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A COMPREHENSIVE REVIEW OF THE ASC QAPI PROGRAM

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Agenda
Quality Management
Risk Management
QI Studies
Infection Control

Quality Management

Abbreviations:

QAPI
CQI
QA
QI

Required by CMS and AOs.

The QAPI Program encompasses and integrates quality improvement activities, risk management, peer review, and infection prevention.

§416.43 Condition for Coverage: Quality Assessment and Performance Improvement

- The ASC must develop, implement and maintain an **ongoing, data-driven** quality assessment and performance improvement (QAPI) program.

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Essentials to RM and QM Plans

- Plans must be in writing
- Approval by your Governing Board must be documented
- Implementation responsibilities must be clear
- Annual evaluation must be documented
- Documented education of plans must be provided to personnel and medical staff



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QAPI: GOALS OF PROGRAM

Documents the safety and quality of services provided in your facility

- Monitors effectiveness of services and quality of care
- Provides an ongoing system to identify “problematic events, policies or practices”
- Identifies areas for improvement
- Prompts action when issues are found
- Prompts evaluation of action taken



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Ongoing Evaluation

Conduct ***persistent and ongoing evaluation*** of the effectiveness of current services

- Clinical
- Business
- One-time issues
- Trends



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Ongoing Evaluation | Clinical

- Peer Review
- Safety Trend
- Pharmacy audits
- Medication Errors
- IC surveillance
- Revised policies
- Pathology Issues
- OSHA Issues
- MR Audits
- Safety Issues
- Environment audits
- Results of Drills



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Ongoing Evaluation | Business

- Evaluation of ancillary services annually
- Credentialing/Expiration date tracking
- Employee Satisfaction
- Physician Satisfaction
- Financial data and reports



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Ongoing Evaluation | One-Time & Trends

ONE TIME ISSUES

- Planned Action
- Follow up

TRENDS

- Planned Action and Follow up
- QI Study/PI Project



Quality Indicators



OUTCOMES / PATIENT SAFETY Indicators

Measure results of care.

Complication rates, healthcare-associated infection rates, cases exceeding 24 hours, transfers to hospitals, wrong site surgeries



PROCESS OF CARE Indicators

Measure how often the standard of care was met for patients with a diagnosis related to that standard.

Administration and time of prophylactic antibiotics



PATIENT PERCEPTION Indicators

Measure a patient's experience of the care he/she received in the ASC.

Patient satisfaction surveys, OAS CAHPS

Which quality indicators should I track?

- Adverse patient events
- Infections
- Patient Satisfaction
- High risk, high volume, problem prone
- # of and severity of issues
- ASC Measures
  - Patient Burn
  - Prophylactic Antibiotic Timing
  - Hospital Transfer
  - Patient Fall
  - Wrong site, side, patient, procedure, implant



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Which quality indicators should I track?

- Mandatory Reportable Indicators
  - State
  - Accrediting Body
  - Watch CMS
- Incident Report Trends
- Safety Report Trends
- Clinical, Administrative, Cost of care



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What do I do with the data?

- Benchmarking
  - internal and external
- QI Studies

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Quality Indicator Dashboard

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	GOAL	TOTAL
	QTR 1			QTR 2			QTR 3			QTR 4				
CLINICAL EFFECTIVENESS														
Number of postoperative infections													0	0%
Number of intra/postoperative complications													0	0%
Number of noncompliance with infection control plan (including timely preoperative prophylactic antibiotic administration)													0	100%
Number of patients experiencing a burn prior to discharge (ASC-1)													0	0%
Number of patients experiencing a fall prior to discharge (ASC-2)													0	0%
Number of patients that experienced a wrong site, side, patient, procedure, or implant event (ASC-3)													0	0%
Number of patients requiring a hospital transfer/admission (ASC-4)													0	0%
Number of average risk patients with appropriate follow-up interval for normal colonoscopy (ASC-9)													0	100%
Number of normothermic patients, if applicable (ASC-13)													0	100%
Number of patients with unplanned anterior vitrectomy, if applicable (ASC-14)													0	
Number of patients with pain being treated as effectively as possible													0	100%
Number of laser procedure exceptions, if applicable.													0	0%
ASC Quality Reporting (ASCQR) measures reported by deadline													0	100%
TRACKING OF IDENTIFIED ISSUES														
Number of procedures that time out was documented													0	100%
Number of charts with H&P completed and updated													0	100%
Number of charts reviewed that had documentation issues for nursing care													0	5%
Number of patients discharged without a physician order													0	0%
Number of Pharmacy Consultant report narcotic documentation issues													0	0%
Number of Pharmacy Consultant report pharmacy inspection concerns													0	0%
Number of physicians that were 15 minutes or more late to start procedures													0	0%
Number of patients receiving a postoperative phone call per policy													0	95%
Number of risk management incident reports													0	5%
RELATIONSHIPS														
Number of patients satisfied with the care and treatment they receive at this facility													0	95%
Physician satisfaction (measured yearly)													0	95%

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Benchmark Comparisons

- Look at the results
- Determine areas for improvement
- Take action
  - Short term action and plan for follow up
  - QI Study/PI Project

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External Benchmarking Resources

- ASCA Benchmarking
- MGMA
- AAAHC Institute for Quality Improvement
- ASC Quality Collaboration
- Literature/Journals
- State ASC Association
- PSS Facebook Group surveys



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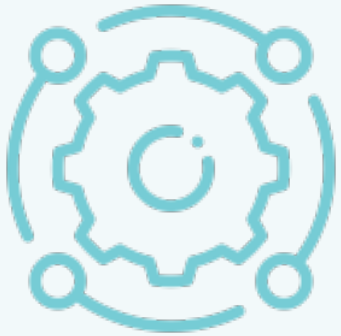
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Risk Management Definition

The process of minimizing risk to an organization by developing systems to identify and analyze potential hazards to prevent accidents, injuries, and other adverse occurrences, and by attempting to handle events and incidents which do occur in such a manner that their effect and cost are minimized.

