

Ethical Infection Prevention and Control Exploring the APIC/IPAC Ethical Infection Prevention and Control (EIPAC) Decision-Making Framework

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Learning objectives

Describe the Ethical Aspects of Infection Prevention and Control

Understand how the core ethical principles relate to infection prevention and control decisions

Summarize the IDEEA steps of the APIC/IPAC Ethical Infection Prevention and Control (EIPAC) Decision-Making framework

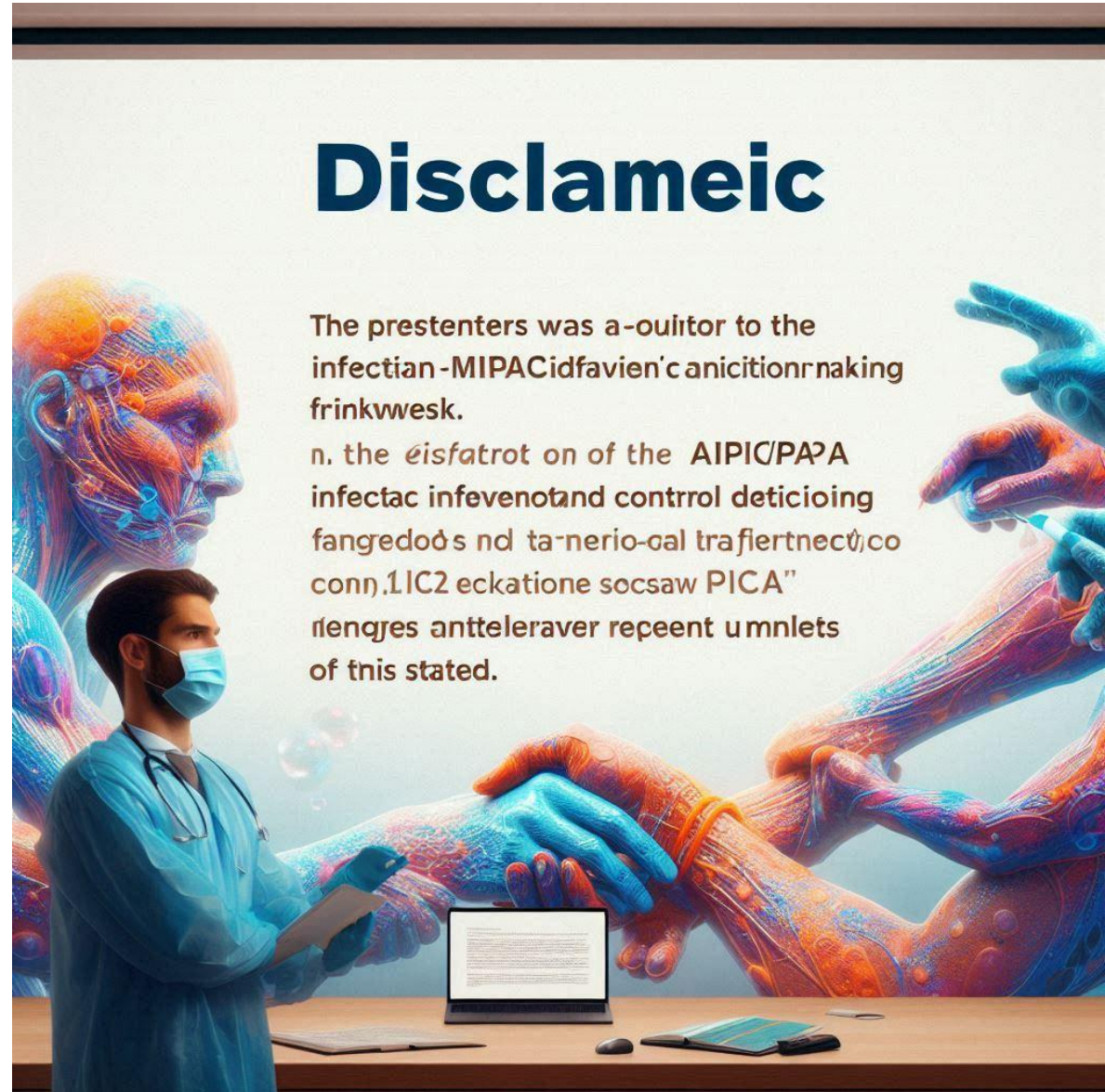
Disclaimer

- The presenter was on the working group for the APIC/IPAC Ethical Infection prevention and control (EIPAC) decision-making framework and has no other relevant conflicts of interest
- Images in this presentation were created by Microsoft Designer, Copilot, and ChatGPT unless otherwise stated
- The presenter is President-elect of APIC
- But first, a little note about AI!

Copilot is obviously still learning...

AI can be a good resource if you know the subject

If you don't know the subject, you may end up with word salad and Scary images



And Sometimes AI even has a sense of
humor





INFECTION CONTROL CITATIONS VARY BY STATE

Three-Year Comparison (April 1, 2022 – March 31, 2025)*



5 STATES WITH THE FEWEST IPC CITATIONS

(F880, F881, F882 Combined)

State	Certified Nursing Homes	F880 (Infection Control Program)	F881 (Antibiotic Stewardship)	F882 (IP Requirements)	TOTAL IPC CITATIONS (F880+F881+F882)	CITATIONS PER 100 FACILITIES
Alaska	20	7	1	0	8	40.0
Vermont	34	9	1	1	11	32.4
Wyoming	36	10	0	1	11	30.6
Hawaii	42	11	1	1	13	31.0
Delaware	44	11	3	0	14	31.8



COMPARISON STATES

(Maryland, Illinois, California, Washington)

State	Certified Nursing Homes	F880 (Infection Control Program)	F881 (Antibiotic Stewardship)	F882 (IP Requirements)	TOTAL IPC CITATIONS (F880+F881+F882)	CITATIONS PER 100 FACILITIES
Maryland	233	307	66	28	401	172.1
Illinois	667	1,311	155	86	1,552	232.7
California	1,162	3,402	336	82	3,820	328.7
Washington	425	593	66	27	686	161.4



Citation frequency varies dramatically across states—*reflecting differences in facility performance, survey activity, enforcement practices, or all three.*



Public health partners must understand not only where facilities are struggling—but the regulatory environment in which their Infection Preventionists work.

