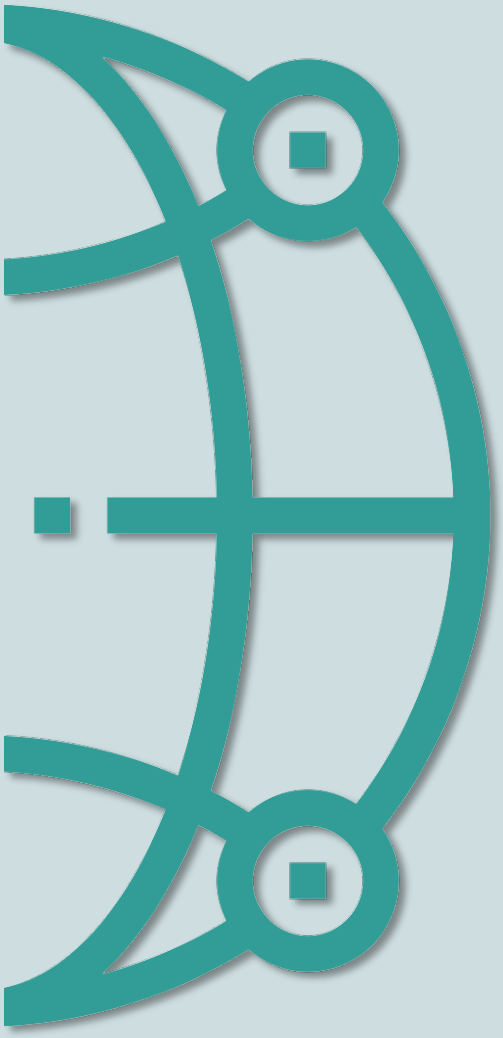
WA State Project Firstline

Infection Control

Needs Assessment Report

The WA DOH Healthcare-Associated Infections & Antimicrobial Stewardship Section's report on the Learning Needs Assessment conducted in 2021 in collaboration with CDC's Project Firstline.



Washington State Department of Health

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Executive Summary

The Project Firstline program initiated by the Centers for Disease Control and Prevention (CDC) aims to educate and train frontline healthcare workers across the nation about infection prevention and control (IPC) practices through partnerships and collaboration with jurisdictions. The Washington State Department of Health is collaborating with CDC to educate and train Washington frontline healthcare workers on IPC practices through Project Firstline. One of our first activities for Project Firstline was to conduct a Learning Needs Assessment (LNA) of Washington frontline healthcare workers.

The goal of the LNA was to gather more specific demographic information, understand gaps in IPC training, desired IPC topics, and preferred training delivery methods. The LNA was conducted from February 1, 2021 to March 26, 2021 using the Opinio online survey platform.

A total of 2,930 responses were analyzed. Because 78% of the job roles had less than 100 respondents, workplace setting was used as a proxy throughout data analysis. Most of the respondents stated having 10 or more years of experience in their job role. Preference in training method for respondents was on their own time or by listening to a person talk live. Electronic or printed materials are the post-training support methods respondents would find most useful. All listed settings in the LNA had respondents who said they have not had previous infection control training, or they preferred not to say. Among COVID-19 educational topics, triage and screening was a top pick for additional training.

Future infection control trainings will be prioritized by topics that are most desired by the frontline healthcare workforce and the topics of most need for education and training. Level of education, experience, preferred language, and preference in training platforms and post-training support will also be taken into consideration and prioritized. Providing Continuing Education Units (CEUs) and Certificates of Completion for the trainings will also be advised to incentivize participation.

In this Learning Needs Assessment Report, the words respondent and participant are used interchangeably.

Acknowledgements

The Project Firstline Learning Needs Assessment would not have been successful without the Washington State Department of Health Healthcare-Associated Infections and Antimicrobial Resistance (HAI & AR) Section and the University of Washington's Northwest Center for Public Health Practice. Please see Appendix A for additional stakeholder acknowledgement.

Purpose

The purpose of the Washington State Department of Health's (DOH) Project Firstline Learning Needs Assessment was to identify gaps and preferred delivery methods in infection prevention and control training among frontline healthcare workers in the state of Washington.

Methods

The following subsections describe methods used to collect data, strengths and limitations of information collected, and key participants involved in the Learning Needs Assessment (LNA).

Data Collection

The method used to collect data was through an online survey platform called Opinio, open from February 1, 2021 to March 26, 2021. The outline of the LNA was provided by CDC and slightly modified to fit Washington's demographics and program goals. The survey was accessible from a computer, laptop, or mobile device (iPad, tablet, iPhone, or Android). There were 29 main questions in the LNA. However, if you selected "neutral," "disagree," or "strongly disagree" on six of the 29 questions, four additional Likert Scale questions were asked. The LNA contained Likert Scale and choice questions. The choice questions ranged from "select one," "select all that apply," or, if the respondent chose "other," "please specify." Likert Scale questions were asked on a "dislike," "might," "like" scale or "strongly disagree," "disagree," "neutral," "agree," "strongly agree" scale. The survey was disseminated through mass email distribution lists, newsletters, presentations, and social media (e.g., Facebook, Instagram, LinkedIn, and Twitter).

Strengths and Limitations

Strengths

The Washington State Department of Health's HAI & AR Section has strong relationships with the state's local health jurisdictions and outside stakeholders, strengthening the LNA. The close

relationships allowed us to easily promote our survey. The stakeholders were willing to share the survey multiple times and allowed us to present at meetings to spread the word. Through these stakeholders, we were able to network and connect to other organizations. We also posted on social media (Facebook, Instagram, LinkedIn, and Twitter), with the ability to target the relative audiences.

Another strength to the survey was the lower literacy level. As the survey was only provided in English, we tried to encourage broad participation by reducing the literacy level to a junior high school reading level.

Limitations

Limitations to our Learning Needs Assessment included a low number of survey responses, survey fatigue, and short turn-around time. The LNA was distributed on twelve GovDelivery lists which included a total of 88,290 individual emails of licensed healthcare providers. However, we could not track response rate as we do not know the exact number of people our survey reached through the mass distribution outlets. Based on the GovDelivery lists and knowing the LNA was further shared by stakeholders, we can assume a low response rate as we obtained a total of 3,308 responses (see Key Participants for specific distribution). The LNA also contained 29 questions. Six of the 29 questions contained four additional questions asking the level to which one agreed or disagreed with the statement. The numerous and repetitive questions could have contributed to survey fatigue and drop out. The LNA was only open for 54 days. It was difficult to continue promotion and send out survey reminders in this short time.

The survey was only provided and promoted online. If the audience did not have access to the internet, they could not have taken the survey, reducing the number of frontline healthcare workers we potentially could have reached. Although we were able to post on social media, we were only able to post twice due to competing needs from other areas of the agencies for social media exposure. As the LNA was distributed in the middle of the COVID-19 pandemic response, our state prioritizes social media posts on COVID-19 topics (vaccination, testing, protective measures, etc.). Due to DOH staff working from home, it was not feasible to provide flyers or posters to many of the targeted workplaces without asking them to print the flyers on their already stretched budget. Additionally, the LNA results demonstrated the respondents being more experienced in their field of work. This could be due to unintentional selection bias. We were not able to provide an incentive for partaking in our LNA. Our motivation for participants was the impact they would have on their future. By not having a tangible incentive, people may not be motivated to fill out a survey, contributing to a limitation in survey responses.

Washingtonians were not familiar with Project Firstline when we first began. We were promoting both the program and the LNA at the same time. Promotion of two projects at once with limited ability on communication posts and outreach could have hindered participation.

Lastly, the ongoing COVID outbreaks and need for response across the state of Washington was a limitation to survey distribution and survey response.

Key Participants

The Learning Needs Assessment (LNA) was distributed across Washington through various stakeholders and reached a wide variety of frontline healthcare occupations and settings. The total number of people the survey reached is unknown as the survey link was sent through mass email distribution lists (Listservs and GovDelivery) and posted in weekly and monthly bulletins and newsletters. Of the information that was received for number of recipients, the survey went out to the following:

- 4,000 rural health subscribers (rural hospitals and health clinics; DOH GovDelivery)
- 2,829 EMS providers on a DOH GovDelivery email subscription
- 4,000 DSHS licensed facilities and supported living agencies (DOH GovDelivery)
- 77,461 subscribers (DOH GovDelivery) to the following groups:
    - Board of Hearing and Speech
    - Dental
    - Medical Assistant
    - Naturopathy Program
    - Nursing Pool
    - Osteopathic Board
    - Physical Therapy Program
    - Radiologic Technology
    - Surgical Technology

In addition to the estimated 88,290 recipients listed above, the survey was also distributed to the following groups:

- Adult Family Home Council (newsletter)
- APTA WA - American Physical Therapy Association Washington (newsletter)
- Association for Professionals in Infection Control and Epidemiology (APIC) Puget Sound Chapter (post on community announcement board and chapter meeting)
- Community Healthcare Workers (DOH newsletter)
- Home Care and Home Health subscribers (DOH GovDelivery)
- LeadingAge (newsletter)
- Local Health Jurisdiction representatives (DOH Listserv)
- Nursing Assistants (DOH GovDelivery)
- Nursing Care Quality Assurance Commission (DOH GovDelivery)
- Occupational Therapy (DOH GovDelivery)

- W4A - Washington Association of Area Agencies on Agencies (regular communication with members, distributing upon communication)
- WA DOH - Washington State Department of Health social media followers (social media post- Facebook (2), Twitter (2), Instagram (1), and LinkedIn (1); targeted towards healthcare professionals)
- WHCA - Washington Health Care Association (newsletter)
- WOTA - Washington Occupational Therapy Association (newsletter and Facebook post)

The LNA was created by CDC's Project Firstline and was adapted to fit the demographics of Washington and the goals of the WA DOH's Project Firstline Program. The editing of the LNA was made possible by the University of Washington's Northwest Center for Public Health Practice (NWCPHP), WA DOH Center for Public Affairs (C4PA), WA DOH Healthcare-Associated Infections and Antimicrobial Resistance Section (HAI & AR), and WA DOH Home Care and Home Health section. Once completed, the LNA data was analyzed by WA DOH's HAI & AR Epidemiology team.

Key Findings

At the close of the survey there were 3,308 stored responses. Of those, 2,360 were completed survey responses (all applicable fields were completed). 300 responses met role requirements but were missing some data. Out of the survey responses 378 were excluded due to no data or lack of sufficient answers. A total of 2,930 survey responses were analyzed.

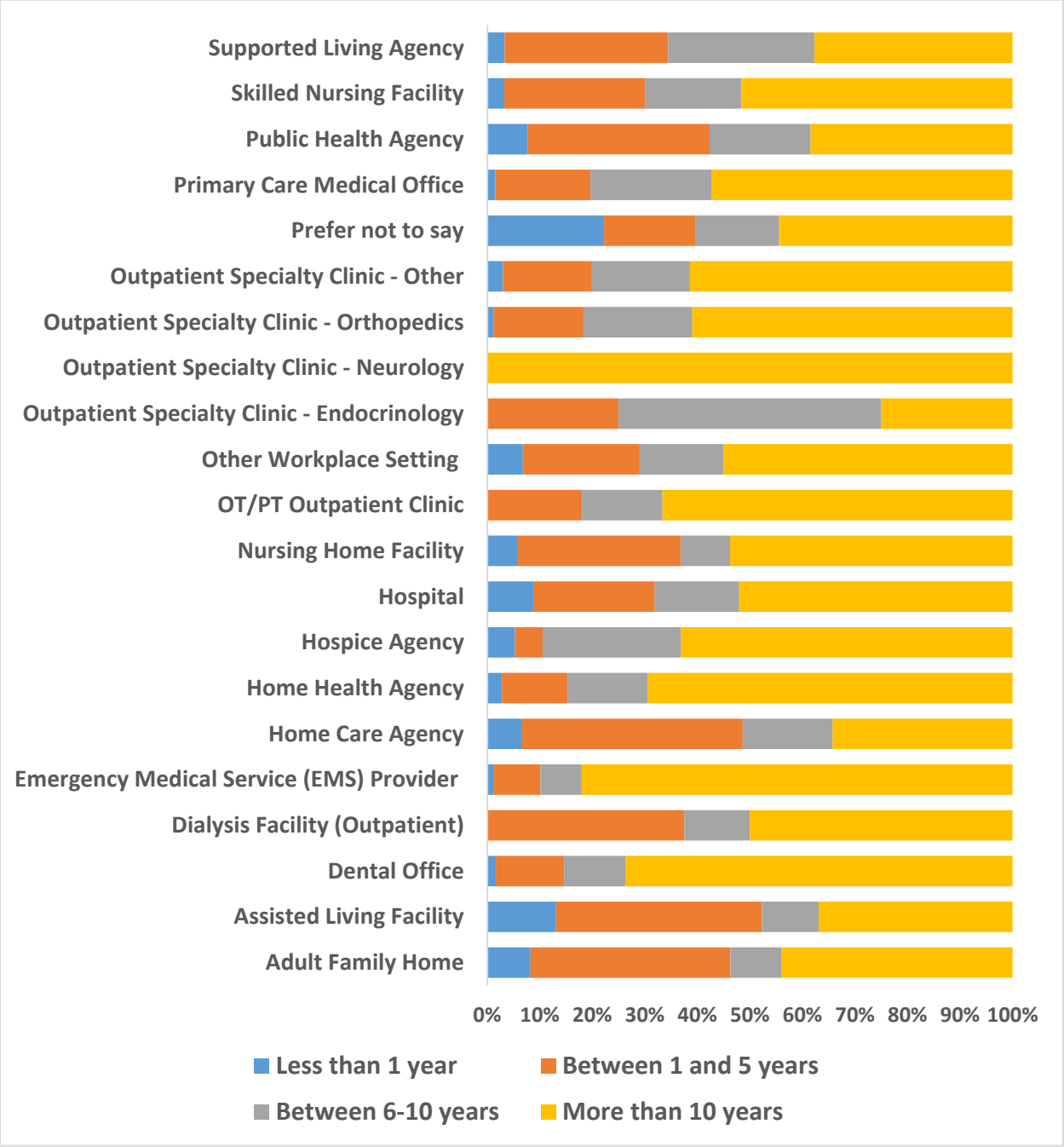
Of the 2,930 survey responses, the respondents work in the following roles:

- Adult Family Home Manager/Owner
- Allied Health, Behavioral Health (Unspecified)
- Community Health Worker
- Dental Assistant
- Dental Hygienist
- Dentist
- Dietitian/Dietary Staff
- EMT/Paramedic
- Epidemiologist
- Health Educator
- Healthcare Administrator
- Home Health or Home Care Aide
- Infection Preventionist
- Laboratorian/Phlebotomist
- Medical Assistant
- Non-Clinical Support Staff
- Nurse Practitioner
- Licensed Nurse
- Registered Nurse
- Nursing Assistant (NA, CNA)
- Occupational Therapist
- Occupational Therapy Assistant
- Personal Care Aide
- Pharmacist/Pharmacy Staff
- Physical Therapist
- Physical Therapy Assistant
- Physician

- Physician Assistant
- Psychiatric Aide
- Regulatory/Quality Improvement
- Social Worker (including Case Management, Care Coordination, Community Health Worker)
- Speech Therapist
- Supported Living Staff (Unlicensed)
- Technician

Because 78% of the roles had less than 100 respondents, their feedback cannot be generalized for that field of work. Setting was used as a proxy throughout our data analysis. Most respondents reported six or more years of work experience in their field (Figure 1).

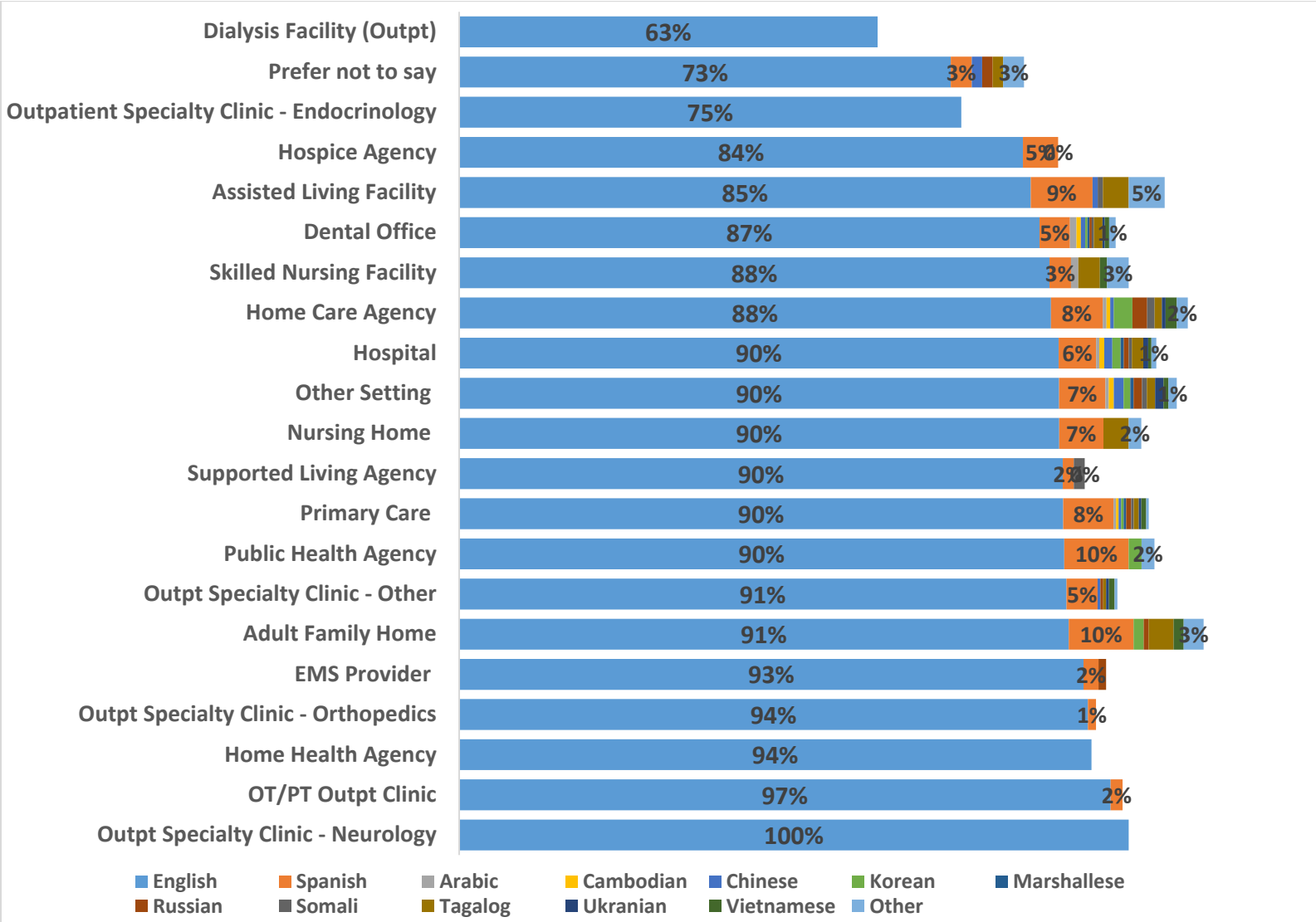
Fig. 1: Years of Experience by Setting



The LNA was only provided in English at a junior high school literacy level. The results showed English (Average 88%) as the preferred language followed by Spanish (Average 5%) (Figure 2). At least 13 other languages were also reported. For the question shown in Figure 2 on language preference, 356 participants did not answer the question or chose no for all options. It was also possible for the participant to choose more than one option. For these reasons, not all categories will add up to 100%.

Previous experiences and findings have shown that employees (healthcare workers) prefer to take trainings in English as they must take certification tests in English, with Home Care Aides as a notable exception. Reference Appendix B for demographic data analysis.

Figure 2: What language(s) do you like to take trainings in? (Select all that apply.)