Risk Management Definition

SYSTEMS



- Proactive risk assessments
- Procedures for identification and response to errors
- Ongoing evaluation of identified risk areas

ADVERSE OCCURENCES AND INCIDENTS



- Patient incident

EFFECT AND COST



- Poor patient outcomes
- Cost to business (licensure/liability claim)

Areas of Risk



Credentialing	Staff
Compliance	Equipment
Ancillary Contracting	Clinical Records
Coding/Billing	Sentinel Events
Peer Review	Safety Issues
Policies/Procedures	Patient Complaints
Facility	Incident Reporting Trends

Risk Assessment and Reduction

RISK ASSESSMENT

look at potential issues in all areas of risk

RISK MINIMINZATION

Develop and implement processes proactively

- Liability Insurance
- Environment: disaster drills
- Credentialing: clear procedures
- Formal reporting process
- Encouraging near miss reporting
- Review of complaints and grievances

RISK REDUCTION

Response to risk and continued assessment

- Procedures for response to errors
- Reporting Systems
- Monitor potential risks (trade magazines, sentinel event alerts)

Risk Management and Insurance Coverage



- Directors and Officers (D&O)
  - Protects directors and officers of a corporation from liability in the event of a claim or lawsuit against them asserting wrongdoing in connection with the company's business
- Property (Business and Personal)
- Commercial General Liability (Fire, damage, terrorism)
- Professional Liability (malpractice)
- Workman's Compensation
- Business Disruption Insurance
- Key Man Insurance
- Cyber Insurance

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Incident Reporting

Incident	Event that could lead to grave consequences
Variance	An event that varies from the normal standard of practice
Occurrence	Event that could lead to grave consequences of a legal nature
Adverse Event	An injury caused by medical management rather than the underlying condition of the patient
Sentinel Event	Resulted in an unanticipated death or major permanent loss of function, NOT related to the natural course of the patient's illness or underlying condition vs. adverse outcome which is primarily related to natural course of illness

Exception Reporting

Near Miss	Any event that has the potential to cause harm but doesn't result in injury or illness
Exception	Does not rise to the level of in incident



Document these in an "Exception Log

Reporting Systems

Incident, Variance, and Occurrence

WHY

- Tracking and trending incidents can provide data to standardize processes and reduce variation
- Analysis and of reporting data drives process improvement and patient safety initiatives
- Required to QAPI Committee, Governing Board
- Meets certain external agency requirements

CONTENTS

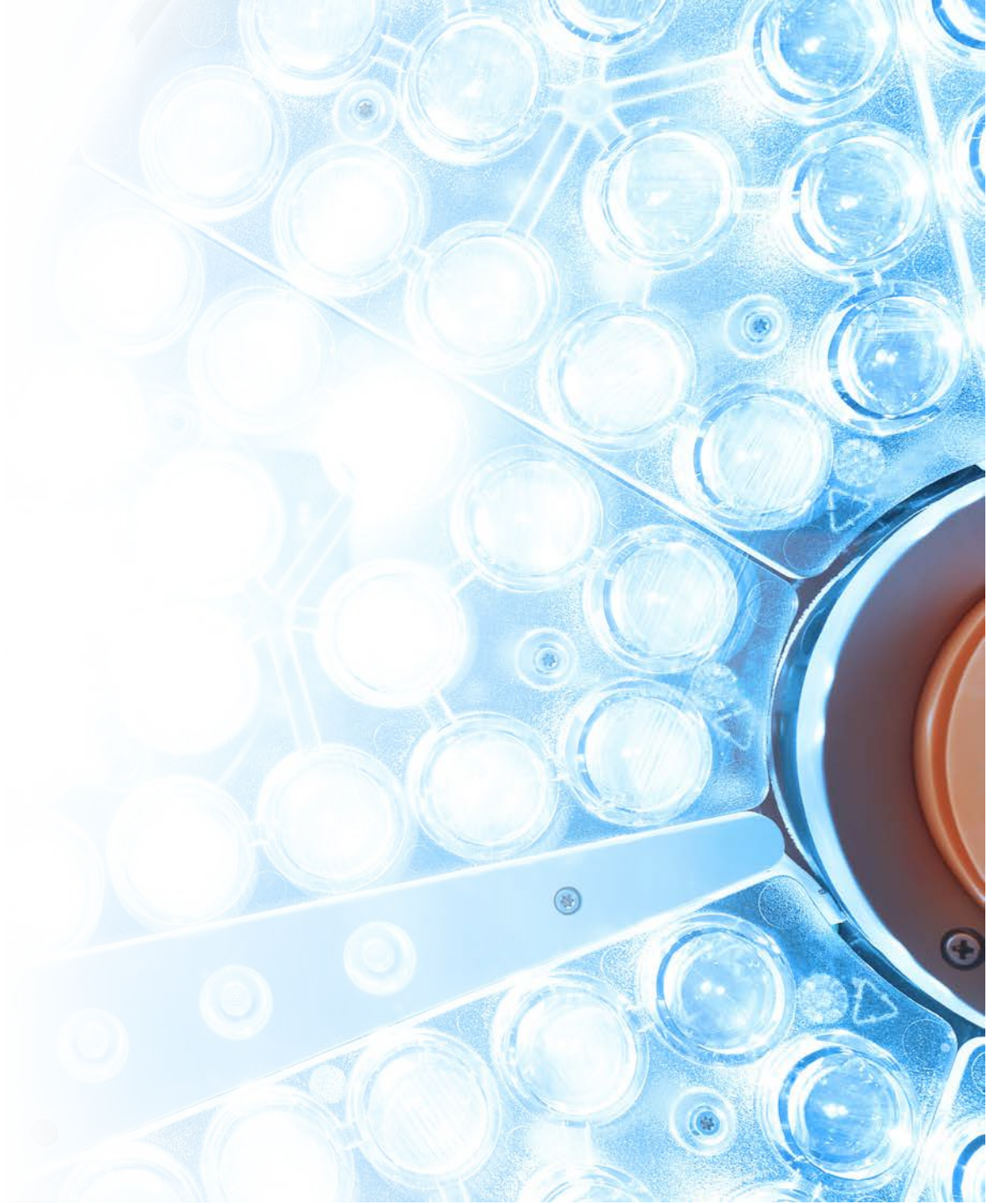
- Name and demographics of patient involved
- Time, date and location of incident
- Patient condition before and after incident
- Staff involved/witnesses
- Name of person who caused incident
- ***OBJECTIVE*** description of event, including “type” of event: fall, equipment, medication, security, etc.

