Stamps Health Services
2023 Quality Report

Completed by:
John Scuderi and Benjamin Holton, MD
5/16/2024
Table of Contents

1. Executive Summary .................................................................................................................. 3
2. Quality Committees .............................................................................................................. 5
3. Strategic Goals .......................................................................................................................... 12
4. Risk Management ................................................................................................................... 13
5. Peer Review ............................................................................................................................. 18
6. After Hours Care ..................................................................................................................... 20
7. Quality Improvement .............................................................................................................. 22
8. Quality Assurance .................................................................................................................. 34
9. COVID-19 ............................................................................................................................... 42
10. Benchmarking ......................................................................................................................... 43
11. Safety Program ....................................................................................................................... 45
Appendix A. Infection Prevention and Control Assessment Tool for Outpatient Settings .......... 46
Appendix B. Safety and Health Program Self-Evaluation Tool .................................................. 72
1. Executive Summary

Stamps Health Services is committed to the principles of providing high quality care, ensuring access to care, delivering care in an efficient manner, stewarding our financial resources in a responsible manner, and providing a workplace environment that supports the personal wellbeing and growth of our employees. This report describes many of our efforts in 2023 to achieve these goals through our Quality Program.

In 2023 Stamps Health Services moved away from operations that had been modified in response to Covid-19. Primary Care Clinic returned to in-person appointments for most appointments. Stamps continued to offer rapid Covid testing for symptomatic patients and Covid-19 vaccination for students. Psychiatry Clinic offered a blend of virtual and in-person visits based on patient and provider preference.

Stamps Health Services’ Quality Program is built around the Quality Committee and its subcommittees, including Medicine Committee, Infection Prevention and Control Committee, Pharmacy and Therapeutics Committee, and the Safety Committee. SHS providers continue to have excellent compliance with reporting of Reportable Diseases. Providers demonstrated strong adherence to updated CDC guidelines for the management of gonorrhea and chlamydia infections in choice of antibiotic used. Compliance with instructing patients to get retested in 3 months after initial diagnosis of chlamydia improved after review of the guidelines. We continue to have an opportunity to improve retesting students diagnosed with pharyngeal gonorrhea in 7-14 days after initial treatment.

SHS met several of its strategic goals in 2023. We successfully transitioned to a single EMR used by SHS and the Center for Mental Health Care and Resources (formerly GT Counseling Center and GT CARES). We also successfully moved from a cassette-based radiology system to a digital system for capturing radiology images, improving the quality and efficiency of our radiology operations.

Stamps Health Services has a robust Risk Assessment program. Fourteen incidents were reported in 2023, 11 of which were judged to be significant or critical with a risk of causing harm or injury if not corrected. Steps were taken to mitigate the risks identified in each of these incidents.

SHS provides an after-hours nurse call service for students to utilize at no charge. For 2023, the number of calls to the after-hours nurse decreased by 30%. 99% of the calls were for medical issues. 99% of these medical calls were followed up within 1-2 business days.

Quality Improvement studies in 2023 again focused on compliance with CDC guidelines for the management of gonorrhea infection and chlamydia infection. For both gonorrhea and chlamydia, SHS providers are consistently following the guidelines for the correct antibiotic and the duration of treatment. We had significant improvement in recommending retesting at 3 months for individuals diagnosed with chlamydia infection but did not quite reach our goal of 95% compliance with this practice. We also identified a need to increase the rate at which students comply with this recommendation for retesting.

SHS participates in opportunities to benchmark our performance against peer institutions or published guidelines for management of specific conditions. In 2023 SHS benchmarked our performance against the CDC guidelines for management of gonorrhea and chlamydia infections.
Stamps Health Services is deeply committed to providing high quality care for our patients. This report provides a summary of the multifaceted approach of our Quality program, showing successes and some areas to improve.

Respectfully submitted,

Benjamin Holton, MD
Senior Director
Chair, Quality Committee
2. Quality Committees

Quality improvement and assurance is the framework used at Stamps Health Services to systematically improve and sustain care. At Stamps, the quality structure includes the following committees: Infection Prevention and Control (IP&C), Pharmacy and Therapeutics (P&T), Medicine, and Safety (ad hoc). Stamps encourage all staff to be part of the quality process. These committees report to the Quality Committee which is the senior level committee accountable directly to the Governing Board.

The purpose of the Quality Committee is to provide oversight and direction in assessing the appropriateness of care and service delivered and to continuously enhance and improve the quality of care and services provided to patients. The Quality Committee’s responsibilities include, but are not limited to, appointing chairs to committees, reviewing and approving committee charters, reviewing committee reports, making recommendations as needed, and commissioning other teams and subcommittees as needed.

2.1 Infection Prevention and Control Committee

Members
Steven Holbrook MD-Chair
Steven Terry, PA
Helen Ukoh, Diagnostics Manager
Huei Chu, Medical Assistant
Wanda Akers, RN
Nicole McCreary, Practice Coordinator

Objectives: What are the results of the committee’s review and evaluation of the objectives? (Please list each objective and results)

- Oversee the program for surveillance, prevention, and control of infection.
- Define epidemiological important issues and approve the type/scope of surveillance and investigation activities.
- Recommend actions to prevent or control infections based on analysis of surveillance and investigation activities.
- Review Infection Control policies and procedures annually.
- Recommend Institute surveillance, prevention, and/or control studies as deemed necessary.
- Increase and maintain the interest of employees in infection prevention and control issues.

The objectives revisions for the upcoming year include: (Please list each)

- Hand hygiene observations.

Performance: What are the results of performance improvement projects selected for the year? (Please list each project and result)

- The infection control committee completed another urine culture study. This looks at our positive urine cultures and reflects sensitivities against antibiotics.
- Conclusions- The stats really haven’t changed in the last 10 years. We hover around 80% of Bactrim sensitivity to E.coli.
- Overall, Bactrim can still be used for uncomplicated female UTI's, Macrobid has really good coverage with 10% resistance overall and Cipro resistance has increased to 16% overall.
• Use findings from the CDC Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings. (See Addendum A)

**Any revisions in the plan/program performance improvement indicators/measures for the upcoming year?**

• Select new chair and committee members.
Metrics:

- Reportable Disease Reporting: Goal: 100%
- **Results:** Reportable disease reporting continues to improve. The number of reportable diseases reported without provider reminders averaged 97%.
- Surveillance testing reporting completed.

**Other Communicable Diseases**

**Strep 2023**

**Flu A 2023**

**Flu B 2023**
### Surveillance Cultures

<table>
<thead>
<tr>
<th>Month</th>
<th>Cultures Performed</th>
<th>Location</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>3</td>
<td>Gold</td>
<td>Negative</td>
</tr>
<tr>
<td>February</td>
<td>3</td>
<td>Blue</td>
<td>Negative</td>
</tr>
<tr>
<td>March</td>
<td>3</td>
<td>Women’s</td>
<td>Negative</td>
</tr>
<tr>
<td>April</td>
<td>3</td>
<td>Silver</td>
<td>Negative</td>
</tr>
<tr>
<td>May</td>
<td>4</td>
<td>Diagnostics</td>
<td>1 pos (x-ray table) for Acinetobacter calcoaceticus</td>
</tr>
<tr>
<td>June</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>July</td>
<td>4</td>
<td>Breakroom</td>
<td>1 pos (upstairs water cooler) for Pseudomonas putida.</td>
</tr>
<tr>
<td>August</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>September</td>
<td>3</td>
<td>TIA</td>
<td>Negative</td>
</tr>
<tr>
<td>October</td>
<td>3</td>
<td>Pharmacy</td>
<td>1 pos for Acinetobacter calcoaceticus</td>
</tr>
<tr>
<td>November</td>
<td>1</td>
<td>Pharmacy</td>
<td>1 pos for Pseudomonas oryzihabitan</td>
</tr>
<tr>
<td>December</td>
<td>2</td>
<td>Water cooler</td>
<td>Water cooler pos for Citrobacter. freundii</td>
</tr>
</tbody>
</table>

**Gonorrhea 2023**

- GC: Gonorrhea cultures
- GC+: GC positive cultures
- GC Rate: Gonorrhea rate

**COVID-19 2023**

- COVID total

![Gonorrhea 2023 chart](chart1.png)

![COVID-19 2023 chart](chart2.png)
2.2 Pharmacy and Therapeutics Committee

Members
- Nina Thoman PharmD-Chair
- Dr. Benjamin Holton
- Dr. Dale Lawson
- Dr. Angelo Galante
- Ashton Strachan
- Dr. Kanakadurga Meyyazhagan
- John Scuderi

Brief Description of Committee
- The P&T Committee serves as the primary formal communications link between pharmacy and medical staff. The P&T Committee is responsible for all matters related to the use of medications within Health Services, including the development and maintenance of the formulary. The basic objectives of the Committee are to specify drugs of choice and alternatives, based on safety and efficacy according to the FDA; to minimize therapeutic redundancies, and to maximize cost-effectiveness. The Committee serves both an advisory and an educational role within Health Services to assist in formulating policies and developing educational programs on all matters relating to the evaluation, selection, and use of pharmacological products while controlling healthcare costs.

Goals
- Review and update the Wholesale Pharmacy Formulary on an annual basis.
- Review data collected for quality initiatives.
- Educate staff members on quality event data and make recommendations for future initiatives.
- Serve as the Drug Utilization Review Board (DUR).

2023 Results
- FY23 Inventory and Wholesale Formulary Update: Inventory count was reported on June 30, 2022, with a variance of -0.053%. A generally acceptable variance is less than 5%. The wholesale Inventory was updated, presented to the P&T Committee (9/21/2023), and reported to the Director of Health Operations (06/30/2023) to be updated in PolicyTech.
- Drug Utilization Reviews completed during 2022: Hibiclens removed (due to red dye: will keep Betasept; switch from Bacteriostic NaCL 0.9% vials to Preservative Free Na CL 0.9% vials (because interchangeable as drug diluent or IV flush). Reports: Stimulant Availability; Dispensing Errors (none); Adverse Drug Reactions (none); Recalls.
- Committee Membership Updated: Nina Thoman, Benjamin Holton, Dale Lawson, Angelo Galante, Ashton Strachan, Kanakadurga Meyyazhagan, Marjan Kirkland, John Scuderi

The objectives for the upcoming year include: (Please list each objective)
- Evaluate and measure the Annual Inventory on June 28, 2024.
- Evaluate and update the Wholesale Inventory listing.
- Complete DURs as needed.
2.3 Medicine Committee

Members

- Emily Richardson, MD- Chair
- Benjamin Holton, MD
- Ina Collins RN- Nurse Manager
- John Scuderi-Director, Health Operations
- Shan Baker, WNP–Women’s Health Mgr.
- Shannon Croft, MD-Lead Psychiatrist
- Tracy Green MA
- Kristen Donaldson PA

Objectives: What are the results of the committee’s review and evaluation of the objectives?
(Please list each objective and results)

- Peer review: chart reviews completed for all clinical departments.
- Quality study in Primary Care regarding compliance with STI guidelines completed.
- Monitored adherence to standard of care: STI treatment quality initiative – Fall 2023 evaluation update.
- Reviewed clinical policies and procedures: reviewed medication reconciliation and documentation of allergies in each patient’s health record.
- Resumed “normal” clinic operations in Spring 2023 as Covid-19 became a more chronic consideration.

The objectives for the upcoming year include: (Please list each objective)

- Continue annual provider & staff chart reviews verifying documentation.
- Provider specific analysis of compliance with STI treatment guidelines.
- Establish “walk in provider” dedicated each day to acute injuries and illnesses.

Performance: What are the results of performance improvement projects selected for the year? (Please list each project and result)

- Chart reviews completed in Primary Care, Women’s Health, and Psychiatry
- Initial data for STI treatment quality study collected. Excellent compliance with selection of antibiotic treatment. Determined that additional patient education is needed to encourage retesting.
- Evaluated flu clinic participation, found increased student participation when evening options were added.
- Regular building fire drills were held along with measurement of exit times.
- CPR drills conducted in Primary Care and Women’s Health clinics.

Any revisions in the plan/program performance improvement indicators/measures for the upcoming year?

- Ongoing assessment of quality of patient care using chart reviews.
- Develop patient education/reminders for retesting after STI diagnosis.
- Updates to the current chaperone policy for sensitive exams.
- Develop plan to address unused appointments in Primary Care.
3. Strategic Goals

1. QUALITY- Provide high-quality health services to empower and promote the physical, mental, and social health of the GT community.
   
   Objective: Move to a single electronic health record for the SEWB division.

2. ACCESS- Provide students with timely access to a broad range of health care services, reduce barriers to access, and provide faculty/staff access to strategically chosen services.
   
   Objective: Provide COVID-19 vaccinations per the latest CDC guidelines to the GT community.

3. HEALTHCARE DELIVERY- Optimize health care delivery processes to ensure quality, safety, and efficiency and to reduce health disparities.
   
   Objective: Convert radiology from CR to DR technology

4. FINANCIAL- Manage financial resources to optimize the delivery of care while controlling the costs of care.
   
   Objective: Change the pricing model for reference lab testing from a percentage basis to cost plus model.

5. WORKPLACE EXPERIENCE- Enhance the workplace experience for Stamps employees to improve and better utilize their skill sets and promote positive interpersonal interactions.
   
   Objective: Staff participation in selected workplace experience sessions.
4. Risk Management

4.1 Risk Management Program

- Stamps uses a process-driven approach to visualize, assess, and manage significant risks that may adversely impact the attainment of key organizational objectives. The governing board is responsible for (1) ensuring the development and ongoing success of the risk management program, (2) allocating resources to implement risk management programs and activities, (3) ensuring that where practicable, employees receive training in risk management, and (4) the program is integrated through the quality improvement process.

- The table below is a review of our program components, areas of concern, and actions.

<table>
<thead>
<tr>
<th>Program Component</th>
<th>Areas of Concern</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss control prevention, which consists of identifying potentially compensable events, risk assessments, occurrence reporting, and management of SHS policy and procedure manual.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ensuring that risks to health and safety are eliminated or controlled when planning the design of new projects, purchasing new equipment; and before introducing construction.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Dismissed from care or refused care.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Impaired health care professionals.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Involve the Office of Legal Affairs at the Georgia Institute of Technology as needed.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Documentation of timely notification to the professional liability insurance carrier when adverse or reportable events occur.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Review and analysis of all adverse incidents and incident reports.</td>
<td>Complaints related to customer service</td>
<td>Reviewed by the Quality Committee and Governing Board.</td>
</tr>
<tr>
<td>Review of patient complaints</td>
<td>See the 2023 Patient Satisfaction Annual Report</td>
<td>Reviewed by the Governing Board.</td>
</tr>
<tr>
<td>Facilitation of Root Cause Analysis (RCA)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ensure linkage between Risk Management and Quality Improvement.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Periodic review of clinical records and clinical record policies.</td>
<td>Policies on a three-year cycle or as appropriate.</td>
<td>None</td>
</tr>
<tr>
<td>Education in risk management activities, including infection control and safety policies and processes, is provided to all staff within 30 days of commencement of employment, annually thereafter, and when there is an identified need.</td>
<td>Onboarding process</td>
<td>We continue to evaluate our onboarding process and work with hiring managers.</td>
</tr>
</tbody>
</table>
4.2 Incident Management Review

The governing board reviews all incident reports as they are reported. Data from each incident report is recorded and used to evaluate trends and risk. Each incident is assigned a risk assessment score (RAS) according to the grid below. Scores range from 1 (most serious) to 5 (least serious or no action needed).

