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INFECTION CONTROL PROGRAM

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This instruction implements AFPD 44-1, *Medical Operations.* It describes procedures for preventing and controlling nosocomial and clinic-acquired infections in patients, visitors, and staff within medical treatment facilities (MTF), dental treatment facilities (DTF), Reserve Component (RC) Medical Units, and the aeromedical evacuation (AE) system. It defines the organization, functions, and responsibilities of the Infection Control Program and key personnel. This instruction applies to all Air Force Medical Service (AFMS) personnel, volunteers, Air National Guard and US Air Force Reserve personnel.

(AFRC) 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).

SUMMARY OF REVISIONS

This document is substantially revised and must be completely reviewed.

This instruction offers a significant amount of guidance to assist Infection Control Officers (ICO) in the field address the rapid, dynamic changing pace of the Infection Control arena. This instruction provides

specific guidance on the components of an Infection Control Program (ICP) and identifies common practices employed from MTF to MTF. It also provides appropriate guidance for issues in which the MTF can adopt or modify practices to ensure that reasonable precautions are being taken to prevent, control, and contain infections in patients, staff, and visitors.

Chapter 1

GENERAL ROLES AND RESPONSIBILITIES

1.1. Air Force Surgeon General (USAF/SG). Establishes policy and delegates broad oversight responsibility for the Infection Control Programs (ICP) in the Air Force Medical Service (AFMS).

1.2. Air Force Medical Operations Agency, Clinical Quality Management Division (AFMOA/SGOC):

1.2.1. Develops, updates, and disseminates Air Force infection control policy via print and electronic media.

1.2.2. Provides clinical consultation, defining and/or clarifying standards of care and practice related to infection control.

1.2.3. Serves as a liaison with military consultants in infection control and related specialties to keep abreast of changes in the field.

1.2.4. Serves as the Air Force resource for information and regulations that influence the practice of infection control.

1.3. Medical Inspection Directorate, Air Force Inspection Agency (HQ AFIA/ SG). Evaluates the programs described in this instruction within Air Force Medical Treatment Facilities (MTF) and Air Reserve Component (ARC) units, in conjunction with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

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

1.4. Major Command Surgeons (MAJCOM/SG):

1.4.1. Allocates appropriate resources to MTFs for infection control.

1.4.2. Disseminates information from AFMOA/SGOC to appropriate MTF points of contact.

1.4.2.1. (Added-AFRC) Disseminate information to MRU Commanders.

1.4.3. To meet the immediate needs of the MAJCOM, each MAJCOM has the option of appointing a consultant for their command. The selected individual will have the following:

1.4.3.1. Certification in Infection Control (CIC).

1.4.3.2. Minimum four years experience as an Infection Control Officer (ICO).

1.4.3.3. A current position as an ICO.

1.4.3.4. Approval by the USAF/SG Chief Consultant for Infection Control.

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

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

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

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

1.5. 383 TRS/XUFB, Sheppard AFB, TX. The Infection Control and Epidemi ology Course (ICE).

1.5.1. Develops curriculum at 383 TRS/XUFB, Sheppard AFB, TX, using the *APIC Infection Control and Applied Epidemiology Principles and Practice* as the primary reference for course content. Additional resources to include published texts, professional standards, guidelines, journal references, etc. are incorporated as appropriate.

1.5.2. Updates the course as needed to maintain currency.

1.5.3. Assists with the maintenance of the Infection Control Internet web page.

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

1.6. Medical Group Commander (MDG/CC) or the Unit Commander for ARC.

1.6.1. Establishes an Infection Control Committee (ICC)/Infection Control Review Function (ICRF) to oversee an effective facility-wide Infection Control Program (ICP).

1.6.1. (AFRC) 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-AFRC) The ICM/ICO administers the ICRF. The ICRF is described in **Chapter 2**, section **2.3.1.**

1.6.2. Appoints the Chief of the Medical Staff, or other qualified medical or dental provider, in writing, as Chairperson of the ICC.

1.6.2. (AFRC) 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.

1.6.3. Provides other resources as required to support the implementation of the Infection Control Annual Plan.

1.6.4. Ensures administrative assistance or secretarial support for the ICP.

1.6.5. Ensures computer and systems support to include appropriate software programs.

1.6.6. Reviews and approves unprogrammed resources for special contingencies, such as external regulatory agency mandates and outbreaks.

1.6.7. Ensures all MTF personnel receive a facility specific Infection Control newcomer orientation that satisfies regulated training requirements.

1.6.7. (AFRC) 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.

1.6.7.1. First assignment employees must receive the briefing prior to assignment to clinical duties.

1.6.7.2. Employees who have worked in a similar position in another MTF will attend the facility's Infection Control newcomer orientation, or a similar forum, within 30 days of arrival.

1.6.7.3. All employees will receive a workplace specific infection control orientation prior to the start of clinical duties.

1.6.8. Ensures all employees receive work area specific continuing education on infection control annually.

1.6.8. (AFRC) 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. Ensures all employees working in specialty areas receive continuing education annually on infection control aspects of patient care pertinent to high risk populations (e.g., intensive care units, transplant units, neonatal intensive care unit, dialysis units, perioperative areas).

1.6.9. (AFRC) 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

1.6.10. Ensures all employees receive training regarding significant changes in external regulatory agency standards.

1.6.11. Establishes a centralized record keeping system to document training.

1.6.12. Ensures the ICC/ICRF Chairperson and the ICO attend a training course in hospital epidemiology and infection control, or possess equivalent training, as soon as possible, but no later than one year after being assigned to the position.

1.6.12. (AFRC) 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.**)

1.6.13. Publishes an MTF/Organizational Instruction on the Infection Control Program.

1.6.14. Ensures reference materials specified in this instruction are obtained, maintained, and updated appropriate for the mission of the specific MTF.

1.7. Infection Control Committee (ICC) or Infection Control Review Function (ICRF) Chair.

1.7.1. Is a member of the Medical or Dental Staff.

1.7.2. Implements the Infection Control Program along with the ICO.

1.7.3. Provides direction and support to the ICO.

1.7.4. Notifies the Chief of the Medical Staff, who then notifies the MTF Commander of situations posing an imminent hazard to patient care. The ICO will ensure notification of other appropriate personnel such as the Risk Manager and the Chief Nurse Executive.

1.7.5. Conducts the ICC/ICRF meetings and verifies the ICC minutes or ICRF summary.

1.7.6. Establishes additional measures to study, prevent, and control infectious diseases when patients or personnel may be at risk.

1.7.7. Activates contingency plans based on engineering control failures (e.g. ventilation surveys).

1.7.8. Acts to minimize risk to the extent possible and/or remove susceptible individuals from environments that pose a health risk.

1.8. Infection Control Officer (ICO).

1.8.1. Is appointed in writing by the Chief of the Medical Staff/Unit Commander. The ICO is qualified by training, a minimum of three years clinical experience in their field (i.e. nursing, dental, etc.), and has an interest to manage the ICP.

