Outpatient Care Infection Prevention Survey Checklist with Answers 2018

The Standards	How to Achieve the Standards
1. Infection Control Policies and Procedures	
a. At least 1 staff has attended the Outpatient .0206 SPICE education.	NC requires at least one clinical person from every clinic that performs invasive procedures to attend this training. Contact Infection Prevention for more information.
b. Staff can articulate the procedure for reportable diseases.	Certain suspected or confirmed communicable diseases are to be reported to the local health department by the patient's physician-of-record. Reporting Of Communicable Diseases policy IC 0063. See Hospital Epidemiology's Did You Know "Reporting Communicable Diseases."
c. Staff can articulate the process for reporting suspected or identified infections related to procedures or surgeries performed at your facility or at **an outside facility.**	Hospital Epidemiology should be notified in the event a surgical site infection is identified or suspected in the outpatient setting. Report the patient's name, medical record number and date of surgery to the Hospital Epidemiology department. Staff directory is online. Ambulatory Care Clinical Services policy IC 0002.
STANDARD PRECAUTIONS: Includes hand hygiene, PPE, respiratory etiquette, isolation	
Aseptic technique is used when performing invasive procedures including injections, foley catheter insertion, central line dressing changes, biopsies, joint injection/aspiration, etc.	
2. Hand Hygiene - Clean Hands Save Lives! You are encouraged to participate in Clean In, Clean Out. Ask Infection Prevention for details.	
a. Artificial fingernails, including gel and shellac polish are not allowed on healthcare professionals.	Hand Hygiene and Use of Antiseptics for Skin Preparation - Policy IC 0024.
b. Soap and paper towels are available.	Paper towels must be accessible and maintained clean and dry. Hospital grade soap and approved alcohol based sanitizer must be available. No refilling of soap dispensers or sanitizer dispensers.
c. Hospital grade alcohol based hand sanitizer is used as appropriate.	Sinks in dirty utility rooms and other areas used for decontaminating equipment or disposal of potentially contaminated items cannot be used for hand hygiene.[2]
d. Staff can explain and/or staff is observed performing hand hygiene per Hand Hygiene and Use of Antiseptics for Skin Preparation policy IC 0024.	Staff performs hand hygiene: Before and after every patient contact, even if gloves are worn; Before and after an invasive procedure such as insertion of IV catheter or surgical procedure even if gloves are worn; After contact with blood or body fluids or non-intact skin even if gloves are worn; After contact with used contaminated equipment or soiled environmental surfaces even if gloves are worn.[2]
e. Hand hygiene is performed prior to donning and after removing gloves.	Hand hygiene is performed prior to donning gloves, prior to direct contact with patients and after removing gloves.[2]
f. Appropriate lotions are available.	Hand lotions/creams must be compatible with both the antimicrobial agent and use of nitrile gloves.[2]
3. Personal Protective Equipment (PPE)	
a. Staff dons and removes gloves at appropriate opportunities.	Wear gloves for procedures that might involve contact with blood or body fluids and when handling potentially contaminated patient equipment; Remove soiled gloves before moving to next task.
b. Additional PPE (i.e. gown, mask, face shield) is available and used if possible exposure to blood and/or bodily fluids is anticipated.	PPE should be matched to the patient's symptoms and the health care personnel's tasks. For example, wear a surgical mask to manage patients with respiratory symptoms and wear a gown to protect yourself from blood, body fluids and other potentially infectious material.[1]

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c. Surgical masks are worn when placing a catheter or injecting material into the spinal canal or subdural space (i.e., during myelograms, lumbar puncture and spinal or epidural anesthesia).	See reference 1.
4. Respiratory Hygiene/Cough Etiquette	
a. Respiratory etiquette signs are posted in the waiting areas with instructions to patients.	Reception areas and waiting rooms must have alcohol-based hand rub, tissues, masks (pediatric and adult as appropriate), trash receptacle and the relevant sign posted. [1]
b. Hand sanitizer, surgical masks, tissues are available.	
c. Patients with respiratory symptoms are placed in a private room (preferred) or cubicle or exam room as soon as possible for further evaluation.	
