BOARD QUALITY REVIEW COMMITTEE MEETING
AGENDA

Wednesday, April 28, 2021
4:00 pm Meeting
Meeting participation to be Virtual pursuant to California Governor Newson’s Executive Order N-29-20
-Please see meeting log-in information below-

PLEASE MUTE YOUR MICROPHONE UPON ENTERING THE VIRTUAL MEETING ROOM
AND WHEN NOT SPEAKING

<table>
<thead>
<tr>
<th>Time</th>
<th>Form A Page</th>
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<tbody>
<tr>
<td>4:00</td>
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1. Establishment of Quorum
   Time: 1 Page: 4:01

2. Public Comments
   Time: 15 Page: 4:16

3. Action Item(s)

4. Standing Item(s)
   a. Medical Executive Committee (MEC) / Quality Management Committee (QMC) Update - Kanchan Koirala, MD, Chair, Quality Management Committee, Palomar Medical Center Escondido
      Sam Filiciotto, MD, Chair, Quality Management Committee, Palomar Medical Center Poway Time: 10 Target: 5:01

5. New Business
      John Steele, MD, Medical Director, Trauma
      Melinda Case, Manager, Trauma Program
      Remiga Paduga, MD, Medical Director, Stroke Program
      Lourdes Januszewicz, MSN APRN ACNS-BC SCRN CCRN, Stroke Program
      Sandeep Soni, MD, Medical Director, Infection Control
      Valerie Martinez, BSN MHA CIC CPHQ NEA-BC, Senior Director, Quality and Patient Safety
      Jamie Pierson, RN, Regulatory Program Manager
      Tricia Kassab, RN EdD, Vice President, Quality and Patient Safety

6. Adjournment to Closed Session
   Time: 1 Target: 5:22

7. Adjournment to Open Session
   Time: 1 Target: 5:33

8. Action Resulting From Closed Session
   Time: 1 Target: 5:34

9. Public Comments
   Time: 15 Target: 5:49

FINAL ADJOURNMENT
   Time: 1 Target: 5:50
### Board Quality Review Committee Members:

<table>
<thead>
<tr>
<th>VOTING MEMBERSHIP</th>
<th>NON-VOTING MEMBERSHIP</th>
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</thead>
<tbody>
<tr>
<td>Linda Greer, RN– Chairperson, Board Member</td>
<td>Diane Hansen, CPA, President / Chief Executive Officer</td>
</tr>
<tr>
<td>Terry Corrales, RN, Board Member</td>
<td>Sheila Brown, RN, MBA, FACHE, Chief Operations Officer</td>
</tr>
<tr>
<td>Laura Barry, Board Member</td>
<td>Omar Khawaja, MD, Chief Medical Officer</td>
</tr>
<tr>
<td>Kanchan Koirala, MD - Chair of Medical Staff Quality Management Committee for Palomar Medical Center Escondido</td>
<td>Michael Bogert, Chief Financial Officer</td>
</tr>
<tr>
<td>Sam Filiciotto, MD - Chair of Medical Staff Quality Management Committee for Palomar Medical Center Poway</td>
<td>Melvin Russell, RN, MSN, Chief Nursing Officer Palomar Medical Center Escondido</td>
</tr>
<tr>
<td>John Clark, Board Member 1st Alternate</td>
<td>Joyce Volesch, PhD, MS, RN, NEA-BC, Chief Nursing Officer Palomar Medical Center Poway</td>
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<td>Kevin DeBruin, Esq., Chief Legal Officer</td>
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<td>David Lee, MD, Medical Quality Officer</td>
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<td>Tricia Kassab, EdD, RN, FACHE, Vice President Quality and Patient Safety</td>
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<tr>
<td></td>
<td>Valerie Martinez, RN, BSN, MHA, CPHQ, CIC – Senior Director, Quality and Patient Safety</td>
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**NOTE:** If you have a disability, please notify us by calling 760.740.6333, 72 hours prior to the event so that we may provide reasonable accommodations.

*Asterisks indicate anticipated action. Action is not limited to those designated items.*

1 5 minutes allowed per speaker with a cumulative total of 15 minutes per group. For further details & policy, see attachment.

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**PLEASE JOIN THE MEETING FROM YOUR COMPUTER, TABLET OR SMARTPHONE**

https://global.gotomeeting.com/join/438703853

Access Code: 438-703-853

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https://global.gotomeeting.com/install/438703853
Board Quality Review Committee Minutes

Wednesday, February 24, 2021

TO: Board Quality Review Committee

MEETING DATE: Wednesday, April 28, 2021

FROM: Carla Albright, Interim Board Administration Staff

Background: Minutes from the Wednesday, February 24, 2021, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Wednesday, February 24, 2021, Board Quality Review Committee minutes.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, April 28, 2021

FROM: Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety

Background: Presenting the 2021 Board Quality Review Committee Performance Improvement Reporting Calendar for the Committee’s annual review and approval.

