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Infection Prevention Plan FY2026

I. Description

Outlines the annual infection prevention priorities of Infection Prevention and UNC Hospitals. An organized, systematic plan based upon the annual infection control risk assessment that provides the foundation for an effective infection prevention program. This plan is the annual supplement to the Infection Prevention policy: Infection Prevention Program.

II. Policy

A. Goals

1. Overall
    - Reduce risk of healthcare-associated infections (HAI) for all patients, staff, and visitors by limiting unprotected exposures to pathogens, transmission of infection associated with procedures, and transmission of infections associated with the use of medical equipment, devices, and supplies.
2. Targeted
    a. Healthcare-associated infection reduction – a 44% reduction of central line-associated bloodstream infections (CLABSI) hospital-wide, excluding those defined as mucosal barrier injuries (MBI).
    b. Healthcare-associated infection reduction – a 44% reduction of *Clostridioides difficile* infections (*C. diff*) hospital-wide.
    c. Improving compliance with hand hygiene guidelines through the Clean In,

Clean Out hand hygiene compliance program.

- Units and departments consistently (>90%) achieve designated thresholds for hand hygiene observations.

B. Risk Assessment

See Attachment 1: UNC Facility Risk Assessment

1. Patient Populations at Increased Risk of Infection
    a. All intensive care unit patients
    b. Solid organ transplant patients
    c. Burn patients
    d. Hematopoietic Stem Cell Transplant (HSCT) and Cellular Therapy patients
    e. Immunosuppressed patients (e.g., absolute neutrophil count [ANC] <1000, agranulocytosis)
2. Procedures/Devices that Increase Infection Risk
    a. Central venous catheters
    b. Indwelling urinary catheters
    c. Tubes, drains, other devices inserted percutaneously
    d. Intubation and prolonged ventilator support
    e. Surgical procedures
    f. Extracorporeal membrane oxygenation (ECMO)/Ventricular assist device (VAD)
3. Epidemiologically Important Pathogens
    a. Legionella
    b. Mold (e.g., Aspergillus, Rhizopus, Mucor)
    c. Methicillin-resistant *Staphylococcus aureus* (MRSA)
    d. Vancomycin-resistant *Enterococcus* (VRE)
    e. *Clostridioides difficile (C. difficile)*
    f. Multidrug-resistant bacteria (MDR) Gram negative bacteria
    g. Carbapenem-resistant *Enterobacteriaceae*
    h. *Candida auris*

4. High Consequence Pathogens

    - High consequence pathogens will include pandemic influenza strains including highly pathogenic avian influenza (e.g., H5N1, H7N9), SARS-CoV, MERS-CoV, *Y. pestis*, agents of viral hemorrhagic fevers (Ebola, Marburg, Lassa, Congo-Crimean fever), certain Hanta viruses, certain pox viruses (e.g., smallpox, Mpox, vaccinia), and any other highly pathogenic emerging infectious disease as deemed appropriate.

C. General Strategies to Reduce Infection Risk

The following are evidence-based strategies recommended to prevent infections. Some of these are led by the Department of Infection Prevention and others by our partners with this department's support.

1. Identify risk for acquiring and transmitting infections based on geographic location, community and population served

    a. Receive public health alerts on community illnesses and trends from the NC Public Health Department.

    b. Public Health Epidemiologist(s) at UNC Hospitals to act as liaison between UNC Hospitals and the Public Health Department.

    c. Attend biannual Public Health Institutional Task (PHIT) Force meetings with Public Health Department leadership and other facilities in our area.

2. Identify and control outbreaks

    a. Review of microbiology, immunology, and molecular microbiology reports

    b. Prospective and syndromic surveillance

    c. Pulsed field gel electrophoresis of outbreak pathogens

    d. Epidemiologic assessment as indicated (e.g., timeline, epidemic curve, case-control study)

    e. Institution of prevention and control measures as indicated (e.g., isolation, cohorting of patients and staff, improved hand hygiene, active surveillance cultures, assessment of environmental cleaning, and enhanced environmental cleaning)

    f. Exposure follow-up (in conjunction with Occupational Health Services [OHS])