5. Isolation	
a. Staff are able to articulate isolation policies (for TB, chickenpox, respiratory illnesses).	See reference 1.
b. Staff are able to state how patients would be managed that have a known resistant organism (e.g. MRSA, VRE, C. difficile, draining wound or rash).	
6. Storage of Supplies	
a. Clean and sterile supplies and equipment are stored appropriately and are protected from contamination and/or tampering.	Clean and sterile supplies must be stored in a manner to prevent contamination. Bins used to store items must be clean upon inspection. Items should be removed from shipping cartons before storage to prevent contamination with soil/debris that might be on the cartons. Outer shipping boxes should not be left in clinical areas due to risk of environmental contamination. Supplies should be stored in plastic, washable containers; storage in cardboard is discouraged.
b. Sterile supplies/instruments set up ahead of time are protected from contamination or tampering.	If sterile supplies and instruments are set-up, if appropriate, ahead of time, they should be protected from contamination and/or tampering.
c. Patient care supplies stored at least 36" from a sink or there is a protective barrier (splash guard) to prevent splash contamination.	On the counter top, all items should be an adequate distance (36") from sink or there must be a splash guard installed next to sink.
d. No storage under sinks except for clean sharps containers, clean trash bags, detergents and cleaning agents (NO hand soaps).	To prevent water damage and/or contamination, only chemicals and reagents that do not react with each other or with water can be stored under sinks.
e. Supplies stored on shelves and off floors. Bottom shelf is at least 8" above the floor. Bottom shelf is a solid material.	Must be 8" off floor. Must be 24" from the ceiling. Items should be removed from shipping cartons before storage to prevent contamination.
f. Supplies are within expiration date.	Sterile items must be clean, within date and properly stored. There should be no open steri-strips or opened packing strip bottles. These items are for single patient use. Supplies should be stocked and rotated "first in, first out" so oldest items are used first.

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g. There is clear separation of clean and dirty activities.	Clean items/areas are clearly separated from dirty items. Need either separate clean/dirty rooms or the designated utility room must flow from clean to dirty.
h. Items labeled as "single use only" are not reused.	Items labeled as single use include: steri-strips, bottles of gauze packing, ultrasound gel, lubricating gel. Individual packets of US gel are preferred. Reuse of Single Use Devices (SUDs) Policy IC 0058 follows the FDA labeled guidelines that prohibit the reuse of SUDs except for rare departures.
7. Risk Analysis	
a. Types of procedures performed and services provided are appropriate for the physical space of the site as well as for the skill level and competency of staff.	New construction or renovations are in compliance with Infection Control standards. Infection Control is consulted prior to initiating new procedures or obtaining new equipment.
8. Medication Management	
a. Medications must be separated by type and dosage.	All medications be stored separated by type and dosage in labeled, plastic, washable bins.
b. Medications are secured.	Secured means that medications are under the direct visual field of health care personnel at all occupied times -- or -- under lock and key.
c. Medications are stored appropriately.	Ideally, medications are stored in a medication grade refrigerator. Topical and internal medications are to be stored to prevent possible cross contamination and medication errors. Chemicals (e.g. nail polish remover, betadine) are not to be stored adjacent to medications. Medication Management: Use Of Multi-Dose Vials/Pens Of Parenteral Medications In Acute Care and Ambulatory Care Environments policy ADMIN 0104.
d. Requirements for storage and use of NC state supplied vaccines are met.	See the NC State immunization website for details: http://www.immunize.nc.gov
e. Irrigation solutions (saline/sterile water) are single patient use	Irrigation solutions (bottles of sterile water, acetic acid, saline, etc.) are single use and must be discarded after use. Betadine or other solutions poured into a secondary container must be labeled with the name of the solution and hazard information (if any) from the primary label or SDS. These solutions, once poured into a secondary container are single use and must be discarded immediately after use.
f. Medications are within date	No expired medications. Multi-dose vials of injectable medications expire according to drug manufacturer's FDA-approved labeling and UNCH Medication Management policy.[3]
g. Medications requiring special care after initial use are stored/labeled appropriately	Special care meds include meds requiring refrigeration or meds not kept at room temp for longer than manufacturer's recommendation, meds with a shorter usage period as stated on the vial label by pharmacy or manufacturer (e.g. specific ophthalmic solutions, insulin-varies by manufacturer and type).