<table>
<thead>
<tr>
<th>SEVERITY CODE</th>
<th>PROBABILITY CODE</th>
<th>Frequent</th>
<th>Likely</th>
<th>Occasional</th>
<th>Rarely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td><strong>Catastrophic</strong></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>High probability of death to staff or patients</td>
<td>Immediate danger to health and safety of the public, staff or property and resources.</td>
<td>Probably will occur in time if not corrected, or probably will occur one or more times.</td>
<td>Possible to occur in time if not corrected.</td>
<td>Unlikely to occur; may assume exposure, will not occur</td>
</tr>
<tr>
<td>II</td>
<td><strong>Critical</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>High probability of injury, illness, or harm to staff or patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td><strong>Significant</strong></td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Medium probability of injury, illness, or harm to staff or patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td><strong>Minor</strong></td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Unlikely to cause injury illness or harm to staff or patients,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td><strong>Negligible</strong></td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>No possibility of causing injury or harm to staff or patients,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• For 2023, there were a total of 14 reported incidents from the areas shown below.

![Incident Location Chart]

- Each incident is categorized and reported as medical or non-medical. For 2023, all reported incidents were medical in nature.

- Each incident is then broken down by subtypes A and B to further define the nature of the incident.

![Incident SubType A Chart]
A risk assessment score (RAS) is assigned to each incident. Of the ten reported incidents, eight were minor, unlikely to cause injury, illness, or harm if not corrected and two were significant possibly causing injury, illness, or harm if not corrected.

After review, a control is assigned to each incident to address the risk. For 2022, all incidents were assigned an administrative control.

<table>
<thead>
<tr>
<th>Control</th>
<th>Definition</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination</td>
<td>Eliminate the risk</td>
<td>1</td>
</tr>
<tr>
<td>Substitution</td>
<td>Provide an alternative that is capable of performing the same task and is safer to use.</td>
<td>2</td>
</tr>
<tr>
<td>Engineering</td>
<td>Provide or construct a physical barrier or guard.</td>
<td>4</td>
</tr>
<tr>
<td>Administrative</td>
<td>Develop policies, procedures practices, and guidelines, in consultation with employees, to mitigate the risk. Provide training, instruction, and supervision about the risk.</td>
<td>5</td>
</tr>
</tbody>
</table>
Incident Subtype B

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination</td>
<td>1</td>
</tr>
<tr>
<td>Substitution</td>
<td>1</td>
</tr>
<tr>
<td>Engineering</td>
<td>1</td>
</tr>
<tr>
<td>Administrative</td>
<td>5</td>
</tr>
<tr>
<td>None</td>
<td>6</td>
</tr>
</tbody>
</table>
5. Peer Review

Peer Review is an essential part of the Quality Program at Stamps Health Services. It occurs in several formats, including chart review and quality studies. Primary Care Clinic focused on chart review, in which 10 patient encounters per provider per year were randomly selected for review by a colleague. Areas assessed for each encounter included the following:

- The diagnosis is appropriate for the finding in the current history and physical exam.
- Medication reconciliation was performed.
- The patient was asked about allergies and sensitivities.
- The patient was asked about other reactions.
- Treatment is consistent with a clinical impression or working diagnosis.
- The record documents appropriate and timely consultation and follow-up of referrals, tests, and findings.
- Entries for patient visits include chief complaint or purpose of visit.
- Entries for patient visits include clinical findings.
- Entries for patient visits include studies ordered (lab or X-ray).
- Entries for patient visits include care rendered and therapies administered.
- Entries for patient visits include any changes in prescription or nonprescription medications, with name and dosage where available.
- Entries for patient visits include discharge diagnosis.
- Entries for patient visits include disposition, recommendations, and instructions given to patients.

For the selected patient encounters no deficiencies were noted for any providers. The records of these completed reviews are maintained by Dr. Lawson, Director of Primary Care.

Women’s Clinic performed Peer Review for Providers in the form of chart reviews (10 charts each) for:

1. Procedure visits (May 2023-Dec 2023)
   The following parameters were assessed:
   - Signed consent for the procedure is in the chart.
   - The note includes a statement that consent was obtained (even if written consent is clearly documented).
   - A time-out was completed.
   - Documentation of written discharge instruction is present.
   - The overall level of care for each encounter either meets requirements or needs improvement.
   - Any noted deficiency was discussed with the provider.

2. Documentation of Chaperone use (January 2023-May 2023)
   The following parameters were assessed:
   - Use of a chaperone or patient declination of chaperone is documented.
   - If chaperone is used, the name of the chaperone is documented in the note.
   - The overall level of care for each encounter either meets requirements or needs improvement.
   - Any noted deficiency was discussed with the provider.
Outcomes: No critical deficiencies were noted for either round of reviews, however, there is opportunity for improvement with chaperone documentation. Compliance was 100% with documenting the presence or declination of a chaperone. The name of the chaperone was documented only 57% of the time. This review was a baseline and will be repeated after chaperone education and training is implemented.

For Women’s Clinic Medical Assistants peer review was performed in December 2023 and May 2023 (10 charts per individual for each time period) and assessed the following: Reconciliation of medications and allergies, substance allergies, assessing pain level (if applicable), adding depression screening, asking about influenza vaccination status (fall semester), documenting chief complaint. No significant deficiencies were noted.

For Medical Assistants in Primary Care, Peer Review included chart reviews for documentation of the review of allergies and medication lists with clinic visits.

Psychiatry Clinic’s Chart review focused on 6 patient encounters per provider per year, randomly selected for review by a colleague. Areas assessed for each encounter included the following:

- An initial intake with appropriate HPI is present.
- Allergies and medications are documented and updated in the clinical record and on the problem list.
- Diagnostic impression and DSM formulation are complete and consistent with data available during the intake session.
- Mental Status exam is documented during each clinical encounter.
- Treatment plan is appropriate and consistent with a diagnostic assessment.
- Patient instructions and health education are documented in the plan and are appropriate.
- Risk of potential harm to self or others is appropriately assessed and managed if present (especially during intakes)
- Potential substance abuse is appropriately evaluated and managed.
- Chart indicates remote treatment (if appropriate) and documents how the patient’s identity was confirmed.
- Documentation reflects the patient’s insight, motivation, and involvement in decision-making about the treatment plan (documentation that the plan was discussed with the patient)
- Noted deficiencies were discussed with a clinician.
- Overall level of care based on the chart (either meets requirements or needs improvement)

All selected patient encounters were noted as meeting requirements, and any rare deficiency was discussed with the clinicians to aid in charting improvement. The records of these completed reviews are maintained by Cassandra Arnold, Manager of the Psychiatry Office.
6. After Hours Care

- The nurse advice line was implemented in March 2016 as a quality initiative to provide students with an after-hours nurse advice line option. This option is available when calling Stamp's main phone number. For 2023, 214 calls were received. This is a 30 percent decrease in calls over the prior year.

- Since 2016, calls received are reported as medical (89%) or as other (11%). No anomalies for 2023.

- Since 2016, to better understand call patterns, we look at time of call and age of caller. No anomalies were observed for 2023. (8:00-16:30 indicates weekend calls)
• All medical calls are reported to Stamps within 1-2 business days. The Senior Director or designee contacts the caller within 2 business days to see if any further assistance can be provided. No anomalies were observed for 2023.

• Calls to the Nurse Advise Line include a wide variety of chief complaints. No anomalies were observed for 2023.
## 7. Quality Improvement

<table>
<thead>
<tr>
<th>Quality Project Name</th>
<th>Compliance with CDC Guidelines for treatment of chlamydia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Owner</td>
<td>Emily Richardson, MD; Kristy Donaldson, PA-C; Benjamin Holton, MD</td>
</tr>
<tr>
<td>Start Date</td>
<td>July 1, 2023</td>
</tr>
<tr>
<td>End Date</td>
<td>December 31, 2023</td>
</tr>
<tr>
<td>Cycle</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Hints for Getting Started</th>
</tr>
</thead>
</table>
| **Component 1** | Briefly state your known or suspected problem  
Describe why it is important for your organization to address this problem |
| A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization. | Use the space below to state the purpose of the QI study you are conducting, and to describe why it is important for your organization to address this problem.  
In 2021 CDC updated their STI Treatment guidelines, including updating recommendations for management of chlamydia infection. The 2021 guidelines recommend Doxycycline 100mg PO BID for 7 days as first-line treatment of chlamydia infection instead of the previously recommended Azithromycin 1 gram PO as a single dose. This study was initiated to determine if providers at Stamps Health Services are following the updated guidance from CDC regarding treatment of chlamydial infection, given that students present to Stamps frequently for STI screening or treatment of STI symptoms. |
| **Component 2** | Determine and describe the level of performance your organization wants to achieve in the area of study. For example, if you are studying medication error rates, your goal might be to have zero medication errors. If you are studying rates of compliance with a particular policy, your goal might be 100% compliance. Before setting your goal, it is often useful to determine if there are internal or external benchmarks available to help you decide on a goal that is both realistic and constructive. Zero occurrences or 100% compliance may not be realistic for every issue you study.  
Use the space below to identify the performance goal for the QI study you are conducting.  
Compliance with updated CDC guidance for treatment of chlamydial infection of >95% for the following recommendations: 1. Treatment with 7 days of Doxycycline 100mg PO as first choice or Azithromycin 1 gram PO as second choice and, 2. Retest all patients with chlamydial infection at 3 months. |
| Identification of the performance goal against which the organization will compare its current performance in the area of study |  |
### Component 3

**Description of the data that have been or will be collected in order to determine the organization’s current performance in the area of study.**

Determine the following:
1. What data is needed in order to verify: Whether the problem actually exists (if this is uncertain), Frequency and severity of the problem expressed as a number or percentage, Source(s) of the problem
2. How will the data be collected? For example, if you are studying medication error rates, what information do you need in order to determine your current error rate? How will you collect that information?

*Use the space below to describe the data you will collect for the QI study you are conducting, and how you will collect it.*

Case review of all patients with a positive test for chlamydia, with collection of the following data: date of testing, source of sample (urine, throat, rectal, vaginal), treatment date, treatment given, whether repeat testing at 3 months recommended, whether positive test reported to Georgia Dept. of Public Health.

### Component 4

**Evidence of data collection**

Describe the data you actually collected. For example, did you review X number of charts for patient visits that occurred from Month A to Month F? What did you look at in those charts? What information did you extract from them? How did you record the data that you collected? At this point you are not trying to describe your conclusions about the data — just the data itself.

*After you have collected the data for the QI study, use the space below to briefly describe the data collected.*

44 individual cases with a positive test for chlamydia were identified during the time period November 2021 through March 2022. 1 case had positive tests from two different sites, so there was a total of 45 positive tests. Chart review was conducted for each of the cases with a positive chlamydia result. Data collected included the date of testing, source of positive sample, treatment date, treatment given, recommendation for testing at 3 months and whether retesting at 3 months occurred. 18 of 44 cases had a positive urine sample for chlamydia, 26 of 44 cases had a positive vaginal swab for chlamydia, and 1 of 44 cases had a positive rectal sample.
Component 5

Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s)

1. Carefully analyze the data you have collected. (The complexity of the analysis you need to do will depend on various factors, such as the amount and type of data you have collected.)
2. Determine what the data tells you about whether the suspected problem actually exists. Describe how the data was analyzed and your findings (conclusions) regarding whether or not the problem exists.
3. If the problem DOES exist, determine what the data tells you about the frequency, severity, and source(s) of the problem(s).
4. If the problem DOES NOT exist, then choose another known or suspected problem and begin again.

Use the space below to briefly record your findings for the QI study you are conducting.

| 18 of 44 cases had a positive urine sample for chlamydia, 26 of 44 cases had a positive vaginal swab for chlamydia, and 1 of 44 cases had a positive rectal sample. 42 of 44 cases (95%) were treated with the recommended first line treatment of Doxycycline 100 mg BID for 7 days. 2 of 44 cases were treated with the recommended second line treatment of Azithromycin 1 gram PO x 1 dose. Of these two patients, one was treated with azithromycin because the patient did not tolerate doxycycline due to vomiting. In 15 of 44 cases (34%), repeat testing at 3 months was recommended. 8 of those 15 cases returned for the testing. 6 of 44 cases had a recommendation to return in <1 month or between 1 and 2 months for test of cure, which is not recommended by the guidelines. |

Component 6

A comparison of the organization’s current performance in the area of study against the previously identified performance goal

1. Compare the results of your data analysis to the performance goal you identified in Component 2. For example, if the data indicates that you currently have 65% compliance and the goal is 90% compliance, a simple statement to that effect is sufficient.

<table>
<thead>
<tr>
<th>Use the space below to briefly record your findings for the QI study you are conducting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our data show that we met our goal of 95% compliance with the guidelines for the choice of antibiotic. Our data show that we did not meet our goal of 95% compliance with the recommendation for retesting at 3 months. Our data show that our providers are recommending repeat testing for test of cure at a time frame less than 3 months in a minority of cases, which is not recommended by the guidelines.</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| Component 5 | Component 6 | }
| Component 7 | Implementation of corrective action(s) to resolve identified problem(s) | 1. Based on what you have learned about the frequency, severity, and source(s) of the problem(s), determine what corrective action(s) you will take to improve your performance in the area of study.  
2. Implement the selected corrective action(s) and determine the appropriate length of time until re-measurement is to occur. |

*Use the space below to describe what corrective action(s) were taken for the QI study you are conducting, including how the corrective actions were implemented*

An educational session was held with providers in which the CDC recommendations were reviewed, the results of our initial data study were presented, and recommended actions going forward were presented. Recommended actions going forward include the following:

1. Treatment with Doxycycline 100 mg BID for 7 days is the current recommended first line treatment.
2. Test of cure approximately one month is not indicated routinely.
3. Repeat testing at 3 months of all patients diagnosed with chlamydia infection is recommended, and scheduling of that appointment for repeat testing at the time of initial treatment is considered best practice.

A second round of data collection is planned for Fall Semester 2023.

| Component 8 | Re-measurement (a second round of data collection and analysis) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement | 1. At the designated re-measurement time, repeat the steps shown for Components 4 and 5  
2. Compare the results of your second round of data collection and analysis to the performance goal you identified as Component 2, and determine whether the corrective actions have achieved the desired performance goal |

*Use the space below to describe the second round of data collected and how you collected it. Also state your comparison of the new current performance vs. goal for the QI study you are conducting*
Chart review of all positive tests for chlamydia from the time frame July-December 2023 was performed. During this time frame 43 cases of chlamydia were identified in 42 unique individuals. Some of the cases were positive at more than one anatomical site. The ratio of male patients to female patients was 28 to 15. 15 cases were positive from a vaginal swab. 24 cases were positive in a urine sample. 6 cases were positive from an anal/rectal sample. 3 cases were positive from a pharyngeal swab. 41 of 43 cases were treated with the recommended first line treatment of doxycycline. Two of these cases were given a prolonged course of doxycycline because of a simultaneous concern for LGV infection. One case was treated with the second line treatment of Azithromycin due to a medically valid reason. One case was treated with Azithromycin by a provider outside of SHS.

Our results show that we are meeting the goal for selection of the proper antibiotic for treatment.

Our results show that we had a dramatic increase in the percentage of times that we are recommending retesting at 3 months. We went from 34% compliance with this parameter to 81% compliance with this parameter. Although we had dramatic improvement, we did not meet our goal of 95% compliance with this parameter.

