FUNDAMENTAL ELEMENTS NEEDED TO PREVENT TRANSMISSION OF INFECTIOUS AGENTS IN OUTPATIENT SETTINGS

Dedicate Resources to Infection Prevention (Administrative Resources)

Infection prevention must be made a priority in any setting where healthcare is delivered. Those with primary administrative oversight of the outpatient facility must ensure that sufficient fiscal and human resources are available to develop and maintain infection prevention and occupational health programs. This includes the availability of sufficient and appropriate equipment and supplies necessary for the consistent observation of Standard Precautions, including hand hygiene products, injection equipment, and personal protective equipment (e.g., gloves, gowns, face and eye protection).

Infection prevention programs must extend beyond Occupational Safety and Health Administration (OSHA) bloodborne pathogens training to address patient protection. Facilities should assure that at least one individual with training in infection prevention is employed by or regularly available (e.g., by contract) to manage the facility's infection prevention program. This individual should be involved in the development of written infection prevention policies and have regular communication with HCP to address specific issues or concerns related to infection prevention. The development and ongoing refinement of infection prevention policies and procedures should be based on evidence-based guidelines, regulations, or standards. These policies and procedures should be tailored to the facility and re-assessed on a regular basis (e.g., annually), taking into consideration the types of services provided by the facility and the patient population that is served. This process (referred to as risk assessment by the Infection Prevention profession) will allow facilities to better prioritize resources and focus extra attention on those areas that are determined to pose greater risk to their patients. For example, an ambulatory surgical center, which performs on-site sterilization of reusable surgical devices, would be expected to have more detailed policies regarding device reprocessing than a primary care office, where on-site sterilization is less likely to be performed. However, both facilities should have policies and procedures addressing handling of reusable medical devices. Similarly, a clinic primarily serving patients infected with tuberculosis will have infection prevention needs beyond those of a general pediatric office.

Facility administrators should also assure that facility policies and procedures address occupational health needs including vaccination of HCP, management of exposures or infections in personnel requiring post-exposure prophylaxis and/or work restrictions, and compliance with the OSHA bloodborne pathogens standard. Recommendations for prevention of infections in HCP can be found in the following resources: Guideline for infection control in healthcare personnel (available at: http://www.cdc.gov/hicpac/pdf/InfectControl98.pdf), Recommended Vaccines for Healthcare Workers (available at: http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html), and OSHA Bloodborne Pathogens and Needlestick Prevention (available at: http://www.osha.gov/SLTC/bloodbornepathogens/index.html).

Key administrative recommendations for outpatient settings:

1. Develop and maintain infection prevention and occupational health programs.
2. Assure availability of sufficient and appropriate supplies necessary for adherence to Standard Precautions (e.g., hand hygiene products, personal protective equipment, injection equipment).
3. Assure at least one individual with training in infection prevention is employed by or regularly available (e.g., by contract) to manage the facility's infection prevention program.
4. Develop written infection prevention policies and procedures appropriate for the services provided by the facility and based upon evidence-based guidelines, regulations, or standards.

Educate and Train Healthcare Personnel

Ongoing education and competency-based training of HCP are critical for ensuring that infection prevention policies and procedures are understood and followed. Education on the basic principles and practices for preventing the spread of infections should be provided to all HCP. Training should include both HCP safety (e.g., OSHA bloodborne pathogens training) and patient safety, emphasizing job- or task-specific needs. Training should be provided upon orientation to the facility and, to maintain competency, should be repeated annually and anytime policies or procedures are updated/revised. Competencies should be documented following each training.

Key recommendations for education and training of healthcare personnel in outpatient settings:

1. Provide job- or task-specific infection prevention education and training to all HCP.
   a. This includes those employed by outside agencies and available by contract or on a volunteer basis to the facility.
2. Training should focus on principles of both HCP safety and patient safety.
3. Training should be provided upon hire and repeated annually and when policies or procedures are updated/revised.
4. Competencies should be documented following each training.