9. Medication Refrigerators and Freezers	
a. Refrigerators and freezers are large enough to properly store medications.	Ideally, medications are stored in a medication grade refrigerator. Refrigerators and freezers must be large enough to store the year's largest inventory of medications.
b. Refrigerators and freezers well maintained and clean.	Clean and well maintained. No expired medications. Store patient food, medications, and specimens in separate labeled refrigerators.

<table>
<tr><th>The Standards</th><th>How to Achieve the Standards</th></tr>
<tr><td>c. Medication refrigerator temperatures maintained between 36-46 degrees F (2-8 degrees Celsius).
Note: Clinics with state-supplied vaccines should use the NC state refrigerator and freezer logs available at http://www.immunize.nc.gov/providers/index.htm</td><td rowspan="2"><table><tr><th></th><th>Fahrenheit</th><th>Celsius</th></tr><tr><td>Medication Freezer</td><td>5° to -13°</td><td>-15° to -25°</td></tr><tr><td>Medication Refrigerator</td><td>36° to 46°</td><td>2° to 8°</td></tr></table></td></tr>
<tr><td>d. Medication freezer maintained below 5 degrees F (below -15 degrees Celsius).</td></tr>
<tr><td>e. An appropriate means to check medication in event of a power outage is in place.</td><td>All areas will have a reliable and traceable method of monitoring temperatures in all medication refrigerators and freezers. Staff demonstrate how to verify the Min/Max temperatures and how to clear the memory if relevant. Minimum and maximum temperatures shall be routinely checked and action taken for out-of-range temperatures. For remote monitoring, staff are identified to receive alerts and pull reports. For power outages of less than two hours, leave doors to refrigerators and freezers closed. Proper storage temperatures will be maintained for at least 2 hours if doors are not opened. In the event of a power outage lasting longer than two hours, call the Pharmacy Support Service during normal working hours. If no answer, call the Inpatient Pharmacy.</td></tr>
<tr><td colspan="2">ONE NEEDLE: ONE SYRINGE: ONE PATIENT: ONE TIME</td></tr>
<tr><td colspan="2">10. Safe Injection Practices</td></tr>
<tr><td>a. Medications are prepared safely</td><td>Medications/injections are prepared using aseptic technique in a clean area away from contamination or contact with blood, body fluids or contaminated equipment. Maintains a clean, uncluttered, and functionally separate area for medication preparation. Needles and syringes are discarded immediately after use. NEVER dismantle dirty needles or syringes where medications are prepared. Maintain separation of clean and dirty activities.</td></tr>
<tr><td>b. Single dose vials are never used as multi-dose vials.</td><td>Single dose vials should be used whenever possible and discarded immediately after use.[3]</td></tr>
<tr><td>c. If multi-dose vials must be used for more than one patient, they should be kept and accessed in a dedicated medication prep area (e.g., nurses station) / medication room), away from immediate patient treatment areas.</td><td>Examples of immediate patient treatment areas include exam rooms, operating and procedure rooms, anesthesia and procedure carts, and patient rooms or bays.</td></tr>
<tr><td>d. Fluid infusion and administration sets (IV bags, tubing, and connectors) are used for one patient only and discarded after use.</td><td>Bags of IV fluids are ALWAYS single use.[3]</td></tr>
<tr><td>e. IV fluids are spiked and primed at time of use.</td><td>IV fluids are spiked and tubing is primed immediately prior to use. Preoperative areas (PCS), GI procedures, and outpatient infusion areas are allowed to spike and prime IV sets up to 96 hours. Spiked and primed IV set-ups must be secured until used.</td></tr>
<tr><td>f. Patient's skin is prepped with an approved prep before IV placement.</td><td>Approved skin prep agents are alcohol or chlorhexidine gluconate (CHG).[2]</td></tr>
</table>

The Standards	How to Achieve the Standards
g. Single dose medications or infusates are used for only one patient and not collected or combined (bags of IV fluids are ALWAYS single use).	No combining of "left-overs" from single dose vials. No flushes drawn from bulk sources such as bags of IV fluids.