*Source: CMS Health Deficiencies Dataset (r5ix-sfxw), deficiencies cited between 04/01/2022 and 03/31/2025.
CMS Provider of Services File (4pq5-n9py), March 2026 (certified nursing homes).



INFECTION CONTROL CITATIONS:

5 States with the Most vs. Key Comparison States

Three-Year Comparison (April 1, 2022 – March 31, 2025)*



5 STATES WITH THE MOST IPC CITATIONS (EXCLUDING CALIFORNIA AND ILLINOIS) (F880, F881, F882 COMBINED)

STATE	CERTIFIED NURSING HOMES**	F880 Infection Control Program	F881 Antibiotic Stewardship	F882 IP Requirements	TOTAL IPC CITATIONS (F880+F881+F882)	CITATIONS PER 100 FACILITIES
Texas	1,174	2,374	—	—	2,374	202.2
Ohio	915	1,578	221	—	1,799	196.6
Missouri	483	931	112	62	1,105	228.8
Pennsylvania	1,114	827	66	40	933	83.7
Florida	696	670	92	51	813	116.8

— = Data not in top 10 states for that F-tag.



KEY COMPARISON STATES (Maryland, Illinois, California, Washington)

STATE	CERTIFIED NURSING HOMES**	F880 Infection Control Program	F881 Antibiotic Stewardship	F882 IP Requirements	TOTAL IPC CITATIONS (F880+F881+F882)	CITATIONS PER 100 FACILITIES
Maryland	220	66	—	—	66	30.0
Illinois	668	1,311	155	86 ★	1,552	232.7
California	1,162	3,402	336	82	3,820	328.7
Washington	194	95	66	—	161	82.9



What the data show:

- Substantial variation in IPC citation frequency across states.
- Raw counts reflect volume; **per-100-facility rates** reflect **citation intensity**.



Illinois Leads the Nation for F882:

86 citations for **IP Requirements**—more than any other state.

Strong reminder: **Supporting Infection Preventionists matters** for residents and for compliance.

* Source: CMS Health Deficiencies Dataset (r5ix-sfxw), deficiency citations between 04/01/2022 and 03/31/2025.

** Source: CMS Provider of Services File (4pq5-n9py), March 2026 (certified nursing homes).



Citation frequency reflects survey activity and state enforcement practices as well as facility performance. Data do not prove that one state has better or worse infection prevention than another.

NACCHO
National Association of County & City Health Officials

APIC
Association for Professionals in Infection Control and Epidemiology

ME: “*I’m re-reading. So, the image generator is a fan of bootstrapping, eh? LOL*”

ChatGPT: “   Apparently it is!

- Give the image generator four verified numbers and a blank cell, and it says, “*I understand statistics. I shall estimate the remainder.*”
- **NO. YOU SHALL NOT.** 
- It is actually a perfect illustration of why we've been separating **analysis from design**. The image generator is terrific at composition, hierarchy, icons, spacing, and making our slides look polished. But it sees a table and wants to make the table *look complete*. It doesn't understand that, in our world, a dash meaning “**not independently verified**” is vastly preferable to a beautifully typeset hallucination”



So Thankful
You are Still
Here



Why Ethics Matter in Infection Prevention



Four Core Medical Ethics Principles

1. Respect for Persons
2. Beneficence & Nonmaleficence (Do Good, Do No Harm)
1. Justice
2. Accountability & Transparency

Practical Healthcare Epidemiology

EDITED BY LOREEN A. HERWALDT, MD

Ethical Aspects of Infection Control

Loreen A. Herwaldt, MD

Epidemiology/Infection Prevention Ethics	Medical/Healthcare Ethics
Population oriented	Person oriented
Do No Harm (Non-maleficence)	Do No Harm (Non-maleficence)
Confidentiality	Confidentiality
Investigation and Reporting	Privacy
Justice	Autonomy

Association for Professionals in Infection Control and Epidemiology Ethics Statement

Ethics

“IPs shall make decisions based on professional standards and values that guide professional behavior, including:

- Hold paramount the safety, health, and welfare of the public in the performance of professional duties.
- Comply with laws and regulations related to practice, geographic location, and settings.
- Maintain confidentiality, and the safety, health, and welfare of all people, in the performance of his/her professional duties.
- Respect the uniqueness, dignity, and autonomy of every patient, visitor, and provider.
- Demonstrate personal and professional honor, integrity, and dignity.
- Establish his/her professional reputation based on personal merit. Accept responsibility and accountability for professional competence.
- Engage in research in a professional manner by using and supporting the advancement of the science of IPC and epidemiology.
- Ensure transparency and disclosure in performing research and/or applying for grants.
- Disclose all potential or perceived conflicts of interest.
- Refrain from competing unfairly with others.
- Refuse gratuities, gifts, or favors that might impair or appear to impair professional judgment and never offer any favor, service, or thing of value to obtain special advantage.”



Respect for Persons Upholding Dignity and Autonomy

- Recognize patient rights and cultural values
- Prioritize informed consent and open communication
- Balance public health priorities with individual freedoms