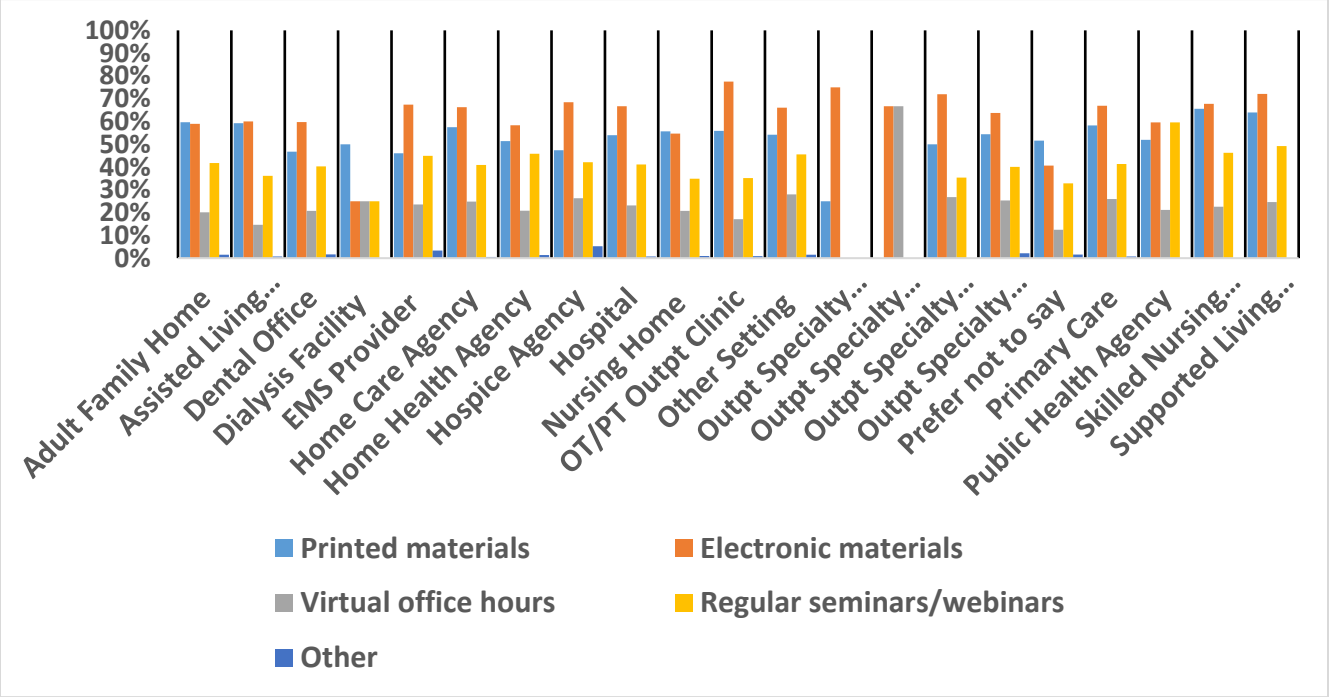


Other languages: American Sign Language, French (several), Swahili (several), Amharic (several), and Omoro

Participants in the LNA prefer to take trainings on their own and listen to a person talk live, as opposed to talking with a group of peers or talking with an expert. When asked between live or recorded training, there was a tie between live online and watch a recording. There is an overall preference for live trainings, whether live in person (when safe, as the LNA was conducted during COVID-19 pandemic) or live online. The training options that were preferred for online methods were webinars (e.g., Zoom, Microsoft Teams, etc.) or online learning platforms (e.g., Canvas) rather than YouTube or Podcast. See Appendix C for full training data analysis.

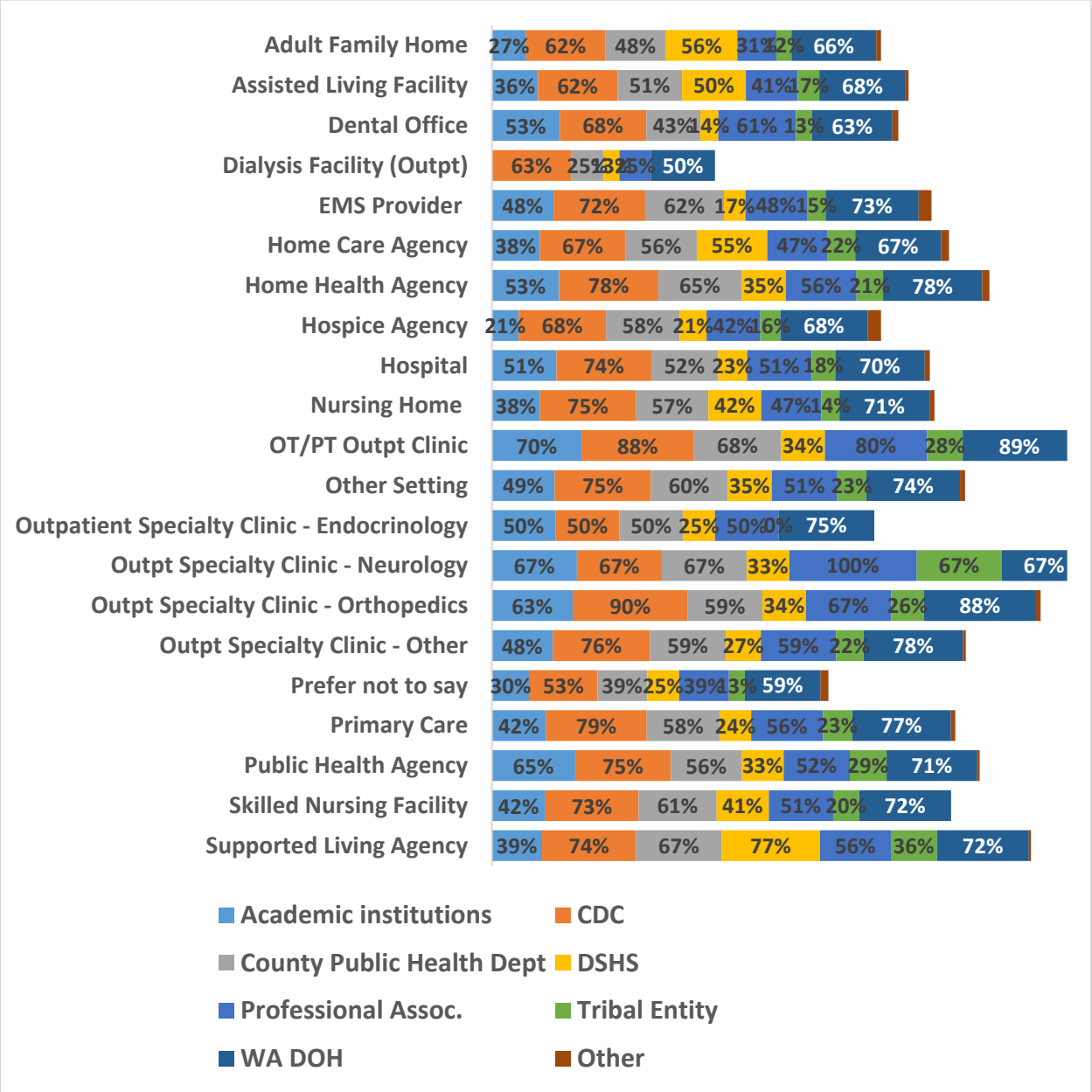
To support the participants post-training, the highest preference throughout all settings was either electronic materials or printed materials (Figure 3). WA DOH and CDC were consistently voted as trusted organizations across all settings (Figure 4).

Figure 3: Post-Training Support



Other: scientific papers supporting the use of infection control practices, ability to ask questions (several), local contacts for guidance.

Figure 4: Trusted Organizations for Infection Control Trainings



Other: WA Adult Family Home Council, Academy of General Dentistry, certified OSHA/WSHA instructors, EMS connect, EMS online, independent agencies (non-governmental), naturopath professionals, military medical

The data related to topics and training for infection control (IC) demonstrates that there is a great need for Project Firstline. While the majority of respondents reported prior participation in IC, there were respondents in each setting type that reported no prior infection control training, with the highest reports from outpatient endocrinology (33%) and adult family home (16%) (Figure 5). The highest trained topics were hand hygiene and PPE while the lowest trained topics were triage and screening and COVID-19 (Figure 6). When asked what IC topics they would like to have additional training on, the top two selections were COVID-19 (Average

41%) and triage and screening (Average 37%) (Figure 7). Comments submitted in the "other" section reflected wanting to know more about infection control in dental settings, disinfection and sterilization of dental/medical instruments, how to improve infection control compliance (staff, patients, providers, etc.), infection control refreshers, and how to talk about vaccination fears for Black, Indigenous, and People of Color (BIPOC) (Figure 7).

Figure 5: Have you ever had training in infection control?

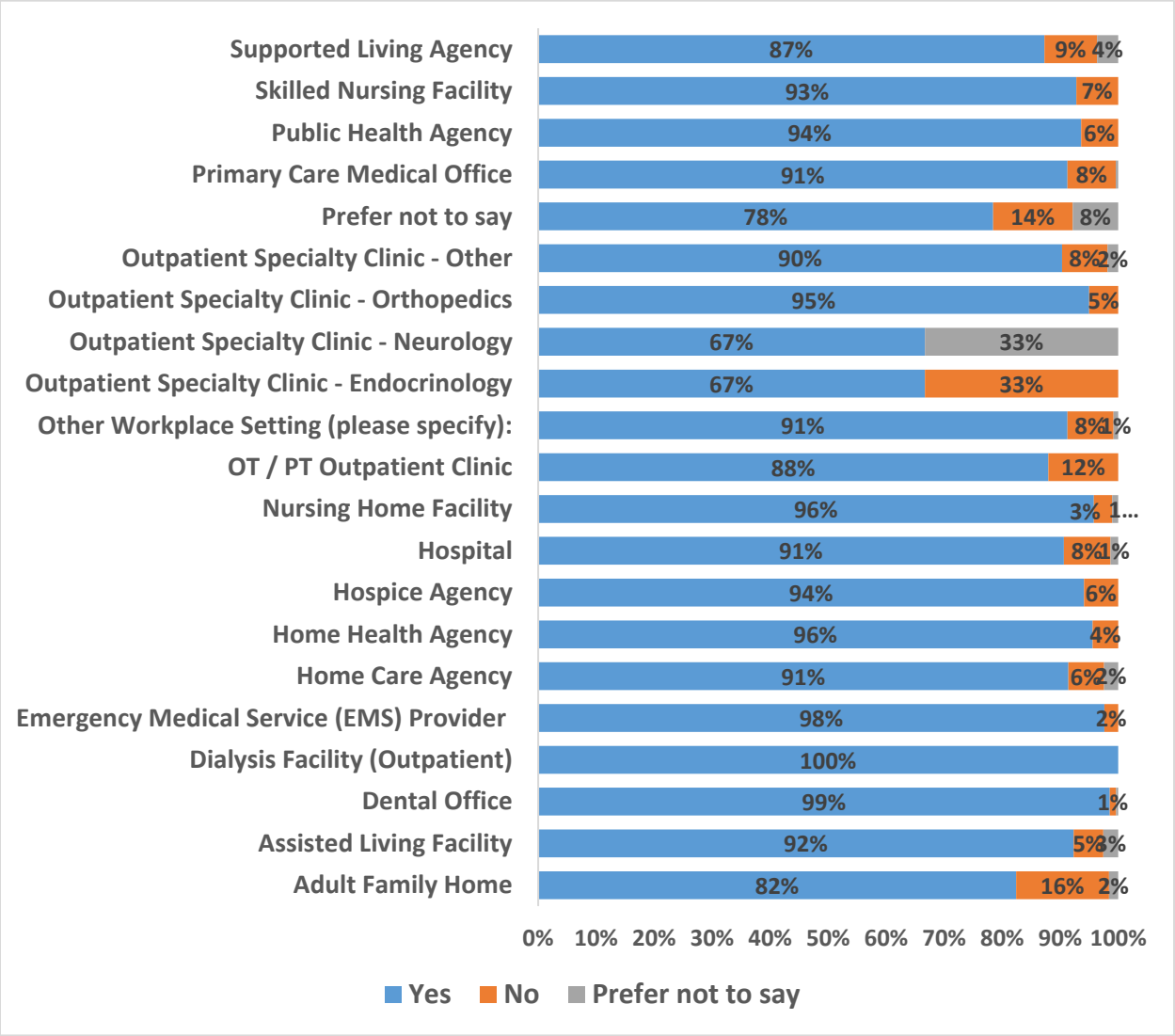
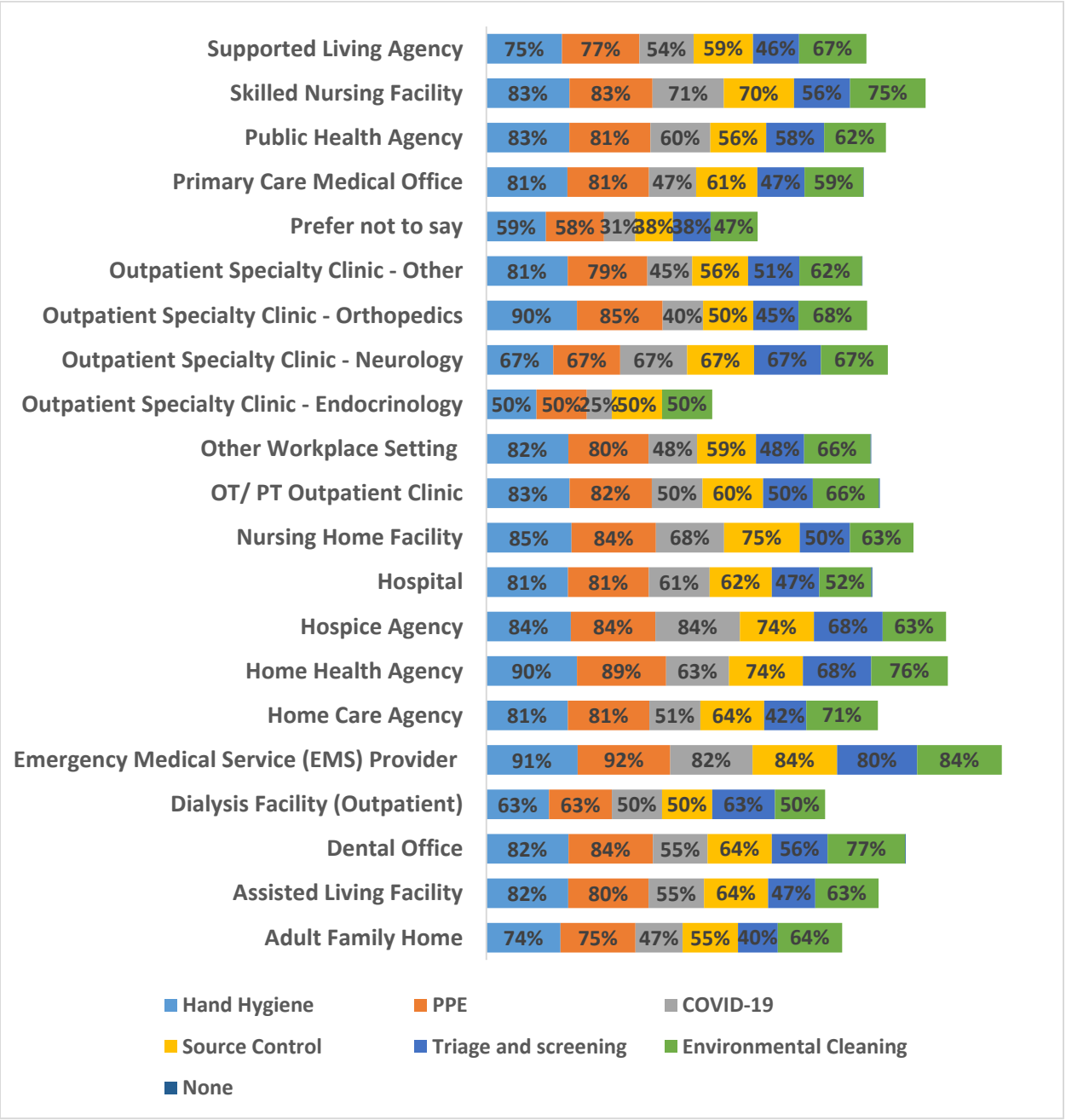
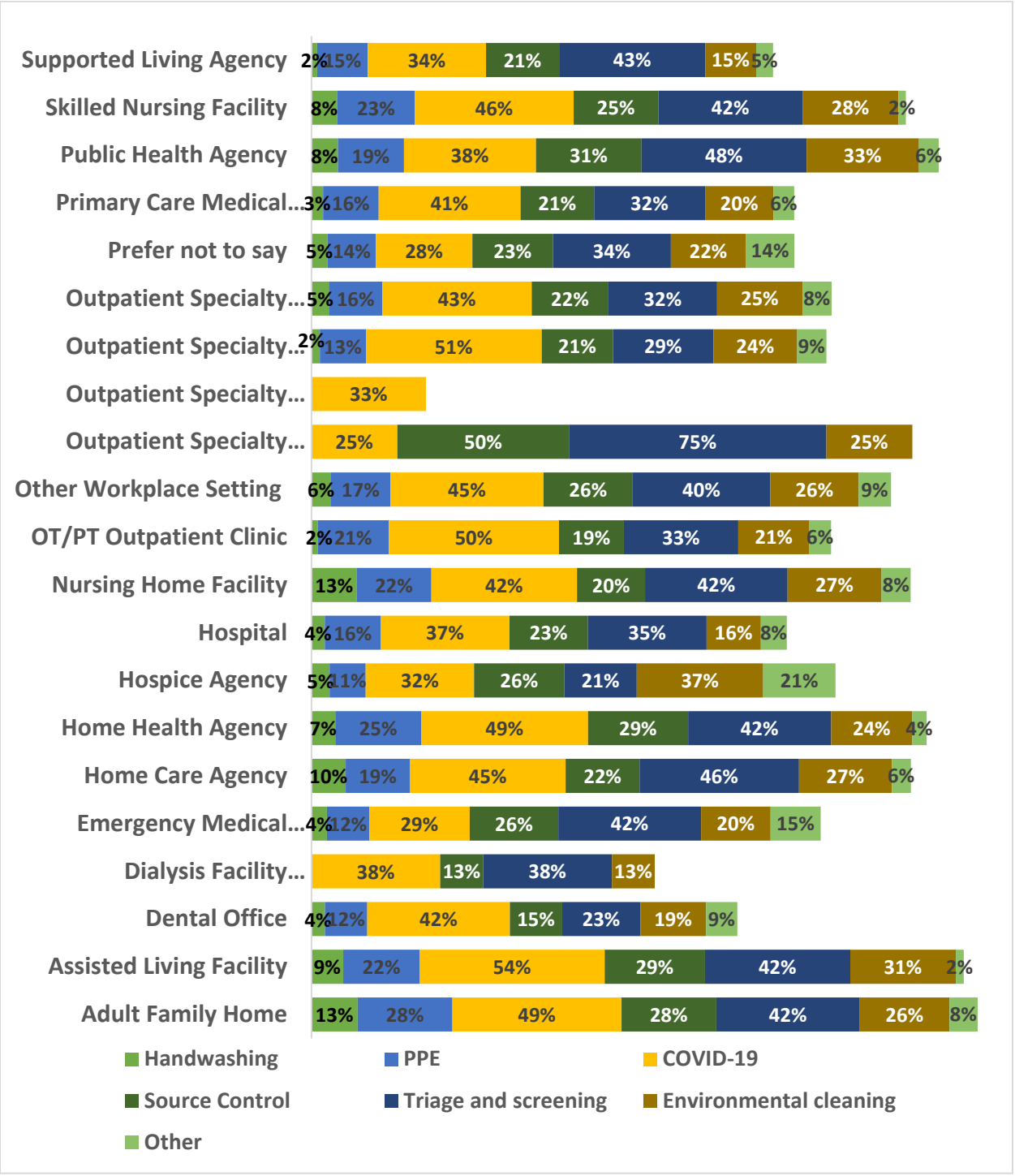


Figure 6: Did the infection control training include any of the following topics?



Other: (average comments) settings felt they did not receive training for general COVID-19 recommendations. Their answers were vague as no one specified if COVID-19 did or did not include all the other categories.

Figure 7: What infection control topics would you like to have additional training on?



Other: dental instrument disinfection/sterilization, more infection control (IC) education in general for dental settings (several responses), general medical instrument sterilization, post-exposure isolation and work guidelines, how to improve IC practice compliance (staff, patients, providers, etc.), ventilation in buildings, frequent IC refreshers, how to talk to BIPOC about vaccination fears.