h. Multi-dose medication vials used for more than one (1) patient are always entered with a new needle and new syringe.	Medication vials used for more than one patient must be labeled as "multi-dose" by the drug manufacturer. Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., exam room, operating room, patient room/cubicle).[1,3]
i. Multi-dose and single dose vials are managed consistent with current Safe Injection Practices guidelines.	The safest practice is to enter a single-dose or single-use vial only once to prevent inadvertent contamination of the vial and infection transmission. Single-dose or single-use vials should be used for a single patient and a single case/procedure/injection. Therefore, they should require only a single entry into the vial. If the single-dose or single-use vial will be entered more than once for a single patient as part of a single procedure, it should be with a new needle and new syringe, and the vial must be discarded at the end of the procedure and not stored for future use. https://www.cdc.gov/injectionsafety/providers/provider_faqs_singlevials.html https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html
j. The rubber septum on a medication/infusate vial is disinfected with alcohol prior to piercing the septum.	Disinfect all rubber septums with a robust wipe with alcohol whether or not the vial has just been opened.
k. Needles and syringes are used for only one patient.	NEVER, NEVER, NEVER re-use needles or syringes.
l. Medications or infusates that are packaged as prefilled syringes are used for only one patient.	Pre-filled syringes are ALWAYS single dose.
m. Hand hygiene is performed before preparing medications.	See Reference 2.
n. Injectable medications are drawn up at start of each procedure, unless otherwise approved by policy.	Any injectable medication drawn from a single dose vial must be injected within an hour of drawing up. Compliance with USP 797 **prohibits** "pre-drawing" injectable medications from a single dose vial unless done under a hood which meets ISO class 5 conditions.
o. Needles and syringes are discarded intact in an appropriate sharps container after use.	Safety devices are deployed; needles should not be removed from syringes.
p. Flushes are not drawn from a bulk container.	Bags of IV fluids are ALWAYS single use. Manufacturer pre-filled syringes, i.e., sterile saline, heparin, are used for IV flushes.
q. Appropriate safety devices are in use. Exceptions have an approval from Hospital Epidemiology.	OSHA regulation requires sharps safety devices to be used unless not appropriate or effective.
r. Sharps are secured.	"Secured" means that sharps (e.g., needles, scalpel blades) are under the direct visual field of health care personnel at all occupied times -- or -- under lock and key.[1]
11. Linens	
a. Linens are stored appropriately	Clean linen must be stored in designated area to prevent contamination from traffic and to reduce risk of linen falling on floor.[1]

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b. Linens are laundered according to UNC Infection Control's Laundry and Linen Service policy	Clean linen must be kept covered if not in a closet, drawer, or cabinet. Laundry and Linen Service policy IC 0034.
c. Soiled linens are handled and stored appropriately.	See Reference 1.
12. Surface Disinfection	
a. Toys are disinfected per UNCH policy.	Toys should be restricted to only those that are non-porous and easily cleaned. Washable toys/sand tables are cleaned with soap and water or surface disinfectant (i.e., Sani-Cloths) and rinsed with tap water on a routine basis (e.g. weekly) and when visibly soiled. Plush toys are to be new and given to the individual patient to take home.[1]
b. Non-critical items and surfaces are cleaned routinely, (i.e., weekly).	Non-critical items are those that come into contact with intact skin. Single use disposable BP cuffs are to be used for one patient and discarded after use. Environmental Services policy IC 0020.