QAPI Study

# of projects should reflect the scope of the ASCs services

Projects must be documented

- Reason for doing the study/project
- Data collected
- Activities of the project
- Actions taken



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QAPI Study Overview

A type of QAPI activity that includes corrective actions and/or other interventions to improve performance and demonstrates, through measurement, that performance improvement has occurred and is sustained.

1	**Definition**	Rationale for the study, what data or nationally-recognized recommendations revealed a problem?
2	**Goal**	What would you like to achieve?
3	Data Sources	Evidence of data collection, data collection tool
4	**Data Findings**	What did your data analysis reveal? How does it compare to the goal?
5	**Action Plan**	What actions will you take? How will you sustain improvement? Will you restudy?
6	Reporting Structure	Results reported to the staff and Governing Body

QAPI Study Format

Date:	
Name of Study:	
Definition:	This must include at a minimum, an explanation of why the study is undertaken. It should indicate what data collected in the facility or based on nationally recognized organizations leads the facility to believe that the project's activities will actually result in improvements in patient health outcomes and safety in the facility.
Goal:	
Data Sources:	
Data Findings:	Explanation of project results. Include verbiage regarding how data compares to the initial goal.
Action Plan:	If the study is unsuccessful, what action is taken as a result of that information? If successful, how is it being sustained? Include details of re-measurement timeframe, if applicable.
Reporting Structure:	The findings and results of this study will be reviewed with all staff at the next facility staff meeting. The findings and results of this study will be reported to the medical staff and Governing Body via the Medical Advisory Committee at the next quarterly meeting.

QAPI Study Format | AAAHC

Step	Standard Requirement	Hints for Getting Started
1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the facility	1. Briefly state your known or suspected problem 2. Describe why it is important for your facility to address this problem
2	Identification of the performance goal against which the facility will compare its current performance in the area of study	Determine and describe the level of performance your facility wants to achieve in the area of study
3	Description of the data that will be collected in order to determine the facility's current performance in the area of study	Determine the following: 1. Whether data is needed in order to verify: • Whether the problem actually exists • The frequency and severity of the problem expressed as a number or percentage • The source(s) of the problem 2. How will the data be collected?
4	Evidence of data collection	Describe the data you actually collected. You are not trying to describe your conclusions about the data – just the data itself.
5	Data analysis that describes findings about the frequency, severity, and source(s) or the problem(s)	1. Carefully analyze the data you have collected. 2. Determine what the data tells you about whether the suspected problem actually exists. Describe how the data was analyzed and your findings regarding whether or not the problem exists. 3. If the problem DOES exist, determine what that data tells you about the frequency, severity, and source(s) of the problem(s), and proceed to step 6. 4. If the problem DOES NOT exist, proceed as described in step 10, then choose another known or suspected problem and begin again.
6	A comparison of the facility's current performance in the area of study against the previously identified performance goal	Compare the results of your data analysis to the performance goal you identified in step 2.

Step	Standard Requirement	Hints for Getting Started
7	Implementation of corrective action(s) to resolve identified problem(s)	1. Based on what you have learned about the frequency, severity, and source(s) of the problem(s), determine what corrective action(s) you will take to improve your performance in the area of study. 2. Implement the selected corrective action(s) and determine the appropriate length of time until re-measurement is to occur.
8	Re-measurement to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement	1. At the designated re-measurement time, repeat the steps 4 and 5. 2. Compare the results of your second round of data collection and analysis to the performance goal you identified in step 2, and determine whether the corrective actions have achieved the desired performance goal.
9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved	1. Determine whether this step is applicable to the study you are conducting. If you have met and are sustaining your performance goal, this step does not apply. 2. If this step does not apply, repeat the steps 7 and 8 until your performance goal has been achieved in a sustainable manner.
10	Communication of findings of the quality improvement activities to the Governing Body and throughout the organization, as appropriate, and incorporation of such findings into the facility's educational activities	1. Report your QI study and its results to your Governing Body. Ensure that the GB's review of the report is appropriately documented. 2. Determine who else in the organization needs to know about the results of the study. Communicate the findings to those people, and document that this has occurred. 3. Determine whether other educational activities of the organization should reflect the findings of the study. If so, take appropriate steps to have this occur.