Monitor and Report Healthcare-associated Infections

Surveillance is defined as the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Surveillance typically refers to tracking of outcome measures (e.g., HAIs) but can also refer to tracking of adherence to specific process measures (e.g., hand hygiene, environmental cleaning) as a means to reduce infection transmission. Surveillance for outcome measures in outpatient settings is challenging because patient encounters may be brief or sporadic and evaluation and treatment of consequent infections may involve different healthcare settings (e.g., hospitals). To assist with identification of infections that may be related to care provided by the facility, patients should be educated regarding signs and symptoms of infection and instructed to notify the facility if such signs or symptoms occur.

At a minimum, outpatient facilities need to adhere to local, state, and federal requirements regarding reportable disease and outbreak reporting. Certain types of facilities (e.g., ambulatory surgical centers) may also be subject to additional HAI surveillance or process measure reporting requirements, for example as part of accreditation, Medicare certification, or state/local statutes. Facilities should check the requirements for their state/region to assure that they are compliant with all regulations and should have contact information for their local and/or state health department available to ensure required reporting is done in a timely manner. (A list of state reportable disease websites is available at: http://www.cste.org/?StateReportable).

Regular focused practice surveys or audits (e.g., audits of infection prevention practices including hand hygiene, medication handling, reprocessing of reusable devices) offer a means to ensure ongoing compliance of HCP with recommended practices. One example of an audit tool being used by federal surveyors to assess infection control in ambulatory surgical centers is available at: http://www.cms.gov/manuals/downloads/som107_exhibit_351.pdf. Another tool is the *Infection Prevention Checklist for Outpatient Settings* (Appendix A), a companion to this guide.

Key recommendations for HAI surveillance and reporting in outpatient settings:

1. Educate patients who have undergone procedures at the facility regarding signs and symptoms of infection that may be associated with the procedure and instruct them to notify the facility if such signs and symptoms occur.
2. Adhere to local, state and federal requirements regarding HAI surveillance, reportable diseases, and outbreak reporting.
3. Perform regular audits of HCP adherence to infection prevention practices.

Adhere to Standard Precautions

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These practices are designed to both protect HCP and prevent HCP from spreading infections among patients. Standard Precautions include: 1) hand hygiene, 2) use of personal protective equipment (e.g., gloves, gowns, masks), 3) safe injection practices, 4) safe handling of potentially contaminated equipment or surfaces in the patient environment, and 5) respiratory hygiene/cough etiquette. Each of these elements of Standard Precautions are described in the sections that follow.

Education and training on the principles and rationale for recommended practices are critical elements of Standard Precautions because they facilitate appropriate decision-making and promote adherence. Further, at the facility level, an understanding of the specific procedures performed and typical patient interactions, as described above in Administrative Measures as part of policy and procedure development, will assure that necessary equipment is available.

The application of Standard Precautions and guidance on appropriate selection and an example of donning and removal of personal protective equipment is described in detail in the 2007 Guideline for Isolation Precautions (available at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).

Hand Hygiene

Good hand hygiene, including use of alcohol-based hand rubs (ABHR) and handwashing with soap and water, is critical to reduce the risk of spreading infections in outpatient settings. Use of ABHR as the primary mode of hand hygiene in healthcare settings is recommended by the CDC and the World Health Organization (WHO)

because of its activity against a broad spectrum of epidemiologically important pathogens, and because compared with soap and water, use of ABHR in healthcare settings can increase compliance with recommended hand hygiene practices by requiring less time, irritating hands less, and facilitating hand hygiene at the patient bedside. For these reasons, ABHR is the preferred method for hand hygiene in most clinical situations. Soap and water should be used when hands are visibly soiled (e.g., blood, body fluids) and is also preferred after caring for a patient with known or suspected *Clostridium difficile* or norovirus during an outbreak.

Complete guidance on how and when hand hygiene should be performed, including recommendations regarding surgical hand antisepsis and artificial nails can be found in the Guideline for Hand Hygiene in Health-Care Settings (available at: http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf).

