Road Map to a Comprehensive Healthcare-Associated Infection (HAI) Prevention Program

APIC

MINNESOTA MDH DEPARTMENT OF HEALTH

Minnesota Hospital Association

StratisHealth

The HAI Road Map provides evidence-based recommendations/standards for Minnesota hospitals in the development of a comprehensive Healthcare-Associated Infection Prevention Program which includes catheter-associated urinary tract infections (CAUTI), central line associated bloodstream infections (CLABSI), ventilator-associated pneumonia (VAP), surgical site infection (SSI) and clostridium difficile infection (CDI). The Road Map and accompanying tool kit were developed as part of the Minnesota HAI Prevention Collaborative which was made possible with funding through the Centers for Disease Control and Prevention (CDC) Epidemiology and Laboratory Capacity Program (ELC) American Reinvestment and Recovery Act (ARRA) and CMS Partner for Patients (P4P) Initiative.

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Definitions

Health Care Personnel (HCP): All persons, paid and unpaid, working in an acute care facility who have potential for exposure to patients and/or infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. This includes persons not directly involved in patient care (e.g. leadership, clerical, housekeeping, and volunteers) but potentially exposed to infectious agents that can be transmitted to and from HCP and patients. This term includes, but is not limited to, physicians, physician assistants, nurse practitioners, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, and contractual personnel.

Prescriber: Health care personnel who are licensed to prescribe medications, including antimicrobial agents.

Road Map to a Comprehensive Healthcare Associated Infection (HAI) Prevention Program

	Safe from HAI	Specific Actions(s)	Audit Questions	Yes	No
S	**Safety Teams and Organizational Structure**	1) Secure endorsements and resources for HAI Prevention Program	1a) The facility's leadership endorses implementation and sustainment of the HAI road map practices.	☐	☐
			1b) Senior leadership has clearly communicated overall goals for the program.	☐	☐
			1c) Senior leadership regularly reviews progress toward goals and supports adding resources as appropriate.	☐	☐
			1d) The facility has a designated senior leadership sponsor for the HAI prevention.	☐	☐
		2) Promote HAI prevention representation/ champions throughout the facility	2a) The facility has an interdisciplinary team involved in implementing the HAI prevention program with representation from across the facility.	☐	☐
			HAI Prevention champions/team members/liaisons with clear roles and expectations have been designated from:		
			2b) Physician/provider knowledgeable in infectious diseases	☐	☐
			2c) Infection Prevention	☐	☐
			2d) Direct Care	☐	☐
			2e) Safety/Quality	☐	☐
			2f) Pharmacy	☐	☐
			2g) Laboratory	☐	☐
			2h) Environmental Services	☐	☐
			2i) Operating room N/A: ☐	☐	☐
			2j) Other physicians as appropriate for specific HAI focus areas (e.g. surgery, pulmonary medicine, hospitalist)	☐	☐
			2k) The facility has a process in place to engage other team members as regular or ad-hoc members as appropriate (e.g., purchasing, education, IV team, human resources, patient/family).	☐	☐
			2l) The facility has a process in place to engage patients and families in HAI prevention as appropriate.	☐	☐
			2m) The facility has a designated coordinator(s) for the HAI prevention program.	☐	☐
			2n) The coordinator(s) has designated time to serve in this coordination function.	☐	☐
		3) Identify gaps and develop action plans	**The interdisciplinary team:**		
			3a) Reviews the HAI prevention program throughout the year and updates the plan as needed.	☐	☐
			3b) Reviews data results at least quarterly and identifies strengths and opportunities.	☐	☐
			3c) Develops a plan to prioritize and address improvement opportunities.	☐	☐
			3d) Commissions subgroups as needed to address priority issues requiring subject matter experts (e.g., pharmacy, respiratory, environmental services)	☐	☐

