Centers for Medicare & Medicaid Services

Hospital Infection Control Worksheet

Name of State Agency: _____

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Infection Control Condition of Participation. Items are to be assessed by a combination of observation, interviews with hospital staff, patients and their family/support persons, review of medical records, and a review of any necessary infection control program documentation. **During the survey, observations or concerns may prompt the surveyor to request and review specific hospital policies and procedures. Surveyors are expected to use their judgment and review only those documents necessary to investigate their concern(s) or to validate their observations.**

The interviews should be performed with the most appropriate staff person(s) for the items of interest, as well as with patients, family members, and support persons.

Hospital Characteristics

1. Hospital name: _____
2. CMS Certification Number (CCN): ☐☐☐☐☐☐
3. Date of site visit:

☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐

Section 1.A. Infection Prevention Program and Resources

Elements to be assessed		Surveyor Notes
1.A.1 The hospital has designated one or more individual(s) as its Infection Control Officer(s).	◯ Yes ◯ No	
1.A.2 The hospital has evidence that demonstrates the Infection Control Officer(s) is qualified and maintain(s) qualifications through education, training, experience or certification related to infection control consistent with hospital policy.	◯ Yes ◯ No	
1.A.3 The Infection Control Officer(s) can provide evidence that the hospital has developed general infection control policies and procedures that are based on nationally recognized guidelines and applicable state and federal law.	◯ Yes ◯ No	
If no to any of 1.A.1 through 1.A.3, cite at 42 CFR 482.42(a) (Tag A-748)		
1.A.4 The Infection Control Officer can provide an updated list of diseases reportable to the local and/or state public health authorities.	◯ Yes ◯ No	
1.A.5 The Infection Control Officer can provide evidence that hospital complies with the reportable diseases requirements of the local health authority.	◯ Yes ◯ No	
No citation risk for questions 1.A.4 and 1.A.5		
1.A.6 The hospital has infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, including the requirement for an infection control risk assessment (ICRA) to define the scope of the project and need for barrier measures before a project gets underway.	◯ Yes ◯ No	
If no to 1.A.6, cite at 42 CFR 482.42(a) (Tag A-748)		

Section 1.B. Hospital QAPI Systems Related to Infection Prevention

Elements to be assessed		Surveyor Notes
The hospital infection prevention program is coordinated into the hospital QAPI program as evidenced by:		
1.B.1 The Infection Control Officer(s) can provide evidence that problems identified in the infection control program are addressed in the hospital QAPI program (i.e., development and implementation of corrective interventions, and ongoing evaluation of interventions implemented for both success and sustainability).	◯ Yes ◯ No	
If no to 1.B.1, cite at 42 CFR 482.21(e)(3) (Tag A-0286)		
1.B.2 Hospital leadership, including the CEO, Medical Staff, and the Director of Nursing Services ensures the hospital implements successful corrective action plans in affected problem area(s).	◯ Yes ◯ No	
If no to 1.B.2, cite at 42 CFR 482.42(b)(2) (Tag A-0756)		
1.B.3 The hospital utilizes a risk assessment process to prioritize selection of quality indicators for infection prevention and control.	◯ Yes ◯ No	
If no to 1.B.3, cite at 42 CFR 482.21(a)(2) (Tag A-0267)		

Section 1.C. Systems to Prevent Transmission of MDROs and Promote Antimicrobial Stewardship

Elements to be assessed		Surveyor Notes
1.C.1 The hospital has policies and procedures to minimize the risk of development and transmission of multidrug-resistant organisms (MDROs) within the hospital (applicable to all persons in the hospital).	◯ Yes ◯ No	
1.C.2 Systems are in place to designate patients known to be colonized or infected with a targeted MDRO and to notify receiving units and personnel prior to movement of such patients within the hospital.	◯ Yes ◯ No	
1.C.3 Systems are in place to designate patients known to be colonized or infected with a targeted MDRO and to notify receiving healthcare facilities and personnel prior to transfer of such patient between facilities.	◯ Yes ◯ No	
If no to any part of 1.C.1 through 1.C.3, cite at 42 CFR 482.42(a) (Tag A-0749)		
1.C.4 The hospital can provide a list of target MDROs. Note: Hospitals should provide a list of MDROs that are targeted for infection control because they are epidemiologically important (e.g., MRSA, VRE). Please refer to CDC's Guideline for Isolation Precautions for criteria that may be used to define epidemiology important organisms: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf	◯ Yes ◯ No	
1.C.5 The hospital can demonstrate the criteria used to determine epidemiologically important MDROs on their list.	◯ Yes ◯ No	
1.C.6 The hospital can provide justification for any epidemiologically important organisms not on their list and otherwise not targeted in their hospital.	◯ Yes ◯ No ◯ N/A	
No citation risk for questions 1.C.4 through 1.C.6; for information only.		

1.C.7 The hospital has an established system(s) to ensure prompt notification to the Infection Control Officer when a novel resistance pattern based on microbiology results is detected.	◯ Yes ◯ No	
If no to 1.C.7, cite at 42 CFR 482.42(a) (Tag A-0749)		
1.C.8 Patients identified as colonized or infected with target MDROs are placed on Contact Precautions. Note: This does not imply that hospitals are required to perform active surveillance testing to detect MDRO colonization among a specific subset or all patients.	◯ Yes ◯ No	
If no to 1.C.8, cite at 42 CFR 482.42(a) (Tag A-0749)		
1.C.9 The hospital has written policies and procedures whose purpose is to improve antibiotic use (antibiotic stewardship).	◯ Yes ◯ No	
1.C.10 The hospital has designated a leader (e.g., physician, pharmacist, etc.) responsible for program outcomes of antibiotic stewardship activities at the hospital.	◯ Yes ◯ No	
1.C.11 The hospital's antibiotic stewardship policy and procedures requires practitioners to document in the medical record or during order entry an indication for all antibiotics, in addition to other required elements such as does and duration.	◯ Yes ◯ No	
1.C.12 The hospital has a formal procedure for all practitioners to review the appropriateness of any antibiotics prescribed after 48 hours from the initial orders (e.g., antibiotic time out).	◯ Yes ◯ No	
1.C.13 The hospital monitors antibiotic use (consumption) at the unit and/or hospital level.	◯ Yes ◯ No	
No citation risk for 1.C.9 through 1.C.13; for information only.		