Our data also show that despite our recommending retesting at 3 months, most students do not return to get retested. Compliance with retesting was only 35%. Although this particular parameter was not one of the stated goals of this study, it does indicate an area in which we can work to improve care.

If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved

1. Determine whether this step is applicable to the study you are conducting. If you have met and are sustaining your performance goal, this step does not apply
2. If this step does apply, repeat the steps shown for Components 7 and 8 until your performance goal has been achieved in a sustainable manner

Our data indicate that we continue to have the opportunity for improving performance. We failed to meet our goal of recommending retesting for all cases of chlamydia at 3 months.

Steps taken to improve performance will include the following:
1. Review of CDC recommendations at a Medical Staff meeting
2. Standardized discharge instructions for chlamydia infection that include the instructions for retesting for reinfection at 3 months for all cases of chlamydia.
3. Brainstorming with Primary Care and Women’s Health providers about how we can improve compliance with retesting recommendations.
4. Individual provider feedback in cases in which guidelines were not met.
<table>
<thead>
<tr>
<th>Component 10</th>
<th>Communication of the findings of the quality improvement activities: to the governing body, throughout the organization, as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Report your QI study and its results to your governing body. Ensure that the governing body’s review of the report is appropriately documented</td>
</tr>
<tr>
<td></td>
<td>2. Determine who else in the organization needs to know about the results of the study. Communicate the findings to those people, and document that this has occurred</td>
</tr>
<tr>
<td></td>
<td>3. Determine whether other educational activities of the organization should reflect the findings of the study. If so, take appropriate steps to have this occur</td>
</tr>
</tbody>
</table>

**Use the space below to describe how the results of the study will be reviewed by the governing body, and how this review will be documented. Also describe other groups that will be notified of the study’s results, and how this notification will take place, and educational activities that will take place as a result of this study**

Results of cycle 2 were presented to and discussed by Governing Board
Results of cycle 2 of the study have been communicated to medical staff via email that included a deidentified listing of cases and a summary of the results. Cycle 3 will be conducted.
<table>
<thead>
<tr>
<th>Quality Project Name</th>
<th>New Guideline Treatment of Gonorrhea infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Owner</td>
<td>Emily Richardson, MD; Kristy Donaldson, PA-C; Benjamin Holton, MD</td>
</tr>
<tr>
<td>Start Date</td>
<td>July 1, 2023</td>
</tr>
<tr>
<td>End Date</td>
<td>December 31, 2023</td>
</tr>
<tr>
<td>Cycle</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Hints for Getting Started</th>
</tr>
</thead>
<tbody>
<tr>
<td>A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.</td>
<td>Briefly state your known or suspected problem. Describe why it is important for your organization to address this problem.</td>
</tr>
</tbody>
</table>

**Component 1**

Use the space below to state the purpose of the QI study you are conducting, and to describe why it is important for your organization to address this problem.

In December 2020, the CDC released new guidelines for the treatment of Gonococcal infection. In 2010 the CDC recommended treating gonococcal infection with a combination of 2 medications - 250 mg of ceftriaxone given intramuscularly and a single 1-gram dose of Azithromycin orally. The new guidelines recommend treatment of gonococcal infection with a single 500mg intramuscular dose of ceftriaxone. Also, treatment for a coinfection with Chlamydia with 100mg Doxycycline twice a day orally for 7 days should be given if Chlamydia infection has not been excluded. The updated guidelines also recommend retesting in 7-14 days of individuals with pharyngeal infection and retesting of all persons treated for gonorrhea at 3 months. This study was initiated to determine if providers at Stamps Health Services are following the updated guidance from CDC regarding treatment of gonococcal infection, given that students present to Stamps frequently for STI screening or treatment of STI symptoms.

**Component 2**

Identification of the performance goal against which the organization will compare its current performance in the area of study.

Determine and describe the level of performance your organization wants to achieve in the area of study. For example, if you are studying medication error rates, your goal might be to have zero medication errors. If you are studying rates of compliance with a particular policy, your goal might be 100% compliance. Before setting your goal, it is often useful to determine if there are internal or external benchmarks available to help you decide on a goal that is both realistic and constructive. Zero occurrences or 100% compliance may not be realistic for every issue you study.

Use the space below to identify the performance goal for the QI study you are conducting.

Compliance with updated CDC guidance for treatment of gonococcal infection of >95% for all 3 recommendations: 1. Treatment with 500mg ceftriaxone IM, 2. Retest patients with pharyngeal gonorrhea in 7-14 days, and 3. Retest all patients with GC infection at 3 months.
### Component 3

**Description of the data that have been or will be collected in order to determine the organization’s current performance in the area of study.**

Determine the following:
1. What data is needed in order to verify:
   - Whether the problem actually exists (if this is uncertain),
   - Frequency and severity of the problem expressed as a number or percentage,
   - Source(s) of the problem
2. How will the data be collected? For example, if you are studying medication error rates, what information do you need in order to determine your current error rate? How will you collect that information?

*Use the space below to describe the data you will collect for the QI study you are conducting, and how you will collect it.*

Case review of all patients with a positive test for gonorrhea, with collection of the following data: date of testing, source of sample (urine, throat, rectal, vaginal), treatment date, treatment given, whether weight of patient less than 150kg, whether patient returned for test of cure (if positive from pharyngeal sample), date of repeat testing, repeat test result, whether positive test reported to Georgia Dept. of Public Health.

### Evidence of data collection

**Describe the data you actually collected.** For example, did you review X number of charts for patient visits that occurred from Month A to Month F? What did you look at in those charts? What information did you extract from them? How did you record the data that you collected? At this point you are not trying to describe your conclusions about the data — just the data itself.

*After you have collected the data for the QI study, use the space below to briefly describe the data collected.*

Data were collected for the months starting August 2021 through March 2022. From this time period there were 14 individual cases of a positive test for gonorrhea. Some of the cases had a positive test from more than one location (urine, rectal, pharyngeal, vaginal). 5 cases were positive from a pharyngeal sample, 8 were positive from a urine specimen, 2 cases positive from a rectal sample, 1 case positive from a vaginal sample. 13 of 14 cases were treated with 500mg Ceftriaxone IM. One case was treated with 240mg Gentamycin IM and 2 Grams Azithromycin PO due to allergy to Ceftriaxone.

A recommendation for retesting for test of cure was made to 5 of 5 cases with a positive pharyngeal sample, although the time frame for retesting was beyond the 14 days recommended by CDC for several of the cases. Retesting at 3 months was correctly recommended in 4 of 14 total cases. In 8 cases no retesting at 3 months was recommended. In 2 cases retesting was recommended but not in the correct time frame. 12 of 14 cases had documentation of notification of the health department.
<table>
<thead>
<tr>
<th>Component 5</th>
<th>Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s)</th>
</tr>
</thead>
</table>
|             | 1. Carefully analyze the data you have collected. (The complexity of the analysis you need to do will depend on various factors, such as the amount and type of data you have collected.)  
2. Determine what the data tells you about whether the suspected problem actually exists. Describe how the data was analyzed and your findings (conclusions) regarding whether or not the problem exists.  
3. If the problem DOES exist, determine what the data tells you about the frequency, severity, and source(s) of the problem(s).  
4. If the problem DOES NOT exist, then choose another known or suspected problem and begin again. |

*Use the space below to briefly record your findings for the QI study you are conducting.*

The data show that in 8 months of data collection, 14 cases of gonorrhea were detected, for a rate of 1.75 cases/month. The data collected show that providers at Stamps Health Services are following the updated guidelines from the CDC with regard to the antibiotic chosen for treatment and the dose given. We also are doing well with regard to retesting of patients with pharyngeal gonorrhea. However, providers at Stamps Health Services did not meet the goal for compliance with recommending retesting at 3 months for all individuals diagnosed with gonorrhea infection.

<table>
<thead>
<tr>
<th>Component 6</th>
<th>A comparison of the organization’s current performance in the area of study against the previously identified performance goal</th>
</tr>
</thead>
</table>
|             | 1. Compare the results of your data analysis to the performance goal you identified in Component  
2. For example, if the data indicates that you currently have 65% compliance and the goal is 90% compliance, a simple statement to that effect is sufficient. |

*Use the space below to briefly record your findings for the QI study you are conducting.*

93% of cases received the recommended first line treatment of 500mg ceftriaxone IM, which is below the stated 95% goal. However, the one case that did not receive the recommended first line treatment had allergy to the indicated treatment. Recommended second line treatment was given, therefore actual compliance was 100% with the updated guidelines for choice of antibiotic and dose given.

Compliance with recommendations for retesting individuals with pharyngeal gonorrhea for test of cure was 100%.

Compliance with recommendation for retesting at 3 months was 29%, which is below our stated goal of 95% and indicates an area upon which we can improve.
<table>
<thead>
<tr>
<th>Component 7</th>
<th>Implementation of corrective action(s) to resolve identified problem(s)</th>
</tr>
</thead>
</table>
|             | 1. Based on what you have learned about the frequency, severity, and source(s) of the problem(s), determine what corrective action(s) you will take to improve your performance in the area of study.  
2. Implement the selected corrective action(s) and determine the appropriate length of time until re-measurement is to occur. |

**Use the space below to describe what corrective action(s) were taken for the QI study you are conducting, including how the corrective actions were implemented**

An educational session was held with providers in which the CDC recommendations were reviewed, the results of our initial data study were presented, and recommended actions going forward were presented. Recommended actions going forward include the following:

1. Continue to treat gonorrhea infection with 500 mg ceftriaxone IM x one dose  
2. Perform a test of cure at 7-14 days for individuals with pharyngeal infection with gonorrhea. This test should be scheduled at the time of the initial visit.  
3. Recommend repeat testing of all individuals with gonococcal infection at 3 months. This return appointment for testing should be scheduled at the time of the initial visit for treatment.

A second round of data collection is planned for Fall Semester 2023.

<table>
<thead>
<tr>
<th>Component 8</th>
<th>Re-measurement (a second round of data collection and analysis) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement</th>
</tr>
</thead>
</table>
|             | 1. At the designated re-measurement time, repeat the steps shown for Components 4 and 5  
2. Compare the results of your second round of data collection and analysis to the performance goal you identified as Component 2, and determine whether the corrective actions have achieved the desired performance goal |

**Use the space below to describe the second round of data collected and how you collected it. Also state your comparison of the new current performance vs. goal for the QI study you are conducting**
Chart review of all positive tests for gonorrhea from the time frame July-December 2023 was performed. During this time frame 13 cases of gonorrhea occurred in 10 unique individuals. Some of the cases were positive in more than one body site. 1 case was positive from a vaginal sample, 3 cases were positive from a urine sample, 2 cases were positive from an anal/rectal sample, and 10 cases were positive from a pharyngeal sample. 11 of 13 cases were treated with 500mg Ceftriaxone IM as a single dose. 2 of 13 cases were treated with 1 gm Ceftriaxone IM as a single dose. No cases were treated with 250mg Ceftriaxone IM, which was the old recommendation for treatment for gonorrhea. In 8 of 10 cases of pharyngeal gonorrhea, a recommendation for test-of-cure was documented in the instructions given to the patient. In 70% of the cases of pharyngeal gonorrhea, a test-of-cure was performed.

In 5 of 13 cases (38%) retesting in 3 months was recommended to the patient by the provider. In 6 of 13 cases (46%) retesting at 3 months was performed.

Comparison of our results with our goals demonstrates the following:

1. We have 100% compliance with treatment of gonorrhea with at least 500mg Ceftriaxone. In no instance was treatment based on the old CDC guidelines of 250mg Ceftriaxone.
2. We recommended test of cure at 7-14 days 80% of the time. This does not meet our goal of 95% and thus offers an opportunity for continued improvement. It was unexpected that we had so many cases of pharyngeal gonorrhea.
3. Recommendation of retesting at 3 months was only 38%. This is better than our initial data but does not meet our goal. This also continues to be an opportunity.

If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved

1. Determine whether this step is applicable to the study you are conducting. If you have met and are sustaining your performance goal, this step does not apply
2. If this step does apply, repeat the steps shown for Components 7 and 8 until your performance goal has been achieved in a sustainable manner

Use the space below to indicate whether this step applies to the QI study you are conducting. If it applies, describe what additional corrective action(s) were taken for the QI study you are conducting, including how the corrective actions were implemented. Also describe the additional round of data collected and how you collected it, and state your comparison of the new current performance vs. goal for the QI study you are conducting.
Our data indicate that we continue to have the opportunity to improve performance. We failed to meet our goal of recommending retesting for test of cure in 7-14 days for cases of pharyngeal gonorrhea and recommending retesting for all cases of gonorrhea at 3 months.

Steps taken to improve performance will include the following:

1. Review of CDC recommendations at a Medical Staff meeting
2. Standardized discharge instructions for gonorrhea infection that include the instructions for retesting for test of cure in 7-14 days for pharyngeal gonorrhea and retesting for reinfection at 3 months for all cases of gonorrhea.
3. Brainstorming with Primary Care and Women’s Health providers about how we can improve compliance with retesting recommendations.
4. Individual provider feedback in cases in which guidelines were not met.

Component 10

Communication of the findings of the quality improvement activities:

1. Report your QI study and its results to your governing body. Ensure that the governing body’s review of the report is appropriately documented
2. Determine who else in the organization needs to know about the results of the study. Communicate the findings to those people, and document that this has occurred
3. Determine whether other educational activities of the organization should reflect the findings of the study. If so, take appropriate steps to have this occur

Results of cycle 2 were presented to and discussed by Governing Board
Results of cycle 2 of the study have been communicated to medical staff via email that included a deidentified listing of cases and a summary of the results. The results were also presented in the All-staff meeting held in April 2024. Cycle 3 will be conducted.
8. Quality Assurance

8.1 Medical Emergency Drills

A scenario-based CPR drill was performed in August 2023.

3 scenarios were completed for the drill:
1. Patient down in Blue Clinic waiting room.
2. Patient down in waiting room for Women’s Clinic
3. Patient developed anaphylaxis after an allergy injection in TIA clinic.

The CPR drill in Blue Clinic went well; staff responded promptly, an overhead page was called; EMS was notified promptly, CPR was initiated, and AED was obtained in a timely fashion. The technique of the administration of CPR by the nursing staff was good. The time to first shock with AED was 3 minutes.

CPR drill in Women’s health went less smoothly. CPR was not initiated when it was first determined that a pulse was not present. Staff waited until the AED arrived to initiate CPR. The overhead page of Code Blue was not heard upstairs in the Women’s Clinic but was heard downstairs and staff from downstairs responded to the overhead page promptly.

During the anaphylaxis drill in TIA, expired vials of epinephrine were found in the cabinets in the rooms used by the nurses to administer immunizations and allergy shots. Each room also had a current epi-pen in the cabinet. The use of an epi-pen was reviewed with staff using a trainer pen. It was clarified with staff that if a student were to develop anaphylaxis in the clinic, epinephrine from one of our epi-pens should be given to the patient, not the student’s own epi-pen. The contents of the Red Emergency Box were reviewed with staff.
8.2 Laboratory Monthly Turnaround Time (UA-TAT) Report
- **Goal:** ≥ 98% of ordered UAs reported in less than 30 minutes.
- **Result:** Variation in achieving the goal, no action required
- **Variance Analysis:** Staffing issues and instrument errors resulted in variances.