A	**Access to Information**	1) Track progress on process and outcome measures	**Data Collection** **A process is in place to collect HAI prevention bundle/process data for the following as applicable:** 1a) Hand hygiene compliance 1b) VAP N/A: ☐ 1c) SSI N/A: ☐ 1d) CAUTI 1e) CDI 1f) CLABSI 1g) MDRO 1h) Environmental cleaning – General 1i) Environmental cleaning – OR N/A: ☐ **A process is in place to collect HAI outcome measures using NHSN definitions for the following as applicable:** 1j) CAUTI rate 1k) CLABSI rate 1l) VAP rate N/A: ☐ 1m) SSI rate N/A: ☐ 1n) CDI rate 1o) MDRO rates 1p) Outcome data is tracked on a regular basis for other surgical areas as identified as high-risk for infections by the hospital. 1q) Standard criteria exist for conducting observational and chart audits. 1r) A process is in place to conduct inter-rater reliability of both the process and outcome data through chart audits. 1s) A process is in place to conduct inter-rater reliability of both the process and outcome data through observational audits. 1t) The facility's documentation system (electronic or paper) is designed to capture sufficient detail about HAI events that do occur to allow for adequate event analysis.	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
		2) Review and analyze data for improvement opportunities	**Data Analysis** 2a) A process is in place to routinely review and analyze data for process improvement opportunities/defects. 2b) A process is in place to track progress against established targets e.g., run charts, control charts, dashboards, scorecards. 2c) A process is in place to prioritize and act upon identified issues.	☐ ☐ ☐	☐ ☐ ☐
		3) Data is shared on a regular basis to promote system-wide learning and transparency	**HAI data and learnings are shared on a regular basis:** 3a) Within units 3b) Across units 3c) Across departments 3d) With leadership 3e) With medical staff 3f) With the board(s) 3g) HAI events are routinely shared through stories as well as through data e.g., include in daily briefings, unit staff meetings, safety committees newsletters.	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐
F	**Facility Expectations**	1) Leadership establishes and communicates clear expectations	1a) Direct patient care staff, e.g., nursing, physicians, therapies is informed of expectations and performance standards regarding their role in HAI prevention. 1b) Support staff, e.g., environmental services, supply chain, facilities/ operations, is informed of expectations and performance standards regarding their role in HAI prevention. 1c) The facility has a well defined process to support a culture that encourages HCP, prescribers to speak up and "stop the line" to inform each other of non-compliance with HAI prevention expectations. 1d) The "stop the line" process clearly outlines: • When to stop the line • How to stop the line (verbal/non-verbal cue) • The chain of command to follow if not supported in stopping the line • Clear communication to staff from managers and leadership that staff will be supported if they speak up	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

		2) Provide education for Health Care Personnel (HCP) and Prescribers	**Expectations and supporting HAI prevention education, including specific roles in preventing transmission of infections for identified patients, have been incorporated into new employee orientation for:** 2a) HCP and prescribers **Expectations and supporting HAI prevention education have been incorporated into employee orientation for personnel employed by outside agencies and contracted personnel.** 2b) Ongoing HAI prevention education is provided for HCP, prescribers annually. 2c) Expectations and supporting HAI prevention education have been incorporated into new physician orientation.	☐ ☐ ☐	☐ ☐ ☐
		3) Establish a structured communication process	3a) The facility has structured communication tools, e.g., Situation, Background, Assessment, Recommendation (SBAR), isolation signage for communication at all levels of the organization. **A structured hand-off process is in place throughout the organization with specific elements outlined that must be included for hand-offs:** 3b) During shift change 3c) Between departments/units 3d) To other facilities	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
		4) Disclose unanticipated events	**A process is in place to promptly inform patients/families when an unanticipated event occurs that has potential to contribute to an HAI to include :** 4a) Direction on who should discuss the unanticipated, e.g. inappropriate reprocessing of endoscopes, unsafe injection practices event with the patient/family and how that discussion should occur. 4b) Individuals designated to provide disclosure to patients receiving training on effective disclosure strategies. 4c) A process for disclosing to and updating, patient/family as the event is reviewed and analyzed. 4d) A designated person is available to provide support and provide just- in-time training to staff members who are about to disclose an unanticipated events to a patient/family.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
E	**Engagement of Patient and Families**	1) Educate and empower patient/ families	1a) A process is in place to assess and address any barriers to patient/ family ability to understand their role in HAI prevention (e.g., cultural, language, hearing impairment and health literacy). 1b) Patients/families are educated on their role in preventing infections and prevention measures they can expect to see from HCP, prescribers caring for them in the hospital e.g., hand washing. 1c) A process is in place to assess patient /families' level of understanding of the education provided e.g., teach back. 1d) The facility has a process in place to encourage patients and families to speak up if they have concerns about HCP, prescribers practices or other issues that may increase infection risk. 1e) A process is in place to report back to patients/families that have shared a concern.	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐

Building Blocks for HAI Prevention

Hand Hygiene

	Safe from HAI	Specific Actions(s)	Audit Questions	Yes	No
	Hand Hygiene Practice	1) Reinforce and sustain hand washing practices	**The facility has instituted an infrastructure, based on CDC or WHO guidelines, to reinforce and sustain hand hygiene practices using the following strategies, at minimum:**		
			1a) Set clear expectations for hand hygiene practices to all health care personnel (HCP) and prescribers.	☐	☐
			1b) Provide visible reminders of hand hygiene expectations, e.g., computer screen savers, posters.	☐	☐
			1c) Provide on-going coaching and just-in-time training to reinforce effective hand hygiene expectations.	☐	☐
			1d) Provide real time performance feedback to HCP, prescribers.	☐	☐
			1e) Tailor education in proper hand hygiene for specific disciplines.	☐	☐
			1f) Make soap/waterless hand sanitizer readily available to HCP, prescribers, patients and visitors.	☐	☐
			1g) Structure the hand washing environment to support hand hygiene, e.g., dedicated space to place items while washing hands.	☐	☐
			1h) Limit the need to frequently enter or exit patient room, e.g., bedside computer, portable phone, adequate supplies in room.	☐	☐
			1i) Identify new technologies to make it easy for HCP, prescribers to remember to wash hands, e.g., radio frequency identification, automatic reminders, warning systems.	☐	☐
			1j) The "Just Culture" model is applied when HCP, prescribers are observed not following facility expectations for appropriate hand hygiene.	☐	☐
			1k) Celebrate improvements in hand hygiene practices.	☐	☐
		2) Provide staff hand hygiene education	2a) A process is in place to provide hand hygiene education for all HCP, prescribers at orientation and on an on-going basis.	☐	☐
		3) Provide ongoing training and education to patients, families, and visitors	3a) A process is in place to provide on-going education to patients, families and visitors on the importance of proper hand hygiene, e.g., signage, fact sheets, easily accessible hand sanitizer dispensers for patients/families.	☐	☐
		4) Set clear expectations for hand hygiene for all health care workers	**The facility has clear expectations that all HCP, prescribers wash hands with soap and water or an alcohol-based hand rub:**		
			4a) If hands are not visibly soiled.	☐	☐
			4b) Before having direct contact with patients.	☐	☐
			4c) After removing gloves.	☐	☐
			The facility has clear expectations that all s HCP, prescribers wash hands with soap and water:		
			4d) When hands are visibly dirty or contaminated.	☐	☐
			4e) Before eating or handling food.	☐	☐
			4f) After using a restroom.	☐	☐
			4g) The facility's hand hygiene and surgical hand scrub products are FDA- approved.	☐	☐
			4h) The facility follows AORN, CDC, and/or WHO guidelines as well as manufacturer's directions when using hand hygiene and surgical hand scrub products.	☐	☐
			In any setting where sterile technique is used, the facility has clear expectations for hand hygiene practices as outlined by AORN guidelines including:		
			4i) Fingernails are short, clean, and without chipped nail polish.	☐	☐
			4j) Artificial nails (any enhancement or resin bonding product including gel, are not worn.	☐	☐
			4k) Rings, watches, and bracelets are removed prior to hand hygiene.	☐	☐
			4l) Cuticles, hands and exposed skin are free of cuts, abrasions, open lesions, and new tattoos.	☐	☐
			4m) A surgical hand scrub is performed by health care personnel before donning sterile gloves for surgical or other invasive procedures.	☐	☐

