BY ORDER OF THE COMMANDER
AIR FORCE RESERVE COMMAND

AIR FORCE INSTRUCTION 44-108

AIR FORCE RESERVE COMMAND
Supplement 1

10 SEPTEMBER 2004

Medical

INFECTION CONTROL PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

NOTICE: This publication is available digitally on the AFDPO WWW site at: **http://www.e-publishing.af.mil.**

OPR: HQ AFRC/SGM (Col Tywana Bowman)

Certified by: HQ AFRC/SG
(Col George P. Costanzo)
Pages: 9
Distribution: F

The OPR for this supplement is HQ AFRC/SGM (Col Tywana Bowman). This instruction implements AFPD 44-1, Medical Operations and AFI 44-108, Infection Control Program, 1 July 2000. This supplement provides guidance on the components of an Infection Control Plan (ICP) and identifies common practices employed in Medical Reserve Unit (MRU) and describes procedures for preventing and controlling health care acquired infections within a (MRU). Medical Reserve Units include Aeromedical Staging Squadron (ASTS), Aeromedical Evacuation Squadron (AES), Aerospace Medicine Squadron (AMDS) and Medical Squadron (MDS), with and without attachment to medical treatment facilities. It defines the organization, specific functions, and responsibilities of key personnel to the ICP. This supplement instruction applies to all United States Air Force Reserve Medical Service (AFRMS) personnel and should be applied in conjunction with the primary AFI 44-108 and AFI 41-307, Aeromedical Evacuation Patient Consideration and Standards of Care (Infection Control attachment 12).

1.3.1. (Added) The MRUs are not inspected by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

1.4.2.1. (Added) Disseminate information to MRU Commanders.

1.4.4. (Added) Numbered Air Force (NAF) has the option of appointing a consultant for their units. The selected consultant will meet the following requirements in **1.4.4.1. (Added)** - **1.4.4.3. (Added)**:

1.4.4.1. (Added) A minimum of four years experience (civilian and or military) in the field of Infection Control.

1.4.4.2. (Added) In a current position as an Infection Control Monitor (ICM)/Infection Control Officer (ICO).

1.4.4.3. (Added) Approved by the respective AFR/NAF.

1.4.4.4. (Added) Certification in Infection Control (CIC) is recommended but not required.

1.5.4. (Added) Develops curriculum that is appropriate and relevant to MRU environment.

1.6.1. Establishes either an Infection Control Review Function (ICRF) or an Infection Control Committee (ICC) to oversee an effective infection control program within MRUs. If the medical reserve unit elects to have an ICC, they must comply with the guidelines in the AFI 44-108. An ICRF is required if the unit decide not to have an ICC.

1.6.1.1. (Added) The ICM/ICO administers the ICRF. The ICRF is described in Chapter 2, section 2.3.1.

1.6.2. Appoints in writing an ICM/ICO who is a qualified professional with a minimal grade of 03 (captain) and one year experience in the reserves. The ICM/ICO may be any of the following: nurse, physician, dentist, public health officer or laboratory officer. ICM/ICOs below the grade of 03, who are currently performing this duty prior to implementation of this AFRC supplement, and who have attended a formal school may continue to work in this position.

1.6.7. Requires all MRU personnel receive an MRU specific infection control newcomer orientation that satisfies regulatory requirements. Orientation is completed within three Unit Training Assemblies (UTAs) after arrival to the MRU or prior to assignment to duties, which ever comes first.

1.6.8. Annual IC training is the minimum requirement for MRUs. Additional training is provided for those areas deemed necessary depending on their mission requirements.

1.6.9. Newcomers orientation is the minimum requirement for all newly assigned personnel. Additional training is provided for those areas deemed necessary, depending on mission requirements. The reservist working in a medical treatment facility (MTF) will receive unit specific infection control education by their sectional supervisors as it pertains to high-risk populations described in the AFI 44-108

1.6.12. Sends the ICM/ICO to a healthcare training course in epidemiology and infection control as soon as possible, but no later than one year after being assigned to the position. (See Chapter 2, Para 2.5.1)

1.8.1.1. (Added) The ICO is referred to as an infection control monitor (ICM) within the reserve component.