QAPI STUDY EXAMPLE

HAND HYGIENE

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Hand Hygiene

- Hand Hygiene is the single most important procedure for preventing Healthcare acquired infections. Underwood Ma. APIC Text 2005

- Keeping hands clean is one of the best ways to prevent the spread of infection and illness. CDC Text 2010

- On average, healthcare providers clean their hands less than half of the times they should. CDC 2016



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QAPI STUDY EXAMPLE

Hand Hygiene efficacy has not been assessed and is suspected to be substandard.

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QAPI STUDY EXAMPLE
Hand Hygiene

DEFINITION

Hand Hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel), or surgical hand antisepsis.

CDC, 2016

QAPI STUDY EXAMPLE
Hand Hygiene

GOAL

80%

adherence to
proper hand hygiene

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QAPI STUDY EXAMPLE
Hand Hygiene

DATA GATHERING

- Compliance with hand hygiene guidelines
- Efficacy of hand hygiene

QAPI STUDY EXAMPLE
Hand Hygiene

EFFICACY ANALYSIS W/ GLOGERM

- Glogerm was placed on each employee's hands
- Employees were asked to wash their hands.
- After washing we checked their hands with a black light which would detect these "glogerms".

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QAPI STUDY EXAMPLE
Hand Hygiene

RESULTS

Only 30%
cleaned their hands adequately

Most common places missed:

- Fingernails
- Side of hands
- Between the fingers





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We had to take ACTION!

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QAPI STUDY EXAMPLE
Hand Hygiene

Held education day and included an in-service on proper hand hygiene

- Showed a fun video produced by the CDC
- Demonstrated proper hand washing technique

ACTION
Education

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Hand Hygiene must occur:

- Before and after patient contact
- Before donning gloves
- After removing gloves
- When moving from a contaminated body site to a clean site
- When changing tasks
- Contact with inanimate objects (equipment)

QAPI STUDY EXAMPLE
Hand Hygiene

ACTION
Education

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Hand Hygiene with soap and water:

- When hands are visibly soiled
- Before and after eating
- After using the restroom
- Before starting day
- At the end of the day
- Before your first scrub (per AORN guidelines)

QAPI STUDY EXAMPLE
Hand Hygiene

ACTION
Education

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QAPI STUDY EXAMPLE
Hand Hygiene

Although we already had many stations where hand hygiene could have been performed, we posted reminders…

ACTION
Post Helpful Reminders

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Signs were placed throughout the facility.









QAPI STUDY EXAMPLE
Hand Hygiene

ACTION
Post Helpful Reminders

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Antiseptic foam was conveniently placed in the ORs with instructions for use (per DFU's)



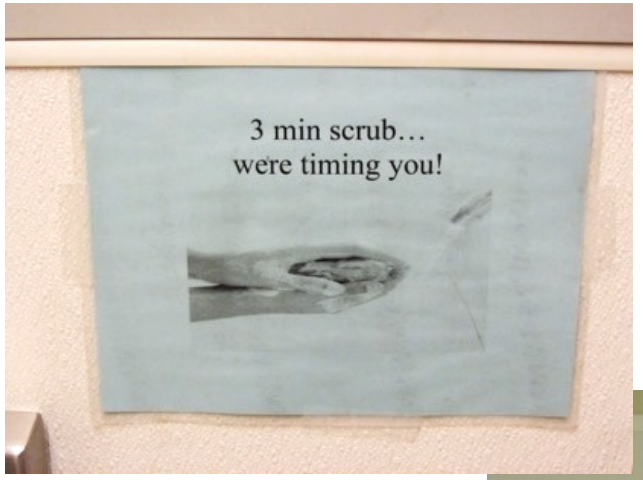
QAPI STUDY EXAMPLE
Hand Hygiene

ACTION
Post Helpful Reminders

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Signs were placed near scrub sinks to remind OR staff to follow facility surgical hand hygiene protocol





QAPI STUDY EXAMPLE
Hand Hygiene

ACTION
Post Helpful Reminders

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QAPI STUDY EXAMPLE
Hand Hygiene

Locations of alcohol-based hand rub was increased to include:

- By doorways in and out of the sterile area
- Patient and family waiting areas
- At front entrance
- At nurse station
- In OR's near charting areas

ACTION
Make it Convenient

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Bins were set up at each patient bay and included an alcohol-based hand rub



QAPI STUDY EXAMPLE
Hand Hygiene

ACTION
Make it Convenient

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QAPI STUDY EXAMPLE
Hand Hygiene

RE-STUDY EFFICACY

The next quarter we re-tested all employees with glogerm.

