This draft pilot worksheet does not reflect current CMS policy and will not be used during current surveys. The questions on the worksheet reflect NPRM language and will be tested during pilot surveys that will not result in citations. There is no CMS commitment to use this tool, or any version, on future surveys after the regulatory language is finalized and implemented.

Draft Centers for Medicare and Medicaid Services
Pilot Hospital Infection Control Worksheet

The following is a list of items that will be assessed during on-site surveys, in order to determine federal regulatory compliance with the Infection Prevention and Control in hospitals. Criteria are to be evaluated through a combination of observation; interviews with staff, patients and their family/support persons; review of medical records and of any necessary infection control program documentation**.** During the survey, observations or concerns may prompt the surveyor to request and review specific hospital policies and procedures. Surveyors are expected to use their judgment and review only those documents necessary to investigate their concern(s) or to validate their observations.
For these unique educational pilot testing surveys, the contracted surveyors will be reviewing ***all*** program documentation for which the worksheet prompts. Additionally, the facilities chosen for sampling will be such that support the increased opportunity for surveyors to observe ***all*** care required to adequately answer worksheet questions. It is understood this approach is for testing purposes only and does not prohibit the final product from utilizing a different survey information gathering process such as one that bases further investigation upon "triggered" areas of concern.

As stated in the SC17-09 policy memorandum released on November 18, 2016; while no citations will be issued, if an Immediate Jeopardy deficiency is noted, a referral to the CMS Regional Office will be made.

Note: Significant breaches of infection control practices would require notification of state health department.

Hospital Characteristics

Hospital Name:	
CMS Certification Number	☐☐☐ ☐☐☐
Start date/time:	____/____/____ and _____AM/PM
End date/time:	____/____/____ and _____AM/PM

Module 1: Infection Prevention Program

Section 1.A. Infection Prevention Program and Resources

Elements to be assessed		Surveyor Notes
1.A.1 The hospital has designated one or more individual(s) responsible for the infection prevention and control program, who is/are appointed by the governing body based on recommendations of the medical staff leadership and nursing leadership.	○ Yes ○ No	
1.A.2 The hospital can provide evidence that the Infection Preventionist, IP(s)/Infection Control Professional, ICP(s) is/are qualified and maintain(s) qualifications through education, training, experience or certification related to infection control consistent with hospital policy.	○ Yes ○ No	
1.A.3 The hospital can provide evidence that the hospital has developed general infection prevention and control policies and procedures that are based on nationally recognized guidelines and applicable state and federal law.	○ Yes ○ No	
1.A.4 The hospital provides evidence of compliance with reportable diseases requirements of the local health authority.	○ Yes ○ No	
1.A.5 The hospital can provide documentation of actions taken to address any infection control issues identified by public health authorities.	○ Yes ○ No	
1.A.6 The infection prevention and control program reflects the scope and complexity of the hospital services provided. Note: Note: For example, a hospital that offers an organ transplant program (contrasted with a hospital that does not offer an organ transplant program) would be expected to have an infection prevention and control program that addresses infection issues specific to the organ transplant patient.	○ Yes ○ No	
1.A.7 The hospital can provide evidence that the hospital performs an annual facility infection risk assessment that evaluates and prioritizes potential risks for infection, contamination, and exposures and the infection prevention and control program's preparedness to eliminate or mitigate such risks	○ Yes ○ No	
1.A.8 The governing body ensures that surveillance systems are actively tracking all infection prevention and control and antibiotic use activities.	○ Yes ○ No	

1.A.9 The IP(s/ICP(s) are responsible for all documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.	○ Yes ○ No	
1.A.10 The hospital has infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, including the requirement for an infection control risk assessment (ICRA) to define the scope of the project and need for barrier measures before a project gets underway.	○ Yes ○ No	

Section 1.B. Hospital QAPI Systems Related to Infection Prevention

Elements to be assessed		Surveyor Notes
The hospital infection prevention and control program is coordinated with the hospital QAPI program as evidenced by:		
1.B.1 The hospital can provide evidence that HAIs and other infections identified in the infection prevention and control program are addressed in collaboration with the hospital QAPI program (i.e., development and implementation of corrective interventions, and ongoing evaluation of interventions implemented for both success and sustainability).	○ Yes ○ No	
1.B.2 The hospital tracks healthcare personnel exposure events, evaluates event data, and develops corrective action plans to reduce the incidence of such events.	○ Yes ○ No	
1.B.3 The hospital utilizes a risk assessment process to prioritize selection of quality indicators for infection prevention and control.	○ Yes ○ No	
1.B.4 The hospital has policies and procedures to prevent the diversion of scheduled drugs.	○ Yes ○ No	

1.B.5 The hospital has a system to track movement of all scheduled drugs from point of entry into the hospital to point of departure (administration to the patient, destruction, or return to the manufacturer).	○ Yes ○ No	
1.B.6 The hospital can provide evidence that data from the tracking system is regularly reviewed and discrepancies or unusual access patterns are investigated in a timely manner.	○ Yes ○ No	
1.B.7 The hospital can provide evidence that patient safety risks (e.g., exposure to pathogens) are assessed, in consultation with the infection prevention program, when diversion involving tampering or substitution is identified.	○ Yes ○ No	
1.B.8 The hospital can provide evidence that appropriate authorities, in accordance with State and Federal laws, are notified when diversion is identified.	○ Yes ○ No	
1.B.9 The hospital can provide evidence that medication control policies and procedures are evaluated whenever diversion is identified and necessary systems and processes are implemented to ensure identified gaps are corrected.	○ Yes ○ No	
1.B.10 The hospital tracks healthcare personnel exposure events, evaluates event data, and develops and implements corrective action plans to reduce the incidence of such events.	○ Yes ○ No	

Section 1.C. Systems for the Surveillance, Prevention, and Control of Healthcare-Associated Infections and Other Infectious Diseases

Elements to be assessed		Surveyor Notes
1.C.1. The hospital has a system in place for early detection and management of potentially infectious persons at initial points of entry to the hospital, including rapid isolation as appropriate. Note: Travel history and previously identified infections in other health care facilities are included as part of admission protocols.	○ Yes ○ No	