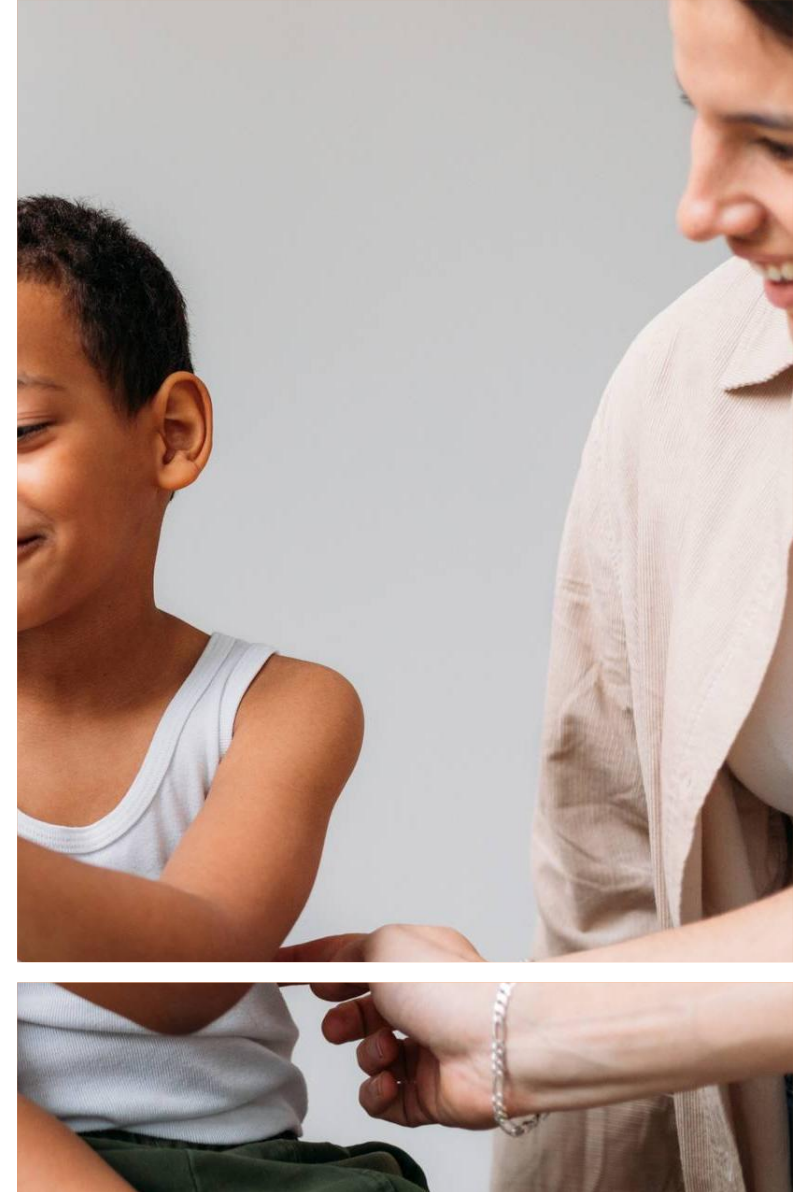
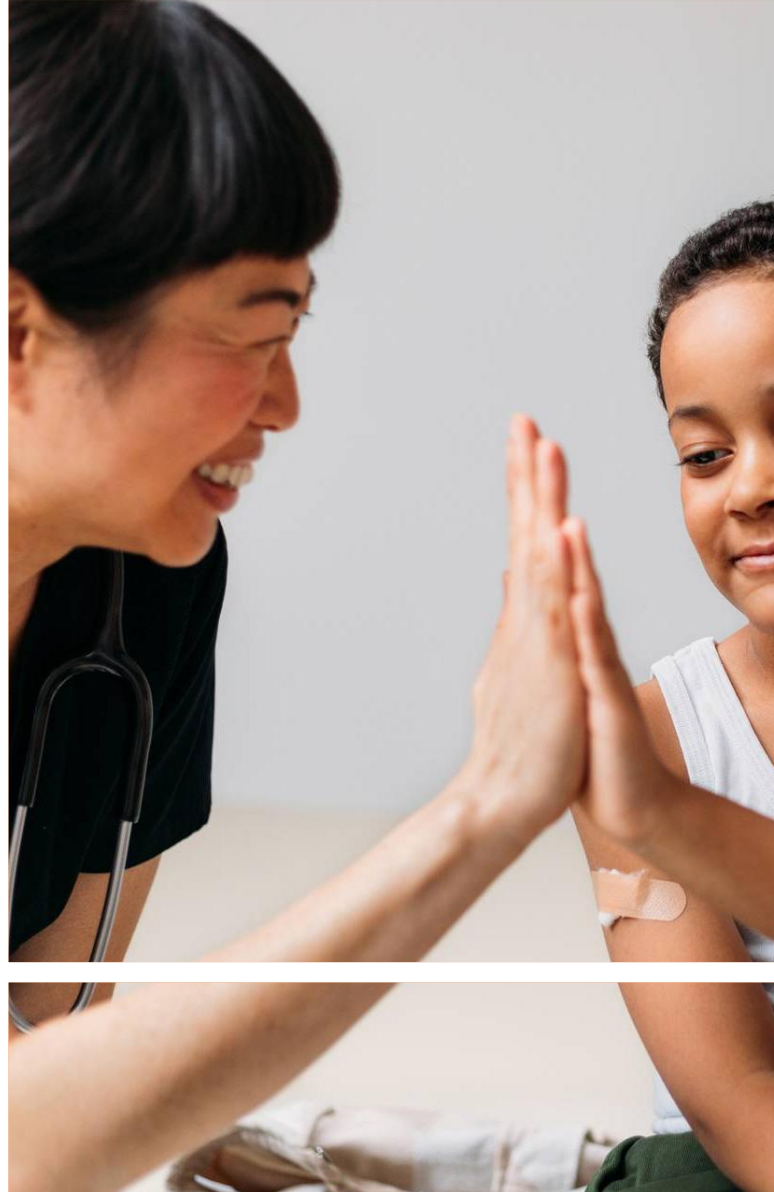
Beneficence & Nonmaleficence

Do Good. Do No Harm

- Evaluate both benefits and risks of interventions
- Seek the *least restrictive* options
- Mitigate unintended consequences (e.g., isolation, fear)

Justice: Promoting Fairness and Equity

- Equitable access to infection control resources
- Advocacy for vulnerable and marginalized populations
- Fair burden-sharing among staff and departments



Accountability & Transparency Building and Maintaining Trust

- Clear, honest communication during uncertainty
- Transparent rationale for policies and protocols
- Accept responsibility and adjust when needed