Data analyzed in October 2020 from consultative Infection Control Assessment and Response (ICAR) visits in Long-term Care Facilities (LTCF) validates the results of the Learning Needs Assessment for previous IC training among staff. These ICARS were conducted by Washington State DOH Infection Preventionists (IPs) from March through September of 2020. ICARs are conducted in person or remotely (over webinar) during which time DOH IPs administer a standard checklist with yes/no responses and areas for comments. Of the 223 facilities in the analysis, 111 were Assisted Living Facilities (50%) and 89 were Nursing Homes (40%) (Figure 8). Three percent of the facilities assessed did not provide any education and/or refresher training to healthcare personnel on the selection and use of PPE (including donning and doffing) or on the cleaning and disinfection of environmental surfaces and resident care equipment. The analysis found that 8% of providers did not maintain education updates on any changes to usual policies/procedures in response to PPE or staffing shortages. The ICAR summaries revealed conflicting findings. While 93% of the facilities answered 'Yes' when asked if they adhere to infection prevention and control (IPC) practices, 53% of the responses were 'No' when IPC practices were reviewed one by one. Out of this data, two categories noted that 12 (6%) of available assessments stated 'No' for: "PPE are removed in a manner to prevent self-contamination, hand hygiene is performed, and new PPE are put on after each resident except as noted" and for "EPA- registered disinfectants are prepared and used in accordance with label instructions." In addition, 7 (3%) facilities had 'No' marked for performing hand hygiene after removing PPE and 4 (2%) facilities do not perform hand hygiene after contact with the resident (PPE or not) (Figure 8). A notable consideration for these data is that the ICAR administration method (in-person versus remote) may have impacted the data quality and comparability. Eighty-eight (39%) of the assessments were done in person while the others were done via video conference/webinar or phone. During in-person ICARs, WA DOH IPs have the opportunity to observe hand hygiene and other practices, but remote assessments rely on self-reports of facility practices; this should be taken into consideration when interpreting these data.

Figure 8. Long-Term Care Facility ICAR Data Analysis from October 2020

Number of Assessments by Facility Type:	#	%
Assisted Living Facility	111	50%
Nursing Home	89	40%
Intermediate Care Facility	1	0%
Retirement Community/Independed Living Facility	2	1%
Other	12	5%
Missing	3	1%

Number of Assessments by Visit Type:	#	%
In Person	88	39%
Video Conference	76	34%
Phone	42	19%
Other	3	1%
Missing	14	6%

HCP Education, Monitoring, and Screening (Summary)	#	%
Any 'No' Responses in Section	39	18%
All 'Yes' Responses in Section	154	73%
Mix of 'Yes' and Missing Responses in Section	19	9%

IPC Practices	#	%
Any 'No' Responses in Section	113	53%
All 'Yes' Responses in Section	67	32%
Mix of 'Yes' and Missing Responses in Section	32	15%

Facility has provided education and refresher training to HCP (including consultant personnel) about adherence to recommended Infection Prevention & Control (IPC) practices	#	%
No	3	1%
Yes	197	93%
Missing	12	6%

Facility has provided education and refresher training to HCP (including consultant personnel) about any changes to usual policies/procedures in response to PPE or staffing shortages	#	%
No	16	8%
Yes	189	89%
Missing	7	3%

Facility has provided education and refresher training to HCP (including consultant personnel) about adherence to recommended Infection Prevention & Control (IPC) practices: **Cleaning and disinfecting environmental surfaces and resident care equipment**	#	%
No	6	3%
Yes	195	92%
Missing	11	5%

Facility has provided education and refresher training to HCP (including consultant personnel) about adherence to recommended Infection Prevention & Control (IPC) practices: **Hand Hygiene**	#	%
No	4	2%
Yes	202	95%
Missing	6	3%

Facility has provided education and refresher training to HCP (including consultant personnel) about adherence to recommended Infection Prevention & Control (IPC) practices: **Selection and use including donning and doffing PPE**	#	%
No	7	3%
Yes	200	94%
Missing	5	2%

PPE are removed in a manner to prevent self-contamination, hand hygiene is performed, and new PPE are put on after each resident except as noted below.	#	%
No	12	6%
Yes	183	86%
Missing	17	8%

Non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use.	#	%
No	7	3%
Yes	192	91%
Missing	13	6%

EPA-registered disinfectants are prepared and used in accordance with label instructions.	#	%
No	12	6%
Yes	182	86%
Missing	18	8%

HCP perform hand hygiene after contact with blood, body fluids, or contaminated surfaces or equipment	#	%
No	4	2%
Yes	175	83%
Missing	33	16%

HCP perform hand hygiene before performing a sterile procedure	#	%
No	27	13%
Yes	139	66%
Missing	46	22%

HCP perform hand hygiene after removing PPE	#	%
No	7	3%
Yes	185	87%
Missing	20	9%

HCP perform hand hygiene after contact with the resident	#	%
No	4	2%
Yes	186	88%
Missing	22	10%

It is important to recognize that if a facility or healthcare setting does not provide education or refresher training, there will be a higher number of respondents who do not have training in IPC practices. Through this understanding, responses to our LNA could be impacted. Although a participant (or facility) may respond as knowing, being able to explain, or perform an IPC topic, this does not mean it is done in practice. Trying to understand why it is not done in practice, we asked what would help respondents correctly follow IPC practices and recommendations.

To correctly follow recommendations, LNA respondents felt they needed additional or adequate supplies for COVID-19, hand hygiene, and PPE. Most of the LNA respondents felt that additional training would help them conduct immediate triage and screening. Training and supplies were a popular choice for helping the respondents properly follow environmental and cleaning protocols. For source control, answers varied between training, supplies, and “other”. The “other” comments for source control contained the following: belief in the guidelines and enforcement from leadership (several responses), break areas are too small, source control is not enforced by my hospital, and additional takeaways were that several people do not understand what the term source control means. See Appendix D for all responses on knowledge and challenges with following IC topic guidelines and recommendations.

Recommendations

In consideration of the key findings in the Washington State Department of Health's Project Firstline Learning Needs Assessment, the Washington State Department of Health (WA DOH) HAI & AR Section will:

- Evaluate, revise, and improve infection prevention and control (IPC) outreach and topic focus across the section and state.
- Prioritize training development topics on:
    - IPC topics that are most desired by respondents
    - IPC topics with the highest levels of "strongly disagree" and "disagree" in the respondent's ability to understand, explain, and perform the IPC topics listed in the assessment
- Consider the following when developing the training modules; based on the respondent's:
    - Level of education
    - Years of experience
    - Preferred languages and literacy level
    - Preferences in training platforms and post-training assistance
- Provide Continuing Education Units (CEUs) and Certificates of Completion to incentivize frontline healthcare workers to increase participation in trainings.
- Use data from the COVID-19 response to prepare for future outbreaks, epidemics, or pandemics. The data from the comments and questions in the Learning Needs Assessment demonstrate gaps in training and communication prior to and during the pandemic.
- Learn from this Learning Needs Assessment for future assessments by:
    - Limiting the number of questions
    - Evaluating the worth of the data behind each question to the goal of the assessment or survey
    - Clearly defining the meaning of each category (e.g., what does "COVID-19" entail when asked in questions to specify rather than generalize)
    - Providing different modes of surveys and survey distribution
    - Narrowing the target audience
    - Providing an incentive (if able)

Appendices

Appendix A: Acknowledgements

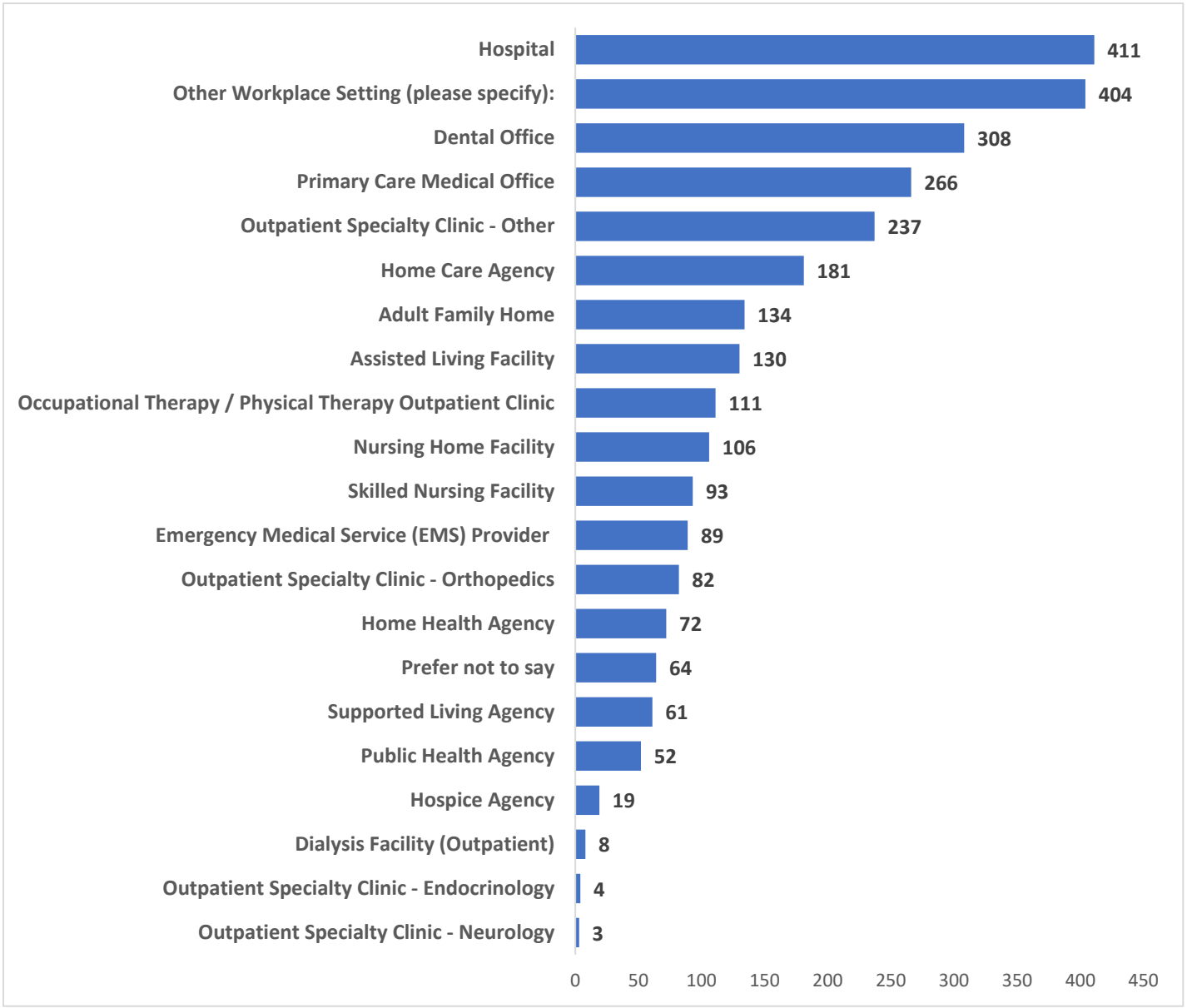
We want to thank and acknowledge the stakeholders that have helped make this Learning Needs Assessment not only possible but successful.

- Adult Family Home Council (Washington)
- American Physical Therapy Association Washington (APTA WA)
- Association for Professionals in Infection Control and Epidemiology (APIC) Puget Sound Chapter
- Centers for Disease Control and Prevention (CDC), Project Firstline
- LeadingAge
- National Indian Health Board (NIHB)
- University of Washington's Northwest Center for Public Health Practice (NWCPHP)
- Washington Adult Family Home Council
- Washington Association of Area Agencies on Agencies (W4A)
- Washington Health Care Association (WHCA)
- Washington Occupational Therapy Association (WOTA)
- Washington State Department of Health (specifically the following areas)
    - Center for Public Affairs (C4PA)
    - Community Healthcare Worker network
    - Emergency Medical Professionals or EMS Providers Program
    - Healthcare Associated Infections and Antimicrobial Resistance Section (HAI&AR)
    - Home Care, Home Health, Hospice: Health Professions and Facilities
    - Nurse Care Quality Assurance Commission (NCQAC)
    - Nursing Assistant Program
    - Office of Health Professions
    - Rural Health
- Washington State Department of Social and Health Services (DSHS)
- Washington State Local Health Jurisdictions

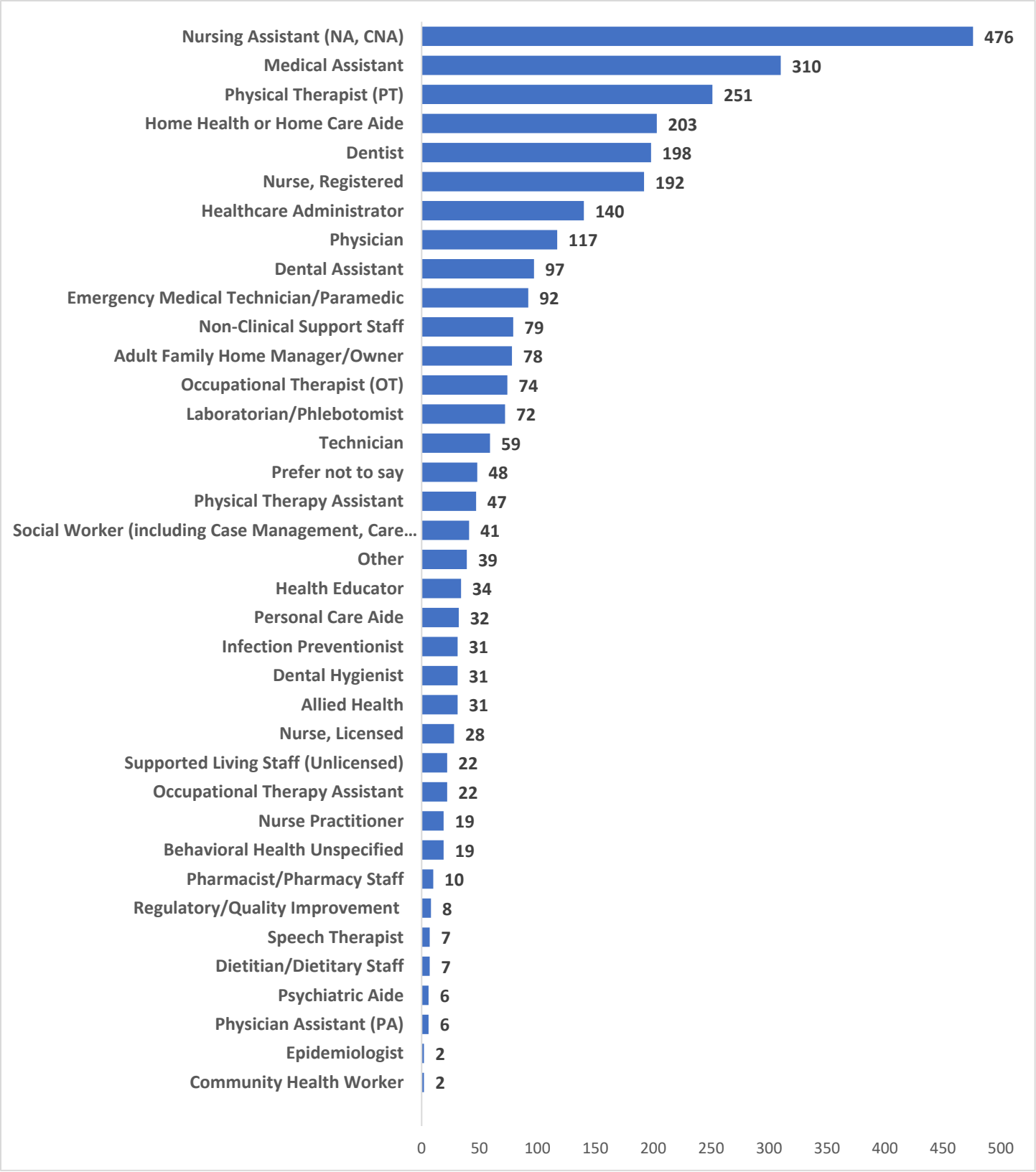
Appendix B: Demographics

The questions asked in the Learning Needs Assessment (LNA) were reworded from the CDC LNA template originally provided to fit the appropriate literacy level of the intended population. Some topics have the questions asked in the LNA for clarification purposes.

