483.80 Infection Control

Welcome. My name is LCDR Megan Hayden, and I'm a Nurse Consultant in the Division of Nursing Homes in the Quality, Safety & Oversight Group at CMS.

Today, I am discussing the significant changes to the infection control portion of the nursing home interpretive guidance.

F Tags

- Regulatory Group: Infection Control
  - F880: Infection Prevention and Control
  - F881: Antibiotic Stewardship Program
  - F882: Infection Preventionist Qualifications/Role
  - F883: Influenza and Pneumococcal Immunizations
- Regulatory Group: Quality Assurance and Performance Improvement
  - F868: QAA Committee

I will discuss the following four F tags that are found under the infection control regulatory grouping. They are F880, F881, F882, and F883. I will also discuss the infection preventionist's (or IP's) role on the quality assessment and assurance or QAA committee at F868.

F880-Water Management

Facilities must be able to demonstrate its measures to minimize the risk of *Legionella* and other opportunistic waterborne pathogen outbreaks in building water systems.

An example of such is a documented water management program.

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An example of such is a documented water management program.

F880-Water Management

A facility must use nationally accepted standards (e.g., ASHRAE, CDC, EPA) to minimize the risk of waterborne pathogens.

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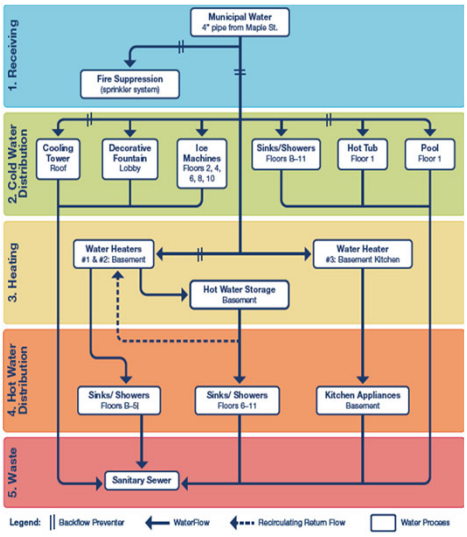
A facility must use nationally accepted standards (for example, ASHRAE formerly the American Society of Heating, Refrigerating, and Air Conditioning Engineers, the Centers for Disease Control and Prevention or CDC, and/or the U.S. Environmental Protection Agency or EPA) to minimize the risk of waterborne pathogens.

F880-Water Management

- An assessment of the building water system to identify where opportunistic waterborne pathogens could grow and spread.



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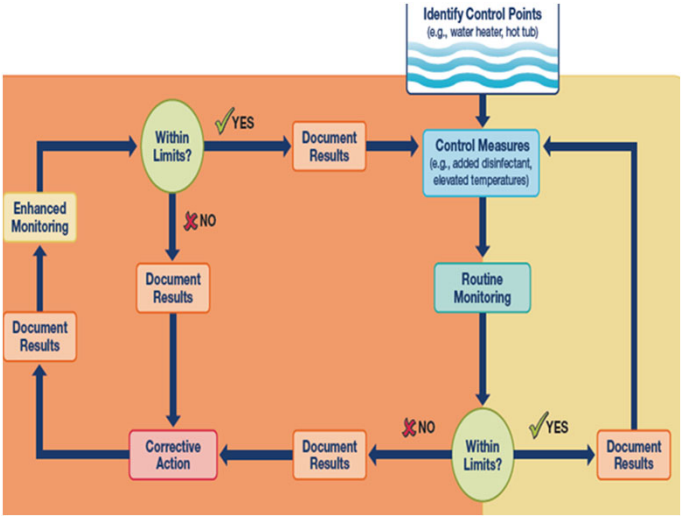
Current standards recommend the following and surveyors should determine through interview (or record review as necessary) whether the facility has:

Assessed the building water system to identify where opportunistic waterborne pathogens could grow and spread. For example, facilities may have a description of the building water systems using text and flow diagrams.

F880-Water Management

- Measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures) and how the facility will monitor them; and
- Established ways to intervene when control limits are not met.



