Care CEUs

Continuing Education for Nursing Home Administrators

Risk Management: How to Manage Risk within Your Company

Introduction

A 84-year-old female resident slips on a wet floor, falls, and breaks her hip. A health care professional administers the wrong medication to a patient, which leads to anaphylaxis. Protected health information (PHI) is compromised due to a lack of effective cybersecurity. A resident is physically abused over a period of two months. Unfortunately, all of the above scenarios can occur within health care organizations. Fortunately, risk management can help health care organizations avoid similar situations. This course reviews risk management, while providing insight into the essential elements of risk management. This course also highlights infection control recommendations, which can play an important role in risk management.

Section 1: Risk Management

This section of the course reviews risk management, while providing insight into the essential elements of risk management. The information found within this section of the course was derived from materials provided by the New England Journal of Medicine (NEJM) Catalyst unless, otherwise, specified (New England Journal of Medicine [NEJM] Catalyst, 2018).

What is risk management?

Risk management, within the context of health care, may refer to the processes used to detect, monitor, assess, mitigate, and prevent risks to patients, health care employees, and health care organizations.

Why is risk management important?

Risk management is important because it can help limit and prevent risks to patients, health care employees, and health care organizations, such as: lawsuits,

sanctions, fines, and patient abuse. Risk management is also important because it can help optimize patient care, and, ultimately, patient outcomes.

What are the key elements of risk management?

- **Identifying risk** - one of the most essential elements of risk management is identifying risk. Identifying risk may refer to a process of identifying potential hazards, safety concerns, ineffective techniques, and problematic situations. Examples of hazards, safety concerns, ineffective techniques, and problematic situations may be found below.
    - A wet floor.
    - Failing to follow standard precautions (note: standard precautions may refer to infection control practices that may be used to prevent the transmission of diseases).
    - Poor hand hygiene (note: hand hygiene may refer to the process of cleaning hands in order to prevent contamination and/or infections).
    - Incorrectly donning personal protective equipment (PPE) (personal protective equipment [PPE] may refer to equipment designed to protect, shield, and minimize exposure to hazards that may cause serious injury, illness, and/or disease).
    - Situations that may lead to a bloodborne pathogen exposure incident (note: the term bloodborne pathogens may refer to infectious microorganisms in human blood that can cause disease in humans; the term bloodborne pathogen exposure incident may refer to any event involving one or more individuals and the potential or actual exposure to blood or other potentially infectious materials (OPIM); a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or OPIM that results from the

performance of an employee's duties) (Occupational Safety and Health Administration [OSHA], 2023).

- Health care administrators should note the following methods that may be used to identify risk: observe and monitor health care professionals; engage health care professionals and other health care employees in open discussions about potential hazards and safety concerns; conduct routine hand hygiene audits (note: the term hand hygiene audit may refer to the process of ensuring hand hygiene techniques are being followed in accordance with relevant recommendations and/or guidelines).

- **Prioritizing risk** - once risks are identified, health care administrators should prioritize risk - meaning identified risks should be ranked based on their likelihood of occurring and potential impact. For example, a patient threatening to commit suicide should be ranked higher than a wet floor.

- **Medical error prevention** - another essential element of risk management is working to prevent medical errors from occurring (note: the term medical error may refer to a preventable adverse effect of care that may or may not be evident or causes harm to a patient) (Joint Commission, 2023). Methods that may be used to prevent medical errors may be found below. The information found below was derived from materials provided by the Joint Commission (Joint Commission, 2023).

    - Use at least two patient identifiers when providing care, treatment, or services; label containers used for blood and other specimens in the presence of the patient, when applicable.

    - Establish communication tools among health care professionals.

    - Develop written procedures for managing the critical results of tests and diagnostic procedures.

- Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.
- Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings; verify all medication or solution labels both verbally and visually.
- Immediately discard any medication or solution found unlabeled.
- Before starting a patient on warfarin, assess the patient's baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust warfarin therapy.
- Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.
- When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.
- Work to prevent health care-associated infections (HAIs).
- Set goals for improving compliance with hand hygiene guidelines.
- Improve compliance with hand hygiene guidelines based on established goals.
- Identify patients that may be suffering from suicidal ideation.
- Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.

- **Infection control** - to build on the previous key element, infection control should be a priority when considering risk management. Health care administrators should pay special attention to policies and procedure regarding coronavirus disease 2019 (COVID-19) (note: coronavirus disease 2019 [COVID-19] may refer to a respiratory illness that can spread from person to person, which is caused by a virus known as the severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]). Health care professionals should routinely update COVID-19 policies and procedures to meet recommendations and requirements.

- **Environmental services** - environmental services is another essential element of risk management, especially when considering environmental services' impact on effective infection control. When assessing risk, health care professionals should ensure the effectiveness of environmental services. Specific information regarding environmental services may be found below. The information found below was derived from materials provided by the Centers for Disease Control and Prevention (CDC) (Centers for Disease Control and Prevention [CDC], 2019).

    - Environmental services may refer to a department or unit within a health care facility that is responsible for cleaning, decontamination, disinfection, sterilization, housekeeping, laundry, and other related duties.

    - One of the main roles of environmental services is to prevent the transmission of infectious diseases through cleaning, decontamination, disinfection, and sterilization; environmental services can be essential to the prevention of health care-associated infections (HAIs).

    - An environmental service manager is essential to safe and effective environmental cleaning. Therefore, health care administrators/health

care organizations should designate an environmental service manager (note: the environmental service manager should have a written job description/terms of reference, along with salary allocation, to cleaning program activities; the environmental service manager is essential regardless of whether environmental cleaning is managed internally or by an external company). The responsibilities of the environmental service manager should include the following: developing the health care facility-specific environmental cleaning policy and corresponding service level agreement or contract, when applicable; developing and maintaining a manual of standard operating procedures for all required cleaning tasks at the health care facility; ensuring that structured training activities are carried out for all new staff and on a recurring basis; ensuring that routine monitoring is implemented and results are used for program improvement; ensuring that cleaning supplies and equipment are available in required quantities and in good condition (i.e., preventing stock-outs); addressing staff concerns and patient questions about the cleaning program; communicating with external companies about required program elements, when needed.

- Health care administrators/health care organizations should designate on-site supervisors. On-site supervision can allow cleaning staff to communicate any challenges or concerns about compliance (e.g., supply shortage, safety concerns). All cleaning staff should know to whom they report and who they can contact if any issues arise during their work. Health care administrators should note that supervisor-cleaner ratios should allow routine performance observations and monitoring (e.g., on a weekly basis).

- Health care administrators and relevant staff should develop and maintain environmental cleaning policies and procedures to help ensure the effectiveness of environmental services. Environmental

cleaning policies and procedures should include the following elements: defined lines of accountability and functional reporting lines and responsibilities for all implicated staff; cleaning schedules for every patient care area and noncritical patient care equipment, specifying the frequency, method, and staff responsible; contingency plans and required cleaning procedures for environmentally hardy organisms and for outbreak management; training requirements and performance standards for cleaning staff; monitoring methods, frequency, and staff responsible; a list of approved cleaning products, supplies, and equipment and any required specifications on their use; a list of necessary PPE and when hand hygiene action is recommended for staff and patient safety. Health care administrators should note the following: it is best to consult national and/or local governmental policies during the development of health care facility policies and procedures in order to ensure that governmental standards for health care environmental cleaning are incorporated into the documents (e.g., governmental bodies might have lists of environmental cleaning products that are approved for use in health care).