c. Expiration dates: spray surface disinfectants, e.g., Metriguard.	Ensure spray disinfectants are not past the manufacturer's expiration dates stamped on the original container.
d. Patient care equipment (e.g., blood pressure cuffs, wall mounted otoscopes, etc.) should be cleaned with an EPA registered disinfectant detergent (e.g., (No Suggestions)®, Super Sani Cloths) once a week, when obviously soiled, and after use for patients requiring Contact Precautions.	Cleaning supplies are in their proper place. Only hospital grade approved germicidals are to be used for cleaning surfaces in the healthcare environment. Exam tables, recliners and short-term use beds should be cleaned weekly, when visibly soiled, and after use for patients requiring Contact Precautions.
e. Areas identified as nursing responsibility are cleaned appropriately.	Some examples include medication storage areas, electrical equipment.
f. Point-of-care devices are cleaned according to policy.	Medical equipment that involves potential cross transmission must be cleaned according to policy; glucometers must be cleaned between every patient with a hospital grade approved disinfectant.
g. Point-of-care control solutions and test strips are dated with open/expiration dates.	
Instrument Reprocessing	
All reusable equipment is high-level disinfected or sterilized according to manufacturer's instructions and/or evidence-based guidelines and according to UNC Cleaning, Disinfection, and Sterilization of Patient-Care Items policy.	
****Please continually reassess all instruments being sent for sterilization to see if any of them can be switched to disposables****	
All elements in the instrument reprocessing sections are consistent with the UNCH Cleaning, Disinfection, and Sterilization Policy, IC 0008	
13. Instrument Decontamination/pre-cleaning	
a. Items are thoroughly pre-cleaned and decontaminated with enzymatic detergent according to manufacturer instructions and/or evidence-based guidelines prior to high level disinfection or sterilization.	Staff can demonstrate understanding of manufacturer's instructions for use.
b. Enzymatic detergents.	Must be accurately measured following the manufacturer's instructions on the label.
c. Enzymatic detergents.	Must have measuring tools, e.g., cups, basins, tubs, sinks.

The Standards	How to Achieve the Standards
d. Enzymatic detergents.	Basins, cups, tubs and sinks must be marked with increments of water and enzymatic detergent.
e. Enzymatic detergents.	Must have simple digital timer for enzymatic soak time. Check product label for required soak times. For example, items decontaminated in Valsure must be soaked for at least 2 - 5 minutes and must have that period of time validated by a timer.
f. Transporting used (dirty) equipment to instrument reprocessing area.	All used and dirty equipment/devices that are bound for sterilization, HLD, or decontamination must be transported from **point of use** in a leak-resistant, rigid or non-rigid container marked "biohazard" such as a plastic basin with a lid or a biohazard bag. Sharps must be transported from **point of use** in a puncture-resistant container.
g. Manufacturer's instructions for cleaning and/or disinfection for every item reprocessed.	There must be hard copies or readily available electronic copies of device/equipment manufacturer's instructions for cleaning, disinfection and/or sterilization on site.
14. High Level Disinfection	
a. Medical instrument and devices are visually inspected for residual soil and re-cleaned as needed before high level disinfection.	
b. HLD equipment (e.g., AER) is maintained according to manufacturer instructions and/or evidence-based guidelines.	AERs are maintained and logs kept of maintenance of AERs strictly in accordance with manufacturer's IFUs.
c. Chemicals used for HLD are prepared according to manufacturer instructions, UNC infection control policy, and evidence-based guidelines.	Only Infection Control-approved HLDs such as Cidex glutaraldehyde, Rapicide glutaraldehyde, Rapicide PA, Resert may be used.
d. Chemicals used for HLD are documented to have been prepared and replaced according to manufacturer instructions and/or evidence-based guidelines	All labels on all HLD products must be read and instructions followed.
e. HLD expiration date must be affixed to original containers and secondary containers.	Note that HLD expiration dates vary depending on the specific HLD chemical in use: Example: when glutaraldehyde (Cidex®) is opened/activated on September 5, the 14 day use-life (or expiration date) is September 19. Example: when Resert (Revital-Ox)® is poured out of the gallon into your secondary container on September 5, the 21 day use-life (or expiration date) is September 26. Check all HLD chemical and test strip labels for correct information.
