0.243)	43% vs 18% (p 0.345)	33% vs 38% vs 0% (p 0.375)
Facility routinely audits (monitors and documents) adherence to reprocessing procedures.	24%	25% vs. 22% (p 0.719)	17% vs 27% (p 0.435)	50% vs 14% vs 0% (p 0.181)
Facility routinely audits (monitors and documents) adherence to recommended practices during point-of-care testing.	19%	38% vs 0% (p 0.027)	0% vs 27% (p 0.107)	17% vs 0% vs 50% (p 0.081)
Facility routinely audits (monitors and documents) adherence to safe injection practices.	16%	25% vs 9% (p 0.348)	0% vs 27% (p 0.107)	14% vs 0% vs 50% (p 0.081)

Figure 2

Results

A total of 19 outpatient healthcare facilities (OHFs) received onsite assessments. Of these, 42.1% were affiliated with a hospital, and 42.1% held external accreditation. All but one were certified by CMS. Most facilities (77.8%) had at least one individual with infection prevention training regularly available. In terms of location, the majority were rural (42.1%), followed by urban (36.8%) and semi-urban (21.1%).

Domains with the lowest percentage of BPR compliance included injection safety (48.8%), device reprocessing (49.7%), and personal protective equipment (51.8%).

Notable BPRs associated with less than 35% compliance are listed in figure 1. Accredited facilities demonstrated greater compliance with BPRs related to device reprocessing (figure 2).

Conclusion

IPC BPRs are not consistently implemented in OHFs. Opportunity exists for proactive onsite assessments to evaluate IPC program infrastructure and to highlight areas for improvement. Consultation should include review of existing policies and procedures as well as observation of practice. Maintaining opportunities for partnership with public health programs is essential. Further studies are needed to understand why accreditation is associated with increased implementation of BPRs.

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