- Training for cleaning staff should be based on national or facility environmental cleaning guidelines and policies. It should be mandatory, structured, targeted, and conducted before staff can work independently within the health care facility. Training and education for cleaning staff should include the following elements: general introduction to the principles of environmental cleaning; the key role cleaning staff play in keeping patients, staff, and visitors safe from infectious diseases; how cleaning staff can protect themselves from infectious diseases; detailed review of the specific environmental cleaning tasks for which they are responsible, including review of policies and procedures, checklists, and other job

aids; when and how to safely prepare and use different detergents, disinfectants, and cleaning solutions; how to prepare, use, reprocess, and store cleaning supplies and equipment; participatory training methods, hands-on component with demonstration and practice; easy-to-use visual reminders that show the cleaning procedures (i.e., without the need for a lot of reading); orientation to the health care facility layout and key areas for the cleaning program (e.g., environmental cleaning services areas); other health and safety aspects, as appropriate; the training program is developed according to the intended audience, in terms of education and literacy level; the training program is developed specifically for cleaning staff who could be responsible for cleaning procedures in specialized patient areas. Health care administrators should note the following: maintain training records, including dates, training content, and names of trainers and trainees; select appropriate, qualified trainers at a facility or district level; conduct periodic competency assessments and refresher trainings as needed (e.g., at least annually, before introduction of new environmental cleaning supplies or equipment); focus refresher training on gaps identified during competency assessments and routine monitoring activities.

- Health care administrators should designate at least one environmental cleaning services area within their health care facility for preparation, storage, and reprocessing of reusable cleaning equipment and supplies. The designated environmental cleaning services area should: be well-ventilated and illuminated (lighting or window access); be labeled with a biohazard sign on the door; have an appropriate water supply (hot and cold water access, if feasible); have a utility sink/floor drain for safe disposal of used solutions; be designed so that, whenever possible, buckets can be emptied into utility sink/floor drains without lifting them or creating splashes; have

a dedicated handwashing sink, used only for handwashing; have access to an eyewash station; have appropriate PPE available; have enough space to keep reprocessing (dirty areas) separate from storage areas for cleaned equipment; be easily accessible in relation to the areas it serves (i.e., easily accessible throughout the facility); be appropriately sized to the amount of materials, equipment, and chemicals stored in the room/area; have printed copies of information related to environmental cleaning products, manufacturer's instructions, and job aids for preparation of cleaning and disinfectant solutions; never contain personal clothing or grooming supplies, food or beverages; there should be a separate area for cleaning staff to store these items; have safe chemical storage and access; have locks fitted to all doors to restrict access only to cleaning staff; be free from clutter; have washable surfaces (floors, walls, shelves). Health care administrators should note that the environmental cleaning services area should not be used for any other purposes.

- Health care administrators should ensure the use of cleaning logs. Cleaning logs may refer to job aids that can help guide the daily workflow for cleaning staff and serve as a cleaning record. Cleaning logs should specify the location, cleaning session (e.g., routine cleaning, terminal cleaning), date, and name/signature of cleaning staff. Health care administrators should note the following: logs should be available in central locations or where the cleaning task occurs so that supervisory staff can manage them on a daily basis, along with staff responsible for periodic monitoring activities; logs should indicate required periodic or scheduled cleaning tasks (e.g., weekly, monthly).

- Health care administrators should conduct program audits. In environmental cleaning programs with functional routine monitoring

programs, the CDC recommends the periodic performance of a comprehensive program audit to review the major program elements and identify areas for improvement at the programmatic level. Health care administrators should note the following recommendations for program audits: program audits should review all of the key program elements; perform them annually or every two years; auditors should not be facility staff or at least should not be directly involved with the program implementation; options for auditors should be context-specific, but some potential options include auditors from an external company, health officers, or staff from another health care facility in the same network; file program audit reports and records on-site at the facility to allow benchmarking and to inform the development of remedial action plans and quality improvement projects.

- Health care administrators should follow recommendations for medication preparation areas. Departments or areas where medication is prepared (e.g., pharmacy or in clinical areas) often service vulnerable patients in high-risk and critical care areas, in addition to other patient populations, and thus, should be regularly cleaned/disinfected. Health care administrators should note the following: the staff who work in the medication preparation area might be responsible for cleaning and disinfecting it, instead of the environmental cleaning staff; health care administrators should develop detailed standard operating procedures and checklists for each facility to identify roles and responsibilities for environmental cleaning in these areas. Health care administrators should also note the following medication preparation area recommendations: countertops and portable carts used to prepare or transport medications should be cleaned/disinfected before and after use; all high-touch surfaces (e.g., light switches, countertops, handwashing sinks, cupboard doors, and floors) should be cleaned/disinfected at

least once every 24 hours; low-touch surfaces, such as the tops of shelves, walls, and vents should be cleaned/disinfected on a scheduled basis.

- Health care administrators should determine an annual budget. An annual budget is essential to an effective environmental cleaning program. Therefore, health care administrators should determine an annual budget for environmental services. The essential elements of an annual budget for environmental services include the following elements: personnel (salary and benefits for cleaning staff, supervisors, and an overall program manager); staff training (at least pre-service and annual refresher); environmental cleaning supplies and equipment; equipment for program monitoring (e.g., fluorescent markers, UV-lights); administrative costs; production and printing costs for checklists, logs, and other job aids; infrastructure/services costs, such as supporting water and wastewater services, when applicable.

- **Investigating and reporting sentinel events** - the term sentinel event may refer to an unanticipated event in a health care setting that results in death or serious physical or psychological injury to a patient(s), not related to the natural course of the patient's illness (Joint Commission, 2023). When a sentinel event occurs, health care administrators should act quickly to investigate and report the sentinel event. Health care administrators should have policies and procedures in place for investigating and reporting sentinel events.

- **Performing compliance reporting** - the Joint Commission, as well as federal and state organizations mandate reporting of certain types of incidents, such as sentinel events, medication errors, and medical device malfunctions; incidents such as wrong-site or patient surgery, workplace injuries, medication errors, should be documented, coded, and reported

(note: the term medical device malfunction may refer to an event related to a medical device that resulted in patient injury or death).

- **Learning from "near-miss incidents"** - the term near-miss incident may refer to an event that occurs when a medical error or adverse reaction is avoided through circumstance or intervention. Learning from near-miss incidents can help health care organizations and health care professionals avoid incidents, such as medical errors. In order to effectively learn from near-miss incidents, health care administrators and health care organizations should work to identify near-miss incidents and analyze the events that lead to the near-miss incident. Health care administrators should consider developing a culture within their health care organizations that promotes the reporting of near-miss incidents.

- **Identifying and/or assisting health care professionals that may be suffering from substance abuse** - substance abuse may lead to medical errors and/or adverse events. Therefore, health care administrators should work to identify/assist health care professionals that may be suffering from substance abuse (note: substance abuse may refer to the harmful or hazardous use of psychoactive substances, such as alcohol and illicit drugs). Health care administrators should note the following signs of alcohol and/or illicit drug use: slurred speech, an active tremor, shakiness, poor coordination, sweating, nausea, vomiting, aggression, agitation, compulsive behavior, craving, red eyes, dry mouth, drowsiness, involuntary eye movements, dilated pupils, nasal congestion, mouth sores, reduced consciousness, lack of pain sensation, intolerance to loud noise, dizziness, confusion, lack of awareness to surroundings, and needle marks.

- **Identifying and reporting patient abuse** - patient abuse may refer to an intentional act or failure to act that causes or creates a risk of harm to a patient in a health care facility. Health care administrators should work to avoid, identify, and report patient abuse. Health care administrators should

note the following types of patient abuse: physical abuse, verbal/emotional abuse, psychological abuse, sexual abuse, financial exploitation/abuse, health care financial fraud, confinement, neglect, and elder abandonment.