![Laboratory Turn Around Time 2023](image)

8.3 Test Not Performed (TNP): due to hemolysis, wrong test, wrong sample, mislabeled, difficult stick, etc.
- **Goal:** ≤ 1% of TNP for any reason
- **Result:** Within the goal
- **Variance Analysis:** None

![Test Not Performed 2023](image)
8.4 Laboratory Monthly Turnaround Time (CMP-TAT) Report
- **Goal**: ≥ 95% of reference laboratory CMP reported within the established TAT of 48 hours.
- **Result**: Within the goal
- **Variance Analysis**: Hemolysis; specimen not received, wrong specimen sent; mislabeled specimen, wrong order, difficult stick

![Laboratory Turn Around Time 2023](image)

8.5 Unacceptable Proficiency Testing Error
- **Goal**: ≤ 5 per year
- **Result**: Within goal (no graph)
- **Variance Analysis**: NA
8.6 Hematology -Hematocrit (Hem-5D) (%) SYMEX XN-530

Results: SHS Laboratory Proficiency Testing was within the acceptable range across all tests.
### SAMPLE XE-08

<table>
<thead>
<tr>
<th>Peer Group</th>
<th># Labs</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Uncertainty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sysmex XN-530</td>
<td>136</td>
<td>15.7</td>
<td>0.5</td>
<td>14 - 17</td>
<td>0.05</td>
</tr>
</tbody>
</table>

![Graph showing labs distribution with acceptable range and result for Sample XE-08](image1.png)

- Acceptable Range: 14 - 17
- Your Result: 16

### SAMPLE XE-09

<table>
<thead>
<tr>
<th>Peer Group</th>
<th># Labs</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sysmex XN-530</td>
<td>136</td>
<td>46.2</td>
<td>0.8</td>
<td>43 - 49</td>
<td>0.09</td>
</tr>
</tbody>
</table>

![Graph showing labs distribution with acceptable range and result for Sample XE-09](image2.png)

- Acceptable Range: 43 - 49
- Your Result: 46
<table>
<thead>
<tr>
<th>Peer Group</th>
<th># Labs</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Uncertainty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sysmex XN-530</td>
<td>136</td>
<td>36.2</td>
<td>0.7</td>
<td>34 - 39</td>
<td>0.08</td>
</tr>
</tbody>
</table>

![Bar chart showing the distribution of results with the acceptable range and result highlighted.](chart.png)
8.7 Radiology Overread Turnaround Times
- **Goal:** 98% of x-rays are reviewed by the radiologist within 24 hours.
- **Result:** Within goal
- **Variance Analysis:** Exams were read after 24hrs due to system error.

8.8 Radiology Overread Addendums
- **Goal:** <2% of the total overreads
- **Results:** 11 addendums reported
- **Variance Analysis:** Discrepancies between overread provider and SHS provider.
8.9 Review of Allergies and Current Medications by Medical Assistant
- **Goal:** 100% of allergies and current medications are documented by the Medical Assistant in Women's Health and Primary Care.
- **Results:** At goal
- **Variance Analysis:** Ensure compliance and continue to monitor.

![Allergies and Medications Review 2023](image)

8.10 Review of Vital Signs - IV Fluid
- **Administration by RN/LPN**
- **Goal:** 100% of IV Fluid Administration is documented by RN in Women's Health and Primary Care
- **Results:** At goal
- **Variance Analysis:** Continue to monitor.

![Vital Signs Surveillance 2023](image)
9. COVID-19

9.1 Clinical Care

- For 2023, Stamps continued to provide care and testing for symptomatic patients for COVID-19 following CDC recommendations and the Georgia Department of Health.

- Stamps Health Services continued its effort to vaccinate the Georgia Tech community based on vaccine eligibility guidelines set by the Georgia Department of Public Health. The vaccination clinic run by Stamps administered 1,598 COVID vaccines.
10. Benchmarking

10.1 Student Health Fees

- Each year Stamps benchmarks against student health fees within our Institute selected peer group. Recognizing service, funding, and population differences amongst the various Institutions, the mandatory health fee at Georgia Tech is well below our peer group. Although this seems favorable, the fee is not sufficient to fully fund fixed and variable expenses.

![Mandatory Health Fee](image)

10.2 Regents'Advisory Committee-Health

- The Regents'Advisory Committee-Health Stamps was established by the University System of Georgia (USG) as a mechanism for USG health centers to share data, ask questions, and benchmark against each other. The following topics were discussed.
  - COVID Protocols
  - Triage & IV
  - Lab(s) to check for immunity for hep B—surface ab quant titer, a hep B panel
  - Use of Accutane
  - Use of negative pressure room

10.3 Student Health Insurance

- Each year, Stamps works with the University System of Georgia Student Health Insurance Advisory Committee. This committee reviews and discusses the plan benefits and helps to establish premium rates for the upcoming policy year. The plan is benchmarked against the external market to assess quality and cost-effectiveness. An example of annual premium benchmarking is shown below.
10.4 CDC

- CDC Guidelines for treatment of chlamydia
- CDC Guidelines for treatment of gonorrhea

Two of the quality studies done in 2023, one which looked at compliance with CDC guidelines for treatment of gonorrhea and one which looked at compliance with CDC guidelines for treatment of chlamydia utilized published guidelines from the CDC regarding treatment of STI's. The guidelines can be found at https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf. These guidelines were used as the benchmark against which we compared our care. We chose 95% compliance with these guidelines as our goal.
11. Safety Program

- In 2022, the quality committee discussed the need for a safety committee. Anecdotally, members of the safety committee felt there was not enough data to review or items to act upon. After review, the Quality Committee decided that a Safety Committee would be convened on an as-needed basis.
- The Occupational and Safety Health Administration (OSHA) Safety and Health Program Self-Evaluation tool was used to assess our safety program. (see Addendum B)
Section 1: Facility Demographics and Infection Prevention and Control (IPC) Infrastructure

Outpatient/Ambulatory Care

General Facility Demographics and IPC Infrastructure

Date of Assessment: 03/16/2024
Facility Name: Stamps Health Services

State/Territory: Georgia County: USA
Zip Code: 30332 State/Territory-assigned Unique ID (if applicable): 

Facility type (Complete the demographic form that corresponds to the type of facility):
- Acute Care Hospital / Critical Access Hospital
- Long-term Care
- Outpatient/Ambulatory Care
- Other (specify):

Facility Respondent Name(s) and Job Title(s):
John Scudder Director, Health Operations

Rationale for assessment:
- [x] Requested by facility
- [ ] Requested by accrediting agency/licensing organization
- [ ] Requested by state or local health department
- [x] HAI prevention focused:
  - CAUTI
  - CLABSI
  - SSI
  - CDI
  - Other (specify):
- [ ] Prevention collaborative (specify partner):
- [ ] Outbreak (specify):
- [ ] Other (specify):

Obtain a list of products used for cleaning and disinfection of environmental surfaces and non-critical patient/resident care equipment in the facility

EPA registration number(s) for products used in patient/resident rooms:

EPA registration number(s) for products used in common areas:

EPA registration number(s) for products used on non-critical patient/resident care equipment (e.g., blood glucose meters):
1. Does the facility have access to onsite IPC expertise?
   - Yes
   - No
   - Unknown
   - Not Assessed

   **If YES, specify:**
   Healthcare epidemiologist (number of full-time equivalents **dedicated** to IPC activities):

   Infection preventionist (number of full-time equivalents **dedicated** to IPC activities):

   Other (specify, including number of full-time equivalents **dedicated** to IPC activities):
   - CIC physician (0.10 FTE)

   **Note:** This is intended to identify individuals who work onsite at the facility or provide IPC oversight at satellite locations (e.g., hospital IP provides IP oversight to affiliated outpatient clinics) and what proportion of their time is dedicated to IPC activities. Example: The facility has two IPs. IP #1 spends 25% of their time on IPC activities and the rest of their time on direct patient care and IP #2 spends 75% of their time on IPC activities and the rest of the time on direct patient care. This would be recorded as IP #1 0.25 FTE dedicated to IPC activities. This breakdown could be further described in the notes.

2. Does the facility have access to **offsite** IPC expertise?
   - Yes
   - No
   - Unknown
   - Not Assessed

   **If YES, specify:**
   Healthcare epidemiologist (number of full-time equivalents dedicated to IPC activities **at the facility**):

   Infection preventionist (number of full-time equivalents dedicated to IPC activities **at the facility**):

   Other (specify, including number of full-time equivalents dedicated to IPC activities **at the facility**):

   **Note:** This is intended to identify individuals who do not work primarily onsite at the facility but might provide IPC support on a contractual or part-time basis. If a full-time equivalent cannot be determined, the level of support should be described in the notes.

3. Does the person(s) charged with directing the IPC program at the facility hold a nationally recognized credential in infection control (e.g., a-IPC, CIC, LTC-CIP, BCIDP)?
   - Yes
   - No
   - Unknown
   - Not Assessed

   Lack of certification does not mean that an individual is not qualified to direct the IPC program. **Describe their qualification(s)** (e.g., other certifications, specialized training):
4. What additional duties are performed by personnel within the IPC program? (select all that apply)
- Occupational Health
- Education of personnel
- Safety officer
- Administrative (e.g., Director of Nursing)
- None
- Not assessed
- Other (specify):

5. What does the director of the IPC program believe are the current strengths and weaknesses in the IPC program?

6. Does the IPC program have access to electronic medical records of patients/residents?
- Yes
- No
- Unknown
- Not Assessed

7. Does the IPC program utilize data mining/reporting software?
- Yes
- No
- Unknown
- Not Assessed

8. Does the IPC program perform an annual facility infection risk assessment that evaluates and prioritizes potential risks for infections, contamination, and exposures and the program’s preparedness to eliminate or mitigate such risks?
- Yes
- No
- Unknown
- Not Assessed

9. Are written infection control policies and procedures available, current, and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations, or standards?
- Yes
- No
- Unknown
- Not Assessed

9a. How frequently are policies and procedures reviewed and updated? (select all that apply)
- Annually
- Every three years
- As needed when new guidelines or evidence is published (e.g., via subscription with a publisher)
- Unknown
- Not assessed
- Other (specify):

Note: Facilities should have a schedule to regularly review policies and procedures to ensure they are current. At a minimum, updates should be made when new evidence-based guidance is published and if the scope of care delivered changes (e.g., new equipment is introduced or new procedures are performed).
10. Does the IPC program provide infection prevention education to patients, family members, and other caregivers?
   - Yes
   - No
   - Unknown
   - Not Assessed

   **If YES:**

10a. What topics are covered? *(specify)*

10b. How is this education provided (e.g., information included in the admission or discharge packet, videos, signage, in-person training)? *(specify)*

11. Does the facility have an interdisciplinary infection control committee to address issues identified by the IPC program?
   - Yes
   - No
   - Unknown
   - Not Assessed

   **Note:** Issues identified by the IPC program often impact multiple areas of the facility. An interdisciplinary committee, including facility leadership (e.g., ownership, chief medical officer, director of nursing), is needed to allocate resources and successfully implement long-term solutions.

   **If YES, specify:**

11a. Who is part of the infection control committee? *(select all that apply)*
   - Chief Medical Officer
   - Director of Nursing
   - Environmental Services
   - Unknown
   - Not Assessed
   - Other *(specify)*: medical assistants, RNs.

11b. How often does the infection control committee meet?
   - Monthly
   - Quarterly
   - Unknown
   - Not Assessed
   - Other *(specify)*: at least semi-annually

   **Notes**
Facility Demographics: Outpatient/Ambulatory Care

1. Is the facility licensed by the state?
   ☐ Yes
   ☐ No

2. Is the facility certified by the Centers for Medicare & Medicaid Services (CMS)?
   ☐ Yes, as an Ambulatory Surgical Center
   ☐ Yes, as a Federally Qualified Health Center
   ☐ Yes, as another provider type (specify): __________________________
   ☐ No

3. Is the facility accredited?
   ☐ Yes
   ☐ No

If YES, specify:

3a. The accreditation organization:
   ☑ Accreditation Association for Ambulatory Health Care (AAAHC)
   ☑ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
   ☑ American Osteopathic Association (AOA)
   ☑ The Joint Commission (TJC)
   ☑ Other (specify): __________________________

3b. Date of last survey (month/year): __________

4. Is the facility part of a hospital system?
   ☐ Yes
   ☐ No

5. Which procedures are performed by the facility? (select all that apply)
   ☐ Chemotherapy
   ☐ Dermatology
   ☐ Endoscopy
   ☐ Imaging
   ☐ Immunizations
   ☐ OB/Gyn
   ☐ Ophthalmologic
   ☐ Orthopedic
   ☐ Pain/mediation
   ☐ Plastic/reconstructive
   ☐ Podiatry
   ☐ Surgery (general)
   ☐ Urology
   ☐ Other (specify): __________

6. How many physicians work at the facility? __________

7. What is the average number of patients seen per day? __________

Notes
Module 1: Training, Auditing and Feedback Facilitator Guide

Training, Auditing and Feedback: This form is intended to aid an ICAR facilitator in generally assessing areas where training, auditing, and feedback are performed by the facility. Additional questions allow for a more detailed assessment of specific areas (e.g., hand hygiene, environmental cleaning).

At a minimum, a more detailed assessment should be conducted if interviews or observations identify gaps in a particular area. For example, if gaps in device reprocessing are identified during the ICAR assessment, a more detailed assessment of device reprocessing training, auditing and feedback, using the additional questions, might be warranted.

Training

1. Does the facility provide job-specific education and training in the following areas? (Select all that apply)
   - [x] Hand hygiene
   - [x] Use of personal protective equipment
   - [x] Cleaning and disinfection of environmental surfaces
   - [x] Reprocessing reusable medical equipment
   - Safe injection practices
   - Point of care blood testing
   - Unknown
   - Not assessed
   - Other (specify): Sharps training

Additional questions if doing a more detailed assessment:

1a. Which HCP are targeted for training?

   General training - non-clinical, specific training - clinical staff

1b. How often is training conducted? (select all that apply)
   - [x] Upon hire
   - [x] Annually
   - Whenever new processes or products are implemented
   - In response to outbreaks
   - Unknown
   - Not assessed
   - Other (specify): 

1c. What content is included in the training? (See Appendix for examples of content that should be included depending on the area)

   Blood borne pathogens, sharps training, hand hygiene, equipment cleaning procedures

1d. Following training, is HCP knowledge assessed (i.e., using a quiz or test)?
   - [x] Yes
   - [ ] No
   - [ ] Unknown
   - [ ] Not Assessed

1e. Following training, is HCP technique assessed (i.e., skill is demonstrated)?
   - [x] Yes
   - [ ] No
   - [ ] Unknown
   - [ ] Not Assessed

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
1f. Does the facility maintain records of training?

☐ Yes
☐ No
☐ Unknown
☐ Not Assessed

Facilities should “develop processes to ensure that all healthcare personnel understand and are competent to adhere to infection prevention requirements as they perform their roles and responsibilities.”

Training should include all HCP who are assigned responsibility for a particular task. For example, all HCP should receive training on hand hygiene. However, training on point-of-care blood testing would only be provided to those responsible for performing such testing or for cleaning and disinfecting point-of-care blood testing equipment.

“Require training before individuals are allowed to perform their duties and at least annually as a refresher. Provide additional training in response to recognized lapses in adherence and to address newly recognized infection transmission threats (e.g., introduction of new equipment or procedures).”