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

1.8.2. Works for the Chief of the Medical Staff, or designee, in performing duties and responsibilities commensurate with the management of the Infection Control Program. In small MTFs where the Chief of the Medical Staff may not be the ICO's rater, they will provide appropriate input to the rater for evaluation purposes.

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

1.8.3. Implements the Infection Control Program with the ICC/ICRF Chair.

1.8.3.1. (Added-AFRC) 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 most current JCAHO standards appropriate for the facility type (i.e. hospital or ambulatory or home environment) and the Health Services Inspection (HSI) Checklist.

1.8.4. (AFRC) 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.

1.8.5. Drafts the Infection Control Annual Plan, with the ICC/ICRF Chairperson, based on those identified needs and obtains ICC/ICRF approval for the plan.

1.8.6. Performs or supervises infection surveillance, prevention, and control activities required by the facility, defined by the Infection Control Annual Plan, and resourced by the MTF Executive Committee.

1.8.6. (AFRC) 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 MTF Instruction for infection control.

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

1.8.8. Conducts formal orientation and ensures annual and inservice training on principles and practices of infection control for all MTF personnel and maintains documentation.

1.8.8.1. Facility newcomer orientation and annual inservice training for infection control:

1.8.8.1.1. Includes the training required by 29 CFR 1910.1030, *Bloodborne Pathogens Standard, Final Rule* and *Tuberculosis Prevention and Control Plan.*

1.8.8.1.2. Is tailored to the needs of the MTF for size and scope of care.

1.8.8.2. Training may be accomplished through a variety of educational media to include lecture, self-learning packets, videotapes, computer-assisted learning packages, etc. (NOTE: A knowledgeable person must be available to answer questions if the lecture style format is not used.)

1.8.9. Maintains infection control files on each activity pertinent to the ICP.

1.8.9.1. Maintains and disposes of records created as a result of prescribed processes in accordance with AFMAM 37-139, *Records Disposition Schedule.*

1.8.10. Maintains infection control references which at a minimum include:

1.8.10.1. APIC Infection Control and Applied Epidemiology Principles and Practice.

1.8.10.1.1. (Added-AFRC) 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. Annual subscription to the *American Journal of Infection Control (AJIC).* Recommend subscription to *Hospital Infection Control and Epidemiology.*

1.8.10.2.1. (Added-AFRC) 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-AFRC) 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**.

1.8.10.3. Other infection control references appropriate to the role of the MTF.

1.8.11. Coordinates and consults on the purchase of supplies and equipment used by MTF personnel in the care of patients.

1.8.12. Coordinates and consults on renovation, construction projects, facility modifications, and relocations within or impacting the MTF.

1.8.13. Coordinates and consults on selected service contracts and plans that have infection control implications. At a minimum, this includes the Hospital Aseptic Management System (HAMS) contract (or equivalent), the linen contract, and the waste management contract.

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

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

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

1.8.14. Plans the ICC agenda, with the ICC Chairperson, based on activities outlined in the Infection Control Annual Plan.

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

1.8.15. Has access to all records and all areas for surveillance activities.

1.8.16. Works in concert with Aerospace Medicine Squadron to develop the MTF Instructions for exposure control plans. (NOTE: Due to the overlapping nature of these programs, the MTF Instruction for Infection Control, Employee Health, the Bloodborne Pathogen Exposure Control Plan, and the Tuberculosis Prevention and Control Plan may all be contained in one MTF instruction.)

1.8.16.1. (Added-AFRC) 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-AFRC) 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-AFRC) 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.**

1.8.17. Maintains active membership in the following groups (if indicated):

1.8.17.1. Safety Committee, or equivalent.

1.8.17.2. Product Evaluation Committee, or equivalent.

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

1.9. Infection Control Technician (if indicated).

1.9.1. The Infection Control Technician is qualified by training, a minimum of three years clinical experience in the medical enlisted career field, and an interest in infection prevention and control.

1.9.2. Works directly for the Infection Control Chair or ICO when performing Infection Control duties.

1.9.3. Assists with the implementation of the Infection Control Program.

1.10. Unit Managers/Supervisors.

1.10.1. Ensures personnel know and comply with all infection control policies and practices.

1.10.2. Writes a unit specific operating instruction (OI), if needed, to augment the MTF Infection Control Instruction. (NOTE: Anything written in the MTF Instruction for Infection Control need not be repeated in the unit specific OI).

1.10.2.1. The section supervisor reviews the OI annually.

1.10.2.2. The OI is submitted to the ICC or ICRF for review at least every two years.

1.10.2.3. Separate section OIs for RC units are generally not required.

1.10.3. Ensures all personnel attend the facility newcomer orientation for Infection Control per the requirements listed in paragraph **1.6.7.**

1.10.4. Ensures the completion of a unit-specific orientation, on-the-job- training, and ongoing inservice education, to include documentation, on infection control for assigned personnel.

1.10.5. Evaluates work practices and engineering controls to find ways of improving employee practices and protection.

1.10.6. Assists ICO with surveillance in their respective areas.

1.10.7. Reports patients with nosocomial or clinic acquired infections to the ICO.

1.10.8. Notifies the ICC/ICRF, through the ICO, prior to the start of new procedures or changes in already established procedures, which may affect infection control practices.

1.10.9. Ensures staff members with infectious illnesses are evaluated by a healthcare provider and duties are modified as required.

1.10.10. Monitors infection control practices within their area of responsibility.

1.11. Commander, Aerospace Medicine Squadron (AMDS) or local equivalent.

1.11.1. Executes the occupational health program in accordance with (IAW) Air Force Instruction (AFI) 48-145, *Occupational Health Program*.

1.11.2. Ensures facility exposure control plans are developed, reviewed annually, and updated as necessary.

1.12. Public Health (PH).

1.12.1. Reports regularly to the ICC/ICRF on health status and disease monitoring in the employee health program as required by instructions or as requested by the ICC/ICRF.

1.12.1.1. Reports on occupational exposures to blood and body fluids, and other infectious disease, as appropriate.

1.12.1.2. Reports on immunization status of MTF employees to the ICC/ICRF at least annually.

1.12.2. Is responsible for reporting to designated authorities and/or agencies reportable diseases or conditions.

1.12.3. Assists ICO in cluster and/or epidemic investigations within the MTF.

1.12.4. In RC units, PH officers may not be available. In such cases, these responsibilities may be incorporated into those of the ICO or assigned otherwise by the unit commander. Requirements however remain the same.

1.13. Bioenvironmental Engineer (BE).

1.13.1. Manages the respiratory protection fit-testing for the N-95 respirator, if required, as a component of the Tuberculosis Prevention and Control Program.

1.13.2. Performs ventilation surveys (air exchanges and air flow studies) as required by MTF Instruction or as requested by the ICC/ICRF (see para **3.13.3.** for locations and frequency). MTFs may need to arrange for alternative ways to accomplish these surveys if the BE lacks the necessary qualifications and/or equipment. The BE will work in concert with the Facility Manager to arrange the necessary testing.

1.13.3. (Added-AFRC) 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.