- **Following guidelines and requirements from relevant organizations, such as the Occupational Safety and Health Administration (OSHA)** - the Occupational Safety and Health Administration (OSHA) may refer to the regulatory agency of the United States Department of Labor responsible for ensuring safe and healthful working conditions for workers by setting and enforcing standards and by providing training, outreach, education, and assistance. Health care administrators should ensure that they are up-to-date with guidelines provided by relevant organizations, such as OSHA. Specific examples of OSHA guidelines and requirements may be found below. The information found below was derived from materials provided by OSHA (OSHA, 2023).

    - Each employer having an employee(s) with occupational exposure should establish a written exposure control plan designed to eliminate or minimize employee exposure.

    - An exposure control plan should contain, at least, the following elements: exposure determination; the schedule and method of implementation for methods of compliance, HIV and HBV research laboratories and production facilities (when applicable), hepatitis B vaccination and post-exposure evaluation and follow-up, communication of hazards to employees, and recordkeeping; the procedure for the evaluation of circumstances surrounding exposure incidents.

    - Each employer shall ensure that a copy of the exposure control plan is accessible to employees.

- The exposure control plan should be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

- An exposure control plan review and update should reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens; and document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

- An employer, who is required to establish an exposure control plan, should solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and should document the solicitation in the exposure control plan.

- Universal precautions should be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids should be considered potentially infectious materials.

- Engineering and work practice controls should be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of such controls, PPE should also be used.

- Engineering controls should be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

- Employers should provide handwashing facilities which are readily accessible to employees.
- When provision of handwashing facilities is not feasible, the employer should provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes (note: when antiseptic hand cleansers or towelettes are used, hands should be washed with soap and running water as soon as feasible).
- Employers should ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other PPE.
- Contaminated needles and other contaminated sharps should not be bent, recapped, or removed (note: contaminated needles and other contaminated sharps should not be bent, recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure).
- Shearing or breaking of contaminated needles is prohibited.
- Bending, recapping, or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.
- Immediately or as soon as possible after use, contaminated reusable sharps should be placed in appropriate containers until properly reprocessed.
- Appropriate sharps containers should be puncture resistant; labeled or color-coded in accordance with this standard; leak proof on the sides and bottom.

- All procedures involving blood or other potentially infectious materials should be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

- Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

- Specimens of blood or other potentially infectious materials should be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping.

- Containers for storage, transport, or shipping should be labeled or color-coded and closed prior to being stored, transported, or shipped.

- Equipment which may become contaminated with blood or other potentially infectious materials should be examined prior to servicing or shipping and should be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

- When there is occupational exposure, the employer should provide, at no cost to the employee, appropriate PPE such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks, eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices (note: PPE will be considered “appropriate” only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used).

- The employer should clean, launder, and dispose of PPE at no cost to the employee.
- The employer should repair or replace PPE as needed to maintain its effectiveness, at no cost to the employee.
- If a garment(s)/PPE is penetrated by blood or other potentially infectious materials, the garment(s)/PPE should be removed immediately or as soon as feasible.
- All PPE should be removed prior to leaving the work area.
- Hepatitis B vaccination should be made available after an employee received the required training and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.
- Following a report of a bloodborne pathogen exposure incident, the employer should make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements: documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred; identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law; the source individual's blood should be tested as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity (note: if consent is not obtained, the employer should establish that legally required consent cannot be obtained).

- The employer should ensure that the health care professional evaluating an employee after an exposure incident is provided the following information: a copy of related regulations; a description of the exposed employee's duties as they relate to the exposure incident; documentation of the route(s) of exposure and circumstances under which exposure occurred; results of the source individual's blood testing, if available; and all medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain.

- The employer should obtain and provide the employee with a copy of the evaluating health care professional's written opinion regarding the bloodborne pathogen exposure incident within 15 days of the completion of the evaluation.

- The employer should institute an occupational exposure training program and ensure employee participation in the program.

- Occupational exposure training should be provided as follows: at the time of initial assignment to tasks where occupational exposure may take place; at least annually thereafter (note: annual training for all employees should be provided within one year of their previous training).

- The training program should contain, at a minimum, the following elements: an accessible copy of related regulatory texts; a general explanation of the epidemiology and symptoms of bloodborne diseases; an explanation of the modes of transmission of bloodborne pathogens; an explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan; an explanation of the appropriate methods for

recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials; an explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment; information on the types, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment; an explanation of the basis for selection of personal protective equipment; information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge; information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials; an explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available; information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident; an explanation of the signs and labels and/or color coding; and an opportunity for interactive questions and answers with the person conducting the training session (note: the individual(s) conducting the training should be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address).

- The employer should establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps.

- The information in the sharps injury log should be recorded and maintained in such a manner as to protect the confidentiality of the injured employee.

    - The sharps injury log should contain, at a minimum: the type and brand of device involved in the incident; the department or work area where the exposure incident occurred; and an explanation of how the incident occurred.

- **Following relevant federal and state laws** - health care administrators should ensure that their health care organization is compliant with relevant federal and state laws. Health care administrators should also ensure that organizational policies and procedures reflect the requirements outlined by state and federal laws.

- **Insurance coverage** - insurance plans can help health care organizations defend against lawsuits and other liability claims. Specific information regarding insurance plans for health care organizations may be found below. The information found below was derived from materials provided by XInsurance (XInsurance, 2023).

    - Examples of situations where a comprehensive insurance plan can mitigate risk include the following: a health care professional administers the incorrect medication to a resident, which results in an adverse event; a family member of a resident alleges that a health care professional abused a resident; a resident transportation accident; a resident slips on a wet floor and falls.

    - General liability plans - general liability plans cover common lawsuits that may arise from regular daily business activities that do not involve employees (e.g., a visitor); general liability insurance covers liabilities that may happen out of the care of an employee or for slip and fall accidents that are considered non-medical negligence.

    - Commercial property insurance - all businesses should have commercial property insurance to protect against any damages that

may happen to the building or any supplies or furniture that is stolen, damaged, or destroyed by a natural disaster like a fire.

- Professional liability insurance - professional liability insurance can protect individuals against claims, such as the following: administering the wrong medication, providing the wrong treatment, and inappropriate interaction with a patient.

- Alleged sexual abuse and molestation liability insurance - alleged sexual abuse and molestation liability insurance can provide further protection against claims of resident sexual abuse and molestation.

- Commercial auto liability - health care organizations that use vehicles to transport residents should have commercial auto liability insurance; such plans typically cover damages, accidents, or injuries that may happen while a commercial vehicle is being used.

- **Quality improvement** - according to the National Academy of Medicine, quality may refer to the degree to which health services for patients increase the likelihood of desired health outcomes and are consistent with current professional knowledge (U.S. Centers for Medicare and Medicaid Services, 2023). Quality improvement may refer to the framework used to systematically improve care (U.S. Centers for Medicare and Medicaid Services, 2023). Specific information regarding quality improvement may be found below. The information found below was derived from materials provided by the U.S. Centers for Medicare and Medicaid Services (U.S. Centers for Medicare and Medicaid Services, 2023).

    - The goal of quality improvement should be to standardize structure and processes to reduce variation, achieve predictable results, and improve outcomes for patients, health care systems, and organizations; structure should include technology, culture, leadership, and physical capital; processes should include knowledge

capital (e.g., standard operating procedures) or human capital (e.g., education and training).

- Quality improvement should include benchmarking; benchmarking may refer to the process of comparing one dimension of care with another for the purpose of quality improvement (e.g., comparing one health care department with another).
- Benchmarking can provide insight into the best practices for patient care.
- Health care administrators can use benchmarking to analyze variation in quality measures to identify research opportunities that can advance professional knowledge.
- Quality measure benchmarks can be used to accurately track improvement progress.
- The mechanism of quality improvement is standardization.
- Quality improvement should include quality measures; the term quality measure may refer to a standard for measuring the performance and improvement of health care services; quality measures may be used to assess health care professionals.