100%

passed glogerm test



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Written QAPI Study | Hand Hygiene

HAND HYGIENE EFFICACY

Step	Standard Requirement	
1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the facility	Hand hygiene efficacy has not been assessed in ASC. Ineffective hand hygiene is suspected based on industry literature. On average, healthcare providers clean their hands less than half of the times they should *CDC 2016.* Hand Hygiene is the **single most important** procedure for preventing Healthcare acquired infections *CDC 2016.*
2	Identification of the performance goal against which the facility will compare its current performance in the area of study	The hand hygiene efficacy rate will be 80%.
3	Description of the data that will be collected in order to determine the facility's current performance in the area of study	Data will be collected to assess effectiveness of hand hygiene for each staff member. Data will be collected through observation of black light results following Glogerm applications. Results will be number of employees without "glogerms" divided by total employees, resulting in a % effective.
4	Evidence of data collection	On April 1, 2016, observation of black light tests showing "glogerms" on each employee was conducted.
5	Data analysis that describes findings about the frequency, severity, and source(s) or the problem(s)	30% of the staff cleaned their hands adequately. Most common places missed were the fingernails, side of hands, between the fingers.
6	A comparison of the facility's current performance in the area of study against the previously identified performance goal	The facility current performance is 30%, compared with the facility goal of 80%.

HAND HYGIENE EFFICACY

Step	Standard Requirement	Hints for Getting Started

7	Implementation of corrective action(s) to resolve identified problem(s)	To implement the following by April 15, 2016
		• Hand hygiene inservice on April 10, 2016
		• Post helpful reminders
		  ○ Hand hygiene signs throughout facility
		  ○ Signs placed near scrub sinks to remind staff of protocols
		• Antiseptic foam conveniently placed with IFUs
		• Increase Alcohol based hand rub locations
		• Set up cubbys at patient bedside containing alcohol hand rub
		Re measurement will occur in 3 months.

8	Re-measurement to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement	On July 15, 2016, the same data collection technique was followed for all employees. 100% of employees showed effectiveness with hand hygiene. No "glogerms" were observed. The corrective actions have achieved and surpassed the desired performance goal.
9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved	N/A
10	Communication of findings of the quality improvement activities to the Governing Body and throughout the organization, as appropriate, and incorporation of such findings into the facility's educational activities	This QI Study was communicated to the QAPI Committee on July 20, 2016, the MEC on July 24, 2016 and the Governing Body on July 30, 2016.

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QAPI Study Ideas



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- Patient process
- Surgical cancellations
- Cost-per-case
- Patient privacy
- Surgical site identification
- Linen
- Patient wait times
- Trends (deviations from standard)
- Patient pain
- Benchmarking
- Time out
- Incident reports
- Near misses
- OR / Biohazard waste
- Hand hygiene
- Medical record documentation
- Radiation / Laser safety
- HLD / Sterilization
- Environmental cleaning
- Specialty specific

QAPI Committee Meeting | Agenda

I. Call to Order

II. Approval of Meeting Minutes <Date of Last Meeting>

III. Old Business

IV. New Business

A. Pharmacy and Therapeutics
- Formulary Edits
- Consulting Pharmacy Audits
- Medication Errors
- Other

B. Tissue
- Positive Lab/Pathology Reports
- Other

C. Infection Control
- Monthly Infection Control Queries
- Infection Control Surveillance Audits
- Postop Infection Investigation
- Hand Hygiene Monitoring
- Other

D. Medical Records
- Medical Records Audit
- Other

E. Patient Satisfaction
- Patient Satisfaction
- Patient Complaints and/or Grievances
- Other

F. Physical Environment
- Physical Environment Checklist/Audit
- OSHA
- Water Quality (ANSI / AAMI ST108)
- Other

G. Incident Reports
- Incident Report Summary
- Peer Review of Incident Reports
- Near Miss Reporting Summary
- Other

H. Performance Measures
- QI Indicator Monitoring Dashboard
- Cancellations
- Facility Utilization
- Other

I. QI Studies
- QI Study (current and planned)
- Benchmarking Study
- Other

J. Policies and Procedures
- New
- Revised
- Other

K. Business Operations
- Scheduling
- Other

V. Other Business

VI. Adjournment

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Annual Board Approvals

- Hazard Vulnerability Analysis
- Ancillary contract review and approval
- CEMP
- QAPI and Infection Control
- TB Risk Assessment
- Infection Control Risk Assessment
- Facility and Building Category Risk Assessment
- Wet OR Risk Assessment
- Delegations of authority



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INFECTION CONTROL

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Infection Control
Elements

- Infection Control Program
  - Assess your risk with IC Risk Assessment
- Surveillance of infections
- Investigation of infections



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Requirements

§416.51

Condition for Coverage

Infection Control

Infection Control

The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases.

- Approved by the GB, include formal risk assessment
- Prevent transmission of infection and/or communicable diseases
- Nationally recognized IC guidelines
- Directed by IC trained healthcare professional
- Ongoing
- Prevent, identify and manage infections and communicable diseases
- Mechanism to immediately implement corrective actions/preventive measures

Infection Control Program Must…

- Be integrated into the ASC’s QAPI program;
- Be ongoing;
- Include actions to prevent, identify and manage infections and communicable diseases; and
- Include a mechanism to immediately implement corrective actions and preventative measures that improve the control of infection within the ASC.

Need infection control policies
in addition to a program that is part of QAPI



Infection Control Program | Risk Assessment

INFECTION CONTROL RISK ASSESSMENT (ICRA)



A systematic process that identifies and prioritizes risks of infection in a facility, and then develops strategies to mitigate or eliminate those risks.