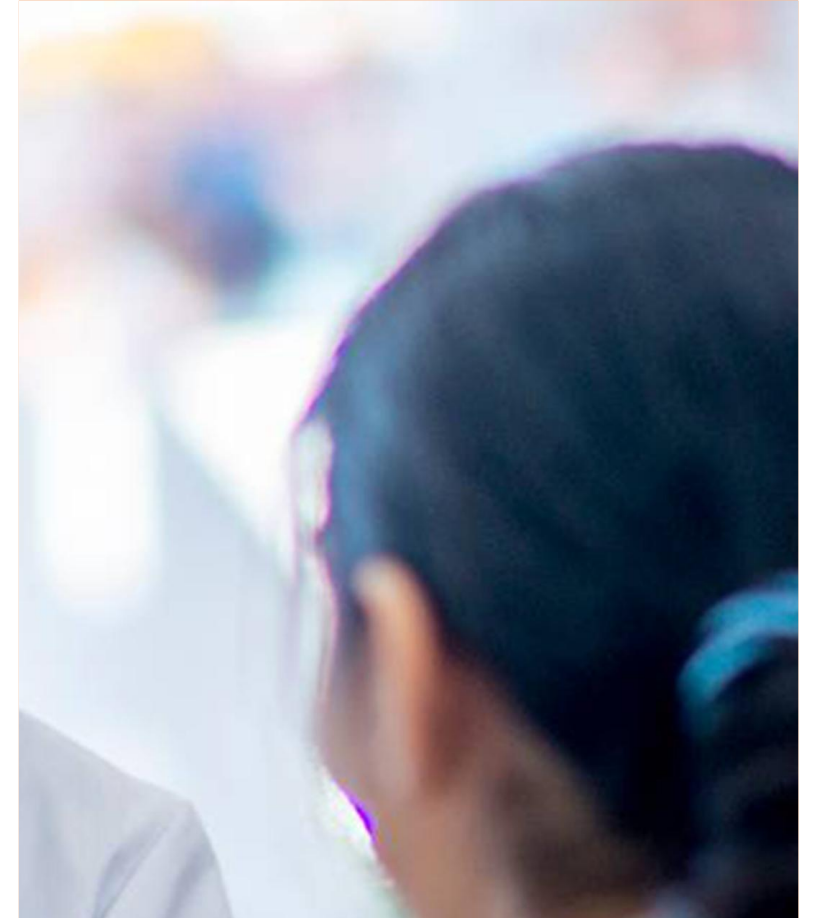


Why Ethics Matter in Infection Prevention

Infection prevention is more than a science—it's a moral duty.

Ethical dilemmas arise daily in our work.

The APIC/IPAC Framework helps us navigate with clarity and conscience.



Ethics in Action Real-World Applications

Cohorting/Admissions

Masking and visitation policies

Resource prioritization during outbreaks

Mandatory reporting vs. patient
confidentiality





CORE MEASURES OF INFECTION PREVENTION AND CONTROL

Each one of these core measures has the potential to create an ethical issue





General Vaccine Administration

Source Control / PPE

Preferred PPE – Use N95 or Higher Respirator

Face shield or goggles

One pair of clean, non-sterile gloves

Isolation gown

Acceptable Alternative PPE – Use Facemask

cdc.gov/COVID19

Antimicrobial Stewardship



Detection,
Isolation/Quarantine
Screening and Surveillance



Hand Hygiene



Surface Cleaning /
Disinfecting

The National Personal Protective Technology Laboratory (NPPTL)

NIOSH-Approved Particulate Filtering Facepiece Respirators

Promoting productive workplaces through safety and health research **NIOSH**

NIOSH-approved N95 Particulate Filtering Facepiece Respirators

Updated July 22, 2021

Image: Harper College

Respiratory Protection / Ventilation

Images CDC, Mommarazzi Images, Harper College, Microsoft.

Core Infection Prevention Practices

But first: How Long Does it Take for Healthcare Evidence to Turn Into Healthcare Practice?

1. 5 Years
2. 10 Years
3. 12 Years
4. 15 Years
5. 17 Years
6. 20 Years
7. 25 Years



REVIEW



The answer is 17 years, what is the question: understanding time lags in translational research

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J R Soc Med 2011; 104: 510–520. DOI 10.1258/jrsm.2011.110180

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3241518/pdf/JRSM-11-0180.pdf>

This Issue

Views 33,887 | Citations 7 | Altmetric 474 | Comments 2

Medical News & Perspectives

April 5, 2023

It Takes an Average of 17 Years for Evidence to Change Practice—the Burgeoning Field of Implementation Science Seeks to Speed Things Up

Rita Rubin, MA

JAMA. 2023;329(16):1333-1336. doi:10.1001/jama.2023.4387



JAMA Medical News

<https://jamanetwork.com/journals/jama/article-abstract/2803716>

Being ethical requires best evidence

Scientific evidence takes time and can be confusing

Clear, honest communication during uncertainty can come off as not knowing

COMMENTARY: Wear a respirator, not a cloth or surgical mask, to protect against respiratory viruses

[Lisa M Brosseau, ScD, CIH](#), [C. R. MacIntyre, PhD](#), [Angela Ulrich, PhD, MPH](#), [Michael T. Osterholm, PhD, MPH](#),

February 23, 2023

Topics: [COVID-19](#), [Influenza](#), [General](#)



US Navy, Jake Greenberg / Flickr cc



SHARE

Dr Brosseau is a national expert on respiratory protection and infectious diseases and a research consultant with the Center for Infectious Disease Research and Policy (CIDRAP) at the University of Minnesota (UMN). **Dr MacIntyre** is Professor of Global Security at the University of New South Wales. She coauthored a separate [critique](#) of the Jefferson Cochrane review. **Dr Ulrich** is a UMN assistant professor in the Division of Environmental Health Sciences and a CIDRAP researcher. **Dr Osterholm** is CIDRAP director and Regents Professor at UMN.

<https://www.cidrap.umn.edu/covid-19/commentary-wear-respirator-not-cloth-or-surgical-mask-protect-against-respiratory-viruses>

Entering the paradigm of people who *talk a good ride*

- “*Talk a good ride* is a slang phrase meaning to boast or brag about one's abilities or accomplishments, especially in a way that isn't backed up by actual evidence or action. It's a way of saying someone talks a lot about how good they are at something without actually performing well or achieving great things.” **Merriam-Webster Slang Dictionary**



© Mommarazzi Images, 1967



Original Article

An ethical framework can help

An ethical framework adapted for infection prevention and control

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Adrienne K. Chan MD, MPH^{1,2,3} and Jerome A. Leis MD, MSc^{1,2,3} 

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Ethical Infection Prevention and Control (EIPAC) Decision-Making Framework

A partnership between The Association for Professionals in Infection Control and Epidemiology (APIC) and Infection Prevention and Control Canada (IPAC Canada)



Situations in infection prevention and control when an ethical framework is indicated

- When there is no established standard or policy
- Deviation from standard or policy is being considered
- Decisions with substantial impact on involved parties
- Decisions that compromise one or more relevant ethical principles
- Complex decisions that are best documented in a structure format
- Decision that may be revisited in light of new information

FIGURE 1: The Ethical Infection Prevention and Control (EIPAC) Framework.

