INTRODUCTION

Penn State Milton S. Hershey Medical Center (PSHMC) is committed to fulfilling its mission and achieving its vision. PSHMC recognizes that there is a significant relationship between infections and patient safety. Healthcare-associated infections (HAIs) are one of the leading causes of morbidity and mortality in patients.

PURPOSE

The purpose of the organization’s Infection Prevention and Control Plan is to provide a systematic process for improving the health and safety of patients and healthcare workers. The plan provides for a comprehensive program that encompasses the surveillance, prevention, and control activities of HAIs with an emphasis on patient safety and promotion of best practices.

POSITION STATEMENT

PSHMC’s Position Statement on Care of Patients with Infectious Diseases states that regardless of diagnosis, it is the responsibility of all employees of PSHMC to fulfill the duties for which they were hired, and medical students and house officers to provide care for all patients assigned to them. In order to implement this position statement the Infection Control Committee has, with the approval of the Medical Staff Executive Committee, instituted the practice of "Standard Precautions" for all patients at PSHMC. Additionally, transmission-based precautions (Contact, Droplet, Airborne, Immune Only, and Special) are used for the care of patients in specific situations.
Although providing care to a patient with an illness caused by a transmissible agent may evoke fear, apprehension or other negative responses, refusal to care for the patient solely on that basis is inconsistent with the mission of PSHMC. Therefore, regardless of diagnosis, it is the responsibility of all employees of PSHMC to fulfill the duties for which they were hired or in the case of medical students and house officers to provide care for all patients assigned to them. Fulfillment of these responsibilities will be a requirement for continued employment or enrollment.

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OBJECTIVES

A. Prevent and/or reduce the risk of acquiring or transmitting HAIs among patients, physicians, staff, students, visitors, volunteers, and contract workers.

B. Establish effective measures for detecting, controlling, and preventing HAIs.

C. Establish culture surveillance processes and policies.

D. Develop a system to identify and designate patients known to be colonized or infected with Methicillin-resistant *Staphylococcus aureus* (MRSA), Carbapenem-resistant Enterobacteriaceae (CRE), or other multi-drug resistant organisms (MDROs) (screening populations, frequency of cultures and screening, timeframe and criteria for re-screening, precaution policies).

E. Develop, implement, and monitor infection prevention and control intervention protocols that are based on nationally recognized evidence-based standards and guidelines that address infection prevention, isolation precautions, appropriate use of antimicrobial agents, and physical plant operations.

F. Establish mandatory education programs for personnel addressing infection prevention and control procedures and activities.

G. Ensure compliance with all applicable state, federal, regulatory and accrediting agencies rules, laws and requirements.

H. Provide documentation to assist with the outreach process for notifying receiving health care facility or ambulatory surgical facility of any patient/resident known to be colonized prior to transfer.

I. Improve influenza vaccination rates in hospital staff with the goal of achieving >90% vaccinated by 2020. Incremental goals will be established annually and published in the Infection Prevention and Control Plan.

PROCEDURE

A. Scope of Care and Services

1. The scope of this plan includes all inpatient and outpatient services of PSHMC. Surveillance, prevention, and control of infections cover a broad range of processes and activities across the organization. Additionally, the Infection Prevention (IP) department collaborates with outside organizations to address infection prevention concerns.

2. The scope of this plan does not include or provide for procedures and protocols for staff who may have had potential exposure to a patient known to be colonized or infected with
MRSA or other MDRO, such as policies on culturing and screening of staff as well as prophylaxis and follow-up care; such policies are maintained by the Employee Health department.