The goal of an ICRA is to prevent infections and reduce health risks to patients, visitors, and staff.

Resources:
https://apic.org/
https://progressivesurgicalsolutions.com/eSupport

Infection Control Program



- Current and customized to facility protocols
- Based on nationally recognized standards and guidelines
  - **AAMI** www.aami.org
  - **AORN** www.aorn.org
  - **APIC** www.apic.org
  - **CDC** www.cdc.org
- Policies should include all aspects of infection control
- Ensure they are reviewed and approved annually

Infection Control Program



Policies should include, at a minimum:

- Aseptic technique
- Communicable disease reporting
- Precleaning, decontamination, sterilization of instruments
- Environment (housekeeping)
- Hand hygiene
- Laundry care of reusable scrubs/linen
- Sterilization monitoring
- Operation of sterilizer
- Standard precautions
- Traffic patterns

Infection Control Program



- Quarterly general surveillance audits
  - Exhibit 351
- Surgeon queries
- Peer review (infections/complications)
- Infection investigations
- QAPI committee reporting
- Annual program evaluation

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Infection Control Program



- Upon hire and annually, at a minimum
- Document training/education/inservice
  - Infection control
  - Environmental disinfectants
  - Hand hygiene
  - Instrument processing



Thank You

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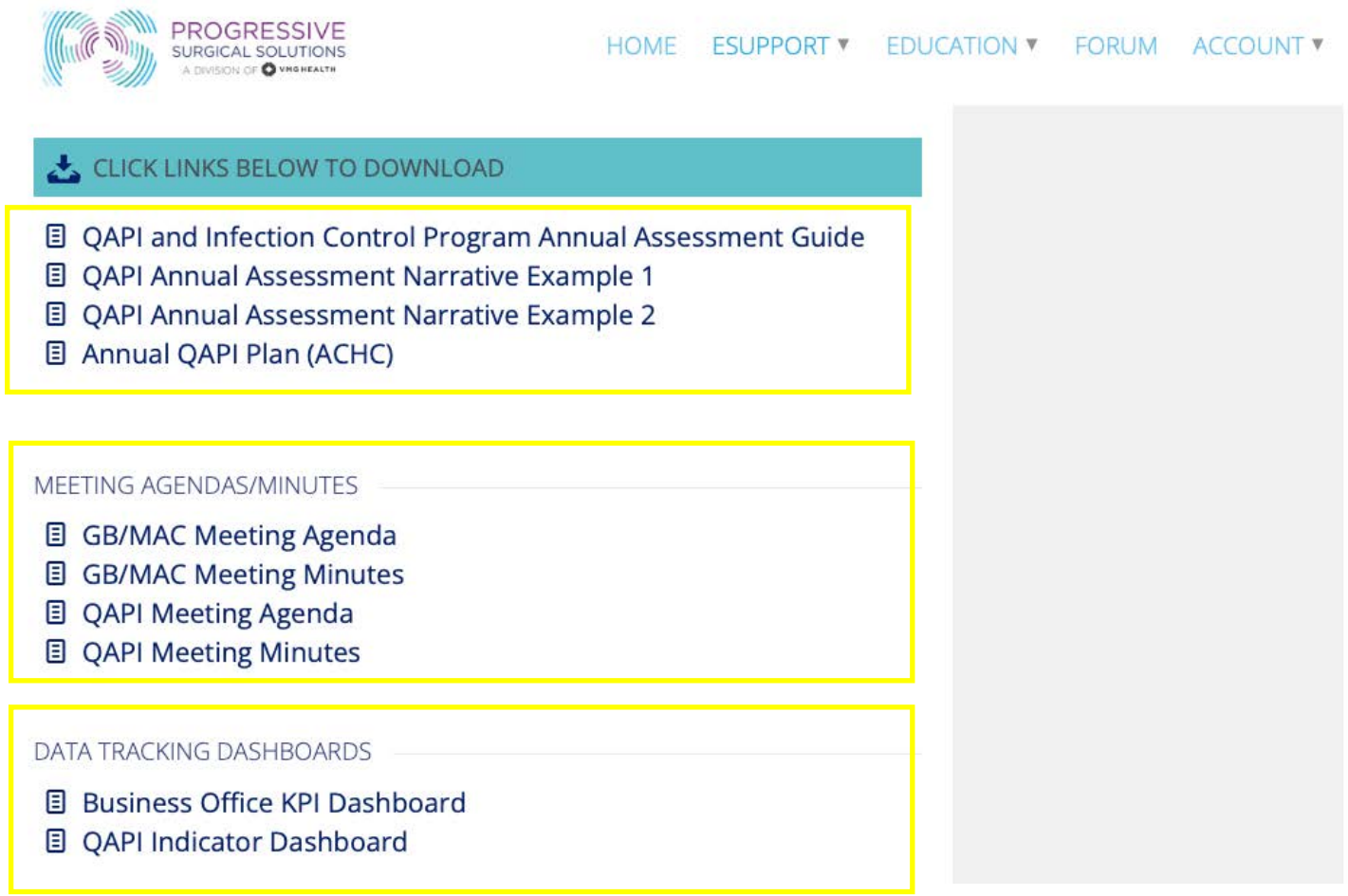
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Compliance & Operations > Quality Management