f. Equipment is high-level disinfected according to manufacturer's instructions and/or evidence-based guidelines and according to UNC Cleaning, Disinfection, and Sterilization of Patient-Care Items policy.	Cleaning, Disinfection, and Sterilization of Patient-Care Items - IC 0008
g. Containers of HLD chemicals must be labeled with chemical name, hazard information and expiration date.	The name of product as shown on the original container label must be affixed to the secondary container. Hazard information may be obtained from the original product container or from the product's SDS. Actual expiration date after original container is opened must be shown on the container into which the chemical is poured, known as the "secondary" container.

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h. Items that undergo HLD are dried before re-use.	A wet instrument is NEVER ready to use on a patient.
i. HLD logs are in order.	There must be an entry on your HLD log for **every day of the month**. If your HLD is not used on a day, indicate that on your log by the date and the words "not used on this day" written on the line to the right of the initials and date. Draw a line through the remainder of that day's entry. There is no need to log the temperature or test the solution on days it is not used.
j. HLD logs are in order.	You must document the temperature of your HLD chemical in the appropriate column on the log once a day on days it is used.
k. HLD logs are in order.	Keep only one sheet immediately available, i.e., in your notebook or on the clipboard. Older sheets should be stored separately but available if asked for. As always, these logs must be kept for 5 years.
l. Chemicals used for HLD are tested for minimum effective concentration (MEC) before each and every use according to manufacturer instructions.	All HLD test strips instruct to test HLD chemicals before each and every use. If the HLD chemical is used 15 times a day, there must be 15 entries on the HLD log.
m. Expiration dates: HLD test strip bottles must be dated when opened and when expiring.	Use a permanent marker (i.e., Sharpie) and write "opened" and "exp" for these dates. It's OK to use the areas supplied by the test strip manufacturer on some bottles for the correct expiration date.
n. Quality control testing of HLD test strips.	**Cidex® brand** test strips require quality control activities when opening a new bottle of test strips. This activity includes testing 3 strips in full-strength solution and 3 in half-strength solution. **FULL DETAILS are in the instructions that came with your test strips.**
o. Quality control testing of HLD test strips.	**Resert (Revital-Ox)®** brand test strips require quality control activities only when opening a bottle of test strips from a **new lot number**. When appropriate, this activity includes testing 3 strips in a full-strength solution and 3 strips in a half-strength solution. **FULL DETAILS are in the instructions that came with your test strips and must be followed.**
p. Quality control testing of HLD test strips.	**Comply® 3M brand** test strips do not require any quality control activities as do Cidex® brand test strips and Resert® brand strips.
q. Individuals with HLD responsibilities have attended the HLD class.	Class is offered monthly by the Infection Prevention Department. Contact Infection Prevention for details.
r. Individuals with HLD responsibilities have the ability to interpret color differences.	Individuals performing HLD have attestation whether or not they are color blind on file at the clinic. Clinics are responsible for keeping this protected health information in a HIPAA-compliant manner.
s. Colonoscopes and bronchoscopes.	Must be stored without any circular arrangement (no "loops") of the insertion tube. A mild "S" shape is acceptable. Ends of the colonoscope or bronchoscope must be hanging free and not touching the bottom of the scope cabinet or any other container.
15. Sterilization	
a. Autoclaves: chemical and biological indicators are used appropriately.	Internal chemical indicators must be used in each package to be sterilized; the chemical indicator must be examined before the contents are used.
b. Biological indicators run at least weekly.	Biological indicators are to be run at least weekly and must be used with each load containing implantable devices.
c. Sterilization logs accurate and up to date.	The required sterilization log must be used for all counter-top and clinic-based sterilizers.