3. The following services are provided by the IP department:

a. Development, review, and approval of guidelines and strategies for clinical care to identify, reduce, and/or prevent infections.

b. Education of patients, physicians, staff, students, visitors, volunteers, and contract workers on infection prevention activities. Education may be in the form of inservices (in person, use of multimedia), written material, collaboration with other departments to develop educational programs, consults, etc. Pertinent information is shared with patients and families upon admission in the Patient and Visitor Welcome Guide. IP provides inservice training to hospital staff and medical staff at PSHMC. All new employees, medical staff, students, volunteers, and ancillary staff receive information regarding infection precautions (i.e., Standard Precautions and Transmission-Based Precautions), HAIs, infection prevention and control measures, employee health issues of infectious concern, and prevention and control of bloodborne diseases and tuberculosis.

c. Reporting of surveillance findings on HAIs is available via the IP dashboard on the infonet for all staff. This information is also discussed at the Infection Control Committee meetings and with other groups as required. This information is used to identify opportunities for improvement and action.

d. Initiation of laboratory tests for surveillance activities as indicated (i.e., culture and sensitivity or antigen detection) under the direction of the Hospital Epidemiologist and/or Associate Hospital Epidemiologist and notification of the appropriate medical staff member of actions taken.

e. Initiation of appropriate epidemiological investigations or control measures when there is reasonable infectious risk to any patients or personnel of the organization, with the authority of the Infection Control Committee and under the direction of the Hospital Epidemiologists.

f. Participation with unit based accountable care teams (UACT) and other multi-disciplinary committees internally as well as collaboration with external organizations as indicated.

g. Performance of annual risk assessment to evaluate the risk of infections in the organization (or more frequently if indicated). Additionally, the organization utilizes a continuous electronic surveillance system (MedMined) that provides house wide monitoring and risk identification as well as alerts based on laboratory findings (i.e., culture reports, antigen detection, toxin assay).
h. Communicate Infection Control Committee recommendations to senior leadership for action, as indicated.

B. Functions and Prioritization

1. An interdisciplinary subgroup, consisting of members of the Infection Control Committee, performs an annual risk assessment to evaluate the risk of infections in the organization. This risk assessment is approved by the full Infection Control Committee and is used to prioritize and set goals for infection prevention and control activities based on the assessment results. Refer to Infection Prevention Policy III-18 Risk Assessment.

2. Refer to Attachment A for key infection prevention and control strategies for fiscal year 2014-2015.

C. Authority, Responsibility, and Reporting Structure

1. The IP department reports to the Director of Clinical Quality. The department works clinically under the direction of the Hospital Epidemiologist, Associate Hospital Epidemiologist, and the Infection Control Committee. There are six Infection Prevention Coordinators (IPC) (6 FTE) and one part-time (0.5 FTE) secretarial support staff member. The Epidemiologists and IPCs are qualified by experience or training.

2. The Infection Control Committee is a standing committee as defined by the Medical Executive Committee and reports to the Performance Improvement Committee. The Infection Control Committee meets a minimum of 5 times each fiscal year. On a monthly basis, the Hospital Epidemiologists consult with the IPPs to determine whether there are sufficient agenda items that require urgent management to require a full committee meeting that month. Each quarter a portion of the working group meeting is dedicated to Healthcare Associated Infection Prevention and Control Act of 2007 (Act 52) reporting requirements. This meeting includes all current members of the Infection Control Committee (working group) as well as the Patient Safety Officer and a Community Member. Separate minutes and a report are generated from this session and reported to the Patient Safety Committee on a regular basis.

   a. The Infection Prevention and Control Program functions under the direction of the Infection Control Committee by authority of the Medical Staff Executive Committee.

3. Facilities Activities

   a. As per defined protocol, IP is actively involved with the Facilities department to ensure that the environment of care is not a significant reservoir for pathogens. Activities with construction and renovation projects include:

      1) Review of projects from design through commissioning.
2) Participation at project meetings.

3) Completion and monitoring of Infection Control Risk Assessment (ICRA).

4) Documentation and communication of deficiencies identified, including follow up of activity taken to resolve.

5) Education of contractors, subcontractors, and facilities staff through regularly scheduled ICRA training sessions.

6) Assistance with policy development.

7) Attendance at Pennsylvania Department of Health (DOH) inspections as required/requested, including consultation as needed.

8) Input is provided as requested/required with issues that arise with regards to utilities.

b. Additionally, IP attends environmental rounds of inpatient and outpatient areas with feedback to units/areas of deficiencies noted.