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- Whether the facility has measures in place to prevent the growth of opportunistic waterborne pathogens (also known as control measures) and how the facility will monitor them. For example, control measures can include visible inspections, use of disinfectant, and/or temperature control that may require mixing valves to prevent scalding. Monitoring may include testing protocols for control measures, acceptable ranges of control measures, and documenting results of testing;

- Additionally, the facility should have established ways to intervene when their control limits are not met.

F880-Water Management

- Interview and record review:
  - Were there any diagnosed cases of legionellosis in residents since the last recertification survey?

- If there was a case of legionellosis identified:
  - Did the facility implement adequate prevention and control measures prior to and once the issue was identified?

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Through interview with the infection preventionist and record review, surveyors should determine whether the facility has:

- Had a resident with legionellosis since the last recertification survey.

Surveyors should determine what actions the facility took in response to the identified case in the facility.

- The State Survey Agency should work with local/state public health authorities, if possible, to determine if the water management was inadequate to prevent the growth of *Legionella* or other opportunistic waterborne pathogens and whether the facility implemented adequate prevention and control measures once the issue was identified.

F881- Feedback to Practitioners

- Revised the requirement to provide feedback to prescribing practitioners

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Let's move on to updates with the antibiotic stewardship program (or ASP) at tag F881, starting with the language around feedback to prescribing practitioners.

We revised the requirement to provide feedback to prescribing practitioners regarding antibiotic resistance data, their antibiotic use and their compliance with facility antibiotic use protocols. While providing feedback to prescribing practitioners is recommended to improve prescribing practices and resident outcomes, it is no longer required as an element for compliance with F881.

F881- ASP Sampling and Tag Clarification

If there are concerns with the antibiotic stewardship program (ASP):

- Assess whether resident(s) are being prescribed antibiotic(s) unnecessarily and whether there were any negative outcomes such as an adverse drug event
- MUST include at least one resident on an antibiotic in the sample

If a resident has been prescribed antibiotics unnecessarily, cite F757.

If the facility does not have or is not implementing the ASP, cite F881.

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If there are concerns with the ASP, surveyors must include at least one resident on an antibiotic in the resident sample to assess whether the resident(s) is being prescribed an antibiotic(s) unnecessarily and whether there were any negative outcomes such as an adverse drug event.

Instances of prescribing antibiotics unnecessarily should be cited at §483.45(d), which is F tag 757. These findings may support citing F881 as well, in which case the surveyor must also show that the facility is not implementing part or all of the ASP.

F882- Infection Preventionist Cont.

- The IP is responsible for assessing, developing, implementing, monitoring, and managing the IPCP.

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Now, I will discuss the infection preventionist's role found under the infection control regulatory grouping at F tag 882. We will also discuss the infection preventionist's role on the quality assessment and assurance or QAA committee at F868.

First, the regulatory language states that the IP is responsible for the infection prevention and control program, or IPCP.

This includes assessing, developing, implementing, monitoring, and managing the IPCP. This does not mean that the IP cannot or should not collaborate with other staff. For example, under F881, we state that development of the antibiotic stewardship program should include leadership support and participation of the medical director, consulting pharmacist, and nursing and administrative leadership. While a well running IPCP is a team effort, the IP is responsible for making sure the program meets regulatory requirements.

Surveyors should determine that the facility designated one or more individual(s) as the infection preventionist, who are responsible for the facility's IPCP.

F882- IP Professional Training

Professionally trained in:

- Nursing
- Medical technology
- Microbiology
- Epidemiology
- Other related field

Now that we have discussed some of the responsibilities of the IP, let's turn to some of the requirements of the position.

The regulation states that the IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or other related field. The facility must provide documentation of the IP's primary professional training.

A professionally-trained nurse must have earned a certificate/diploma or degree in nursing.

If the facility employs a medical technologist as the IP, then the facility must provide evidence of an associate's degree (or higher) in medical technology or clinical laboratory science.