1.C.2 The hospital has a respiratory/hygiene cough etiquette program to prevent transmission of respiratory pathogens at points of entry to the hospital and in other waiting/common areas.	○ Yes ○ No	
1.C.3 The hospital has a surveillance program to monitor incidence of epidemiologically important organisms targeted for prevention and control. Note: Infectious agents may be considered epidemiologically important based on the following characteristics: propensity for transmission within healthcare facilities, association with serious clinical disease, antibiotic resistance to first-line therapies or multiple classes of agents, unusual patterns of resistance, newly discovered or reemerging pathogen. Please refer to CDC's Guideline for Isolation Precautions for further details: https://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf	○ Yes ○ No	
1.C.4 The hospital has policies and procedures to minimize the risk of healthcare-associated infections and transmission of targeted epidemiologically important organisms within the hospital. Note: Hospitals defines epidemiologically important organisms as: Infectious agents that have one or more of the following characteristics: 1) are readily transmissible; 2) have a proclivity toward causing outbreaks; 3) may be associated with a severe outcome; or 4) are difficult to treat. CDC Isolation Guidelines	○ Yes ○ No	
1.C.5 The hospital uses surveillance data to implement corrective actions rapidly when increased rates of healthcare-associated infections or transmission of targeted epidemiologically important organisms are detected.	○ Yes ○ No	
1.C.6 The hospital has systems in place for early detection and management of infectious patients identified during the hospital stay, including rapid isolation of patients as appropriate. Note: System includes prompt notification of the IP by the clinical microbiology laboratory when epidemiologically important organisms (e.g. new novel or targeted antibiotic-resistant organisms are detected).	○ Yes ○ No	
1.C.7 Hospital has policies and procedures to minimize exposure of medications and medical equipment to tap water.	○ Yes ○ No	
1.C.8 Hospital has a water management program to reduce the risk of *Legionella* growth and spread. Note: Please see https://www.cdc.gov/legionella/downloads/toolkit.pdf for key elements of a water management program.	○ Yes ○ No	
1.E.9 The hospital follows recommendations of the Advisory Committee on Immunization Practices (ACIP) for immunization of healthcare personnel, including offering hepatitis B and influenza vaccination.	○ Yes ○ No	

Section 1.D. Systems for the Optimization of Antibiotic Use Through Stewardship

Elements to be assessed		Surveyor notes
1.D.1The hospital has an active hospital-wide program for optimizing antibiotic use through stewardship.	○ Yes ○ No	
1.D.2 An individual who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship is appointed by the governing body as the leader of the antibiotic stewardship program based on the recommendations of medical staff and pharmacy leadership.	○ Yes ○ No	
1.D.3 A pharmacist who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship provides drug expertise to the antibiotic stewardship program.	○ Yes ○ No	
1.D.4 Antibiotic stewardship program follows nationally recognized guidelines for improving antibiotic use.	○ Yes ○ No	
1.D.5 Antibiotic stewardship program reflects scope and complexity of hospital services provided.	○ Yes ○ No	
1.D.6 Antibiotic stewardship program includes competency-based training and education of hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on the practical application of antibiotic stewardship guidelines, policies, and procedures.	○ Yes ○ No	
1.D.7 Antibiotic stewardship program demonstrates coordination among all components of the hospital responsible for antibiotic use and resistance, including the infection prevention and control program, QAPI program, medical staff, nursing services, and pharmacy services.	○ Yes ○ No	
1.D.8 Antibiotic stewardship program documents the evidence-based use of antibiotics in all departments and services of the hospital.	○ Yes ○ No	
1.D.9 Antibiotic stewardship program tracks antibiotic use and demonstrates sustained improvements in appropriate antibiotic use in all departments and services of the hospital.	○ Yes ○ No	

Section 1.E. Infection Prevention Systems, and Training Related to Personnel

Elements to be assessed		Surveyor Notes
1.E.1 The hospital can provide evidence of documented job-specific training for all healthcare personnel on hospital infection control practices, policies, and procedures upon hire, and at least annually.	○ Yes ○ No	
1.E.2 The hospital can provide evidence that its training programs address problems identified by the IP(s)/ICP(s).	○ Yes ○ No	
1.E.3 The hospital infection control system trains personnel for whom contact with blood or other potentially infectious material is anticipated on the OSHA blood borne pathogens standards upon hire, as needed and at least annually.	○ Yes ○ No	
1.E.4 The hospital infection control system puts in place and monitors efforts to prevent needle sticks, sharps injuries, and other employee exposure events.	○ Yes ○ No	
1.E.5 Following an exposure incident, post-exposure evaluation and follow-up, including prophylaxis as appropriate, is available to the individual and performed by or under the supervision of a practitioner.	○ Yes ○ No	
1.E.6 The hospital's respiratory protection program details required worksite-specific procedures and elements for required respirator use and ensures that respiratory fit testing is provided at regular intervals to personnel at risk.	○ Yes ○ No	
1.E.7 Hospital has well-defined policies concerning contact of personnel with patients when personnel have potentially transmissible conditions. Note: The hospital provides education to personnel on need for prompt reporting of illness to supervisor and/or occupational health. The hospital has work-exclusion policies that encourage reporting of illnesses and does not penalize with loss of wages, benefits, or job status.	○ Yes ○ No	

Section 1.F. Infection Prevention, Stewardship, and Responsibility of Care During Care Transitions

Elements to be assessed		Surveyor Notes
Intent: To prevent the transmission of infections and maintain continuity of care during transitions of care		
1.F.1 The hospital has a process and can demonstrate evidence that communication of patient information to receiving (e.g. nursing home) providers includes direct contact information [name, phone number, email] for patient's treating clinician (MD, APN, PA), transferring nursing unit, and case manager (if applicable) before or at the time of transfer? See http://www.cdc.gov/hai/pdfs/toolkits/InfectionControlTransferFormExample1.pdf for the Inter-facility Infection Control Transfer Form.	○ Yes ○ No	
1.F.2 The hospital has a process and can demonstrate evidence that communication of patient infection, colonization or known history of positive culture with multidrug-resistant organism, *C. difficile,* or other epidemiologically important organism (e.g. scabies) is sent to receiving provider before or at the time of transfer?	○ Yes ○ No	
1.F.3 The hospital has a process and can demonstrate evidence that communication of the presence of clinical signs or symptoms of potentially communicable diseases (e.g., vomiting, diarrhea, cough) is sent to receiving provider before or at the time of transfer?	○ Yes ○ No	
1.F.4 The hospital has a process and can demonstrate evidence that communication of critical information regarding central lines and urinary catheters (i.e. insertion date, rationale), or other medical devices, is sent to receiving provider before or at the time of transfer?	○ Yes ○ No	
1.F.5 The hospital has a process and can demonstrate evidence that communication of the rationale and use of transmission-based precautions/PPE is sent to receiving provider before or at the time of transfer (e.g. C difficile with diarrhea)?	○ Yes ○ No	
1.F.6 The hospital has a process and can demonstrate evidence that communication of current or recent (i.e. within past 7 days) antibiotic use, which includes dose, route, indication, start date/stop date, and date and time of last antibiotic administered is sent to receiving provider before or at the time of transfer?	○ Yes ○ No	
1.F.7 The hospital verifies that critical medications and equipment is available at the receiving facility at the time of transfer to prevent disruptions in the continuity of care (e.g., IV antibiotics and administration equipment).	○ Yes ○ No	

1.F.8 The hospital has a process for and can demonstrate evidence that they have sent additional information about potentially transmissible infections, resistant organisms, and antibiotic use if missing or unavailable at the time of patient arrival at the nursing home.	○ Yes ○ No	
1.F.9 The hospital has evidence that essential information about potentially transmissible infections, resistant organisms, and antibiotic use is reviewed and addressed (e.g. transmission-based precautions) at the time of patient arrival from a transferring facility (e.g. nursing home)?	○ Yes ○ No	

Module 2: General Infection Prevention Elements - to be applied to all locations providing patient care .