QI Dashboard, QAPI/GB Meeting Templates, Annual Assessment Guide





Compliance & Operations > Quality Management

QAPI Study Templates and Completed Samples



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QI STUDY FORMATS AND SUGGESTIONS

- Quality Improvement Study Format Sample
- Quality Improvement Study Format Sample (AAAHC)
- Quality Improvement Study Suggestions

QUALITY IMPROVEMENT STUDY SAMPLES

- A/R Benchmarking
- Biohazardous Waste
- Biohazardous Waste Re-Study
- Case Cancellation 1
- Case Cancellation 2
- CRNF (Closed Reduction Nasal Fracture Post-Operative Pain)
- Hand Hygiene 1
- Hand Hygiene 2
- I.C.E. (Limit Inflammation and Corneal Edema)
- R.I.C.E. (Limit Reoccurring Inflammation and Corneal Edema)
- Infection Control: Environmental Cleaning and Disinfection
- IV Necessity
- Medical Record Audits
- Medical Record Documentation 1
- Medical Record Documentation 2

Compliance & Operations > Infection Control

Infection Control Program Guidance and Tools



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INFECTION CONTROL: OVERVIEW

CMS Conditions for Coverage require that ASCs comply with the following standards:

416.51 Standard: Infection Control

The ASC must maintain an infection control program that seeks to minimize infections and communicable disease.

416. 51 (a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.

416.51 (b) The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is:
(1) Under the direction of a designated and qualified professional who has training in infection control
(2) An integral part of the ASC's quality assessment and performance improvement program; and
(3) Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.

CLICK LINKS BELOW TO DOWNLOAD

CMS Infection Control Surveyor Worksheet (2022)

SEARCH

INFECTION CONTROL

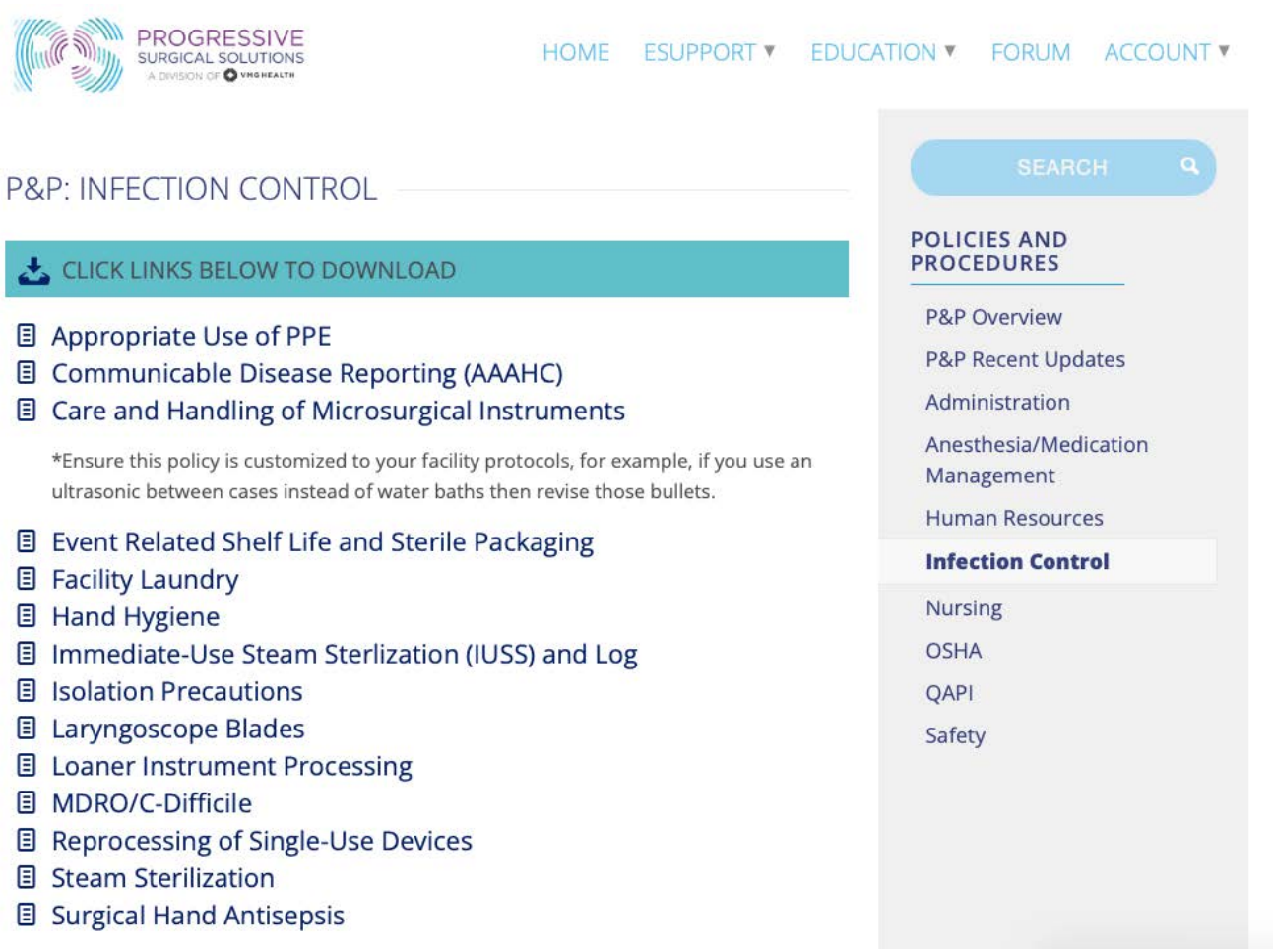
- **Infection Control Overview**
- Infection Control Coordinator
- Infection Prevention & Investigation
- Hand Hygiene
- Surgical Eye Prep
- Instrument Decontamination and Sterilization
- Environmental Sanitation
- Tuberculosis Control Program
- Vaccine Storage and Handling
- Water Quality
- Scope Processing
- Infection Control Resources
- COVID-19 & Influenza