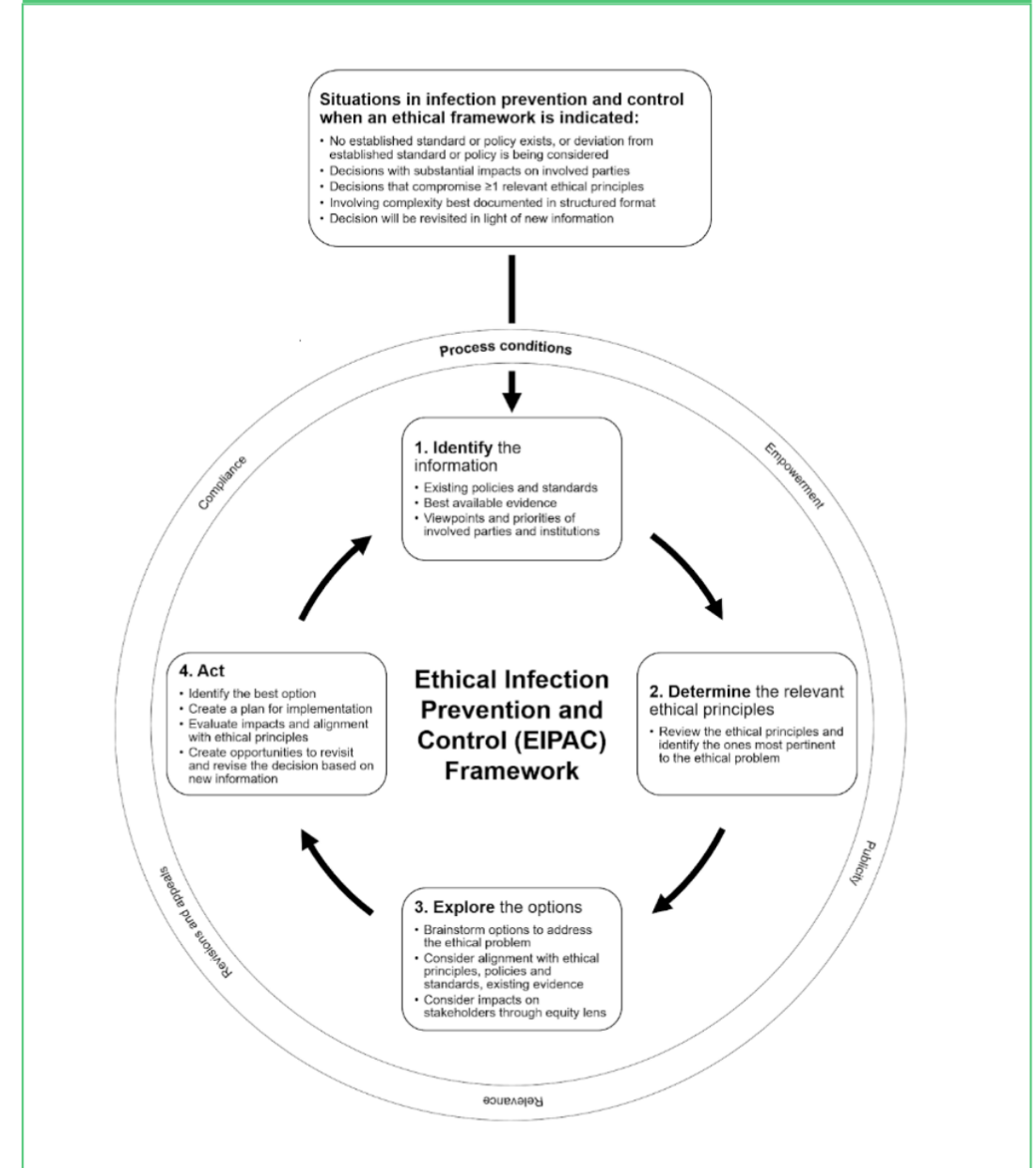


Figure reproduced with permission from Tan, C., Ofner, M., Candon, H. L., Reel, K., Bean, S., Chan, A. K., & Leis, J. A. (2023). An ethical framework adapted for infection prevention and control. *Infection Control & Hospital Epidemiology*, 10, 1-6.

Detailed overview of the EIPAC framework

IDEA steps

The four steps of the EIPAC decision-making tool:



Identify the facts



**Determine the
relevant IPC
ethical values and
principles**



**Explore the
options**

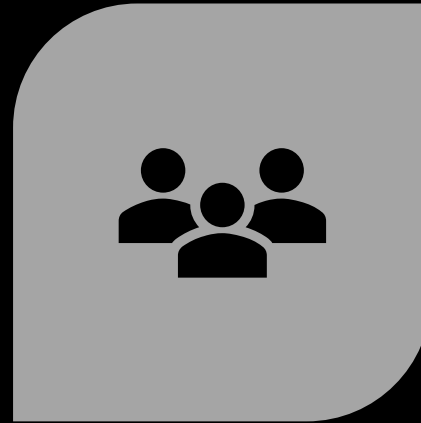


Act

THE ETHICAL INFECTION PREVENTIONIST MORE THAN A ROLE—A RESPONSIBILITY



USE THE FRAMEWORK TO GUIDE
TOUGH DECISIONS



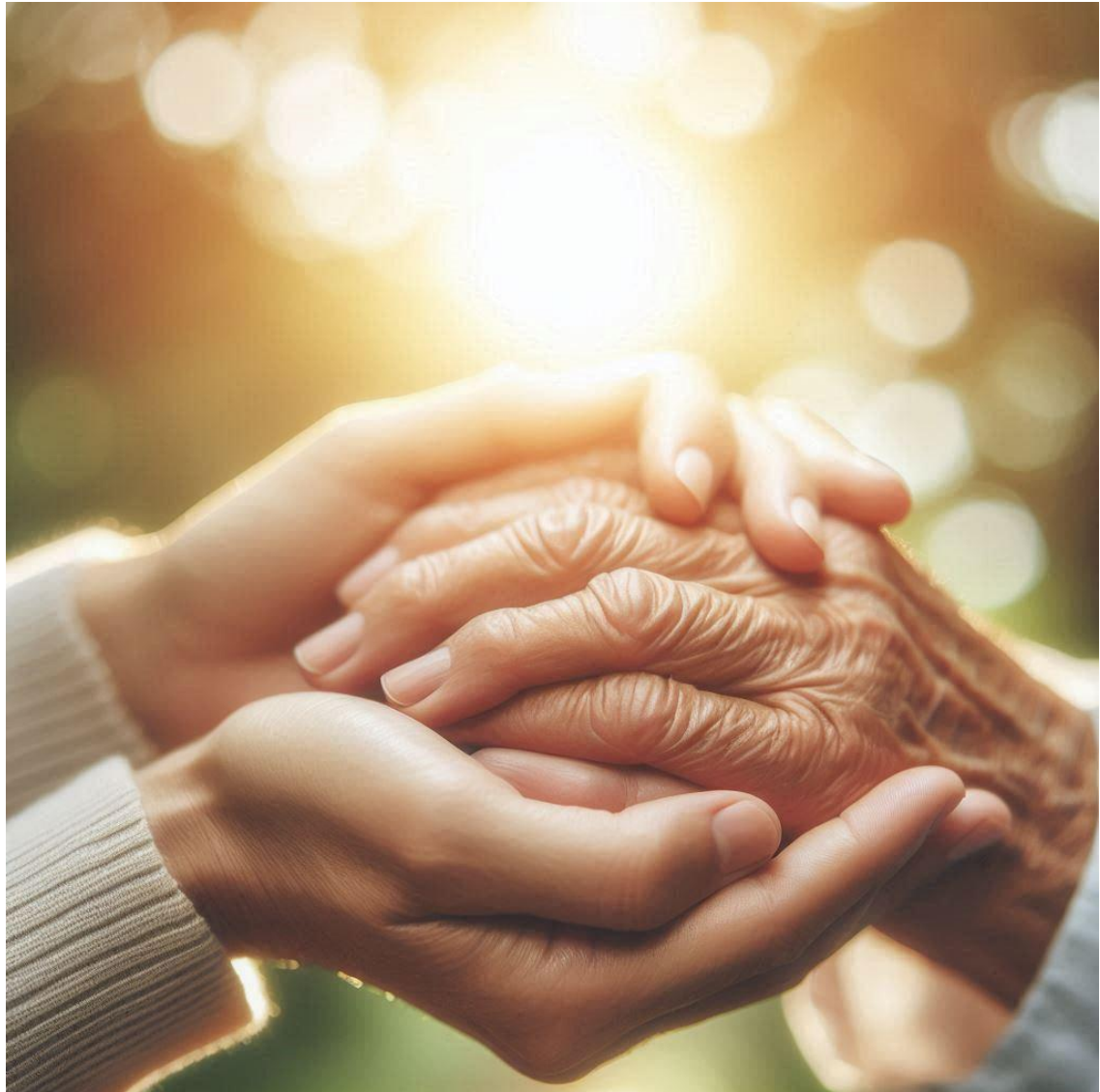
ENGAGE INTERDISCIPLINARY
TEAMS IN ETHICAL REFLECTION



LEAD WITH COURAGE,
COMPASSION, AND CONSISTENCY

Ethics: The Strongest Side of Prevention

- Let data guide us—but let values ground us
- Protect lives *and* honor dignity
- Infection prevention done right is infection prevention done ethically



#1 Neonatal intensive care visitation

A neonatal intensive care unit (NICU) has a strong family-centered care philosophy and a longstanding open visitation policy for families and caregivers provided they are asymptomatic for respiratory and other potentially transmissible diseases.

However, the parents of two patients have asked about the possibility of restricting visitation amidst an unprecedented level of respiratory virus circulating in the community. The Infection Prevention and Control (IPC) team is also concerned about this risk of introduction of infection into the NICU population, which can be associated with increased mortality.

Some peer facilities have considered restricting family members and visitors under 5 years of age given the increased risk posed by this age group and the challenges of accurately screening them, but the NICU team feel the screening is adequate and are concerned about detrimental effects on families whose lives are already profoundly complicated by NICU admission. NICU Leadership is seeking guidance from IPC on the optimal approach, balancing patient (neonate) and family needs with the increased risk of viral respiratory transmission.

STEP 1: IDENTIFY THE FACTS

NICUs follow a family-centered care model; best practice is for family members and visitors to be screened for viral respiratory infection and educated about their role in infection prevention.

What are the preferences of the patients, family and/or staff?

Patients' families and NICU staff express a preference for symptom-based screening as a protective measure for vulnerable neonates. There is a shared understanding among families, visitors, and staff about the significant harm that respiratory viruses can pose to neonates. While acknowledging the crucial roles that family members and visitors play in the care and well-being of hospitalized children, it is also recognized that they can inadvertently expose neonates to viruses.

There is concern around the appropriateness of permitting children under the age of 5 years to visit, as they may be more prone to transmitting infection given some are not able to reliably symptom screen. Striking a balance between maintaining open visitation where possible and safeguarding against potential virus transmission remains a key consideration for families and staff alike.

STEP 1: IDENTIFY THE FACTS, continued

NICUs follow a family-centered care model; best practice is for family members and visitors to be screened for viral respiratory infection and educated about their role in infection prevention.

What is the evidence?

Evidence suggests that symptom screening in NICUs is an important measure to reduce transmission of viral infections in the setting; however, the best approach to visitor screening, specifically as it relates to age restrictions, is not established.

What is the ethical issue?

Should an age restriction to visitation be implemented in the NICU limiting children under the age of 5 years during a period of unprecedented viral respiratory activity, in order to protect neonates from exposure to viral respiratory illnesses?

STEP 2: DETERMINE THE ETHICAL VALUES AND PRINCIPLES

Fairness (equity): Striving for equitable implementation of visitor restrictions, taking into account the vulnerability of neonates to respiratory viruses while considering the needs and concerns of families with children under the age of 5 years.

Demonstrating respect: Acknowledging the autonomy of families to participate in the care of their hospitalized child, while balancing it with the responsibility to minimize the risk of virus transmission.

Promoting well-being: Striking a just balance between facilitating family involvement in neonatal care and safeguarding neonates from potential harm due to viral exposure, especially during respiratory seasons.

Minimizing harm: Implementing visitor restrictions, specifically targeting children under age 5 years, in proportion to the potential risk of neonate viral infection.

STEP 3: EXPLORE THE OPTIONS

Option 1: Open visitation—no restrictions by age.

Option 2: Restricting children under age 5 years, with no exceptions

Option 3: Restricting children under age 5 years, with an appeals process and certain exceptions

STEP 4: ACT (THE ‘HOW’)

Option 3 is selected as the preferred approach for the NICU visitation policy, embodying the value of fairness through balancing the ethical principles of demonstrating respect, minimizing harm, and promoting well-being.