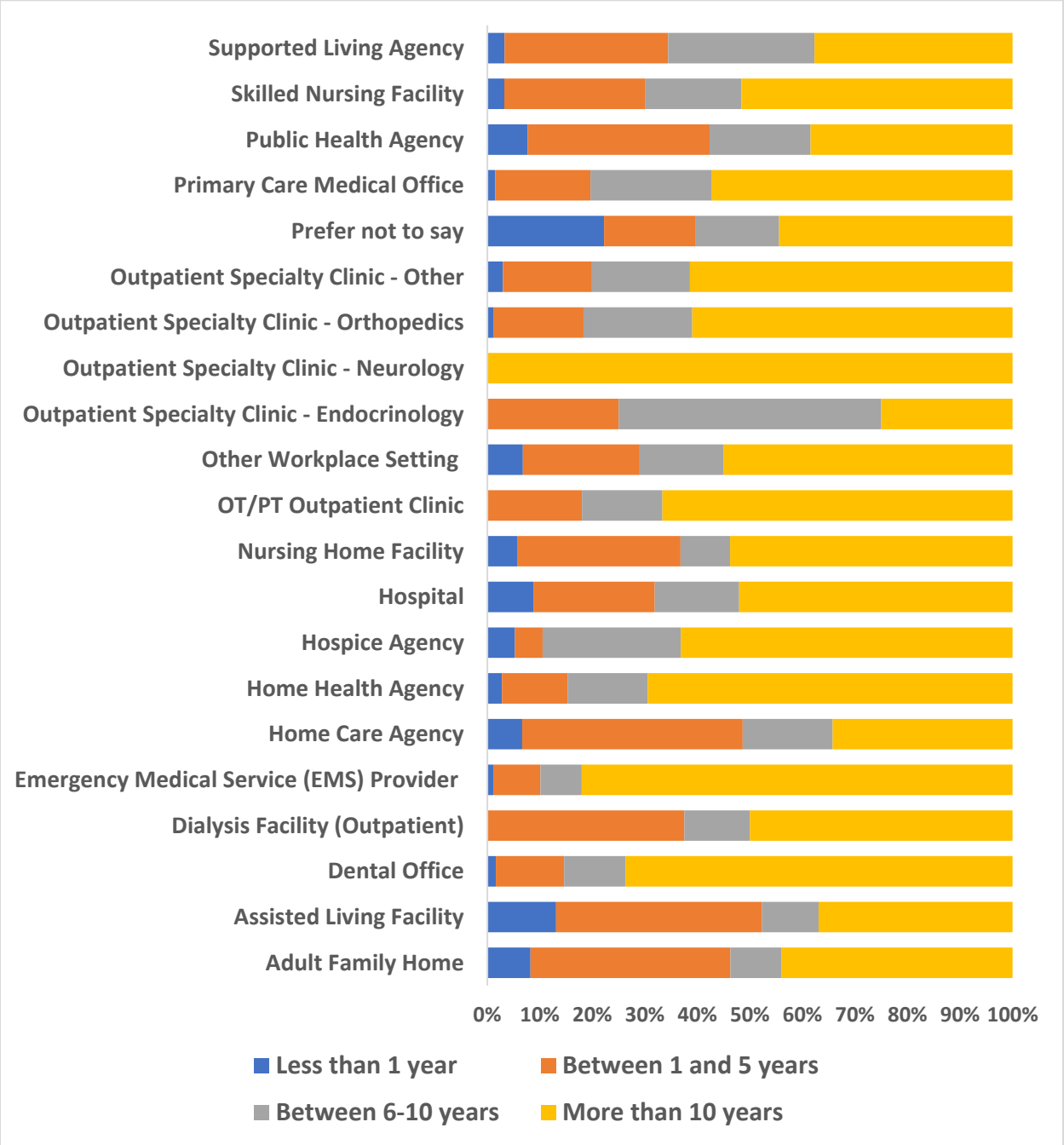
Respondent Workplace Setting



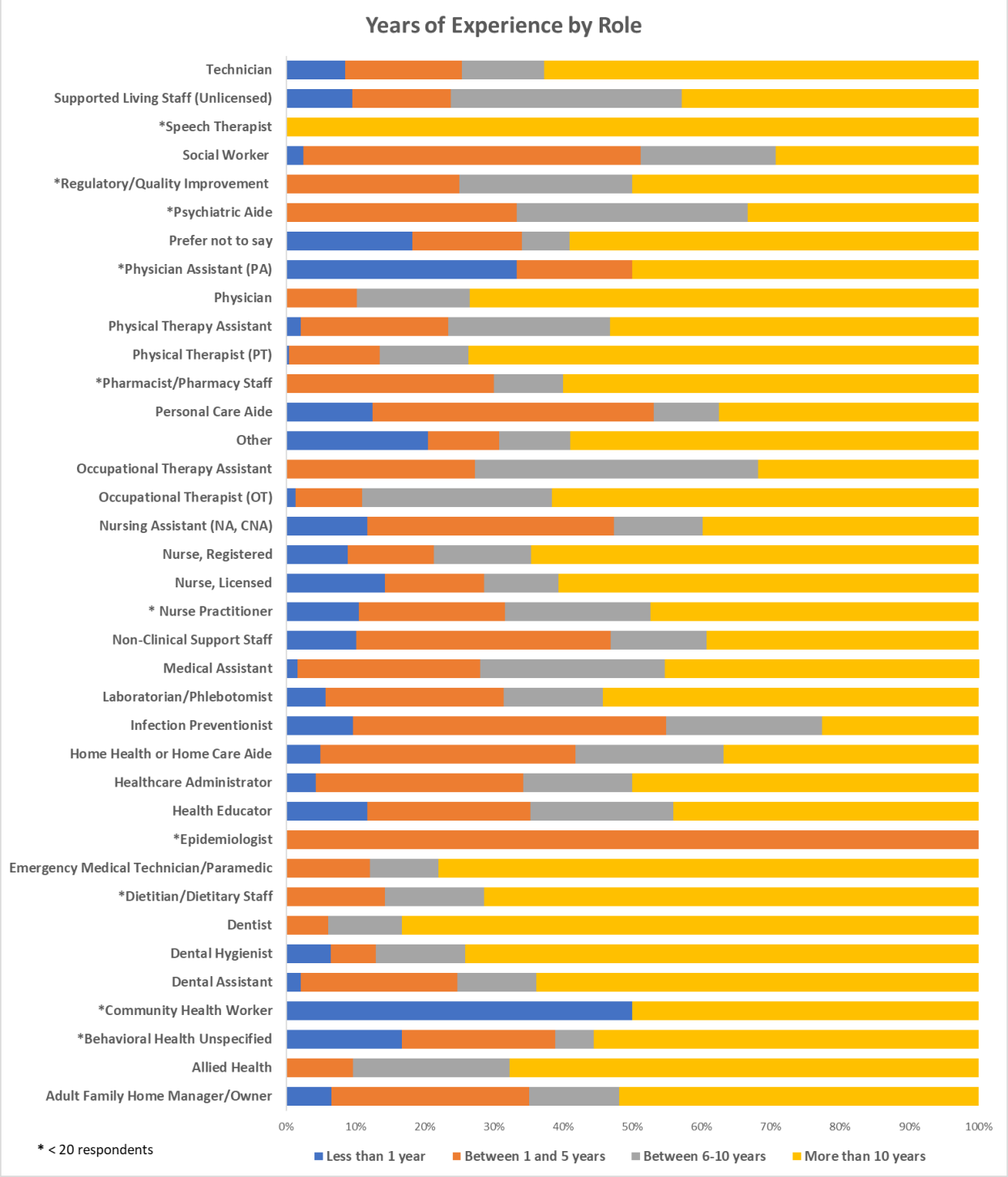
Respondent Job Role



Years of Experience by Setting

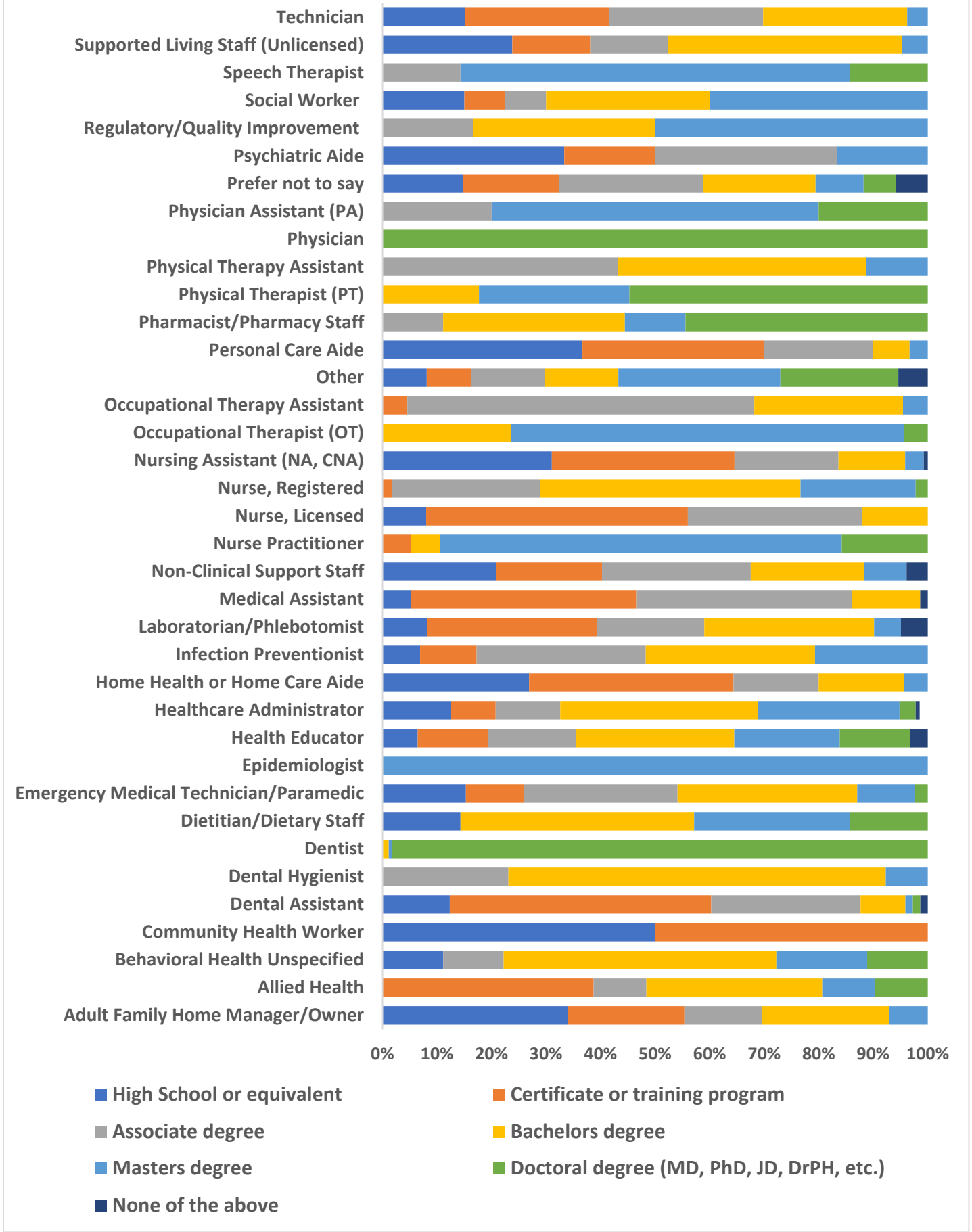


Years of Experience by Role



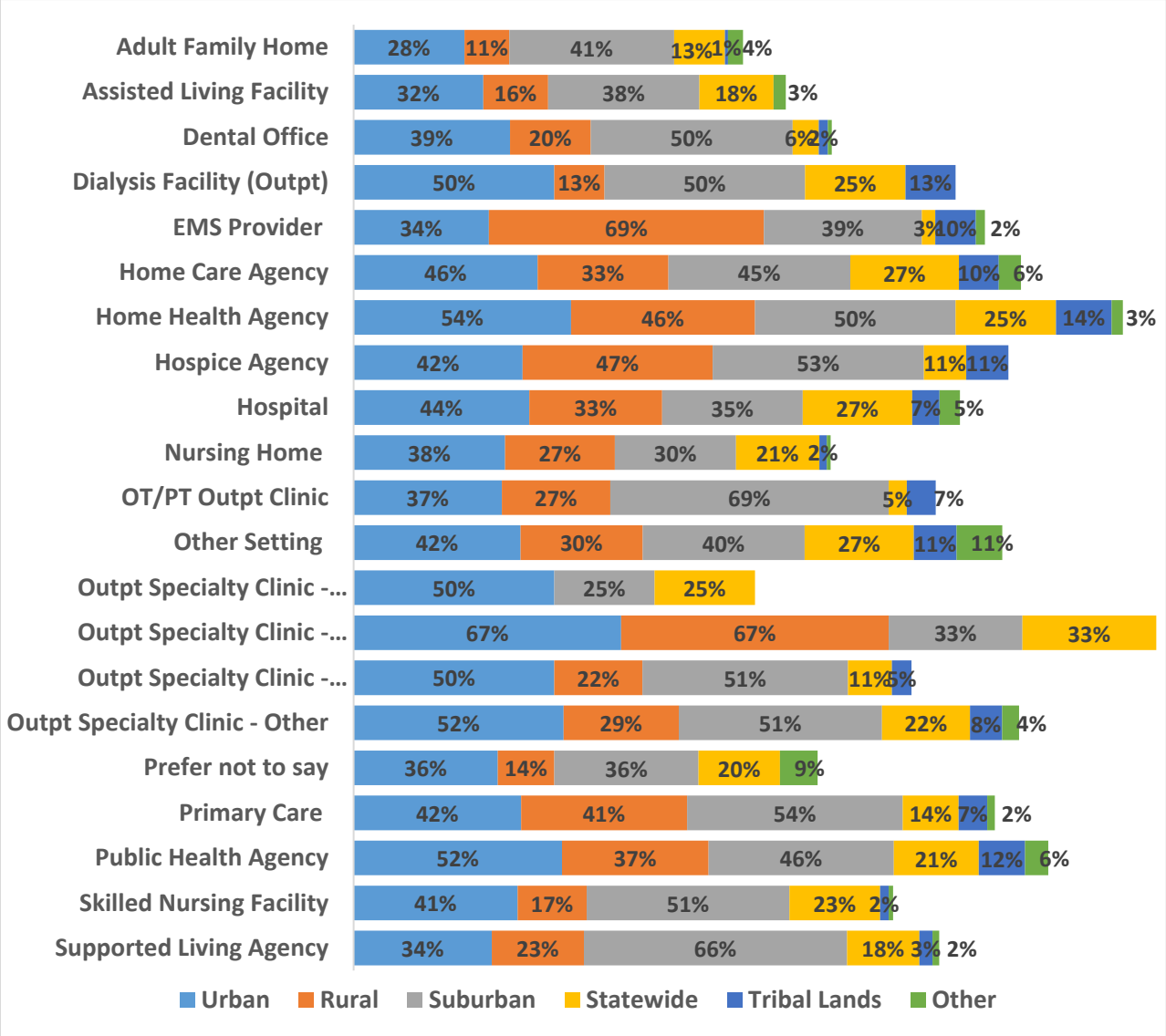
Highest Level of Education by Setting

Highest Level of Education by Role



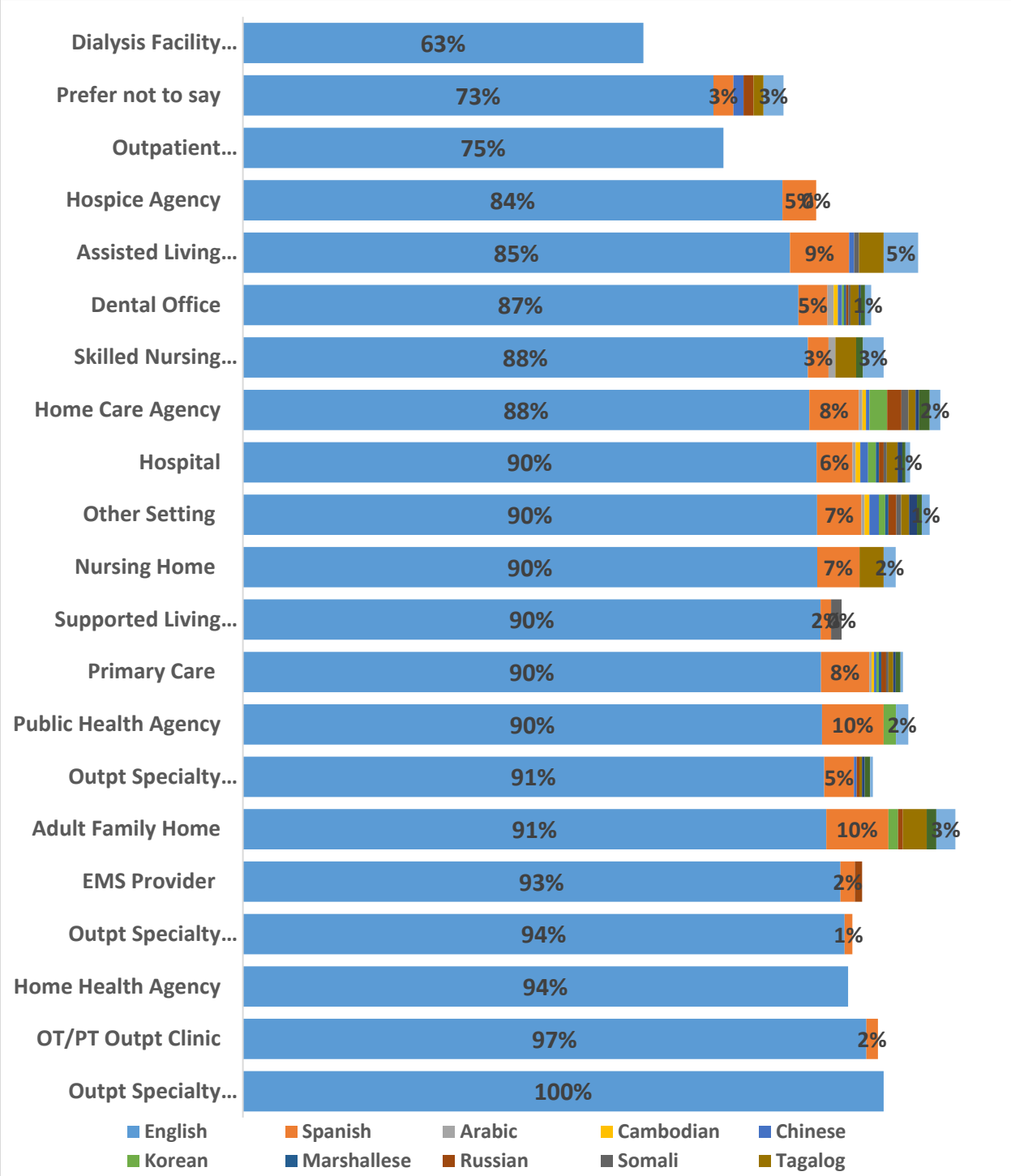
Geographic Location of Respondent Facility or Organization

Question: What type of area(s) does your facility or organization serve? (Select all that apply.)



Preferred Language for Trainings

Question: What language(s) do you like to take trainings in? (Select all that apply.)

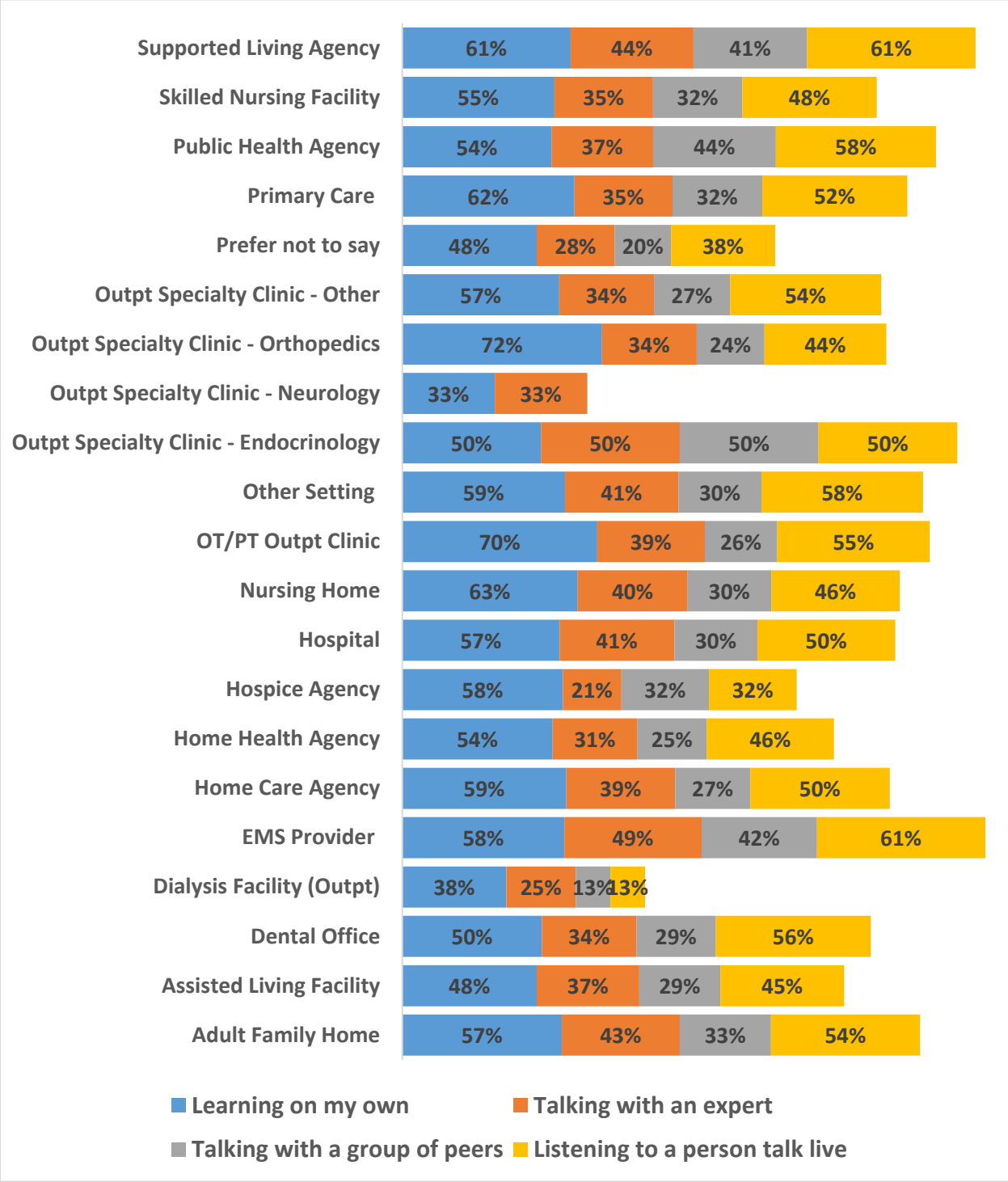


Other languages: American Sign Language, French (several), Swahili (several), Amharic (several), Omoro

Appendix C: Infection Control Training Data

The Learning Needs Assessment (LNA) was reworded from the original CDC LNA template to fit the intended population. Some topics have the questions asked for clarification purposes.