- **Effectively managing health care contracts** - health care contracts are an essential aspect of health care, and an essential aspect of risk management. Specific information regarding health care contracts may be found below. The information found below was derived from materials provided by ContractSafe unless, otherwise, specified (Bishop, 2021).
    - A health care contract may refer to a written agreement between an individual or entity and a health care organization.

- Health care administrators should note that the term contracted services may refer to services that are provided according to a written agreement between a health care organization and the individual or individuals providing the services.

- Examples of health care contracts include the following: medical director contract, physician recruitment contract, physician employment contract, managed care contract, managed services contract, patient transfer contract, an equipment lease contract, a purchased service contract, technology licensing contract, and a joint venture contract.

- Health care administrators can effectively manage health care contracts by determining the goals of each contract; designing contracts to meet specific goals; ensuring the terms of each contract meet specific goals; selecting a state law to govern the contract; determining the contract duration; establishing employee schedules; establishing on-call requirements; establishing contract termination procedures; establishing a contract expiration date; establishing non-renewal stipulations; considering laws and requirements that may apply to health care contracts; keeping the contract process simple; selecting a project manager, when needed; meeting timelines; reviewing contracts; identifying methods to resolve contract disputes; respecting confidentiality agreements; storing and organizing contracts; ensuring contacts do not lapse.

- Health care administrators should note that contracted services can help mitigate risk; for example, a contract with an environmental service provider can help health care organizations mitigate the risk of infections throughout the health care facility.

- **Emergency preparedness** - emergency preparedness may refer to the process of preparing how to safely and effectively respond to an emergency. Health care administrators should note the following: emergencies can create a variety of hazards for employees and patients in the impacted area; preparing before an emergency incident plays a vital role in ensuring that employers and employees have the necessary equipment, know where to go, and know how to keep themselves safe when an emergency occurs (OSHA, 2023). Health care administrators should routinely update emergency preparedness policies and procedures as well as protocols to ensure their effectiveness.

- **Cybersecurity** - cybersecurity may refer to the processes for protecting electronic information and assets from unauthorized access, use, and disclosure. Specific information regarding cybersecurity may be found below. The information found below was derived from materials provided by the American Hospital Association (American Hospital Association, 2023).

    - Health care organizations often face evolving cyberthreats that can put patient safety at risk. Thus, health care administrators should ensure their health care organizations have adequate cybersecurity.

    - Health care administrators should ensure the following type of information is adequately secure: patients protected health information (PHI), financial information (e.g., credit card and bank account numbers), and personally identifying information (PII) (e.g., Social Security numbers). Health care administrators should note that inadequate cybersecurity will not effectively protect the aforementioned types of information.

- To ensure a health care organization's cybersecurity is adequate, a health care administrator should elevate the issue of cyber risk as an enterprise and strategic risk-management issue.

- To ensure a health care organization's cybersecurity is adequate, a health care administrator should dedicate at least one individual to lead an information security program, and prioritize the role so that he or she has sufficient authority, status, and independence to be effective.

- To ensure a health care organization's cybersecurity is adequate, a health care administrator and his or her team should receive regular updates on the health care organization’s strategic cyber risk profile and whether adequate measures are dynamically being taken to mitigate the constantly evolving cyber risk.

- To ensure a health care organization's cybersecurity is adequate, a health care administrator should instill a patient safety-focused culture of cybersecurity.

- Health care administrators can instill a patient safety-focused culture of cybersecurity through education and open communication.

- **Creating a health care risk management plan** - a health care risk management plan may refer to a document that outlines how an organization should strategically identify, manage, and mitigate risk.

What are the components of a health care risk management plan?

The fundamental components of a health care risk management plan include the following: education and training; purpose, goals, and metrics; communication plan; contingency plan; reporting protocols; response and mitigation; patient and family grievances. Specific information regarding the aforementioned components of a health care risk management plan may be found below.

- **Education and training** - health care risk management plans should detail employee training requirements, such as the following: new employee orientation, ongoing and in-service training, annual review and competency validation, and event-specific training.

- **Purpose, goals, and metrics** - health care risk management plans should clearly define the purpose and benefits of the health care risk management plan; specific goals to reduce liability claims, sentinel events, near-misses, and the overall cost of the health care organization's risk should also be included; additionally, reporting on quantifiable and actionable data should be detailed and mandated by the plan.

- **Communication plan** - information about how to communicate risk and with whom should be provided in the health care risk management plan. Health care administrators should note that the communication plan should promote a safe, "no-blame" culture and should include anonymous reporting capabilities, when applicable.

- **Contingency plan** - risk management plans should include contingency preparations for adverse system-wide failures and catastrophic situations, such as security breaches and cyber attacks. Health care administrators should note that the contingency plan should include emergency preparedness for events, such as: disease outbreaks, long-term power loss, and terror attacks or mass shootings.

- **Reporting protocols** - health care organizations should have an easy-to-use system for documenting, classifying, and tracking possible risks and adverse events; reporting systems should include protocols for mandatory reporting.

- **Response and mitigation** - plans for health care risk should include collaborative systems for responding to reported risks and events including: acute response, follow-up, reporting, and repeat failure prevention.

- **Patient and family grievances** - to promote patient satisfaction and reduce the likelihood of litigation, procedures for documenting and responding to patient and family complaints should be included in a health care risk management plan. Health care administrators should note that response times, staff responsibilities, and prescribed actions should be outlined within the plan.

Section 1 Summary

Risk management, within the context of health care, may refer to the processes used to detect, monitor, assess, mitigate, and prevent risks to patients, health care employees, and health care organizations. The key elements of risk management include the following: identifying risk; prioritizing risk; medical error prevention; infection control; environmental services; investigating and reporting sentinel events; performing compliance reporting; learning from near-miss incidents; identifying and/or assisting health care professionals that may be suffering from substance abuse; identifying and reporting patient abuse; following guidelines and requirements from relevant organizations, such as OSHA; following relevant federal and state laws; insurance coverage; quality improvement; effectively managing health care contracts; emergency preparedness; cybersecurity; and a health care risk management plan. Finally, health care administrators should develop health care risk management plans that meet the needs of their specific health care organizations.

Section 1 Key Concepts

- Risk management is important because it can help limit and prevent risks to patients, health care employees, and health care organizations, such as: lawsuits, sanctions, fines, and patient abuse. Risk management is also important because it can help optimize patient care, and, ultimately, patient outcomes.

Section 1 Key Terms

Risk management (when used within the context of health care) - the processes used to detect, monitor, assess, mitigate, and prevent risks to patients, health care employees, and health care organizations

Identifying risk - a process of identifying potential hazards, safety concerns, ineffective techniques, and problematic situations

Standard precautions - infection control practices that may be used to prevent the transmission of diseases

Hand hygiene - the process of cleaning hands in order to prevent contamination and/or infections

Personal protective equipment (PPE) - equipment designed to protect, shield, and minimize exposure to hazards that may cause serious injury, illness, and/or disease; the minimum infection prevention practices that apply to all patient care

Bloodborne pathogens - infectious microorganisms in human blood that can cause disease in humans (OSHA, 2023)

Bloodborne pathogen exposure incident - any event involving one or more individuals and the potential or actual exposure to blood or other potentially infectious materials (OPIM); a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or OPIM that results from the performance of an employee's duties (OSHA, 2023)

Hand hygiene audit - the process of ensuring hand hygiene techniques are being followed in accordance with relevant recommendations and/or guidelines

Medical error - a preventable adverse effect of care that may or may not be evident or causes harm to a patient (Joint Commission, 2023)