3. Perform surveillance for healthcare-associated infections

    a. Follow CDC National Healthcare Safety Network (NHSN) definitions

    b. Prospective and targeted retrospective

c. Comprehensive: inpatient-related and outpatient-detected

d. Calculation/distribution of monthly infection rates and line listing of infected patients for each inpatient unit/service line

e. Analysis of infection data to examine healthcare equity issues

f. Monthly and as needed analysis of potential for cross-transmission

g. Targeted surveillance for home health/hospice infections

h. Monitor incidence of healthcare-associated device-related or procedure-related infections

    i. Central Line-Associated Bloodstream Infections (CLABSI)

    ii. Ventilator-Associated Events (VAE)

    iii. Surgical Site Infections (SSI)

    iv. Catheter-Associated Urinary Tract Infections (CAUTI)

i. Monitor incidence of *Clostridioides difficile* infections (CDI) in hospitalized patients

4. Monitor and audit key process data on healthcare-associated device-related or procedure-related infections and make accessible to stakeholders, including leaders, licensed practitioners, nursing staff, and all UNC Hospitals staff through dashboard.

5. Conduct routine monitoring

    a. Biological indicators for tabletop sterilizers

    b. Endoscopes used for Endoscopic Retrograde Cholangiopancreatography (ERCP)

    c. Dental water lines

    d. Water baths in Transfusion Services

6. Improve Hand Hygiene Compliance

    a. Support compliance monitoring through Clean In, Clean Out program and provide feedback to staff

    b. Routinely evaluate the availability and acceptability of hand hygiene products

    c. Provide just-in-time peer coaching

    d. Offer tailored education on when and how to perform hand hygiene

    e. Enlist organizational leaders to serve as role models

f. Ensure commitment of leadership to achieve and sustain compliance of ≥ 90%. Managers must hold everyone accountable for proper hand hygiene.

g. Continue to support efforts to engage patients and families in hand hygiene improvements activities.

h. Continue to promote engagement in Clean In, Clean Out across all areas.

7. Support Infection Control Liaison Program

    a. Unit-based staff, outpatient care services clinical staff, and ancillary care staff (i.e., Environmental Services, Nutrition and Food Services, Patient Transport) with focused infection control training provided by Infection Prevention.

    b. Responsible for assessing their area's compliance with infection control policies/procedures and conducting performance improvement activities related to infection prevention (e.g., reducing device-associated infections, monitoring, and improving hand hygiene compliance)

    c. Serves as the contact person to disseminate infection control information, updates, and answer staff questions

8. Ensure compliance with Infection Prevention related Joint Commission National Patient Safety Goals

    - Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and/or the current World Health Organization (WHO) hand hygiene guidelines.

9. Prevent HAI due to multi-drug resistant organisms (MDROs)

    a. Annual risk assessment for MDRO

    b. Ensure infection control policies support prevention strategies

10. Implement evidence-based strategies for prevention of Central Line-Associated Bloodstream Infections (CLABSI)

    a. Annually review and revise Central Line Insertion, Access, and Maintenance Bundle as needed, and provide ongoing education on bundle

    b. Monitor and promote chlorhexidine gluconate (CHG) treatments in intensive care units, select step-down units, and dedicated oncology units

    c. Promote processes for daily assessment of central line need

    d. Collect and analyze peer audit data on central line dressing, tubing, and disinfecting cap maintenance, and disseminate compliance data to unit leadership monthly

e. Provide just-in-time coaching on central line dressings, tubing, and disinfecting caps to frontline staff and periodic feedback to nurse managers

f. Support units and service leader teams in performing case reviews for CLABSI, if part of unit's prevention strategy

g. Create educational materials as needed on specific topics around CLABSI prevention projects:

    i. Carolina Antimicrobial Stewardship Program (CASP): diagnostic stewardship

    ii. Center for Nursing Excellence (CNE): all CLABSI prevention-related education

    iii. Central Line Insertion Quality Improvement Consortium (CLIQIC): support for standardized insertion training and checklist for providers

    iv. CVAD Liaison Team: various projects including central line necessity and maintenance of challenging dressings

    v. Epic team: improvement of EMR related to documentation on central lines

    vi. Vascular and Interventional Radiology (VIR) and Venous Access Team (VAT): best line type for patient

    vii. Value Analysis Team: product roll outs

    viii. Multidisciplinary colleagues: Providers, nursing, pharmacy, nursing assistants, etc.