Budget Impact: N/A

Staff Recommendation: Approval

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee  
MEETING DATE: Wednesday, April 28, 2021  
FROM: Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Safety

**Background:** In compliance with the Palomar Health By-Laws, Section 6, item C (i), the Quality Assessment Performance Improvement Plan (QAPI) has been reviewed and updated. A red-line edit of the current Quality Assurance Performance Improvement Plan showing the proposed changes is submitted for the committee’s review.

**Budget Impact:** N/A

**Staff Recommendation:** Recommendation for Approval

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, April 28, 2021

FROM: Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Safety

Background: In compliance with the Palomar Health By-Laws, Section 6, item C (i), the Infection Prevention and Control Risk Assessment and Surveillance Plan has been reviewed and updated. A red-line edit of the current Infection Prevention and Control Risk Assessment and Surveillance Plan showing the proposed changes is submitted for the committee’s review.

Budget Impact: N/A

Staff Recommendation: Recommendation for Approval

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
Board Quality Review Committee
Infection Control and Prevention Program 2020
Annual Review and Program Assessment
Wednesday, April 28, 2021

TO: Board Quality Review Committee
MEETING DATE: Wednesday, April 28, 2021
FROM: Tricia Kassab, RN, EdD, Vice President, Quality and Patient Safety
Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety

Background: The Infection Control and Prevention Program 2020 Annual Review and Program Assessment was provided to the Board Quality Review Committee for informational purposes

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

**COMMITTEE RECOMMENDATION:**

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, April 28, 2021

FROM: Tricia Kassab, RN, EdD, Vice President, Quality and Patient Safety
       Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety

Background: The 2021 Home Health (HH) Infection Control Surveillance Plan was provided to the Board Quality Review Committee for informational purposes

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, April 28, 2021

FROM: Tricia Kassab, RN, EdD, Vice President, Quality and Patient Safety
Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety

Background: The 2021 The Villas at Poway (VillaPom) Infection Control Surveillance Plan was provided to the Board Quality Review Committee for informational purposes

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee  
MEETING DATE: Wednesday, April 28, 2021  
FROM: John Steele, MD, Medical Director, Trauma  
Melinda Case, Manager, Trauma Program  

Background: The annual Trauma Program report for calendar year 2020 was provided to the Board Quality Review Committee for review 

Budget Impact: N/A 

Staff Recommendation: Informational only  

Committee Questions: 

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<thead>
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<th>COMMITTEE RECOMMENDATION:</th>
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<td>Motion:</td>
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<td>Information: X</td>
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<td>Required Time:</td>
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</table>
TO: Board Quality Review Committee

MEETING DATE: Wednesday, April 28, 2021

FROM: Remiga Paduga, MD, Medical Director, Stroke Program
Lourdes Januszewicz, MSN, APRN, ACNS-BC, SCRN, CCRN, Stroke Program

Background: The annual Stroke Program report for calendar year 2020 was provided to the Board Quality Review Committee for review

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, April 28, 2021

FROM: Sandeep Soni, MD, Medical Director, Infection Control
       Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety

Background: The annual Infection Control and Prevention report for calendar year 2020 was provided to the Board Quality Review Committee for review

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: ×

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, April 28, 2021

FROM: Jami Pierson, RN, Regulatory Program Manager
Tricia Kassab, RN, EdD, Vice President, Quality
and Patient Safety

Background: The biennial Regulatory Update report for calendar year 2020 was provided to the Board Quality Review Committee for review

Budget Impact: N/A

Staff Recommendation: Informational only

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
ADDENDUM A
**BOARD QUALITY REVIEW COMMITTEE MEETING**
**ATTENDANCE ROSTER - CALENDAR YEAR 2021**

### VOTING MEMBERS

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<td>LINDA GREER, RN, Chairperson, Board Member</td>
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<td>TERRY CORALES, RN, Board Member</td>
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<td>LAURA BARRY, Board Member</td>
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<td>KANCHAN KOIRALA, MD, Chair, Medical Staff Quality Management Committee, PMC Escondido</td>
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<td>SAM FILICIOTTO, MD, Chair, Medical Staff Quality Management Committee, PMC Poway</td>
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<td>JOHN CLARK, 1st Board Alternate</td>
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### NON-VOTING MEMBERS

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<td>DIANE HANSEN, CPA, President &amp; CEO</td>
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<td>SHEILA BROWN, RN, MBA, FACHE, Chief Operations Officer</td>
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<td>OMAR KHAWAJA, MD, Chief Medical Officer</td>
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<td>MICHAEL BOGERT, Chief Financial Officer</td>
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<td>JOYCE VOLSCH, PhD, MS, RN, NEA-BC, Chief Nursing Officer, PMC Poway</td>
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<td>MEL RUSSELL, RN, MSN, Chief Nursing Officer, PMC Escondido</td>
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<td>TRICIA KASSAB, EdD, RN, FACHE, Vice President, Quality and Patient Safety</td>
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<td>VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety</td>
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<td>DAVID LEE, MD, Medical Quality Officer</td>
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<td>KEVIN DEBRUIJN, Esq., Chief Legal Officer</td>
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*Special Session*
# BOARD QUALITY REVIEW COMMITTEE MEETING MINUTES – WEDNESDAY, FEBRUARY 24, 2021

