**Section 250.1100 Infection Control**

a) A hospital shall designate a person or persons as Infection Prevention and Control Professionals to develop and implement policies governing control of infections, communicable diseases, and Antibiotic Stewardship Programs. The Infection Prevention and Control Professionals shall be qualified through education, training, experience, or certification. The qualifications shall be documented.

b) A multidisciplinary Infection Control Committee, composed at least of members of the medical staff and nursing staff, the Infection Prevention and Control Professionals, and the supervisor of Central Sterile Supply and administration, shall be responsible for investigations and recommendations for the prevention and control of infections within the hospital. This Committee shall *perform an annual facility-wide infection control risk assessment.* (Section 6.23 of the Act)

c) Policies and procedures for reporting cases of communicable diseases and for the care of patients with communicable diseases shall be in accordance with the Control of Communicable Diseases Code, the Control of Sexually Transmissible Infections Code and the Control of Tuberculosis Code.

d) When patients having a communicable disease, or presenting signs and symptoms suggestive of that diagnosis, are admitted, proper precautionary measures shall be taken to avoid cross-infection to personnel, other patients, or the public.

e) The hospital shall provide facilities and equipment for the isolation of known or suspected cases of infectious disease.

f) Policies and procedures for handling infectious cases shall include orders for nursing and non-professional staffs providing for proper isolation technique.

g) *A hospital shall develop a policy for testing its water supply for Legionella* pneumophila *bacteria.* The policy shall be based on the ASHRAE publications "Managing the Risk of Legionellosis Associated with Building Water Systems" and "Legionellosis: Risk Management for Building Water Systems", and the Centers for Disease Prevention and Control's "Toolkit for Controlling Legionella in Common Sources of Exposure". *The policy shall include the frequency with which testing is conducted. The policy and the results of any tests* and corrective actions taken *shall be made available to the Department upon request*. (Section 6.29 of the Act) The policy shall include, at a minimum:

1) A procedure to conduct a facility risk assessment to identify potential Legionella and other waterborne pathogens in the facility water system;

2) A water management program that identifies specific testing protocols and acceptable ranges for control measures; and

3) A system to document the results of testing and corrective actions taken.

h) All persons who care for patients with, or suspected of having, a communicable disease, or whose work brings them in contact with materials that are potential conveyors of communicable disease, shall take appropriate safeguards to avoid transmission of the disease agent.

i) *The hospital shall develop and implement comprehensive interventions to prevent and control multidrug-resistant organisms (MDROs), including methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant enterococci (VRE), and certain gram-negative bacilli (GNB), that take into consideration guidelines of the Centers for Disease Control and Prevention for the management of MDROs in health care settings,* including the "Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" and "Guidelines for Hand Hygiene in Health-Care Settings". (Section 6.23 of the Act)

j) All hospitals shall comply with the Centers for Disease Control and Prevention publication "Guidelines for Infection Control in Health Care Personnel".

k) The multidisciplinary Infection Control Committee shall be responsible for developing, implementing, monitoring, and enforcing a hand hygiene program in the hospital. For the purposes of this Section, "hand hygiene" is a general term that applies to hand washing with plain soap and water; antiseptic hand wash using soap containing antiseptic agents and water; antiseptic hand rub using a waterless antiseptic product, most often alcohol based, rubbed on the surface of the hands; or surgical hand antiseptic.

1) The Committee shall assess the current practices and compliance, assess hand hygiene products that are currently being used, solicit input from clinical staff, and develop a hand hygiene program for all staff.

2) All staff (including contractual and medical) shall be educated in the hand hygiene program during initial orientation and at least annually. This education shall be documented.

3) The program shall have clear written goals that require quantitative, time-specific improvement targets.

4) The Committee shall develop and implement measurement tools to be used to assure ongoing compliance with the program.

5) The program shall incorporate the requirements for hand hygiene in educational materials presented to all staff on an ongoing basis; engage patients and families in the hand hygiene efforts; monitor compliance of all staff with recommended measurement tools for hand hygiene, including immediate feedback to personnel; and track compliance over time.