Section 1.D. Infection Prevention Systems, and Training Related to Personnel

Elements to be assessed		Surveyor Notes
1.D.1 Personnel receive job-specific training on hospital infection control practices, policies, and procedures upon hire and at regular intervals.	◯ Yes ◯ No	
1.D.2 The hospital infection control system trains personnel expected to have contact with blood or other potentially infectious material is anticipated on the blood borne pathogen standards upon hire, at regular intervals, and as needed.	◯ Yes ◯ No	
1.D.3 The hospital infection control system puts in place and monitors efforts to prevent needle sticks, sharps injuries, and other employee exposure events.	◯ Yes ◯ No	
1.D.4 Following an exposure incident, post-exposure evaluation and follow-up including prophylaxis as appropriate, is available to the individual and performed by or under the supervision of a practitioner. Note: An exposure incident refers to a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an individual's duties.	◯ Yes ◯ No	
1.D.5 The hospital tracks healthcare personnel exposure events, evaluates event data, and develops corrective action plans to reduce the incidence of such events.	◯ Yes ◯ No	
1.D.6 The hospital infection control system ensures all personnel are screened for tuberculosis (TB) upon hire and, for those with negative results, determine ongoing TB screening criteria based upon facility/unit risk classification. Note: Risk classification based on aggregated rates of TB test conversions are periodically reviewed by the Infection Control Officer to determine the need for modification to the screening and TB control measures due to increases or decreases in transmission.	◯ Yes ◯ No	

1.D.7 The hospital infection control system ensures personnel with TB test conversions are provided with appropriate follow-up (e.g. evaluation and treatment, as needed).	◯ Yes ◯ No	
1.D.8 The hospital infection control system ensures the hospital has a respiratory protection program that details required worksite-specific procedures and elements for required respirator use.	◯ Yes ◯ No	
1.D.9 The hospital infection control system ensures that respiratory fit testing is provided at regular intervals to personnel at risk.	◯ Yes ◯ No	
1.D.10 Hospital has well-defined policies concerning contact of personnel with patients when personnel have potentially transmissible conditions. • The hospital provides education to personnel on need for prompt reporting of illness to supervisor and/or occupational health.	◯ Yes ◯ No	
If no to any of 1.D.1 through 1.D.10, cite at 42 CFR 482.42(a) (Tag A-0749)		
1.D.11 Personnel competency and compliance with job-specific infection prevention policies and procedures are ensured through routine training and when the Infection Control Officer has identified problems requiring additional training.	◯ Yes ◯ No	
If no to 1.D.11, cite at 42 CFR 482.42(b) (Tag A-0756)		

1.D.12 The hospital infection control system provides Hepatitis B vaccination series to all employees who have potential occupational exposure and offers post-vaccination testing for immunity after the third vaccine dose is administered.	◯ Yes ◯ No	
1.D.13 The hospital infection control system ensures and documents that all personnel have presumptive evidence of immunity to measles, mumps, and rubella.	◯ Yes ◯ No	
1.D.14 The hospital infection control system provides Tdap (tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis) vaccination for all personnel who have not previously received Tdap. Note: Tdap is not licensed for multiple administrations; therefore, after receipt of Tdap, HCP should receive Td (Tetanus diphtheria) for future booster vaccination against tetanus and diphtheria.	◯ Yes ◯ No	
1.D.15 The hospital infection control system ensures and documents that all personnel have evidence of immunity to varicella.	◯ Yes ◯ No	
1.D.16 The hospital infection control system ensures that all personnel are **offered** annual influenza vaccination.	◯ Yes ◯ No	
No citation risk for 1.D.12 through 1.D.16, for information only.		

Module 2: General Infection Prevention Elements - to be applied to all locations providing patient care

Section 2.A. Hand Hygiene

Elements to be assessed		Surveyor Notes
Hand hygiene is performed in a manner consistent with hospital infection control practices, policies, and procedures to maximize the prevention of infection and communicable disease including the following: Note: Observations for compliance with hand hygiene elements should be assessed throughout the hospital.		
2.A.1 Soap, water, and a sink are readily accessible in appropriate locations including, but not limited to, patient care areas and food and medication preparation areas. Note: Medications should not be prepared near areas of splashing water (e.g. within 3 feet of a sink). Alternately when space is limited, a splash guard can be mounted beside the sink.	◯ Yes ◯ No	
2.A.2 Alcohol-based hand rub is readily accessible and placed in appropriate locations. The locations may include: • Entrances to patient rooms, • At the bedside, • In individual pocket-sized containers carried by healthcare personnel, • Staff workstations, and/or • Other convenient locations.	◯ Yes ◯ No	
2.A.3 Personnel perform hand hygiene: • Before contact with the patient • Before performing an aseptic task (e.g., insertion of IV or urinary catheter)	◯ Yes ◯ No	

2.A.4 Personnel perform hand hygiene: • After contact with the patient • After contact with blood, body fluids, or visibly contaminated surfaces • After removing gloves	◯ Yes ◯ No	
2.A.5 Personnel perform hand hygiene using soap and water when hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected *C. difficile* or norovirus during an outbreak. Note: In all other situations, alcohol-based hand rub is preferred.	◯ Yes ◯ No	
2.A.6 Personnel do not wear artificial fingernails and/or extenders when having direct contact with patients at high risk of infection (e.g., those in intensive care units or ORs) per hospital policy.	◯ Yes ◯ No	
If no to any of 2.A.1 through 2.A.6, cite at 42 CFR 482.42(a) (Tag A-0749)		

Section 2.B. Injection Practices and Sharps Safety (Medications and Infusates)

Elements to be assessed		Surveyor Notes		Surveyor Notes
Injections are given and sharps safety is managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Note: If possible, questions in this section should be assessed through observation in two separate patient care areas or settings of the hospital.			◯ Second observation not available (If selected, questions 2.B.1 – 2.B.15 RIGHT column will be blocked)	
2.B.1 Injections are prepared using aseptic technique in an area that has been cleaned and is free of contamination (e.g., visible blood, or body fluids).	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.2 Needles are used for only one patient.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.3 Syringes are used for only one patient (this includes manufactured prefilled syringes).	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.4 Insulin pens are used for only one patient.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.5 The rubber septum on all medication vials, whether unopened or previously accessed, is disinfected with alcohol prior to piercing.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

2.B.6 Medication vials are entered with a new needle. Note: Reuse of syringes and/or needles to enter a medication vial contaminates the contents of the vial, making the vial unsafe for use on additional patients. If a surveyor sees needles or syringes being reused to enter a vial to obtain additional medication for the same patient, no citation should be made if the vial is discarded immediately.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.7 Medication vials are entered with a new syringe. Note: Reuse of syringes and/or needles to enter a medication vial contaminates the contents of the vial making the vial unsafe for use on additional patients. If a surveyor sees needles or syringes being reused to enter a vial to obtain additional medication for the same patient, no citation should be made if the vial is discarded immediately.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.8 Medication vials labeled for single dose – single use are only used for one patient.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.9 Bags of IV solution are used for only one patient (and not as a source of flush solution for multiple patients).	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.10 Medication administration tubing and connectors are used for only one patient.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