Coronavirus disease 2019 (COVID-19) - a respiratory illness that can spread from person to person, which is caused by a virus known as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

Environmental services - a department or unit within a health care facility that is responsible for cleaning, decontamination, disinfection, sterilization, housekeeping, laundry, and other related duties

Cleaning logs - job aids that can help guide the daily workflow for cleaning staff and serve as a cleaning record

Sentinel event - an unanticipated event in a health care setting that results in death or serious physical or psychological injury to a patient(s), not related to the natural course of the patient's illness (Joint Commission, 2023)

Medical device malfunction - an event related to a medical device that resulted in patient injury or death

Near-miss incident - an event that occurs when a medical error or adverse reaction is avoided through circumstance or intervention

Patient abuse - an intentional act or failure to act that causes or creates a risk of harm to a patient in a health care facility

Occupational Safety and Health Administration (OSHA) - the regulatory agency of the United States Department of Labor responsible for ensuring safe and healthful working conditions for workers by setting and enforcing standards and by providing training, outreach, education, and assistance

Quality - the degree to which health services for patients increases the likelihood of desired health outcomes and are consistent with current professional knowledge (U.S. Centers for Medicare and Medicaid Services, 2023)

Quality improvement - the framework used to systematically improve care (U.S. Centers for Medicare and Medicaid Services, 2023)

Benchmarking - the process of comparing one dimension of care with another for the purpose of quality improvement (U.S. Centers for Medicare and Medicaid Services, 2023)

Quality measure - a standard for measuring the performance and improvement of health care services (U.S. Centers for Medicare and Medicaid Services, 2023)

Health care contract - a written agreement between and individual or entity and a health care organization (Bishop, 2021)

Emergency preparedness - the process of preparing how to safely and effectively respond to an emergency

Cybersecurity - processes for protecting electronic information and assets from unauthorized access, use, and disclosure

Health care risk management plan - a document that outlines how an organization should strategically identify, manage, and mitigate risk

Section 1 Personal Reflection Question

Why is it important for health care administrators to develop health care risk management plans that meet the needs of their specific health care organizations?

Section 2: Infection Control Recommendations

The section of the course highlights infection control recommendations, which can play an important role in risk management. The information found within this section of the course was derived from materials provided by the CDC unless, otherwise, specified (CDC, 2019; CDC, 2022).

Infection Control Recommendations

- Health care administrators should regularly meet with occupational health services leaders to review results of risk assessments related to infection prevention and control; health care administrators should also regularly meet with occupational health services leaders to set performance goals, and charge relevant health care organization departments and individuals to reduce risks.
- Conduct, or collaborate with other health care organization departments or individuals in, regular risk assessments and risk reduction activities related to occupational infection prevention and control.
- Establish organizational goals, policies and procedures, infrastructure, and interventions that foster communication and collaboration about occupational infection prevention and control.
- Notify health care organization leaders and departments about hazards identified and risk reduction plans, progress, and priorities for health care employees.
- Maintain logs of work-related injuries and illnesses meeting certain criteria, including infectious diseases exposures.
- Conduct workplace evaluations to assess implementation of an Exposure Control plan for all affected employees.
- Evaluate respiratory hazards in the workplace, and implement a respiratory protection program, when needed.
- Establish an influenza vaccination program for staff, setting incremental vaccination goals to increase coverage, and reporting influenza immunization rates to key stakeholders.

- Provide job descriptions with sufficient detail to assess job-related infection risks to occupational health services staff before the pre-placement medical evaluation.

- Develop, review, and update when necessary, policies and procedures for providing preplacement, periodic, and episodic medical evaluations that include health assessments, screening and diagnostic testing, immunization services, exposure and illness management, counseling, and reporting of findings of medical evaluations.

- Review each employee's job description for duties that may affect risk of acquiring or transmitting infections in health care settings.

- Collect a directed health inventory to assess: history of medical conditions and other factors that may affect the risk of acquiring or transmitting infections in health care settings, and evidence of immunity to vaccine-preventable diseases recommended for health care personnel by the Advisory Committee on Immunization Practices (ACIP).

- Conduct or refer health care personnel for physical examination, as indicated, to assess medical conditions that might affect risk of acquiring or transmitting infections in health care settings.

- Conduct or refer health care personnel for infectious diseases screening as recommended by the CDC.

- Test for evidence of immunity to vaccine-preventable infections as recommended by the ACIP.

- Provide or refer health care employees for services that reduce risks of infectious disease transmission (e.g., immunizations, medical clearance for respirator fit testing).

- Provide or refer health care employees for information regarding: health conditions that may increase their risk of acquiring or transmitting infections in health care settings, and recommended actions to reduce those risks; procedures for preventing and managing workplace exposures and illnesses; work restrictions and sick leave policies; and confidentiality of their health information.
- Provide additional doses of vaccines recommended for health care personnel by the ACIP.
- Perform or refer health care employees for indicated follow-up testing.
- Provide or refer health care employees for periodic respirator fit testing, if indicated.
- Conduct periodic screening for tuberculosis, if indicated, as recommended by the CDC.
- For episodic medical evaluations, conduct or refer health care personnel for medical evaluations on an as-needed basis to evaluate and manage potentially infectious exposures and illnesses; evaluate and manage new health conditions (e.g., pregnancy, rashes) that may affect risk of acquiring or transmitting infections or ability to perform job functions; provide pre-placement medical evaluations for health care personnel who are changing job duties; survey health care employees for exposures and/or illness during outbreaks of infectious diseases in health care settings, if indicated.
- Provide health care employees dedicated time during their normal work hours to complete occupational infection prevention and control education and training.
- Collaborate with appropriate health care organization departments or individuals to develop occupational infection prevention and control education and training.

- Support initial, periodic, and as-needed education and training that is appropriate in content to the educational level, literacy, and language of health care employees.
- Periodically review health care employees exposure data to identify high risk sub-populations for refresher infection prevention and control education and training.
- Determine periodic refresher education topics based upon analyses of health care employees' exposure incident reports, risk assessments, and other methods that identify infectious hazard vulnerabilities for health care personnel.
- Health care administrators should note the following examples of topics for initial, periodic, and as-needed education and training: federal, state, and local education and training requirements; modes of infectious disease transmission and implementation of standard and transmission-based precautions; hand hygiene; sharps injury prevention; immunizations recommended by the ACIP for health care personnel; health care personnel screening for selected infectious diseases before job placement and periodically thereafter; how to access occupational health services, when needed, and expectations for reporting exposures; expectations for reporting illnesses or conditions (work-related or acquired outside of work), such as rashes or skin conditions; sick leave and other policies and procedures related to infectious health care personnel, including the risks of presenteeism to other health care personnel and patients.
- Set goals to achieve high rates of evidence of immunity to vaccine-preventable diseases recommended for health care personnel by the ACIP.
- Adhere to ACIP recommendations for immunizing health care personnel.

- Indicate all preplacement, annual, and other job-related immunizations that health care personnel should receive.
- Specify strategies to offer vaccines to health care personnel and to achieve high immunization coverage.
- Specify strategies for gathering and reviewing information on why recommended immunizations are not administered to inform program quality improvement.
- Use organizational leaders as role models (e.g., visibly vaccinating institutional leaders).
- Conducting education or organizational campaigns to promote awareness and knowledge about vaccines.
- Consider providing free access (i.e., no out-of-pocket expense) to vaccines.
- Consider providing incentives to encourage immunization, such as coupons for the hospital cafeteria and gift certificates.
- Consider offering flexible worksite vaccine delivery (e.g., at multiple locations and times, via mobile carts).
- Implement sick leave options for health care personnel that encourage reporting of potentially infectious exposures or illnesses, appropriate use of sick leave, and adherence to work restrictions.
- Develop, review, and update when necessary policies and procedures about health care personnel exposure and illness management services that include methods to provide job-related exposure and illness management services.