Training should be job-specific and include information about why, how and when specific practices should be performed.

**Competency-based assessment** is defined as, “The verification of IP competency through the use of knowledge-based testing and direct observation. If direct observation is not included as part of a competency assessment, an alternative method to ensure that healthcare personnel possess essential knowledge, skills, and abilities should be used.”

**Sources:**

https://www.cdc.gov/hicpac/recommendations/core-practices.html

Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings

Module 2: Hand Hygiene Facilitator Guide

Hand Hygiene: This form is intended to aid an ICAR facilitator in the review of a healthcare facility’s hand hygiene practices and policies (Part A) and guide hand hygiene-based facility (Part B) and healthcare personnel (Part C) observations.
Additional information and resources for hand hygiene in healthcare settings are available at: Hand Hygiene in Healthcare Settings | CDC

Part A. Hand Hygiene Interview Questions

1. In most clinical situations, how do healthcare personnel (HCP) clean their hands?
   - Alcohol-based Hand Sanitizer (ABHS)
   - Handwashing with soap and water
   - Unknown
   - Not assessed
   - Other (specify):

   "Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink."
   
   Source: Core Practices | HCPAC | CDC

2. When are HCP expected to clean their hands? (select all that apply)
   - At room entry and exit
   - Immediately before touching a patient
   - Before performing an aseptic task
   - Before moving from work on a soiled body site to a clean site on the same patient
   - After touching patient or the patient’s immediate surroundings
   - After contact with blood, body fluids, or contaminated surfaces
   - Immediately after glove removal
   - Unknown
   - Not assessed
   - Other (specify):

   The CDC Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings lists indications for hand hygiene that are generally consistent with the WHO 5 moments for hand hygiene.
   "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications:
   a. Immediately before touching a patient.
   b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices.
   c. Before moving from work on a soiled body site to a clean body site on the same patient.
   d. After touching a patient or the patient’s immediate environment.
   e. After contact with blood, body fluids or contaminated surfaces.
   f. Immediately after glove removal."
   
   Source: Core Practices | HCPAC | CDC

3. Are there certain times when HCP must wash their hands with soap and water? (select all that apply)
   - When hands are visibly soiled
   - Before eating
   - After using the restroom
   - Unknown
   - Not assessed
   - Other (specify):

   Handwashing with soap and water is specifically recommended when hands are visibly soiled and, “before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water.”

   Source: CDC 2002 Guideline for Hand Hygiene in Healthcare Settings: Hand Hygiene | Guidelines Library | Infection Control | CDC
4. Are sinks used only for hand washing (i.e., not used to dispose of waste)?
   - Yes
   - No
   - Unknown
   - Not assessed

   Disposal of nutritive waste (e.g., excess tube feedings, breast milk) in handwashing sinks may promote the development of biofilms.

   **Sources:**

5. Is there a process to ensure hand hygiene supplies are readily available/restocked and that dispensers are properly functioning?
   - Yes
   - No
   - Unknown
   - Not assessed

   Facilities should “ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered.”

   Inaccessibility to hand hygiene supplies is perceived as a barrier to hand hygiene practice.

   Responsibility for maintaining supplies for hand hygiene may be assigned to individuals or departments at the facility’s discretion. Healthcare personnel should know who is responsible and who to contact if supplies are needed.

   “Do not add soap to a partially empty soap dispenser. This practice of “topping off” dispensers can lead to bacterial contamination of soap.” [187,419]

   **Source:** Hand Hygiene | Guidelines Library | Infection Control | CDC

   As part of fire safety for AHIS dispenser:

   “The dispenser shall:
   • Not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.
   • Not dispense more solution than the amount required for hand hygiene consistent with label instructions.
   • Be designed, constructed and operated in a manner that ensures accidental or malicious activation is minimized.
   • Be tested in accordance with the manufacturer’s care and use instructions each time a new refill is installed.

   Any activation of the dispenser shall only occur when an object is placed within 4 inches (100mm) of the sensor. An object placed within the activation zone and left in place shall not cause more than one activation.”

   **Source:** Fire Safety and ABS | Hand Hygiene | CDC

6. Is facility approved hand lotion supplied for use on units?
   - Yes
   - No
   - Unknown
   - Not assessed

   The 2002 CDC Guideline for Hand Hygiene in Healthcare recommends provision of hand lotions or creams to minimize the occurrence of irritant contact dermatitis associated with hand antiseptics or handwashing. Facility approved lotions or creams should be evaluated for compatibility with AHIS or if applicable, other antiseptics used by HEP at the facility (e.g., chlorhexidine gluconate). Fragrances in AHIS and lotions are the most frequent cause of allergic dermatitis among HEP.

   **Source:** Hand Hygiene | Guidelines Library | Infection Control | CDC

7. Does the facility hand hygiene policy include elements related to fingernails? *(select all that apply)*
   - Fingernail length
   - Use of nail polish
   - Use of artificial nails/gel nails
   - None are included
   - Unknown
   - Not assessed
   - Other (specify): __________________________

   The 2002 Guidelines for HH in Healthcare state that artificial fingernails or extenders should not be worn during contact with patients at high risk (e.g., those in intensive-care units or operating rooms). Natural nails tips should be kept less than ⅛ in long.

   **Source:** Hand Hygiene | Guidelines Library | Infection Control | CDC
8. How do patients, residents and visitors clean their hands? (select all that apply)
   - [ ] ABHS
   - [ ] Antimicrobial-impregnated wipes (specify antiseptic e.g., alcohol):
   - [ ] Handwashing with soap and water
   - [ ] Unknown
   - [ ] Not assessed
   - [ ] Other (specify): provide hand hygiene stations

   Towelettes may provide an additional mode of dispensing hand antiseptics including alcohol sanitizers while these may be provided to patients. "Antimicrobial-impregnated wipes (i.e., towelettes) may be considered as an alternative to washing hands with nonantimicrobial soap and water. Because they are not as effective as alcohol-based hand rubs or washing hands with an antimicrobial soap and water for reducing bacterial counts on the hands of HCWs, they are not a substitute for using an alcohol-based hand rub or antimicrobial soap."

   Source: Hand Hygiene: Guidelines Library | Infection Control | CDC

9. When are patients, residents and visitors encouraged to clean their hands? (select all that apply)
   - [ ] Upon arrival at the facility
   - [ ] Before entering the patient/resident care area
   - [ ] During their visit, before and after assisting the patient/resident with care
   - [ ] Unknown
   - [ ] Not assessed
   - [ ] Other (specify):

   Healthcare personnel should educate patients/residents and visitors about hand hygiene and encourage frequent hand hygiene prior to entering the patient room and during care before and after touching items in the care area.

   Source: Core Practices | HICPAC | CDC

Notes
Module 3: Transmission Based Precautions (TBP) Facilitator Guide

Transmission-Based Precautions (TBP): This form is intended to aid an ICAR facilitator in the review of a healthcare facility’s TBP practices and policies (Part A) and guide TBP facility (Part B) and healthcare personnel (Part C) observations. This form is intended primarily for use in acute care facilities and long-term care facilities. Parts D and E can be used to conduct a targeted assessment of practices in outpatient healthcare facilities.

Note: Transmission-Based Precautions should be used in addition to Standard Precautions. Additional information on precautions can be found in Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf).

Part A. TBP Interview Questions

1. Please name the different types of TBP the facility uses and some common pathogens for which each is used (select all that apply):
   - [ ] Contact Precautions — Common pathogens for which it is utilized:
   - [ ] Droplet Precautions — Common pathogens for which it is utilized:
   - [ ] Airborne Precautions — Common pathogens for which it is utilized:
   - [ ] Enhanced Barrier Precautions — Common indications and pathogens for which it is utilized:
   - [ ] Other (please specify Precaution type and common pathogens for which it is utilized):
   - [ ] Unknown
   - [ ] Not assessed

   Implement additional precautions (i.e., Contact, Droplet, and/or Airborne Precautions) for patients with documented or suspected diagnoses where contact with the patient, their body fluids, or their environment presents a substantial transmission risk despite adherence to Standard Precautions. Adapt transmission-based precautions to the specific healthcare setting, the facility design characteristics, and the type of patient interaction.”

   Source: Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings (HICPAC)

   “Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission.

   Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking.

   Use Airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route (e.g., tuberculosis, measles, chickenpox, disseminated herpes zoster).”

   Source: https://www.cdc.gov/infectioncontrol/basics/transmission_based_precautions.html

   Use Contact, Droplet, or Airborne precautions by pathogen type and duration as specified in CDC’s Guidelines for Isolation Precautions, Appendix A
   https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html

   Enhanced Barrier Precautions are recommended in nursing homes (when Contact Precautions do not otherwise apply) for residents with any of the following:
   - Wounds or indwelling medical devices, regardless of MDR colonization status
   - Infection or colonization with an MDR

   Source: https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html
NOTE: This Section is Intended to be Used for a Targeted Assessment Of Practices in Outpatient Healthcare Facilities

Part D: Targeted Assessment Of Practices in Outpatient Healthcare Facilities

Interview Questions

1. Describe how the facility identifies potentially infectious persons at initial points of patient encounter and determines the need for TBR.
   - Sign at front door - symptom based
   - Screening question on intake/abatement for travel

   ‘Develop and implement systems for early detection and management (e.g., use of appropriate infection control measures, including isolation precautions, personal protective equipment (PPE)) of potentially infectious persons at initial points of patient encounter in outpatient settings (e.g., triage areas, emergency departments, outpatient clinics, physician offices).’ [89]
   Source: Guideline for Isolation Precautions, page 77: https://www.cdc.gov/infectioncontrol/guidelines/Isolation/index.html
   Examples of clinical conditions (e.g., rash, respiratory symptoms, acute diarrhea) warranting empiric transmission-based Precautions are addressed in https://www.cdc.gov/infectioncontrol/guidelines/Isolation/appendix/transmission-precautions.html

2. How does the facility ensure PPE is always readily available at point of use (select all that apply)?
   - Designated personnel are assigned this task
   - Personnel caring for the patient restock their supplies as needed
   - Supervisors or charge nurses restock supplies as needed
   - Other (specify):
     - Unknown
     - Not assessed

   ‘Healthcare organizations can demonstrate a commitment to preventing transmission of infectious agents by incorporating infection control into the objectives of the organization’s patient and occupational safety programs. A key administrative measure is provision of fiscal and human resources for maintaining infection control and occupational health programs that are responsive to emerging needs. Specific components include...adequate supplies and equipment including facility ventilation systems.”

Notes

For outpatient facilities that care for patients for which respirator (N95 or higher-level respirator) use for healthcare personnel is recommended (e.g. SARS-CoV-2, Tuberculosis):

3. Does the facility have a respiratory protection program for healthcare personnel that includes:
   3a. Medical clearance for respirator use
       - Yes
       - No
       - Unknown
       - Not assessed

   3b. Respirator use training
       - Yes
       - No
       - Unknown
       - Not assessed

   3c. Annual fit testing
       - Yes
       - No
       - Unknown
       - Not assessed
3d. Who performs the fit testing?
   - Designated person within the facility
   - Contracted company: HCP fit tested at the healthcare facility
   - Contracted company: HCP fit tested at another site (i.e., at a building run by the contracting company)
   - Other (specify): EHS
   - Unknown
   - Not assessed

*Respiratory protection is broadly regulated by Occupational Safety and Administration (OSHA) under the general industry standard for respiratory protection (29CFR1910.134) which requires that U.S. employers in all employment settings implement a program to protect employees from inhalation of toxic materials. OSHA program components include medical clearance to wear a respirator; provision and use of appropriate respirators, including fit-tested NIOSH-certified N95 and higher particulate filtering respirators; education on respirator use and periodic re-evaluation of the respiratory protection program.*


For medical clearance:

“The physician or other licensed healthcare professional (PLHCP) may be a hospital employee but must not be the employee’s supervisor. If the hospital does not have internal occupational health services, the PLHCP may be a contracted provider. The best outside sources for such evaluations are occupational medicine providers or clinics. These clinics provide medical clearance for respirator use and may also provide fit testing services.”

For fit testing:

“Fit testing must be performed by an individual knowledgeable in respiratory protection, and qualified to follow the protocol and train the employee to properly put on and take off the respirator.”

**Source:** [https://www.cdc.gov/niosh/docs/2015-117/pdfs/2015-117.pdf](https://www.cdc.gov/niosh/docs/2015-117/pdfs/2015-117.pdf)

If medical clearance and fit testing must take place at an offsite location, considerations regarding distance, allotment of time to HCP to complete those tasks, and the sharing of documentation need to be considered.

**Additional sources:**
- Fit Testing FAQ: [https://www.cdc.gov/niosh/topics/respiratory/faq_part/respsource3fittest.html](https://www.cdc.gov/niosh/topics/respiratory/faq_part/respsource3fittest.html)
- NIOSH Healthcare Respiratory Protection Resources (information on the key requirements necessary for an effective hospital respiratory protection program): [https://www.cdc.gov/niosh/topics/respiratory/default.html](https://www.cdc.gov/niosh/topics/respiratory/default.html)
4. Does the facility have airborne infection isolation rooms (AIR)?
   - Yes
   - No
   - Unknown
   - Not assessed

   **IF YES:** Does the facility have the following elements in place for the maintenance and monitoring of their airborne infection isolation rooms (AIR)?

4a. At least 6 (for existing facilities) or ≥ 12 (for renovated or new construction) air changes per hour depending upon facility age or per state licensure rules.
   - Yes
   - No
   - Unknown
   - Not assessed

4b. Direct exhaust of air to outside. If not possible, all air returned to air handling system or adjacent spaces is directed through HEPA filters.
   - Yes
   - No
   - Unknown
   - Not assessed

4c. When in use for patient/resident care, air pressure is monitored daily with visual indicators (e.g., smoke tubes, flutter strips), regardless of the presence of differential pressure sensing devices (e.g., manometers).
   - Yes
   - No
   - Unknown
   - Not assessed

*In acute care hospitals and long-term care settings, place patients who require Airborne Precautions in an AIR that has been constructed in accordance with current guidelines.
- Provide at least six (existing facility) or 12 (new construction/renovation) air changes per hour.
- Direct exhaust of air to the outside. If it is not possible to exhaust air from an AIR directly to the outside, the air may be returned to the air handling system or adjacent spaces if all air is directed through HEPA filters.
- Whenever an AIR is in use for a patient on Airborne Precautions, monitor air pressure daily with visual indicators (e.g., smoke tubes, flutter strips), regardless of the presence of differential pressure sensing devices.
- Keep the AIR door closed when not required for entry and exit*


**Notes**

will consider a second visual indicator
Module 4: Environmental Services Facilitator Guide

Environmental Services (EVS): This form is intended to aid an ICAR facilitator in the review of a healthcare facility’s EVS practices and policies (Part A) and guide EVS observations (Part B and Part C). In outpatient settings, emphasis should be placed on the process for cleaning and disinfecting non-critical equipment, medication preparation areas, and high-touch surfaces in procedure rooms between patients.

**Part A. EVS Interview Questions**

*This interview should include the person in charge of EVS. If possible, responses should be verified with frontline staff through direct observation of practices or informal interviews while conducting the ICAR.*

1. Are there policies indicating which environmental surfaces are to be routinely (e.g., daily) cleaned and disinfected in patient/resident rooms?
   - Yes
   - No
   - Unknown
   - Not assessed

   **If YES**, please describe, including if and how these policies differ by room type or area:

   [Blank space for response]

   "Develop standardized protocols for routine (e.g., daily) and discharge/transfer (also known as terminal) cleaning and disinfection for each major patient care room type (i.e., intensive care unit or ward) or area type (i.e., operating room, emergency department, radiology suite)."
   