2.B.11 Multi-dose vials are dated when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) beyond-use date for that opened vial. Note: The beyond-use date is different from the expiration date printed on the vial by the manufacturer. The beyond-use date should never exceed the expiration date. The multi-dose vial can be dated by the hospital with either the date opened or the discard date as per hospital policy, as long as it is clear what the date represents and the same policy is used consistently throughout the hospital.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.12 Multi-dose medication vials used for more than one patient are storedappropriatelyand do not enterthe immediate patient treatment area(e.g., operating room, patient room, anesthesia carts). Note: If multi-dose vials enter the immediate patient treatment area, they must be dedicated for single patient use and discarded immediately after use.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.B.13 All sharps are disposed of in puncture-resistant sharps containers.	◯ Yes ◯ No		◯ Yes ◯ No	
2.B.14 Sharps containers are replaced when the fill line is reached.	◯ Yes ◯ No		◯ Yes ◯ No	
2.B.15 Sharps containers are disposed of appropriately as medical waste.	◯ Yes ◯ No		◯ Yes ◯ No	
If no to any of 2.B.1 through 2.B.15, cite at 42 CFR 482.42(a) (Tag A-0749) ***See notes on 2.B.6, 2.B.7, and 2.B.11 if "no" is checked.**				

Section 2.C. Personal Protective Equipment/Standard Precautions

Elements to be assessed		Surveyor Notes		Surveyor Notes
Personal protective equipment is utilized in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Note: If possible, observe health care personnel use of personal protective equipment in two different patient care areas or settings in hospital.			◯ Second observation not available (If selected, questions 2.C.1 – 2.C.7 RIGHT column will be blocked)	
2.C.1 Supplies for adherence to Standard Precautions using personal protective equipment (e.g., gloves, gowns, mouth, eye, nose, and face protection) are available and located near point of use.	◯ Yes ◯ No		◯ Yes ◯ No	
2.C.2 Personnel wear gloves for procedures/activities where contact with blood and/or other potentially infectious materials, mucous membranes, non-intact skin or potentially contaminated intact skin could occur.	◯ Yes ◯ No		◯ Yes ◯ No	
2.C.3 Healthcare personnel change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.C.4 Gowns are worn to prevent contamination of skin and clothing during procedures/activities where contact with blood, body fluids, secretions, or excretions could occur.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

2.C.5 Gowns and gloves are removed and hand hygiene is performed: • Before leaving the patient's environment (e.g. including moving to another patient).	◯ Yes ◯ No		◯ Yes ◯ No	
2.C.6 Appropriate mouth, nose and eye protection is worn for aerosol-generating procedures and/or procedures/activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
2.C.7 Facemasks (procedure or surgical) are worn by healthcare personnel who are placing a catheter or injecting materials into the epidural or subdural space.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 2.C.1 through 2.C.7, cite at 42 CFR 482.42(a) (Tag A-0749)				

Section 2.D. Environmental Services

Elements to be assessed		Surveyor Notes
Environmental service are provided in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following: For some questions an observation may not be		
2.D.1 During environmental cleaning procedures, personnel wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection).	◯ Yes ◯ No ◯ Unable to observe	
2.D.2 Environmental surfaces in patient care areas are cleaned and disinfected, using an EPA-registered disinfectant on a regular basis (e.g., daily), when spills occur and when surfaces are visibly contaminated. Note: High-touch surfaces (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected more frequently than minimal-touch surfaces.	◯ Yes ◯ No ◯ Unable to observe	
2.D.3 After a patient vacates a room, all visibly or potentially contaminated surfaces are thoroughly cleaned and disinfected and towels and bed linens are replaced with clean towels and bed linens.	◯ Yes ◯ No ◯ Unable to observe	
2.D.4 Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	◯ Yes ◯ No ◯ Unable to observe	
2.D.5 Separate clean (laundered if not disposable) cloths are used to clean each room and corridor.	◯ Yes ◯ No ◯ Unable to observe	

2.D.6 Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques (e.g., following manufacturer instructions when laundering microfiber items).	◯ Yes ◯ No ◯ Unable to observe	
2.D.7 The hospital decontaminates spills of blood or other body fluids according to its policies and procedures, using appropriate EPA-registered hospital disinfectants.	◯ Yes ◯ No ◯ Unable to observe	
2.D.8 The hospital has established and follows a schedule for areas/equipment to be cleaned/serviced regularly (e.g., HVAC equipment, refrigerators, ice machines, eye wash stations, scrub sinks).	◯ Yes ◯ No	
Laundry is processed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
2.D.9 Personnel handle soiled textiles/linens with minimum agitation to avoid contamination of air, surfaces, and persons.	◯ Yes ◯ No	
2.D.10 Soiled textiles/linens are bagged or otherwise contained at the point of collection in leak-proof containers or bags and are not sorted or rinsed in the location of use. Note: Covers are not needed on contaminated textile hampers in patient care areas.	◯ Yes ◯ No	
2.D.11 The receiving area for contaminated textiles is clearly separated from clean laundry areas and is maintained at negative pressure compared with the clean areas of the laundry in accordance with FGI (formerly AIA) construction standards in effect during the time of facility construction.	◯ Yes ◯ No	
2.D.12 If hospital laundry services are contracted out and performed offsite, the contract must show evidence that the contractor's laundry service meets these design standards.	◯ Yes ◯ No ◯ N/A	

2.D.13 Clean textiles are packaged, transported, and stored in a manner that ensures cleanliness and protection from dust and soil.	◯ Yes ◯ No	
Reprocessing of non-critical items is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
2.D.14 Reusable noncritical patient-care devices (e.g., blood pressure cuffs, oximeter probes) are disinfected on a regular basis (e.g., after use on each patient, once daily, or once weekly) and when visibly soiled.	◯ Yes ◯ No	
2.D.15 For patients on Contact Precautions, if dedicated, disposable devices are not available, noncritical patient-care devices are disinfected after use on each patient.	◯ Yes ◯ No	
2.D.16 There is clear designation of responsibility for disinfection of reusable noncritical patient-care devices.	◯ Yes ◯ No	
2.D.17 Manufacturers' instructions for cleaning noncritical medical equipment are followed.	◯ Yes ◯ No	
2.D.18 Hydrotherapy equipment (e.g., Hubbard tanks, tubs, whirlpools, spas, birthing tanks) are drained, cleaned, and disinfected using an EPA-registered disinfectant according to manufacturer's instructions after each patient use.	◯ Yes ◯ No ◯ N/A	
If no to any of 2.D.1 through 2.D.18, cite at 42 CFR 482.42(a) (Tag A-0749)		