4. Environmental Health Services

IP works closely with Environmental Health Services to decrease opportunities for the environment to be a reservoir for transmission of pathogens. This is accomplished by collaborative development of regular cleaning schedules and effective cleaning methods, consulting on development of policies and procedures, and selecting of appropriate cleaning agents and equipment as per policy.

5. Collaboration with Employee Health Services

The IP department and the Employee Health department work closely to reduce the risk of acquiring infectious diseases by employees, and reducing the risk to patients contracting a transmissible infection from a member of the hospital staff. The Employee Health department performs services in several general areas:

a. Employee assessment, screening, and vaccination.

b. Improve employee influenza vaccination rates through several modalities over upcoming seasons:

1) Goal for 2014/2015 is 89% vaccination rate.
2) Increase opportunities for employee vaccination at meetings, lectures, and highly frequented areas adjacent to the cafeteria.

4) Public display of clinical leaders receiving vaccine.

5) Communication by leadership of the expectation that all employees should receive vaccine with emphasis on aligning unit and department leadership to support this agenda.

6) If an employee declines vaccination, the employee will be asked to sign documentation acknowledging the risk potentially posed to patients and fellow employees. Employees who work in clinical areas that have not received the influenza vaccine must wear a surgical mask during influenza season whenever they are within six (6) feet of any patient (inpatient and outpatient), during clinical encounters (not in elevators, hallways, cafeteria, etc.). The start and end of influenza season will be determined by IP and the Hospital Epidemiologist based on local and regional influenza activity.

c. Employee follow-up following recognized exposure to communicable diseases/invasive incidents.

d. Employee evaluation for acute infectious diseases which manifest during working hours.

e. Routine MRSA surveillance screening of staff will not be performed at PSHMC. Screening/prophylaxis of employees will be done under the direction of the Hospital Epidemiologist or his/her designee only. There are no current standards that recommend universal screening for staff that care for patients colonized or infected with a MDRO.

6. Infection Control Committee

a. The Infection Control Committee is a multi-disciplinary committee that has the following responsibilities and duties:

1) Review and approve policies and standards related to infection surveillance, infection prevention and education, environmental control and utility management, and use of antimicrobial agents.

2) Review and approve infection prevention interventions during renovation and construction activities.

3) Review and approve the mechanisms and parameters of the programs for the surveillance and prevention of infections throughout PSHMC.
4) Make recommendations for purchasing of infection prevention-related equipment, supplies, and patient-care products with due concern for standardization, scientific data, and cost-effectiveness.

5) Provide input into the content and scope of the employee health program as it relates to prevention and control of infections.

6) Review and update the Infection Prevention Manual as well as review departmental policies and procedures as they relate to infection prevention and control. Additionally the committee makes recommendations to provide for patient and personnel safety.

7) Maintain written reports or document verbal reports given to the committee, and disseminate information as appropriate, reflecting the results of all monitoring activities performed and actions taken.

8) Review and make recommendations based on national standards for the appropriate use of antimicrobial agents.

9) Review data reflecting total antibiotic use patterns obtained by the Pharmacy Service and presented to the Infection Control Committee on a semi-annual basis. The report delineates total use in acquisition cost for each antibiotic.

b. The Infection Control Committee membership shall include at least one member from the departments of Medicine, Obstetrics and Gynecology, Orthopaedics, Pediatrics, Radiology (preferably an interventional radiologist), and Surgery. Additional members shall include the Hospital Epidemiologist, Children’s Hospital Epidemiologist, Infection Prevention Coordinators, Nurse Manager or Perioperative Director of the Operating Room, Nurse Manager or other representative of the SAICU, the Manager of Environmental Services, and representatives from Administration, Nursing Administration, Clinical Labs, Employee Health, Facilities, Dietary, Materials Management, Pharmacy, Safety, Medical Group and other ad-hoc representatives as appropriate.

c. The committee shall meet at a minimum 5 times per fiscal year. Medical staff members are required by the Medical Staff bylaws to attend at least 50% of committee meetings. Attendance records are forwarded to Medical Staff Affairs annually. In the event a member is unable to attend, a substitute representative should attend.