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>CONCLUSION/ACTION</th>
<th>FOLLOW UP / RESPONSIBLE PARTY</th>
<th>FINAL?</th>
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<tbody>
<tr>
<td><strong>NOTICE OF MEETING</strong></td>
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<tr>
<td>The Notice of Meeting was posted at Palomar Health Administrative Office; also posted with full agenda packet on the Palomar Health website on Friday, February 19, 2021, which is consistent with legal requirements.</td>
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<td><strong>CALL TO ORDER</strong></td>
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<td>Pursuant to California Governor Newsom’s Executive Order N-29-20 the meeting was held virtually and was called to order at 3:03 p.m. by Director Linda Greer, RN.</td>
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<td><strong>ESTABLISHMENT OF QUORUM</strong></td>
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<tr>
<td>• Quorum comprised of Board Directors: Director Linda Greer, RN.; Director Terry Corrales, RN.; Director Laura Barry; and Physician Chair of the Medical Staff Quality Management Committees, Kanchan Koirala, M.D. Palomar Medical Center Escondido.</td>
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<td>• Excused Board Absences: Sam Filiciotto, MD, Palomar Medical Center Poway</td>
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<td><strong>PUBLIC COMMENT</strong></td>
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<tr>
<td>There were no public comments.</td>
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<td><strong>INFORMATION ITEMS:</strong></td>
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<tr>
<td>A. * REVIEW / APPROVAL: OPEN/EXECUTIVE SESSION MEETING MINUTES / ATTENDANCE ROSTER – OCTOBER 19, 2020</td>
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<td>The BQRC Open / Executive Session meeting minutes of October 19, 2020 were presented for review and approval. Dr. Kanchan Koirala motioned for approval and was second by Director Laura Barry to approve the meeting minutes as submitted. All in favor. None were opposed.</td>
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<td>Chair Greer asked for clarification regarding re-admission reduction program. Dr. David Lee clarified how the data is captured in the program for the Board. There were no further questions.</td>
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<td>(See Addendum A for additional information)</td>
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MOTION: by Dr. Kanchan Koirala second by Director Laura Barry, and carried to approve the meeting minutes of October 19, 2020 as submitted. Roll call voting was utilized.

- Director Linda Greer, RN – Aye
- Director Terry Corrales, RN – Aye
- Director Laura Barry – Aye
- Kanchan Koirala, MD – Aye

N/A

Y
All in favor. None opposed. The meeting minutes were approved as submitted.

<table>
<thead>
<tr>
<th>B. <strong>ADOPT BOARD QUALITY REVIEW COMMITTEE MEETING RESOLUTION FOR CALENDAR YEAR 2021</strong></th>
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<tbody>
<tr>
<td>The BQRC Meeting Resolution for Calendar Year 2021 was presented for review and approval. Director Laura Barry motioned for approval and was second by Director Terry Corrales to approve the meeting resolution for calendar year 2021 to reflect meetings being held every other month. All in favor. None were opposed. Board members discussed moving BQRC meetings to every other month versus monthly.</td>
</tr>
<tr>
<td><strong>MOTION:</strong> by Director Laura Barry second by Director Terry Corrales, and carried to approve the meeting resolution for calendar year 2021 to reflect meeting every other month. Motion to be brought to Board of Directors Meeting, March 8, 2021. Roll call voting was utilized.</td>
</tr>
<tr>
<td>Submit BQRC Calendar Resolution to Board of Directors for approval</td>
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<tr>
<td><strong>Y</strong></td>
</tr>
<tr>
<td>Director Linda Greer, RN – Aye Director Terry Corrales, RN – Aye Director Laura Barry – Aye Kanchan Koirala, MD – Aye</td>
</tr>
<tr>
<td>All in favor. None opposed. The BQRC meeting resolution for calendar year 2021 to reflect meeting being held every other month.</td>
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(See Addendum B for additional information)

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<tr>
<th>C. <strong>REVIEW BY-LAWS OF PALOMAR HEALTH, ARTICLE VIII, B, 6 a-c</strong></th>
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<tbody>
<tr>
<td>The by-laws of Palomar Health, Article VIII, B, 6 a-c was presented for review and approval. Director Laura Barry motioned for approval and was second by Dr. Kanchan Koirala to approve the suggested edits and member additions as submitted. Motion to be moved to Board Governance Council for approval All in favor. None were opposed.</td>
</tr>
<tr>
<td><strong>MOTION:</strong> by Director Laura Barry second by Kanchan Koirala, MD, and carried to approve the suggested edits and member additions as submitted. Motion to be moved to Board Governance Council for approval. Roll call voting was utilized.</td>
</tr>
<tr>
<td>Submit by-laws of Palomar Health, Article VIII, B, 6 a-c to Board Governance for approval</td>
</tr>
<tr>
<td><strong>Y</strong></td>
</tr>
<tr>
<td>Director Linda Greer, RN – Aye Director Terry Corrales, RN – Aye Director Laura Barry – Aye Kanchan Koirala, MD – Aye</td>
</tr>
<tr>
<td>All in favor. None opposed. The suggested edits and member additions were approved as submitted.</td>
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(See Addendum C for additional information)
### D. *2021 BOARD QUALITY REVIEW COMMITTEE REPORTING CALENDAR*

The 2021 BQRC Performance Reporting Calendar was deferred to the April 19, 2021 meeting. The reporting calendar will be updated to reflect the changes approved during action item B.