Module 3: Equipment Reprocessing

Section 3.A. Reprocessing of Semi-Critical Equipment

Semi-critical equipment are objects that contact mucous membranes or non-intact skin and require, at a minimum, high-level disinfection prior to reuse (e.g. some endoscopes, speculums, laryngoscope blades)

Elements to be assessed		Surveyor Notes		Surveyor Notes
High-Level Disinfection (HLD) is defined as the complete elimination of all microorganisms in or on an instrument, except for small amounts of bacterial spores. INSTRUCTIONS: • Use the items in Section 3.C. "Single-Use Devices" to assess the reprocessing of any item(s) of semi-critical equipment that is (are) labeled as a single use device. Any item(s) of semi-critical equipment that is (are) labeled as a single use device must be reprocessed by a reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. • For all items labeled reusable, use section 3A.				
HLD of Reusable Instruments and Devices is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including:				
3.A.1 Hospital policies address steps to take when there are discrepancies between a device manufacturer's instructions and automated high-level disinfection equipment manufacturer's instruction for completing high-level disinfection.	◯ Yes ◯ No ◯ Unable to observe			
3.A.2 Only devices labeled as reusable are reprocessed directly by the hospital onsite or offsite via a reprocessing vendor.	◯ Yes ◯ No ◯ Unable to observe			
3.A.3 All reusable semi-critical items receive at least high-level disinfection prior to reuse.	◯ Yes ◯ No ◯ Unable to observe			

3.A.4 If any high-level disinfection is performed off-site, the item(s) are decontaminated prior to off-site transport.	◯ Yes ◯ No ◯ Unable to observe	
If no to any of 3.A.1 through 3.A.4, cite at 42 CFR 482.42(a) (Tag A-0749)		
3.A.5 Is ALL high-level disinfection done Off-site?	◯ Yes: STOP here and SKIP to Section 3.B. ◯ No: Answer all questions in this Section. NOTE: If any high-level disinfection is done onsite, complete questions 3.A.6 through 3.A.18.	
No citation risk for 3.A.5, for information only.		

If possible, obtain two sets of observations for the items in this section. Observe the main area for central sterilization/reprocessing services and if possible, also assess reprocessing in another area.	Central Reprocessing ◯ Unable to observe elements in central reprocessing area. (If selected, questions 3.A.6 – 3.A.18 LEFT column will be blocked)		Other Reprocessing Area ◯ Unable to observe elements in non-central reprocessing setting. (If selected, questions 3.A.6 – 3.A.18 RIGHT column will be blocked)	
3.A.6 Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle. (An endoscope is an instrument designed to visually examine the interior of a bodily canal or hollow organ such as the colon. bladder, or stomach)	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.7 Items are thoroughly pre-cleaned according to manufacturer instructions and visually inspected for residual soil prior to high-level disinfection. Note: For instruments with lumens (e.g., endoscopes), pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

3.A.8 Enzymatic cleaner or detergent is used and discarded according to manufacturer's instructions (typically after each use).	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.9 Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturer's instructions) at least daily.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.10 For chemicals used in high-level disinfection, manufacturer's instructions are followed for: • Preparation, • Testing for appropriate concentration, and • Replacement (e.g., prior to expiration or loss of efficacy).	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.11 If automated reprocessing equipment is used, the manufacturer's recommended connectors are used to assure that all endoscope channels are appropriately disinfected.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.12 Devices undergo disinfection for the appropriate length of time as specified by manufacturer's instructions.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.13 Devices undergo disinfection at the appropriate temperature as specified by manufacturer's instructions.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

3.A.14 After high-level disinfection, devices are rinsed with sterile water, filtered water, or tap water followed by a rinse with 70% - 90% ethyl or isopropyl alcohol. Note: There is no recommendation to use sterile or filtered water rather than tap water for rinsing semi-critical equipment that contact the mucous membranes of the rectum or vagina.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.15 Devices are dried thoroughly prior to reuse. Note: For instruments with lumens (e.g., endoscopes), this includes flushing all channels with alcohol and forcing air through the channels.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.16 Routine maintenance procedures for high-level disinfection equipment are performed regularly. (Confirm maintenance records are available.)	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.17 After high-level disinfection, devices are stored in a manner to protect from damage or contamination Note: Endoscopes must be hung in a vertical position.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
3.A.18 The hospital has a system in place to identify which endoscope was used on a patient for each procedure.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 3.A.6 through 3.A.18, cite at 42 CFR 482.42(a) (Tag A-0749)				

Section 3.B. Reprocessing of Reusable Critical Equipment, Instruments and Devices: Sterilization

Critical equipment, instruments and devices are objects that enter sterile tissue or the vascular system and must be sterile prior to use (e.g. surgical instruments, cardiac and urinary catheters, implants, and ultrasound probes used in sterile body cavities)

Elements to be assessed		Surveyor Notes
Sterilization is a validated process used to render a product free of all forms of viable microorganisms. INSTRUCTIONS: • Use the items in Section 3.C. "Single-Use Devices" to assess the reprocessing of any item(s) of critical equipment that is (are) labeled as a single use device. Any item(s) of critical equipment that is (are) labeled as a single use device must be reprocessed by a reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. • Add reference to single use • If possible, obtain two sets of observations for the items in this Section: one in Central Sterile Services (CSS) and another in in a non-CSS area (e.g. GI suites, Radiology, Outpatient clinics, OB suites). Sterilization of reusable equipment, instruments and devices is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease s including the following:		
3.B.1 Hospital policies address steps to take when there are discrepancies between a device manufacturer's instructions and the sterilizer's manufacturer's instruction for completing sterilization.	◯ Yes ◯ No	
3.B.2 All reusable critical items are sterilized prior to reuse.	◯ Yes ◯ No	
3.B.3 If any sterilization is performed off-site, the item(s) are decontaminated prior to off-site transport.	◯ Yes ◯ No ◯ N/A	
If no to any of 3.B.1 through 3.B.3, cite at 42 CFR 482.42(a) (Tag A-0749)		

3.B.4 Is ALL sterilization done off-site?	◯ Yes: STOP here and SKIP to Section 3.C ◯ No: Answer all questions in this section Note: If any sterilization is done onsite, complete questions 3.B.5 through 3.B.19			
If possible, obtain two sets of observations for the items in this section. Observe the main area for central sterilization services and if possible, also assess sterilization in another area.	Central Sterilization Area ◯ Unable to observe elements in central sterilization area. (If selected, question 3.B.5 – 3.B.19 LEFT column will be blocked)		Other non-Central Sterilization Area ◯ Unable to observe elements in non-central sterilization setting. (If selected, question 3.B.5 – 3.B.19 RIGHT column will be blocked)	
3.B.5 Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.6 Enzymatic cleaner or detergent is used and discarded according to manufacturer's instructions (typically after each use).	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.7 Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturer's instructions) at least daily.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.8 After pre-cleaning, items are appropriately wrapped-packaged for sterilization (e.g., package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.9 A chemical indicator (process indicator) is placed correctly in the instrument packs in every load.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.10 A biological indicator is used at least weekly for each sterilizer and with every load containing implantable items.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.11 For dynamic air removal-type sterilizers (e.g., prevacuum steam sterilizer), an air removal test (Bowie-Dick test) is performed each day the sterilizer is used to verify efficacy of air removal.	◯ Yes ◯ No ◯ N/A		◯ Yes ◯ No ◯ N/A	