Available to eSupport Members

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Compliance & Operations > Policies & Procedures > Infection Control

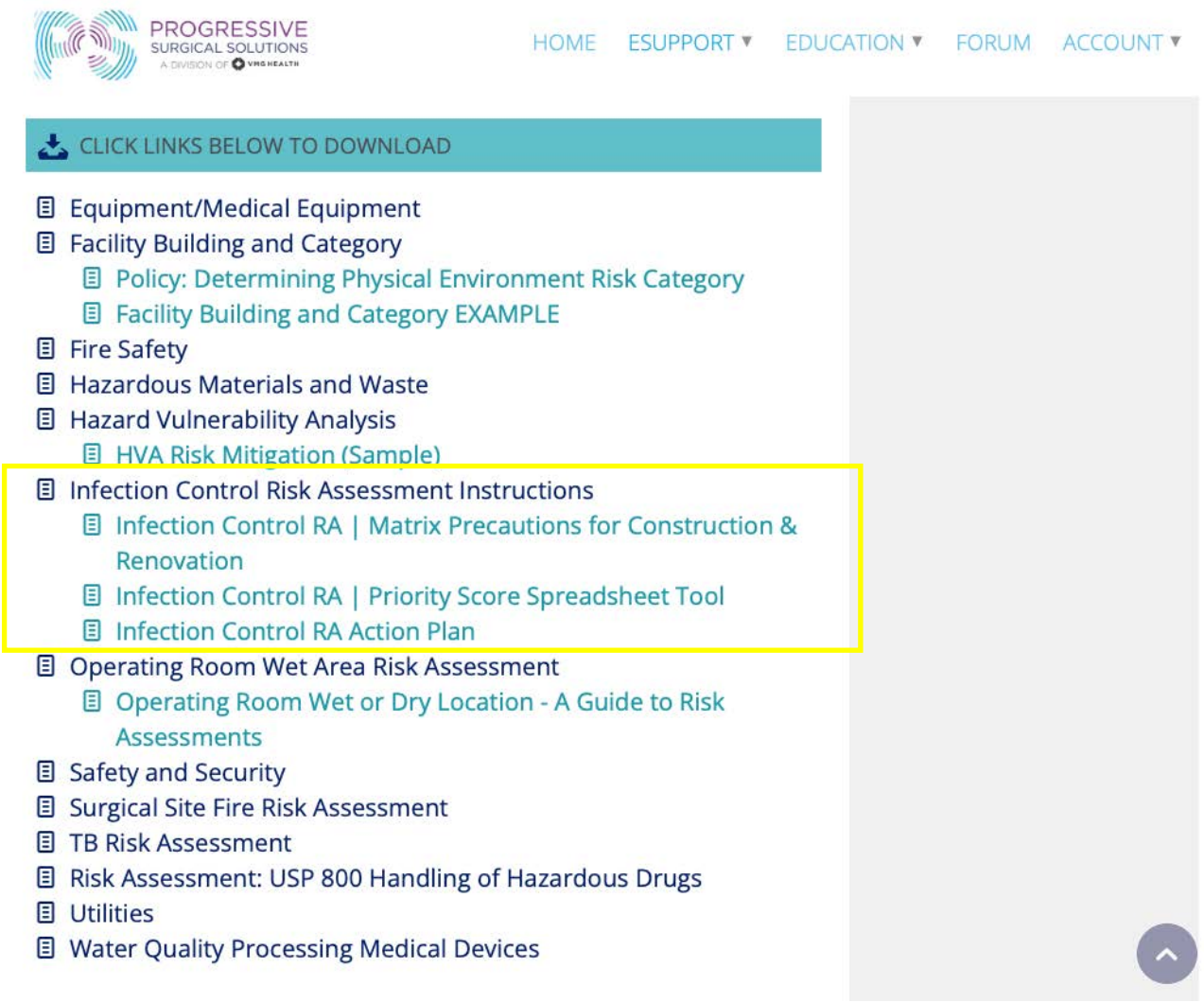
Infection Control Policy Samples



Compliance & Operations > Risk Assessments

Infection Control Risk Assessment





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Education > My CE Courses

QAPI Program, Infection Control 1 & 2







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Any questions regarding CE Credit, contact **Jenna@pss4asc.com**

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Upcoming Webinars

DATE		CE	WEBINAR TOPIC	SPEAKER
NOV 25	20		Annual Survey Watch Report 2024	Apryl McElheny
DEC 13	60	RN, CASC CAIP	Infection Control Risk Assessment: A Guided Review	Crissy Benze

www.ProgressiveSurgicalSolutions.com/webinars

2025
PSS WEBINAR CALENDAR
coming soon!



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ASC Quality Reporting Update

Gina Throneberry, ASC Association

Stay tuned for registration details in the New Year.