*(See Addendum D for additional information)*

| MOTION: Deferred | Add updated 2021 BQRC Performance Reporting Calendar to April 19, 2021, meeting agenda for approval | Y |

### *STANDING ITEM*

#### a. *Medical Executive Committee / Quality Management Committee Updates*

Kanchan Koirala, MD, Physician Chair for the Quality Management Committee at Palomar Medical Center Escondido provided an update on the following items for both campuses:

- Quality Management Committee was dark in January and February of 2021
- COVID-19 Update was provided.
- Dr. Koirala thanked the FMS nurses and other parties available, which has allowed staff to decompress.

There were no additional items presented for discussion.

| MOTION: N/A | N/A | Y |

### ADJOURNMENT TO EXECUTIVE SESSION

- Pursuant to Health and Safety Code Section 32155 - Report of Hospital Medical / Quality Assurance Audits

| MOTION: N/A | Y |

### ADJOURNMENT TO OPEN SESSION

- Action taken, if any – There were no action items identified in the Executive Session of the meeting.

### PUBLIC COMMENTS

There were no public comments.
**FINAL ADJOURNMENT** - The meeting adjourned at 3:46 p.m.

**MOTION:** N/A

**SIGNATURES:**

<table>
<thead>
<tr>
<th>COMMITTEE CHAIR</th>
<th>Linda Greer, RN</th>
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<tr>
<td>COMMITTEE ASSISTANT</td>
<td>Carla Albright (Interim)</td>
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ADDENDUM B
## Performance Improvement Reporting Schedule

<table>
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<th>Date</th>
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<th>19-2021</th>
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<tr>
<td>1-Jan</td>
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### Board Quality Review Cttee (BQRC)

<table>
<thead>
<tr>
<th>Reports due Quality Department Executive Assistant by 0900</th>
<th>Green - Annually</th>
<th>Blue - Quarterly</th>
<th>Yellow-Biannual</th>
<th>Purple-Triannual</th>
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<tr>
<td>1-Jan</td>
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<td>18-Jan</td>
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<td>26-Feb</td>
<td>2-Apr</td>
<td>30-Apr</td>
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<td>2-Feb</td>
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<td>30-Jun</td>
<td>3-Jul</td>
<td>31-Aug</td>
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<td>7-Feb</td>
<td>15-Mar</td>
<td>19-Apr</td>
<td>17-May</td>
<td>21-Jun</td>
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<td>19-Jul</td>
<td>16-Aug</td>
<td>20-Sep</td>
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<td>2-Jul</td>
<td>29-Aug</td>
<td>15-Nov</td>
<td>16-Dec</td>
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### Annual BQRC Assessment

- √

### Annual Review of BQRC By-Laws

- √

### Annual Review of BQRC Reporting Calendar

- √

### Annual Review of Quality Assessment Performance Improvement Plan

- Valerie Martinez, BSN, MHA, CIC, CPHQ, NEA-BC, Sr Dir Quality/Patient Safety
- Tricia Kassab, RN, EdD, VP Quality/Patient Safety
- √

### Annual Quality & Patient Safety Report to the Board of Directors

- √

### Centers of Excellence

- Bariatric Svcs (MBSAQIP Accredited) - Brian Cohen, Sr. Dir; Karen Hanna, MD
- Cardiovascular Svcs - Brian Cohen, Sr. Dir; Mikhail Malek, MD
- Orthopedic/Spine Svcs - Brian Cohen, Sr. Dir; Jim Bried, MD; Andrew Nguyen, MD
- √

### Continuum Care/Outpatient Services

- Virginia Barragan, VP, Continuum Care
- Taja Singh, Jr., MD, Medical Director, Continuum Care
- √

### Contracted Services

- Valerie Martinez, BSN, MHA, CIC, CPHQ, NEA-BC, Sr Dir Quality / Patient Safety
- Tricia Kassab, RN, EdD, VP Quality / Patient Safety
- √

### Dietary Services (Food and Nutrition Services)

- Megan Jakusz, Director, FANS
- Russ Riehl, Sr. Director Operational Support Svcs
- √

### Discharge Planning (Clinical Resource Management) / Patient Throughput

- Christine Casaglione, Mgr Clinical Resource Management
- Joseph Parker, Transitions Officer
- √