3.B.12 Sterile packs are labeled with the sterilizer used, the cycle or load number, and the date of sterilization, and, if applicable, the expiration date.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.13 Logs for each sterilizer cycle are current and include results from each load.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.14 Routine maintenance for sterilization equipment is performed regularly (confirm maintenance records are available).	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.15 After sterilization, medical devices and instruments are stored so that sterility is not compromised.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.16 Sterile packages are inspected for integrity and compromised packages are repackaged and reprocessed prior to use.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.17 If immediate-use steam sterilization is performed, all of the following criteria are met: • Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization. • Once clean, the item is placed within a container intended for immediate use. The sterilizer cycle and parameters used are selected according to the manufacturers' instructions for use for the device, container, and sterilizer. The sterilizer function is monitored with monitors (e.g., mechanical, chemical and biologic) that are approved for the cycle being used. • The processed item must be transferred immediately*, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
*"Immediate use" is defined as the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another.				

3.B.18 Immediate-use sterilization is NOT performed on the following devices: • Implants (except in documented emergency situations when no other option is available). • Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease or similar disorders. • Devices that have not been validated with the specific cycle employed. • Single-use devices that are sold sterile.	◯ Yes ◯ No		◯ Yes ◯ No	
3.B.19 In the event of a reprocessing error/failure that could result in the transmission of infectious disease, personnel respond (i.e., recall(removal) of device and risk assessment) according to hospital policies and procedures.	◯ Yes ◯ No		◯ Yes ◯ No	
If no to any of 3.B.5 through 3.B.19, cite at 42 CFR 482.42(a) (Tag A-0749)				

Section 3.C. Single-Use Devices

Elements to be assessed		Surveyor Notes		Surveyor Notes
Single use devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Note: If possible, evaluate the elements below in multiple clinical treatment or patient care areas.			◯ Second observation not available (If selected, questions 3.C.1 – 3.C.2 RIGHT column will be blocked)	
3.C.1 If the hospital elects to reuse any devices labeled for single use by the manufacturer, these devices are reprocessed by an entity or a third party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital has documentation from the third party reprocessor confirming this is the case.	◯ Yes ◯ No ◯ N/A		◯ Yes ◯ No ◯ N/A	
3.C.2 Devices labeled for single use by the manufacturer are discarded after use and not used for more than one patient if they have not been reprocessed by an approved third-party reprocessor.	◯ Yes ◯ No		◯ Yes ◯ No	
If no to 3.C.1 or 3.C.2, cite at 42 CFR 482.42(a) (Tag A-0749)				

Section 4.A. Indwelling Urinary Catheters

Elements to be assessed		Surveyor Notes		Surveyor Notes
Urinary catheters are inserted, accessed, and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Insertion:				
4.A.1 The hospital has guidelines for appropriate indications for urinary catheters.	◯ Yes ◯ No			
If no to 4.A.1 cite at 42 CFR 482.24(c)(2)(vi) (Tag A-0467)				
4.A.2 The hospital can provide evidence that only properly trained personnel are given the responsibility of inserting and maintaining urinary catheters.	◯ Yes ◯ No			
If no to 4.A.2 cite at 42 CFR 482.23(b)(5) (Tag A-0397)				
If unable to observe any catheter insertions, skip questions 4.A.3 through 4.A.6.	◯ No observations available (If selected, ALL questions from 4.A.3 – 4.A.6 will be blocked)		◯ Second observation not available (If selected, questions 4.A.3 – 4.A.6 RIGHT column will be blocked)	
4.A.3 Hand hygiene is performed before and after insertion of the urinary catheter.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.A.4 Catheter is placed using aseptic technique and sterile equipment.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

4.A.5 Catheter is secured properly after insertion. Note: This may not apply to catheters placed in the OR if the catheter is removed in the OR immediately after the procedure.	◯ Yes ◯ No ◯ N/A		◯ Yes ◯ No ◯ N/A	
If no to any of 4.A.3 through 4.A.5, cite at 42 CFR 482.42(a) (Tag A-0749)				
4.A.6 Catheter insertion and indication are documented.	◯ Yes ◯ No		◯ Yes ◯ No	
If no to 4.A.6 cite at to 42 CFR 482.24(c)(2)(vi) (Tag A-0467)				
Urinary catheter access and maintenance:				
4.A.7 Hand hygiene is performed before and after manipulating catheter.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.A.8 Urine bag is kept below level of bladder at all times.	◯ Yes ◯ No		◯ Yes ◯ No	
4.A.9 Catheter tubing is unobstructed and free of kinking.	◯ Yes ◯ No		◯ Yes ◯ No	
4.A.10 Urine bag is emptied using aseptic technique, using a separate, clean collection container for each patient; drainage spigot does not touch collecting container.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

4.A.11 Urine samples are obtained aseptically (via needleless port for small volume).	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 4.A.7 through 4.A.11, cite at to 42 CFR 482.42(a) (Tag A-0749)				
4.A.12 Need for urinary catheters is reviewed and documented daily with prompt removal of urinary catheters no longer needed.	◯ Yes ◯ No		◯ Yes ◯ No	
No citation risk 4.A.12; for information only.				