1.8.2.1. (Added) Reports ICP items to the MRUs Commander or designee.

1.8.3.1. (Added) Medical reserve units attached to an active duty MTF, the ICM communicates with the MTFs ICO to be kept abreast of applicable IC issues (i.e. safety device, needle device, etc.).

1.8.4. Assesses facility's infection control needs by performing an annual self-inspection using the Air Reserve Component (ARC) Health Services Inspection (HSI) Checklist as a guideline.

1.8.6. Performs or supervises prevention and control of infectious activities pertinent to the mission that is defined in the infection control program plan (ICPP) and approved by the Executive Management Committee (EMC) or its equivalent.

1.8.7. Develops and maintains the MRU Operating Instructions (OIs) for infection control.

1.8.10.1.1. (Added) Implements ICP in accordance with (IAW) current infection control standards. Purchase of the Association of Practitioners in Infection Control and Epidemiology (APIC) manual is optional. Resources can be obtained from appropriate websites as described in section **1.8.10.2.1. (Added)**

1.8.10.2.1. (Added) Annual subscriptions are optional for MRUs. This material may be obtained from appropriate websites of the Centers for Disease Control (CDC) and APIC manual.

1.8.10.2.2. (Added) The following are key websites used to obtain current infection control standards: **http://www.cdc.gov**, **http://www.cdc.gov/mmwr/**, **http://www.cdc.gov/ncidod/**, **http://www.apic.org**.

1.8.13. Coordinates and consults on selected service contracts that have infection control implications, when applicable to the particular MRU.

1.8.13.1. (Added) Reports discrepancies in housekeeping, linen or waste management to the senior air reserve technician (ART).

1.8.13.2. (Added) Provides oversight of appropriate storage of immunizations/vaccines as applicable to the MRU.

1.8.14. A formal agenda is not required for an ICRF; however an ongoing documented plan of action with interventions and follow up are required.

1.8.16.1. (Added) Work in concert with Aerospace Medicine Squadron/Public Health as described in the AFI 44-108 in developing exposure control plans that are relevant to the MRU.

1.8.16.2. (Added) The MRU may elect to use the host MTFs exposure control plans. In such cases, the MRU must coordinate with the host MTF and establish in writing their agreement on protocols and shared resources. The exposure plan will include at a minimum: delineation in areas of responsibilities between the MRU and MTF, describe method (s) by which the MTF will keep the MRU abreast of changes in protocols and the exposure control plan must be signed by both the MRU and MTF.

1.8.16.3. (Added) If there is not an Aerospace Medicine Squadron/Public Health, the ICM/ICO or designated person by the unit commander will be responsible for the development of the MRU exposure control plans. In addition the ICM/ICO or designated person will be responsible to report on occupational exposures to blood/body fluids, and other infectious disease, as appropriate, while the member is in reserve status. Refer to the AFI44-108 1.12.4.

1.8.18. (Added) If IC related host-tenant agreement/memorandum of understanding (MOU) exist, the ICO/ICM will review prior to expiration.

1.13.3. (Added) Some MRUs may not have a BE available. In such cases, review the host-tenant agreement or MOU between the MRU and MTF. The host BE office is responsible for providing Industrial Hygiene Support, which includes respiratory fit testing to the tenant MRU. The BEs at the full time Reserve bases are also responsible for the non-collocated MRU for fit testing. If required, management of the respiratory protection fit-testing for the N-95 Respirator Mask is a component of the Tuberculosis Prevention and Control Program.

1.14. **Facility Manager.** The senior ART performs these functions or a designated individual. Refer to section **1.17. (Added)**

1.14.6. If the AF Form 714, Customer Complaint Record, is not utilized within the MRU, use another method to assess and document complaints as it relates to housekeeping issues.