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

1.14.1. Cross-feeds information obtained from BE ventilation surveys to the ICC.

1.14.2. Alerts the ICO and recommends corrective action if the ventilation survey fails to meet the design criteria listed in the most current version of Military Handbook 1191, *Medical Military Construction Program Facilities Design and Construction Criteria*. This is the reference used in the design and construction of Air Force MTFs and by Air Force MTF Facility Managers for identification and verification of ventilation requirements.

1.14.3. Consults with personnel who provide oversight of linen, housekeeping, HAMS, and regulated medical waste contracts.

1.14.4. Coordinates contract changes with the ICC/ICRF.

1.14.5. Coordinates facility renovation, clinical services relocation, and construction within the MTF with the ICO. Dental clinics will consult the USAF Dental Investigative Service (DIS) for renovation, relocation, or construction issues.

1.14.6. Reports to the ICC/ICRF on any infection control implications noted on AF Form 714, Customer Complaint Record.

1.14.6. (AFRC) 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 RC units, ventilation surveys are not generally required. Functions of the facility manager typically are the responsibility of the unit administrator.

1.14.7. (AFRC) 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.

1.15. Medical Treatment Facility (MTF)/Unit Personnel.

1.15.1. Comply with MTF and unit infection control instructions.

1.15.2. Comply with work practice and engineering controls.

1.15.3. Report occupational exposures and injuries as specified in MTF/unit policy.

1.15.4. Report suspected/actual nosocomial or clinic acquired infections per the mechanism identified by the MTF/organization.

1.16. (Added-AFRC) Aeromedical Evacuation Squadron (AES)

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

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

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

1.17. (Added-AFRC) Senior Air Reserve Technician (ART)

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

Chapter 2

INFECTION CONTROL PROGRAM POLICY

Section 2A—Overview

2.1. Scope of the Program. The Infection Control Program is a multifaceted MTF/unit-wide program/function that complies with current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, Occupational Safety and Health Administration (OSHA) regulations, and other regulatory agencies.

2.1. (AFRC) 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.

2.1.1. The Program focuses on preventing and controlling infections among patients, staff, and visitors by implementing guidelines developed by the Centers for Disease Control and Prevention (CDC), the Association for Professionals in Infection Control and Epidemiology (APIC), Healthcare Infection Control Practices Advisory Committee (HICPAC) and other professional organizations.

2.1.2. The Program involves all AFMS personnel, volunteers, Air National Guard and US Air Force Reserve personnel.

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

2.1.3. Hospitals, free-standing clinics, and ARC units adapt the Program's surveillance, prevention, and control activities to meet the needs of their specific facilities and services.

2.2. Program Authority . The MTF/unit executive management team oversees the Infection Control Committee (ICC) or the clinical staff performing the Infection Control Review Function (ICRF) through the Executive Committee of the Medical Staff (ECOMS) or its equivalent.

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

Section 2B—Program Implementation/Administration

2.3. Infection Control Committee (ICC) or Infection Control Review Function (ICRF):

2.3.1. Is a multidisciplinary group designed to coordinate all activities related to the surveillance, prevention, and control of infection.

2.3.1. (AFRC) Infection Control Function Review Committee (ICRF).

2.3.1.1. (Added-AFRC) Membership.

2.3.1.1.1. (Added-AFRC) 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-AFRC) 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. (Added-AFRC) 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.

2.3.2. Identifies and reduces risks of endemic (common cause) and epidemic (special cause) nosocomial or clinic acquired infections in patients and healthcare workers at the direct patient care level and at the patient care support level.

2.3.3. The MTF may call this multidisciplinary group a committee or a review function depending on the size of the facility and the infrastructure for program management.

2.3.4. Meets at least quarterly.

2.3.4.1. The ICC submits committee minutes to ECOMS or the equivalent. The ICRF submits a summary to ECOMS or it's equivalent.

2.3.4.2. The minutes or summary:

2.3.4.2.1. Reflect the activities of the ICC/ICRF by addressing, at a minimum, the components of the Infection Control Annual Plan.

2.3.4.2.2. Use a format that includes general discussion and action taken on each item.

2.3.4.2.3. Contain quantifiable data that is mostly longitudinal and can give a good comparison over time. (For example, it may not be helpful to describe monthly or quarterly surgical site infection rates unless you have comparative data from 6-12 months prior or you benchmark against a nationally accepted rate or standard.)

2.3.4.2.3. (AFRC) 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. Coordinates on the MTF Infection Control Instruction.

2.3.5.1. The ICC/ICRF may consider integrating the following instructions into one user friendly document: Infection Control Program, Employee Health, Bloodborne Pathogen Exposure Control Plan and the Tuberculosis Prevention and Control Plan.

2.3.5.1.1. Combined instructions must be clearly identified at the beginning of the instruction.

2.3.5.1.2. Appropriate coordination, by process owners is imperative. (For example, Aerospace Medicine coordinates the Exposure Control Plans.)

2.3.5.1.3. The instruction specifies all components of those various programs for the associated standard.

2.3.5.1.4. If separate instructions are maintained, it is imperative that these instructions work in concert with one another.

2.3.5.2. The MTF Instruction will, at a minimum:

2.3.5.2.1. Identify the scope of the program.

2.3.5.2.1. (AFRC) Identify the scope of the ICP relevant to the mission of the MRU.

2.3.5.2.2. Give authority to isolate infectious patients.

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

2.3.5.2.3. Give authority to culture any drainage site suspected as a nosocomial or clinic-acquired infection.

2.3.5.2.4. Define policy and procedures for the prevention and control of infection that is consistent throughout the organization.

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

2.3.5.2.5. Identify an approved antiseptic and disinfectant list.

2.3.6. Coordinates on the development of the Annual Plan written by the ICC Chairperson and ICO.

2.3.6. (AFRC) Include coordination on the development of the ICPP.

2.3.6.1. Contents of the Annual Plan, at a minimum:

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

2.3.6.1.1. Specify the time-frame for which it is written, i.e., calendar year vs. fiscal year.

2.3.6.1.2. Identify the scope of the program.

2.3.6.1.3. Identify and define surveillance strategies and reporting mechanisms.

2.3.6.1.4. Identify the method of policy and procedure review.

2.3.6.1.4.1. The MTF Instruction for Infection Control is reviewed annually.

2.3.6.1.4.2. Infection Control Operating Instructions are reviewed every two years at a minimum.

2.3.6.1.5. Identify education and training on infection control practices/procedures.

2.3.6.1.6. Identify quality initiatives and improvements of the ICP.

2.3.6.1.7. Identify the resources required to implement the Plan.

2.3.6.2. The Annual Plan presents the framework for the annual summary report to be submitted to ECOMS at the end of the annual plan period.

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

Section 2C—Infection Control Program Management Training

2.4. ICC/ICRF Chairperson Training: The ICC/ICRF Chair attends a training course appropriate for the position within six months to one year of assignment to the position. Such courses are offered by Society for Healthcare Epidemiology of America (SHEA), CDC, and the American Hospital Association (AHA), and the Association for Practitioners in Infection Control and Epidemiology (APIC).