11. Implement evidence-based strategies for prevention of Surgical Site Infections (SSI)

    a. Annually review and revise SSI Prevention Bundle as needed and provide ongoing education on bundle.

    b. Collaborate with PreOp colleagues to ensure CHG wipes and appropriate education are available for patients.

    c. Promote standardized, evidence-based practices for patient skin preparation prior to surgery. Use previously created LMS for staff education and update LMS as needed.

    d. Collaborate with local and system groups as needed to include evidence-based SSI prevention measures on Enhanced Recovery After Surgery (ERAS) pathways.

    e. Ensure Peri-Operative Services and Anesthesia infection control policies support prevention strategies.

f. Participate in Peri-operative Quality Council to provide perspective from infection prevention on all peri-op projects

g. Trend surgical procedure-specific infection rates and unit rates, provide feedback to key stakeholders, and plan collaborative interventions as necessary.

12. Implement evidence-based strategies for prevention of Catheter-Associated Urinary Tract Infections (CAUTI)

    a. Annually review and revise CAUTI Prevention Bundle as needed and provide ongoing education on bundle.

    b. Collaborate with CNE to ensure staff education includes:

        i. Aseptic insertion of catheter

        ii. Daily assessment for urinary catheter need

        iii. Appropriate maintenance of indwelling urinary catheters

    c. Collaborate with Carolina Antimicrobial Stewardship Program (CASP) on work related to diagnostic stewardship.

    d. Collect and analyze peer audit data on urinary catheter securement, collection bag placement, and catheter care completion and disseminate compliance data to unit leadership monthly.

    e. Provide just-in-time coaching on indwelling urinary catheter maintenance to front-line staff and periodic feedback to nurse managers.

13. Implement evidence-based strategies for prevention of *Clostridioides difficile* infections

    a. Annually review and revise *C. difficile* Prevention Bundle as needed and provide ongoing education on bundle.

    b. Collaborate with Carolina Antimicrobial Stewardship Program (CASP) on work related to diagnostic and antimicrobial stewardship

    c. Partner with Clean In, Clean Out program to promote appropriate hand hygiene during care of patients with *C. difficile*.

    d. Collaborate with provider and nursing colleagues on use of enteric precautions for patients with *C. difficile* infection during treatment and for 30 days post treatment.

    e. Continue partnership with Environmental Services in ensuring:

        i. Use of bleach for daily and terminal cleaning for rooms of patients with *C. difficile* infection

ii. Use of ultraviolet light technology for terminal cleaning of rooms of patients with *C. difficile* infection

iii. Monitor compliance with terminal cleaning practices

iv. Promote standardization of terminal cleaning responsibilities by involving other disciplines as needed (i.e., nursing, patient equipment).

14. Manage HAIs as Sentinel Events When Indicated

    a. Review all HAIs for indications of an unanticipated death or permanent loss of function

    b. Notify Risk Management of suspected sentinel event via internal notification system

    c. Participate in root cause analysis and follow up as requested

15. Construction Rounds and Construction Risk Assessment Meetings

    a. Rounds with Plant Engineering every 2 weeks to active construction and renovation sites in UNC Hospitals and on an as needed basis

    b. Attend construction meetings held by Plant Engineering and Contract Services as needed

    c. Review blueprints and risk assessments for all new construction and renovations in clinical areas

16. Infection Prevention Rounds

    a. Evaluate compliance with infection prevention policies and practices

    b. Communicate recommendations to manager with their follow-up documented

17. Policy Review and Revision

18. Committee Participation: Refer to the Infection Prevention policy: Infection Prevention Program for committee information

