6a. Infection Control

Presented by:

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INFECTION CONTROL

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Texas Association for Home Care & Hospice
Administrator Program

PRESENTERS

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- Jennifer Elder, Director of Regulatory Affairs, TAHC&H
Learning objectives

1. The learner will understand the basic state and federal regulatory Infection Control requirements.

2. The learner will understand the basic principles of an infection control plan.

3. The learner will be able to discuss the requirements for surveillance in infection control.
Chapter 558 Licensing Standards for HCSSA (STATE)

- 26 TAC Part 1, Chapter 558, Subchapter C
- §558.259(d)(8) The first-time Administrator/Alternate Administrator must have Infection Control training as part of the required additional 16 clock hours
- §558.260 (a)(1) any one of the educational training subjects listed in §558.259(d) of this division
- §558.285 Infection Control
- §558.286 Disposal of Special or Medical Waste
- §558.287 Quality Assessment and Performance Improvement

42 CFR 484.70 Infection Prevention and Control (Federal)

- §484.70(a) Standard: Prevention
- §484.70(b) Standard: Control
- §484.70(c) Standard: Education
- §484.70(d) Standard: COVID-19 Vaccination of Home Health Agency Staff
Chapter 558 Licensing standards for HCSSA (STATE)

- §558.285 Infection Control
  - An agency must adopt and enforce written policies addressing infection control, including the prevention of the spread of infectious and communicable disease.
  - The policies must:
    - (1) ensure compliance by the agency, its employees, and its contractors with:
      - (A) Texas Health & Safety Code, Chapter 81 relating to prevention and control of communicable diseases;
      - (B) Occupational Safety and Health Administration (OSHA), 29 CFR Part 1910.1030 and Appendix A relating to Bloodborne Pathogens; and
      - (C) Texas Health & Safety Code, Chapter 85, Subchapter I, concerning the prevention of the transmission of human immunodeficiency virus (HIV) and hepatitis B virus;

§558.285(2)(A)(B) con't Infection Control

558.285(2) require documentation of infections that the client acquires while receiving services from the agency

Licensed Agencies other than PAS
- * Date the infection detected
- *Client's name
- *Primary DX
- *S/S
- *Type of Infection
- *Pathogens identified
- *Treatment

PAS Agencies
- * Date the infection was disclosed to agency employee
- *Client's name
- *Treatment (as disclosed by the client)
Reporting of Reportable Diseases, Chapter 81

- Texas Health and Safety Code
- Sec. 81.041
- Reportable Diseases
- (a) The executive commissioner shall identify each communicable disease or health condition that shall be reported under this chapter.
- (b) The executive commissioner shall classify each reportable disease according to its nature and the severity of its effect on the public health.
- (c) The executive commissioner shall maintain and revise as necessary the list of reportable diseases.
- (d) The executive commissioner may establish registries for reportable diseases and other communicable diseases and health conditions. The provision to the department of information relating to a communicable disease or health condition that is not classified as reportable is voluntary only.
- (e) Acquired immune deficiency syndrome and human immunodeficiency virus infection are reportable diseases under this chapter for which the executive commissioner shall require reports.

Reporting of Reportable Diseases, Chapter 81 (con’t)

- (f) In a public health disaster, the commissioner may require reports of communicable diseases or other health conditions from providers without the adoption of a rule or other action by the executive commissioner. The commissioner shall issue appropriate instructions relating to complying with the reporting requirements of this section.
- Amended by:
  - Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0223, eff. April 2, 2015.
(A) Texas Health & Safety Code, Chapter 81, Reportable Diseases

The following persons shall report to the local health authority or the department a suspected case of a reportable disease and all information known concerning the person who has or is suspected of having the disease if a report is not made as required by Subsections (a)-(d): Sec. 81.042. PERSONS REQUIRED TO REPORT.