### Emergency Management

- Russ Riehl, District Sr. Dir, Operational Support Svcs
- Sheila Brown, RN, MBA, Chief Operations Officer
- √

### Infection Control & Prevention

- Valerie Martinez, BSN, MHA, CIC, CPHQ, NEA-BC, Sr Dir of Quality / Patient Safety
- Sandeep Soni, MD, Medical Director Infection Control
- √

### Laboratory Services

- Gloria Austria, Director of Laboratories
- Jerry Kolins, MD, Medical Director Laboratories
- √

### Management of the Care Environment (EOC)

- Dan Farrow, Sr. Director, Facilities
- Paul Sas, Chief Administrative Officer
- √

### Management of the Medical Record

- Kim Jackson, Director, Health Information Services
- Michael Bogert, Chief Financial Officer
- √

### Radiology & Nuclear Medicine

- Donna Rolin, BSBA, ARRT, CR (F), District Director, Imaging Services
- Bruce Biederman, MD, Chair, Department of Radiology
- √

### Anesthesia Services

- Eva Fadul, MD, Anesthesia Services
- Richard C. Engel, MD, Medical Director Anesthesia Services
- Omar Khawaja, MD, Chief Medical Officer
- √
## Performance Improvement Reporting Schedule

<table>
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<th>Reports due by Month</th>
<th>Green - Annually</th>
<th>Blue - Quarterly</th>
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### Trauma Program
- Melinda Case, Manager, Trauma Program
- John Steele, MD, Medical Director, Trauma

### Medication Management (Pharmacy)
- Donna Gelos, Director of Pharmacy
- Sheila Brown, RN, MBA, FACHE, Chief Operations Officer

### Nursing Services (Includes Behavioral Health Svs)
- Mel Russell, RN, MSN, CNO, Palomar Medical Center Escondido
- Joyce Volsch, RN, PhD, CNO, Palomar Medical Center Poway

### Operative and Invasive Procedures Services
- Trisch Turner, MSN, VP Perioperative Services

### Pay for Performance Programs Update / Leapfrog Grade (when available will present)
- Valerie Martinez, BSN, MHA, CIC, CPHQ, NEA-BC, Sr Dir Quality/Patient Safety
- David Lee, MD, Medical Quality Officer
- Tricia Kassab, RN, EdD, VP Quality/Patient Safety

### Regulatory Update
- Jami Pearson, RN, Regulatory Program Manager

### Rehabilitation Services
- William Levanholzki MA, OTR/L, CHT, Director of Rehabilitation Services
- Virginia Barragan, FACHE, DPT, MOMT, VP Continuum Care

### Respiratory Services
- Gloria Austria, District Director, Laboratory, Pulmonary, and EEG Services

### Service Excellence (HCAHPS)
- Mel Russell, RN, MSN, CNO, Palomar Medical Center Escondido
- Joyce Volsch, RN, PhD, CNO, Palomar Medical Center Poway
- Valerie Martinez, RN, BSN, MHA, CIC, CPHQ, NEA-BC, Sr Dir, Quality / Patient Safety
- Tricia Kassab, RN, EdD, VP Quality/Patient Safety

### Stroke Program
- Lourdes Januszewicz, MSN APRN ACNS-BC, SCRN CCRN, Stroke Program Coordinator
- Remia Paduga, MD, Medical Director, Stroke Program

### Number of Reports Due by Month
- 0 3 0 5 0 8 0 6 0 5 0 4

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**Date Printed:** 3/29/2021  
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ADDENDUM C
I. PURPOSE:

A. To outline the framework for a leadership driven, systematic, interdisciplinary approach to continuous improvement using our performance improvement model known as Plan, Do, Study, Act (PDSA). Our efforts will focus on all care and service outcomes for our patient populations and meet the mission, vision, and standards of excellence for Palomar Health as follows:

1. Mission: The mission of Palomar Health is to heal, comfort, and promote health in the communities we serve.
2. Vision: Palomar Health will be the health system of choice for patients, physicians, and employees, recognized nationally for the highest quality of clinical care and access to comprehensive services.
4. Palomar Health's Patient Safety Officers are the Senior Director of Quality/Patient Safety and the Medical Quality Officer.

II. DEFINITIONS:

A. Quality Assessment Performance Improvement (QAPI) Plan

1. QAPI is the merger of two complementary approaches to quality, namely Quality Assessment (QA) and Performance Improvement (PI). Both involve seeking and using information, but they differ in key ways:

   a. QA is a process of meeting quality standards and assuring that care reaches an exceptional level. Hospitals and health systems typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is the data collection and analysis through which the degree of conformity to predetermined standards and criteria are exemplified. If the quality, through this process is found to be unsatisfactory, attempts are made to discover the reason for this. On the basis of this, remedial actions are instituted and the quality reevaluated after a suitable time period.

   b. PI (also called Quality Improvement—QI) is a proactive and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches in order to fix underlying causes of persistent/systemic problems. PI in hospitals and health systems across the care continuum aims to improve processes involved in health care delivery and quality of life. PI can make good quality even better.