Key recommendations for hand hygiene in outpatient settings:

1. Key situations where hand hygiene should be performed include:
   - **a.** Before contact with a patient.
   - **b.** Before performing an aseptic task (e.g., insertion of IV, preparing an injection).
   - **c.** After contact with the patient or objects in the immediate vicinity of the patient.
   - **d.** After contact with blood, body fluids or contaminated surfaces.
   - **e.** If hands will be moving from a contaminated-body site to a clean-body site during patient care.
   - **f.** After removal of personal protective equipment (PPE).
2. Use soap and water when hands are visibly soiled (e.g., blood, body fluids), or after caring for patients with known or suspected *Clostridium difficile* or norovirus during an outbreak. Otherwise, the preferred method of hand hygiene in clinical situations is with an alcohol-based hand rub.

Personal Protective Equipment

Personal Protective Equipment (PPE) refers to wearable equipment that is intended to protect HCP from exposure to or contact with infectious agents. Examples include gloves, gowns, face masks, respirators, goggles and face shields. The selection of PPE is based on the nature of the patient interaction and potential for exposure to blood, body fluids or infectious agents. Examples of appropriate use of PPE for adherence to Standard Precautions include: use of gloves in situations involving possible contact with blood or body fluids, mucous membranes, non-intact skin or potentially infectious material; use of a gown to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated; use of mouth, nose and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids. Hand hygiene is always the final step after removing and disposing of PPE.

Each outpatient facility should evaluate the services they provide to determine specific needs and to assure that sufficient and appropriate PPE is available for adherence to Standard Precautions. All HCP at the facility should be educated regarding proper selection and use of PPE.

Complete guidance on the appropriate selection of PPE, including one approach for donning and removing PPE is provided in the 2007 Guideline for Isolation Precautions (available at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).

Key recommendations for use of PPE in outpatient settings:

1. Facilities should assure that sufficient and appropriate PPE is available and readily accessible to HCP.
2. Educate all HCP on proper selection and use of PPE.
   a. PPE, other than respirators, should be removed and discarded prior to leaving the patient's room or care area. If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door.
   b. Hand hygiene should be performed immediately after removal of PPE.
3. Wear gloves for potential contact with blood, body fluids, mucous membranes, non-intact skin or contaminated equipment.
   a. Do not wear the same pair of gloves for the care of more than one patient.
   b. Do not wash gloves for the purpose of reuse.
4. Wear a gown to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated.
   a. Do not wear the same gown for the care of more than one patient.
5. Wear mouth, nose and eye protection during procedures that are likely to generate splashes or sprays of blood or other body fluids.

Injection Safety

Injection safety includes practices intended to prevent transmission of infectious diseases between one patient and another, or between a patient and healthcare provider during preparation and administration of parenteral medications.

Implementation of the OSHA Bloodborne Pathogens Standard has helped increase the protection of HCP from blood exposure and sharps injuries, but there is room for improvement in outpatient settings. For example, efforts to increase uptake of hepatitis B vaccination and implementation of safety devices that are designed to decrease risks of sharps injury are needed.

Further attention to patient protection is also needed as evidenced by continued outbreaks in outpatient settings resulting from unsafe injection practices. Unsafe practices that have led to patient harm include 1) use of a single syringe, with or without the same needle, to administer medication to multiple patients, 2) reinsertion of a used syringe, with or without the same needle, into a medication vial or solution container (e.g., saline bag) to obtain additional medication for a single patient and then using that vial or solution container for subsequent patients, 3) preparation of medications in close proximity to contaminated supplies or equipment and, 4) failure to wear a facemask (e.g., surgical mask) when placing a catheter or injecting material into the epidural or subdural space (e.g., during myelogram, epidural or spinal anesthesia).

Guidance on safe injection practices can be found in the 2007 Guideline for Isolation Precautions (available at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf). Additional materials, including a list of frequently asked questions from providers and a patient notification toolkit, are also available (http://www.cdc.gov/injectionsafety/). The *One & Only Campaign* is a public health effort to eliminate unsafe medical injections.

