

General Infection Prevention and Control Assessment Tool for Investigation of Potential Healthcare-associated Viral Hepatitis Transmission

Transmission of HBV and HCV to patients has occurred in healthcare settings either from:

- Patient-to-patient transmission through infection prevention and control breaches when handling shared medications or patient equipment (e.g., administering injections, performance of blood glucose monitoring)
- Provider-to-patient transmission, largely through diversion of controlled substances by infected healthcare personnel
- Patient-to-patient transmission through infected blood, organs, and tissues*

*This assessment tool is not intended for assessment of transmission linked to blood, organs, and other tissues

Assessment, Checklist

During a site visit, health departments are encouraged to use the complete infection prevention and control checklist available at the following link (<http://www.cdc.gov/HAI/settings/outpatient/checklist/outpatient-care-checklist.html>) to assess practices in the facility. In addition to interviewing staff about practices in the facility, investigators should observe procedures, focusing on the same procedures/healthcare personnel who provided care to the index patient. Investigators should pay particular attention to medications or equipment used for more than one patient and any opportunities for diversion/theft of controlled substances by healthcare personnel.

Opportunities for transmission will depend on the healthcare setting and the types of procedures performed. For example, in a long-term care facility, investigation should not focus solely on employees of the facility but should also look at practices of healthcare personnel that provide periodic on-site services (e.g., podiatry, dental, home health agency personnel) and should consider practices of the individual residents (e.g., sexual activity in the facility, sharing of personal care equipment). Likewise, in a hospital, observations should not focus solely on the ward where the patient was admitted but should also focus on other areas of the hospital where the patient received care or had procedures performed (e.g., operating room, radiology, emergency department).

Need for notification

Certain inappropriate infection prevention and control practices (e.g., syringe reuse from patient to patient or to reenter medication vials used for more than one patient) have been documented on multiple occasions to result in bloodborne pathogen transmission. If these practices are identified by investigators during the site visit, they should be immediately corrected and should result in notification of all patients who were potentially exposed to these unsafe practices, regardless of identification of additional cases or source patients. CDC is available to assist with discussion of best practices surrounding patient notification if such practices are identified.