Section 2.A. Hand Hygiene

Elements to be assessed		Surveyor Notes
Hand hygiene is performed in a manner consistent with hospital infection control practices, policies, and procedures to maximize the prevention of infection and communicable disease including the following: Note: Observations for compliance with hand hygiene elements should be assessed throughout the hospital.		
2.A.1 Soap, water, and a sink are readily accessible in appropriate locations including, but not limited to, patient care areas and food and medication preparation areas. Note: Medications should not be prepared near areas of splashing water (e.g. within 3 feet of a sink). Alternately when space is limited, a splash guard can be mounted beside the sink.	○ Yes ○ No	
2.A.2 Alcohol-based hand rub is readily accessible and placed in appropriate locations. The locations may include: • Entrances to patient rooms, • At the bedside, • In individual pocket-sized containers carried by healthcare personnel, • Staff workstations, and/or • Other convenient locations.	○ Yes ○ No	

2.A.3 Personnel perform hand hygiene: • Before contact with the patient • Before performing an aseptic task (e.g., insertion of IV or urinary catheter)	○ Yes ○ No	
2.A.4 Personnel perform hand hygiene: • After contact with the patient • After contact with blood, body fluids, or visibly contaminated surfaces • After removing gloves	○ Yes ○ No	
2.A.5 The hospital hand hygiene policies promote preferential use of alcohol-based hand rub (ABHR) over soap and water in most clinical situations. Note: Soap and water should be used when hands are visibly soiled (e.g., blood body fluids) and is also preferred after caring for a patient with known or suspected *C. difficile* or norovirus during an outbreak or if rates of *C. difficile* infection in the facility are persistently high.	○ Yes ○ No	
2.A.6 Personnel do not wear artificial fingernails and/or extenders when having direct contact with patients at high risk of infection (e.g., those in intensive care units or ORs) per hospital policy.	○ Yes ○ No	
2.A.7 The hospital can provide evidence that all healthcare personnel have documented training and competency to perform proper hand hygiene.	○ Yes ○ No	
2.A.8 The hospital can provide evidence that routine audits of adherence to hand hygiene policies are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	

Section 2.B. Injection Practices and Sharps Safety (Medications and Infusates)

Elements to be assessed		**Surveyor Notes**
Injections are given and sharps safety is managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
2.B.1 Injections are prepared using aseptic technique in an area that has been cleaned and is free of contamination (e.g., visible blood, or body fluids).	○ Yes ○ No ○ Unable to observe	
2.B.2 Needles are used for only one patient.	○ Yes ○ No ○ Unable to observe	
2.B.3 Syringes are used for only one patient (this includes manufactured prefilled syringes).	○ Yes ○ No ○ Unable to observe	
2.B.4 Insulin pens are used for only one patient.	○ Yes ○ No ○ Unable to observe	
2.B.5 The rubber septum on all medication vials, whether unopened or previously accessed, is disinfected with alcohol prior to piercing.	○ Yes ○ No ○ Unable to observe	

2.B.6 Medication containers are entered with a new needle. Note: Reuse of syringes and/or needles to enter a medication container contaminates the contents of the container, making the container unsafe for use on additional patients. If a surveyor sees needles or syringes being reused to enter a container to obtain additional medication for the same patient, no citation should be made if the container is discarded immediately.	○ Yes ○ No ○ Unable to observe	
2.B.7 Medication containers are entered with a new syringe. Note: Reuse of syringes and/or needles to enter a medication container contaminates the contents of the container making the container unsafe for use on additional patients. If a surveyor sees needles or syringes being reused to enter a container to obtain additional medication for the same patient, no citation should be made if the container is discarded immediately.	○ Yes ○ No ○ Unable to observe	
2.B.8 Medication containers labeled for single dose – single use are only used for one patient.	○ Yes ○ No ○ Unable to observe	
2.B.9 Bags of IV solution are used for only one patient (and not as a source of flush solution for multiple patients).	○ Yes ○ No ○ Unable to observe	
2.B.10 Medication administration tubing and connectors are used for only one patient.	○ Yes ○ No ○ Unable to observe	

2.B.11 Multi-dose vials are dated when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) beyond-use date for that opened vial. Note: The beyond-use date is different from the expiration date printed on the vial by the manufacturer. The beyond-use date should never exceed the expiration date. The multi-dose vial can be dated by the hospital with either the date opened or the discard date as per hospital policy, as long as it is clear what the date represents and the same policy is used consistently throughout the hospital.	○ Yes ○ No ○ Unable to observe	
2.B.12 Multi-dose medication vials used for more than one patient are stored appropriately and do not enter the immediate patient treatment areas (e.g., operating room, patient room, anesthesia carts). Note: If multi-dose vials enter the immediate patient treatment area, they must be dedicated for single patient use and discarded immediately after use.	○ Yes ○ No ○ Unable to observe	
2.B.13 All sharps are disposed of in puncture-resistant sharps containers.	○ Yes ○ No	
2.B.14 Sharps containers are replaced when the fill line is reached.	○ Yes ○ No	
2.B.15 Sharps containers are disposed of appropriately as medical waste.	○ Yes ○ No	
2.B.16 The hospital can provide evidence that all healthcare personnel who prepare and/or administer injections and parenteral infusions have documented training and competency to perform the procedures using safe injection practices.	○ Yes ○ No	
2.B.17 The hospital can provide evidence that routine audits of adherence to safe injection practices are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	

Section 2.C. Personal Protective Equipment (PPE) for Standard Precautions

Elements to be assessed		Surveyor Notes
Personal protective equipment is utilized in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
2.C.1 Supplies for adherence to Standard Precautions using PPE (e.g., gloves, gowns, mouth, eye, nose, and face protection) are available and located near point of use.	○ Yes ○ No	
2.C.2 Personnel wear gloves for procedures/activities where contact with blood and/or other potentially infectious materials, mucous membranes, non-intact skin or potentially contaminated intact skin could occur.	○ Yes ○ No	
2.C.3 Healthcare personnel change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	○ Yes ○ No ○ Unable to observe	
2.C.4 Gowns are worn to prevent contamination of skin and clothing during procedures/activities where contact with blood, body fluids, secretions, or excretions could occur.	○ Yes ○ No ○ Unable to observe	
2.C.5 Gowns and gloves are removed and hand hygiene is performed before leaving the patient's room or care area (e.g. including moving to another patient).	○ Yes ○ No	

2.C.6 Appropriate mouth, nose and eye protection is worn for aerosol-generating procedures and/or procedures/activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions.	○ Yes ○ No ○ Unable to observe	
2.C.8 The hospital can provide evidence that all healthcare personnel who use PPE have documented training and competency to properly select and use PPE, including proper donning and doffing.	○ Yes ○ No	
2.C.9 The hospital can provide evidence that routine audits of adherence to proper use of PPE are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	