Section 4.B. Central Venous Catheters

Elements to be assessed		Surveyor Notes		Surveyor Notes
Central venous catheters are inserted, accessed and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Insertion:				
4.B.1 The hospital can provide evidence that only properly trained personnel who demonstrate competence for insertion of central intravascular catheters are given this responsibility.	◯ Yes ◯ No			
If unable to observe any central venous catheter insertions, skip 4.B.2 through 4.B.7.	◯ No observations available (If selected, ALL questions from 4.B.2 – 4.B.7 will be blocked)		◯ Second observation not available (If selected, questions 4.B.2 – 4.B.7 RIGHT column will be blocked)	
4.B.2 Hand Hygiene is performed before and after insertion.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.B.3 Maximal barrier precautions are used for insertion (includes use of cap, mask, sterile gown, sterile gloves, and a sterile full body drape).	◯ Yes ◯ No		◯ Yes ◯ No	
4.B.4 >0.5% chlorhexidine with alcohol is used for skin antisepsis prior to insertion (If contraindicated [e.g., neonatal population], tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives).	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.B.5 Sterile gauze or sterile, transparent, semi-permeable dressing is used to cover catheter site (may not apply for well-healed tunneled catheters).	◯ Yes ◯ No		◯ Yes ◯ No	

4.B.6 If the femoral site is used for central venous catheter insertion for adults, justification for this site is in the medical record.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 4.B.2 to 4.B.6, cite at 42 CFR 482.42(a) (Tag A-0749)				
4.B.7 Central venous line insertion and indication are documented.	◯ Yes ◯ No		◯ Yes ◯ No	
If no to 4.B.7, cite at to 42 CFR 482.24(c)(2)(vi) (Tag A-0467)				
Accessing/Maintenance				
4.B.8 The hospital can provide evidence that only properly trained personnel who demonstrate competence for access and maintenance of central intravascular catheters are given this responsibility.	◯ Yes ◯ No			
If unable to observe the access or maintenance of any central venous catheters, skip 4.B.9 through 4.B.13.	◯ No observations available (If selected, ALL questions from 4.B.9 – 4.B.13 will be blocked)		◯ Second observation not available (If selected, questions 4.B.9 – 4.B.13 RIGHT column will be blocked)	
4.B.9 Hand hygiene is performed before and after manipulating catheter.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.B.10 Dressings that are wet, soiled, or dislodged are changed promptly.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

4.B.11 Dressing is changed with aseptic technique using clean or sterile gloves.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.B.12 Access port is scrubbed with an appropriate antiseptic (chlorhexidine, povidone iodine, an iodophor, or 70% alcohol) prior to accessing.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.B.13 Catheter is accessed only with sterile devices.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 4.B.8 to 4.B.13, cite at 42 CFR 482.42(a) (Tag A-0749)				
4.B.14 Need for central venous catheters is reviewed daily and documented with prompt removal of lines when no longer needed.	◯ Yes ◯ No			
No citation risk; for information only.				

Section 4.C. Ventilator/Respiratory Therapy

Elements to be assessed		Surveyor Notes		Surveyor Notes
Respiratory procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
If no observations available, skip questions 4.C.1 through 4.C.8.	◯ No observations available (If selected, ALL questions from 4.C.1 – 4.C.8 will be blocked)		◯ Second observation not available (If selected, questions 4.C.1 – 4.C.8 RIGHT column will be blocked)	
4.C.1 through 4.C.8: General respiratory therapy practices (applies to patients with and without ventilators):				
4.C.1 Hand hygiene is performed before and after contact with patient or any respiratory equipment used on patient.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.C.2 Gloves are worn when in contact with respiratory secretions and changed before contact with another patient, object, or environmental surface.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.C.3 Only sterile solution (e.g., water or saline) are used for nebulization.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.C.4 Single-dose vials for aerosolized medications are not used for more than one patient.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	

4.C.5 If multi-dose vials for aerosolized medications are used, manufacturers' instructions for handling, storing, and dispensing the medications are followed.	◯ Yes ◯ No ◯ N/A ◯ Unable to observe		◯ Yes ◯ No ◯ N/A ◯ Unable to observe	
4.C.6 If multi-dose vials for aerosolized medications are used for more than one patient, they are stored appropriately and do not enter the immediate patient treatment area.	◯ Yes ◯ No ◯ N/A		◯ Yes ◯ No ◯ N/A	
If no to any of 4.C.1 to 4.C.6, cite at to 42 CFR 482.42(a) (Tag A-0749)				
4.C.7 Jet nebulizers are for single patient use and are cleaned as per hospital policy, rinsed with sterile water, and air-dried between treatments on the same patient. Note: Mesh nebulizers, which remain in the ventilator circuit and are not cleaned or disinfected, are changed at an interval recommended by manufacturer's instructions. Nebulizer/drug combination systems are cleaned and disinfected according to manufacturer's instructions.	◯ Yes ◯ No		◯ Yes ◯ No	
No citation risk; for information only.				
4.C.8 Head of bed is elevated at an angle of 30--45 degrees, in the absence of medical contraindication(s), for patients at high risk for aspiration (e.g., a person receiving mechanically assisted ventilation and/or who has an enteral tube in place).	◯ Yes ◯ No		◯ Yes ◯ No	
If no to 4.C.8, cite at 42 CFR 482.42(a) (Tag A-0749)				

Ventilators:				
Ventilators are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
If no observations available, skip questions 4.C.9 through 4.C.13.	◯ No observations available (If selected, ALL questions from 4.C.9 – 4.C.15 will be blocked)		◯ Second observation not available (If selected, questions 4.C.9 – 4.C.15 RIGHT column will be blocked)	
4.C.9 Ventilator circuit (i.e., ventilator tubing and exhalation valve and the attached humidifier) is changed if visibly soiled or mechanically malfunctioning.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.C.10 Sterile water is used to fill humidifiers.	◯ Yes ◯ No		◯ Yes ◯ No	
4.C.11 Condensate that collects in the tubing of a mechanical ventilator is periodically drained and discarded, taking precautions not to allow condensate to drain toward the patient.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.C.12 If single-use open-system suction catheter is employed, a sterile, single-use catheter is used.	◯ Yes ◯ No ◯ N/A		◯ Yes ◯ No ◯ N/A	
4.C.13 Only sterile fluid is used to remove secretions from the suction catheter if the catheter is used for re-entry into the patient's lower respiratory tract.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 4.C.9 to 4.C.13, cite at 42 CFR 482.42(a) (Tag A-0749)				

4.C.14 Hospital has a program for sedation to be lightened daily in eligible patients.	◯ Yes ◯ No		◯ Yes ◯ No	
4.C.15 Assessment of readiness to wean (e.g., spontaneous breathing trials) are performed daily in eligible patients.	◯ Yes ◯ No		◯ Yes ◯ No	
No citation risk for 4.C.14 and 4.C.15; for information only.				