D. Planned Approach to Detecting, Controlling, and Preventing Healthcare Associated Infections
The purpose of surveillance is to continually improve patient safety, quality of care, and patient outcomes by monitoring the effectiveness of prevention and control strategies for our patient population.

1. Methods of Surveillance

   a. MedMined electronic data mining system

      1) Data mining surveillance system (DMSS) patterns: Patterns provide a method of ongoing risk assessment identifying significant changes in laboratory culture data occurring within the organization, including improvements. Patterns include specific referenced, evidence-based recommendations to aid in intervention activities. Patterns are reviewed on a regular basis. Patterns are shared with teams/committees as appropriate.

      2) Virtual Surveillance Interface (VSI): The VSI provides ongoing review of laboratory culture information in an effort to promptly identify outbreaks, as well as providing drill down capabilities for ongoing assessment of performance against goals. Any significant information is communicated to the departments or managers as appropriate.

      3) Nosocomial Infection Marker (NIM): The NIM is an electronic surrogate marker for the presence of an HAI. NIMs are received and reviewed weekly by the IP Coordinators. Using Centers for Disease Control and Prevention (CDC) definitions for infections, IP determines if a NIM meets the criteria for an HAI. All HAIs are entered into the National Healthcare Safety Network (NHSN). Reports are generated and shared with committees, departments and other outside entities, as noted above and as appropriate.

      4) The sentinel alert is set up to alert the IP Coordinators to monitor “organisms of interest” as defined by the program. This may be used to track MDROs, such as MRSA, vancomycin resistant Enterococcus (VRE), pan-resistant Acinetobacter species, extended spectrum beta-lactamase (ESBL) producing gram negative organisms, CRE, or other organisms of interest, such as influenza.

   b. Significant Findings Review: A significant findings log is generated by the Clinical Laboratory daily based on organisms identified by the IP Coordinators as important to know as soon as possible. Organisms identified include, but are not limited to, Neisseria meningitidis, acid fast bacilli, MRSA, VRE, Varicella, etc. These reports are reviewed frequently by the IP Coordinator to identify new cases of MRSA/VRE, to identify reportable diseases and conditions, or to initiate an exposure investigation.

   c. Surgical Site Infection Surveillance: Surveillance for surgical site infections is conducted utilizing wound and other appropriate NIMs, admission diagnoses and reports from providers, clinics or other institutions as methods of data collection. This
information is reported to the Infection Control Committee and the Surgical Care Improvement Project (SCIP) team, and others as appropriate for analysis and action as indicated.

d. MDRO Surveillance: MDRO surveillance is performed regularly. A risk assessment was conducted reviewing cases of MRSA, VRE and resistant gram negative organisms. The isolates of resistant gram negative organisms continue to be sporadic and/or in relatively small numbers and would be reviewed on a case by case basis. MRSA was previously an organizational initiative and cases of HAIs with MRSA will continue to be tracked as part of the Joint Commission National Patient Safety Goals.

1) New cases of MRSA/VRE are identified based on laboratory cultures, review of continuous task list in Powerchart, surveillance screening (MRSA only) reported to IP via fax, and reporting of patients who are positive by healthcare providers/others in the organization who may become aware of new cases. New cases are investigated by the IPCs to identify whether they are healthcare associated, community acquired, or reported as having a prior history. Ongoing review of these cases is used to identify possible transmission within the organization. Staff members are notified by the laboratory of any abnormal findings as per the laboratory protocol.

2) Surveillance is conducted via MedMined and the significant findings report from the laboratory for resistant gram negative organisms.

e. Screening of High Risk Patients

1) MRSA PCR Screening: The process for screening inpatients for MRSA via polymerase chain reaction (PCR) was begun in 2007, in an effort to identify potentially colonized patients early in their hospital stay and to use contact precautions to reduce transmission of MRSA. Screening PCRs are being done on patients admitted to all units in the hospital except labor and delivery and well newborn nursery who are not already known to be positive. Screening PCRs are done upon admission to the hospital and every seven days the patient remains hospitalized.