The Campaign is led by the Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition (SIPC). To learn more about safe injection practices, and access training videos and other educational resources, please visit OneandOnlyCampaign.org

Key recommendations for safe injection practices in outpatient settings:

1. Use aseptic technique when preparing and administering medications.
2. Cleanse the access diaphragms of medication vials with alcohol before inserting a device into the vial.
3. Never administer medications from the same syringe to multiple patients, even if the needle is changed or the injection is administered through an intervening length of intravenous tubing.
4. Do not reuse a syringe to enter a medication vial or container.
5. Do not administer medications from single-dose or single-use vials, ampoules, or bags or bottles of intravenous solution to more than one patient.
6. Do not use fluid infusion or administration sets (e.g., intravenous tubing) for more than one patient.
7. Dedicate multidose vials to a single patient whenever possible. If multidose vials will be used for more than one patient, they should be restricted to a centralized medication area and should not enter the immediate patient treatment area (e.g., operating room, patient room/cubicle).
8. Dispose of used sharps at the point of use in a sharps container that is closable, puncture-resistant, and leak-proof.
9. Wear a facemask (e.g., surgical mask) when placing a catheter or injecting material into the epidural or subdural space (e.g., during myelogram, epidural or spinal anesthesia).

Environmental Cleaning

Outpatient facilities should establish policies and procedures for routine cleaning and disinfection of environmental surfaces as part of their infection prevention plan. Cleaning refers to the removal of visible soil and organic contamination from a device or environmental surface using the physical action of scrubbing with a surfactant or detergent and water, or an energy-based process (e.g., ultrasonic cleaners) with appropriate chemical agents. This process removes large numbers of microorganisms from surfaces and must always precede disinfection. Disinfection is generally a less lethal process of microbial inactivation (compared to sterilization) that eliminates virtually all recognized pathogenic microorganisms but not necessarily all microbial forms (e.g., bacterial spores).

Emphasis for cleaning and disinfection should be placed on surfaces that are most likely to become contaminated with pathogens, including those in close proximity to the patient (e.g., bedrails) and frequently-touched surfaces in the patient-care environment (e.g., doorknobs). Facility policies and procedures should also address prompt and appropriate cleaning and decontamination of spills of blood or other potentially infectious materials.

Responsibility for routine cleaning and disinfection of environmental surfaces should be assigned to appropriately trained HCP. Cleaning procedures should be periodically monitored or assessed to ensure that they are consistently and correctly performed. EPA-registered disinfectants or detergents/disinfectants with label claims for use in healthcare should be selected for disinfection. Disinfectant products should not be used as cleaners unless the label indicates the product is suitable for such use. Healthcare professionals should follow manufacturer's recommendations for use of products selected for cleaning and disinfection (e.g., amount, dilution, contact time, safe use, and disposal).

Complete guidance for the cleaning and disinfection of environmental surfaces, including for cleaning blood or body substance spills, is available in the Guidelines for Environmental Infection Control in Health-Care Facilities (available at: http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf) and the Guideline for Disinfection and Sterilization in Healthcare Facilities (available at: http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf).

Key recommendations for cleaning and disinfection of environmental surfaces in outpatient settings:

1. Establish policies and procedures for routine cleaning and disinfection of environmental surfaces in the facility.
   a. Policies and procedures should also address prompt and appropriate cleaning and decontamination of spills of blood or other potentially infectious materials.
2. Select EPA-registered disinfectants or detergents/disinfectants with label claims for use in healthcare.
3. Follow manufacturer's recommendations for use of cleaners and EPA-registered disinfectants (e.g., amount, dilution, contact time, safe use, and disposal).

Medical Devices

Medical devices are labeled by the manufacturer as either reusable or single-use. Reusable medical devices (e.g., endoscopes) should be accompanied by instructions for cleaning and disinfection or sterilization as appropriate. Single-use devices (SUDs) are labeled by the manufacturer for only a single use and do not have reprocessing instructions. They may not be reprocessed except by entities which have complied with FDA regulatory requirements and have received FDA clearance to reprocess specific SUDs as outlined in FDA Guidance for Industry and FDA Staff (available at: http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm071434). Legally marketed SUDs are available from FDA-registered Third Party Reprocessors.