- Establish a timely, confidential, and non-punitive mechanism for health care personnel to report potentially infectious exposures and access exposure and illness management services 24 hours a day and 7 days per week.
- Include sick leave options that encourage reporting of potentially infectious exposures and illnesses and that discourage presenteeism.
- Facilitate access to clinical providers with expertise in exposure and illness management who are available 24 hours a day and seven days per week.
- Facilitate prompt access to laboratory testing and treatment for managing exposures and illnesses.
- Describe work restrictions for exposed or ill health care personnel that specify methods of communication between occupational health services, health care personnel, and others (e.g., human resources, managers) about work restrictions.
- Identify how work restrictions are imposed and health care personnel are cleared for return to work.
- Define criteria, methods, and individuals responsible for reporting potentially infectious exposures and illnesses or suspected infectious outbreaks to internal departments and external authorities.
- Provide or refer health care personnel who have sustained job-related potentially infectious exposures or illnesses for prompt management that includes: evaluating the exposed or ill health care personnel; evaluating the exposure incident and source, including whether the source was potentially infectious and whether others remain at risk.
- Arranging for any needed testing, when applicable.
- When applicable, provide counseling regarding: risk of exposure or illness, testing, options for and risks and benefits of postexposure prophylaxis or

treatment, need for specialty care, follow-up testing and treatment, work restrictions, if indicated, risk of transmitting infections to others and methods to prevent transmission, and signs and symptoms of illness to report after an exposure, including potential side effects of prophylaxis.

- Establish systems to maintain confidential work-related health care personnel health records, preferably in electronic systems, that: limit access only to authorized personnel; enable rapid access by authorized clinical providers; facilitate aggregation and de-identification of information; allow tracking and assessments of trends in infectious risks, screening tests, exposures, and infections; and enable confidential reporting to internal departments and individuals or external groups.

- Consider enabling electronic system features that: notify occupational health services when occupational infection prevention and control services are due; and communicate work restrictions with other health care organization data systems (e.g., human resources information systems).

- Participate in the development of policies and plans that facilitate confidential, efficient exchange of health care personnel health information.

- Maintain health care personnel records and databases that include medical evaluations, infectious disease screening, evidence of immunity and immunizations, exposure and illness management, and work restrictions.

- Maintain confidentiality, use appropriate authorizations, and provide only necessary information when sharing health care personnel records.

- Facilitate health care personnel data aggregation for reporting performance measures and supporting occupational health services quality improvement activities.

- Create copies of individual records promptly available to health care personnel upon their request, preferably within 15 days.

- Health care administrators should note the following: safeguarding the confidentiality of health information ensures compliance with requirements and can build confidence; defining who may access confidential health records can facilitate protection of information and enforcement of record access restrictions; keeping employee records and information in the same system as patient care information can risk unauthorized staff access to private information; state and local requirements for the separation of employee and patient records may exist.

- Health care administrators should note the following: The 1996 Health Insurance Portability and Accountability (HIPAA) Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates, and grants patients several rights with respect to that information; requesting or providing employee medical information or records may require HIPAA-compliant consent, depending on the purpose and recipient of the information.

- For health care personnel who have an exposure to diphtheria, regardless of vaccination status: administer postexposure prophylaxis in accordance with CDC recommendations; exclude from work and obtain nasal and pharyngeal swabs for diphtheria culture; if nasal and pharyngeal cultures are negative for toxin-producing *C. diphtheriae*, health care personnel may return to work while completing postexposure antibiotic therapy; if nasal or pharyngeal cultures are positive for toxin-producing *C. diphtheriae* complete postexposure antibiotic therapy; health care personnel may return to work when: postexposure antibiotic therapy is completed and at least 24 hours after completion of postexposure antibiotic therapy, two consecutive pairs of nasal and pharyngeal cultures, obtained at least 24 hours apart, are negative for toxin-producing *C. diphtheriae*.

- Implement daily monitoring for the development of signs and symptoms of diphtheria for seven days after the last exposure.

- For health care personnel with respiratory diphtheria infection, exclude from work until: antibiotic and antitoxin (if needed) therapy are completed; and at least 24 hours after completion of antibiotic therapy, two consecutive pairs of nasal and pharyngeal cultures, obtained at least 24 hours apart, are negative for toxin-producing *C. diphtheriae*.

- For health care personnel with cutaneous diphtheria infection or other diphtheria infection manifestations, determine the duration of exclusion from work in consultation with federal, state, and local public health authorities.

- Postexposure prophylaxis and work restrictions are not necessary for health care personnel who have an exposure to group A *Streptococcus*.

- For health care personnel with known or suspected group A *Streptococcus* infection, obtain a sample from the infected site, if possible, for group A *Streptococcus* and exclude from work until group A *Streptococcus* infection is ruled out, or until 24 hours after the start of effective antimicrobial therapy, provided that any draining skin lesions can be adequately contained and covered.

- For draining skin lesions that cannot be adequately contained or covered (e.g., on the face, neck, hands, wrists), exclude from work until the lesions are no longer draining.

- Work restrictions are not necessary for health care personnel with known or suspected group A *Streptococcus* colonization, unless they are epidemiologically linked to transmission of the organism in the health care setting.

- For health care personnel with group A *Streptococcus* colonization who are epidemiologically linked to transmission of the organism in the health care setting: administer chemoprophylaxis in accordance with CDC

recommendations; exclude from work until 24 hours after the start of effective antimicrobial therapy; obtain a sample from the affected site for group A Streptococcus testing seven to 10 days after completion of chemoprophylaxis; if positive, repeat administration of chemoprophylaxis and again exclude from work until 24 hours after the start of effective antimicrobial therapy.

- Administer antimicrobial prophylaxis to health care personnel, regardless of vaccination status, who have an exposure to *N. meningitidis*.
- Exclude health care personnel with invasive *N. meningitidis* disease from work until 24 hours after the start of effective antimicrobial therapy.
- Work restrictions are not necessary for health care personnel who only have nasopharyngeal carriage of *N. meningitidis*.
- For asymptomatic health care personnel, regardless of vaccination status, who have an exposure to pertussis and are likely to interact with persons at increased risk for severe pertussis: administer postexposure prophylaxis; if not receiving postexposure prophylaxis, restrict from contact (e.g., furlough, duty restriction, or reassignment) with patients and other persons at increased risk for severe pertussis for 21 days after the last exposure.
- For asymptomatic health care personnel, regardless of vaccination status, who have an exposure to pertussis and are not likely to interact with persons at increased risk for severe pertussis: administer postexposure prophylaxis; or implement daily monitoring for 21 days after the last exposure for development of signs and symptoms of pertussis.
- For asymptomatic health care personnel, regardless of vaccination status, who have an exposure to pertussis and who have preexisting health conditions that may be exacerbated by a pertussis infection administer postexposure prophylaxis.

- Exclude symptomatic health care personnel with known or suspected pertussis from work for 21 days from the onset of cough, or until five days after the start of effective antimicrobial therapy.

- Work restrictions are not necessary for asymptomatic health care personnel who have an exposure to pertussis and receive postexposure prophylaxis, regardless of their risk for interaction with persons at increased risk for severe pertussis.

- For health care personnel who have an exposure to rabies virus, administer postexposure prophylaxis in accordance with CDC and ACIP recommendations and in consultation with federal, state, and local public health authorities.

- Work restrictions are not necessary for asymptomatic health care personnel who have an exposure to rabies virus.

- For health care personnel who have a suspected or confirmed rabies virus infection, exclude from work in consultation with federal, state, and local public health authorities.