2.5. ICO Training:

2.5.1. The ICO attends the ICE/ICE-ARC course at Sheppard AFB, TX, or an equivalent course, within six months to one year of assignment to the position.

2.5.1. (AFRC) 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.

2.5.2. It is recommended that an ICO be utilized in IC for at least two years after completion of the ICE course.

2.6. IC Technician Training:

2.6.1. The IC Technician attends the ICE course at Sheppard AFB, TX, within six months to one year of assignment to the position.

2.6.2. The IC Technician is utilized in IC for at least two years after completion of the ICE course.

Chapter 3

PREVENTION AND CONTROL OF INFECTION

Section 3A—Employee Health and Safety

3.1. Prevention is a Readiness Issue.

3.1.1. Infection Control is a prevention activity that is focused equally on the safety of the healthcare worker (HCW), the patient, and the communities we serve.

3.1.2. The prevention and the control of infection are significant in sustaining the warfighting capability of our forces.

3.1.3. Healthcare workers must understand the basic principles and practices of infection control as they apply in their day-to-day activities in order to be prepared to respond intelligently to situations that alter the normal conditions.

3.2. MTF Personnel Responsibilities for Personal Health and Safety. All MTF personnel are responsible to:

3.2.1. Seek prompt medical evaluation and treatment for any health condition that may be associated with an infectious or communicable disease.

3.2.2. Notify the immediate supervisor and PH of any duty restrictions or limitations as a result of an infectious or communicable disease.

3.2.3. Accomplish periodic health examinations, immunizations, and clinical laboratory studies as deemed necessary by appropriate medical authority or Department of Defense (DoD) mandate to prevent, detect, or control infections or communicable diseases.

3.3. Guidelines for the Health and Safety of MTF Personnel. As a component of force protection, the following guidelines in their most current edition are utilized for the prevention and control of infection in MTF personnel. (NOTE: Issues that have been recurrent sources of question and concern are specified here.)

3.3.1. CDC and Healthcare Infection Control Practices Advisory Committee **(**HICPAC): *Guideline for Isolation Precautions in Hospitals.*

3.3.1.1. MTFs/ARC use Standard Precautions. All blood and body fluids are treated as if potentially infectious.

3.3.1.2. MTFs use Transmission Based Isolation Procedures. For both hospitals and clinics, isolation precautions are defined for the use of Airborne, Droplet, and Contact Precautions. If desired, the MTF may utilize a fourth precaution known as Special Precautions for epidemiologically significant pathogens, such as Vancomycin Resistant Enterococcus (VRE) or other significant infectious diseases or outbreak situations that are determined to be of great clinical concern.

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

3.3.2. OSHA: *Bloodborne Pathogens, Final Rule.*

3.3.2.1. Personal Protective Attire (PPA) are supplied by the MTF and appropriate for the task the HCW is performing. NOTE: PPA is the same as Personal Protective Equipment (PPE).

3.3.2.2. Personnel wear PPA (gloves, gowns, goggles, masks) appropriate for the task they are performing to form a barrier of protection against exposure.

3.3.2.3. Protective outer garments (impervious gowns or aprons) are worn appropriate for the task being performed. Note: Scrubs are not considered PPA.

3.3.2.4. Safety designed devices are considered and made available based on work practices, reported exposure trends, and the laws of the State for any individual MTF.

3.3.3. CDC: *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-care Facilities.*

3.3.4. HICPAC: *Guideline for Infection Control in Healthcare Personnel*.

3.3.5. Work restrictions for pregnant healthcare workers caring for patients with selected infectious diseases. (See reference **3.3.4.** above.)

3.3.6. Exposure Workups. (See reference section.)

3.3.7. Dental: Follow the existing guidelines outlined in 2000 USAF Dental Infection Control Guidelines.

3.3.8. Respiratory Protection for TB: Follow guidelines in AFOSH Std 48-137, *Respiratory Protection Program* and 29 CFR 1910.139, *Respiratory Protection for M. Tuberculosis*.

Section 3B—Patient Care Practices

3.4. Authority Statements.

3.4.1. The ICC/ICRF has the authority, through its Chairperson, to institute any surveillance, prevention, and control measures deemed necessary when there is reason to believe a condition exists that places the facility, patients, visitors, or personnel in jeopardy.

3.4.1. (AFRC) 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 Chairperson of the ICC will ensure the MTF Commander is promptly notified of the danger.

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

3.4.1.2. The patient's primary provider is advised when isolation precautions are instituted.

3.4.2. The ICC/ICRF, ICO, and the medical/dental provider, nurse, or technician responsible for the care of the patient has the authority to initiate the appropriate isolation precautions and to culture suspected infected sites based on pre-established protocols for care.

3.4.2.1. Personnel must be trained in culturing techniques according to laboratory guidelines.

3.4.2.2. Sites that may be cultured include: urine, sputum, wound, stool, peripheral and central venous access sites, and other external drainage. The probing of a deep wound, to include intra-oral surgical sites, is done by the provider.

3.4.2.3. Documentation of culture submission is required in the medical or dental record.

3.4.2.4. The provider is advised when a culture was submitted.

3.5. Guidelines for the Prevention and Control of Infection in Patients. The following guidelines in their most current edition are followed for the prevention and control of infection in patients. Additional current literature may be used to augment these guidelines. (NOTE: Issues that have been recurrent sources of question and concern are specified here.)

3.5.1. APIC*: Guidelines for Handwashing and Hand Antisepsis in Healthcare Settings.*

3.5.2. CDC*: Guideline for Handwashing and Environmental Control.*

3.5.3. HICPAC**:** *Guideline for Isolation Precautions in Hospitals* (see **3.3.1.** above).

3.5.4. HICPAC: *Guideline for Prevention of Nosocomial Pneumonia*

3.5.5. HICPAC: *Guideline for Prevention of Intravascular Device-Related Infection.*

3.5.6. HICPAC: *Guideline for Prevention of Surgical Site Infections*.

3.5.7. CDC: *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Facilities.*

3.5.8. *Infection Control in the Outpatient Setting*. See reference section.

3.5.9. American College of Surgeons: *Guidelines for Optimal Office-Based Surgery*. See reference section.

3.5.10. Dental: Follow the existing guidelines outlined in 2000 USAF Dental Infection Control Guidelines.

3.5.11. General guidelines for infection control are found in, *APIC Infection Control and Applied Epidemiology, Principles and Practice.*

3.6. Antiseptics . An ICC/ICRF approved list of antiseptics is posted in the MTF Instruction for Infection Control or as an attachment to the Infection Control Annual Plan.

3.6.1. Include antimicrobial handwashing agents for use by healthcare workers.

3.6.2. Include any antiseptics that may be used on a patient.

Section 3C—Environmental Controls

3.7. Disinfectants.

3.7.1. The APIC *Guideline for Selection and Use of Disinfectants,* most current edition, is utilized as a guide for decision making. (NOTE: Recurrent issues/questions/concerns are specified here.)