Section 4.D. Spinal Injection Procedures

Elements to be assessed		Surveyor Notes
Spinal injection procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
If unable to observe spinal injection procedure, skip questions 4.D.1 through 4.D.3.	◯ No observation available (If selected, questions 4.D.1 – 4.D.3 will be blocked)	
4.D.1 Hand hygiene performed before and after the procedure.	◯ Yes ◯ No	
4.D.2 The spinal injection procedure is performed using aseptic technique and sterile equipment, including use of sterile gloves.	◯ Yes ◯ No	
4.D.3 Facemasks are worn by healthcare personnel who are placing a catheter or injecting materials into the epidural or subdural space.	◯ Yes ◯ No	
If no to any of 4.D.1 to 4.D.3, cite at 42 CFR 482.42(a) (Tag A-0749)		

Section 4.E. Point of Care Devices (e.g. Blood Glucose Meter, INR Monitor)

Elements to be assessed		Surveyor Notes		Surveyor Notes
Point of care devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Note: One observation to be completed. If possible make a second observation in a different patient care area in the hospital.			◯ Second observation not available(If selected, questions 4.E.1 – 4.E.4 RIGHT column will be blocked)	
4.E.1 Hand hygiene is performed before and after the procedure.	◯ Yes ◯ No		◯ Yes ◯ No	
4.E.2 Gloves are worn by healthcare personnel when performing the finger stick procedure to obtain the sample of blood, and are removed after the procedure (followed by hand hygiene).	◯ Yes ◯ No		◯ Yes ◯ No	
4.E.3 Finger stick devices are not used for more than one patient. Note: This includes both the lancet and the lancet holding device.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.E.4 If used for more than one patient, the point-of-care testing device (e.g., blood glucose meter, INR monitor) is cleaned and disinfected after every use according to manufacturer's instructions. Note: if manufacturer does not provide instructions for cleaning and disinfection, then the device should not be used for >1 patient.	◯ Yes ◯ No ◯ N/A		◯ Yes ◯ No ◯ N/A	
If no to any of 4.E.1 to 4.E.4, cite at 42 CFR 482.42(a) (Tag A-0749)				

Section 4.F. Isolation: Contact Precautions

Elements to be assessed		Surveyor Notes		Surveyor Notes
Patients requiring contact isolation are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
If possible, observe for compliance with Contact Precautions elements in multiple patient care areas in the hospital. If unable to observe a patient on Contact Precautions skip elements 4.F.1 to 4.F.12.	◯ No observation available (If selected ALL questions from 4.F.1 – 4.F.12 will be blocked)		◯ Second observation not available (If selected questions 4.F.1 – 4.F.12 RIGHT column will be blocked)	
4.F.1 Patient with known or suspected infections or with evidence of syndromes that represent an increased risk for contact transmission are placed on Contact Precautions.	◯ Yes ◯ No		◯ Yes ◯ No	
4.F.2 Gloves and gowns are available and located near point of use.	◯ Yes ◯ No		◯ Yes ◯ No	
4.F.3 Signs indicating patient is on Contact Precautions are clear and visible.	◯ Yes ◯ No		◯ Yes ◯ No	
4.F.4 Patients on Contact Precautions are housed in single-patient rooms when possible or cohorted based on a clinical risk assessment.	◯ Yes ◯ No		◯ Yes ◯ No	
4.F.5 Hand hygiene is performed before entering patient care environment. Note: Soap and water must be used when bare hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected *C. difficile* or norovirus during an outbreak. In all other situations, alcohol-based hand rub is preferred.	◯ Yes ◯ No		◯ Yes ◯ No	

4.F.6 Gloves and gowns are donned upon entry into the room or cubicle.	◯ Yes ◯ No		◯ Yes ◯ No	
4.F.7 Gloves and gowns are removed and discarded, and hand hygiene is performed before leaving the patient care environment.	◯ Yes ◯ No		◯ Yes ◯ No	
4.F.8 Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs) is used, or if not available, then equipment is cleaned and disinfected prior to use on another patient according to manufacturers' instructions.	◯ Yes ◯ No		◯ Yes ◯ No	
4.F.9 The hospital limits the movement of patients on Contact Precautions outside of their room to medically necessary purposes only.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.F.10 If a patient on Contact Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and to prevent transmission of infectious disease.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.F.11 Objects and environmental surfaces in patient care areas that are touched frequently (e.g., bed rails, overbed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected with an EPA-registered disinfectant frequently (at least daily) and when visibly soiled.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.F.12 After patient discharge, all visibly or potentially contaminated surfaces are thoroughly cleaned and disinfected and all textiles (e.g. linens and towels) are replaced with clean textiles.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 4.F.1 to 4.F.12, cite at 42 CFR 482.42(a) (Tag A-0749)				

Section 4.G. Isolation: Droplet Precautions

Elements to be assessed		Surveyor Notes		Surveyor Notes
Patients requiring Droplet Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4.G.1 Patients known or suspected to be infected with pathogens transmitted by respiratory droplets (e.g., seasonal influenza, rhinovirus, *Neisseria meningitidis*, mycoplasma) are placed on Droplet Precautions.	◯ Yes ◯ No			
If possible, observe for compliance with Droplet Precautions elements in multiple patient care areas in the hospital. If unable to observe a patient on Droplet Precautions, skip elements 4.G.2 to 4.G.9.	◯ No observation available (If selected ALL questions from 4.G.2 – 4.G.9 will be blocked)		◯ Second observation not available (If selected questions 4.G.2 – 4.G.9 RIGHT column will be blocked)	
4.G.2 Facemasks are available and located near point of use.	◯ Yes ◯ No		◯ Yes ◯ No	
4.G.3 Signs indicating patient is on Droplet Precautions are clear and visible.	◯ Yes ◯ No		◯ Yes ◯ No	
4.G.4 Patients on Droplet Precautions are housed in single-patient rooms when available or cohorted based on a clinical risk assessment.	◯ Yes ◯ No		◯ Yes ◯ No	
4.G.5 Hand hygiene is performed before contact with the patient.	◯ Yes ◯ No		◯ Yes ◯ No	
4.G.6 Personnel don facemasks upon entering the patient care environment or private room.	◯ Yes ◯ No		◯ Yes ◯ No	

4.G.7 Facemask is removed and discarded and hand hygiene is performed upon leaving the patient care environment.	◯ Yes ◯ No		◯ Yes ◯ No	
4.G.8 The hospital limits movement of patients on Droplet Precautions outside of their rooms to medically necessary purposes only.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.G.9 If a patient on Droplet Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and to prevent transmission of infectious disease, including the use of a facemask by the patient if possible. Note: The hospital may have specific policies regarding the use of PPE for pediatric patients.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 4.G.1 to 4.G.9, cite at 42 CFR 482.42(a) (Tag A-0749)				

Section 4.H. Isolation: Airborne Isolation Precautions

Elements to be assessed		Surveyor Notes		Surveyor Notes
Patients requiring Airborne Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4.H.1 Patients with known or suspected infectious agents that are transmitted person-to-person by the airborne route (e.g., TB, measles, chickenpox, disseminated herpes zoster) are placed on Airborne Isolation Precautions.	◯ Yes ◯ No			
If possible, observe for compliance with Airborne Isolation Precautions elements in multiple patient care areas in the hospital. If unable to observe a patient on Airborne Isolation Precautions, skip elements 4.H.2 to 4.H.8.	◯ No observation available (If selected ALL questions from 4.H.2 – 4.H.8 will be blocked)		◯ Second observation not available (If selected questions 4.H.2 – 4.H.8 RIGHT column will be blocked)	
4.H.2 NIOSH-approved particulate respirators (N-95 or higher) are available and located near point of use.	◯ Yes ◯ No		◯ Yes ◯ No	
4.H.3 Signs indicating patient is on Airborne Isolation Precautions are clear and visible.	◯ Yes ◯ No		◯ Yes ◯ No	
4.H.4 Personnel wear a NIOSH-approved particulate respirator (N95 or higher) when entering the airborne infection isolation room (AIIR) for patients with confirmed or suspected TB. Hospital policies are followed for other pathogens requiring AIIR.	◯ Yes ◯ No		◯ Yes ◯ No	