2) Precautions Policy for Patients Identified to be Colonized or Infected with MRSA: Please refer to Infection Prevention Policy V-4 Contact Precautions.

2. Transfer of MRSA/MDRO Patients to Other Institutions, Home Care, or Community

a. Care coordinators and social workers will notify all potential placement facilities and/or home health care agencies of the patient’s MRSA/MDRO status when the first referral contact/discussion occurs.
b. Patients will not be transferred to another facility or home health agency until that facility or agency acknowledges acceptance of the patient and awareness that the patient is known to be MRSA/MDRO positive.

c. If a patient’s discharge is delayed due to a receiving facility or agency’s denial to accept that patient solely based on their MRSA/MDRO status, PSHMC IP is to be notified by the care coordinator. IP will then contact the IP Coordinator at the receiving facility to review the basis for denial and DOH regulations. The PSHMC IP Coordinator will advise the care coordinator of the conversation and the status of the transfer.

E. Quality and Performance Improvement Program

1. The purpose of the PSHMC Performance Improvement Plan and accompanying programs is to demonstrate a systematic process for prioritizing and improving those important organizational and patient care functions that have the greatest impact on patient care and safety and those issues that are considered high risk, high volume, problem-prone, or associated with high cost. The process is driven by the patient-focused functions, organization functions and structures with functions as outlined in Policy A-63 HAM Performance Improvement Plan, as well as improvement opportunities identified through monitoring processes within the organization.

F. Patient Safety Program

1. The purpose of the PSHMC Patient Safety Program is to improve patient safety and reduce risk to patients through an environment that encourages:

   a. Recognition and acknowledgement of risks to patient safety and medical/health care errors.

   b. The initiation of actions to reduce these risks.

   c. The internal reporting of what has been found and the actions taken.

   d. A focus on processes and systems.

   e. Minimization of individual blame or retribution for involvement in a medical/health care error.

   f. Organizational learning about medical/health care errors.

   g. Support of the sharing of that knowledge to effect behavioral changes in itself and other health care organizations.
h. Appropriate disclosure is made to patients, and when appropriate, their families, of information regarding the outcomes of their care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. Please refer to *A-62 HAM Disclosure of Unanticipated Outcomes, Serious Events, & Sentinel Events*, *A-09 HAM Occurrence Reporting Policy*, and *A-48 HAM Sentinel Event Policy*.

2. HAI Disclosure Process

a. Serious Event (as defined per Act 52): The occurrence of a CDC-defined HAI in a hospital is deemed a Serious Event as defined by the MCARE Act section 302. If an infection meets the criteria for reporting to NHSN, that infection shall be reported to the Patient Safety Authority as a serious event as required by Act 13 and Act 52, subject to the additional requirements described in the Pennsylvania Bulletin Notice dated March 1, 2008. The Patient Safety Authority has access to NHSN.

b. HAIs reported through NHSN are subject to the same patient notification requirements set forth by Act 13 for all serious events. For purposes of meeting the 24-hour reporting requirement for serious events set forth by Act 13, hospitals must submit reports of HAIs to the NHSN system within 24 hours of their confirmation. In addition, serious event disclosure letters must be completed for all infections submitted through NHSN.

c. Verbal disclosure for a CDC-defined HAI serious event is provided by the attending physician, or designee, to the patient affected by a serious event or, with the consent of the patient, to an available family member or designee.

1) If the patient is unable to give consent, the notification shall be given to an adult member of the immediate family.

2) If an adult member of the immediate family cannot be identified or located, notification shall be given to the closest adult family member.

3) For unemancipated patients who are under 18 years of age, the parent or guardian shall be notified.

d. Written disclosure for a CDC-defined HAI serious event is provided by the IP department to the patient affected by a serious event. If the patient is an unemancipated minor under 18 years of age or is deceased, the notification is given to the nearest legal representative listed in the patient’s medical record.

e. The IP department maintains the Act 52 written disclosure database.

G. Conflict of Interest
Physicians or personnel involved in Performance Improvement activities will not perform the review of any case in which he/she is personally or professionally involved.