   **Source:** Reduce Risk from Surfaces | IAH | CDC
   
   Examples of high-touch surfaces include, but are not limited to: bed rails, bed frames, moveable lamps, call buttons, tray table, bedside table, handles, IV pole, and surfaces in and around toilets in patients’ rooms.
   
   **Sources:**
   
   Guidelines for Environmental Infection Control in Health-Care Facilities (cdc.gov)
   Environmental Cleaning 102 (cdc.gov)

2. Is there a process for selecting products used by the facility for cleaning and disinfection?
   - Yes
   - No
   - Unknown
   - Not assessed

   **If YES**, please describe the factors considered when selecting products (e.g., efficacy against common pathogens, compatibility with surfaces):

   create a list of cleaning products. Review core practices. Products cover respiratory illnesses and manufacturers use.

   "Select EPA-registered disinfectants that have microbicidal activity against the pathogens most likely to contaminate the patient-care environment."
   
   **Source:** Core Practices | HICPAC | CDC

   Ideally, the infection preventionist is included in the process of selecting products used for cleaning and disinfection. Factors to consider when selecting products include, but are not limited to:
   
   - Spectrum of activity (e.g., a sporidial option [List X] available for the rooms of patients with C. diff)
   - EPA has [lists of products] that are registered against common pathogens (e.g., List P are products registered with EPA for claims against *Candida auris*)
   - Ease of use (e.g., shorter contact times, one-step cleaner/disinfectants, mixing and dilution not required)
   - Compatibility with environmental surfaces
   - Safety
3. How often are high-touch environmental surfaces in patient/resident rooms cleaned and disinfected? (Select all that apply)
   - [ ] Daily
   - [x] More than Daily
   - [ ] Less than Daily
   - [ ] Unknown
   - [ ] Not assessed
   - [ ] Other (specify):

   In general, high-touch surfaces in:
   - Patient rooms should be cleaned and disinfected when soiled, daily, and when the patient is discharged.
   - Rooms/areas where invasive procedures are performed should be cleaned and disinfected when soiled and after each procedure.
   Examples of high-touch surfaces include, but are not limited to: bed rails, bed frames, moveable lamps, call buttons, tray table, bedside table, handles, IV poles, and surfaces in and around toilets in patients' rooms.

   Sources:
   - Guidelines for Environmental Infection Control in Health-Care Facilities (cdc.gov)
   - Environmental Cleaning 102 (cdc.gov)

4. Are there policies addressing the order in which environmental surfaces are cleaned and disinfected in patient/resident rooms (e.g., top to bottom, clean to dirty, toilet cleaned and disinfected last)?
   - [x] Yes
   - [ ] No
   - [ ] Unknown
   - [ ] Not assessed

   If YES, please describe:

   In order to ensure surfaces are not missed, it is helpful to have a general order in which environmental surfaces are cleaned and disinfected in patient rooms. To avoid spreading dirt and microorganisms, recommended practice is to proceed from top to bottom and from cleaner to dirtier areas (e.g., clean toilets last). However, spills of blood or body fluids should be cleaned immediately.

   Source: Environmental Cleaning 102 (cdc.gov)

5. Is there a process to indicate when a room/bed space has been cleaned and disinfected?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - [ ] Not assessed

   If YES, please describe:

   "Develop standardized protocols for routine (e.g., daily) and discharge/transfer (also known as terminal) cleaning and disinfection for each patient care room type. Include in the protocols "processes for easy identification of equipment and rooms that have been properly cleaned and disinfected and are ready for patient use (e.g., tagging system, placement in dedicated clean area)."

   Source: Reduce Risk from Surfaces | HAI | CDC

Notes
6. Is there a process for determining the minimum cleaning time of a patient/resident room?
   - Yes
   - No
   - Unknown
   - Not assessed

   **If YES:**
   6a. What factors are considered in the process? *(select all that apply):*
   - Size of the room
   - Number of surfaces
   - Number of patients/residents in the room
   - Type of cleaning and disinfection (e.g., routine vs terminal)
   - Feedback from EVS personnel
   - Feedback from other personnel (e.g., nursing)
   - Unknown
   - Not assessed
   - Other *(specify):*

   *These questions are intended to assess if sufficient staffing and time has been allotted to allow for proper cleaning and disinfection of patient rooms.*
   "Establish the minimal cleaning time (MCT) for routine and discharge/transfer cleaning for each major patient care room type or area.
   - Define a process to establish MCTs, for example by observing standardized cleaning protocols performed by experienced personnel.
   - Align MCTs with staffing plans to ensure that effective cleaning and disinfection can be completed and sustained.
   - Disseminate MCTs so that others who are responsible for patient flow, such as bed control and nursing, are aware of them for each patient care area.
   - Enforce MCTs and empower EVS staff to require adherence to MCTs.
   - Track cleaning times to:
     - Identify factors that influence them
     - Assess the need for mitigating those factors or revising the MCT"
   *Source: Reduce Risk from Surfaces | HAI | CDC*

   While touring the facility and performing observations, EVS workers can be asked if they feel they have sufficient time to correctly perform routine and terminal cleaning activities.

7. Does the facility have communal shower areas for patient/resident bathing?
   - Yes
   - No
   - Unknown
   - Not assessed

   **If YES, please describe the frequency and process for cleaning and disinfection (e.g., which surfaces are cleaned and disinfected between residents, how are shower trolleys handled):**

8. Who is assigned responsibility for cleaning and disinfecting the following reusable, non-critical patient/resident care equipment?
   **8a. Portable radiology equipment (e.g., X-rays, ultrasound machine). *(select all that apply)*
   - EVS personnel
   - Nursing personnel
   - Certified nursing assistant (CNA)
   - User
   - Unknown
   - Not assessed
   - Other *(specify):*

   **8b. Respiratory therapy equipment (e.g., ventilators). *(select all that apply)*
   - EVS personnel
   - Nursing personnel
   - Respiratory therapists
   - User
   - Unknown
   - Not assessed
   - Other *(specify):*
8c. Lifts/scales (select all that apply)
- EVS personnel
- Nursing personnel
- Certified nursing assistant (CNA)
- User
- Unknown
- Not assessed
- Other (specify):

8d. Infusion equipment (e.g., IV poles, pumps) (select all that apply)
- EVS personnel
- Nursing personnel
- Certified nursing assistant (CNA)
- User
- Unknown
- Not assessed
- Other (specify):

“Clearly define responsibilities for the cleaning and disinfection of noncritical equipment, shared medical equipment, and other electronics (e.g., ICU monitors, ventilator surfaces, bar code scanners, point-of-care devices, mobile workstations, code carts, airway boxes).
1. Make sure that staff involved in cleaning and disinfection are aware of their responsibilities and are appropriately trained to fulfill them.
2. Make sure that cleaning and disinfection supplies are easily accessible (e.g., cleaning cart and patient care areas are adequately stocked).”
Source: Badbug Risk from Surfaces | HAI | CDC

9. How often is non-critical patient/resident care equipment that is used for more than one patient/resident cleaned and disinfected? (Select all that apply)
- When visibly dirty
- Daily
- After each use
- Prior to use on another patient/resident
- Unknown
- Not assessed
- Other (specify):

10. Is there a process to indicate when reusable, non-critical patient/resident care equipment has been cleaned and disinfected?
- Yes
- No
- Unknown
- Not assessed

If yes, please describe:

“Clean and reprocess (disinfect or sterilize) reusable medical equipment (e.g., blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes, surgical instruments, endoscopes) prior to use on another patient and when soiled.”
“Maintain separation between clean and soiled equipment to prevent cross contamination.”
Source: Core Practices | HICPAC | CDC

Notes
Part A. High-level Disinfection and Sterilization Interview Questions

1. What types of reprocessing are performed onsite or offsite? (select all that apply)
   1a. High-level disinfection
       - Onsite
       - Offsite
       - Unknown
       - Not assessed
       - Not performed

   1b. List all areas where onsite high-level disinfection is performed (e.g., endoscopy suites, bronchoscopy suite):
       Women’s Health

   1c. Sterilization (by any method)
       - Onsite
       - Offsite
       - Unknown
       - Not assessed
       - Not performed

   1d. List all areas where onsite sterilization, including immediate use steam sterilization, is performed (e.g., operating room area, central processing):
       TIA. Women’s Health

Understanding the types of medical device reprocessing and locations where it is performed will allow the ICAR facilitator to ensure observations and assessments are performed in all relevant areas of the facility.

2. Does the facility use devices or instruments/instrument trays that are supplied by a vendor?
   - Yes
   - No
   - Unknown
   - Not Assessed

   If YES:
   2a. Prior to use do all vendor devices undergo the appropriate level reprocessing at the facility?
       - Yes
       - No
       - Unknown
       - Not Assessed

   Some equipment or instruments may be on loan from a vendor (e.g., specialized orthopedic equipment). There should be a process in place to ensure such equipment has been sterilized or high-level disinfected (as appropriate) prior to use at the facility. “Policies should include the management of ‘loaner’ endoscopes (i.e., endoscopes that are not owned by the healthcare facility but are provided for temporary use by manufacturers, equipment suppliers or other healthcare facilities) to ensure adherence to the same reprocessing standards described above required for facility-owned equipment. This includes:
       1. Assessing the condition (e.g., visual inspection, leak testing) of loaner endoscopes prior to use.
       2. Cleaning and high level disinfection or sterilization of loaner endoscopes supplied by the manufacturer or another healthcare facility prior to use.”

   Source: *Essential Elements of a Reprocessing Program for Flexible Endoscopes. Recommendations of the HICPAC (cdc.gov)*

Notes
3. Does the facility ever use single-use devices for more than one patient?
   - [ ] Yes
   - [x] No
   - [ ] Unknown
   - [ ] Not Assessed

   **If YES:**
   3a. Prior to reuse do they undergo the appropriate level reprocessing?
      - [ ] Yes
      - [ ] No
      - [ ] Unknown
      - [ ] Not Assessed

   If the facility elects to reuse single-use devices, these devices must be reprocessed prior to reuse by a third-party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The facility should have documentation from the third-party reprocessor confirming this is the case.

   **Note:** The individual responding to questions may not know that HCP are reusing single-use devices. Even if the answer is no, the ICAR facilitator should watch for such practices while performing observations.

4. Does the facility have policies and procedures (e.g., logging the cleaning and use of individual devices and patients in whom they were used) outlining facility response (i.e., risk assessment and recall of device) in the event of a reprocessing error or failure?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown
   - [ ] Not Assessed

   **If YES:**
   4a. How are potentially contaminated devices identified/recalled?
      
   Direct observation of vaginal probe

   4b. How are potentially exposed patients identified?
      
   Log links probe to patient

   4c. Who is involved in the process of assessing potential risks to patients on whom the equipment was used?
      
   Clinic management

   Facilities should have policies and procedures addressing how they will respond to reprocessing errors or failures, particularly if such errors are not detected until after equipment has been released and used on a patient.

   “Each breach is a result of unique circumstances and should be evaluated to determine the risk of disease transmission. A multi-disciplinary team that includes infection prevention, risk management, and (reprocessing) personnel should review each event carefully to determine the necessary corrective steps and the need for patient notification. . . . the decision to notify patients of their potential exposure should be made in consultation with an infection preventionist and state and local health departments.”

   In addition to engagement with the health department, potential errors or failures of medical devices should be reported to the device manufacturer and FDA MedWatch.

   **Source:** Essential Elements of a Reprocessing Program for Flexible Endoscopes – Recommendations of the HICPAC (cdc.gov)

   Information that can aid in these situations include a mechanism to determine:
   - Dates the reprocessing error/failure occurred.
   - Which equipment/trays were potentially impacted by the failure (e.g., if only one autoclave was affected, which equipment was sterilized in that autoclave)
   - Which patients were exposed to the potentially contaminated equipment. Having a log system that records the equipment trays or endoscopes used during the procedure can help facilitate this process.

**Notes**
5. Is there a process for reporting suspected device-associated infections to public health officials?
   - Yes
   - No
   - Unknown
   - Not Assessed

   **If Yes:**

   5a. Does this process include reporting to the manufacturer?
   - Yes
   - No
   - Unknown
   - Not Assessed

   5b. Does this process include reporting to FDA MedWatch?
   - Yes
   - No
   - Unknown
   - Not Assessed

6. Is routine maintenance for reprocessing equipment (e.g., automated washers, steam autoclaves, automated endoscope reprocessors) and endoscopes regularly performed?
   - Yes
   - No
   - Unknown
   - Not Assessed

   **If Yes:**

   6a. Who performs this maintenance?
   - The facility
   - The device manufacturer
   - Unknown
   - Not Assessed
   - Other (specify): __________________________

   6b. Does the facility maintain records of all maintenance?
   - Yes
   - No
   - Unknown
   - Not Assessed

---

"Maintain records of preventive maintenance and repair of endoscopes and reprocessing equipment (e.g., leak testers, automated endoscope reprocessors [AEIs], sterilizers)."

**Source:** Essential Elements of a Reprocessing Program for Flexibe Endoscopes — Recommendations of the HICPAC (cdc.gov)

If possible, confirm that maintenance records are available. If the ICAR is being performed in response to an outbreak or reprocessing error/failure, these records can sometimes help with determining how long such errors/failures might have been occurring. Device representatives can also be an important resource to ensure the equipment is currently functioning as intended.

---

**Notes**
Part B. Sterilization Observations

Ideally, observations should be conducted in each area of the facility where sterilization is performed. If direct observations cannot be gathered, then information can be obtained by asking staff.

1. Are policies, procedures, and manufacturer reprocessing instructions available in the reprocessing area?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   "Manufacturer's instructions for reprocessing reusable medical equipment should be readily available and used to establish clear operating procedures and training content for the facility. Instructions should be posted at the site where equipment reprocessing is performed."

   "Compare the reprocessing instructions (e.g., for the appropriate use of endoscope connectors, the capping/noncapping of specific lumens) provided by the instrument manufacturer and the sterilizer manufacturer and resolve any conflicting recommendations by communicating with both manufacturers. Category B"

   Sources: [https://www.cdc.gov/hicpac/recommendations/core-practices.html](https://www.cdc.gov/hicpac/recommendations/core-practices.html)

2. Is there an appropriate supply of equipment for the volume of procedures performed to allow adequate time for all reprocessing steps, including drying, to be correctly performed?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   "Do not use immediate-use steam (flash) sterilization for convenience, as an alternative to purchasing additional instrument sets, or to save time. Category II"


   If the facility is routinely having to flash sterilize trays (immediate-use steam sterilization) in order to meet procedural needs, this could be a sign that they do not have an appropriate supply of equipment.

3. Is there a clear separation between soiled and clean workspaces?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   "The reprocessing area should be in a space that is separate from the patient procedural area."

   "Review the physical setting to ensure a ‘one way’ workflow that separates contaminated work spaces from clean work spaces."

   "Maintain separation between clean and soiled equipment to prevent cross contamination."

   Sources: [https://www.cdc.gov/hicpac/recommendations/core-practices.html](https://www.cdc.gov/hicpac/recommendations/core-practices.html)

4. Do HCP have access to a handwashing sink that is not used for cleaning devices?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   "Staff should have access to a handwashing sink that is separate from the reprocessing sink(s)."