		5) Conduct hand hygiene audits	5a) The facility has a method in place to audit compliance with hand hygiene in all departments, e.g., no. of hand hygiene episodes/no. of hand hygiene opportunities, appropriate hand washing technique, when outbreaks of infection occur, artificial nail wearing practices, monitoring the volume of alcohol-based hand rub (or detergent used for hand washing or hand antisepsis) used per 1,000 patient-days. 5b) The facility uses trained observers to monitor appropriateness of hand hygiene. 5c) The facility has a process to identify hand hygiene system issues and target solutions, e.g., supplies not readily available, faulty/empty hand sanitizer dispenser. **The facility provides feedback on hand hygiene adherence:** 5d) Within units 5e) Across units 5f) Across departments 5g) With leadership 5h) With medical staff 5i) With the board(s)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Transmission					
	Standard and Transmission-based Isolation Precautions	1) Establish Standard Precaution practices	1a) The facility has a process in place to apply standard infection prevention practices for all patients, regardless of suspected or confirmed infection status which includes, at a minimum: • Hand hygiene • Use of gloves • Gown • Mask • Eye protection or face shield, depending on the anticipated exposure • Safe injection practices • Respiratory Hygiene/Cough Etiquette • Use of masks for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures	☐	☐
		2) Establish Transmission-based Precaution practices	2a) The facility's infection prevention program addresses the use of transmission-based isolation precautions based on current public health and other evidence-based guidelines which addresses, at a minimum: • Contact Precautions • Droplet Precautions • Airborne Precautions	☐	☐
		3) Appropriately room patients to reduce exposure	**The facility's process for patient placement/room selection includes:** 3a) Private/single-patient room preferred for patients requiring isolation precautions when available. 3b) If private room availability is limited, cohort patients according to CDC guideline. 3c) Patients with discordant status of infection or colonization with other epidemiologically important organisms (e.g., VRE, MRSA) are not cohorted. 3d) Airborne isolation infection room (AIIR) according to CDC guideline for patients with infectious agents requiring airborne precautions or a process to transfer patients requiring airborne isolation to another facility.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
		4) Communicate precaution status	4a) The facility has a process is in place to immediately post Isolation Precautions signage in visible location outside suspected and positive patient rooms. 4b) The facility has a process in place to communicate isolation precaution status to receiving departments/facilities when isolation patients are transferred.	☐ ☐	☐ ☐

		5) Ensure effective use of personal protective equipment (PPE)	5a) Adequate supplies for compliance with Isolation Precautions (e.g., gowns, gloves) are readily accessible outside of the patient room. 5b) HCP, prescribers wear PPE according to Standard Precautions and Transmission-based precautions. 5c) Gloves are changed immediately if visibly soiled and after touching or handling contaminated surfaces/materials. 5d) HCP, prescribers change gown and gloves and perform hand hygiene when moving between cohorted patients. 5e) Respiratory protection is worn according to CDC guidelines for patients with infectious agents requiring airborne precautions and for performance of aerosol-generating procedures. 5f) PPE is removed before exiting the patient room (exception: N95 respirator is removed after exiting patient room). 5g) The CDC Guideline instructions on donning and removal of PPE are followed.	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐
		6) Follow appropriate precaution for patient transport	6a) The facility provides clear expectations that patient transport or movement for patients with infections, outside of the room is avoided unless medically necessary. 6b) When transport is necessary, a process is in place to ensure that infected or colonized areas of the patient's body are contained and covered.	☐ ☐	☐ ☐
		7) Establish effective practices for environmental cleaning and disinfection	7a) The facility has processes in place for routine and targeted cleaning and disinfection of environmental surfaces as indicated by level of patient contact and degree of soiling which includes emphasis on high-touch surfaces in the patient care environment. 7b) The facility uses EPA-registered disinfectant products that have microbiocidal activity against the pathogens most likely to contaminate the patient care environment. 7c) The facility has a process in place to use disinfectant products in accordance with manufacturer instructions for use and contact time.	☐ ☐ ☐	☐ ☐ ☐
		8) Establish effective practices for linen and waste management	8a) The facility has a process in place to follow Standard Precautions for the handling of soiled linen and waste materials. 8b) The facility has a process in place to dispose of infectious/biohazard waste according to the OSHA Bloodborne Pathogen Standard and state/local regulations.	☐ ☐	☐ ☐
		9) Establish effective practices for patient care supply/ equipment management	9a) Patient care equipment and instruments are handled according to Standard Precautions. 9b) Single-use or dedicated patient care equipment is utilized when possible (e.g. blood pressure cuff). 9c) Reusable patient-care equipment is cleaned and disinfected between patients. 9d) The amount of supplies stocked in the patient room is limited to what will be needed for care. 9e) Responsibility is assigned for regularly checking and restocking supplies. 9f) A defined process is in place for handling supplies remaining in the patient room after discharge.	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐
		10) Communicate clear expectations for patient and visitors	10a) The facility has a process in place to educate patients/families on recommended hand hygiene, respiratory hygiene and transmission-based precautions as well as infectious agent specific information as appropriate. 10b) The facility has a process to clearly communicate and enforce requirements for visitors to enter isolation rooms (e.g., hand hygiene, PPE requirement). 10c) The facility has established a process to clearly communicate and enforce restrictions for visitors based on potential for their exposure as well as if they have signs/symptoms of infection (e.g., fever, acute respiratory symptoms, gastrointestinal symptoms).	☐ ☐ ☐	☐ ☐ ☐

