Health Center
Infection Control (IC) Checklist

Administrative Basics

The organization:

☐ Selected and followed nationally recognized IC guidelines (select all that apply):
  □ Hand hygiene (CDC/HIPAC/WHO)
  □ Guidelines for Isolation Precautions (CDC/HIPAC)
  □ Disinfection/Sterilization in Healthcare Facilities (CDC/HIPAC/AAMI)
  □ Perioperative Standards and Recommended Practices (AORN)
  □ Guidelines for Infection Control in Dental Healthcare Settings (CDC)

☐ Appointed an individual to lead IC activities
  □ IC leader received training regarding health facility IC practices
  □ IC leader was appointed in writing via appointment letter or position description, etc.

☐ Completed a written IC risk assessment:
  □ Developed with input from directors, managers, supervisors and front-line staff of multiple departments (such as dental clinics, radiology and departments performing high level disinfection or sterilization)
  □ Reflected site specific/unique information related to geographic location, population served, services provided and infection surveillance data

☐ Completed a written IC Plan based on risk assessment
  □ The plan was approved by leadership
  □ The plan included hand hygiene improvement activities
  □ The plan included influenza improvement goals
  □ The plan was evaluated and renewed annually

☐ Appropriately managed contracts related to any IC issues
  □ IC related contracts include: housekeeping, off-site sterilization, linen management, etc.
  □ IC contracts were immediately available and reviewed annually
☐ Implemented a system to actively identify infections that may have been related to procedures performed at the health center. This was done by (select all that apply):

☐ Including a specified method to identify and follow-up on patients/procedures that involved implants (IUDs, Norplants, dental implants, etc.)
☐ Sending emails to patients who had procedures performed
☐ Follow-up with providers after procedures are performed
☐ Relying on providers who performed the procedures to obtain and report this information to the Health Center after post procedure visits

☐ Developed and maintained currency of appropriate IC policies and procedures

☐ Written policies/procedures existed related to IC, housekeeping, sterilization, high-level disinfection, isolation precautions, hand hygiene and other IC related topics appropriate to the center. (Select all that apply):

☐ Written policies reflect evidence-based guidelines
☐ Policies described how staff operated medical devices according to manufacturer’s recommendations (point-of-care testing devices, temperature probes, hair clippers, ultrasonic cleaners, ultrasound devices, sterilizers, etc.)
☐ Policies described methods staff use to clean/disinfect medical devices according to manufacturer’s recommendations (point-of-care testing devices, temperature probes, hair clippers, ultrasonic cleaners, ultrasound devices, sterilizers, etc.) using products approved by manufacturer and evidence-based guideline
☐ Policies described the method, products and environmental surfaces that were cleaned and disinfected between patient use, and those cleaned/disinfected on a daily, weekly and monthly basis
☐ The organization had a procedure in place to decontaminate gross spillage of blood

☐ Staff had a working knowledge and physical access to written policies, procedures, equipment/device manufacturer’s instructions for use and facility selected clinical practice guidelines

☐ Staff exhibited consistent IC processes/practices throughout organization (i.e., consistent concepts in environmental cleaning/disinfection practices, equipment/device manufacturer’s recommendations for use, sterilization practices, hand hygiene, etc.)

**IC Training /Competency**

☐ Evidence existed that all staff receive IC training (physicians, dentists, nurses, technicians, cleaning staff, others involved in patient care activities) initially (upon hire) and annually

☐ Competency documentation existed describing initial and on-going competency and training of front-line staff/users and those with oversight for sterilization/high-level disinfection processes
Patient Care Areas

☐ All areas had soap and water or alcohol-based hand sanitizers

☐ Staff performed hand hygiene:
  ☐ Before and after patient contact
  ☐ Before and after wear of exam gloves
  ☐ Before and after performing invasive procedures (including IV insertion)
  ☐ Before preparing and administering medications
  ☐ Before and after conducting point-of-care patient testing
  ☐ After contact with blood, body fluids or contaminated surfaces (even if gloves were worn)