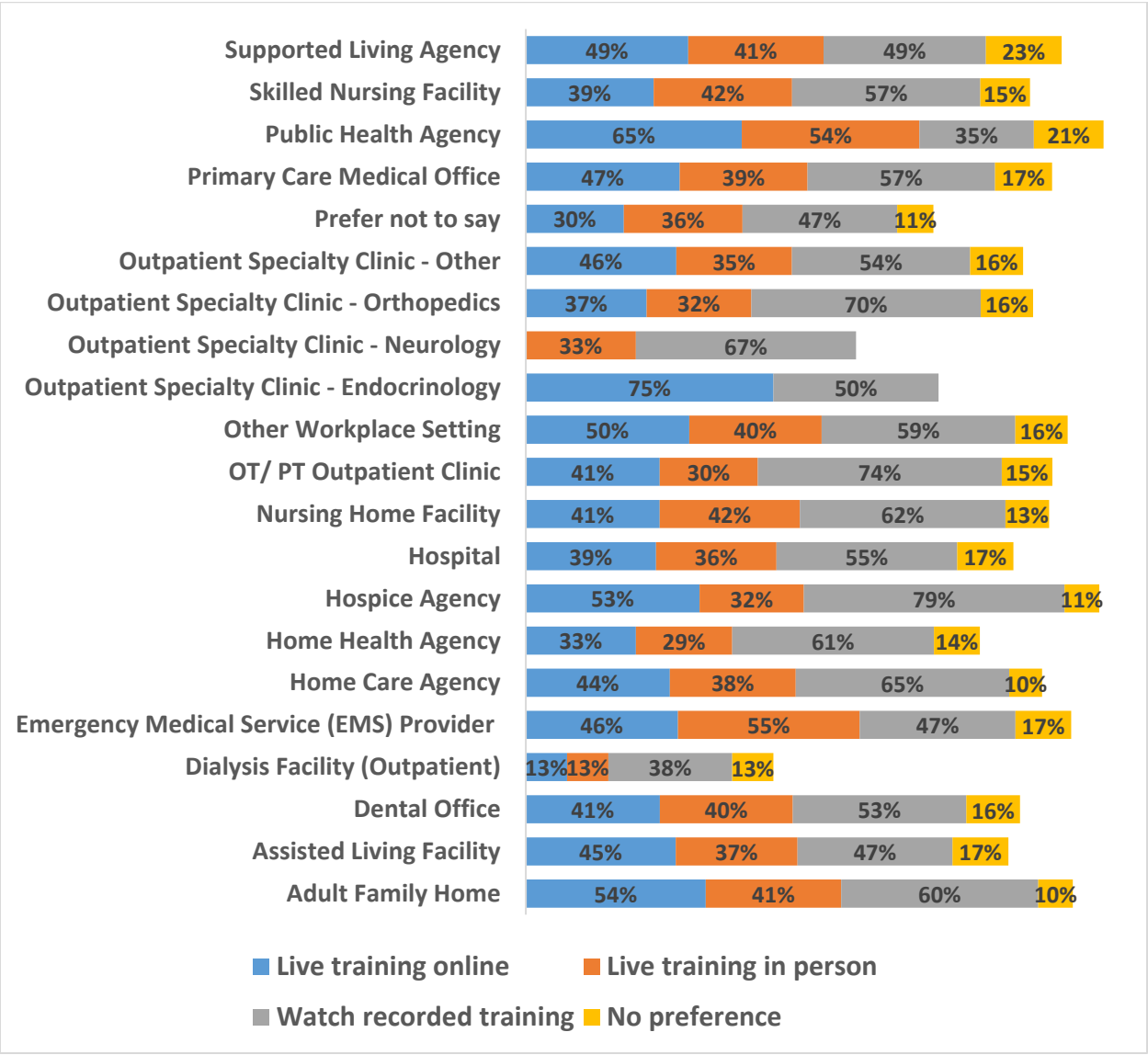
Preference in Training Method



*Question: How do you prefer to take trainings? (Select all that apply.)
**Talking/Listening options stated "(in person or on the computer)"

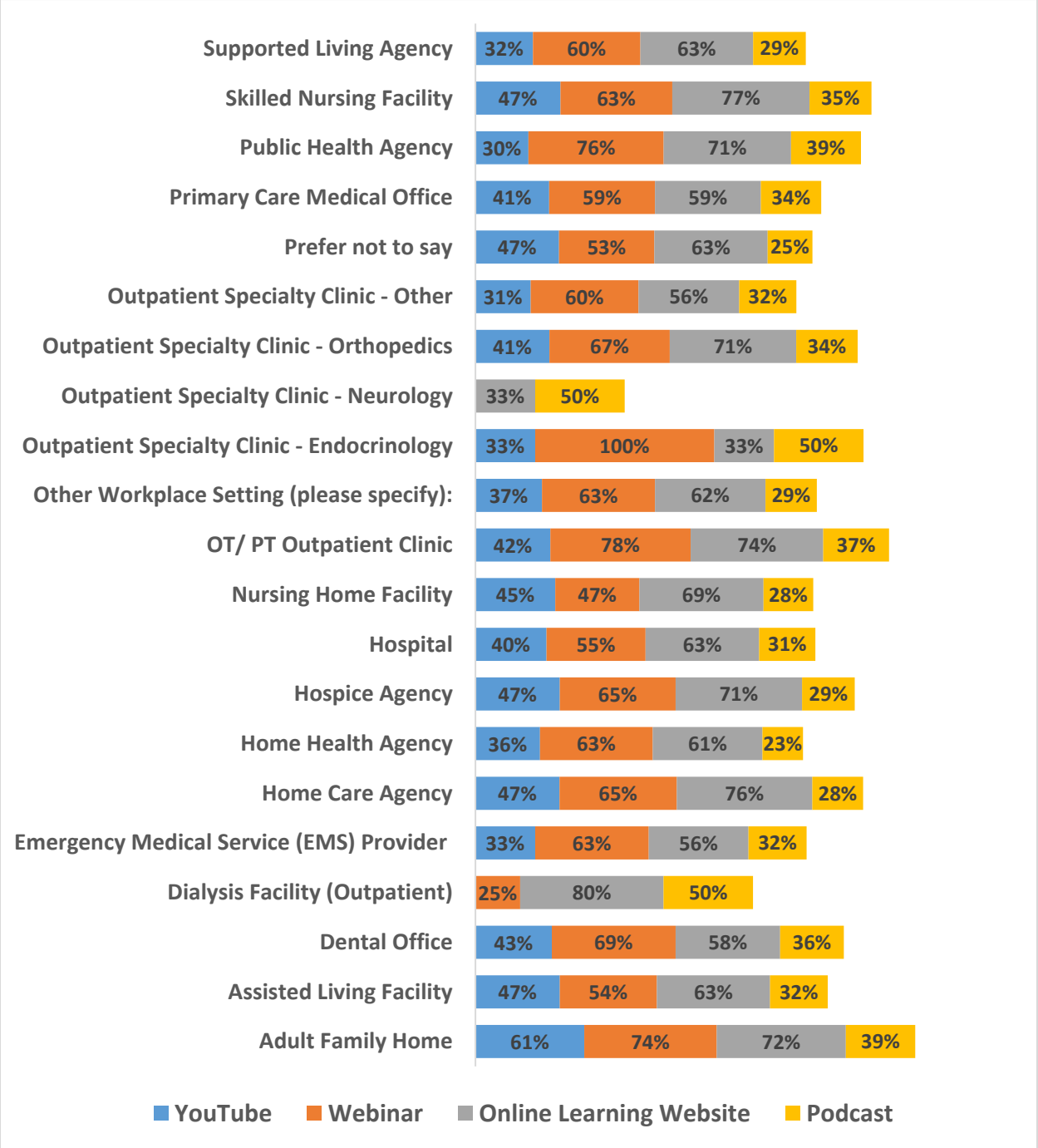
Preference in Live or Recorded Training by Setting

Question: Would you choose to attend a live training or a recorded training (Select all that apply.)



Preference in Training Delivery Method by Setting

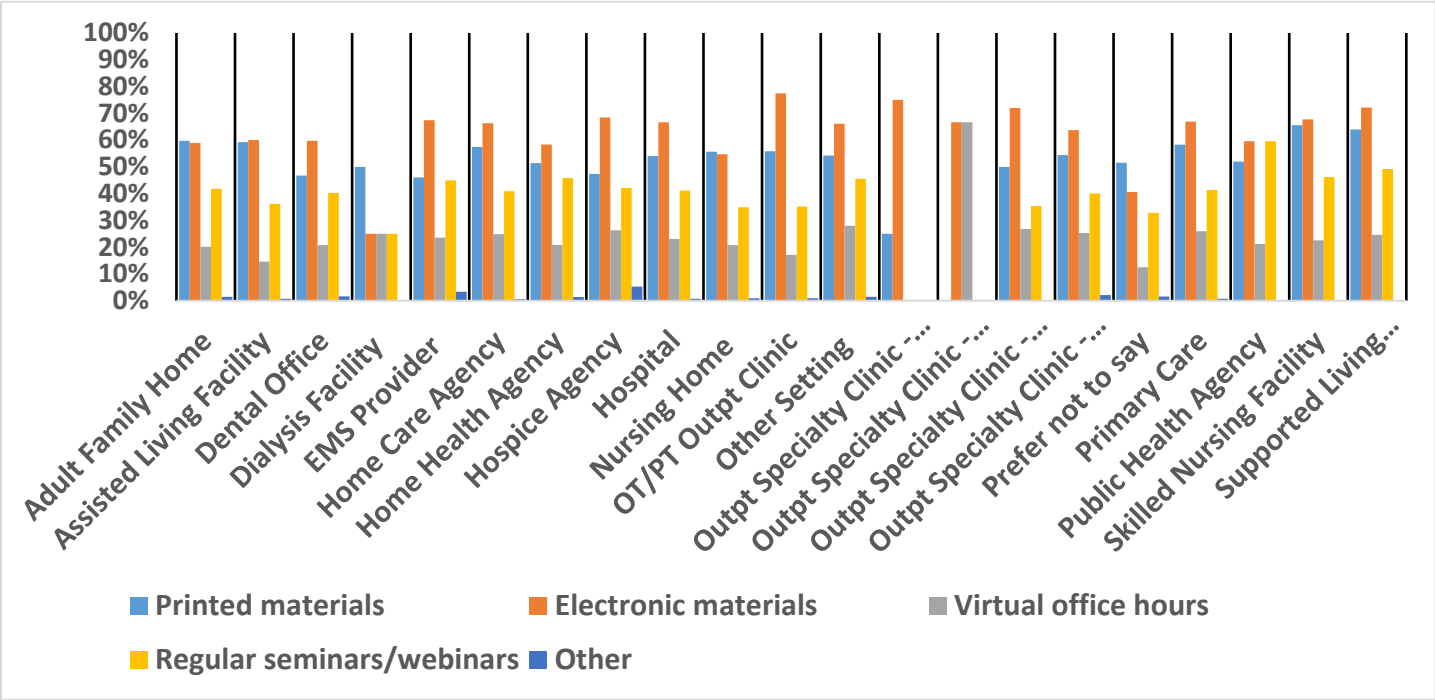
Question: Would you like to attend a training via…



Answer options: "dislike," "might," or "like." Data analysis was done on answers for "like."

Post-Training Support by Setting

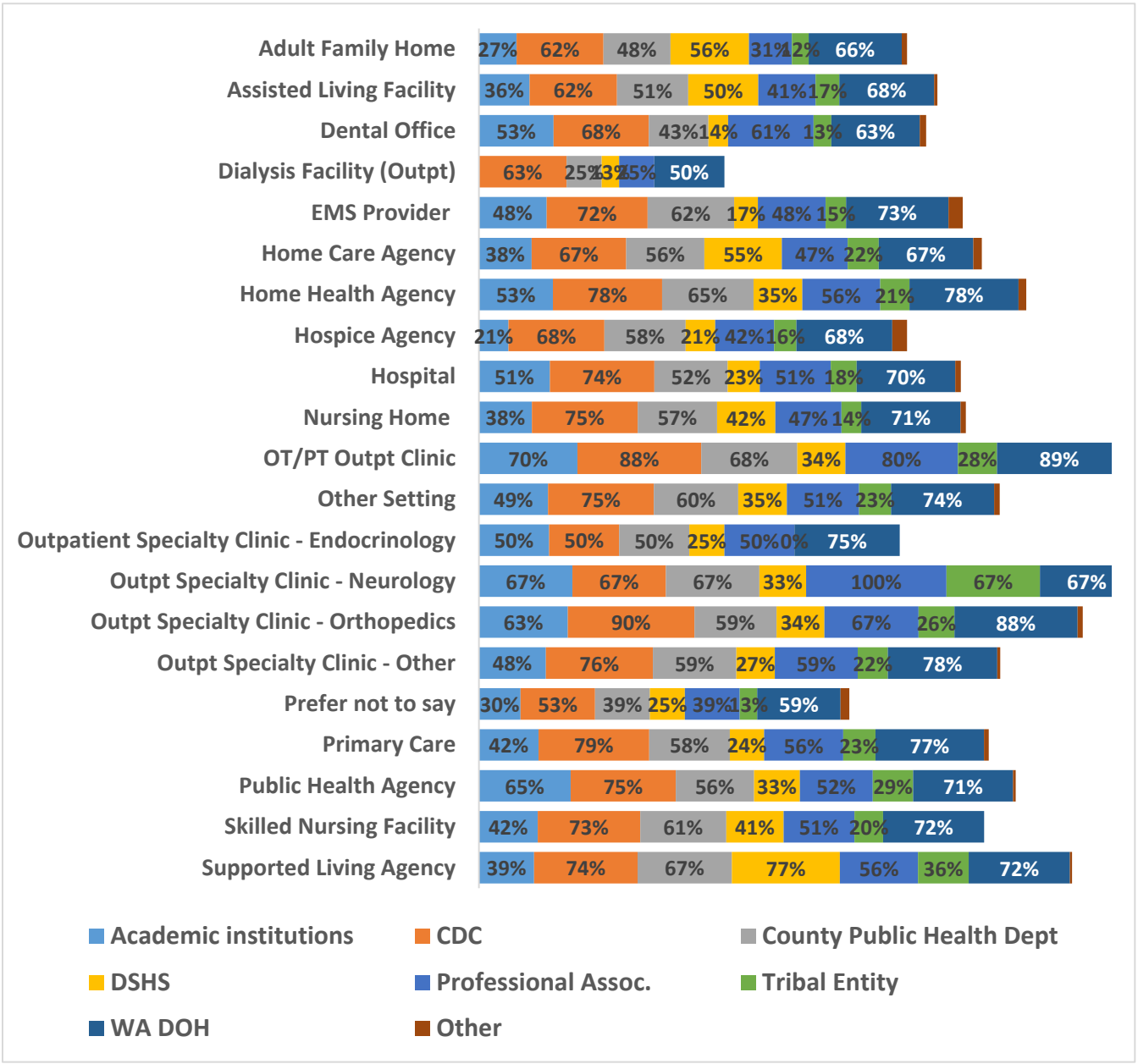
Question: What types of help after the training would you find most useful? (Select all that apply.)



Other: scientific papers supporting the use of infection control practices, ability to ask questions (several), local contacts for guidance.

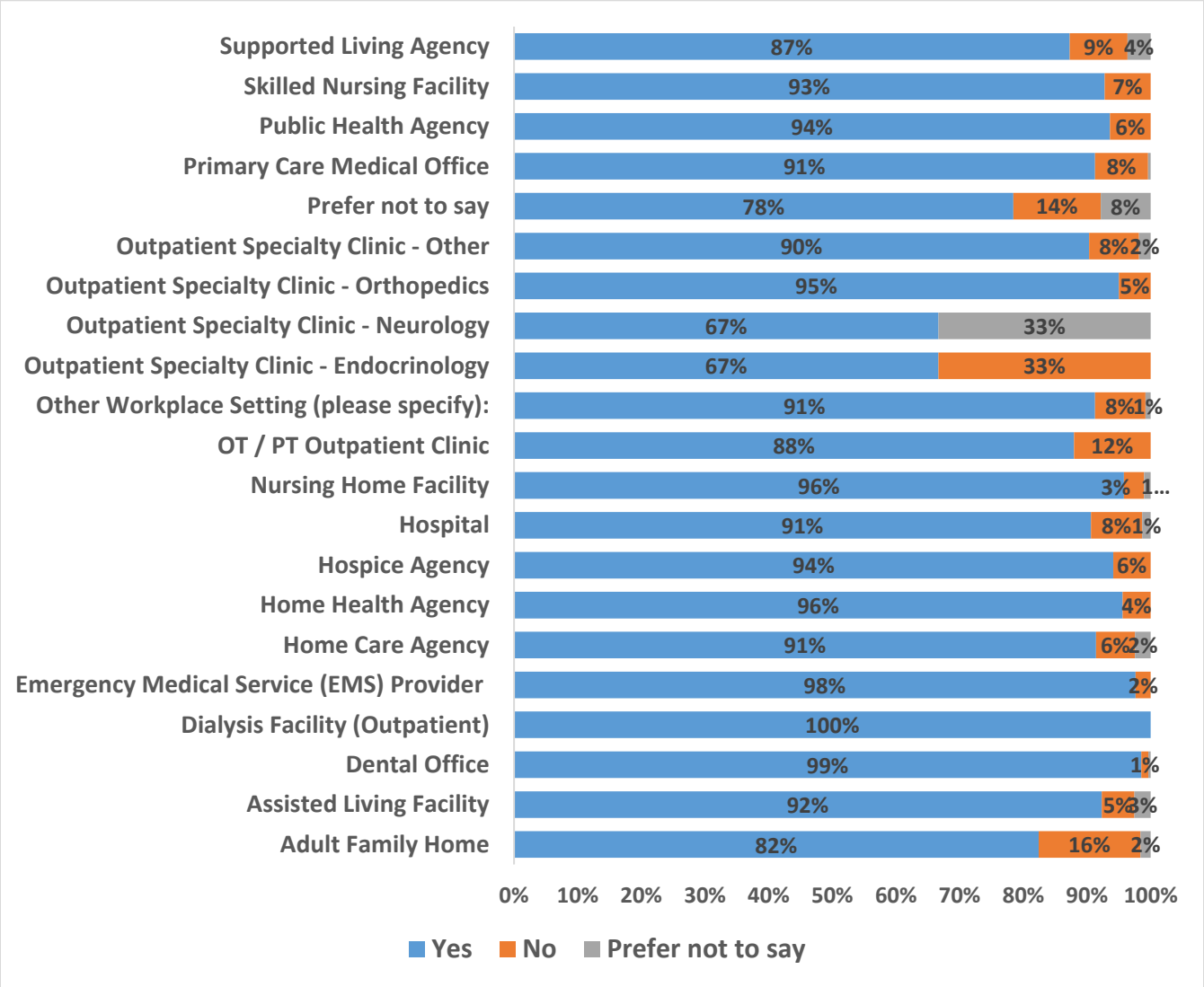
Trusted Organizations for Infection Control Trainings by Setting

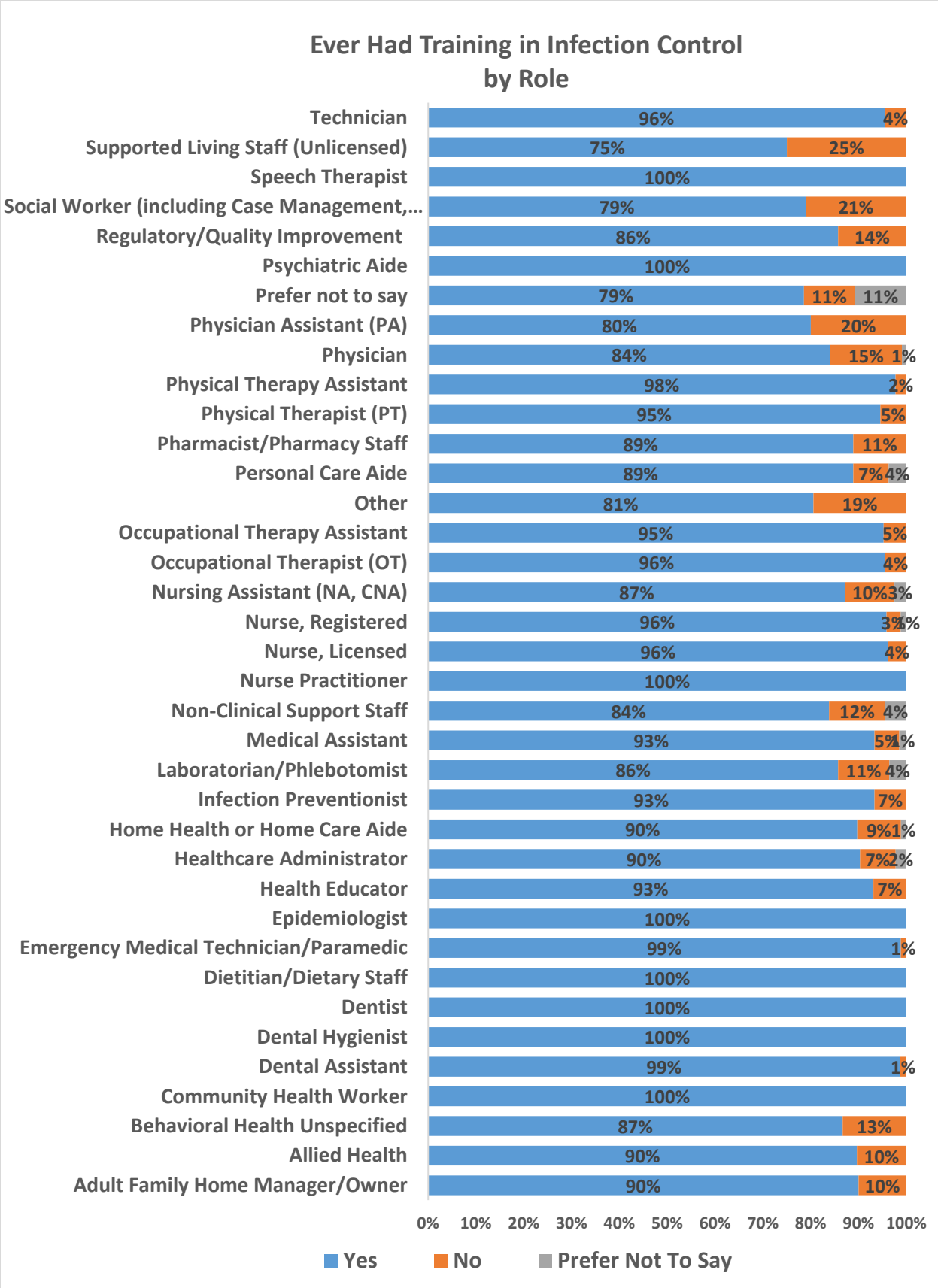
Question: What organizations would you trust to give training about infection control? (Select all that apply.)
"Infection control practices" have to do with ways to prevent or stop the spread of infections in healthcare.