(4) an administrator of a home health agency

(e) The following persons shall report to the local health authority or the department a suspected case of a reportable disease and all information known concerning the person who has or is suspected of having the disease if a report is not made as required by Subsections (a)-(d):

(1) a professional registered nurse;
(2) an administrator or director of a public or private temporary or permanent child-care facility;
(3) an administrator or director of a nursing home, personal care home, adult respite care center, or day activity and health services facility;
(4) an administrator of a home health agency;
(B) Occupational Safety and Health Administration (OSHA), 29 CFR Part 1910.1030 and Appendix A relating to Bloodborne Pathogens

- Exposure Determination
- Engineering and Work Practice Controls
- Personal Protective Equipment
- Recordkeeping
- Bloodborne Pathogens Exposure Control Plan and Evaluation
  - Hep B Vaccination or Declination
  - TB Evaluation risk assessment tool
  - Current CDC Guidelines for HC workers on TB

(B) Occupational Safety and Health Administration (OSHA), 29 CFR Part 1910.1030 and Appendix A relating to Bloodborne Pathogens

- Exposure Determination
- Engineering and Work Practice Controls
(B) Occupational Safety and Health Administration (OSHA), 29 CFR Part 1910.1030 and Appendix A relating to Bloodborne Pathogens

- Personal Protective Equipment
- Recordkeeping

- Bloodborne Pathogens Exposure Control Plan and Evaluation
  - Hep B Vaccination or Declination
  - TB Evaluation risk assessment tool
  - Current CDC Guidelines for HC workers on TB
TB- evaluating risk and preventing it through testing

CDC outpatient TB risk assessment

Taken from: https://www.cdc.gov/tb/publications/guidelines/AppendixB_092706.pdf

Appendix B. Tuberculosis (TB) risk assessment worksheet

This worksheet should be used for performing TB risk assessments for health-care facilities and nontraditional facility-based settings. Facilities with more than one type of setting will need to apply this table to each setting.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>X or Y = Yes</th>
<th>X or N = No</th>
<th>NA = Not Applicable</th>
</tr>
</thead>
</table>

3. Incidence of TB

What is the incidence of TB in your community (city or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do these rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.) This information can be obtained from the state or local health department.

Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?

Yes No

If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)?

Reevaluate laboratory data, infection-control records, and databases containing discharge diagnoses.

If no, does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?

Yes No

TB Screening Risk Classifications

TB Screening Procedures for Settings (or HCWs) Classified as Low Risk

All HCWs should receive baseline TB screening upon hire, using two-step TST or a single BAMT to test for infection with M. tuberculosis. After baseline testing for infection with M. tuberculosis, additional TB screening is not necessary unless an exposure to M. tuberculosis occurs.

TB Screening Procedures for Settings (or HCWs) Classified as Medium Risk

All HCWs should receive baseline TB screening upon hire, using two-step TST or a single BAMT to test for infection with M. tuberculosis. After baseline testing for infection with M. tuberculosis, HCWs should receive TB screening annually (i.e., symptom screen for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results).

TB Screening Procedures for Settings (or HCWs) Classified as Potential Ongoing Transmission

Testing for infection with M. tuberculosis might need to be performed every 8–10 weeks until lapses in infection control have been corrected, and no additional evidence of ongoing transmission is apparent. The classification of potential ongoing transmission should be used as a temporary classification only. It warrants immediate investigation and corrective steps. After a determination that ongoing transmission has ceased, the setting should be reclassified as medium risk. Maintaining the classification of medium risk for at least 1 year is recommended.

Current CDC Guidelines for Home Care workers regarding TB
Texas Health and Safety Code, Chapter 85, Subchapter I

- The provisions of this chapter are related specifically to HIV, AIDS, & Hepatitis B.
- These provisions note that employees who are positive for any of these viral processes should not be working in health care roles that require them to perform invasive procedures, but that in order to utilize the professional’s skill and experience, they should be offered alternative roles within the health care provider’s operations.
- Additionally, the requirements for exposure control found within other related regulation are repeated, including exposure control plan requirements, and lastly the requirement for Hepatatis B testing and prevention for health care workers who have a risk for exposure during the course of work.
- Sharps Injury Log
- Occupational Exposures
§558.286 Disposal of Special or Medical Waste

- (a) An agency must adopt and enforce a written policy for the safe handling and disposal of biohazardous waste and materials, if applicable.
- (b) An agency that generates special or medical waste while providing home health services must dispose of the waste according to the requirement in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment and Disposition of Special Waste from Health Care-Related Facilities). An agency must provide both verbal and written instructions to the agency’s clients regarding the proper procedure for disposing of sharps. For purposes of this subsection, sharps include:
  - Hypodermic needles
  - Hypodermic syringes with attached needles
  - Scalpel blades
  - Razor blades
  - Disposable razors
  - Disposable scissors used in medical procedures
  - Intravenous stylets and rigid introducers