Section 2.D. Environmental Services

Elements to be assessed		Surveyor Notes
The hospital infection prevention and control program maintains a clean and sanitary environment to avoid sources and transmission of infection. Environmental service are provided in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
2.D.1 During environmental cleaning procedures, personnel wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection).	○ Yes ○ No ○ Unable to observe	
2.D.2 Environmental surfaces in patient care areas are cleaned and disinfected, using an EPA-registered disinfectant when spills occur and when surfaces are visibly contaminated, and on a regular basis (e.g., daily). Note: High-touch surfaces (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected more frequently than minimal-touch surfaces.	○ Yes ○ No ○ Unable to observe	

2.D.3 After a patient vacates a room, all visibly or potentially contaminated surfaces are thoroughly cleaned and disinfected and towels and bed linens are replaced with clean towels and bed linens.	○ Yes ○ No ○ Unable to observe	
2.D.4 Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ Unable to observe	
2.D.5 Separate clean (laundered if not disposable) cloths are used to clean each room and corridor.	○ Yes ○ No ○ Unable to observe	
2.D.6 Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques (e.g., following manufacturer instructions when laundering microfiber items).	○ Yes ○ No ○ Unable to observe	
2.D.7 The hospital decontaminates spills of blood or other body fluids according to its policies and procedures, using appropriate EPA-registered hospital disinfectants.	○ Yes ○ No ○ Unable to observe	
2.D.8 The hospital has established and follows a schedule for areas/equipment to be cleaned/serviced regularly (e.g., HVAC equipment, refrigerators, ice machines, eye wash stations, scrub sinks).	○ Yes ○ No	
Laundry is processed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
2.D.9 Personnel handle soiled textiles/linens with minimum agitation to avoid contamination of air, surfaces, and persons.	○ Yes ○ No	

2.D.10 Soiled textiles/linens are bagged or otherwise contained at the point of collection in leak-proof containers or bags and are not sorted or rinsed in the location of use. Note: Covers are not needed on contaminated textile hampers in patient care areas.	○ Yes ○ No	
2.D.11 The receiving area for contaminated textiles is clearly separated from clean laundry areas and is maintained at negative pressure compared with the clean areas of the laundry in accordance with FGI (formerly AIA) construction standards in effect during the time of facility construction.	○ Yes ○ No	
2.D.12 If hospital laundry services are contracted out and performed offsite, the contract must show evidence that the contractor's laundry service meets these design standards.	○ Yes ○ No ○ N/A	
2.D.13 Clean textiles are packaged, transported, and stored in a manner that ensures cleanliness and protection from dust and soil.	○ Yes ○ No	
Reprocessing of non-critical items is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
2.D.14 Reusable noncritical patient-care devices (e.g., blood pressure cuffs, oximeter probes) are disinfected on a regular basis (e.g., after use on each patient, once daily, or once weekly) and when visibly soiled.	○ Yes ○ No	
2.D.15 Hospital has policies that clearly define responsibilities for cleaning and disinfection of non-critical equipment, mobile devices, and other electronics (e.g., ICU monitors, ventilator surfaces, bar code scanners, point-of-care devices, mobile work stations, code carts, airway boxes).	○ Yes ○ No	
2.D.16 Manufacturers' instructions for cleaning noncritical medical equipment are followed.	○ Yes ○ No	
2.D.17 Hydrotherapy equipment (e.g., Hubbard tanks, tubs, whirlpools, spas, birthing tanks) are drained, cleaned, and disinfected using an EPA-registered disinfectant according to manufacturer's instructions after each patient use.	○ Yes ○ No ○ N/A	

2.D.18 The hospital can provide evidence that all personnel responsible for cleaning and disinfection have documented training and competency to clean and disinfect according to hospital policies and procedures.	○ Yes ○ No	
2.D.19 The hospital can provide evidence that routine audits of adherence to cleaning and disinfection procedures are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	

Module 3: Equipment Reprocessing

Section 3.A. Reprocessing of Semi-Critical Equipment

Semi-critical equipment are objects that contact mucous membranes or non-intact skin and require, at a minimum, high-level disinfection prior to reuse (e.g. some endoscopes, speculums, laryngoscope blades)

Elements to be assessed		Surveyor Notes
High-Level Disinfection (HLD) is defined as the complete elimination of all microorganisms in or on an instrument, except for small amounts of bacterial spores. INSTRUCTIONS: • Use the items in Section 3.C. "Single-Use Devices" to assess the reprocessing of any item(s) of semi-critical equipment that is (are) labeled as a single use device. Any item(s) of semi-critical equipment that is (are) labeled as a single use device must be reprocessed by a reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. • For all items labeled reusable, use section 3A.		
HLD of Reusable Instruments and Devices is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including:		
3.A.1 Hospital policies address steps to take when there are discrepancies between a device manufacturer's instructions and automated high-level disinfection equipment manufacturer's instruction for completing high-level disinfection.	○ Yes ○ No	

3.A.2 Only devices labeled as reusable are reprocessed directly by the hospital onsite, or offsite via a reprocessing vendor.	○ Yes ○ No ○ Unable to observe	
3.A.3 All reusable semi-critical items receive at least high-level disinfection prior to reuse.	○ Yes ○ No ○ Unable to observe	
3.A.4 If any high-level disinfection is performed off-site, the item(s) are decontaminated prior to off-site transport.	○ Yes ○ No ○ Unable to observe	
3.A.5 Is all high-level disinfection done off-site?	○ Yes: STOP here and SKIP to Section 3.B. ○ No: Answer all questions in this Section. NOTE: If any high-level disinfection is done onsite, complete questions 3.A.6 through 3.A.18	
Observe the main area for central sterilization/reprocessing services. Surveyors must assess reprocessing if performed on-site.	Central Reprocessing ○ Unable to observe elements in central reprocessing area. (If selected, Do not complete questions 3.A.6 – 3.A.18	
3.A.6 A workflow pattern is followed such that devices flow from soiled areas to clean/sterile areas and there is clear separation between soiled and clean workspaces.	○ Yes ○ No	

3.A.7 Items are thoroughly pre-cleaned according to manufacturer instructions as soon as practical after use.	○ Yes ○ No ○ Unable to observe	
3.A.8 Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle. (An endoscope is an instrument designed to visually examine the interior of a bodily canal or hollow organ such as the colon, larynx, bladder, or stomach)	○ Yes ○ No ○ Unable to observe	
3.A.9 Items are thoroughly cleaned according to manufacturer instructions as soon as practical after use and visually inspected for residual soil prior to high-level disinfection. Note: For instruments with lumens (e.g., endoscopes), cleaning of devices must include all channels using cleaning brushes of appropriate size.	○ Yes ○ No ○ Unable to observe	
3.A.10 Enzymatic cleaner or detergent is used and discarded according to manufacturer's instructions (typically after each use).	○ Yes ○ No ○ Unable to observe	
3.A.11 Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturer's instructions) at least daily.	○ Yes ○ No ○ Unable to observe	
3.A.12 For chemicals used in high-level disinfection, manufacturer's instructions are followed for: • Preparation, • Testing for appropriate concentration, and • Replacement (e.g., prior to expiration or loss of efficacy).	○ Yes ○ No ○ Unable to observe	