6) The results of the monitoring shall be incorporated in the Quality Assurance/Quality Improvement Program.

l) Contaminated material shall be handled and disposed of in a manner designed to prevent the transmission of the infectious agent.

m) Thorough hand hygiene shall be required after touching any contaminated or infected material.

n) Whenever the Control of Communicable Diseases Code and the Control of Tuberculosis Code require the submission of laboratory specimens for the release of a patient from isolation or quarantine and the hospital laboratory is not approved by the Department for the performance of the specific tests, the specimens shall be submitted to the laboratories of the Illinois Department of Public Health or other laboratory licensed by the Department for the specific tests required.

o) The hospital shall establish a systematic plan of checking and recording cases of infection, known or suspected, that develop in the institution; these cases shall be reported to the Infection Control Committee and hospital administration. The Committee shall be empowered and directed to investigate health care-associated infections to determine the causative organism and its possible sources. The findings and recommendations of the Infection Control Committee shall be reported to the medical staff and administration for corrective action.

p) Policies and procedures related to this Section and to the following items shall be developed:

1) The admission and isolation of patients with specific or suspected infectious diseases, and protective isolation of appropriate patients.

2) In-service education programs on the control of infectious diseases.

3) Policies and procedures for isolation techniques appropriate to the working diagnosis of the patient, and protective routines for personnel and visitors.

4) The recording and reporting of all infections of clean surgical cases to the Infection Control Committee, and procedures for the investigation of those cases.

q) *In order to improve the prevention of hospital-associated bloodstream infections due to methicillin-resistant Staphylococcus aureaus (MRSA), every hospital shall establish an MRSA control program that requires:*

1) *Identification of all MRSA-colonized patients in all intensive care units, and other at-risk patients identified by the hospital, through active surveillance testing.*

2) *Isolation of identified MRSA-colonized or MRSA-infected patients in an appropriate manner.*

3) *Monitoring and strict enforcement of hand hygiene requirements.*

4) *Maintenance of records and reporting of cases under Section 10 of* the *Act*. (Section 5 of the MRSA Screening and Reporting Act)

r) *Each hospital shall adopt, implement, and update* no less than every three years *evidence-based protocols for the early recognition and treatment of patients with sepsis, severe sepsis, or septic shock (sepsis protocols) that are based on generally accepted standards of care. Sepsis protocols shall include components specific to the identification, care, and treatment of adults and of children, and shall clearly identify where and when components will differ for adults and for children seeking treatment in the emergency department or as an inpatient. These protocols shall also include the following components*:

1) *A process for the screening and early recognition of patients with sepsis, severe sepsis, or septic shock*;

2) *A process to identify and document individuals appropriate for treatment through sepsis protocols, including explicit criteria defining those patients who should be excluded from the protocols, such as patients with certain clinical conditions or who have elected palliative care*;

3) *Guidelines for hemodynamic support with explicit physiologic and treatment goals, methodology for invasive or non-invasive hemodynamic monitoring, and timeframe goals*;

4) *For infants and children, guidelines for fluid resuscitation consistent with current, evidence-based guidelines for severe sepsis and septic shock with defined therapeutic goals for children*;

5) *Identification of the infectious source and delivery of early broad spectrum antibiotics with timely re-evaluation to adjust to narrow spectrum antibiotics targeted to identified infectious sources; and*

6) *Criteria for use, based on accepted evidence of vasoactive agents*.

s) *Each hospital shall ensure that professional staff with direct patient care responsibilities and, as appropriate, staff with indirect patient care responsibilities, including, but not limited to, laboratory and pharmacy staff, are periodically trained to implement the sepsis protocols required under subsection* (r). *The hospital shall ensure updated training of staff if the hospital initiates substantive changes to the sepsis protocols*.

t) *Each hospital shall be responsible for the collection and utilization of quality measures related to the recognition and treatment of severe sepsis for purposes of internal quality improvement*.

u) *The evidence-based protocols adopted* by the hospital *under* Section 6.23a of the Act *shall be provided to the Department upon the Department's request*.

v) *Hospitals submitting sepsis data as required by the Centers for Medicare and Medicaid Services Hospital Inpatient Quality Reporting Program are presumed to meet the sepsis protocol requirements outlined in this Section*. (Section 6.23a of the Act)

(Source: Amended at 46 Ill. Reg. 15597, effective September 1, 2022)