☐ Staff wore gloves:
  ☐ When performing procedures that may involve contact with blood/body fluids
  ☐ When performing a finger stick to obtain blood sample
  ☐ When starting IVs
  ☐ When handling potentially contaminated patient equipment

☐ Low level disinfection was performed on medical equipment used to assess patients (thermometer, pulse oximeter and stethoscopes) between use on different patients and/or on a scheduled basis (i.e., BP cuffs as appropriate)

☐ Solutions used for cleaning/low level disinfection were mixed, labeled and discarded in accordance with manufacturer recommendations
  ☐ Care was taken to note appropriate contact and dry time for each cleaning solution used

☐ Rooms were cleaned/disinfected with an EPA approved disinfectant between patients

☐ Items in the health center had not been used beyond the manufacturer’s expiration date (unless documented approval by the manufacturer) to include antiseptic wipes, disposable sterile items, medications, environmental cleaners, chemical solutions used for decontamination/high level disinfection, etc.

☐ Documentation existed that rooms with special ventilation (i.e., negative pressure, etc.) had been monitored and maintained in accordance with environmental requirements

☐ Water line quality testing was performed on dental equipment according to manufacturer’s recommendations

Injection Practices

☐ Policies existed regarding safe injection practices including management/use of multi-dose vials
☐ Needles and syringes were used for only one patient

☐ The rubber septum on medical vials and IV ports were disinfected with alcohol prior to piercing (whether newly opened or previously pierced)

☐ Medication vials were always pierced with both a new needle and new syringe

☐ Medications that were predrawn were labeled with the date and time of draw, initialed by individual drawing the med, medication name, strength and beyond-use date and time

☐ Single dose (single vial) medications were used for only one patient

☐ Bags of IV solutions were used for only one patient (i.e., were not used as a flush for more than one patient)

☐ Medication tubing and connectors were used for only one patient

☐ Multidose vials were dated when they are opened and were discarded within 28 days of opening unless the manufacturer specified a different (shorter or longer) expiration period. Note: This is different than the expiration date for the vial.

☐ Multidose vials were stored appropriately and did not enter the immediate patient care area (i.e., the medication was stored and drawn in a central/medication/nursing station area)

**Sterilization and High Level Disinfection**

☐ Sterilization was performed (select all that apply):

  ☐ Steam
    ☐ Table top sterilizer
    ☐ Large chamber gravity displacement/prevacuum autoclave
  ☐ Gas
    ☐ Formaldehyde
    ☐ Hydrogen Peroxide
    ☐ Peracetic acid
    ☐ Ethylene oxide

☐ If sterilization processes were not performed in-house, or if sterilization processes were outsourced, see items annotated with *

☐ High-level disinfection was performed (select all that apply):

  ☐ Manual process
  ☐ Automated process
☐ Name of high-level disinfectant chemical used:
   ☐ Glutaraldehyde
   ☐ Cidex OPA
   ☐ Other: ____________

☐ If high-level disinfection processes were not performed in-house, or if these processes were out-sourced, see items annotated with ^

Sterilization and High-Level Disinfection Basics:

☐ Regardless of room size, there was a designated flow of traffic in the decontamination area -- from dirty to clean

   ☐ *Flow = contaminated area where instruments were brought after use and decontaminated (cleaned) -- to the area where they were processed (assembled/wrapped) -- to the area where they were sterilized/high-level disinfected

☐ *^Decontamination, sterilization and high-level disinfection processes across the organization were consistent (i.e., decontamination processes, sterilizer management, etc. were consistent among Primary Care, Gyn and Dental Clinics in the same organization)

☐ *Shelf life – the organization determined event-related versus expiration/date related based on risk assessment

☐ *^Decontamination of instruments:

   ☐ Instrument decontamination began at the point-of-use by wiping off gross contaminates
   ☐ Instruments were kept moist immediately after use, during transport to the decontamination area and while they waited processing (using approved enzymatic/pretreatment spray, moist towels, etc.)
   ☐ Instrument enzymatic/pretreatment sprays and solutions were used in accordance with manufacturer’s recommendations
   ☐ *Contaminated instruments were contained during transport from point-of-use to the decontamination area in a manner that reduced the potential for staff contamination or injury from sharp items, such as a closed, leak proof, puncture-resistant container
   ☐ Contaminated instruments were labeled as biohazardous during transport from point-of-use to the decontamination area
   ☐ Instruments/devices were decontaminated as soon as possible (i.e., not left sitting to allow contaminates to dry)
   ☐ Decontamination work areas included at least one sink which was designated ‘dirty’
☐ Staff hand washing was performed in designated ‘clean’ sink or alternative method for hand washing was immediately available, i.e., wall/separate hand hygiene apparatus
☐ Staff performing decontamination processing wore appropriate PPE including a clean, long-sleeved fluid resistant gown, face/eye protection and durable gloves that prevented tearing/leakage of chemicals
☐ Solutions used for decontamination were approved for specific instrument cleaning and mixed according to manufacturer instructions
☐ Solutions used for cleaning were used at the appropriate temperature specified by the manufacturer instructions
☐ Instruments were cleaned in accordance with manufacturer’s instructions or, if the manufacturer does not provide instructions, according to the organization’s chosen evidence-based guideline
☐ Instruments were brushed using brushes approved by individual manufacturers
☐ Brushing was accomplished below the water level to reduce room aerosolization
☐ Brushes were cleaned or disposed of in accordance with manufacturer recommendations
☐ Hinged instruments were cleaned in the open position, instruments with multiple parts were disassembled prior to cleaning
☐ Lumens were cleaned, brushed and flushed in accordance with manufacturer recommendations
☐ Instruments were rinsed after cleaning according to manufacturer guidelines
☐ Disinfectant solutions used in ultrasonic cleaners were measured, prepared and disposed of in accordance with manufacturer’s recommendations
☐ Ultrasonic units were cleaned/disinfected in accordance with manufacturer’s recommendations

☐ *^Single-use items:

☐ If single-use items were reprocessed, they were devices that were approved for reprocessing by the FDA
☐ If single use items were reprocessed, they were done by an FDA approved reprocessor

☐ Processing (assembly/wrapping):

☐ Instruments and medical devices were visually inspected and recleaned as needed prior to packaging for sterilization
☐ Hinged instruments were processed in the open position, instruments with multiple parts remained disassembled prior to wrapping
☐ An appropriate level chemical indicator (i.e., level 3 or 4 or 5) was placed correctly in every package, as directed by the manufacturer’s instructions for use
☐ Wrappers and peel packs were used in accordance with manufacturer’s instructions
☐ Appropriate indicator tape was used on wrapper in accordance with manufacturer’s instructions for use (i.e., steam tape for steam, tape for use with peracetic acid used on appropriate wrappers, etc.)
☐ Packages (textile, peel pack, metal containers) were labeled with sterilization information (date, load, sterilizer number) to facilitate package recall if necessary

☐ Peel packs:
  ☐ Double peel packs were not routinely used (done after risk assessment -- used in circumstances such as keeping small pieces together, etc.)
  ☐ Double peel packs were only used when manufacturer approved the packaging material for double peel-packing
  ☐ If double peel packaging was used, there was no folding over of the inner paper/plastic peel pouch
  ☐ Tips of sharp items were protected using paper or plastic tip guards specifically made for this use
  ☐ Gauze, tape or other extraneous items were not added as filler or protectants unless approved by peel package manufacturer for use