19. Periodic Comprehensive TB Risk Assessment

20. Consultation, Education/Training

    a. In-services, presentations, educational material to staff, visitors/families, licensed practitioners, contract employees, students, and volunteers

    b. Computer-based training modules

    c. Educational videos

d. Newsletter articles

e. Educational materials (e.g., flyers, booklets, brochures)

f. Quality Improvement support from Infection Prevention Quality Improvement Staff

g. On-call availability 24/7 for Infection Prevention consultation

21. Additional Strategies to Reduce Infections for the Immunosuppressed Patient (e.g., absolute neutrophil count [ANC<1000], agranulocytosis)

    a. Ideally a private positive pressure room, HEPA filtration for hematopoietic stem cell transplantation (HSCT) patients

    b. No live plants or fresh flowers

    c. Immunosuppressed diet per physician order

    d. Patient must wear tight-fitting surgical mask when outside room

    e. Child visitor restrictions during periods of high respiratory viral activity

22. Additional Strategies for Home Health and Hospice

    - Trend analysis of device-related infections (urinary catheter-associated UTIs and central line-associated bloodstream infections)

D. Specific Strategies to Address Infection Risks

1. Based on the Facility Risk Assessments, the following strategies will be employed in FY26 for elements with scores of ≥ 5:

    a. Care of a patient with a suspected or confirmed high consequence pathogen

        i. Coordinate High Consequence Pathogen Preparedness Committee

        ii. Refine Special Pathogen Response Center (SPARC) activation protocols, training, and exercise development

    b. Outbreaks with vaccine preventable diseases (e.g., measles, pertussis, meningococcal)

        i. Provide infection prevention education to staff who may encounter patients with vaccine preventable diseases

        ii. Develop internal workflows for outbreak prevention and control

    c. CLABSI Prevention

        i. Partner with and support Service Leader Teams and Local Quality

Councils for quality improvement initiatives

ii. All strategies listed in section III, C, 10.

d. *C. difficile* Prevention

i. Partner with Nursing, Environmental Services, and Patient Equipment to prepare patient care rooms for terminal cleaning

ii. All strategies listed in section III, C, 13.

e. SSI Prevention

i. Partner with surgical services to standardize surgical site infection prevention strategies.

ii. All strategies listed in section III, C, 11.

f. Water intrusion

i. Interdisciplinary partnership focused on improving the notification process and collaboration on remediation efforts.

ii. Continue to expand the use of products to prevent wipes from being flushed.

g. Appropriate placement of patient care supplies to prevent water contamination from hand washing sinks

i. Assessment and recommendations for splashguards in patient rooms where needed

ii. Education on the importance of not storing patient care items near sinks

h. Appropriate assessment of negative pressure room to ensure functionality

i. Provide education on the importance of performing assessment of negative pressure room when needed.

ii. Ensure staff understand proper steps to follow when assessing negative pressure room functionality.

E. Evaluation of Plan Effectiveness

See Attachment 2 - Hospital Quality Assessment Performance Improvement Plan

1. Statistical analysis of infections
2. Trend analysis of infection rates
3. Device-associated rates to include home health and hospice

4. Monthly infection reports available for nurse managers, clinical directors, infection control liaisons
5. Monthly infection reports to Infection Control Committee
6. Infection Prevention rounds report and annual compliance assessment
7. Support Occupational Health Services to monitor compliance with required and recommended immunizations
8. Annual assessment of communicable disease exposures with trend analysis
9. Annual risk assessment for MDROs with trend analysis
10. Periodic assessment of process measures with staff feedback
    a. Evidence based processes to prevent surgical site infections
    b. Evidence based processes to prevent central line-associated bloodstream infections
    c. Evidence based processes to prevent indwelling catheter associated urinary tract infections
    d. Evidence based processes to prevent *Clostridioides difficile* infections
    e. Evidence based processes to prevent ventilator associated pneumonia and ventilator associated events
    f. Hand hygiene compliance
    g. Isolation precautions compliance

III. Responsible for Content

Infection Prevention

Attachments

- 01: UNC Facility Risk Assessment FY26
- 02: Hospital Quality Assessment Performance Improvement (QAPI) Plan FY26

Approval Signatures

Step Description	Approver	Date

Policy Stat Administrator	Judith Strubin: Mgr Program-IP	08/2025
AVP Quality UNCMC	Erin Burgess: HCS Exec Dir Quality Improvement Complex AMC	08/2025
Dir Epidemiology	Emily Vavalle: HCS Exec Dir Infection Prevention	08/2025
	Sherie Goldbach: Project Coordinator	08/2025

Applicability

UNC Medical Center