3.A.13 If automated reprocessing equipment is used, the manufacturer's recommended connectors are used to assure that all endoscope channels are appropriately disinfected.	○ Yes ○ No ○ Unable to observe	
3.A.14 Devices undergo disinfection for the appropriate length of time as specified by manufacturer's instructions.	○ Yes ○ No	
3.A.15 Devices undergo disinfection at the appropriate temperature as specified by manufacturer's instructions.	○ Yes ○ No ○ Unable to observe	
3.A.16 After high-level disinfection, devices are rinsed in accordance with manufacturers' instructions.	○ Yes ○ No ○ Unable to observe	
3.A.17 Devices are dried completely prior to reuse. Note: For instruments with lumens (e.g., endoscopes), this includes flushing all channels with alcohol and forcing air through the channels.	○ Yes ○ No ○ Unable to observe	
3.A.18 Routine maintenance procedures for high-level disinfection equipment are performed regularly by qualified personnel in accordance with manufacturer's instructions. (Confirm maintenance records are available.)	○ Yes ○ No ○ Unable to observe	

3.A.19 After high-level disinfection, devices are stored in a manner to protect from damage or contamination Note: Endoscopes must be hung in a vertical position or according to the scope cabinet manufacturer's instructions.	○ Yes ○ No ○ Unable to observe	
3.A.20 The hospital has a system in place to identify which endoscope was used on a patient for each procedure.	○ Yes ○ No	
3.A.21 The hospital has policies and procedures outlining hospital response (i.e. risk assessment and recall) in the event of a reprocessing failure	○ Yes ○ No	
3.A.22 The hospital can provide evidence that all personnel given responsibility for semi-critical device reprocessing have documented training **and competency** in accordance with hospital policies and procedures and/or manufacturers' instructions.	○ Yes ○ No	
3.A.23 The hospital can provide evidence that routine audits of adherence to semi-critical device reprocessing procedures are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	

Section 3.B. Reprocessing of Reusable Critical Equipment, Instruments and Devices: Sterilization

Critical equipment, instruments and devices are objects that enter sterile tissue or the vascular system and must be sterile prior to use (e.g. surgical instruments, cardiac and urinary catheters, implants, and ultrasound probes used in sterile body cavities)

Elements to be assessed		Surveyor Notes
Sterilization is a validated process used to render a product free of all forms of viable microorganisms. INSTRUCTIONS: • Use the items in Section 3.C. "Single-Use Devices" to assess the reprocessing of any item(s) of critical equipment that is (are) labeled as a single use device. Any item(s) of critical equipment that is (are) labeled as a single use device must be reprocessed by a reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. Sterilization of reusable equipment, instruments and devices is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable diseases including the following:		
3.B.1 Hospital policies address steps to take when there are discrepancies between a device manufacturer's instructions and the sterilizer's manufacturer's instruction for completing sterilization.	○ Yes ○ No	
3.B.2 All reusable critical items are sterilized prior to reuse.	○ Yes ○ No	
3.B.3 If any sterilization is performed off-site, the item(s) are decontaminated prior to off-site transport.	○ Yes ○ No ○ N/A	

3.B.4 Is all sterilization done off-site?	○ Yes: STOP here and SKIP to Section 3.C ○ No: Answer all questions in this section Note: If any sterilization is done onsite, complete questions 3.B.5 through 3.B.19	
Observe the main area for central sterilization services and if possible, also assess sterilization in another area.	Central Sterilization Area ○ Unable to observe elements in central sterilization area. (If selected, question 3.B.5 – 3.B.19 LEFT column should not be answered)	
3.B.5 Contaminated instruments are transported to the decontamination area in a manner that protects patients and personnel from exposure to pathogens. (e.g. a covered container that is leak proof, puncture resistant, and labeled with a biohazard legend).	○ Yes ○ No	
3.B.6 Personnel working in the decontamination area and handling contaminated instruments wear PPE.	○ Yes ○ No	
3.B.7 Items are thoroughly pre-cleaned according to manufacturers' instructions as soon as practical after use and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	○ Yes ○ No	
3.B.8 A workflow pattern is followed such that devices flow from soiled areas to clean/sterile areas and there is clear separation between soiled and clean workspaces.	○ Yes ○ No	
3.B.9 Enzymatic cleaner or detergent is used and discarded according to manufacturer's instructions (typically after each use).	○ Yes ○ No	
3.B.10 Items are thoroughly cleaned according to manufacturers' instructions as soon as practical after use and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, cleaning of devices must include all channels using cleaning brushes of appropriate size.	○ Yes ○ No	

3.B.11 Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturer's instructions) at least daily.	○ Yes ○ No	
3.B.12 After cleaning, items are appropriately wrapped-packaged for sterilization (e.g., package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	○ Yes ○ No	
3.B.13 A chemical indicator (process indicator) is placed correctly in the instrument packs in every load.	○ Yes ○ No	
3.B.14 A biological indicator, intended specifically for the type and cycle parameters of the sterilizer, is used at least weekly for each sterilizer and with every load containing implantable items.	○ Yes ○ No	
3.B.15 For dynamic air removal-type sterilizers (e.g., prevacuum steam sterilizer), an air removal test (Bowie-Dick test) is performed in an empty dynamic-air removal sterilizer each day the sterilizer is used to verify efficacy of air removal.	○ Yes ○ No ○ N/A	
3.B.16 Sterile packs are labeled with the sterilizer used, the cycle or load number, and the date of sterilization, and, if applicable, the expiration date.	○ Yes ○ No	
3.B.17 Logs for each sterilizer cycle are current and include results from each load.	○ Yes ○ No	
3.B.18 Routine maintenance for sterilization equipment is performed regularly by qualified personnel in accordance with manufacturer's instructions (confirm maintenance records are available).	○ Yes ○ No	
3.B.19 After sterilization, medical devices and instruments are stored so that sterility is not compromised.	○ Yes ○ No	
3.B.20 Sterile packages are inspected for integrity and compromised packages are repackaged and reprocessed prior to use.	○ Yes ○ No	

*"Immediate use" is defined as the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another.		
3.B.21 If immediate-use steam sterilization is performed, all of the following criteria are met: • Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization. • Once clean, the item is placed within a container intended for immediate use and not stored for later use or for use in another surgical case. • The sterilizer cycle and parameters used are selected according to the manufacturers' instructions for use for the device, container, and sterilizer. • The sterilizer function is monitored with monitors (e.g., mechanical, chemical and biologic) that are approved for the cycle being used. • The processed item must be transferred immediately*, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure.	○ Yes ○ No ○ Unable to observe	
3.B.22 Immediate-use sterilization is NOT performed on the following devices: • Implants (except in documented emergency situations when no other option is available). • Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease or similar disorders. • Devices that have not been validated with the specific cycle employed. • Single-use devices that are sold sterile.	○ Yes ○ No	
3.B.23 In the event of a reprocessing error/failure that could result in the transmission of infectious disease, personnel respond using a risk assessment and recall/remove device) according to hospital policies and procedures.	○ Yes ○ No	
3.B.24 The hospital can provide evidence that all personnel given responsibility for semi-critical device reprocessing have documented training and competency in accordance with hospital policies and procedures and/or manufacturers' instructions.	○ Yes ○ No	
3.B.25 The hospital can provide evidence that routine audits of adherence to device reprocessing procedures are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	