This strategy acknowledges the potential vulnerability of neonates to viral respiratory infection while providing a mechanism for families to present their unique circumstances, such as homeschooling or siblings at specific developmental stages who would be unable to bond with a new sibling for an extended period. The inclusion of an appeals mechanism contributes to compliance with process conditions. The decision prioritizes the well-being of both neonates and families, maintaining a delicate balance by regularly assessing proportionality and implementing additional measures, e.g., masking, additional ventilation, private space, etc.

This dynamic and responsive approach underscores a commitment to promoting familial involvement while safeguarding the health of vulnerable neonates, fostering trust through transparent communication with families.

#2 Long Term Care Celebration

A resident in a long-term care community (LTCF) is turning 100 years old and a birthday celebration has been planned at the facility by the resident's family.

Residents from the facility, as well as external guests (including people from outside the country) have been invited. The day before the party, a gastroenteritis outbreak is declared on the resident's unit.

The resident is not symptomatic at this time. The LTCF and the resident's family are asking for guidance from the infection preventionist regarding whether the party can still proceed.

STEP 1: IDENTIFY THE FACTS

Guidelines and regional best practice recommendations advise restricting nonessential visitors and events involving congregation during gastroenteritis outbreaks.

- **What are the preferences of the patients, family and/or staff?**

The birthday celebration cannot be rescheduled as guests have flown in from other countries. The risks associated with the outbreak, as well as the recommended restrictions in light of it, were explained to all stakeholders.

- **The resident** prioritized proceeding with their 100-year birthday to see their family and friends—for some of the more distant ones it will likely be the last time.

Residents invited to the celebration, as well as non-resident community guests, prioritized attending the celebration with the resident

STEP 1: IDENTIFY THE FACTS (con't)

- **What is the evidence?**

Gastroenteritis outbreaks, especially those caused by norovirus, are typically highly communicable, with a low infectious dose required for transmission. Studies have demonstrated high secondary attack rates during outbreaks in various settings, including congregate living facilities. In vulnerable populations, there is a significant risk of complications including dehydration, delirium, and need for hospitalization.

Among effective control measures, gatherings of residents such as communal dining should be avoided to prevent further transmission.

- **What is the ethical issue?**

Should the 100-year birthday party be canceled/postponed due to risk of outbreak, or be allowed to proceed due to the exceptional circumstances of this gathering?

STEP 2: DETERMINE THE ETHICAL VALUES AND PRINCIPLES

- **Demonstrating respect:** The meaning of this event is important to the resident and their invited guests.
- **Minimizing harm:** Reduce risk of norovirus transmission among invited guests, especially vulnerable individuals living in the LTCF
- **Working together:** As infection prevention and control measures will present risk and burdens to all stakeholders it is important to include everyone involved at one point or other. Consensus is important.

STEP 3: EXPLORE THE OPTIONS

Option 1: Cancel the 100-year birthday party in the setting of a gastroenteritis outbreak.

Option 2: Proceed with the 100-year birthday party but only with community guests and not with any of the other residents.

Option 3: Hold the birthday party as scheduled with all invited guests.

STEP 4: ACT (THE ‘HOW’)

Option 3 is selected as the best option in this instance.

- This option aligns with the ethical principle of minimizing harm and promoting well-being, as long as appropriate IPC measures are in place.
- These include education and screening of guests for gastrointestinal symptoms, exclusion of symptomatic residents from attending unless recovered for at least 48 hours, ensuring hand washing has taken place, making alcohol-based hand rub widely available and encouraging frequent hand hygiene, having food catered in from a reliable external source, serving LTCF residents separately so they do not participate in family-style dining, and disinfecting the event space with a product active against non-enveloped viruses.
- Attendees who may have trouble adhering to precautions are paired with another able and willing guest or with a staff member to promote adherence.
- Heightened surveillance for gastrointestinal illness is implemented afterward among the residents who attend the event, with a low threshold for instituting transmission-based/additional precautions.

#3 Lapse In Sterility

A lapse of sterility has been identified in nerve block procedures at your hospital. New nerve block kits, specifically designed for regional anesthesia for shoulder surgeries, were introduced without proper adherence to sterility guidelines.

These kits, received from the supplier, contain sterile items inside, but the clinical team was unaware that the outer packaging of the kit is non-sterile. The non-sterile outer packages were therefore unknowingly placed in the sterile field during nerve blocks.

Anesthesiologists, dressed in sterile gowns and gloves, have been in contact with the unsterile packaging during insertion of nerve block catheters for shoulder surgeries. This practice may have compromised the sterility of nerve blocks and has gone unrecognized for one month—affecting approximately 500 patients. The lapse in sterility prompts consideration of whether patient disclosure is necessary.

STEP 1: IDENTIFY THE FACTS

There are no legal or procedural standards in IPC speaking directly to thresholds relating to the risk of infections in similar situations. Best practices for maintaining a sterile field include adhering to strict aseptic technique to prevent contamination during procedures, with no non-sterile items or staff entering the sterile field.

What are the preferences of the patients, family and/or staff?

Preferences for patients should balance possible duress from unnecessary disclosure versus duty to inform regardless of risk.

For staff, significant healthcare resources will be required to trace all patients who were exposed, provide disclosure, and conduct ongoing surveillance. The hospital's Risk Management team is also involved in the process

STEP 1: IDENTIFY THE FACTS, continued

What is the evidence?

For this scenario, the specific risk of infection is not known. Non-sterile packaging was introduced into a sterile field and handled by anesthesiologists donned in sterile gowns and gloves. However, the specific equipment for the nerve blocks within the packaging was sterile. Therefore, the overall risk of infection is expected to be extremely low.

Furthermore, the nerve block equipment was not used between patients; therefore, there is no risk of bloodborne transmission, but rather environmental organisms found on the outer packaging.

STEP 1: IDENTIFY THE FACTS, continued

What is the ethical issue?

Should a potential, yet likely minimal, risk of infection during nerve blocks introduced through non-sterile packaging be disclosed to affected patients? While the scenario does not meet legal or procedural thresholds for disclosure, does it meet an ethical threshold?

STEP 2: DETERMINE THE ETHICAL VALUES AND PRINCIPLES

Trust: Not disclosing the lapse in sterile technique and resultant infection risk may erode trust with affected patients.