H. Confidentiality

1. The Infection Control Committee receives the same confidentiality protections granted by the Patient Safety Committee under Act 13 of 2002. Therefore, all documents, materials, or information prepared by, or review and analysis performed by the medical staff or organizational personnel for the purposes of infection prevention and control and in accordance with the peer review process and this Infection Prevention and Control Plan are confidential and protected by Act 13.

2. All individuals participating in review activities will maintain confidentiality of information.

3. The functions of infection prevention and control are performed in a manner that protects patient, physician, and caregiver confidentiality.

4. The records are regarded as confidential and are made available only to duly authorized representatives of the hospital and medical staff, accrediting, licensing or inspecting bodies, and other appropriate governmental/fiscal agencies, as indicated.

5. All data are secured in the Risk Management, Patient Safety and Quality Services department to prevent loss or use by unauthorized individuals.

I. Annual Review

The objectives, scope, organization and mechanisms for overseeing the effectiveness of monitoring, assessing, evaluating and problem solving activities in the Infection Prevention and Control Plan are evaluated annually and revised as necessary. Included in this review is the assessment by the PSHMC Board of Directors and leaders of the adequacy of allocation of human, information, physical, and financial resources in support of identified healthcare associated infection and prevention priorities and activities, performance improvement, safety improvement and risk reduction priorities and activities.

REFERENCES

Healthcare Associated Infection Prevention and Control Act of 2007 (ACT 52)

Medical Care Availability and Reduction of Error (MCARE) Act of 2002 (ACT 13)

POSITION RESPONSIBLE FOR REVIEW OF PROCEDURE

Infection Prevention Coordinator
Director, Clinical Quality
Hospital Epidemiologist

12/07  
revised: 04/08  
revised: 01/10  
revised: 10/10  
revised: 02/12  
revised: 05/12  
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<td>Infection Prevention and Control Plan</td>
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Attachment A

KEY INFECTION PREVENTION AND CONTROL FOCUS AREAS AND PRIORITIES
FISCAL YEAR 2014 - 2015

The following have been selected as the fiscal year 2014-2015 key infection prevention and control focus areas and priorities. Selection was based upon evaluation of the 2012–2013 Infection Prevention and Control Plan and program results, surveillance activities, HAI prevention project outcomes and lessons learned, as well as the fiscal year 2013-2014 Risk Assessment outcomes.

Prevent and/or reduce the risk of acquiring or transmitting HAIs among patients and staff:

- **Reduce number of HAIs by 10%**
  Target – 280 (including SSI, CAUTI, CLABSI, Cdiff)

- **Central Line Associated Bloodstream Infections (CLABSI)**
  Target – Standardized Infection Ration (SIR) ≤ 0.59

- **Catheter Associated Urinary Tract Infections (CAUTI)**
  Target – SIR ≤ 1.00

- **CDI Lab ID**
  Target – SIR ≤ 1.00

- **Multi-drug Resistant Organisms Prevalence (MDROs)**
  Due to the national increase of MDROs, organisms with specific resistance patterns are included as part of daily surveillance in an attempt to identify clusters should they occur.

- **Appropriate Hand Hygiene Compliance**
  The Joint Commission “wash in, wash out” hand hygiene program was newly operationalized encompassing all inpatient and outpatient units with a goal to ultimately achieve ≥ 98% overall compliance across the organization.

- **HighMark Surgical Site Infection**
  Inpatient SSI target - ≤ 1.30
  Outpatient SSI target - ≤ 0.13

- **Joint Commission National Patient Safety Goal compliance – Reduce the risk of HAIs**
  - Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.
  - Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.
- Implement evidence-based practices to prevent central line–associated bloodstream infections.
- Implement best practices for preventing surgical site infections.
- Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI)

- **Other activities to prevent and/or reduce HAIs include, but are not limited to, the following:**
  - Working toward the goal of standardization of cleaning and disinfection practices of medical devices (i.e. scopes, ultrasound probes) that require high level disinfection.
  - Working toward the goal of standardization of cleaning practices of equipment that require low level disinfection.
  - Unit-based IP staff to be members of unit based accountable care teams (UACT) to enhance accessibility and communication with units.