2. QAPI is a data-driven, proactive approach to improving the quality of care and services across the care continuum. The activities of QAPI engage members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

III. Authority and Responsibility

A. Governing Body

The Governing Body authorizes the establishment of this performance improvement program. This Governing Body is responsible for assuring:

1. Th at an ongoing program for quality improvement is defined, implemented, and maintained.
2. That an ongoing program for patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
3. That the organization-wide quality assessment and performance improvement efforts address priorities for improved quality of care, and patient safety and that all improvement actions are evaluated.
4. That clear expectations for safety are established.
That adequate resources are allocated for measuring, assessing, improving, and sustaining the health system’s performance and patient safety.

A determination of the number of distinct improvement projects is conducted annually.

Medical Executive Committee / Quality Management Committee
The Governing Body delegates the development, implementation, and evaluation of this program to the Medical Executive Committee (MEC). The MECs are responsible for monitoring and improving, the quality of care, safety and service provided by its medical staff. The MEC has formed a Quality Management Committee to carry out this responsibility.

Administration & Management
The Governing Body also delegates the development, implementation, and evaluation of this program to the organization’s Administrative team. Administration is responsible for improving the quality of care, safety, and service provided by organization staff. The Administrative team has developed structures and processes to carry out this responsibility.

Further Delegation of Authority and Responsibility
The MEC and/or Administration & Management may further delegate aspects of this program as necessary.

IV. Core Components

A. The following are the core components of the framework:
   1. Recognizing that defects are primarily from processes and systems, not people. Performance improvement will focus on systems, processes and outcomes.
   2. Leadership driven by a commitment to a culture of safety and transparency that uses a Quality Dashboard as the monitoring tool.
   3. Data driven based on evidenced based practices using national benchmarks (when available) and comparative data.
   4. Integrated and coordinated processes to engage all levels of leadership, physicians, employee staff, and community members.
   5. Proactive by design in order to sustain continuous performance improvement, promote high reliability, quality, safe patient care and services.
   6. Communication through a common language created by an ongoing process to prioritize Quality Assessment/Performance Improvement opportunities using consistent methods and statistical tools that are the tenets of PDSA and when appropriate Lean/Six Sigma -- i.e., Define, Measure, Analyze, Improve and Control (DMAIC).
   7. A calendar of reporting to ensure ongoing systematic communication to all key constituents, assure accountability and maintain the ongoing improvement gains for all continuous quality assessment/performance improvement activities.
   8. Educational programs and meetings to enhance statistically-based quality assessment/performance improvement tools for every level of leadership, physicians, and staff.
   9. Standardized processes for investigation of events and followup on near miss adverse, adverse events and sentinel events. These standardized processes address:
      a. An investigation into the cause of the adverse event may be undertaken pursuant to the Medical Center’s Review Process.
      b. The investigation would be conducted for the purpose of the evaluation and improvement of the quality of care.
      c. What practice / process change is required to prevent recurrence
      d. How the practice/process change will be accomplished
      e. Who is responsible for the practice/process change
      f. Timeline for completion
      g. Description of the monitoring process to prevent a recurrence.
      a. CMS is waiving 482.21(a)-(d) and (f), and 485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program’s performance improvement activities, and integrated QAPI.
b. Any improvements to the plan must focus on the Public Health Emergency. While this waiver decreases the burden associated with the development of a hospital or QAPI program, the requirement that hospitals maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain.

c. Upon declaration of end of pandemic, QAPI will return to normal processes.

d. Waivers will be tracked and monitored accordingly throughout Pandemic.

v. Goals

A. As part of the annual evaluation of the Quality Assessment Performance Improvement (QAPI) activities and goals are identified for each calendar year to ensure continuous improvement. The following actions should be taken in forming specific goals:

1. Enhance key processes to ensure that "Evidence Based Practices" are considered in all opportunities for improvement of care and services.
2. Integrate the Quality Assessment/Performance Improvement Plan into a culture of safety that recognizes the key behaviors and attitudes that result in a safe environment for patients, families, employees, and physicians.
3. Create a support structure for data collection and analysis through collaboration with Information Technology, Strategy, and Finance.
4. Review and revise as necessary the peer review methodology to ensure a quality driven process that provides a consistent, objective, data-driven evaluation of physician and nurse performance via their respective peer review programs.
5. Identify core components for Quality Assessment/Performance Improvement methods and tools for the organization.