1.14.7. In MRUs, ventilation surveys are generally not required. Functions of the facility manager are typically the responsibility of the unit administrator or the senior ART.

1.16. (Added) **Aeromedical Evacuation Squadron (AES)**

1.16.1. (Added) Reviews File Crew Information Files (FCIF) as released.

1.16.2. (Added) Reads Flight Crew Bulletin (FCB) quarterly.

1.16.3. (Added) Directs staff members with infectious illnesses to be evaluated by a healthcare provider/ Flight Surgeon and duties are modified as required. Refer to AFI 41-307.

1.17. (Added) **Senior Air Reserve Technician (ART)**

1.17.1. (Added) Consults with personnel who provide oversight of linen, housekeeping, and regulated medical waste contracts when the MRU provides health care activities.

1.17.2. (Added) Coordinates facility renovation/construction of clinics within the MRU with the ICM. Dental clinics will consult the USAF Dental Investigative Service (DIS) for renovation, relocation, or construction issues.

1.17.3. (Added) Medical Reserve Units are manned only during UTAs. The ART or designee is responsible for maintaining the immunization refrigerator temperature checks during the month.

1.17.4. (Added) An emergency response plan is required if the MRU has an immunization refrigerator. This emergency response plan, at a minimum, addresses a 24-hour notification process in the event of a failure. (example: the system is connected to the command post for immediate notification).

1.17.4.1. (Added) In the event of an alarm or failure of temperature parameters of the immunization refrigerator, notifies Civil Engineer or appropriate personnel immediately.

2.1. **Scope of the Program.** The Infection Control Program is a multifaceted MRU/unit-wide program that complies with current standards of Occupational Safety and Health Administration (OSHA) regulations and other regulatory agencies.

2.1.2. The Program involves all US Air Force Reserve personnel assigned or attached to a medical unit.

2.2. **Program Authority.** The MRU executive management team oversees the ICRF/ICC through the Executive Management Committee (EMC) or its equivalent.

2.3.1. Infection Control Function Review Committee (ICRF).

2.3.1.1. (Added) Membership.

2.3.1.1.1. (Added) Consists of personnel who have a commensurate level of authority in the MRU, for critical decision making and timely implementation of recommended actions.

2.3.1.1.2. (Added) Includes, but not limited to: ICM, Public Health, BE, Immunizations and other representatives as deemed necessary from nursing, administrative, dental etc.

2.3.1.1.3. The ICRF does not have independent decision-making authority. The ICM submits a summary report and recommendations to the EMC or its equivalent at least twice a year. The ICRF meets at least quarterly. Meetings can either be in person or electronically to address issues pertaining to the management of the ICP as described in the ICPP.

2.3.4.2.3. Due to limited scope of practice in MRUs, routine reporting of infection rates are not required. Medical reserve units do not perform invasive procedures and therefore will not be able to generate quantifiable data as described in the AFI 44-108.

2.3.5.2.1. Identify the scope of the ICP relevant to the mission of the MRU.

2.3.5.2.2. Define policy and procedures for the prevention and control of infection.

2.3.5.2.4. List approved antiseptic and disinfectant agents IAW the MRU mission (if applicable).

2.3.6. Include coordination on the development of the ICPP.

2.3.6.1. The ICPP is reviewed and updated annually with a focus on specific MRU activities to be accomplished.

2.3.6.2. The ICPP presents the framework for the annual summary report to be submitted to the EMC yearly or as required by the MRU.

2.5.1. The ICM attends the Infection Control-ARC (IC-ARC) course at Sheppard AFB, TX, or an equivalent course, within one year of assignment to the position.

3.3.1.2.1. (Added) Patients on an aeromedical evacuation mission, who are considered contagious, will be isolated IAW AFI 41-307.

3.4.1. Authority Statements. The ICRF has the authority, through its ICM, to institute prevention, and control measures deemed necessary when there is reason to believe a condition exists that places the facility, patients, or personnel at risk.

3.4.1.1. The ICM will ensure the Squadron Commander is promptly notified of the risk.

3.7.6. (Added) The AES will use approved detergents/disinfectants IAW current AES allowance standards.