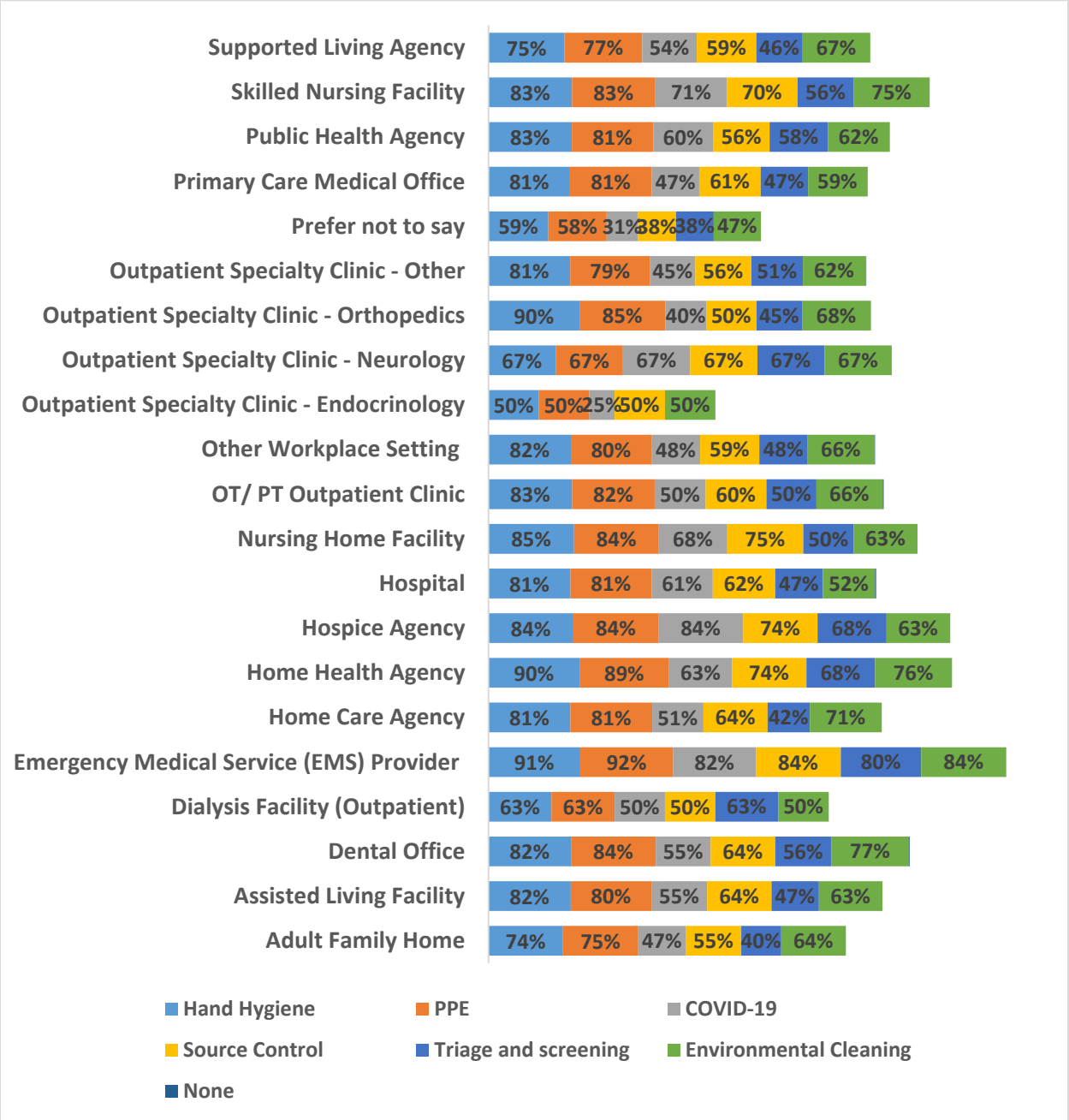
Other: WA adult family home council, Academy of General Dentistry, certified OSHA/WSHA instructors, EMS connect, EMS online, independent agencies (non-governmental), naturopath professionals, military medical

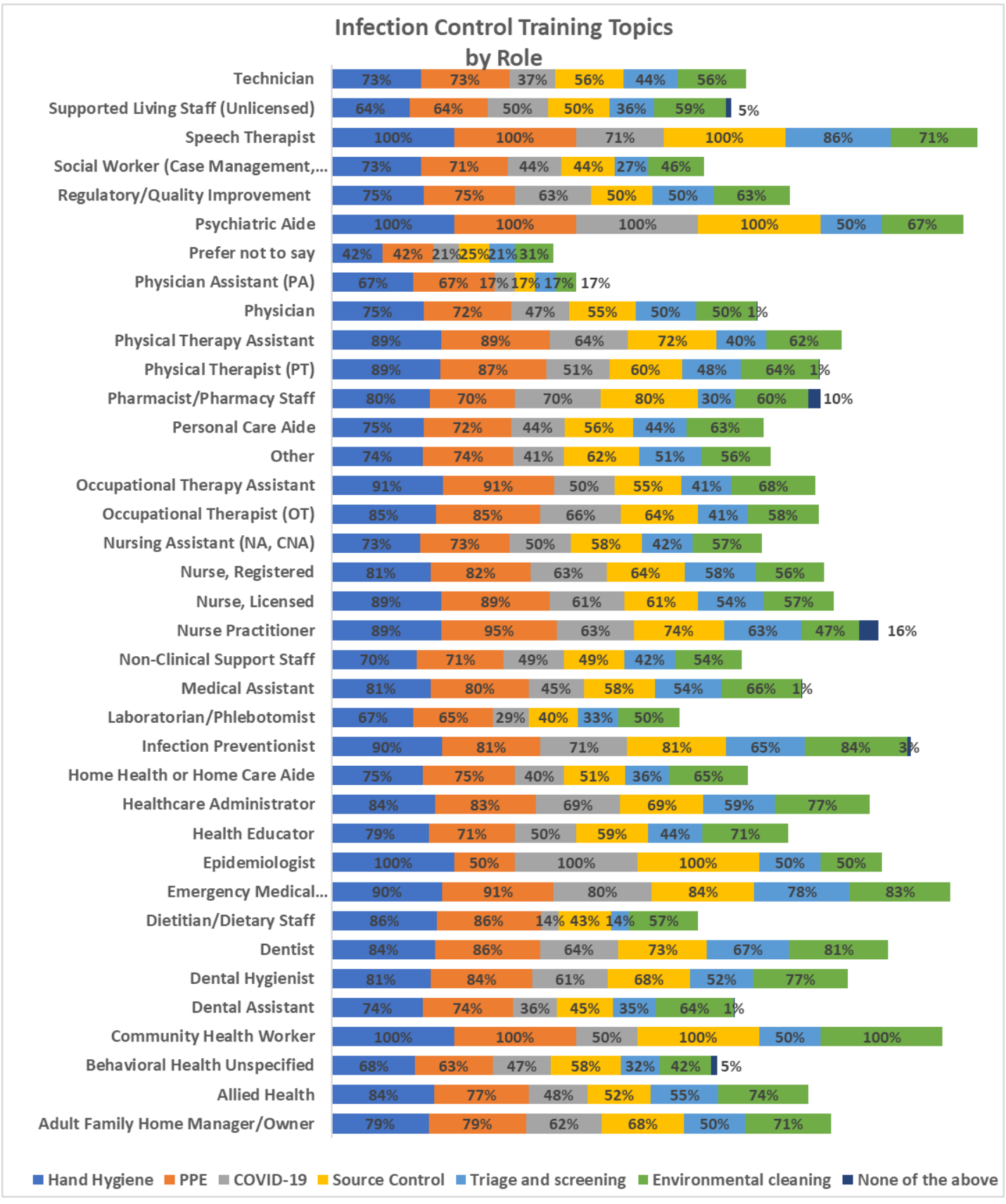
Previous Infection Control Training Experience by Setting and Role




Ever Had Training in Infection Control by Role
Technician 96% 4%
Supported Living Staff (Unlicensed) 75% 25%
Speech Therapist 100%
Social Worker (including Case Management,... 79% 21%
Regulatory/Quality Improvement 86% 14%
Psychiatric Aide 100%
Prefer not to say 79% 11% 11%
Physician Assistant (PA) 80% 20%
Physician 84% 15% 1%
Physical Therapy Assistant 98% 2%
Physical Therapist (PT) 95% 5%
Pharmacist/Pharmacy Staff 89% 11%
Personal Care Aide 89% 7% 4%
Other 81% 19%
Occupational Therapy Assistant 95% 5%
Occupational Therapist (OT) 96% 4%
Nursing Assistant (NA, CNA) 87% 10% 3%
Nurse, Registered 96% 3% 1%
Nurse, Licensed 96% 4%
Nurse Practitioner 100%
Non-Clinical Support Staff 84% 12% 4%
Medical Assistant 93% 5% 1%
Laboratorian/Phlebotomist 86% 11% 4%
Infection Preventionist 93% 7%
Home Health or Home Care Aide 90% 9% 1%
Healthcare Administrator 90% 7% 2%
Health Educator 93% 7%
Epidemiologist 100%
Emergency Medical Technician/Paramedic 99% 1%
Dietitian/Dietary Staff 100%
Dentist 100%
Dental Hygienist 100%
Dental Assistant 99% 1%
Community Health Worker 100%
Behavioral Health Unspecified 87% 13%
Allied Health 90% 10%
Adult Family Home Manager/Owner 90% 10%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Yes
No
Prefer Not To Say

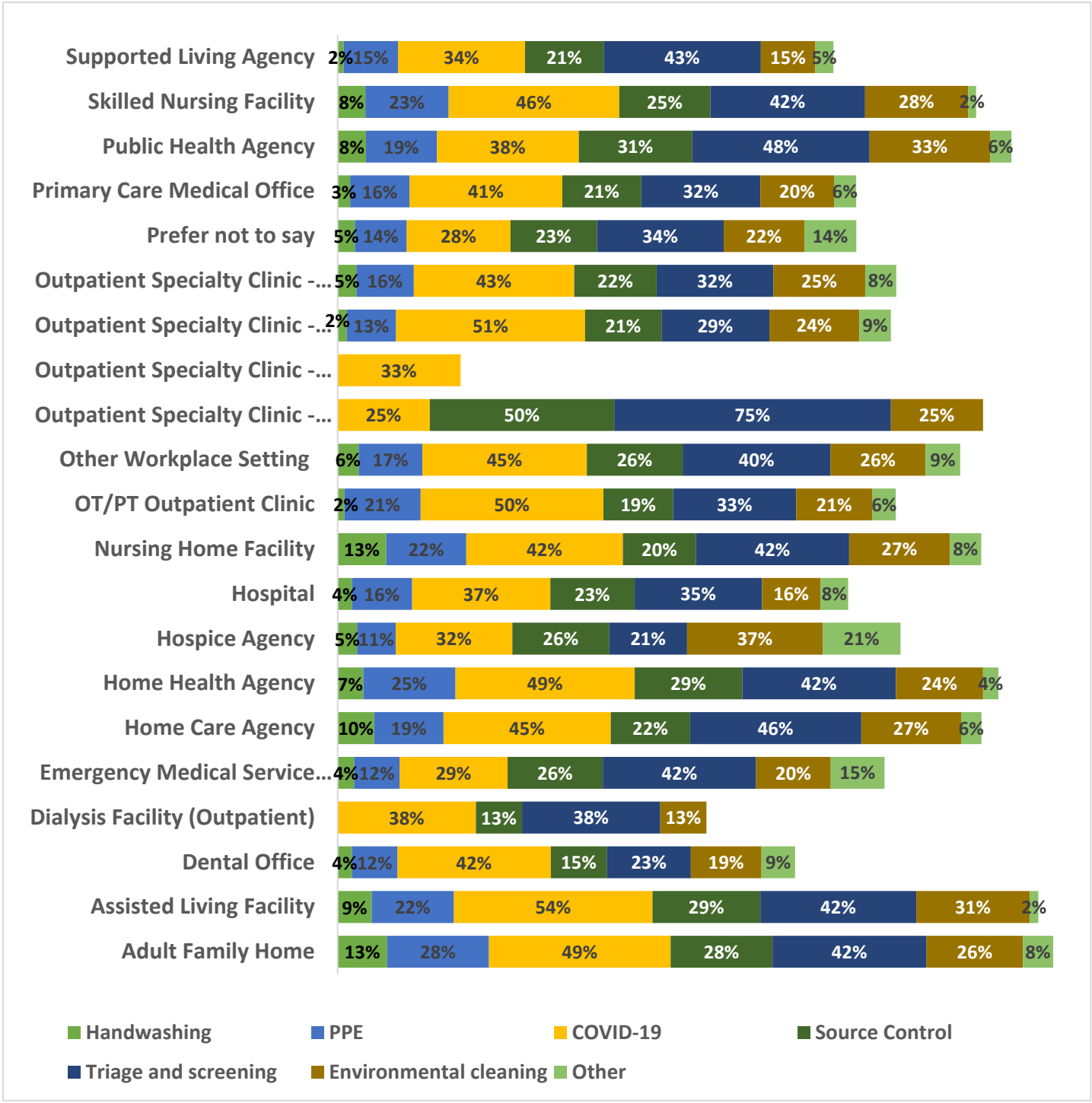
Topics of Previous Infection Control Training by Setting and Role




Infection Control Training Topics by Role
Technician 73% 73% 37% 56% 44% 56%
Supported Living Staff (Unlicensed) 64% 64% 50% 50% 36% 59% 5%
Speech Therapist 100% 100% 71% 100% 86% 71%
Social Worker (Case Management,... 73% 71% 44% 44% 27% 46%
Regulatory/Quality Improvement 75% 75% 63% 50% 50% 63%
Psychiatric Aide 100% 100% 100% 100% 50% 67%
Prefer not to say 42% 42% 21% 25% 21% 31%
Physician Assistant (PA) 67% 67% 17% 17% 17% 17%
Physician 75% 72% 47% 55% 50% 50% 1%
Physical Therapy Assistant 89% 89% 64% 72% 40% 62%
Physical Therapist (PT) 89% 87% 51% 60% 48% 64% 1%
Pharmacist/Pharmacy Staff 80% 70% 70% 80% 30% 60% 10%
Personal Care Aide 75% 72% 44% 56% 44% 63%
Other 74% 74% 41% 62% 51% 56%
Occupational Therapy Assistant 91% 91% 50% 55% 41% 68%
Occupational Therapist (OT) 85% 85% 66% 64% 41% 58%
Nursing Assistant (NA, CNA) 73% 73% 50% 58% 42% 57%
Nurse, Registered 81% 82% 63% 64% 58% 56%
Nurse, Licensed 89% 89% 61% 61% 54% 57%
Nurse Practitioner 89% 95% 63% 74% 63% 47% 16%
Non-Clinical Support Staff 70% 71% 49% 49% 42% 54%
Medical Assistant 81% 80% 45% 58% 54% 66% 1%
Laboratorian/Phlebotomist 67% 65% 29% 40% 33% 50%
Infection Preventionist 90% 81% 71% 81% 65% 84% 3%
Home Health or Home Care Aide 75% 75% 40% 51% 36% 65%
Healthcare Administrator 84% 83% 69% 69% 59% 77%
Health Educator 79% 71% 50% 59% 44% 71%
Epidemiologist 100% 50% 100% 100% 50% 50%
Emergency Medical... 90% 91% 80% 84% 78% 83%
Dietitian/Dietary Staff 86% 86% 14% 43% 14% 57%
Dentist 84% 86% 64% 73% 67% 81%
Dental Hygienist 81% 84% 61% 68% 52% 77%
Dental Assistant 74% 74% 36% 45% 35% 64% 1%
Community Health Worker 100% 100% 50% 100% 50% 100%
Behavioral Health Unspecified 68% 63% 47% 58% 32% 42% 5%
Allied Health 84% 77% 48% 52% 55% 74%
Adult Family Home Manager/Owner 79% 79% 62% 68% 50% 71%
Hand Hygiene
PPE
COVID-19
Source Control
Triage and screening
Environmental cleaning
None of the above

Want Additional Training in Infection Control Topics

Question: Which infection control topics would you like to have more training on? (Select all that apply.)

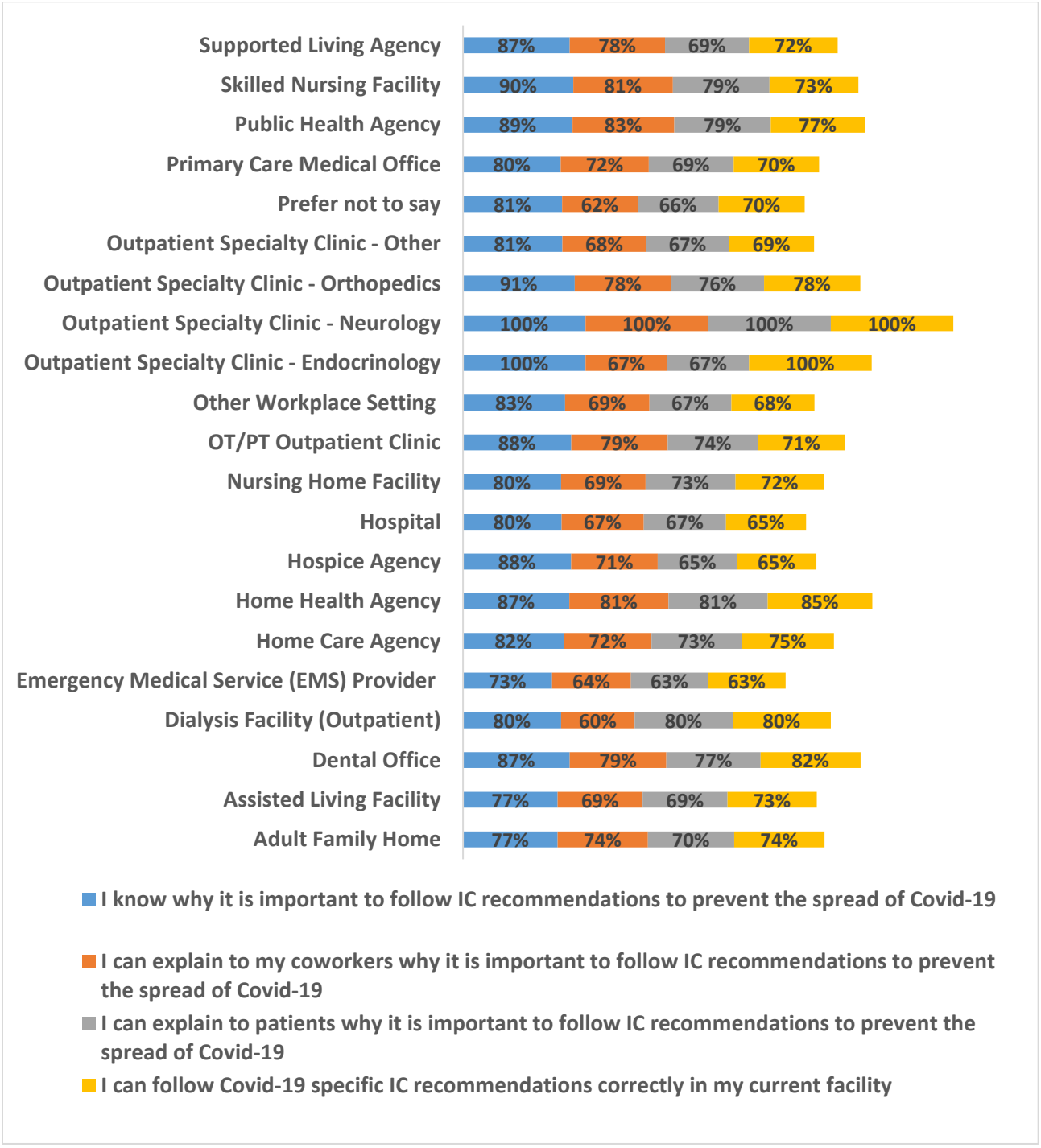


Other: dental instrument disinfection/sterilization, more IP education in general for dental settings (several responses), general medical instrument sterilization, post-exposure isolation and work guidelines, how to improve IP practice compliance (staff, patients, providers, etc.), ventilation in buildings, frequent IP refreshers, how to talk to BIPOC about vaccination fears.