Section 3.C. Single-Use Devices

Elements to be assessed		Surveyor Notes
Single use devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
3.C.1 If the hospital elects to reuse any devices labeled for single use by the manufacturer, these devices are reprocessed by an entity or 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 hospital has documentation from the third party reprocessor confirming this is the case.	○ Yes ○ No ○ N/A	
3.C.2 Devices labeled for single use by the manufacturer are discarded after use and not used for more than one patient if they have not been reprocessed by an approved third-party reprocessor.	○ Yes ○ No	
3.C.3 The hospital can provide evidence that all personnel given responsibility for device reprocessing have documented training and competency in accordance with hospital policies and procedures and/or manufacturers' instructions.	○ Yes ○ No	

Module 4: Patient Tracers

Section 4.A. Indwelling Urinary Catheters

Elements to be assessed		Surveyor Notes
Urinary catheters are inserted, accessed, and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
4.A.1 The hospital can provide evidence that only properly trained personnel with **documented competency** to insert and maintain urinary catheters are given the responsibility to perform these procedures.	○ Yes ○ No	
4.A.2 The hospital can provide evidence that routine audits of adherence to urinary catheter insertion and maintenance procedures are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	
4.A.3 The hospital has guidelines for appropriate indications for urinary catheters.	○ Yes ○ No	
Urinary catheter access and maintenance:		
4.A.4 Catheter is secured properly after insertion. Note: This may not apply to catheters placed in the OR if the catheter is removed in the OR immediately after the procedure.	○ Yes ○ No ○ N/A	
4.A.5 Catheter insertion and indication are documented.	○ Yes ○ No	
4.A.6 Hand hygiene is performed before and after manipulating catheter.	○ Yes ○ No ○ Unable to observe	

4.A.7 Urine bag is kept below level of bladder at all times.	○ Yes ○ No	
4.A.8 Catheter tubing is unobstructed and free of kinking.	○ Yes ○ No	
4.A.9 Urine bag is emptied using aseptic technique, using a separate, clean collection container for each patient; drainage spigot does not touch collecting container.	○ Yes ○ No ○ Unable to observe	
4.A.10 Urine samples are obtained aseptically (via needleless port for small volume).	○ Yes ○ No ○ Unable to observe	

Section 4.B. Central Venous Catheters

Elements to be assessed		Surveyor Notes
Central venous catheters are inserted, accessed and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
Insertion:		
4.B.1 The hospital can provide evidence that only properly trained personnel with **documented competency** to insert central venous catheters are given this responsibility.	○ Yes ○ No	
4.B.2 The hospital can provide evidence that routine audits of adherence to central venous catheter insertion procedures are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	
If unable to observe any central venous catheter insertions, skip 4.B.3 through 4.B.8.	○ No observations available (If selected, ALL questions from 4.B.2 – 4.B.7 will be blocked)	

4.B.3 Hand Hygiene is performed before and after insertion.	○ Yes ○ No ○ Unable to observe	
4.B.4 Maximal barrier precautions are used for insertion (includes use of cap, mask, sterile gown, sterile gloves, and a sterile full body drape).	○ Yes ○ No	
4.B.5 Personnel use >0.5% chlorhexidine with alcohol for skin antisepsis prior to insertion (If contraindicated [e.g., neonatal population], tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives).	○ Yes ○ No ○ Unable to observe	
4.B.6 Sterile gauze or sterile, transparent, semi-permeable dressing is used to cover catheter site (may not apply for well-healed tunneled catheters).	○ Yes ○ No	
4.B.7 If the femoral site is used for central venous catheter insertion for adults, justification for this site is in the medical record.	○ Yes ○ No ○ Unable to observe	
4.B.8 Central venous line insertion and indication are documented.	○ Yes ○ No	
Accessing/Maintenance		
4.B.9 The hospital can provide evidence that only properly trained personnel with **documented competency** to access and maintain central intravascular catheters are given this responsibility.	○ Yes ○ No	
4.B.10 The hospital can provide evidence that routine audits of adherence to central venous catheter maintenance procedures are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	

If unable to observe the access or maintenance of any central venous catheters, skip 4.B.11 through 4.B.15.	○ No observations available (If selected, ALL questions from 4.B.9 – 4.B.13 will be blocked)	
4.B.11 Hand hygiene is performed before and after manipulating catheter.	○ Yes ○ No ○ Unable to observe	
4.B.12 Dressings that are wet, soiled, or dislodged are changed promptly.	○ Yes ○ No ○ Unable to observe	
4.B.13 Dressing is changed with aseptic technique using clean or sterile gloves.	○ Yes ○ No ○ Unable to observe	
4.B.14 Access port is scrubbed with an appropriate antiseptic (chlorhexidine, povidone iodine, an iodophor, or 70% alcohol) prior to accessing.	○ Yes ○ No ○ Unable to observe	
4.B.15 Catheter is accessed only with sterile devices.	○ Yes ○ No ○ Unable to observe	

Section 4.C. Ventilator/Respiratory Therapy

Elements to be assessed		Surveyor Notes
Respiratory procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
If no observations available, skip questions 4.C.1 through 4.C.8.		
4.C.1 through 4.C.8: General respiratory therapy practices (applies to patients with and without ventilators):		
4.C.1 Hand hygiene is performed before and after contact with patient or any respiratory equipment used on patient.	○ Yes ○ No ○ Unable to observe	
4.C.2 Gloves are worn when in contact with respiratory secretions and changed before contact with another patient, object, or environmental surface.	○ Yes ○ No ○ Unable to observe	
4.C.3 Only sterile solution (e.g., water or saline) is used for nebulization.	○ Yes ○ No ○ Unable to observe	
4.C.4 Single-dose vials for aerosolized medications are not used for more than one patient.	○ Yes ○ No ○ Unable to observe	

4.C.5 If multi-dose vials for aerosolized medications are used, manufacturers' instructions for handling, storing, and dispensing the medications are followed.	○ Yes ○ No ○ N/A ○ Unable to observe	
4.C.6 If multi-dose vials for aerosolized medications are used for more than one patient, they are stored appropriately and do not enter the immediate patient treatment area.	○ Yes ○ No ○ N/A	
4.C.7 Manufacturer's instruction are followed for use and cleaning of Jet nebulizers. Note: Mesh nebulizers, which remain in the ventilator circuit and are not cleaned or disinfected, are changed at an interval recommended by manufacturer's instructions. Nebulizer/drug combination systems are cleaned and disinfected according to manufacturer's instructions.	○ Yes ○ No	
4.C.8 Head of bed is elevated at an angle of 30--45 degrees, in the absence of medical contraindication(s), for patients at high risk for aspiration (e.g., a person receiving mechanically assisted ventilation and/or who has an enteral tube in place).	○ Yes ○ No	