§558.287 Quality Assessment and Performance Improvement (QAPI)

- (a) Quality Assessment and Performance Improvement Program.
  - (1) An agency must maintain a QAPI Program that is implemented by a QAPI Committee. The QAPI Program must be ongoing, focused on client outcomes that are measurable, and have a written plan of implementation. The QAPI Committee must review and update or revise the plan of implementation at least once within a calendar year, or more often if needed. The QAPI Program must include:
    - (A) A system that measures significant outcomes for optimal care. The QAPI Committee must use the measures in the care planning and coordination of services and events. The measures must include the following as appropriate for the scope of services provided by the agency:
      - (i) A review of:
        - (ii) Infection control activities
Top 10 Deficiencies Cited FY 2021: Home Health and Hospice Agencies

- **Home Health**
  - **Federal: Infection Control:** 42 CFR 484.70(b)(1)(2), TAG 0684
  - The agency failed to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control and investigation of infectious and communicable disease that is an integral part of the agency’s quality assessment and performance improvement (QAPI) program.

- **Hospice**
  - **Federal: Prevention:** 42 CFR 418.60(a), TAG 0579
  - The hospice failed to follow accepted standards of practice to prevent the transmission of infections and communicable diseases.

42 CFR 484.70 Infection Prevention and Control (Federal)

- The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases.
- (a) **Standard: Prevention.** The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.
- PPE Requirements
  - CDC (Burn Rate Calculator)
  - OSHA
  - Standard Precautions
- Safe injection Practices/Safe Sharps Practices
- Hand Hygiene
- Bag Technique
- Car Checks
- Equipment Cleaning
Safe Sharps

Sharps have a direct relationship to infection control. Additionally, Texas law requires that agencies provide education verbally and written to patients regarding safe sharps disposal.

PPE Burn Rate Calculator - CDC

How can an agency calculate how much PPE it will need?

Answer: The CDC has 2 types of “calculators” to estimate how many days a PPE supply will last given current inventory levels and PPE use rate. The first “calculator” is the PPE Burn Rate Excel Spreadsheet (3 sheets).

To use the calculator, enter the number of full boxes of each type of PPE in stock (gowns, gloves, surgical masks, respirators, and face shields, for example) and the total number of HCSSA clients.

The tool will calculate the average consumption rate, also referred to as a “burn rate,” for each type of PPE entered in the spreadsheet.

This information can then be used to estimate how long the remaining supply of PPE will last, based on the average consumption rate. Using the calculator can help HCSSAs make order projections for future needs.

The second “calculator” is the National Institute for Occupational Safety and Health (NIOSH) phone app (NIOSH PPE Tracker). Based on the Excel spreadsheet model, the app features several improvements, including an easy-to-use interface and the ability to add restock. The app is available for both iOS and Android devices.

NIOSH App: https://www.cdc.gov/niosh/ppe/ppeapp.html
Hand gel vs Hand washing

- **Hand Gel:**
- If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations (most of the time)

- **Hand washing:**
- 1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water (IA) (66).
- 2. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water.
- 3. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if exposure to Bacillus anthracis is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores (this also applies to C-diff spores/infection.)

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**When should I use?**

**Soap and Water**
- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone who is sick
- Before and after treating a cut or wound
- After using the bathroom, changing diapers, or cleaning up a child who has used the bathroom
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal food or treats, animal cages, or animal waste
- After touching garbage
- If your hands are visibly dirty or greasy

**Alcohol-Based Hand Sanitizer**
- Before and after visiting a friend or a loved one in a hospital or nursing home, unless the person is sick with *Clostridium difficile* (if so, use soap and water to wash hands).
- If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol, and wash with soap and water as soon as you can.
- *Do NOT* use hand sanitizer if your hands are visibly dirty or greasy; for example, after gardening, playing outdoors, or after fishing or camping (unless a handwashing station is not available). Wash your hands with soap and water instead.