3.12.3. The ICRF reviews housekeeping policies, procedures, and cleaning agents every two years if applicable to MRU.

3.13. **Ventilation.** This is limited to MRU's that have areas as described in the AFI 44-108. Most MRUs will not have this requirement due to their limited scope of practice.

4.3.4. (Added) Surveillance in MRUs will consist primarily of observation of the environment, monitoring of training requirements and adherence to infection control standards. (Refer to Chapter 2 for examples).

4.3.4.1. (Added) Surveillance in the reserve setting is used primarily to monitor processes, and assess knowledge level and implementation of the ICP by the unit personnel.

4.3.4.2. (Added) Each MRU determines appropriate surveillance activities based on the type of services provided. (Refer to Chapter 2 for examples).

4.4.11. (Added) Surveillance Activities in the ICPP. The examples in chapter 4, section "4.4. (Surveillance Activities in Annual Plan)" in AFI 44-108 are not applicable for MRUs. Consider the following questions in the development of MRU surveillance process:

4.4.11.1. (Added) What is to be surveyed? Examples: Knowledge of how to clean-up blood spills or what to do if MRU personnel sustain an exposure to blood or body fluids; and appropriate storage of supplies.

4.4.11.2. (Added) Areas to be surveyed? Examples: All MRU personnel and/or applicable work areas (dental clinic, immunizations clinic, etc)

4.4.11.3. (Added) Length of time areas is surveyed? This will vary dependent on what you are surveying. Examples: can be quarterly, twice a year, once a year etc.

4.4.11.4. (Added) What is the surveillance methodology? Examples: Visual observation of personnel administering immunizations; interviewing staff regarding their knowledge of standard precautions and isolation of contagious patients during an aeromedical evacuation mission.

4.4.11.5. (Added) What is the method for reporting and providing feedback? Examples: reports are presented to the ICRF and forwarded to the EMC or its equivalent. Report findings to the area surveyed.

4.5. **CDC NNIS Definitions.** This is not relevant within MRU's due to the limited scope of practice. The CDC definitions are for inpatient hospitals only.

References (Added)

AFI 41-307, *Aeromedical Evacuation Patient Consideration and Standards of Care* (Infection Control attachment 12)

Attachment 2 (Added)

EXAMPLES OF SURVEILLANCE FOR MRUS

A2.1. (Added) Format Examples:

DEFINITION: Process surveillance includes the series of steps taken to achieve a desired outcome.

PURPOSE: Assess knowledge in action or application of infection control duties.

METHOD: Observation and verbal questioning/interviews of any unit personnel. Use a checklist guide.

ACTION: Correct infractions and /or deficiencies with education, product change, practice etc.

EXAMPLES: The list below is not exhaustive:

A2.2. (Added) Surveillance Examples:

A2.2.1. (Added) Handwashing:

A2.2.1.1. (Added) Does the staff wash or sanitize their hands when the opportunity presents itself?

A2.2.1.2. (Added) Does the staff have knowledge and practice appropriate handwashing techniques?

A2.2.1.3. (Added) Do the staff members have artificial nails, nail extenders or long nails? (IAW unit policies and host agreements). For example, at most institutions nails are prohibited for health care workers (HCW) performing patient care.

A2.2.2. (Added) Supply Storage:

A2.2.2.1. (Added) Are soiled and contaminated supplies separated from those that are clean and sterile?

A2.2.2.2. (Added) Are supplies stored 6-8 inches above the floor (to permit adequate cleaning of the floor), 18-20 inches below the ceiling, (away from vents, sprinklers, and lights to safe guard supplies from damage)?

A2.2.2.3. (Added) Are sterile and clean supplies stored on shelves, bins, or in drawers designed to protect the items from damage?

A2.2.2.4. (Added) Is supply rotation of “first in first out” being used?

A2.2.2.5. (Added) Are washable storage bins with dividers made of a non-porous material used?