Notes
5. Do HCP engaged in sterilization activities wear appropriate PPE to prevent exposure to infectious agents or chemicals?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   *Ensure that workers wear appropriate PPE to preclude exposure to infectious agents or chemicals through the respiratory system, skin, or mucous membranes of the eyes, nose, or mouth. PPE can include gloves, gowns, masks, and eye protection. The exact type of PPE depends on the infectious or chemical agent and the anticipated duration of exposure. The employer is responsible for making sure such equipment and training are available. Category II, IC.*
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cd.gov)

6. Is a precleaning step performed as soon as practical after use (e.g., at the point of use)?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   *Clean medical devices as soon as practical after use (e.g., at the point of use) because soiled materials become dried onto the instruments. Dried or baked materials on the instrument make the removal process more difficult and the disinfection or sterilization process less effective or ineffective. Category IE.*
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cd.gov)
   Such observations can be made by observing precleaning at the point of care (e.g., endoscopy suite) or looking at how items are packaged when they arrive at the reprocessing area (e.g., appropriately soaking in detergent/cleaner in a biohazard container).

7. Are devices thoroughly cleaned according to manufacturer instructions and visually inspected for residual soil prior to sterilization?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   *Meticulously clean patient-care items with water and detergent, or with water and enzymatic cleaners before high-level disinfection or sterilization procedures.
   1. Remove visible organic residue (e.g., residue of blood and tissues) and inorganic salts with cleaning. Use cleaning agents that are capable of removing visible organic and inorganic residues. Category IB.
   Perform either manual cleaning (i.e., using friction) or mechanical cleaning (e.g., with ultrasonic cleaners, washer-disinfectors, washer-sterilizers). Category IE.*
   Ensure appropriately sized cleaning brushes are selected for cleaning device channels and lumens.
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cd.gov)

8. Is the enzymatic cleaner or detergent used for cleaning discarded according to manufacturer’s instructions (typically after each use)?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   *Discard enzymatic cleaners (or detergents) after each use because they are not microbicidal and, therefore, will not retard microbial growth. Category IB.*
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cd.gov)

Notes
9. Are disposable cleaning brushes discarded after use or, if reusable, cleaned and high-level disinfected or sterilized (per manufacturer’s instructions) after use?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   “Use cleaning brushes appropriate for the size of the endoscope channel or port (e.g., bristles should contact surfaces). Cleaning items (e.g., brushes, cloth) should be disposable or, if they are not disposable, they should be thoroughly cleaned and either high-level disinfected or sterilized after each use. Category II”
   
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

10. After cleaning, are instruments appropriately wrapped-packaged for sterilization?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   “Ensure that packaging materials are compatible with the sterilization process and have received FDA 510(k) clearance. Category IB.”
   “Place items correctly and loosely into the basket, shelf, or cart of the sterilizer so as not to impede the penetration of the sterilant. Category IB”
   “…hinged instruments should be opened; items with removable parts should be disassembled unless the device manufacturer or researchers provide specific instructions or test data to the contrary…” devices with concave surfaces should be positioned to facilitate drainage of water; heavy items should be positioned not to damage delicate items.”

   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

11. Is a chemical indicator (process indicator) placed correctly in the instrument packs in every load?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   “Monitor each load with mechanical (e.g., time, temperature, pressure) and chemical (internal and external) indicators. If the internal chemical indicator is visible, an external indicator is not needed. Category II.”

   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

12. Is a biological indicator, intended specifically for the type and cycle parameters of the sterilizer, used at least weekly for each sterilizer and with every load containing implantable items?
   - Yes
   - No
   - Not observed but endorsed by reprocessing staff
   - Not observed and not endorsed by reprocessing staff

   “Use biologic indicators to monitor the effectiveness of sterilizers at least weekly with an FDA-cleared commercial preparation of spores…intended specifically for the type and cycle parameters of the sterilizer. Category IB”
   “Use biologic indicators for every load containing implantable items and quarantine items, whenever possible, until the biologic indicator is negative. Category IB”

   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

Notes
13. For dynamic air removal-type sterilizers (e.g., prevacuum steam sterilizer), is an air removal test (Bowie-Dick test) performed in an empty dynamic-air removal sterilizer each day the sterilizer is used?
   ○ Yes
   ○ No
   ○ Not observed but endorsed by reprocessing staff
   ○ Not observed and not endorsed by reprocessing staff

   "An air removal test (Bowie-Dick Test) must be performed daily in an empty dynamic-air removal sterilizer (e.g., prevacuum steam sterilizer) to ensure air removal.”
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

14. Are sterile packs labeled with a load number that indicates the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date?
   ○ Yes
   ○ No
   ○ Not observed but endorsed by reprocessing staff
   ○ Not observed and not endorsed by reprocessing staff

   "Label sterilized items with a load number that indicates the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date. Category IB”
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

15. Are sterilization logs current and complete (include results from each load)?
   ○ Yes
   ○ No
   ○ Not observed but endorsed by reprocessing staff
   ○ Not observed and not endorsed by reprocessing staff

   "For each sterilization cycle, record the type of sterilizer and cycle used; the load identification number; the load contents; the exposure parameters (e.g., time and temperature); the operator’s name or initials; and the results of mechanical, chemical, and biological monitoring. Category II”
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

16. Is immediate-use steam sterilization only done in circumstances in which routine sterilization procedures cannot be performed?
   ○ Yes
   ○ No
   ○ Not observed but endorsed by reprocessing staff
   ○ Not observed and not endorsed by reprocessing staff

   "Do not use flash sterilization for convenience, as an alternative to purchasing additional instrument sets, or to save time. Category II”
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

17. Are instruments that undergo immediate-use steam sterilization used immediately and not stored?
   ○ Yes
   ○ No
   ○ Not observed but endorsed by reprocessing staff
   ○ Not observed and not endorsed by reprocessing staff

   "When using flash sterilization, make sure the following parameters are met: 1. clean the item before placing it in the sterilizing container (that are FDA cleared for use with flash sterilization) or tray; 2. prevent exogenous contamination of the item during transport from the sterilizer to the patient; and 3) monitor sterilizer function with mechanical, chemical, and biological monitors. Category IB”
   Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

Notes
18. After sterilization, are medical devices stored so that sterility is not compromised?

☐ Yes
☐ No
☐ Not observed but endorsed by reprocessing staff
☐ Not observed and not endorsed by reprocessing staff

"Ensure the sterile storage area is a well-ventilated area that provides protection against dust, moisture, insects, and temperature and humidity extremes. Category II.

Store sterile items so the packaging is not compromised (e.g., punctured, bent). Category II."

Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

19. Are sterile packages inspected for integrity and compromised packages reprocessed prior to use?

☐ Yes
☐ No
☐ Not observed but endorsed by reprocessing staff
☐ Not observed and not endorsed by reprocessing staff

"Evaluate packages before use for loss of integrity (e.g., torn, wet, punctured). The pack can be used unless the integrity of the packaging is compromised. Category II.

If the integrity of the packaging is compromised (e.g., torn, wet, or punctured), repack and reprocess the pack before use. Category II."

Source: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov)

Notes
## Appendix B. Safety and Health Program Self-Evaluation Tool

### SECTION 1: MANAGEMENT LEADERSHIP

<table>
<thead>
<tr>
<th>ACTION</th>
<th>Deficiencies</th>
<th>Guidance</th>
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| Management implements and communicates a written, signed policy supporting the safety program. | X | • An **effective program**’s written policy commits the entire enterprise to continuous improvement in safety and health and integrates safety and health into all business operations. It is communicated to and understood by all.  
• An **inferior program** does not include safety and health in business policies or treats safety and health as a secondary organizational value. |
| Management routinely demonstrates visible commitment to the program. | X | • In an **effective program**, managers walk the facility to actively look for hazards and talk to Staff about the hazards they face. Safety and health topics are brought up during meetings and informal conversation. Management follows safety and health rules when walking through the facility.  
• In an **inferior program**, managers assign responsibility then mostly disengage from safety and health issues. |
| Management defines specific goals and expectations for the program, along with plans for achieving the goals. | X | • An **effective program**’s goals emphasize prevention of injuries and illnesses through active participation in the safety and health program. The goals are measurable, and the program defines specific plans or actions needed to achieve them.  
• An **inferior program** has no goals, non-specific goals (such as “safer operations”), or goals that reflect only lagging performance (such as “reduce injuries by 10 percent”). |
| Management assigns responsibility and accountability for implementing and maintaining the program. | X | • An **effective program** assigns responsibility to one person, or a few, based on the size of the company and the hazards present, and holds them accountable  
• An **inferior program** assigns responsibility to many people, such as all members of a large safety and health committee or “all workers.” This ensures that no one takes personal ownership of the program. |
| Management encourages, recognizes, and rewards worker contributions to workplace safety and health. | X | • An **effective program** recognizes Staff whose actions contribute to the goals of the program.  
• An **inferior program** only recognizes Staff who are not injured during a period of time. |
## SECTION 2: WORKER PARTICIPATION

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<th>ACTION</th>
<th>Deficiencies</th>
<th>Guidance</th>
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<tbody>
<tr>
<td><strong>Action</strong></td>
<td>None</td>
<td>Minor</td>
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| Staff are encouraged to participate in the program, have the means to participate, and feel comfortable participating and giving input on safety and health issues. | X | - An effective program is developed by a team or committee that includes Staff. Management asks all Staff to contribute, recognizes Staff who participate, and shows them appreciation.  
- An inferior program is developed by a small group of managers or the professional safety and health staff alone, and is not widely accepted.|
| Staff are trained on how to report an injury, illness, hazard, or concern, including good catches/near misses. | X | - In an effective program, Staff know how to report injuries, incidents, and concerns and are encouraged to do so. The reporting system is easily accessible, and reports reach upper management.  
- In an inferior program, Staff are unclear about reporting procedures and typically rely on the first line supervisor to inform upper management.|
| Staff report injuries, illnesses, hazards, and concerns without fear of reprisal. | X | - In an effective program, management encourages, appreciates, and rewards worker reports because of the valuable information they provide.  
- In an inferior program, management does not acknowledge receiving reports and fails to inform Staff when issues have been resolved.|
| Reports of injuries, illnesses, hazards, or other concerns are acknowledged promptly. | X | - In an effective program, management acknowledges reports immediately and provides updates as an issue is addressed.  
- In an inferior program, management does not acknowledge receiving reports and fails to inform Staff when issues have been resolved.|
| Reports of injuries, illnesses, hazards, or other concerns are resolved promptly, after worker input is sought, and are tracked to completion. | X | - In an effective program, management shows the value it places on worker input by engaging them in finding and implementing solutions. Resolution is prompt and solutions are communicated to all.  
- In an inferior program, Staff play no role in finding solutions and are not informed of selected controls until after they have been implemented.|
| Staff have access to information they need to understand safety and health hazards and hazard control measures in the workplace. | X | - In an effective program, Staff have access to injury and illness logs, incident investigations, Safety Data Sheets, job hazard analyses, industrial hygiene monitoring results, and other information indicative of hazards in the workplace.  
- In an inferior program, Staff see only information the employer is required to post by law.|
| Staff are assigned roles in or are otherwise involved in all aspects of the program. | X | - An effective program involves Staff in all aspects of development, such as assessing training needs, investigating incidents, and evaluating the program.  
- In an inferior program, safety and health staff or management make decisions about training, perform investigations and inspections without Staff, or evaluate the program without worker input.|
| Staff can participate without encountering language, skill, or education barriers; restrictions on participating during work time; or fear of retaliation or discrimination. | X | - An effective program reflects diversity in education, language, and skill levels in the workplace. Staff feel comfortable participating during work time.  
- An inferior program provides materials in a one-size-fits-all format. Staff are hesitant to speak up. |
Staff have authority to initiate or request a temporary suspension or shutdown of any work activity or operation they believe to be unsafe

- In an **effective program**, management empowers employees and contractors to use stop work authority when needed.
- In an **inferior program**, employees and contractors do not have, are not aware of, or are reluctant to exercise stop work authority.

**SECTION 3: HAZARD IDENTIFICATION AND ASSESSMENT**

<table>
<thead>
<tr>
<th>ACTION</th>
<th>Deficiencies</th>
<th>None</th>
<th>Minor</th>
<th>Full</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written materials such as injury/illness logs, Safety Data Sheets, medical reports, workplace inspection results, incident investigation reports, and manufacturers’ literature are reviewed to help identify hazards.</td>
<td>X</td>
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<tr>
<td>The workplace is inspected regularly to identify conditions that pose or could pose a safety or health concern. Inspections cover all areas and activities and include plant and transportation vehicles.</td>
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<tr>
<td>Before making changes to operations, workflow, physical plant, equipment, or materials, Staff and managers conduct a review to identify any safety or health issues.</td>
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<tr>
<td>The workplace is evaluated to identify worker exposure to health hazards</td>
<td>X</td>
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<tr>
<td>Trends in injury and illness data, reports of hazards, incidents, etc. are analyzed to identify common hazards.</td>
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<tr>
<td>Incidents (including close calls/near misses) and employee complaints are investigated to identify any hazards previously</td>
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</tbody>
</table>

- In an **effective program**, management and Staff review relevant data and materials, particularly injury reports and incident investigations, to ensure that known hazards are recognized. These reviews occur regularly (at least annually) and when there are significant changes. Sources of hazard information are monitored to maintain awareness of emerging hazards or new information. Management ensures that information is available to Staff because they have unique insight into workplace hazards.
- An **inferior program** relies primarily on visual inspections of the workplace to reveal hazards.

- An **effective program** uses exposure monitoring (e.g., air sampling) to evaluate chemical, noise, or other health hazards and performs analysis on the results. Results at or above occupational exposure limits are addressed and where feasible, opportunities for further exposure reduction are examined.
- An **inferior program** recognizes health hazards only after workers show signs and symptoms of illness.

- In an **effective program**, management reviews injury and illness records, incidents, and other safety and health records regularly (at least annually) to find common causes.
- In an **inferior program**, management uses injury and illness records for Staff compensation purposes only.

- In an **effective program**, management and Staff investigate incidents to determine the root cause(s) and identify program/management/hazard control shortcomings that may have led to an incident.
unrecognized or inadequately controlled. Investigations focus on identifying the root cause(s) of each incident.