3.7.2. A list of disinfectants approved by the ICC/ICRF is posted in the MTF Infection Control Instruction or as an attachment to the Infection Control Annual Plan.

3.7.2.1. Disinfectants used by the HAMS/Clinic Housekeeping Services provider will be maintained and approved on a separate list to ensure healthcare workers are not confused as to which products are approved for their use. (See paragraph **3.10.**)

3.7.2.2. The HAMS/Clinics Housekeeping Services Provider purchases disinfectants for use in the implementation of that contract.

3.7.2.3. HAMS/Clinics Housekeeping Services contractor owned/supplied chemicals, supplies, and equipment should only be used during an emergency and only when a housekeeper is not available for emergency response.

3.7.3. Glutaraldehyde.

3.7.3.1. Due to the potentially hazardous nature of glutaraldehyde, all MTFs are encouraged to seek alternative high-level disinfectants or sterilants for use.

3.7.3.2. If glutaraldehyde is employed, comply with ventilation requirements, PPA, manufacturer's use directions, and ensure the appropriate training of healthcare workers who will be using the product.

3.7.3.3. Appropriate hazard and exposure evaluations are performed by the BE in areas in which glutaraldehyde is the only alternative for high-level disinfection.

3.7.3.4. Glutaraldehyde is not used to disinfect the environment.

3.7.4. Quality indicators for liquid disinfectants/sterilizing agents.

3.7.4.1. Test strips or other quality indicators made by the manufacturer of a liquid disinfecting/ sterilizing agent (glutaraldehyde, hydrogen peroxide based products, peracetic acid, etc.) are used per manufacturers directions as a validation of the product integrity and effective concentration of its active ingredient.

3.7.4.2. Documentation of quality indicator results is made daily or prior to the use of the agent if the product is not used on a daily basis.

3.7.5. Household Bleach (Sodium Hypochlorite).

3.7.5.1. Bleach will not be used as a primary hospital grade disinfectant in the MTF. It lacks detergent and may be corrosive to some surfaces.

3.7.5.2. Bleach may be used in Nutritional Medicine as a disinfectant.

3.7.5.3. Bleach may be used as an additional disinfection step if deemed necessary and approved by the ICC/ICRF. (For example, due to its highly effective kill of enterovirus, bleach may be used as a second step disinfection. The surface is first cleaned with a detergent or detergent/ disinfectant, allowed to dry, and then followed by a disinfection of the appropriately mixed bleach and water solution.)

3.7.5.4. Dental Clinics may use a manufacturer recommended 1:10 bleach solution to disinfect dental unit water lines.

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

3.8. Cleaning, Disinfection, and Sterilization .

3.8.1. References.

3.8.1.1. *APIC Infection Control and Applied Epidemiology, Principles and Practice*, Chapter 15.

3.8.1.2. CDC: *Guidelines for Handwashing and Environmental Control*. Section 2: Cleaning, Disinfecting, and Sterilizing Equipment.

3.8.1.3. *AORN: Standards and Recommended Practices and Guidelines*.

3.8.1.4. *AAMI Standards and Recommended Practices*, Vol. 1.1 and Vol. 1.2.

3.8.1.4.1. Biological indicators are run in accordance with (IAW) AAMI Standards.

3.8.1.4.2. New technologies for sterilization indicators (e.g. Rapid enzyme indicators) are not used until approved by AAMI.

3.8.1.4.3. Sterilizer reports are submitted to the ICC/ICRF at least quarterly.

3.8.1.5. APIC: *Guideline for Infection Prevention and Control in Flexible Endoscopy.*

3.8.2. Determination of appropriate levels of disinfection/sterilization are IAW the criteria for critical, semi-critical, and non-critical items.

3.8.3. Use event-related sterility whenever possible. This practice recognizes that the product should remain sterile until some event compromises the integrity of the package (i.e., it becomes torn, wet, dropped on a contaminated surface, etc.)

3.8.4. Reprocessing of disposable supplies and equipment items labeled as "single patient use only" will not occur in the MTF. Reprocessing may occur by a third party reprocessing company that follows the Food and Drug Administration (FDA) Good Manufacturing Practice Guidelines and is a member of Association for Medical Device Reprocessors (AMDR).

3.9. Storage of Clean and Sterile Supplies.

3.9.1. References.

3.9.1.1. *AAMI Standards and Recommended Practices*, Vol 1.1 and Vol 1.2.

3.9.1.2. *APIC Infection Control and Applied Epidemiology, Principles and Practice*, Chapter 15.

3.9.2. Storage areas are in a clean, organized, environmentally controlled location.

3.9.2.1. As a general rule, keep like items together (i.e., sterile with sterile and clean with clean). Store liquids on lower shelves to prevent compromise to other supplies in the event leakage occurs.

3.9.2.2. All supplies are to be rotated using a "first in, first out" plan; so that older items are used first, thus preventing waste due to expiration.

3.9.2.3. Supplies are stored 6-8 inches above the floor (to permit adequate cleaning of the floor), 18-20 inches below the ceiling (away from vents, fire sprinklers, and lights to safeguard supplies from damage and for compliance with the National Fire Protection Association (NFPA) 101, Code for Safety to Life from Fire in Buildings and Structures (The Life Safety Code), and approximately 6 inches from an outside wall (to protect package integrity and permit air circulation).

3.9.2.4. Supplies are not stored or piled on top of plastic covered racks, above cabinets, or in any other manner that may be deemed unsafe.

3.9.2.5. Supplies are never stored on the floor.

3.9.2.6. No shipping boxes are brought in the MTF, except to deliver supplies which are promptly placed into an appropriate clean storage bin.

3.9.2.6.1. Shipping boxes are “dirty”. They are potentially laden with contamination from animal urine and feces which may serve as a mode of transmission of diseases associated with such contamination.

3.9.2.6.2. Shipping boxes potentially house vectors such as roaches.

3.9.2.6.3. Interior boxes may be used to store a supply item, but are discarded when the last item is used and not “reused” to store other items.

3.9.2.7. Rubber bands are not used to bundle items together, they may compromise the integrity of the package.

3.9.2.8. Chux or cloth towels are not used to line drawers or shelves.

3.9.2.9. Supply levels are realistic and maintained in a sufficient quantity to serve the patient care demands of the using area.

3.9.2.10. Check for outdated supplies monthly, at a minimum.

3.9.2.11. All supplies are checked at point of use for expiration dates.

3.10. Linen.

3.10.1. The ICO reviews the linen contract annually.

3.10.1.1. Any concerns are addressed through the MTF’s Linen Quality Assurance Evaluator (QAE) to the base Contracting Officer.

3.10.1.2. The ICO will tour the linen facility with the Linen QAE, prior to contract award for locally purchased contracts, and annually thereafter, to evaluate and ensure the practice is IAW the scope of work for the contract.

3.10.1.3. The ICO reports findings of the assessment and any recommendations to the ICC/ICRF.

3.10.2. All clean linen is transported and stored in carts used exclusively for this purpose or in linen carts that were cleaned and disinfected after being used to transport soiled linen.