☐ Sterilization:
  ☐ Each sterilizer was tested with a biological indicator at least weekly, and with every load containing an implantable item
  ☐ Sterilization loads run with a biologic indicator were run according to manufacturer’s instructions, i.e., run in a full load if required by the manufacturer or chosen clinical practice guideline
  ☐ Each load was monitored with mechanical indicators (i.e., time, temperature and pressure)
  ☐ The correct mechanical and biological indicators were used in each sterilizer in accordance with manufacturer’s recommendations
  ☐ Documentation/logs for each piece of sterilization equipment included:
    ☐ Biologic indicator lot number, load contents, temperature and exposure time, reviewer initials, Bowie-Dick testing (if dynamic removal feature available), chemical indicator and biological indicator results as appropriate
    ☐ Documentation of valve flushing and filter changes if these processes were recommended by manufacturer
    ☐ Daily, weekly, monthly, quarterly and annual cleaning and maintenance as required by manufacturer’s recommendations
  ☐ Documentation was immediately available to support evidence that biologic testing of sterilization processes conducted off-site were monitored
Sterilizer settings were used that were appropriate for contents in accordance with instrument, device and manufacturer’s recommendations, i.e., items containing lumens or batteries may require special sterilization and dry settings.

*Items were appropriately handled to ensure sterility was not compromised

- Items were dried appropriately before handling and processing
- After sterilization, items were stored in a designated clean area so that sterility was not compromised
- Layering of heavy instrument sets was avoided to prevent wrapper tears
- Overloading of storage bins was avoided to prevent peel pack tears when handling
- Storage bins were appropriately labeled to reduce sterile supply handling by users
- Sterile packages were inspected for integrity and compromised packages were reprocessed

*Sterilized items were not released for patient use until biologic testing results were complete/validated efficacy of sterilizer cycle

*Policies were in place to describe procedure for a recall of sterilized items

Immediate Use Steam Sterilization (IUSS) (Formally referred to as “Flash Sterilization”) (IUSS describes unwrapped instruments that are subjected to cleaning, an abbreviated steam sterilization exposure time and then used promptly after cycle completion without being stored)

- If IUSS is used, policies were immediately available
- Instruments/devices intended for IUSS were decontaminated/cleaned using the same method as were all other instruments in the facility prior to sterilization
- A plan existed to reduce the practice of IUSS (i.e., schedule procedures with enough time between to fully process instruments, purchase additional instruments, add disposable instruments of items most commonly sterilized using this method, etc.)

IUSS was not performed on the following devices:

- Implants
- Single-use devices that are sold sterile
- Used instruments post-procedure on a patient known to have Creutzfeldt-Jakob disease or similar disorder
- Devices that have not been validated for IUSS

*^Instruments brought from an outside facility by a medical provider or company representative went through the complete decontamination, processing and sterilization cycle (even if they arrived wrapped/sterilized by another health organization)
☐ High-Level Disinfection:

☐ Work areas were well ventilated
☐ ^Items were precleaned according to manufacturer’s instructions or, if the manufacturer did not provide instructions, according to the organization’s chosen evidence-based guidelines
☐ ^Items were visually inspected, leak-tested (if appropriate) and recleaned as needed prior to completion of cleaning process and high-level disinfection
☐ ^Scope cleaning was undertaken immediately after the endoscope was used to prevent drying and hardening of secretions
☐ Items were cleaned (manual or automated) according to manufacturer’s instructions for use, or, if the manufacturer did not provide instructions, according to evidence-based guidelines
☐ Items were dried (manual or automated) after cleaning according to manufacturer’s instructions for use, or, if the manufacturer did not provide instructions, according to evidence-based guidelines
☐ Endoscope channels were dried prior to and after installation of 70% alcohol (in accordance with manufacturer’s instructions)