B. The organization has an effective program that assesses the quality and safety of its services including Local, State, and Federal regulations to identify opportunity for improvement, and works to address those opportunities. Services include but not limited to:

1. Contract Services
2. Management of the Care Environment
3. Management of the Medical Record
4. Infection Prevention and Control
5. Patient Rights
6. Medication Management
7. Anesthesia Services
8. Dietary Services
9. Discharge Planning
10. Laboratory Services
11. Nuclear Medicine Services
12. Nursing Services
13. Operative and Invasive Services
14. Outpatient Services
15. Radiology Services
16. Rehabilitation Services
17. Contracted Service: All contracted services, including one for shared services and joint ventures, patient care services, and all other services, provided under contract are subject to the same hospital-wide quality assessment and performance improvement (QAPI) evaluation as other services provided directly by the hospital. The hospital will assess the services furnished directly by hospital staff and those services provided under contract, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities.
18. Patient Grievances - The hospital’s Governing Body has delegated the grievance process to the Quality/Patient Safety Department. The Quality/Safety department receives, reviews, and collaborates with appropriate unit/department leader and/or physician, in addition to, but not limited to; Regulatory, Finance, and Risk Management for review and investigation. Upon completion of the investigation, a
letter will be sent to the complainant informing them of the outcome. Outcome data will be presented to various stakeholder meetings including up to the Governing Body.

v. **Reporting Structure, Responsibilities, and Constituents of the QAPI Plan**

![Quality Assessment Performance Improvement (QAPI) Information Flow Structure 2021](image)

**A. Board Quality Review Committee (BQRC):**
1. **Duties:**
   a. Pursuant to the BQRC bylaws. The Board Quality Review Committee shall also review the prioritized proposed performance improvement projects and patient safety activities and shall report to the governing body.
2. **Composition:**
   a. Voting Membership: The committee shall consist of five voting members, including three members of the Governing Body and the Chairs of the Quality Management Committees (QMC) of Palomar Medical Center Escondido and Palomar Medical Center Poway. Nonvoting Members include: The President and Chief Executive Officer; the Chief Operations Officer; the Chief Medical Officer; Medical Quality Officer; the Chief Legal Officer; the Chief Nursing Officers of Palomar Medical Center Escondido and Palomar Medical Center Poway; Senior Director of Quality/Patient Safety, Senior Director of Quality/Patient Safety.

**B. Medical Staff Executive Committees (MEC):**
1. **Duties:**
   a. The Medical Executive Committee (MEC) is the primary governance committee for the independent medical staff. The MEC, with input from the medical staff, makes key leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement initiatives. They are also responsible for adopting and implementing medical staff policies and procedures, and creating
medical staff appointment and reappointment criteria. The Executive Committees of the Medical Staffs, with the consent of the Governing Body, and in conjunction with organizational leaders, are responsible for the overall administration and effectiveness of the improvement of organizational performance and safe patient care.

b. The MECs review and approve all recommendations submitted by the Quality Management Committee and initiate any special studies or recommendations as deemed appropriate to maintain an effective program.

2. Composition:
   a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the Medical Staff Bylaws.

c. The Quality Management Committee (QMC) of the Medical Staffs:
   1. Purpose:
      a. The Quality Management Committees of the Medical Staffs will regularly review specified performance metrics recognized as measurements of quality and safety, including but not limited to: blood usage, medication usage, pharmacy and therapeutics, nutrition, medical record timeliness, special care review, utilization review, nursing sensitive (e.g., falls, hospital acquired pressure injuries, and medical restraint use) patient outcomes, infection control, patient safety, and other items identified in the body of this plan. Appropriate summaries and recommendations first referred to the appropriate clinical departments and subcommittees are then forwarded to the respective Medical Staff Executive Committees for review and approval.
      b. The QMC reviews and prioritizes proposed performance improvement projects as recommended by the Interdisciplinary Governance Council (IGC).
      c. The QMC provides oversight for the Quality Assessment Performance Improvement (QAPI) activities of medical staff, nursing, and clinical departments and committees.
   2. Composition:
      a. The Committee has Physician Chairs (preferably the Chief of Staff-elect at each licensed acute care facility). Committee members will include the department chairs-elect of the medical staffs or their designee, along with representatives from Medical Staff, Administration, Nursing, Department Directors, and staff responsible for overseeing quality assessment and performance improvement activities.
   3. Voting Membership: Physicians and Executive Leadership Team (VPs, CNOs, Executives) present at time of voting.

d. Interdisciplinary Governance Council (IGC):
   1. Purpose: The Interdisciplinary Governance Council is responsible for providing oversight and approval for all councils in the IGC infrastructure. The Governance Council will work closely with the Regulatory Steering Committee and QMC. The intention is to improve communication, efficiency, and effectiveness in regard to decision making and to provide a mechanism and structure for a communication and approval process that will expedite process improvement changes as well as implementation.
   2. Governance: The IGC is the oversight council for Education and Organizational Development Council (EODC), Clinical Informatics Council (CIC), the Patient and Medication Safety Council (PMSC) and the Regulatory Steering Committee. The Staff Practice Council (SPC) will report through the PMSC.

e. Clinical Informatics Council (CIC):
   1. Purpose: The Clinical Informatics Council is an interdisciplinary group that whose purpose is to serve as the oversight body for all clinical Informatics projects. The council discusses and oversee clinical informatics requests, and change orders to determine priority and provide feedback and support to end users. This council is the team that advises on priorities and recommendations regarding electronic health record (EHR) support of safe patient care.
   2. Governance: This council will make recommendations for final approval to the Interdisciplinary Governance Council based on the authority level granted. Recommendations regarding project prioritization, strategy, or capital expense will then be referred to the IT Steering Committee.

f. Education/Leadership Development Council (EODC):
   1. Purpose: The purpose of the Education and Leadership Development Council (EODC) is to develop, implement, evaluate, and provide oversight over integrated education and leadership development plan
that meets regulatory requirements, as well as to facilitate implementation of strategic initiatives that support a culture of excellence.