Working together: Engaging all involved stakeholders, including patients, anesthesiologists, operating room nursing staff, and reprocessing department in honest and respectful communication on what has happened and possible solutions.

Minimizing harm: Unintentional harm can be caused by unnecessary disclosure when risk of infection is minimal, as patients may feel emotional duress. This needs to be balanced against the possible risk of infection resulting from the non-sterile packaging.

STEP 3: EXPLORE THE OPTIONS

Option 1: Non-disclosure with passive surveillance

Option 2: Non-disclosure with active surveillance

Option 3: Disclosure to affected patients

STEP 4: ACT (THE 'HOW')

Option 2 is selected as the preferred option. This would prevent the unnecessary disclosure to patients with a low quantifiable risk of infection and the associated use of healthcare resources. Close monitoring for any signal of increased infection, including longer term (2-month) review for any infections that could be missed, is a more justifiable burden of follow-up to ensure patient well-being and organizational accountability. The decision is reviewed with the hospital's Risk Management team to ensure it is reasonable and abides by considerations deemed relevant by involved stakeholders.

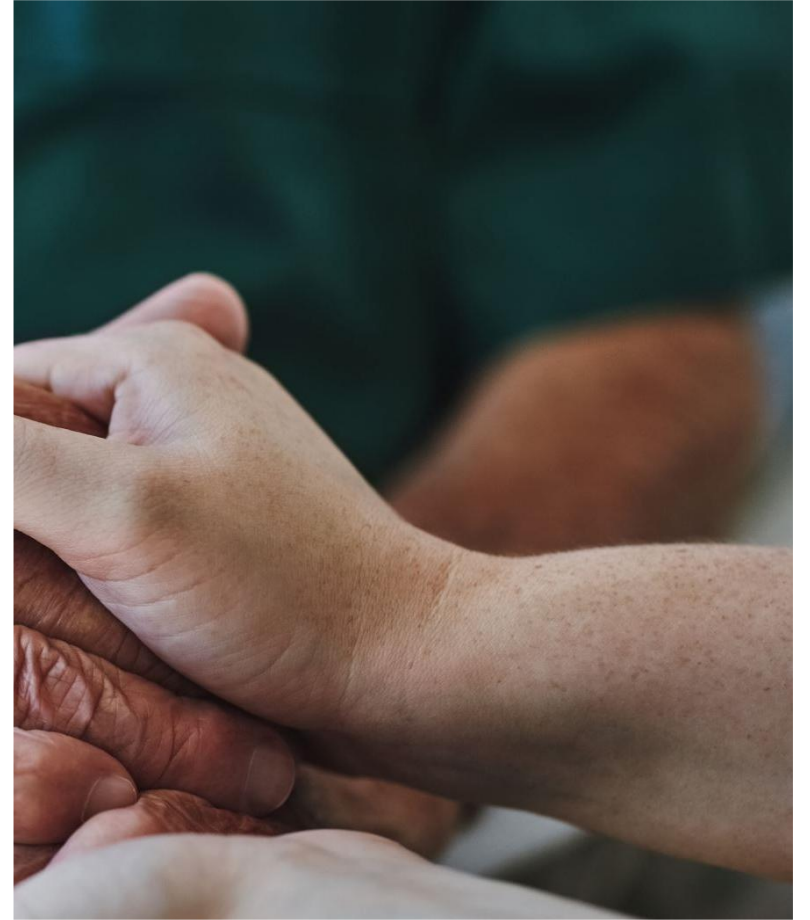
#4 Ethical Scenario: Overuse of Enhanced Barrier Precautions (EBP) in Endemic MDROs

- A SNF is applying Enhanced Barrier Precautions (EBP) to all residents with XDROs AND with:
 - Methicillin-resistant Staphylococcus aureus (MRSA)
 - Vancomycin-resistant Enterococcus (VRE)
 - Extended-spectrum beta-lactamase producing organisms (ESBL)
- As a result:
 - ~40% of residents are on EBP
 - Staff compliance is inconsistent
- This is occurring in an **endemic setting**, without evidence of increased transmission, severe illness, or outbreak. CDC states that, *“Determinations about an organism being epidemiologically important may be influenced by factors that include: local epidemiology, presence of ongoing or past outbreaks, propensity for transmission in healthcare facilities, association with severe outcomes, or targeting for local prevention efforts.”*
- Personal cost and economic cost of EBP needs to be considered vs. Risk of Transmission in an endemic environment

Step 1: Identify the Ethical Problem

Core Ethical Question

Is it appropriate to apply Enhanced Barrier Precautions in addition to Standard Precautions broadly for endemic MDROs when doing so may **not provide additional benefit** and may **cause harm to residents, and increase personal and economic cost?**



STEP 2: DETERMINE THE ETHICAL VALUES AND PRINCIPLES

Fairness: MRSA, VRE, ESBL are **endemic** in the facility. No outbreak or increase in infection rates caused by these MDROs therefore the risk of utilizing Standard Precautions for transmission control is appropriate

Demonstrating respect: The focus is not to over-isolate residents who need to have autonomy in decisions that affect their health.

Promoting well-being: Utilizing Standard Precautions removes the possible over-isolation of residents

<https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html>

Step 3: Explore the Options

- Option 1: Continue Current Practice (Broad EBP Use)
- Option 2: Implement Targeted, Risk-Based EBP using EBP only for organisms of concern/XDROs, or novel organisms to the facility

STEP 4: ACT (THE ‘HOW’)

Option 2 is selected as the best option given all the information available at the time. From a fairness and well-being lens, it focuses on the use of Standard Precautions rather than EBP.

It is consistent with CDC guidance related to endemic organisms that are not causing outbreaks or an increase in infection rate.



SUMMARY

- There are core ethical principles (e.g., autonomy, beneficence, non-maleficence, and justice) that relate to infection prevention and control decisions
- Through the EIPAC steps you can analyze common ethical dilemmas that arise when implementing infection prevention and control measures while maintaining family and visitor engagement, and evaluate strategies for addressing these conflicts

Ethics: The Strongest Side of Prevention

- Let data guide us—but let values ground us
- Protect lives *and* honor dignity
- Infection prevention done right is infection prevention done ethically





Thank you so much for still being here!!!

infection prevention is a journey, not a sprint

Questions?

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Resources Used

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