4.H.5 Hand hygiene is performed before contact with the patient.	◯ Yes ◯ No		◯ Yes ◯ No	
4.H.6 Patients on Airborne Precautions are housed in AIIR that meet all of the following specifications: • At least 6 (existing facility) or 12 (new construction/renovation) air changes per hour or per state licensure rules; • Direct exhaust of air to outside. If not possible, all air returned to air handling system or adjacent spaces is directed through HEPA filters; • When AIIR is in use for a patient on Airborne Precautions, air pressure is monitored daily with visual indicators (e.g., smoke tubes, flutter strips), regardless of the presence of differential pressure sensing devices (e.g., manometers); • AIIR door kept closed when not required for entry and exit Note: If AIIR is not available, hospital policy should address patient transfer to a hospital that has an available AIIR.	◯ Yes ◯ No		◯ Yes ◯ No	
4.H.7 The hospital limits movement of patients on Airborne Precautions outside of their room to medically-necessary purposes.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.H.8 If a patient on Airborne Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and to prevent transmission of infectious disease, including the use of a facemask by the patient if possible. Note: The hospital may have specific policies regarding the use of PPE for pediatric patients.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
If no to any of 4.H.1 to 4.H.8, cite at 42 CFR 482.42(a) (Tag A-0749)				

Section 4.I. Surgical Procedures

Elements to be assessed		Surveyor Notes		Surveyor Notes
Surgical procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
If unable to observe any surgical procedure, skip elements 4.I.1 to 4.I.8.	◯ No observation available (If selected ALL questions from 4.I.1 – 4.I.8 will be blocked)		◯ Second observation not available (If selected questions 4.I.1 – 4.I.8 RIGHT column will be blocked)	
4.I.1 Healthcare personnel perform a surgical scrub before donning sterile gloves for surgical procedures (in OR) using either an antimicrobial surgical scrub agent or an FDA-approved alcohol-based antiseptic surgical hand rub. Note: If visibly soiled, hands and forearms should be prewashed with soap and water before using an alcohol-based antiseptic surgical hand rub.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.I.2 After surgical scrub, hands and arms are dried with a sterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.I.3 Surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair are worn by all personnel and visitors in semi restricted and restricted areas. Note: Restricted area includes ORs, procedure rooms, and the clean core (sterile supply) area. The semi restricted area includes the peripheral support areas of the surgical suite.	◯ Yes ◯ No		◯ Yes ◯ No	
4.I.4 Surgical masks are worn fully covering mouth and nose by all personnel in restricted areas where open sterile supplies or scrubbed personnel are located.	◯ Yes ◯ No		◯ Yes ◯ No	

4.I.5 A fresh, clean surgical mask is worn for every procedure.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.I.6 Sterile drapes are used to establish sterile field.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.I.7 Sterile field is maintained and monitored constantly. Ensure that: • Items used within sterile field are sterile. • Items introduced into sterile field are opened, dispensed, and transferred in a manner to maintain sterility. • Sterile field is prepared in the location where it will be used and as close as possible to time of use. • Movement in or around sterile field is done in a manner to maintain sterility.	◯ Yes ◯ No ◯ Unable to observe		◯ Yes ◯ No ◯ Unable to observe	
4.I.8 Traffic in and out of OR is kept to minimum and limited to essential personnel.	◯ Yes ◯ No		◯ Yes ◯ No	
If no to any of 4.I.1 to 4.I.8, cite at 42 CFR 482.42(a) (Tag A-0749)				

Processes ensuring infection control in the OR are accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
If the hospital does not provide any surgical services, skip 4.I.9 through 4.I.17.	◯ No surgical services (If selected, questions 4.I.9 – 4.I.17 will be blocked)	
4.I.9 Cleaners and EPA-registered hospital disinfectants are used and dated in accordance with hospital policies and procedures and manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time). Note: The cleaners and disinfectants can be dated by the hospital with either the date opened or the discard date as per hospital policy, as long as it is clear what the date represents and the same policy is used consistently throughout the hospital.	◯ Yes ◯ No ◯ Unable to observe	
4.I.10 All horizontal surfaces (e.g., furniture, surgical lights, booms, equipment) are damp dusted before the first procedure of the day using a clean, lint-free cloth and EPA-registered hospital detergent/disinfectant.	◯ Yes ◯ No ◯ Unable to observe	
4.I.11 High touch environmental surfaces are cleaned and disinfected between patients.	◯ Yes ◯ No ◯ Unable to observe	
4.I.12 ORs are terminally cleaned after last procedure of the day (including weekends) and each 24-hour period during regular work week. Terminal cleaning includes wet-vacuuming or mopping floor with an EPA-registered disinfectant.	◯ Yes ◯ No ◯ Unable to observe	

4.I.13 Anesthesia equipment surfaces that are touched by personnel while providing patient care or while handling contaminated items are cleaned and low-level disinfected between use on patients, according to manufacturers' instructions.	◯ Yes ◯ No ◯ Unable to observe	
4.I.14 Exterior surfaces of anesthesia equipment that are not knowingly contaminated during patient care are terminally low-level disinfected at the end of the day, according to manufacturers' instructions.	◯ Yes ◯ No ◯ Unable to observe	
4.I.15 Internal components of the anesthesia machine breathing circuit are cleaned per hospital policy or manufacturer's instructions.	◯ Yes ◯ No ◯ Unable to observe	
4.I.16 Reusable noncritical items (e.g., blood pressure cuffs, ECG leads, tourniquets, oximeter probes) are cleaned and disinfected between patients.	◯ Yes ◯ No ◯ Unable to observe	
4.I.17 Ventilation requirements meet the following: • Positive pressure, ≥15 air exchanges per hour (at least 3 of which are fresh air) • 90% filtration (HEPA is optional), air filters checked regularly and replaced according to hospital policies and procedures • Temperature and relative humidity levels are maintained at required levels • Doors are self-closing • Air vents and grill work are clean and dry.	◯ Yes ◯ No	
If no to any of 4.I.9 to 4.I.17, cite at 42 CFR 482.42(a) (Tag A-0749)		