Ventilators:		
Ventilators are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
4.C.9 The hospital can provide evidence that only properly trained personnel with **documented competency** to provide respiratory therapy for ventilated patients are given this responsibility.	○ Yes ○ No	

4.C.10 The hospital can provide evidence that routine audits of adherence to respiratory therapy procedures for ventilated patients are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	
If no observations available, skip questions 4.C.11 through 4.C.15.	○ No observations available (If selected, ALL questions from 4.C.11 – 4.C.17 will be blocked)	
4.C.11 Ventilator circuit (i.e., ventilator tubing and exhalation valve and the attached humidifier) is changed if visibly soiled or mechanically malfunctioning.	○ Yes ○ No ○ Unable to observe	
4.C.12 Sterile water is used to fill humidifiers.	○ Yes ○ No	
4.C.13 Condensate that collects in the tubing of a mechanical ventilator is periodically drained and discarded, taking precautions not to allow condensate to drain toward the patient.	○ Yes ○ No ○ Unable to observe	
4.C.14 If single-use open-system suction catheter is employed, a sterile, single-use catheter is used.	○ Yes ○ No ○ N/A	
4.C.15 Only sterile fluid is used to remove secretions from the suction catheter if the catheter is used for re-entry into the patient's lower respiratory tract.	○ Yes ○ No ○ Unable to observe	

Section 4.D. Spinal Injection Procedures

Elements to be assessed		Surveyor Notes
Spinal injection procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
If unable to observe spinal injection procedure, skip questions 4.D.1 through 4.D.3.		
4.D.1 Hand hygiene performed before and after the procedure.	○ Yes ○ No	
4.D.2 The spinal injection procedure is performed using aseptic technique and sterile equipment, including use of sterile gloves.	○ Yes ○ No	
4.D.3 Facemasks are worn by healthcare personnel who are placing a catheter or injecting materials into the epidural or subdural space (e.g., during myelogram, epidural or spinal anesthesia).	○ Yes ○ No	

Section 4.E. Point of Care Devices (e.g. Blood Glucose Meter, INR Monitor)

Elements to be assessed		Surveyor Notes
Point of care devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
4.E.1 The hospital can provide evidence that all personnel responsible for using point-of-care devices have documented training **and competency** to perform the procedures according to hospital policies and/or manufacturers' instructions.	○ Yes ○ No	

4.E.2 The hospital can provide evidence that routine audits of adherence to point-of-care device procedures are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	
4.E.3 Hand hygiene is performed before and after the procedure.	○ Yes ○ No	
4.E.4 Gloves are worn by healthcare personnel when performing the finger stick procedure to obtain the sample of blood, and are removed after the procedure (followed by hand hygiene).	○ Yes ○ No	
4.E.5 Finger stick devices are not used for more than one patient. Note: This includes both the lancet and the lancet holding device.	○ Yes ○ No ○ Unable to observe	
4.E.6 If used for more than one patient, the point-of-care blood testing device (e.g., blood glucose meter, INR monitor) is cleaned and disinfected after every use according to manufacturer's instructions. Note: if manufacturer does not provide instructions for cleaning and disinfection, then the device should not be used for >1 patient.	○ Yes ○ No ○ N/A	

Section 4.F. Isolation: Contact Precautions

Elements to be assessed		Surveyor Notes
Patients requiring contact isolation are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
If unable to observe a patient on Contact Precautions skip elements 4.F.1 to 4.F.12.	○ No observation available (If selected ALL questions from 4.F.1 – 4.F.12 will be blocked)	

4.F.1 Patient with known or suspected infections or with evidence of syndromes that represent an increased risk for contact transmission are placed on Contact Precautions.	○ Yes ○ No	
4.F.2 Gloves and gowns are available and located near point of use.	○ Yes ○ No	
4.F.3 Signs indicating patient is on Contact Precautions are clear and visible.	○ Yes ○ No	
4.F.4 Patients on Contact Precautions are housed in single-patient rooms when possible or cohorted based on a clinical risk assessment.	○ Yes ○ No	
4.F.5 Hand hygiene is performed before entering patient care environment.	○ Yes ○ No	
4.F.6 Gloves and gowns are donned upon entry into the environment (e.g. room or cubicle).	○ Yes ○ No	
4.F.7 Gloves and gowns are removed and discarded, and hand hygiene is performed before leaving the patient care environment.	○ Yes ○ No	
4.F.8 Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs) is used, or if not available, then equipment is cleaned and disinfected prior to use on another patient according to manufacturers' instructions.	○ Yes ○ No	
4.F.9 The hospital limits the movement of patients on Contact Precautions outside of their room to medically necessary purposes only.	○ Yes ○ No ○ Unable to observe	

4.F.10 If a patient on Contact Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and to prevent transmission of infectious disease.	○ Yes ○ No ○ Unable to observe	
4.F.11 Objects and environmental surfaces in patient care areas that are touched frequently (e.g., bed rails, overbed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected with an EPA-registered disinfectant frequently (at least daily) and when visibly soiled.	○ Yes ○ No ○ Unable to observe	
4.F.12 After patient discharge, all visibly or potentially contaminated surfaces are thoroughly cleaned and disinfected and all textiles (e.g. linens and towels) are replaced with clean textiles.	○ Yes ○ No ○ Unable to observe	

Section 4.G. Isolation: Droplet Precautions

Elements to be assessed		Surveyor Notes
Patients requiring Droplet Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
4.G.1 Patients known or suspected to be infected with pathogens transmitted by respiratory droplets (e.g., seasonal influenza, rhinovirus, *Neisseria meningitidis*, mycoplasma) are placed on Droplet Precautions.	○ Yes ○ No	
If unable to observe a patient on Droplet Precautions, skip elements 4.G.2 to 4.G.9.	○ No observation available (If selected ALL questions from 4.G.2 – 4.G.9 will be blocked)	
4.G.2 Facemasks are available and located near point of use.	○ Yes ○ No	

4.G.3 Signs indicating patient is on Droplet Precautions are clear and visible.	○ Yes ○ No	
4.G.4 Patients on Droplet Precautions are housed in single-patient rooms when available or cohorted based on a clinical risk assessment.	○ Yes ○ No	
4.G.5 Hand hygiene is performed before contact with the patient.	○ Yes ○ No	
4.G.6 Personnel don facemasks upon entering the patient care environment or private room.	○ Yes ○ No	
4.G.7 Facemask is removed and discarded and hand hygiene is performed upon leaving the patient care environment.	○ Yes ○ No	
4.G.8 The hospital limits movement of patients on Droplet Precautions outside of their rooms to medically necessary purposes only.	○ Yes ○ No ○ Unable to observe	
4.G.9 If a patient on Droplet Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and to prevent transmission of infectious disease, including the use of a facemask by the patient if possible. Note: The hospital may have specific policies regarding the use of PPE for pediatric patients.	○ Yes ○ No ○ Unable to observe	