3.10.2.1. Clean linen is stored in clean storage areas.

3.10.2.2. Clean linen remains protected until the point of use.

3.10.3. Soiled linen will be handled in a manner that minimizes dispersal of particles into the air and surrounding area.

3.10.3.1. Soiled linen will be placed in a rolling type hamper at the patient’s bedside. This will eliminate hand carrying by personnel down the corridors to a collection hamper.

3.10.3.2. Any linen that is extremely soiled or wet may be wrapped loosely in clean linen or placed directly in a plastic bag then into the linen hamper.

3.10.4. Linen hamper covers may be used for aesthetic purposes; if used, they must be kept clean.

3.10.5. Linen is not rinsed or sorted in MTFs that have a linen contract.

3.10.6. Double bagging of soiled linen is not required unless the first bag has been damaged or is leaking.

3.10.7. All soiled linen is treated as potentially infectious so there is no need to "color code" soiled linen into special bags based on isolation or amount of contamination.

3.10.8. Soiled linen is not placed in red bags unless it is intended to be handled as regulated medical waste.

3.11. Regulated Medical Waste (RMW). RMW is handled IAW host nation or state laws governing the disposal of such waste. NOTE: If host nation standards are less than what would normally be adhered to in the U.S., we will hold to the more stringent standard.

3.12. HAMS/Clinic Housekeeping Contracts.

3.12.1. HAMS contracts are centrally managed by HQ AFMSA/SGSLC and centrally procured by a single contracting office. Clinic Housekeeping contracts may be procured by local base contracting.

3.12.1.1. The contract specifies the contractor provides cleaning to achieve an environment of "total clean" ensuring the proper level of asepsis.

3.12.1.2. Housekeeping personnel are employees of the civilian contract company.

3.12.1.3. Appropriate ongoing, documented training of housekeepers is provided by the contractor.

3.12.2. Housekeeping contracts indicate housekeepers shall clean all government owned property and equipment unless it is attached to a patient.

3.12.2.1. Any equipment not to be cleaned by housekeeping personnel is referenced in the Individual Medical Facility Exhibit (IMFE).

3.12.2.2. If an individual MTF, or section therein, determines that a specific piece of medical equipment should not be cleaned by housekeeping they must notify the Housekeeping Quality Assurance Evaluator (QAE) to update the IMFE.

3.12.3. The ICC/ICRF reviews housekeeping policies, procedures, and cleaning agents annually.

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

3.12.4. Section managers insure housekeeping personnel are appropriately informed of any patients with infectious or communicable disease. Posting of appropriate isolation or precaution signs is an effective method of communication.

3.12.5. The Facility Manager manages the housekeeping function if performed "in-house" and serves as or oversees the QAE if a contractor performs housekeeping. AFI 41-201, Managing Clinical Engineering Programs, Section 4.10, addresses the Facilities Manager's role in housekeeping functions and with the ICC.

3.12.5.1. Contract surveillance is a responsibility of a QAE assigned to Facility Management.

3.12.5.2. QAEs are the only MTF agents authorized as liaisons between the users and contractor, except for emergency services.

3.12.5.3. Quarterly, QAEs instruct all management representatives of contract requirements and the proper method for completing the AF Form 714, Customer Complaint Record.

3.12.5.4. Questions regarding contractual requirements or performance are addressed to the QAE.

3.12.6. Housekeeping Customer. The employees, patients, and visitors of the MTF are the customers of the contract.

3.12.6.1. NCOICs of MTF functional areas conduct informal visual inspections on a regular basis and complete a customer complaint if work is not completed to their satisfaction.

3.12.6.2. Observed deficiencies are documented on the AF Form 714, Customer Complaint Record, and then reported to the QAE.

3.12.6.3. The QAE will validate the complaint in accordance with the performance work statement (PWS).

3.12.6.4. Discrepancies listed must be specific; a description of the problem, room number, and the name and phone number of the person reporting the problem.

3.12.6.5. Customers do not contact the contractor or housekeeping personnel directly to report lapses in contract performance, except for emergency services.

3.12.6.6. Customers coordinate with the contractor to provide access to various rooms and areas.

3.12.6.7. All tasks are performed with minimum interruption to patient care.

3.12.7. Emergency Service Response Procedures. Blood or body fluid spills are considered an emergency and housekeeping responds promptly to clean the area. If housekeeping service is not immediately available, healthcare workers may be taught to clean the spill following the guidelines of 29 CFR Part 1910.1030, Occupational Exposure to Bloodborne Pathogens; Final Rule.

3.13. Ventilation.

3.13. (AFRC) 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.

3.13.1. References.

3.13.1.1. American Institute of Architects Academy of Architecture for Health, with assistance from the U.S. Dept. of Health and Human Services. *Guidelines for Design and Construction of Hospital and Health Care Facilities*. 1996-97.

3.13.1.2. *APIC Infection Control and Applied Epidemiology, Principles and Practice*, Chapter 103.

3.13.1.3. Ventilation requirements are found in Military Handbook (MIL-HDBK) 1191, Medical Military Construction Program Facilities Design and Construction Criteria. Studies are referenced to the original design of the room.

3.13.2. True negative pressure ventilation does not recirculate air back into the facility.

3.13.3. The Facility Manager coordinates the monitoring of ventilation pattern (air flow pressure and air exchanges per hour) within the MTF.

3.13.3.1. Areas to be tested include, but are not limited to the Operating Rooms, Delivery Rooms, Central Sterile Supply, negative pressure isolation rooms, autopsy areas, minor surgical rooms such as cardiac catheterization labs or interventional radiology suites, Dental Instrument Processing Centers, rooms where glutaraldehyde is in use, and any other rooms deemed appropriate by the ICC/ICRF based on the design or use of the building.

3.13.3.2. Ventilation studies are performed at least two times a year. More frequent studies may be performed as deemed necessary by the ICC/ICRF.

3.13.3.3. The results of the study are submitted to the ICC/ICRF.

3.13.4. The Facility Manager Coordinates regular preventive maintenance of the ventilation system.

Chapter 4

SURVEILLANCE

4.1. References.

4.1.1. APIC Infection Control and Applied Epidemiology, Principles and Practice.

4.1.2. CDC: *Recommended Practices for Surveillance*.

4.1.3. CDC: *Definitions for Nosocomial Infections.*

4.2. Definition : Surveillance is defined as the "ongoing, systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know."

4.3. Surveillance Appropriate to MTF.

4.3.1. Surveillance is not performed just for the sake of surveillance.

4.3.2. Surveillance is performed to monitor an outcome or process.

4.3.3. Surveillance is performed to monitor key indicators in a process or as an evaluation of outcome. The goal is to look at issues that may have significant impact on patient care practices or employee health/safety. (Examples: (1) It is important to survey laboratory results for epidemiologically significant pathogens, such as MRSA to ensure providers have access to resistance patterns that will impact antibiotic prescribing practices. (2) It is important to survey/monitor employee exposures to ensure work practices are safe, or appropriate safety devices are available for the task the healthcare worker is performing.)