Updated Hand Hygiene Guidance from the CDC

COVID-19 specific hand hygiene guidance

- **Methods**
  - **CDC recommends using ABHR with 60-95% alcohol** in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink.
  - **Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom**
  - The **USP hand sanitizer toolkit external icon formulas** have final concentrations of 80% ethanol or 75% isopropyl alcohol concentrations. A final concentration of 80% ethanol or 75% isopropyl alcohol recommended in the USP hand sanitizer toolkit are aligned with World Health Organization (WHO) formulations external icon. These formulations have been defined at a single concentration value that falls within the range recommended by CDC.

For updated CDC guidance on hand hygiene:
Issues that impact clinician compliance with hand hygiene (CDC)

Observed risk factors for poor adherence to recommended hand-hygiene practices
- Physician status (rather than a nurse)
- Nursing assistant status (rather than a nurse)
- Male sex
- Working in an intensive-care unit
- Working during the week (versus the weekend)
- Wearing gowns/gloves
- Automated sinks
- Activities with high risk of cross-transmission
- High number of opportunities for hand hygiene per hour of patient care

Self-reported factors for poor adherence with hand hygiene
- Handwashing agents cause irritation and dryness
- Sinks are inconveniently located/shortage of sinks
- Lack of soap and paper towels
- Often too busy/insufficient time
- Understaffing/overcrowding
- Patient needs take priority
- Hand hygiene interferes with health-care worker relationships with patients
- Low risk of acquiring infection from patients
- Wearing of gowns/boots that glove use obviates the need for hand hygiene
- Lack of knowledge of guidelines/protocols
- Not thinking about it/fingerless gloves
- No role model from colleagues or superiors
- Skepticism regarding the value of hand hygiene
- Disagreement with the recommendations
- Lack of scientific information of definitive impact of improved hand hygiene on health-care-associated infection rates

Additional perceived barriers to appropriate hand hygiene
- Lack of active participation in hand hygiene promotion at individual or institutional level
- Lack of role model for hand hygiene
- Lack of institutional priority for hand hygiene
- Lack of administrative sanction of noncompliers/rewarding compliers
- Lack of institutional safety climate

Hand Hygiene/PPE Monitoring

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
<th>Date:</th>
<th>&gt;&gt;&gt; Orientation</th>
<th>Annual Competency</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Hand Hygiene Techniques:</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Notes:</td>
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<tr>
<td>Using Alcohol-based Hand Rubs:</td>
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<td>Dispense the recommended volume of product.</td>
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<td>Apply product to the palm of one hand.</td>
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<tr>
<td>Rub hands together, covering all surfaces of hands and fingers until they are dry (no rinsing is required).</td>
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<tr>
<td>Handwashing with Soap and Water:</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Notes:</td>
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<td>Wash hands first with water (avoid using hot water).</td>
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<td>Apply soap to hands.</td>
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<td>Rub hands vigorously for at least 15 seconds, covering all surfaces of hands and fingers.</td>
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<td>Rinse hands with water and dry thoroughly with paper towel.</td>
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<td>Use paper towel to turn off water faucet.</td>
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<td>Performed hand hygiene in the following situations:</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Notes:</td>
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<td>Before touching a patient, even if gloves will be worn.</td>
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<td>Before caring for the patient’s care area or after touching the patient or the patient’s immediate environment.</td>
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<td>After contact with blood, bodily fluids or secretions, or wound dressing.</td>
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<td>Prior to performing an aseptic task (e.g. accessing a port, preparing an injection).</td>
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<td>If hands will be coming from a contaminated body site to a clean-body site during patient care.</td>
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<td>After glove removal.</td>
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<td>Personal Protective Equipment:</td>
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<tr>
<td>Appropriate PPE is utilized, as applicable.</td>
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Compliance with Hand Hygiene Practices: | Yes | No
Opportunities for improvement: 
Signature: ___________________ DATE: ___________

Bag technique monitoring

Sample Bag Technique evaluation tool

Bag Technique Monitoring

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
<th>Date:</th>
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</table>

Bag Techniques: No / N/A

Upon arrival:
Place bag on clean surface in the home. If no clean surface, place a barrier inside the bag. (i.e. paper towels, small plastic bag)
Remove hand hygiene items and perform hand hygiene.
Remove supplies/equipment needed for the visit.