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d. Sterilizer maintenance logs must be accurate and up to date.	Logs of at least weekly, monthly, and periodic maintenance must be kept.
e. Sterile packages are inspected for integrity and compromised packages are reprocessed.	Instruments in torn, wet, or damaged sterilization pouches must be re-sterilized.
e. Sterilization equipment (e.g., sterilizers, ultrasonic cleaners, washer/disinfectors) is maintained according to manufacturer instructions and/or evidence-based guidelines.	Sterilizer manuals must be onsite and reviewed by all staff using the sterilizer.
16. Trophon	
a. Cleans probe with the appropriate Sani Cloth. Probe is dry prior to commencing the HLD process.	Cleans hands, wear gloves.[4]
b. Cartridge date changed and expiration date is on log.	Cartridges expire 30 days after installing in the Trophon.
c. Cartridge is not expired.	Cartridges expire 30 days after installing in the Trophon.
d. Chemical indicators are not expired.	Only Trophon chemical indicators may be used.
e. Chemical indicators (CI) are used for every HLD cycle.	Only Trophon chemical indicators may be used.
f. Chemical indicators are stored in a clean/dry area, out of direct heat/UV light.	Chemical indicators expire on manufacturer's stamped expiration date.
g. Disinfected probes are stored and covered with an unused peel pouch, separate from where they are disinfected.	High-level disinfected vaginal probes or rectal probes that are ready-to-use must be covered with a peel pack "sleeve". The sleeve should have a second label from the Trophon cycle in which it was high-level disinfected.[4]
h. Log is complete for disinfection cycle: Pass/Fail; All boxes checked, date and initials present.	The prescribed log must be used for all Trophon cycles.[4]
17. General Decontamination/HLD/Sterilization	
a. Proper PPE is worn when processing dirty equipment.	Water-proof or water-resistant gown, disposable gloves (nitrile if performing HLD activities), and full face protection must be worn when processing dirty instruments.
b. Competencies are maintained for cleaning, disinfection and sterilization processes.	Records of staff training must be documented. HLD competency is evaluated at commencement of employment and at least yearly thereafter.
c. HLD, decontamination, and /or sterilization is performed in appropriate environment.	HLD, decontamination and/or sterilization may not be performed in a patient care area.
e. Areas used for cleaning or disinfection flow from dirty to clean.	There must be clear separation between clean and dirty areas of these rooms. It may be helpful to place a line of demarcation between these areas in your room.
f. There is a procedure in place for identification and recall of inadequately sterilized or high level disinfected instruments.	UNC Infection Prevention department must be notified immediately if there is a suspected/known HLD or sterilization failure: 984-974-7500.

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<tr><td>g. After sterilization or high level disinfection, devices and instruments are stored in a designated clean area so sterility/cleanliness is not compromised.</td><td>Sterilized and high-level-disinfected items should not be stored in instrument processing areas.</td></tr>
<tr><td>h. There is a distinct separation strategy in place to clearly differentiate dirty, not-ready-to-use instruments from clean, ready-to-use instruments.</td><td>High-level disinfected vaginal probes or rectal probes that are ready-to-use may be covered with a peel pack "sleeve." Flexible endoscopes of any type (ENT, cystoscopes, hysteroscopes, etc.) should use a tagging system: a green tag means "ready to use and clean," and a red tag means "dirty" and must be high-level disinfected before use on the next patient. Consult with Infection Prevention for guidance.</td></tr>
<tr><td colspan="2">18. General Issues</td></tr>
<tr><td>a. Areas free of dust, dirt, soil, trash, odors, clutter and hazards (fixtures, walls, ceilings, floors).</td><td>Ceiling tiles all intact, clean, dry and no stains.</td></tr>
<tr><td>b. Areas and furnishings are in good repair.</td><td>Paint intact, cabinet doors functioning properly, no rips, holes, or cracks in vinyl upholstery.</td></tr>
<tr><td>c. Exam tables/procedure chairs are not ripped or torn.</td><td>Unable to be properly cleaned/disinfected.</td></tr>
<tr><td>e. Staff food and drinks are placed in appropriate areas.</td><td>Stored away from patient care areas and in compliance with NC OSHA blood borne pathogen regulations.</td></tr>
<tr><td colspan="2">19. Nourishment Refrigerator</td></tr>
<tr><td>a. Nourishments and medications are stored separately.</td><td>Patient nourishments are to be single-serving, individually sealed portions. Patient food refrigerator temperatures are must monitored and documented routinely on the appropriate refrigerator log.