All reusable medical devices must be cleaned and maintained according to the manufacturer's instructions to prevent patient-to-patient transmission of infectious agents. The Spaulding Classification is a traditional approach that has been used to determine the level of disinfection or sterilization required for reusable medical devices, based upon the degree of risk for transmitting infections if the device is contaminated at the time of use.

- ❑ Critical items (e.g., surgical instruments) are objects that enter sterile tissue or the vascular system and must be sterile prior to use.
- ❑ Semi-critical items (e.g., endoscopes used for upper endoscopy and colonoscopy) contact mucous membranes or non-intact skin and require, at a minimum, high-level disinfection prior to reuse.
- ❑ Noncritical items (e.g., blood pressure cuffs) are those that may come in contact with intact skin but not mucous membranes and should undergo low- or intermediate-level disinfection depending on the nature and degree of contamination.
- ❑ Environmental surfaces (e.g., floors, walls) are those that generally do not contact the patient during delivery of care. Cleaning may be all that is needed for the management of these surfaces but if disinfection is indicated, low-level disinfection is appropriate.

Cleaning to remove organic material must always precede disinfection or sterilization because residual debris reduces the effectiveness of the disinfection and sterilization processes.

Facilities should establish policies and procedures for containing, transporting, and handling devices that may be contaminated with blood or body fluids. Manufacturer's instructions for reprocessing any reusable medical device in the facility (including point-of-care devices such as blood glucose meters) should be readily available and used to establish clear and appropriate policies and procedures. Instructions should be posted at the site where device reprocessing is performed. Responsibility for cleaning and disinfection or sterilization of medical devices should be assigned to HCP with training in the required reprocessing steps and in the appropriate use of PPE necessary for handling of contaminated devices. Competencies of HCP responsible for reprocessing of devices should be documented initially upon assignment of those duties, annually, and whenever new devices are introduced or policies/procedures change.

Recommendations for the cleaning, disinfection, and sterilization of medical devices, including general guidance on endoscope reprocessing are available in the Guideline for Disinfection and Sterilization in Healthcare Facilities (available at: http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf). Materials specific for the handling of blood glucose monitoring devices are also available. (http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html)

FDA regulations on reprocessing of single-use devices are available at: http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm071434 and http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/ReprocessingofSingle-UseDevices/default.htm.

Key recommendations for cleaning and disinfection or sterilization of medical devices in outpatient settings:

1. Facilities should ensure that reusable medical devices (e.g., blood glucose meters and other point-of-care devices, surgical instruments, endoscopes) are cleaned and reprocessed appropriately prior to use on another patient.
2. Reusable medical devices must be cleaned and reprocessed (disinfection or sterilization) and maintained according to the manufacturer's instructions. If the manufacturer does not provide such instructions, the device may not be suitable for multi-patient use.
3. Assign responsibilities for reprocessing of medical devices to HCP with appropriate training.
    a. Maintain copies of the manufacturer's instructions for reprocessing of devices in use at the facility; post instructions at locations where reprocessing is performed.
    b. Hands-on training on proper selection and use of PPE and recommended steps for reprocessing assigned devices should be provided upon hire (prior to being allowed to reprocess devices), annually, and when new devices are introduced or policies/procedures change.
        i. HCP should be required to demonstrate competency with reprocessing procedures (i.e., correct technique is observed by trainer) following each training.
4. Assure HCP have access to and wear appropriate PPE when handling and reprocessing contaminated medical devices.

Respiratory Hygiene/Cough Etiquette

Respiratory Hygiene/Cough Etiquette is an element of Standard Precautions that highlights the need for prompt implementation of infection prevention measures at the first point of encounter with the facility (e.g., reception and triage areas). This strategy is targeted primarily at patients and accompanying family members or friends with undiagnosed transmissible respiratory infections, and applies to any person with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions when entering the facility.