When the visit is completed:
Clean vital sign equipment storage
Clean field zips down
Clean field equipment
Perform hand hygiene.
Place supplies/equipment in the bag.
Clean vital sign equipment (i.e. PPE)

If supplies/equipment is contaminated with blood or body fluids:
Clean with soap and water and disinfect immediately if possible.
If unable to clean immediately, they are to be placed in a designated labeled bag until cleaning or disinfection can take place.

The nurse is responsible for the following as needed or monthly:

- Dispose of and/or replace expired items.
- Clean the bag with antibacterial agent.

Compliant with bag technique practices? Yes / No
Opportunities for improvement: ____________________________
Signature: ____________________________ Date: ________________

Hand hygiene storage
Items for visit such as dressings, etc. PPE, spill kits
“dirty side”
Clean vital sign equipment storage
Clean field zips down

Regardless of the model/color of bag they carry, make sure your clinical staff, (including contractors) understand the principles of asepsis when it comes to using their bags.
42 CFR 484.70 Infection Prevention and Control (Federal)

(b) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA’s quality assessment and performance improvement (QAPI) program. The infection control program must include:

1. A method for identifying infectious and communicable disease problems; and
2. A plan for the appropriate actions that are expected to result in improvement and disease prevention.

Surveillance Program (cross reference QAPI §484.65(a))
- Trending of Infectious disease in agency
  - Patient population
  - Clinician population
  - Community Population
- Risk Assessment
- Monitoring, Auditing, Feedback, Outcome Measures
- Measures of Processes and Outcomes
  - High risk
  - High volume
  - Problem prone

The purpose of surveillance in home health and hospice care is to assess the safety and quality of patient care provided by establishing a baseline at each agency, to monitor trends within the agency, to use findings to improve care, and to prevent HAI and other complications. Valid written definitions enhance consistency, accuracy, and reproducibility of the surveillance data; however, definitions are only one piece of surveillance.

Describing an infection as home health and/or hospice healthcare associated does not necessarily indicate that the infection was caused by the home health agency or hospice personnel. The association is temporal (related to a time, place, or event), not causal.
Infection Control Performance Improvement

Sample Improvement Plan

- **SAMPLE**
- **Performance Improvement Project**
- **Problem**: Correlation between wound infection and individual clinician(s) is high at 9%
- **Date Identified**: January 1, 2020
- **Data Source/Baseline Data**: Infection Control Surveillance via worksheets
- **Goal**: Correlation between wound infection and clinician will be 5% or less by the end of the second quarter of 2019.
  - (must include objective target, timeframe and measurable outcome)
- **Potential Causes**: Ask why, then ask why again, until the root cause (process based) is determined (Use **5 Whys** tool to determine cause(s))
  - Problem - infections correlating with clinical staff is too high
  - Why? - Data shows that correlation between particular clinicians performing wound care and incidence of wound infection is too high
  - Why? - Certain clinicians are promoting the spread of infection
  - Why? - Administrative/clinical overview has not ensured that all clinicians have appropriate technique with wound care
  - Why? - The DON has not had time to review appropriate techniques in infection control, hand hygiene, and bag technique with all staff both in office and in the patient's home as is best practice
- **Primary cause intervention**: The DON will train the ADON to perform these competencies

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**Customize your risk assessment plan to your organization**

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<th>Location: XYZ</th>
<th>High</th>
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<td>Potential Infections based on population, Community and geographic location served</td>
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<td>Catheter/Bloodstream Inf</td>
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(c) **Standard: Education.** The HHA must provide infection control education to staff, patients, and caregiver(s).

- **Staff**
  - Competency Based Education
  - Training program on Bloodborne pathogens
  - Risk for self-contamination
  - Core contents in the Home Care Bag
  - Breaches in Infection Control

- **Patients/Caregivers**
  - Infection Control Handouts (ie hand washing, safe sharps, principles of IC)

### Types of patient handouts

**How to Handrub?**

*RUB HANDS FOR HAND HYGIENE / WASH HANDS WHEN VISIBLY SOILED*

- Duration of the entire procedure: 20-30 seconds

1. **Apply a pat of the palm to a cupped hand, covering all surfaces.**
2. **Rub hands palm to palm.**
3. **Right palm over left dorsum with interlaced fingers and vice versa.**
4. **Palm to palm with fingers interlaced.**
5. **Some of fingers to opposing palms with fingers interlaced.**
6. **Rotation of left thumb cleaned in right palm and vice versa.**
7. **Rotation of right thumb cleaned in left palm and vice versa.**
8. **Once dry, your hands are safe.**

**Break the Chain of Infection**

- Proper handwashing
- Covering coughs
- Isolation precautions
- Preventing cross-contamination
- Sterile technique
- Use of personal protective equipment
- Disinfection and sterilization
- Proper disposal of waste
- Surveillance and reporting
- Education and training
(d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

(1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement.