☐ Chemicals for high-level disinfection were:
☐ Stored according to manufacturer’s instructions
☐ Measured, prepared, mixed and labeled according to manufacturer’s instructions
☐ Stored (after mixing) in a closed container intended for high level disinfectant solutions
☐ Tested for appropriate concentration according to manufacturer’s instructions
☐ Replaced according to manufacturer’s instructions
☐ Documented to have been prepared, tested and replaced according to manufacturer’s instructions

☐ High-level disinfection equipment was maintained according to manufacturer’s instructions, including daily, weekly, monthly, quarterly and annual cleaning and maintenance
☐ Instruments/devices were disinfected for the appropriate length of time as determined by the manufacturer’s instructions, or, if the manufacturer did not provide instructions, according to evidence-based guidelines
☐ Items placed in plastic/peel packages as dust covers after high-level disinfection were labeled as having undergone the high-level disinfection process so as to distinguish them from sterilized items
☐ Written policies were in place regarding plastic packaging and labeling of items that have undergone high-level disinfection
☐ Disinfectant used to perform high-level disinfection was used at the appropriate temperature (35 degrees)/as determined by the manufacturer’s instructions, or, if the manufacturer did not provide instructions, according to evidence-based guidelines
☐ ^After high-level disinfection, items were stored in a designated clean area so that sterility was not compromised
Documentation related to high-level disinfection included:
- Daily/load test of disinfectant concentration level, according to manufacturer’s recommendations
- Batch number of disinfectant product, date product was mixed/placed into container/instilled and date expiration date/date product was changed
- Log included patient, date of procedure, instrument/scope details, temperature of solution/biocide, and immersion time in solution/biocide
- Name of person who conducted processing
- Computer print-outs from automated machines were attached to the unit record (if applicable)

Multiple-use dental dispensers: The following information should be used to help reduce the risk of cross-contamination between patients:

- Tips are intended to be discarded after each patient use.
- Apply disposable barrier sleeves/wraps over multiple-use dental dispensers before use with each patient.
- Use new, uncontaminated gloves when handling multiple use dental dispensers
- Use dental assistants to dispense material for the dentist
- Avoid contact of the reusable parts (i.e., the body of the multiple use dental dispenser) with the patient’s mouth
- Do not reuse the multiple use dental dispenser if it becomes contaminated
- Do not reprocess a contaminated multiple-use dental dispenser by using chemical wipes or disinfectants
- Do not immerse multiple-use dental dispensers in a high-level chemical disinfectant. (This may damage the dispenser and the material in the device.)
- Do not sterilize multiple-use dental dispensers. (This may damage the material contained in the device.)

*If sterilization processes were not performed in-house, or if sterilization processes were outsourced, see items annotated with *

^If high-level disinfection processes were not performed in-house, or if these processes were out-sourced, see items annotated with ^
Infection Control References

- 2008 CDC Guideline for Disinfection and Sterilization in Healthcare Facilities.” Centers for Disease Control and Prevention

- 2018 Association of Perioperative Registered Nurses, AORN Guidelines for Perioperative Practice


- APIC Infection Control Risk Assessment Template https://www.google.com/search?q=apic+infection+control+risk+assessment&rlz=1C1GCEU_enUS826US826&oq=APIC+Infection+Control+Risk+Assessment&aqs=chrome.0.0l2.11136j0j9&sourc eid=chrome&ie=UTF-8

- APIC Infection Control Risk Assessment Example https://apic.org/Resource_/TinyMceFileManager/Academy/ASC_101_resources/Risk_Assessment/Risk_Assessment_Example_2.docx


- IAHCSMM educational materials: www.iahcsmm.org/education/online-lessons.html

  https://www.cdc.gov/oralhealth/infectioncontrol/pdf/recommendations-excerpt.pdf

- The Joint Commission High Level Disinfection and Sterilization Booster Pack:  
  https://www.jointcommission.org/assets/1/6/TJC_HLD_BoosterPak.pdf

- “Using the Risk Assessment to Set Goals and Develop the Infection Prevention and Control Plan.” Joint Commission Resources  