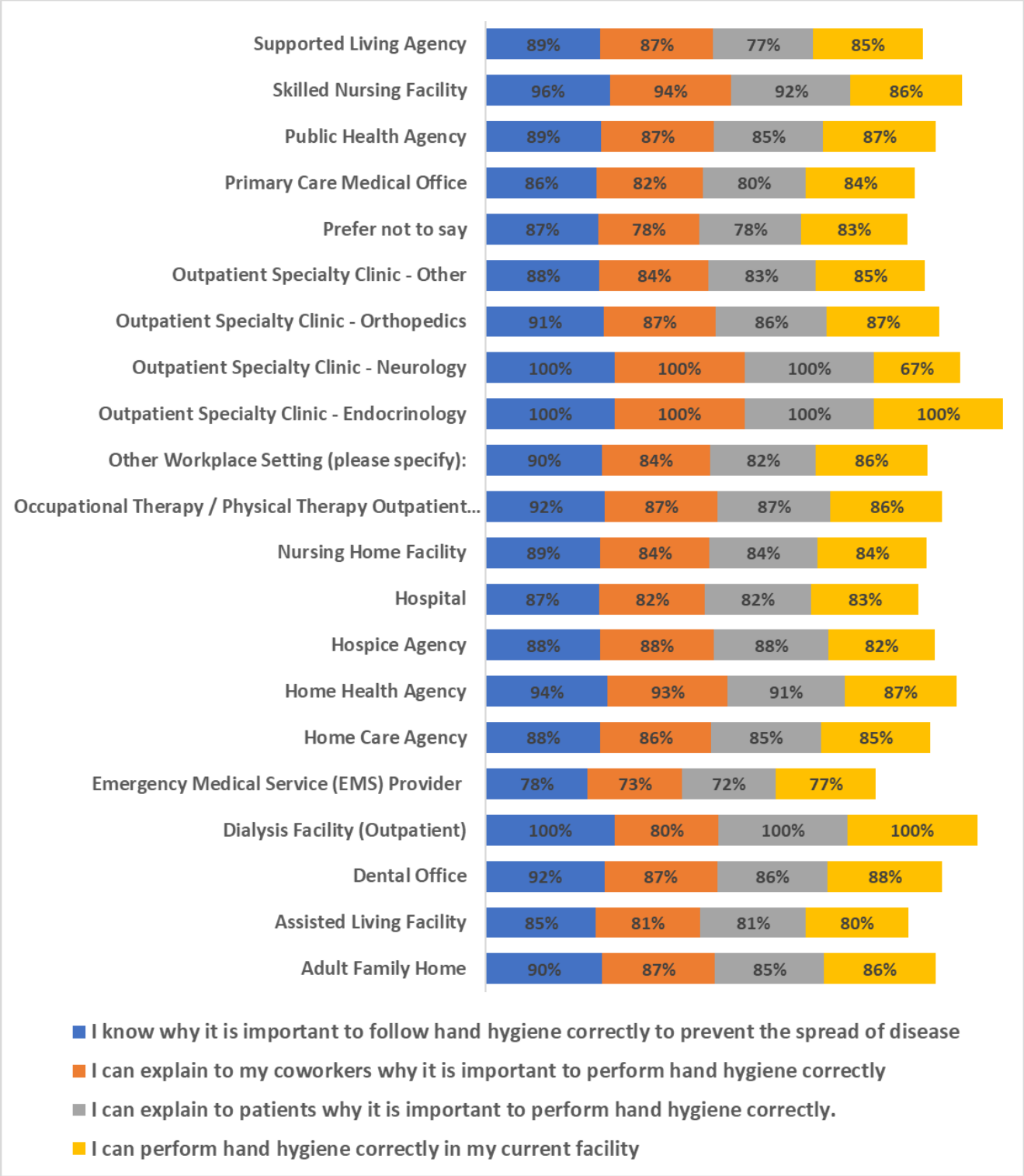
Appendix D: Infection Control Guideline Data by Topic

Appendix D shows data analyzed regarding the participant following infection control guidelines and recommendations. Each question stated: "Please select the level to which you agree or disagree with each statement below." *The graphs shown reflect the "strongly agree" answer.*