If the facility employs a microbiologist or epidemiologist as the IP, then the facility

must provide evidence of a bachelor's degree (or higher) in microbiology or epidemiology since this is the entry-level degree for these fields.

Examples of other related fields of training that are appropriate for the role of an IP include physicians, pharmacists, and physician's assistants, and the facility must show the IP’s completion of this training.

F882- IP Hours

- The IP must work at least part-time at the facility.

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At section 483.80(b)(3), the language states that the IP must work at least part-time at the facility. There is not a specified number of hours the IP must work. The reason for this is the hours per week can vary greatly based on the facility and its resident population. Therefore, the amount of time required to fulfill the role should be determined by the facility assessment, conducted according to section §483.70(e), to determine the staff hours it needs for its IPCP. As part of this, a nursing home should consider resident census as well as resident characteristics and the complexity of the healthcare services it offers in determining the amount of IP hours needed. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility; address training requirements, and participate on the QAA committee.

The surveyor should perform interviews to determine if the IP has adequate time to perform the role.

The second part of the requirement states that the IP must work "at the facility".

This does mean that the IP must physically work onsite at the facility, and not at a separate location such as a corporate office. If you think about it, it is hard to manage an IPCP to include infection control practices such as hand hygiene, environmental cleaning and disinfection, and implementation of transmission-based precautions if you are not on-site. Therefore, surveyors should interview the IP and other facility staff to determine where work is performed.

F882- IP Specialized Training

- The IP must have completed specialized training in infection prevention and control.

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Next, I want to review the specialized training requirement.

The specialized training in infection prevention and control must be beyond the initial professional training or education previously mentioned. Infection prevention and control training must be sufficient to perform the role of the IP, and the facility must provide evidence of completion of the specialized training to the surveyor. For example, this may include a certificate of training.

IP Participation on the QAA Committee

§483.80 (c) IP participation on quality assessment and assurance committee.

- The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
- Cite at F868.

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Well, I think that completes the discussion of the IP qualifications. Let's turn to the IP's participation on the QAA committee. The

IP must be a participant on the facility's QAA committee and report on the IPCP and on incidents, for example, healthcare-associated infections, identified under the program. Reporting may include, but is not limited to, facility process and outcome surveillance, occupational communicable diseases (for example, influenza), and the antibiotic stewardship program related to antibiotic use and resistance data. In order to be considered an active participant, the IP should attend each QAA meeting. If the IP cannot attend, another staff member should report on his/her behalf.

The IP's participation on the QAA committee is reviewed for each recertification survey under the QAA and QAPI Plan pathway. If the surveyor finds a deficiency, then the surveyor would cite at tag F868. Since IP participation was mentioned under the regulatory language at both section 483.80(c) and section 483.75(g), we chose F868 as the logical place to include reviewing and citing for this requirement.

Immunization Update

- Removed the outdated language related to the Advisory Committee on Immunization Practices (ACIP) recommendations for the 13-valent pneumococcal conjugate vaccine (PCV13) in those ≥65 years

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Lastly, let's discuss revised language under tag F883.

On November 22, 2019, the Advisory Committee on Immunization Practices or ACIP released updated recommendations on the use of 13-valent pneumococcal conjugate vaccine (or PCV13) among adults aged greater than or equal to 65 years. ACIP states that PCV13 vaccination is no longer routinely recommended for all adults aged greater than or equal to 65 years. Instead, shared clinical decision-making for PCV13 use is recommended for these individuals who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant and who have not previously received PCV13.

Facilities must follow the ACIP recommendations for vaccines. And surveyors should review residents' medical records for pneumococcal immunization status per ACIP recommendations and remain vigilant on ACIP updates to recommendations.

Congratulations

You have completed this section of the training.

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Congratulations! You have successfully completed this section of the training.

Thank You

If you have questions about this training, please send them to:

DNH_TriageTeam@cms.hhs.gov

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If you have questions about this training please send them to the DNH Triage mailbox at: DNH_TriageTeam@cms.hhs.gov

Thank you for your continued efforts towards our shared goal in providing quality care to America's nursing home residents.