Additional information related to respiratory hygiene/cough etiquette can be found in the 2007 Guideline for Isolation Precautions (available at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf). Recommendations for preventing the spread of influenza are available at: http://www.cdc.gov/flu/professionals/infectioncontrol/.

Key recommendations for Respiratory Hygiene/Cough Etiquette in outpatient settings:

1. Implement measures to contain respiratory secretions in patients and accompanying individuals who have signs and symptoms of a respiratory infection, beginning at point of entry to the facility and continuing throughout the duration of the visit.
    - **a.** Post signs at entrances with instructions to patients with symptoms of respiratory infection to:
        - **i.** Inform HCP of symptoms of a respiratory infection when they first register for care,
        - **ii.** Cover their mouths/noses when coughing or sneezing,
        - **iii.** Use and dispose of tissues,
        - **iv.** Perform hand hygiene after hands have been in contact with respiratory secretions.
    - **b.** Provide tissues and no-touch receptacles for disposal of tissues.
    - **c.** Provide resources for performing hand hygiene in or near waiting areas.
    - **d.** Offer masks to coughing patients and other symptomatic persons upon entry to the facility, at a minimum, during periods of increased respiratory infection activity in the community.
    - **e.** Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible. If available, facilities may wish to place these patients in a separate area while waiting for care.
2. Educate HCP on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens.

Considerations Related to Transmission-based Precautions

The majority of outpatient settings are not designed to implement all of the isolation practices and other Transmission-Based Precautions (e.g., Airborne Precautions for patients with suspected tuberculosis, measles or chicken pox) that are recommended for hospital settings. Nonetheless, specific syndromes involving diagnostic uncertainty (e.g., diarrhea, febrile respiratory illness, febrile rash) are routinely encountered in outpatient settings and deserve appropriate triage. Facilities should develop and implement systems for early detection and management of potentially infectious patients at initial points of entry to the facility. To the extent possible, this includes prompt placement of such patients into a single-patient room and a

systematic approach to transfer when appropriate. When arranging for patient transfer, facilities should inform the transporting agency and the accepting facility of the suspected infection type.

Additional information related to Transmission-Based Precautions (contact precautions, droplet precautions and airborne precautions) can be found in the 2007 Guideline for Isolation Precautions (available at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf). Recommendations regarding management of multidrug-resistant organisms can be found in the Guideline for the Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006 (available at: http://www.cdc.gov/hicpac/pdf/guidelines/MDROGuideline2006.pdf)

Risk Assessment

Facilities are encouraged to use the *Infection Prevention Checklist for Outpatient Settings* (Appendix A), a companion to the summary guide, to periodically assess practices in their facility and ensure they are meeting the minimum expectations for safe care. In the course of auditing practices, facilities may identify lapses in infection control. If such lapses are identified, efforts should be made to correct the practices, appropriately educate HCP (if applicable), and determine why the correct practice was not being performed. In addition, consideration should also be made for determining the risk posed to patients by the deficient practices. Certain infection control lapses (e.g., reuse of syringes on more than one patient or to access a medication container that is used for subsequent patients; reuse of lancets) have resulted in bloodborne pathogen transmission and should be halted immediately. Identification of such lapses warrants immediate consultation with the state or local health department and appropriate notification and testing of potentially affected patients. Additional resources describing approaches to evaluation and management of infection control breaches identified in healthcare settings, including those involving lapses related to reprocessing of medical devices, can be found in CDC's Steps for Evaluating and Infection Control Breach (available at: http://www.cdc.gov/hai/outbreaks/steps_for_eval_IC_breach.html). In addition, for circumstances warranting patient notification, CDC has developed a Patient Notification Toolkit (available at: http://www.cdc.gov/injectionsafety/pntoolkit/index.html) to assist healthcare facilities with conducting a patient notification.

Conclusions

The recommendations described in the preceding document represent the absolute minimum infection prevention expectations for safe care in outpatient (ambulatory care) settings. This guidance is not all-encompassing. Facilities and HCP are encouraged to refer to the original source documents, which provide more detailed guidance and references for the information included in this document.