(2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section.

(3) The policies and procedures must include, at a minimum, the following components:

(i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients;

(ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;

(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;

(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section;

(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;

(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;

(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements;

(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA’s COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.
COVID Specific Requirements and Recommendations
COVID-19 – HHSC Current Guidance

- Emergency rules for HCSSA providers related to the response to COVID-19 were effective as of April 3, 2020. This rule (558.960) expired effective July 21, 2022.

- Effective July 22, 2022, HHSC expects agencies to follow their infection control policy and procedures. It is expected that agencies will continue to implement precautions related to COVID-19 based on their agency policy for Infection Control. Per HHSC, providers should continue to monitor infection levels within their community, continue to follow the CDC recommendations, and continue to implement precautions as necessary to prevent spread.

- With the expiration of the Emergency Rule, providers are no longer required by rule to perform screenings on patients or employees. Screenings can still be used as a method to prevent spread, but they are not required daily and are no longer required to be documented. We recommend that providers consider continuing them when a patient or employee presents with symptoms or reports an exposure. The agency is still held responsible for infection control, and that includes preventing spread.

- The updated HHSC HCSSA Provider FAQ’s state the following, “Do agencies have to document screenings for clients and staff? HCSSA Emergency Rules for COVID-19 expired on July 21, 2022 and all requirements for screening ended. If a HCSSA chooses to screen, there is no requirement for the documentation of that screening.”

- What about masks? The HHSC emergency rule itself never mandated masks due to Governors EO GA-34. HHSC’s stance is that agencies must have policies and procedures in place that follow TAC 558.285 (Infection Control), including wearing PPE as appropriate. It’s expected that agencies will take appropriate infection control precautions, based on CDC guidance and infection control policies, when appropriate.

COVID-19 – HHSC Current Guidance

- TAC Chapter 558, Rule 558.285 – Infection Control
- Texas Health and Safety Code, Chapter 81 – Communicable Diseases
- HHSC COVID-19 Provider FAQ’s (Expected to be retired soon)
The CDC infection control guidance no longer recommends masking and/or other source control for employees who are seeing patients in low risk COVID-19 areas, saying “When SARS-CoV-2 Community Transmission levels are not high, healthcare facilities could choose not to require universal source control. However, even if source control is not universally required, it remains recommended for individuals in healthcare settings who: Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure; or Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or Have otherwise had source control recommended by public health authorities.”

As with our state expectations on screening, the CDC feels that COVID-19 screening of health care workers is now at the discretion of the agency, saying “Performance of expanded screening testing of asymptomatic HCP without known exposures is at the discretion of the facility.”

They have also changed their stance on some testing recommendations saying now that COVID-19 testing is “generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days.” They do still recommend that “Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.”

The Interim Guidance for Managing Healthcare Personnel with COVID or Exposure to COVID now states “In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2.” The guidance also includes updated recommendations for testing frequency to detect potential for variants with shorter incubation periods and to address the risk for false negative antigen tests in people without symptoms.

The Strategies to Mitigate Healthcare Personnel Staffing Shortages has updated the conventional strategies to advise that, “in most circumstances, asymptomatic healthcare personnel (HCP) with higher-risk exposures do not require work restriction, regardless of their vaccination status; therefore, the contingency and crisis strategies about earlier return to work for these HCP was removed.”
COVID-19 – OSHA Current Guidance

- The OSHA Healthcare ETS from June 2021 was the only rule that required weekly testing for unvaccinated employees.

- On December 27, 2021, the ETS was suspended and providers were no longer required to follow 99% of the rule. The only parts of the ETS that continued to be required were the record-keeping portions, specifically the COVID-19 plan and the Reporting requirements. All other parts of the rule were suspended and are not currently enforceable.