<table>
<thead>
<tr>
<th>Hazards associated with emergencies and non-routine operations are identified in the emergency action plan and operating procedures, respectively.</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In an <strong>inferior program</strong>, management is satisfied with findings that Staff did not follow procedures or the incident resulted from worker error or misconduct.</td>
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</tr>
<tr>
<td>• An <strong>effective program</strong> uses scenario planning to predict the types of hazards that may arise during non-routine activities and emergencies.</td>
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</tr>
<tr>
<td>• In an <strong>inferior program</strong>, management looks only for the hazards associated with routine operations</td>
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</table>

<table>
<thead>
<tr>
<th>All identified hazards are characterized with respect to the severity of potential outcomes, likelihood of an event or exposure, and number of Staff who might be exposed. This information is identified in operating procedures.</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In an <strong>effective program</strong>, management and Staff evaluate hazards using a systematic approach based on best available data.</td>
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<tr>
<td>• In an <strong>inferior program</strong>, management prioritizes hazards using an ad hoc approach, or does not prioritize them at all.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Interim controls are adopted while permanent controls are being determined</th>
<th>X</th>
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</thead>
<tbody>
<tr>
<td>• In an <strong>effective program</strong>, management and Staff take immediate steps to reduce or minimize hazards.</td>
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</tr>
<tr>
<td>• In an <strong>inferior program</strong>, management notes hazards but takes no measures to control them while identifying long-term solutions.</td>
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</table>

<table>
<thead>
<tr>
<th>All serious and recognized hazards are addressed immediately, while prioritizing remaining hazards for further control.</th>
<th>X</th>
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</thead>
<tbody>
<tr>
<td>• In an <strong>effective program</strong>, management and Staff classify hazards and take prompt measures to control all serious and recognized hazards.</td>
<td></td>
</tr>
<tr>
<td>• In an <strong>inferior program</strong>, management treats all hazards the same and addresses them as funding becomes available.</td>
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</tbody>
</table>

### SECTION 4: HAZARD PREVENTION AND CONTROL

<table>
<thead>
<tr>
<th>ACTION</th>
<th>Deficiencies</th>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Options for controlling hazards are identified using sources such as OSHA, NIOSH, industry best practices, and input from Staff.</td>
<td>X</td>
<td>• In an <strong>effective program</strong>, management and Staff seek guidance on effective control methods from authoritative sources (e.g., ANSI, ASME, NFPA, OSHA regs).</td>
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<tr>
<td></td>
<td></td>
<td>• In an <strong>inferior program</strong>, management relies on “shop-designed” control approaches that have not been shown to be effective.</td>
</tr>
<tr>
<td>Controls are selected according to the “hierarchy of controls,” Emphasizing (in order of priority) elimination, substitution, engineering controls, administrative controls, and PPE.</td>
<td>X</td>
<td>• An <strong>effective program</strong> uses primarily engineering controls or substitution to prevent or eliminate hazards.</td>
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<tr>
<td></td>
<td></td>
<td>• An <strong>inferior program</strong> relies on work procedures and PPE to reduce exposure to hazards.</td>
</tr>
<tr>
<td>A risk management plan is used to plan and prioritize controls.</td>
<td>X</td>
<td>• An <strong>effective program</strong> creates and maintains a hazard control plan that tracks progress toward controlling hazards until completion, removes hazards from the plan when they are fully addressed, and adds new hazards as they are identified.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• An <strong>inferior program</strong> has no hazard control plan and reacts to hazards on an ad hoc basis. Management waits until the annual program evaluation to update the hazard control plan, if one exists.</td>
</tr>
</tbody>
</table>
| Interim controls are used when permanent controls cannot be immediately implemented. | X | • An **effective program** uses interim controls when needed, but also ensures that effective engineering controls are implemented as soon as possible, reducing the reliance on procedures, work practices, and PPE.  
• An **inferior program** allows interim controls to be permanent. |
| --- | --- | --- |
| Staff are involved in selecting controls | X | • An **effective program** involves Staff in choosing, designing, and implementing control methods to ensure that they are feasible and effective, and will be used properly.  
• In an **inferior program**, management buys equipment and establishes procedures that often are ignored and unused because Staff have no input. In an **inferior program**, plans cover only fires and contain dated information. Plans are exercised infrequently. |
| Once installed, controls are monitored to ensure that Staff understand their use and application and to verify that they are effective. | X | • An **effective program** assigns a person (or persons) to monitor control methods to ensure that they are implemented, maintained, operate as designed, and remain effective over time.  
• An **inferior program** assumes that controls remain effective long after they are installed. |
| Implementation of controls is tracked to completion. Controls are inspected and maintained. | X | • An **effective program** includes a system to track progress in controlling hazards, (to ensure that hazard control is completed in a timely manner) and verifies that controls remain effective over time.  
• In an **inferior program**, management verbally assigns responsibility to control a hazard but does not follow up to ensure that the work is completed or that the control is effective. |

**SECTION 5: EDUCATION AND TRAINING**

<table>
<thead>
<tr>
<th>ACTION</th>
<th>Deficiencies</th>
<th>Guidance</th>
</tr>
</thead>
</table>
| Managers, supervisors, and Staff understand the elements of the safety and health program and how to participate in it. | None | X | • In an **effective program**, Staff are trained in all elements of program, with an emphasis on ways that they can be involved in both operating and continually improving it.  
• In an **inferior program**, Staff do not understand the elements of the program or how it is intended to operate |
| Staff understand the employers’ responsibilities under the program. | X | • An **effective program** empowers Staff to recognize deficiencies, question management, and point out lapses in management’s commitment  
• An **inferior program** does not encourage Staff to question management’s implementation of it. |
| Each worker understands his or her own role in the program. | X | • In an **effective program**, Staff know how to interact with the program, how to be involved, and what is expected of them.  
• In an **inferior program**, Staff are unsure of the mechanisms for participation. |
| Staff know whom to contact with concerns or questions, and understand the procedures for reporting injuries, incidents, hazards, and concerns. | X | • In an **effective program**, Staff are trained in the ways that they can report injuries, hazards, and concerns.  
• In an **inferior program**, Staff are directed to report only through their supervisors. |
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Deficiencies</th>
<th>Action</th>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff know that they have a right to participate in the program and report injuries and illnesses without fear of retaliation or discrimination.</td>
<td>X</td>
<td></td>
<td>• An <strong>effective program</strong> gives Staff a blame-free environment where they can report injuries, illnesses, hazards, and concerns without fear.</td>
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<tr>
<td></td>
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<td></td>
<td>• An <strong>inferior program</strong> uses blame, retaliation, or misguided incentive programs to discourage reporting.</td>
</tr>
<tr>
<td>Staff with assigned roles under the program receive training in how to carry out their roles.</td>
<td>X</td>
<td></td>
<td>• In an <strong>effective program</strong>, Staff expected to participate in inspections, incident investigations, or emergency response receive training for those duties.</td>
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<td></td>
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<td></td>
<td>• An <strong>inferior program</strong> assigns roles but gives minimal training or instruction.</td>
</tr>
<tr>
<td>Staff are trained to understand how to recognize hazards and effective techniques for their control.</td>
<td>X</td>
<td></td>
<td>• An <strong>effective program</strong> includes instruction on tools such as job hazard evaluations, and how to use them to identify hazards.</td>
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<td></td>
<td>• An <strong>inferior program</strong> gives Staff no role in controlling hazards, and thus no need for training.</td>
</tr>
<tr>
<td>Staff can ask questions, receive answers, and provide feedback during and after training.</td>
<td>X</td>
<td></td>
<td>• An <strong>inferior program</strong> gives Staff information, but not encouragement to ask questions and give feedback.</td>
</tr>
<tr>
<td>Employers, managers, and supervisors understand their responsibilities under the OSH Act; procedures for responding to Staff’ reports of injury, illness, or concern; techniques for identifying and controlling hazards; and fundamentals of incident investigation.</td>
<td>X</td>
<td></td>
<td>• In an <strong>effective program</strong>, managers and supervisors receive core safety and health competency training.</td>
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<td></td>
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<td>• An <strong>inferior program</strong> relies on a single person with no formal training for all safety and health-related expertise.</td>
</tr>
<tr>
<td>Staff receive supplemental training when a change in the workplace could introduce new or increased hazards.</td>
<td>X</td>
<td></td>
<td>• An <strong>effective program</strong> trains Staff about hazards related to new equipment or procedures and how to use them safely.</td>
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<td></td>
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<td></td>
<td>• In an <strong>inferior program</strong>, management installs new equipment and implements new procedures without informing Staff about safety and health concerns. Staff are expected to learn about the hazards of a new assignment “on the job.”</td>
</tr>
<tr>
<td>Staff receive training in a language and at a literacy level that all of them can understand.</td>
<td>X</td>
<td></td>
<td>• An <strong>effective program</strong> trains Staff in languages spoken in the workplace and at appropriate literacy levels.</td>
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<td></td>
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<td></td>
<td>• An <strong>inferior program</strong> provides &quot;one-size-fits-all&quot; training and does not account for differences in language or literacy.</td>
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</table>

**SECTION 6: PROGRAM EVALUATION AND IMPROVEMENT**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Deficiencies</th>
<th>Guidance</th>
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<tbody>
<tr>
<td>Performance indicators are used to track progress toward program goals.</td>
<td>X</td>
<td>• An <strong>effective program</strong> identifies key indicators of progress toward goals. Indicators are measurable and quantifiable.</td>
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<td></td>
<td></td>
<td>• An <strong>inferior program</strong> tracks only what is required by law.</td>
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<tr>
<td>Performance is tracked using both lagging and leading indicators.</td>
<td>X</td>
<td>• An <strong>effective program</strong> monitors indicators of program implementation, program participation, and program maturity.</td>
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<td></td>
<td></td>
<td>• An <strong>inferior program</strong> monitors only the incidence of workplace injuries and illnesses.</td>
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</table>
Performance data are analyzed and shared with Staff. | X | • An effective program features regular updates on performance, with Staff involved in evaluating progress.  
• An inferior program shares performance data only with managers.

Management does an initial review (and subsequent annual reviews) to evaluate the program and ensure that it is fully implemented and functioning as planned. | X | • An effective program is evaluated at least annually to determine if goals are being met, shortcomings are identified, and performance is continually improving.  
• In an inferior program, management assumes no improvement is needed after implementation. The program’s goals stay the same year after year.

Program reviews examine key processes to ensure that they are operating as intended. | X | • In an effective program, evaluations examine whether and how key processes are being used, such as injury/illness/incident reporting, inspections hazard control, and performance monitoring  
• In an ineffective program, evaluations focus mainly on progress toward goals.

The program is modified as needed to correct shortcomings. | X | • An effective program is modified as soon as deficiencies are detected or opportunities to improve arise. Controls for identified deficiencies are tracked to completion.  
• An inferior program is expected to operate effectively once implemented, without need for modification.

## SECTION 7: COMMUNICATION AND COORDINATION FOR HOST EMPLOYERS, CONTRACTORS, AND STAFFING AGENCIES

<table>
<thead>
<tr>
<th>ACTION</th>
<th>Deficiencies</th>
<th>Guidance</th>
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</table>
| Before contractors or staffing agencies bring their Staff onsite, they and the host employers determine which among them will implement the various elements of the safety and health program | None | • In an effective program, host employers and contractors/staffing agencies meet to review each other’s safety and health program and determine which actions each will take. Decisions are documented in the form of an agreement, letter of intent, memorandum of understanding, or contract documents.  
• In an ineffective program, host employers have no communication with contractors and staffing agencies about safety and health before they come onsite.  
• Lack of communication leads to omissions or conflicts that result in unsafe conditions. |

| Before contractors or staffing agencies bring their Staff onsite, host employers give them enough information to assess hazards those Staff may encounter, to understand the measures taken to control them (e.g., safety and health rules, when PPE is required, whom to contact in an emergency, etc.), and to avoid creating hazards that affect Staff on the site. | X | • An effective program gives contractors, staffing agencies, and their Staff access to information about hazards at the worksite and measures taken to control them (including, but not limited to, site safety and health rules, when personal protective equipment is required, whom to contact in an emergency, etc.). Contractors and staffing agencies adjust work practices and implement any additional controls needed to avoid creating new hazards while onsite.  
• In an ineffective program, contractors and staffing agencies learn of hazards only as they encounter them during their work. |

<p>| Contractors and staffing agencies inform the host employer about injuries, illnesses, hazards, or concerns | X | • In an effective program, contractors and staffing agencies promptly communicate with the host employer when their employees report an injury, illness, hazard, or |</p>
<table>
<thead>
<tr>
<th>Reported by their employees, and the results of any tracking or trend analysis that they perform.</th>
<th>X</th>
<th></th>
<th>An inferior program, information on injuries, illnesses, hazards, or concerns among contractor or staffing agency employees is not shared with the host employer.</th>
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<tbody>
<tr>
<td>Contractors and staffing agencies inform the host employer of any hazards arising from their work onsite and the controls in place to address those hazards.</td>
<td>X</td>
<td></td>
<td>In an effective program, before arriving at the site, contractors and staffing agencies inform the host employer and other employers at the site about the hazards inherent in their work and measures they will take to control them.</td>
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<td>An inferior program allows staff and contractor personnel to work in the same area without sharing information about hazards.</td>
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<tr>
<td>Before contractors or staffing agencies bring their Staff onsite, the host employer gives them the opportunity to conduct site visits or inspections and to review injury and illness records and other safety and health information.</td>
<td>X</td>
<td></td>
<td>An effective program informs contractors and staffing agencies and their Staff of hazards they will encounter, as well as site safety and health rules, hazard controls, and procedures. It does so by including contractor personnel and staffing agency Staff in general safety and health awareness training and allowing them to participate in site inspections before they begin work.</td>
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<td>An inferior program allows contractor personnel and staffing agency Staff to discover hazards on the job.</td>
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<tr>
<td>Host employers communicate with contractors and staffing agencies and their Staff about non-routine and emergency hazards and emergency procedures.</td>
<td>X</td>
<td></td>
<td>An effective program provides information and training to contractor personnel about emergency procedures before they start work.</td>
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<td></td>
<td>An inferior program does not anticipate that emergencies may affect contractor personnel.</td>
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<tr>
<td>Host employers include any safety-related specifications or qualifications in bid documents and contracts</td>
<td>X</td>
<td></td>
<td>In an effective program, host employers establish safety and health performance requirements and expectations in bid documents and contracts. Contractor and staffing agency qualifications and responses to performance requirements are considered during the selection process.</td>
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<td></td>
<td>In an inferior program, safety and health is not addressed during the selection of contractors or staffing agencies.</td>
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<tr>
<td>Host employers coordinate with contractors and staffing agencies to ensure that work is planned and scheduled to minimize impacts on safety and health</td>
<td>X</td>
<td></td>
<td>In an effective program, host employers, contractors, and staffing agencies coordinate on work planning, scheduling, and resolving program differences to identify and work out any concerns or conflicts that could affect safety or health.</td>
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<td>In an inferior program, scheduling issues and conflicts are not resolved until they occur.</td>
</tr>
<tr>
<td>Staffing agency Staff are adequately trained and equipped before arriving onsite.</td>
<td>X</td>
<td></td>
<td>In an effective program, host employers communicate any requirements for temporary worker training or equipment to staffing agencies before Staff arrive onsite. Staffing agencies have enough lead time to properly train and equip their Staff.</td>
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<td></td>
<td>In an inferior program, temporary Staff arrive at the worksite and begin work without having received training and without proper equipment.</td>
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<tr>
<td>Host employer, contractor, and staffing agency policies and procedures are aligned to ensure that all Staff receive</td>
<td>X</td>
<td></td>
<td>In an effective program, host employers, contractors, and staffing agencies review each other’s safety and health policies and procedures before work begins and resolve any discrepancies. All Staff onsite receive consistent safety and health information and messaging.</td>
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<td>• In an <strong>inferior program</strong>, Staff are confronted with inconsistent or conflicting information about safety and health issues, leading to confusion or lack of focus.</td>
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<td>consistent safety and health information.</td>
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<td></td>
<td>• In an <strong>effective program</strong>, all Staff onsite can identify and have access to someone responsible for resolving safety and health issues between host employers, contractors, and staffing agencies.</td>
</tr>
<tr>
<td>Staff have access to managers with decision-making authority, to resolve any coordination issues or discrepancies.</td>
<td>X</td>
<td>• In an <strong>inferior program</strong>, Staff are unsure whom to contact, or do not have access to the person expected to resolve safety and health issues.</td>
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</tbody>
</table>