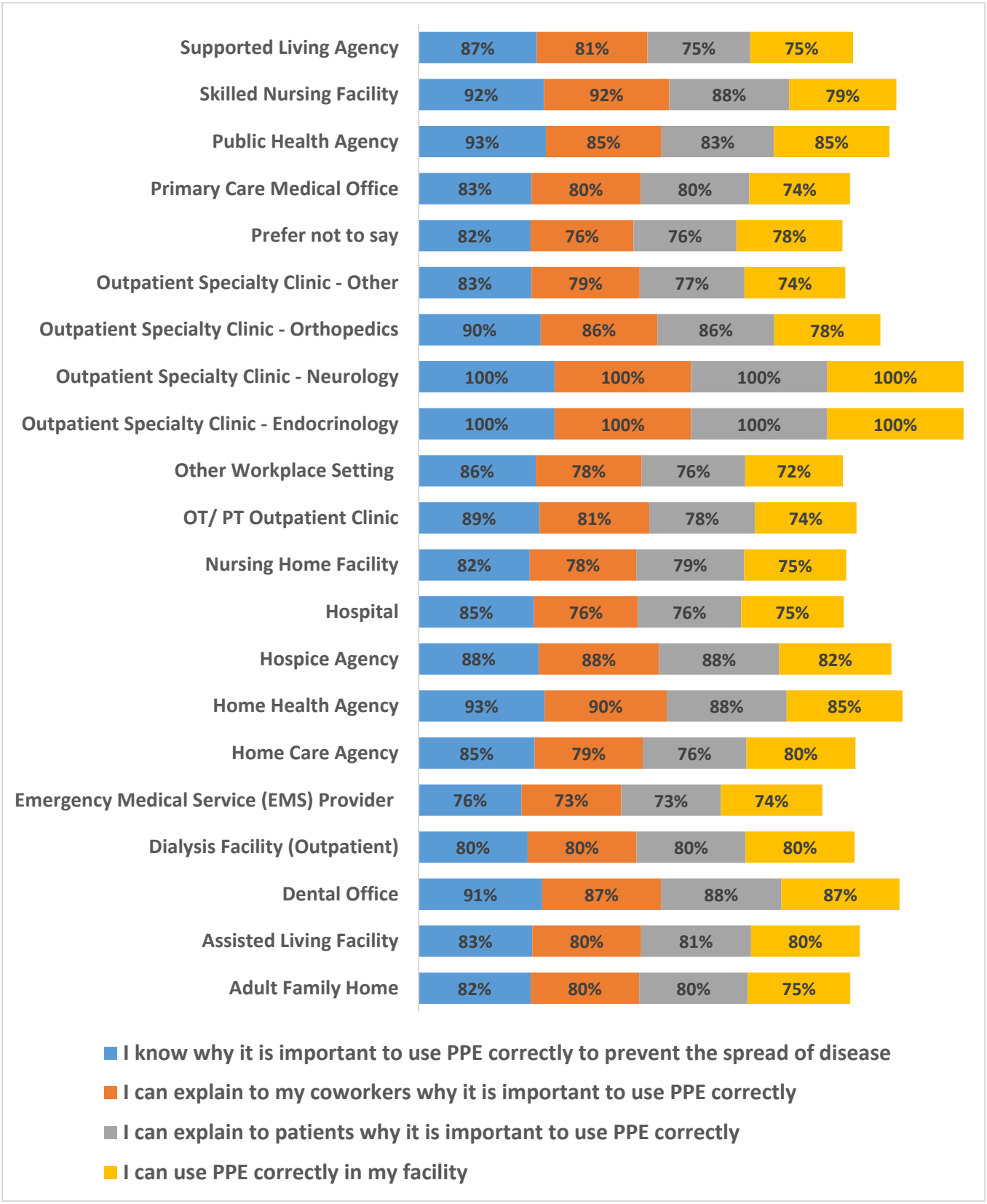
COVID-19



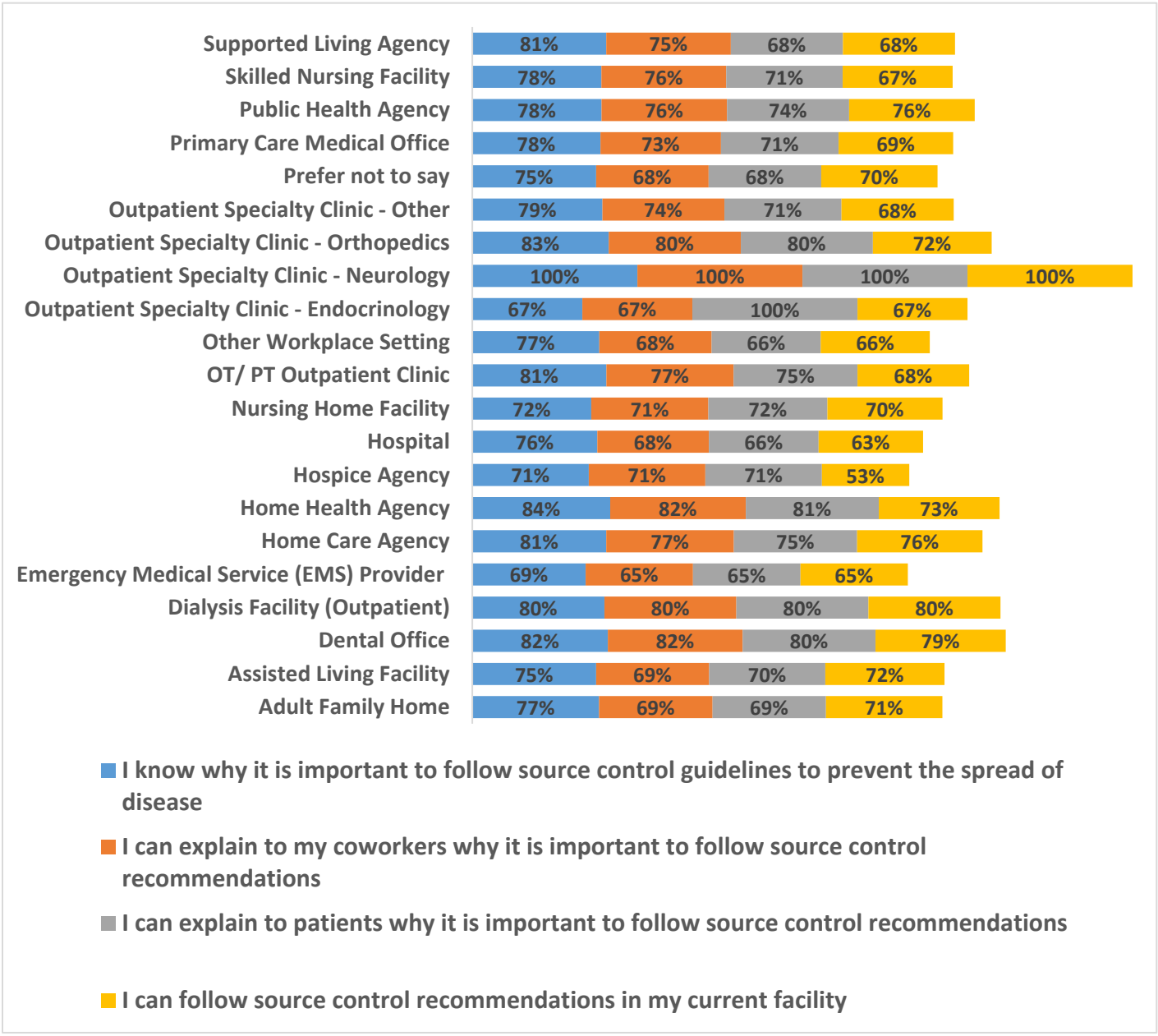
Hand Hygiene



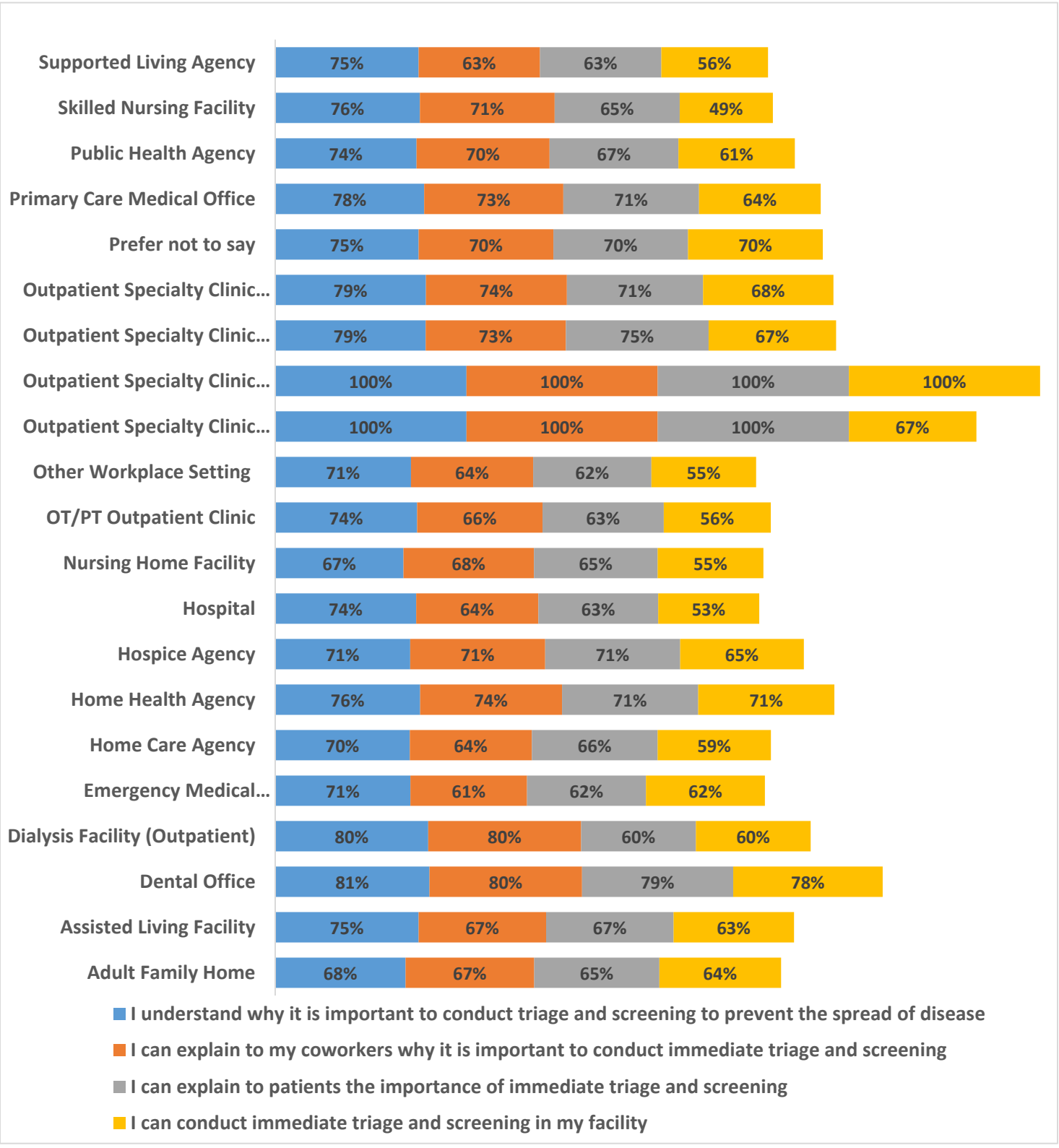
Personal Protective Equipment (PPE) Use



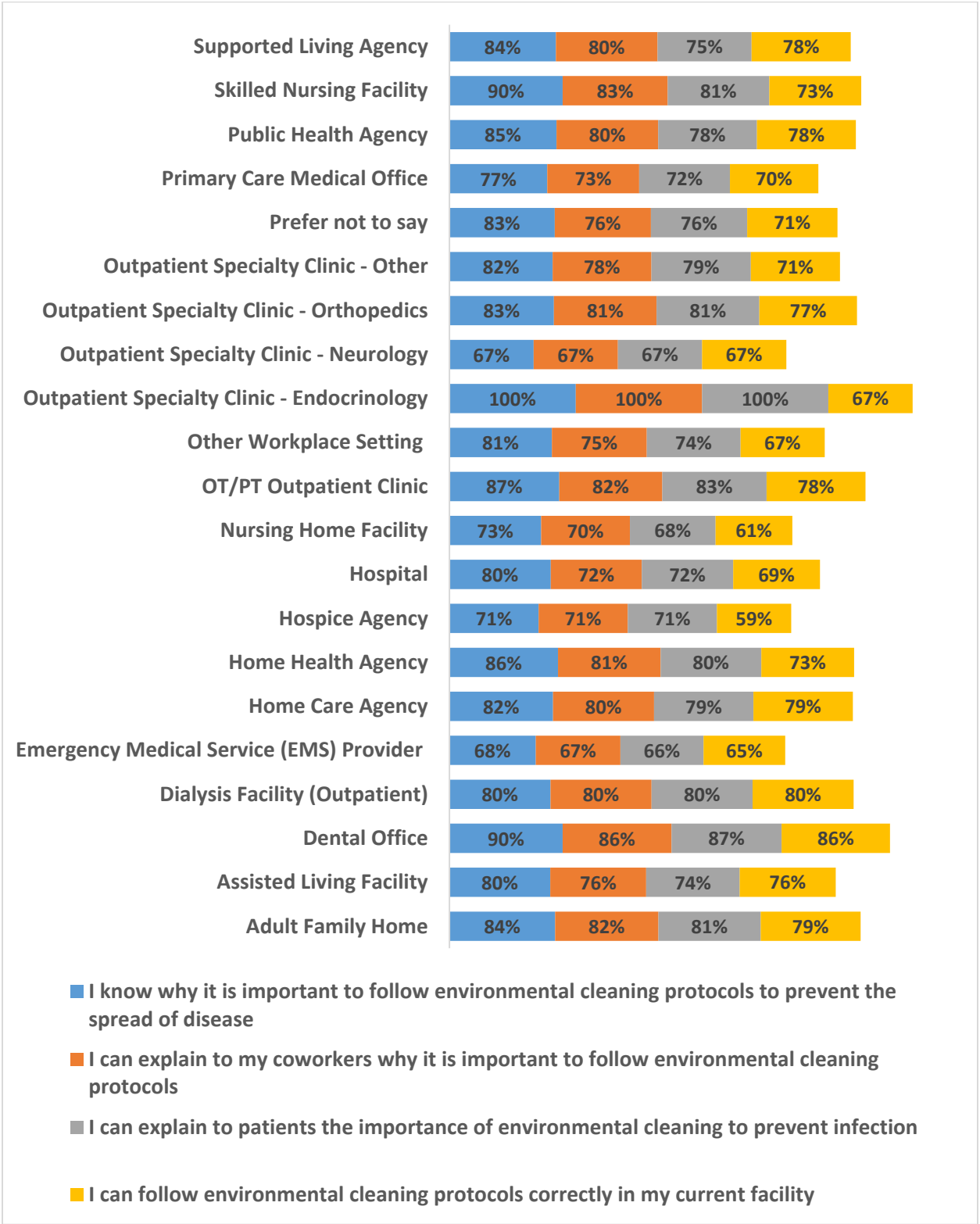
Source Control



Triage and Screening

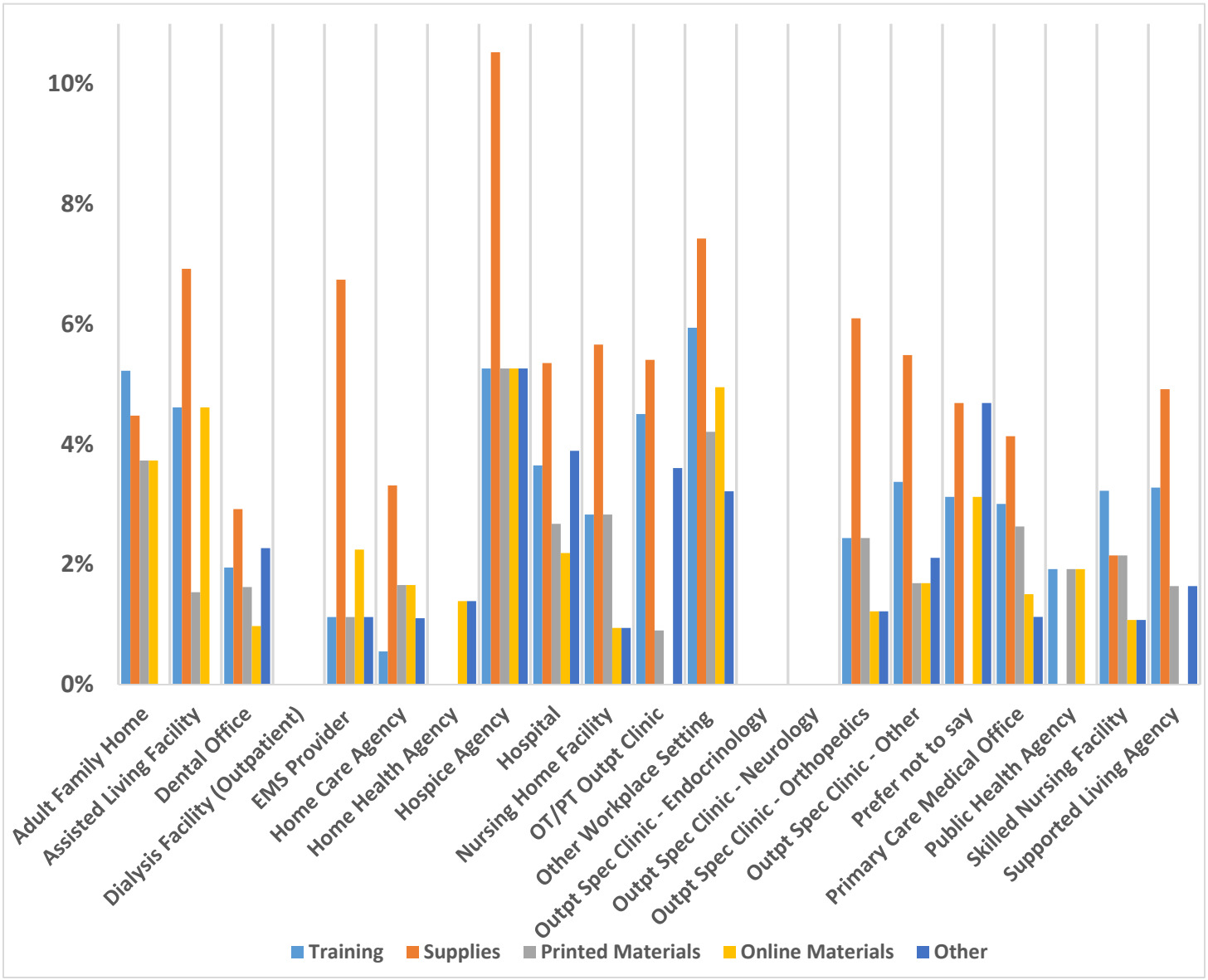


Environmental Cleaning



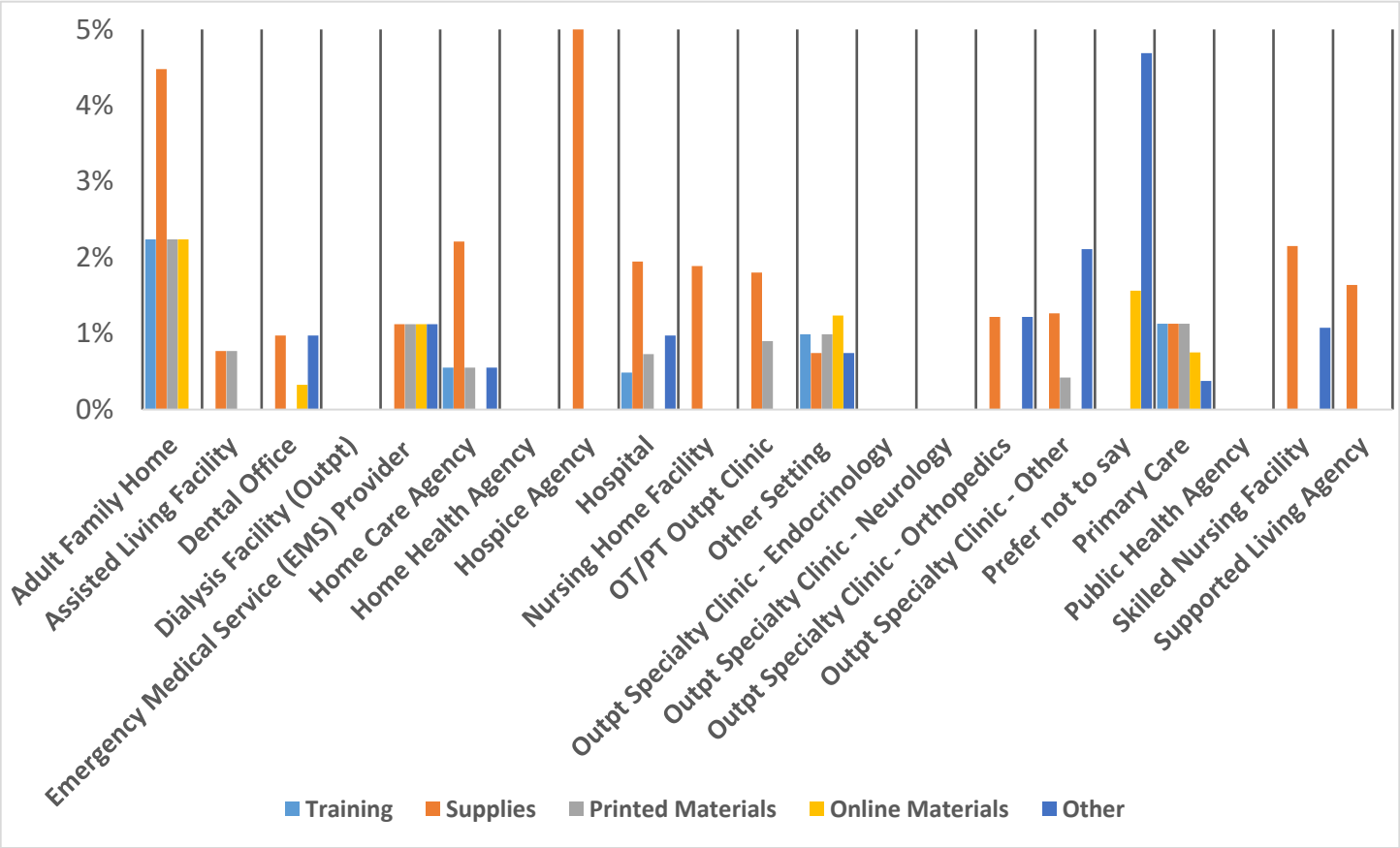
When participants responded with "neutral," "disagree," or "strongly disagree" they were asked what would help them correctly follow the specific infection control topic recommendations. The data analysis is below.

COVID-19



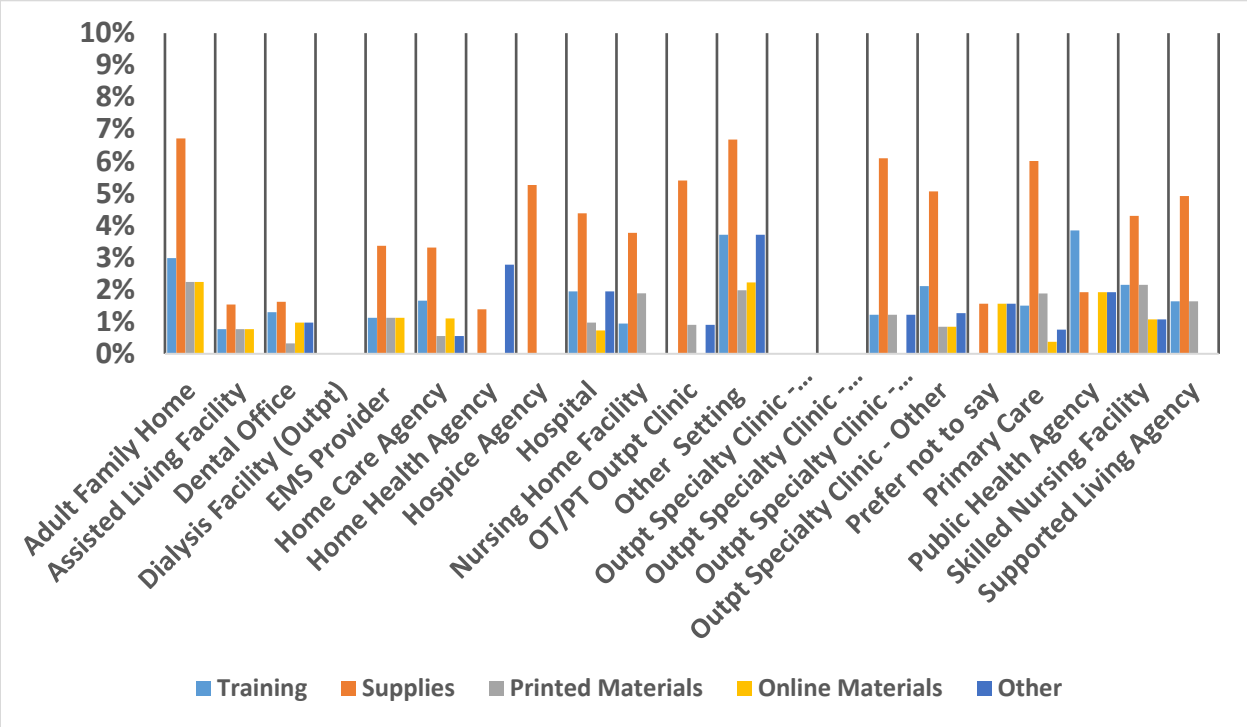
Other: more space for breakrooms, more support from leaders to follow guidelines (several responses), less conflicting/inconsistent guidance (several responses for this), more space and more time between caring for patients (several responses), more staff (several responses), consistent supervision and enforcement, timely updates, discipline for coworkers not following guidelines.

Hand Hygiene



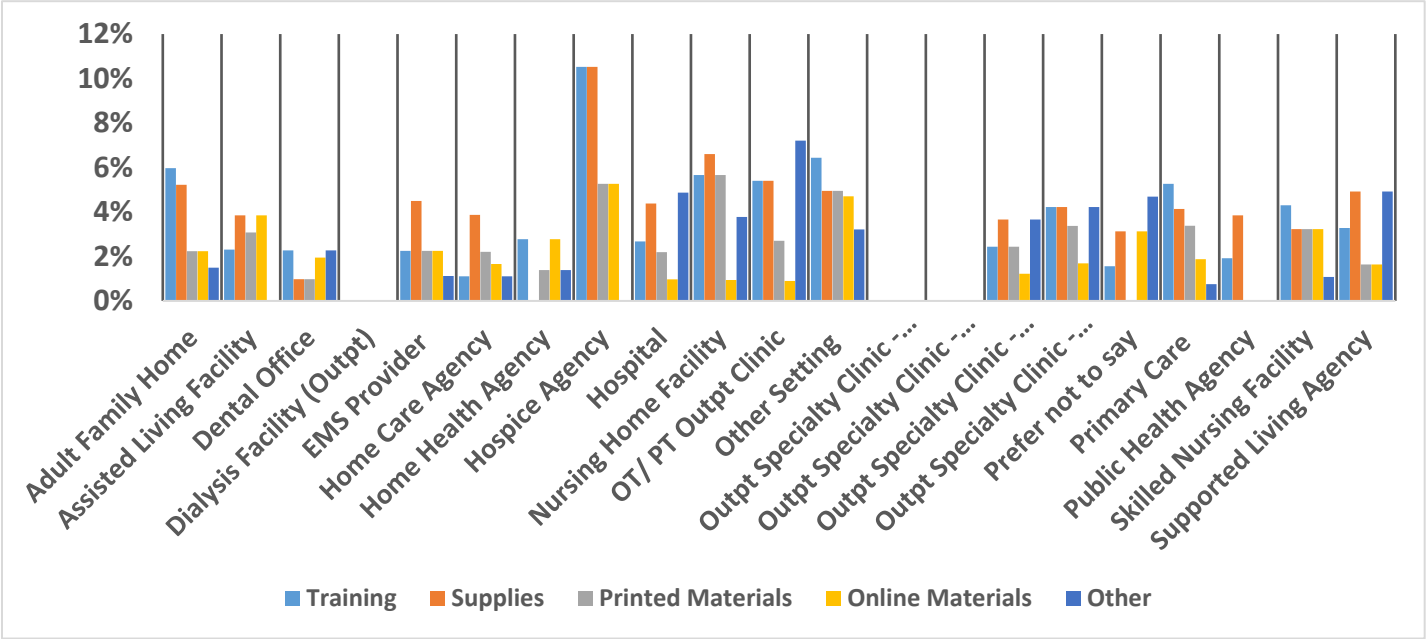
Other: more washing stations/sinks in care areas, help with coworker compliance.

Personal Protective Equipment (PPE)



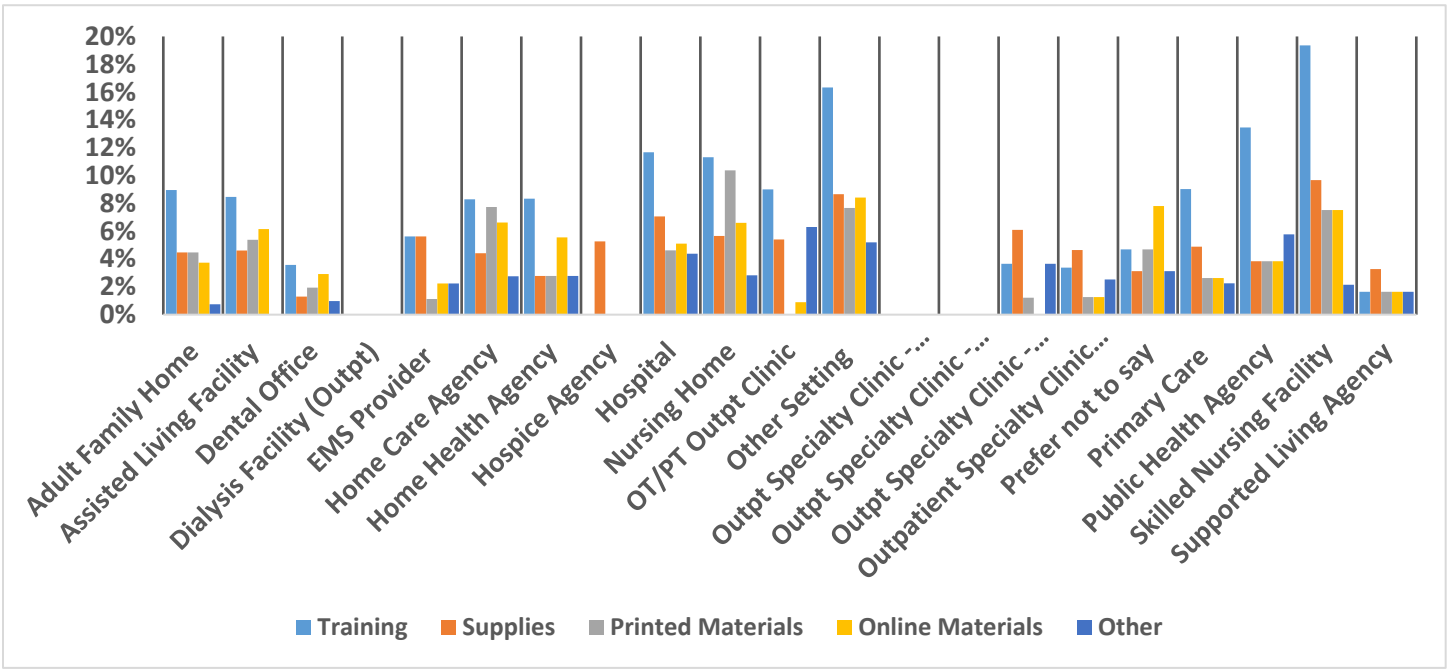
Other: having designated stations for donning/doffing, confusing when recommendations keep changing, employer needs to be willing to participate, more mandates, consistency from experts

Source Control



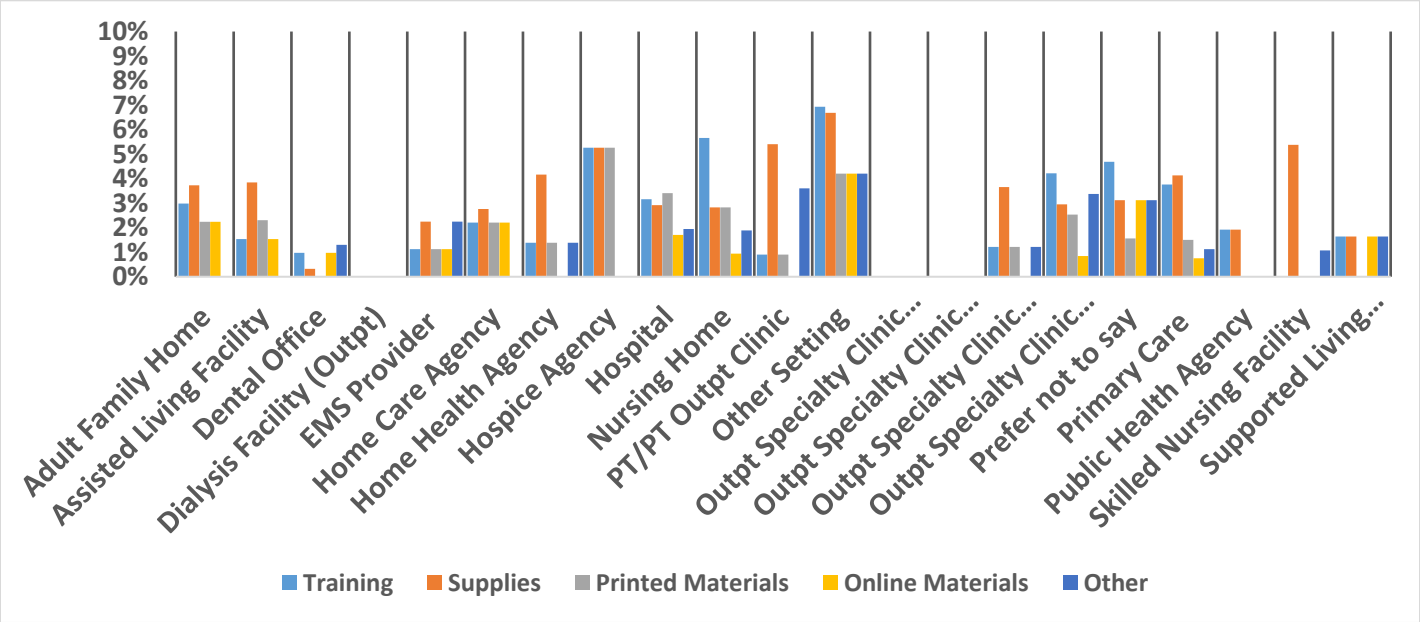
Other: belief in the guidelines and enforcement from leadership (several responses), break areas are too small, source control is not enforced by my hospital, (additionally several people who clearly do not understand what the term source control means)

Triage and Screening



Other: enforcement of screening policy, don't have enough staff to screen (several responses), lack of isolation rooms/areas to keep patients away from others, we can screen them but they are not being honest, this doesn't apply to my job setting (dental office).

Environmental Cleaning Protocols



Other: not enough staff, more staff to help clean (several responses), not my job, more time needs to be allowed for cleaning (several responses), adequate time for cleaning not provided since it is not billable, need support and follow through from management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