- Shortly after the ETS was suspended, OSHA came back and said that all HC providers/employers were required to follow the OSHA general duty clause and its general standards, including the Personal Protective Equipment (PPE) and Respiratory Protection Standards. At this same time, OSHA said continued adherence of the precautions related to infection control in the OSHA Healthcare ETS would be the easiest way to meet the requirements of the GDC and the general standards.

- This means providers MUST 1) follow the General Duty Clause and the OSHA General Standards; OR they can choose to 2) continue adherence to the infection control precautions in the Healthcare ETS to cover these requirements. The processes are left up to the agency as long as the standards are met. The OSHA Healthcare ETS (parts related to infection control precautions and prevention of spread) is optional (and recommended) guidance for HCSSA providers in order to meet the required OSHA standards above.

COVID-19 – OSHA Current Guidance

- Under the General Duty Clause, employers are expected to furnish to its employees with "employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees..."

- Employers can be cited for violation of the General Duty Clause if a recognized serious hazard, such as COVID-19, exists in their workplace and the employer does not take reasonable steps to prevent or abate the hazard. The General Duty Clause is used only where there is no standard that applies to the particular hazard. The following elements are necessary to prove a violation of the General Duty Clause:
  - The employer failed to keep the workplace free of a hazard to which employees of that employer were exposed;
  - The hazard was recognized;
  - The hazard was causing or was likely to cause death or serious physical harm; and
  - There was a feasible and useful method to correct the hazard.
COVID-19 – CMS Current Guidance

- If you are a Licensed and Certified HCSSA agency, vaccines are still required through the CMS Vaccine Mandate (see home health infection control COP 484.70 (d) see hospice infection control COP 418.60 (d)). This is the only rule that currently requires vaccinated staff and/or allows for vaccine exceptions due to medical/religious exemptions as noted in the CMS Vaccine Mandate FAQ’s.

- Additional precautions are left to the determination of the agency and could include testing (not specific to weekly), physical distancing, masking, barriers, etc. for the medical or religious exempted employees.

Bottom Line = Infection Control and Prevention

- No matter the regulatory body, the overall expectation is that employers will protect employees and clients from transmission of COVID-19 through appropriate infection control and additional precautions to prevent spread.

- What is an Additional Precaution? Additional precautions are measures used in addition to Standard Precautions when extra protections are necessary to prevent the spread of specific infectious diseases.
  - This includes testing, masking, full PPE, barriers, physical distancing, screening, isolation, removal, etc.

- All of the current guidance makes the agency responsible for determining which additional precautions they will use to prevent spread of COVID-19. As long as the standards are met, agencies must choose appropriate additional precautions to include in their infection control policies and procedures.
Infection Control (PAS)

- In accordance with 26 TAC §558.285, all agencies must adopt and enforce infection control policies.
- Since a personal assistance services (PAS) agency does not provide clinical services, their policies will differ from those of a home health or hospice agency. During the COVID-19 pandemic, HHSC developed an Infection Control Probe Tool for PAS-only agencies to review the effectiveness of their infection control policies.
- We encourage PAS agencies to use the tool to determine whether their infection control policies and procedures prevent and control the spread of communicable diseases, such as COVID-19.
- Use of the tool is not required but is an important part of an agency’s Quality Assessment and Performance Improvement (QAPI) process.

Infection Control Probe (PAS)

**PPE for PAS Agencies**

- **Question:** Does HHSC have any guidance for PAS agencies with respect to their unlicensed staff wearing full PPE when they are not trained to don and doff PPE appropriately?
- **Answer:** If unlicensed staff at a PAS agency need to use full PPE, the PAS agency must ensure staff are trained in how to put on and take off PPE properly. The CDC has information about:
  - how to don and doff PPE to minimize infection transmission (see https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html); and
  - the sequence for donning and doffing PPE (see https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf).

**PPE Guidance**

Specifically mentioned as guidance for PAS agencies in the FAQ’s, this information is appropriate for all provider types, and published by the CDC as best-practice information.

PPE Guidance for patients and clients


Education for patients/clients & caregivers

TRIVIA NIGHT

FRIENDLY FACE OFF

QUESTIONS
Resources

- https://www.cdc.gov/HAI/pdfs/ppe/PPEslides6-29-04.pdf
- Great resource from TAHCH: https://greatplainsqin.org/providers/home-health/home-health-infection-prevention/

Resources

Resources