<table>
<tr><th></th><th>Fahrenheit</th><th>Celsius</th></tr>
<tr><td>Food Freezer</td><td>Below 0°</td><td>Below -17°</td></tr>
<tr><td>Food Refrigerator</td><td>41° or less</td><td>7° or less</td></tr>
</table></td></tr>
<tr><td>b. Nourishments are within date.</td><td>Expiration date should be visible on all food/medication.</td></tr>
<tr><td>c. Nourishment refrigerator does not contain specimens, culture media and/or medications.</td><td>Medications and food must be stored in separate refrigerators with all items within date and not stored with specimens.</td></tr>
<tr><td>d. Ice chests and ice machines are maintained according to national and North Carolina state guidelines.</td><td>Machines that automatically dispense ice are preferred. Periodic cleaning and maintenance must be per the manufacturer's instructions and be documented. After cleaning, rinse all surfaces of the ice machine with tap water and wipe dry. Ice machines shall be cleaned on a regular schedule such that they are kept free of scum, rust, mold or other contamination. Ice machines shall be maintained in good repair and shall be protected from the elements, splash, drip, dust, vermin, other contamination. Ice machines which are accessible to patients or the public shall provide ice through automatic ice dispensing equipment which prevents the contamination of stored ice. 1A NCAC 18A.1314.</td></tr>
<tr><td>e. Food refrigerators are clearly marked "staff" or "patient" food as appropriate.</td><td>Infection Control Guidelines for Adult and Pediatric Inpatient Care Policy IC 0030. Guidelines for Infection Control in Nutrition and Food Services Policy IC 0039</td></tr>
<tr><td colspan="2">20. Lab Refrigerators</td></tr>
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<tr><th>The Standards</th><th>How to Achieve the Standards</th></tr>
<tr><td>a. Specimen and culture media are stored separately from food and medications.</td><td>Medications and food must not be stored with specimens.</td></tr>
<tr><td>b. Specimens and lab regents are stored appropriately.</td><td>Laboratory reagents and specimens must be stored separately from medications.</td></tr>
<tr><td>c. Specimen refrigerator temperature monitoring.</td><td>To maintain integrity of specimens for testing.[1]
<table>
<tr><th></th><th>Fahrenheit</th><th>Celsius</th></tr>
<tr><td>Specimen Freezer</td><td>5° to -4°</td><td>-15° to -20°</td></tr>
<tr><td>Specimen Refrigerator</td><td>36° to 46°</td><td>2° to 8°</td></tr>
</table></td></tr>
<tr><td>d. Specimen refrigerators must display a BIOHAZARD label.</td><td>OSHA regulation.</td></tr>
<tr><th colspan="2">21. References</th></tr>
<tr><td colspan="2">1. Ambulatory Care Clinical Services policy IC 0002</td></tr>
<tr><td colspan="2">2. Hand Hygiene and Use of Antiseptics for Skin Preparation policy IC 0024</td></tr>
<tr><td colspan="2">3. Medication Management: Use Of Multi-Dose Vials/Pens Of Parenteral Medications In Acute Care and Ambulatory Care Environments policy ADMIN 0104</td></tr>
<tr><td colspan="2">4. Cleaning, Disinfection, and Sterilization of Patient-Care Items policy IC 0008</td></tr>
<tr><td colspan="2">CMS Infection Control Worksheet for Ambulatory Surgical Centers. https://www.cms.gov</td></tr>
<tr><td colspan="2">Injection Safety. https://www.cdc.gov/injectionsafety/index.html</td></tr>
<tr><td colspan="2">Compounding Standards USP 797</td></tr>
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