		11) Establish parameters for discontinuation of precautions	11a) The facility has a process in place to discontinue precautions based on CDC recommendations, such as: • after signs and symptoms of infection have resolved and patient is no longer contagious • according to pathogen-specific recommendations • if infectious agents that require isolation precautions have been ruled out	☐	☐
		Practice effective Hand Hygiene practices	Hand Hygiene (see specific practices under " Hand Hygiene" section of the roadmap) • Follow hand hygiene practices according to CDC or WHO guidelines		
Antimicrobial Stewardship Program (ASP)					
	Antimicrobial Stewardship Program (ASP)	1) An antimicrobial stewardship program (ASP) is in place	1a) A physician who is knowledgeable about antimicrobials and is respected by peers has been appointed to serve as a champion for the ASP. 1b) The facility has established an ASP Team that includes, at a minimum, the physician champion and a pharmacy champion. 1c) Senior leadership supports the ASP by providing compensation and/or time for team members to work on the ASP. 1d) The ASP Team is familiar with the key published ASP literature. 1e) The pharmacy provides antimicrobial use data to the ASP team. 1f) The ASP Team (or pharmacy or Pharmacy and Therapeutics Committee) has reviewed and updated the formulary to promote optimal, non-duplicative availability of antimicrobials. 1g) The facility's laboratory produces a facility-specific antibiogram or has access to a region-specific antibiogram that is updated annually. 1h) A baseline assessment of resources and barriers for an ASP has been conducted. 1i) The ASP Team utilizes antimicrobial use data and microbiology data (e.g., antibiogram) to prioritize ASP strategies.	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Injection Practices					
	Injection Practices	1) Implement safe injection practices	**The facility has established policies/protocols with clear expectations that the practices below are followed:** 1a) Aseptic technique is used to avoid contamination of sterile injection equipment. 1b) Used syringes, needles and cannulas are discarded at the point of use in an approved sharps container immediately after use. 1c) Single-dose vials are used whenever possible and discarded immediately after use on a single patient. 1d) Medications are not administered from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. 1e) Needles, cannulae, and syringes are sterile, single-use items and should not be reused for another patient or to access a medication or solution that might be used for a subsequent patient. 1f) A syringe or needle/cannula is considered contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set. 1g) Medication is not prepared in one syringe to transfer to another syringe. 1h) A sterile syringe and needle/cannula is always used when entering a vial —never one that has been used on another patient. 1i) Vials are discarded 28 days after opening, unless specified by the manufacturer, or sooner if sterility is questioned or compromised. 1j) Multi-dose vials are not kept in the immediate patient treatment area and are stored in accordance with the manufacturer's recommendations. 1k) A needle, cannula, or spike device is never left inserted into a medication vial rubber stopper because it leaves the vial vulnerable to contamination. 1l) Fluid infusion and administration sets (i.e., intravenous bags, tubing, and connectors) are used for one patient only and discarded appropriately after use. 1m) Bags or bottles of intravenous solution are not used as a common source of supply for multiple patients. 1n) Once IV solution bags have been spiked; administration must begin within 1 hour. 1o) All opened vials, IV solutions and prepared or opened syringes that were used in an emergency situation are discarded.	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

System-wide Environmental Cleaning

CORE Prevention Strategies = Strategies that should always be in place.

ENHANCED Prevention Strategies = Strategies to be considered in addition to core strategies when:

a) There is evidence that the core strategies are being implemented and adhered to consistently.
b) There is evidence of on-going transmission as appropriate.
c) There is evidence that rates are not decreasing.
d) There is evidence of change in pathogenesis as appropriate (e.g. increased morbidity/mortality among patients).