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

4.4. Surveillance Activities in Annual Plan . Surveillance is defined in the Infection Control Annual Plan. Use the following questions as a guide in the writing of the annual plan.

4.4.1. What is being surveyed? Examples: All outpatient GI endoscopy procedures. Epidemiologically significant pathogens such as nosocomial VRE or MRSA.

4.4.2. Population to be surveyed? Examples: All inpatients who have a cholecystectomy. All employees who are responsible for the cleaning/disinfection of the endoscope.

4.4.3. Length of time? Examples: 1 Jan – 30 Jun. First 50 patients.

4.4.4. Case finding and surveillance methodology? Examples: Prospective review of patient record, lab results, antibiotics prescribed, etc. Visual observation of personnel who perform the cleaning of the endoscope.

4.4.5. Definition of infection if a procedure is being surveyed? National Nosocomial Infection Surveillance (NNIS) definition of Surgical Site Infection (SSI). Steps in the process if a process is being surveyed.

4.4.6. Risk Adjustment (if any)? Example: NNIS risk stratification (CDC wound class, length of surgery, and American Society of Anesthesiologists (ASA) preoperative assessment score).

4.4.7. Types of rates generated (if any)? Examples: Rates are presented for the procedure as a whole, divided by service (if necessary). Rates are presented quarterly. Provider specific rates or trends are presented to the Division Chief or Service Chief.

4.4.8. Method of analysis? Example: Risk category rates compared to NNIS system data and to our MTF previous year rates.

4.4.9. Threshold? Example: NNIS system medians.

4.4.10. Reporting and feedback. Quarterly reports are presented to the ICC/ICRF and forwarded to the ECOMS or it's equivalent. Service specific rates and provider specific rates are provided to respective Flight Commanders. Rates exceeding established thresholds are forwarded to (flight name) Quality Assurance Officers for recommendations. These items will be carried as ICC/ICRF agenda items to ensure follow-up at subsequent meetings. (NOTE: The above are only examples. Each MTF determines what is appropriate based on the type of services it provides.)

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

4.4.11.3. (Added-AFRC) 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-AFRC) 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-AFRC) 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 . CDC NNIS definitions are recommended for nosocomial infection surveillance.

4.5. (AFRC) 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.

4.5.1. If it is determined by the ICC/ICRF, the ICC/ICRF Chair, or the ICO that a different definition is used, it must be clearly defined.

4.5.2. Any rate comparison is IAW the definition used. (NOTE: It may be appropriate to perform statistical comparisons between the MTF rate and the comparison rate, i.e., a Z-statistic, 95% confidence interval or a Fisher exact test, see *APIC Infection Control and Applied Epidemiology, Principles and Practice.*)

4.6. Surveillance Reports.

4.6.1. Are submitted to the ICC/ICRF, per the Infection Control Annual Plan, for review and recommendations.

4.6.2. Are provided as feedback to the provider or healthcare worker group(s) who perform the service being surveyed.

4.6.3. Are used as an opportunity to improve patient/employee/process outcome.

4.6.4. Are included in the Infection Control Annual Summary.

PAUL K. CARLTON, JR., Lt General, USAF, MC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFI 41-201, *Managing Clinical Engineering Program*

AFI 48-101, *Aerospace Medical Operations.*

AFI 48-105, *Control of Communicable Diseases.*

AFI 48-115, *Tuberculosis Detection and Control Program.*

AFI 48-135, *HIV Program.*

AFI 48-145, *Occupational Health Program.*

AFI 91-301, *Air Force Occupational and Environmental Safety, Fire and Health Prevention (AFOSH) Program.*

AFJI 48-110, *Immunization Requirements and Procedures (PA).*

AFMAN 37-139, *Records Disposition Schedule*

AFOSH Standard 48-137, *Respiratory Protection Program*.

USAF DIS-37, *USAF Dental Service Infection Control Program.*

AHA Guidelines for Health Care Linen Service Revised. Prepared by Joint Committee on Health Care Laundry Guidelines, 1994.

AHA. American Society for Healthcare Central Service Personnel (ASHCSP): *Recommended Practices for Central Service.*

AHA. American Society for Healthcare Central Service Personnel (ASHCSP): *Recommended Practices for Central Service.*

American College of Surgeons. *Guidelines for Optimal Office-Based Surgery*. Second Edition. Chicago: American College of Surgeons, 1996.

American Institute of Architects Academy of Architecture for Health, with assistance from the U.S. Dept. of Health and Human Services. *Guidelines for Design and Construction of Hospital and Health Care Facilities*. 1996-97. Washington, D.C.: American Institute of Architects Press, 1996.

Association for the Advancement of Medical Instrumentation (AAMI). *AAMI Standards and Recommended Practices, Volume 1.1, 1.2, 1.3.* Arlington, VA.: Association for the Advancement for Medical Instrumentation, 1998.

Association of Operating Room Nurses, Inc. *AORN Standards and Recommended Practices*, 1999. Denver, CO.: Association of Operating Room Nurses, Inc., 1999.

Belkin NL. Use of scrubs and related apparel in health care facilities. *American Journal of Infection Control* 1997;25:401-4.

Beneson, et al., *Control of Communicable Diseases Manual,* 16th Ed. Washington D.C.: American Public Health Association, 1995.

Bennet, John V. and Brachman, Philip S. *Hospital Infections*. 5th Ed. Boston: Little, Brown and Company, 1995.

Bolyard EA, Tablan OC, Williams WW, Pearson ML, Shapiro CN, Deithman SD. HICPAC. Guideline for infection control in health care personnel 1998. *American Journal of Infection Control* 1998;26(3):289-354.

Centers for Disease Control and Prevention. *Issues and answers: What is the risk of acquiring hepatitis C for health care workers and what are the recommendations for prophylaxis and follow-up after occupational exposure to hepatitis C virus?*

Centers for Disease Control and Prevention. *Update: provisional Public Health Service Recommendations for Chemoprophylaxis after Occupational Exposure to HIV.* MMWR, June 7, 1996: 468-473.

Enforcement Procedures for Occupational Exposure to Bloodborne Pathogens Standard 29 CFR 1910.1030 (6 March 1992).

Garner JS, Jarvis WR, Emori TG, Horan TC, Hughes JM. CDC definitions for nosocomial infections. In: Olmsted RN, ed*.: APIC Infection Control and Applied Epidemiology: Principles and Practice. St. Louis:* Mosby;1996:pp.A-1—A-20.

Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities, Fed. Reg. 28: pp 54242-54303, 1994.

Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities, 1994. MMWR 1994;43(RR-13):1-132.

Herwaldt LA, Pottinger RN, Carter CD, Barr BA, Miller ED, Exposure Workups. *Infection Control and Hospital Epidemiology* 1997;18:850-871.

Herwaldt LA, Smith SD, Carter CD, Infection Control in the Outpatient Setting. *Infection Control and Hospital Epidemiology* 1998;19:41-74.