A2.2.2.6. (Added) Are shelves being wiped down?

A2.2.2.7. (Added) Are outdated supplies found?

A2.2.2.8. (Added) Is the storage area clean?

A2.2.2.9. (Added) Are cardboard shipping boxes stored in areas with clean/sterile supplies?

A2.2.3. (Added) Equipment cleaning/disinfection/sterilization: Primarily for areas that perform these activities such as an AMDS.

A2.2.3.1. (Added) Are appropriate personnel trained in cleaning/disinfecting/sterilization and the required documentation?

A2.2.3.2. (Added) Is appropriate cleaning being accomplished in patient care areas to include: the correct environmental cleaner?

A2.2.3.3. (Added) Is spore testing being done per protocol and documented? (where sterilizers are used)

A2.2.4. (Added) Employee Health Program (EHP):

A2.2.4.1. (Added) Is compliance to EHP demonstrated by compliance to immunizations? (Flu-MMR-HAV-HBV-chickenpox-documentation, etc.)

A2.2.4.2. (Added) Compliance to EHP demonstrated by compliance to required testing (examples: PPD-HIV).

A2.2.4.3. (Added) Do personnel know the proper procedure for work restrictions concerning communicable diseases?

A2.2.5. (Added) Blood borne pathogen program and the Tuberculosis (TB) Control Plan:

A2.2.5.1. (Added) Standard precautions: Are they practiced appropriately?

A2.2.5.2. (Added) Are blood spills cleaned-up IAW with policies?

A2.2.5.3. (Added) Exposure incident: Is there documentation of incident and follow-up of exposed person and source?

A2.2.5.4. (Added) Are safety devices available per OSHA regulations?

A2.2.5.5. (Added) Are safety devices being used appropriately?

A2.2.5.6. (Added) Has the heath care worker been fit tested on the N95 respirator if they take care of a patient with/or suspected TB? If not, do they know where to get fit-tested?

A2.2.6. (Added) Visual inspection:

A2.2.6.1. (Added) Do personnel know where to go to get information concerning Infection Control in the unit?

A2.2.6.2. (Added) Is the general environment clean?

Storage of supplies: Is there appropriate rotation, removal of outdated items, cleanliness of area?

A2.2.6.3. (Added) Linen: Is there protected storage and cleanliness of storage area?

A2.2.6.4. (Added) Unique environmental issues for special workplaces: Are infection control practices maintained?

A2.2.6.5. (Added) Immunization Clinic/mobile immunization lines.

A2.2.6.5.1. (Added) Dental clinic.

A2.2.6.5.2. (Added) Laboratories.

A2.2.6.5.3. (Added) Aircraft.

A2.2.6.5.4. (Added) Patient exam rooms.

A2.2.6.6. (Added) Does staff know where to get personal protective equipment (PPE)?

A2.2.6.7. (Added) Are personnel performing risk-associated activities by using task appropriate PPE and techniques?

A2.2.6.8. (Added) Is regulated waste (if any) disposed of IAW local policy?

A2.2.6.9. (Added) Does food or drink consumption occur only in designated areas within the clinic?

A2.2.6.10. (Added) Are unit members familiar with the intent of Standard Precautions?

A2.2.6.11. (Added) Are needles and syringes placed intact in sharps containers after use?

A2.2.6.12. (Added) Has the HCW been familiarized with the safety devices used in the MRU?

A2.2.6.13. (Added) Has the reservist been given a briefing on issues related to health/infection control prior to a mobilization?

A2.2.6.14. (Added) Have OSHA/infection control briefings been properly documented? (Form 55, WIB-ITS etc).

A2.2.6.15. (Added) Are immunization refrigerators being monitored daily?

A2.2.6.16. (Added) Is there an alarm system to notify personnel that a malfunction has occurred?

A2.2.6.17. (Added) Are only immunizations stored in the refrigerators?

A2.2.6.18. (Added) Are the immunization refrigerators being cleaned on a routine basis?

JOHN J. BRADLEY, Lt General, USAF
Commander