	Safe from HAI	Specific Actions(s)	Audit Questions	Yes	No
	System-wide environmental cleaning and disinfection practices	CORE PREVENTION 1) Patient rooms and patient care equipment are appropriately cleaned and disinfected	**The facility has a standardized environmental cleaning and disinfection protocol that includes:** 1a) Hospital grade EPA-registered germicide is used for routine disinfection and in accordance with the manufacturers' instructions. 1b) Manufacturer product recommendations are followed for use, including contact time and dilution. 1c) There is a process in place to assess current practices in cleaning/ disinfection before changing products or processes.	☐ ☐ ☐	☐ ☐ ☐
		2) Provide cleaning/ disinfection education for nursing/support staff	2a) The facility has a process in place to provide cleaning and disinfection education for nursing and support staff.	☐	☐
		3) Provide education and competency testing for environmental services trainers	**The facility has a process in place to require person(s) responsible for environmental services training to:** 3a) Receive education on current environmental cleaning/disinfection practices at least annually. 3b) Complete a competency evaluation of cleaning/disinfection practices at least annually.	☐ ☐	☐ ☐
		4) Provide cleaning/ disinfection training and evaluation for environmental services staff	4a) Training materials are provided in HCP, prescribers native language(or ensure communication of the information through other means). 4b) Environmental services staff training includes return demonstration. 4c) A systematic process is in place to periodically evaluate terminally cleaned rooms. 4d) Processes are in place to address issues identified through evaluations.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
		5) Provide competency testing to environmental services staff	5a) Environmental services staff training includes written or verbal competency testing which includes demonstrated understanding of the rationale for cleaning/disinfection components. 5b) Expectations are in place for environmental services staff to pass a competency test prior to assignment to patient care areas. 5c) Expectations are in place for environmental services staff that do not pass the competency test to receive additional training or be assigned to non-patient care areas.	☐ ☐ ☐	☐ ☐ ☐
		ENHANCED PREVENTION 6) Establish enhanced cleaning & disinfection practices	6a) The facility has a process to consider technology to monitor for room cleanliness, e.g., ATP, bioluminescence, fluorescent dye/marker, as appropriate. 6b) The facility has a process to consider other technologies for environmental disinfection, e.g., UV light, hydrogen peroxide vapor	☐ ☐	☐ ☐

HAI Specific Topics

	HAI Specific Practices	1) Implement CAUTI Roadmap Practices	1a) The facility provides care for patients with Foley catheters. 1b) The facility has performed a gap analysis of current policies and practices against the CAUTI recommendations. 1c) An implementation plan has been developed to address relevant gaps. 1d) The plan to address relevant gaps has been implemented to achieve at least 90% of the recommended practices.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
		2) Implement CLABSI Roadmap Practices	2a) The facility provides care for patients with central lines. 2b) The facility has performed a gap analysis of current policies and practices against the CLABSI recommendations. 2c) An implementation plan has been developed to address relevant gaps.	☐ ☐ ☐	☐ ☐ ☐
		3) Implement SSI Roadmap Practices	3a) The facility has an OR and does surgeries. 3b) The plan to address relevant gaps has been implemented to achieve at least 90% of the recommended practices. 3c) The facility has performed a gap analysis of current policies and practices against the SSI recommendations. 3d) An implementation plan has been developed to address relevant gaps. 3e) The plan to address relevant gaps has been implemented to achieve at least 90% of the recommended practices.	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
		4) Implement VAP Roadmap Practices	4a) The facility provides care for patients on ventilators. 4b) The facility has performed a gap analysis of current policies and practices against the VAP recommendations. 4c) An implementation plan has been developed to address relevant gaps. 4d) The plan to address relevant gaps has been implemented to achieve at least 90% of the recommended practices.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
		5) Implement CDI Roadmap Practices	5a) The facility has a process in place to manage patients with CDI. 5b) The facility has performed a gap analysis of current policies and practices against the CDI recommendations. 5c) An implementation plan has been developed to address relevant gaps. 5d) The plan to address relevant gaps has been implemented to achieve at least 90% of the recommended practices.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