- *Clostridioides difficile*, also referred to as *C. difficile* or *C. diff*, is a bacterium that causes diarrhea and colitis; *C. diff* can be life-threatening.

- Exposure to *C. diff* may lead to colonization. Colonization may refer to the presence of a microorganism on and/or in a host, with growth and multiplication of the organism, but without interaction between host and organism (e.g., the individual colonized will not appear sick).

- Individuals can spread *C. diff* to others while they are colonized; *C. diff* is more common in health care settings, such as nursing homes.

- Methods that may be used to prevent *C. diff include:* hand hygiene, routine bathing (e.g., taking a daily bath or shower), and routine cleaning.

- The regular cleaning of frequently touched surfaces (e.g., counter tops) can help prevent the transmission of *C. diff* in health care settings.
- If *C. diff* infection (CDI) occurs in a health care setting, health care administrators and other health care professionals should isolate and initiate contact precautions for suspected or confirmed CDI.
- Health care administrators should create health care-driven protocols to facilitate rapid isolation of patients with suspected or confirmed CDI.
- Patients with diarrhea should be isolated while evaluation for the cause is ongoing (e.g., patient remains isolated during a trial of laxatives).
- For suspected patients, health care administrators should ensure rapid evaluation by health care professionals and infection prevention.
- Health care administrators should place symptomatic patients on contact precautions, in a single-patient room with a dedicated toilet.
- If single-patient rooms are not available, health care administrators should room patients with confirmed CDI together.
- For patients with confirmed CDI, health care administrators should maintain contact precautions for at least 48 hours after diarrhea has resolved, or longer.
- Health care administrators should adhere to recommended hand hygiene practices.
- Health care professionals should use dedicated patient-care equipment (e.g., blood pressure cuffs, stethoscopes).
- Health care professionals should implement daily patient bathing or showering with soap and water.

- When transferring patients, health care professionals should notify receiving wards or facilities about the patient's CDI status so contact precautions are maintained at the patient's new location.
- To help prevent CDIs, health care administrators should create and assess daily and terminal cleaning protocols and checklists for patient-care areas and equipment.
- Health care administrators should ensure the daily cleaning of CDI patient rooms using a *C. difficile* sporicidal agent (e.g., EPA List K agent).
- Health care administrators should ensure the patient-care environment is cleaned and disinfected (including the immediate vicinity around a CDI patient and high touch surfaces) at least once a day, including toilets.
- Health care professionals should clean and disinfect all shared equipment prior to use with another patient (e.g., wheelchairs, gurneys).
- Health care administrators should ensure environmental services perform terminal cleaning after CDI patient transfer/discharge with a *C. difficile* sporicidal agent (e.g., EPA List K agent) (note: terminal cleaning may refer to the thorough cleaning/disinfection of all surfaces including floors and reusable equipment either within a health care facility and/or within an individual ward/department/unit).
- Health care administrators should ensure the cleaning of additional areas that are contaminated during transient visits by patients with suspected or confirmed CDI (e.g., Radiology, Emergency Departments, Physical Therapy) with a *C. difficile* sporicidal agent (e.g., EPA List K agent).
- To help prevent CDIs, health care administrators should develop an infrastructure to support CDI prevention and environmental services.

- Health care administrators should incorporate processes to reduce CDIs into the facility health care-associated infection prevention program, including but not limited to the design, implementation, evaluation, and feedback of intervention results.

- Health care administrators should develop a multidisciplinary workgroup, consisting of physicians, nursing, environmental services, and antibiotic stewardship to identify and implement the following strategies: monitor facility CDI rates, and target units with highest incidence of CDI for evaluation and intervention; review hospital-onset CDI cases to help identify potential gaps and opportunities for improvement; focus on opportunities for improvement across each strategy (e.g., test indications, antibiotic appropriateness); utilize findings to engage relevant care teams and staff in gap remediation and performance improvement as soon after the CDI case as possible; educate and train health care professionals on prevention practices for CDI.

- Health care administrators should routinely audit the following: adherence to hand hygiene; adherence to contact precautions; adequacy of room cleaning; the completeness of terminal cleaning.

- Health care administrators should provide CDI rates and other performance improvement measures to senior leadership, clinical providers, laboratory personnel, environmental services, and other stakeholders.

- Health care administrators should ensure the appropriate individuals and facility departments are notified about changes in the incidence (or frequency), complications (including recurrences), or severity of CDI.

- Health care administrators and managers should dedicate health care professionals to the care of patients with CDI only (i.e., without responsibility to care for non-CDI patients), who are typically cohorted on a single ward or unit, to minimize the risk of transmission to others.

- Health care professionals should work to restrict the use of antibiotics with the highest risk for CDI (e.g., fluoroquinolones, carbapenems, 3rd and 4th generation cephalosporins).
- Health care professionals should limit the use of other medications (e.g., proton pump inhibitors) that are hypothesized to increase risk for CDI.
- Health care professionals should evaluate and test asymptomatic patients at high risk for CDI to detect carriage.
- Health care professionals should isolate patients that test positive, but health care professionals should not treat in the absence of symptoms.
- Health care administrators should consider developing policies and procedures for the isolation of patients with diarrhea, until the diarrhea resolves, as a routine strategy.
- Health care administrators should ensure environmental services carry out additional disinfection of CDI patient rooms with no-touch technologies (e.g., UV light).
- Health care administrators should use environmental disinfection strategies (e.g., sporicidal agents [e.g., EPA List K agent]) for daily and terminal cleaning in all rooms on affected units.
- Methicillin-resistant *Staphylococcus aureus* (MRSA) may refer to a bacterium that causes infections in different parts of the body.
- MRSA is a cause of staph infection that is difficult to treat because of resistance to some antibiotics.
- MRSA is usually spread by direct contact with an infected wound or from contaminated hands, usually those of a health care professional.

- MRSA can survive outside of the body on surfaces for hours, days, or even weeks; MRSA can spread to individuals who touch a contaminated surface.
- Individuals colonized by MRSA can spread the bacteria to others.
- Research indicates that about one in three (33%) people carry *S. aureus* bacteria in their nose, usually without any illness; about two in every 100 people carry MRSA; many individuals carry MRSA bacteria in their nose, most do not develop serious MRSA infections.
- The symptoms of a MRSA infection depend on the part of the body that is infected. For example, individuals with MRSA skin infections often can get swelling, warmth, redness, and pain in infected skin. In most cases it is hard to tell if an infection is due to MRSA or another type of bacteria without laboratory tests (note: some MRSA skin infections can have a fairly typical appearance and can be confused with a spider bite).
- Most *S. aureus* skin infections, including MRSA, appear as a bump or infected area on the skin that might be: red, swollen, painful, warm to the touch, full of pus or other drainage, and accompanied by a fever.
- In health care settings, MRSA may lead to bloodstream infections, pneumonia, surgical site infections, and death.
- MRSA can be prevented; methods that may be used to prevent MRSA include: hand hygiene, routine bathing (e.g., taking a daily bath or shower), and routine cleaning/disinfecting.
- Hand hygiene is an important step to prevent MRSA; individuals should use soap and water to clean their hands if available. After wetting the hands and adding soap, individuals should scrub their hands for at least 20 seconds. If individuals cannot access soap and water, they should use an alcohol-based hand sanitizer that contains at least 60% alcohol to clean their hands. Individuals should apply the sanitizer to one hand, rub the

hands together, trying to cover all surfaces of the hands and fingers until the hands are dry.

- Disinfectants effective against *Staphylococcus aureus*, or staph, are also effective against MRSA (note: the disinfectant's label should have a list of germs that the product can kill, along with an EPA registration number).

- Routine laundry procedures, detergents, and laundry additives will all help to make clothes, towels, and linens safe to wear or touch (note: hot water washing is not necessary to remove MRSA from laundry).