HICPAC. Guidelines for Isolation Precautions in Hospitals. *American Journal of Infection Control 1996;24/24-52.*

HICPAC. Guideline for Prevention of Intravascular Device-Related Infection. *American Journal of Infection Control* 1996;24:262-293.

HICPAC. Guideline for Prevention of Nosocomial Pneumonia – 1994. *American Journal of Infection Control* 1994;22:247-292.

HICPAC. Recommendations for preventing the spread of vancomycin resistance: recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC*). American Journal of Infection Control* 1995;Apr;23(2):87-94.

Horan TC, Emori TG. Definitions of key terms used in the NNIS System. *American Journal of Infection Control* 1997;25(2):112-6.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO). *Accreditation Manual for Hospitals,* use latest edition.

Joint Committee on Healthcare Guidelines. *Guidelines for Healthcare Linen Service—1994.*

Larson EL. APIC Guidelines for Handwashing and Hand Antisepsis in Health Care Settings. *American Journal of Infection Control* 1995*;23:251-69.*

Lee TB, Baker OG, Lee JT, Scheckler WE, Steele L, Laxton CE, APIC Surveillance Initiative Working Group. Recommended Practices for Surveillance. *American Journal of Infection Control* 1998;26:277-288.

Mangram AJ, Horan TC, Pearson ML, Silver LC, Jarvis WR. Guideline for Prevention of Surgical Site Infection, 1999. Centers for Disease Control and Prevention (CDC) Hospital Infection Control Practices Advisory Committee. *American Journal of Infection Control* 1999;27(2):97-132.

Martin MA, Reichelderfer M. APIC Guideline for Infection Prevention and Control in Flexible Endoscopy, *American Journal of Infection Control* 1994;22:19-38.

Military Handbook (MIL-HDBK) 1191, *Medical Military Construction Program Facilities Design and Construction Criteria.*

MMWR, 26 Dec 97; Vol. 46; No. RR-18. *"Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC)".*

MMWR, 15 May 98; Vol. 47; No. RR-7. *"Public Health Service Guidelines for the Management of Health-Care Worker Exposures to HIV and Recommendations for Postexposure Prophylaxis".*

MMWR, 16 Oct 98, Vol. 47, No. RR-19. *"Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease".*

National Fire Protection Association (NFPA) 101, *Code for Safety to Life from Fire in Buildings and Structures (The Life Safety Code).*

National Institute for Occupational Safety and Health (NIOSH). *Recommended Guidelines for Personal Respiratory Protection of Workers in Health-Care Facilities Potentially Exposed to Tuberculosis* (21 Sep 92).

Olmstead RN, ed.: *APIC Infection Control and Applied Epidemiology Principles and Practice*. St. Louis: Mosby, 1996.

OSHA Instruction CPL 2-2.44D. *Enforcement Procedures for Occupational Exposure to Bloodborne Pathogen Standard* (5 Nov 99).

OSHA Regulation 29 CFR 1910.139, *Respiratory Protection for M. tuberculosis.*

Peters, Georges: *1997 Red Book: Report of the Committee on Infectious Diseases.* 24th ed. Elk Grove Village, IL: American Academy of Pediatrics, 1997.

Rutala WA. APIC guideline for selection and use of disinfectants. *American Journal of Infection Control* 1996;24:313-42.

Wenzel RP, et al. *Prevention and Control of Nosocomial Infections*, 3rd ed. Baltimore, Williams and Wilkins, 1997

Wong ES. Guideline for prevention of catheter-associated urinary tract infections. *American Journal of Infection Control* 1983 Feb;11(1):28-36.

References (Added-AFRC)

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

Abbreviations and Acronyms

AAMI—Association for the Advancement of Medical Instrumentation

AF—Air Force

AFB—Air Force Base

AFI—Air Force Instruction

AFIA—Air Force Inspection Agency

AFMOA—Air Force Medical Operations Agency

AFPD—Air Force Policy Directive

AFMS—Air Force Medical Service

AHA—American Hospital Association

AMDR—Association for Medical Device Reprocessors

AMDS—Aerospace Medicine Squadron

AORN—Association of Operating Room Nurses

APIC—Association for Professionals in Infection Control and Epidemiology

ARC—Air Reserve Component

ASA—American Society of Anesthesiologist

BE—Bioenvironmental Engineering

BEE—Bioenvironmental Engineer

CC—Commander

CDC—Centers for Disease Control and Prevention

CFR—Code of Federal Regulations

CIC—Certified Infection Control

DCRAF—Discussion Conclusion Recommendation Action Follow-up

DoD—Department of Defense

DIS—Dental Investigative Service

DTF—Dental Treatment Facility

ECOMS—Executive Committee of the Medical Staff

FDA—Food and Drug Administration

GI—Gastrointestinal

HAMS—Hospital Aseptic Management System

HCW—Healthcare Worker

HICPAC—Healthcare Infection Control Practices Advisory Committee

HQ—Headquarters

HSI—Health Services Inspection

IAW—In Accordance With

ICC—Infection Control Committee

ICE—Infection Control and Epidemiology

ICO—Infection Control Officer

ICP—Infection Control Program

ICRF—Infection Control Review Function

IMFE—Individual Medical Facility Exhibit

JCAHO—Joint Commission on Accreditation of Healthcare Organizations

MAJCOM—Major Command

MDG/CC—Medical Group Commander

MDS/CC—Medical Squadron Commander

MRSA—Methicillin Resistant *Staphylococcus aureus*

MTF—Medical Treatment Facility

NNIS—National Nosocomial Infection Surveillance

OI—Operating Instruction

OSHA—Occupational Safety and Health Administration

PACAF—Pacific Air Forces

PH—Public Health

PPA—Personal Protective Attire

PPE—Personal Protective Equipment

PWS—Performance Work Statement

QAE—Quality Assurance Evaluator

RMW—Regulated Medical Waste

SHEA—Society for Healthcare Epidemiology of America

SG—Surgeon General

SSI—Surgical Site Infection

TRS—Training Squadron

USAF—United States Air Force

USAFE—United States Air Forces Europe

VRE—Vancomycin Resistant *Enterococcus*

Attachment 2 (Added-AFRC)

EXAMPLES OF SURVEILLANCE FOR MRUs

A2.1. (Added-AFRC) 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-AFRC) Surveillance Examples:

A2.2.1. (Added-AFRC) Handwashing:

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

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

A2.2.1.3. (Added-AFRC) 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-AFRC) Supply Storage:

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

A2.2.2.2. (Added-AFRC) 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-AFRC) Are sterile and clean supplies stored on shelves, bins, or in drawers designed to protect the items from damage?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A2.2.5.6. (Added-AFRC) 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-AFRC) Visual inspection:

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

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

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

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

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

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

A2.2.6.5.1. (Added-AFRC) Dental clinic.

A2.2.6.5.2. (Added-AFRC) Laboratories.

A2.2.6.5.3. (Added-AFRC) Aircraft.

A2.2.6.5.4. (Added-AFRC) Patient exam rooms.

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

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

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

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

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

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

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

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

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

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

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

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

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