Section 4.H. Isolation: Airborne Isolation Precautions

Elements to be assessed		Surveyor Notes
Patients requiring Airborne Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
4.H.1 Patients with known or suspected infectious agents that are transmitted person-to-person by the airborne route (e.g., TB, measles, chickenpox, disseminated herpes zoster) are placed on Airborne Isolation Precautions.	○ Yes ○ No	
If possible, observe for compliance with Airborne Isolation Precautions elements in multiple patient care areas in the hospital. If unable to observe a patient on Airborne Isolation Precautions, skip elements 4.H.2 to 4.H.8.	○ No observation available (If selected do not answer questions from 4.H.2 – 4.H.8)	
4.H.2 NIOSH-approved particulate respirators (N-95 or higher) are available and located near point of use.	○ Yes ○ No	
4.H.3 Signs indicating patient is on Airborne Isolation Precautions are clear and visible.	○ Yes ○ No	
4.H.4 Personnel wear a fit tested NIOSH-approved particulate respirator (N95 or higher) when entering the airborne infection isolation room (AIIR) for patients with confirmed or suspected TB. Hospital policies are followed for other pathogens requiring AIIR.	○ Yes ○ No	
4.H.5 Personal Air-Purified Respirators (PAPRs) are available for healthcare personnel who cannot be fit tested.	○ Yes ○ No	

4.H.5 Hand hygiene is performed before contact with the patient.	○ Yes ○ No	
4.H.6 Patients on Airborne Precautions are housed in AIIR that meet all of the following specifications: • At least 6 (existing facility) or 12 (new construction/renovation) air changes per hour or per state licensure rules; • Direct exhaust of air to outside. If not possible, all air returned to air handling system or adjacent spaces is directed through HEPA filters; • When AIIR is in use for a patient on Airborne Precautions, 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); • AIIR door kept closed when not required for entry and exit Note: If AIIR is not available, hospital policy should address patient transfer to a hospital that has an available AIIR.	○ Yes ○ No	
4.H.7 The hospital limits movement of patients on Airborne Precautions outside of their room to medically-necessary purposes.	○ Yes ○ No ○ Unable to observe	
4.H.8 If a patient on Airborne Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and to prevent transmission of infectious disease, including the use of a facemask by the patient if possible. Note: The hospital may have specific policies regarding the use of PPE for pediatric patients.	○ Yes ○ No ○ Unable to observe	

Section 4.I. Surgical Procedures

Elements to be assessed		Surveyor Notes
Surgical procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
4.I.1The hospital can provide evidence that routine audits of adherence to recommended infection control practices for surgical site infection (SSI) prevention are conducted and feedback from audits is provided to personnel.	○ Yes ○ No	

4.I.2The hospital can provide evidence that the SSI prevention program addresses appropriate prophylactic antibiotic use, including preoperative timing of administration, appropriate antibiotic selection, and discontinuation postoperatively.	○ Yes ○ No	
If unable to observe any surgical procedure, skip elements 4.I.3 to 4.I.10.	○ No observation available (If selected ALL questions from 4.I.3 – 4.I.10 will be blocked)	
4.I.3 Healthcare personnel perform a surgical scrub before donning sterile gloves for surgical procedures (in OR) using either an antimicrobial surgical scrub agent or an FDA-approved alcohol-based antiseptic surgical hand rub. Note: If visibly soiled, hands and forearms should be prewashed with soap and water before using an alcohol-based antiseptic surgical hand rub.	○ Yes ○ No ○ Unable to observe	
4.I.4 After surgical scrub, hands and arms are dried with a sterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.	○ Yes ○ No ○ Unable to observe	
4.I.5 Surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair are worn by all personnel and visitors in semi restricted and restricted areas. Note: Restricted area includes ORs, procedure rooms, and the clean core (sterile supply) area. The semi restricted area includes the peripheral support areas of the surgical suite.	○ Yes ○ No	
4.I.6 Surgical masks are worn fully covering mouth and nose by all personnel in restricted areas where open sterile supplies or scrubbed personnel are located.	○ Yes ○ No	
4.I.7 A new surgical mask is worn for every procedure.	○ Yes ○ No ○ Unable to observe	

4.I.8 Sterile drapes are used to establish sterile field.	○ Yes ○ No	
4.I.9 Sterile field is maintained and monitored constantly. Ensure that: • Items used within sterile field are sterile. • Items introduced into sterile field are opened, dispensed, and transferred in a manner to maintain sterility. • Sterile field is prepared in the location where it will be used and as close as possible to time of use. • Movement in or around sterile field is done in a manner to maintain sterility.	○ Yes ○ No ○ Unable to observe	
4.I.10 Traffic in and out of OR is kept to minimum and limited to essential personnel.	○ Yes ○ No	

Processes ensuring infection control in the OR are accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
If the hospital does not provide any surgical services, skip 4.I.9 through 4.I.17.	○ No surgical services (If selected, Do not answer questions 4.I.9 – 4.I.17)	
4.I.11 Cleaners and EPA-registered hospital disinfectants are used and dated in accordance with hospital policies and procedures and manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time). Note: The cleaners and disinfectants can be dated by the hospital with either the date opened or the discard date as per hospital policy, as long as it is clear what the date represents and the same policy is used consistently throughout the hospital.	○ Yes ○ No ○ Unable to observe	
4.I.12 All horizontal surfaces (e.g., furniture, surgical lights, booms, equipment) are damp dusted before the first procedure of the day using a clean, lint-free cloth and EPA-registered hospital detergent/disinfectant.	○ Yes ○ No ○ Unable to observe	
4.I.13 High touch environmental surfaces are cleaned and disinfected between patients.	○ Yes ○ No ○ Unable to observe	

4.I.14 ORs are terminally cleaned after last procedure of the day (including weekends) and each 24-hour period during regular work week. Terminal cleaning includes wet-vacuuming or mopping floor with an EPA-registered disinfectant.	○ Yes ○ No ○ Unable to observe	
4.I.15 Anesthesia equipment surfaces that are touched by personnel while providing patient care or while handling contaminated items are cleaned and low-level disinfected between use on patients, according to manufacturers' instructions.	○ Yes ○ No ○ Unable to observe	
4.I.16 Exterior surfaces of anesthesia equipment that are not knowingly contaminated during patient care are terminally low-level disinfected at the end of the day, according to manufacturers' instructions.	○ Yes ○ No ○ Unable to observe	
4.I.17 Internal components of the anesthesia machine breathing circuit are cleaned per hospital policy or manufacturer's instructions.	○ Yes ○ No ○ Unable to observe	
4.I.18 Reusable noncritical items (e.g., blood pressure cuffs, ECG leads, tourniquets, oximeter probes) are cleaned and disinfected between patients.	○ Yes ○ No ○ Unable to observe	
4.I.19 Ventilation requirements meet the following: • Positive pressure, ≥15 air exchanges per hour (at least 3 of which are fresh air) • 90% filtration (HEPA is optional), air filters checked regularly and replaced according to hospital policies and procedures • Temperature and relative humidity levels are maintained at required levels • Doors are self-closing • Air vents and grill work are clean and dry.	○ Yes ○ No	