- Shared equipment that comes into direct skin contact should be cleaned after each use and allowed to dry. Equipment should be cleaned according to the equipment manufacturers' instructions to make sure the cleaner will not harm the item.

- Many items such as computer keyboards or handheld electronic devices may be difficult to clean or disinfect because they could be damaged if they become wet. If these items are touched by many individuals during the course of the day, a cleanable cover/skin (e.g., keyboard skin) could be used on the item to allow for cleaning while protecting the item.

- Large surfaces, such as floors and walls, are not associated with the spread of staph and MRSA. There is no evidence that spraying or fogging rooms or surfaces with disinfectants will prevent MRSA infections more effectively than the targeted approach of cleaning frequently touched surfaces and surfaces that have been exposed to open wounds.

- To help prevent MRSA transmission, health care administrators should ensure environmental services work to clean and disinfect surfaces and equipment that may be contaminated with pathogens, including those that are in close proximity to a patient (e.g., bed rails, over bed tables) and frequently-touched surfaces in the patient care environment (e.g., door

knobs, surfaces in and surrounding toilets in patients' rooms) on a more frequent schedule compared to that for minimal touch surfaces (e.g., horizontal surfaces in waiting rooms).

- To help prevent MRSA transmission, health care administrators should prioritize room cleaning of patients on Contact Precautions.
- Health care professionals should dedicate noncritical medical items to use on individual patients known to be infected or colonized with MRSA.
- To help prevent MRSA transmission, health care administrators should consider the following MRSA prevention strategies: use dedicated patient-care equipment (e.g., blood pressure cuffs, stethoscopes), and single use disposable items (e.g., single patient digital thermometer) whenever possible; if common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient; provide regular competency-based training on use of personal protective equipment (PPE) and monitor adherence; use active surveillance testing (screening) for MRSA.
- To help prevent MRSA transmission, health care administrators should incorporate MRSA prevention strategies into health care-associated infection prevention programs.
- To help prevent MRSA transmission, health care administrators should develop a multidisciplinary workgroup, including nursing, environmental services, and infection prevention to identify and implement strategies and to follow results of interventions.
- To help prevent MRSA transmission, health care administrators should monitor facility MRSA counts, and target units with the highest number of MRSA infections for evaluation and intervention; provide MRSA rates to senior leadership, clinical staff, and other stakeholders; notify appropriate

individuals and facility departments about changes in the incidence (or frequency), and complications (including recurrences).

- To help prevent MRSA transmission, health care administrators should review individual MRSA episodes to assess modifiable risk factors including clinical management decisions and the use of infection control measures to identify gaps; educate and train all health care employees on prevention practices and core infection control practices, such as: hand hygiene, PPE use, Standard Precautions, Contact Precautions, and environmental cleaning and disinfection.

- To help prevent MRSA transmission, health care administrators should routinely audit and conduct competency-based assessments for core infection control practices; adherence to hand hygiene, Standard Precautions, and Contact Precautions; and ensure the adequacy of room cleaning and environmental services.

- Provide administrative support, and both fiscal and human resources, to prevent and control MRSA transmission within a health care facility.

- Provide necessary leadership, funding, and day-to-day oversight to implement MRSA prevention strategies; involve the governing body and leadership of a health care facility.

- Evaluate health care system factors for their role in creating or perpetuating transmission of MRSA, including: staffing levels, education and training, availability of consumable and durable resources, communication processes, policies and procedures, and adherence to recommended infection control measures (e.g., hand hygiene and Standard or Contact Precautions).

- Develop, implement, and monitor action plans to correct system failures.

- Update health care professionals and other administrators on the progress and effectiveness of the intensified interventions; include information on changes in prevalence, rates of infection and colonization; results of assessments and corrective actions for system failures; degrees of adherence to recommended practices; and action plans to improve adherence to recommended infection control practices to prevent MRSA transmission.

- When needed, health care administrators should intensify the frequency of MRSA educational programs for health care professionals and environmental services staff.

- Intensify and reinforce training of environmental services staff who work in areas targeted for intensified MDRO control and monitor adherence to environmental cleaning policies (note: health care administrators should consider assigning dedicated staff to targeted patient care areas to enhance consistency of proper environmental cleaning and disinfection services).

- Monitor (i.e., supervise and inspect) cleaning performance to ensure consistent cleaning and disinfection of surfaces in close proximity to the patient and those likely to be touched by the patient and HCP (e.g., bed rails, carts, bedside commodes, doorknobs, and faucet handles).

- Obtain environmental cultures (e.g., surfaces, shared medical equipment) when there is epidemiologic evidence that an environmental source is associated with ongoing transmission of MRSA.

- Vacate units for environmental assessment and intensive cleaning when previous efforts to eliminate environmental reservoirs fail.

- Implement policies for patient admission and placement as needed to prevent transmission.

- Both cleaning (use of soap or detergent) and disinfection (use of a product or process designed to inactivate SARS-CoV-2) can reduce the risk of COVID-19 transmission; evidence suggests cleaning reduces the amount of soil (e.g., dirt, microbes and other organic agents, and chemicals) on surfaces, but efficacy varies by the type of cleaner used, cleaning procedure, and how well the cleaning is performed; a 90 - 99.9% reduction of microbe levels is possible depending on the cleaning method and the surface being cleaned; in addition to physical removal of SARS-CoV-2 and other microbes, surface cleaning can be expected to degrade the virus; surfactants in cleaners can disrupt and damage the membrane of an enveloped virus like SARS-CoV-2.

- To substantially inactivate SARS-CoV-2 on surfaces, the surface must be treated with a disinfectant product.

- Surface disinfection has been shown to be effective for preventing secondary transmission of SARS-CoV-2 between an infected person and other individuals.

- Routine cleaning performed effectively with soap or detergent, at least once per day, can substantially reduce virus levels on surfaces; when focused on high-touch surfaces, cleaning with soap or detergent should be enough to further reduce the relatively low transmission risk in situations when there is not a suspected or confirmed case of COVID-19 indoors; in situations when there is a suspected or confirmed case of COVID-19 indoors within the last 24 hours, the presence of infectious virus on surfaces is more likely and therefore high-touch surfaces should be disinfected.

- The CDC recommends a layered approach to reduce exposures to SARS-CoV-2; this approach includes using multiple mitigation strategies, including improvements to building ventilation, to reduce the spread of disease and lower the risk of exposure.

Section 2 Summary

Infection control plays an important role in risk management. Health care administrators should work to prevent the transmission of infections within their health care organizations. Health care administrators should routinely update their health care organizations' infection control policies and procedures to reflect the most up-to-date recommendations and requirements.

Section 2 Key Concepts

- Health care administrators should regularly meet with occupational health services leaders to review results of risk assessments related to infection prevention and control.
- Health care administrators should regularly meet with occupational health services leaders to set performance goals, and charge relevant health care organization departments and individuals to reduce risks.

Section 2 Key Terms

Clostridioides difficile (also referred to as *C. difficile* or *C. diff*) - *a* bacterium that causes diarrhea and colitis

Colonization - the presence of a microorganism on and/or in a host, with growth and multiplication of the organism, but without interaction between host and organism

Terminal cleaning - the thorough cleaning/disinfection of all surfaces including floors and reusable equipment either within a health care facility and/or within an individual ward/department/unit

Methicillin-resistant *Staphylococcus aureus* (MRSA) - a bacterium that causes infections in different parts of the body

Section 2 Personal Reflection Question

How can health care administrators effectively educate health care employees about infection control policies and procedures?

Conclusion

Risk is ever present in health care organizations. Therefore, health care administrators should work to mitigate risks. Risk management can help health care administrators mitigate risks within health care organizations.

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