2. Governance: The EODC will make recommendations regarding education plans and practices to the IGC for approval.

G. Regulatory Steering Committee:

1. Purpose: The purpose of the Regulatory Steering Committee is to provide guidance and oversight for the implementation and monitoring of CMS Conditions of Participation (COP), and the Joint Commission (TJC) accreditation standards for maintaining Medicare Reimbursement and Quality Accreditation approved status as an organization. The oversight and guidance also applies to all applicable local, state, and federal regulatory regulations across the system (i.e. Title 22, OSHA, etc.)

2. Governance: The committee will provide a monthly report to the IGC.

H. Patient and Medication Safety Council (PMSC):

1. Purpose: The purpose of the Patient and Medication Safety Council is to promote a culture of safety through oversight and implementation of the Quality Assessment and Performance Improvement (QAPI) Plan. The council will ensure the development of documents, policies, procedures, and practices that reflect evidence-based practice (EBP) and meet the standards of professional organizations, state and federal professional practice acts, scopes of practice, as well as regulatory standards. Responsibility will include oversight for medication safety and recommendations for process improvement projects that will facilitate an interdisciplinary approach to the Plan, Do, Study, Act (PDSA) model for daily work processes.

2. Governance: The Patient and Medication Safety Council will make recommendations for final approval of policies to be sent to specialty committees (e.g. Infection Prevention, QMC) and will refer policies/procedures to IGC for approval for posting. This council will also make recommendations regarding various committee and project proposals to the IGC.

I. Patient Experience Council (PEC):

1. Purpose: The purpose of the Patient Experience Council is to provide oversight and guidance on achieving and sustaining patient-centered care. The council will oversee the development, implementation and monitoring for all best practices, performance metrics, policies and procedures that enhance and/or promote the ideal patient and family experience while always advocating for the communities we serve, aligning with our mission, vision, and values.

2. Governance: The Patient Experience Council will make recommendations regarding performance improvement plans and best practices to the Interdisciplinary Governance Council for approval.

J. Staff Practice Council:

1. Purpose: The purpose of the Staff Practice Council is to facilitate staff input and feedback from an interdisciplinary perspective into decisions effecting patient care and professional practice. The council also seeks to enhance sharing and reporting of unit/dept. specific work plans related to the Plan for Patient Care Services, the organizational strategic plan related to clinical practice, patient and employee satisfaction, and quality and patient safety. The work, conversations, and recommendations from the council should be based on the Relationship Based Care model. The SPC serves as Interdisciplinary fall team for the system. Teams reporting into SPC include: Nursing Peer Review; Safe Patient Handling and Patient Classification.

2. Composition: The Staff practice Council (SPC) will be made up of representatives of the Unit/Department Based Practice Council Chairs, a sponsor from the Patient and Medication Safety Council (PMSC), and staff representatives from teams that have been meeting to make decisions with staff input (e.g. Staff on Safety (SOS), Nursing Peer Review, Patient Classification, and Safe Patient Handling).

3. Governance: This council will report to the PMSC. The PMSC will provide guidance and mentoring for professional practice. Sponsors will provide updates from (PMSC) and also the Interdisciplinary Governance Council (IGC).

K. Medical Staff Committees: Pursuant to the Medical Staff Bylaws, Medical Staff departments and committees are responsible for the quality of care, service and safety of patient care delivered by the members of their respective departments. Medical Staff Departments and Committees shall demonstrate quality assurance and performance improvement by:

1. Participating in departmental and quality assessment/performance improvement activities.

2. Utilizing results and recommendations from interdisciplinary performance improvement efforts to improve services.
3. Utilizing information from the Medical Staff Peer Review Committee (MSPRC) and Quality Department that includes data addressing each of the six physician core competencies for credentialing, privileging and the reappointment process.
4. Reviewing and analyzing summary reports of trended data reported out by department and/or by physician for processes dependent primarily on the activities of one or more individuals with clinical privileges.
5. Sharing responsibility for planning, designing, measuring, assessing, and improving the overall safe care of patients.

L. Medical Staff Peer Review Committee (MSPRC):
   1. Duties:
      a. Review cases referred by physicians and staff or by screening criteria with the goal of improving physician performance at the individual and aggregate levels, improving patient outcomes, and supporting a culture of compassion and respect.
      b. Promote efficient use of physician and quality staff resources.
      c. Provide accurate and timely performance data as available for physician feedback and Ongoing Professional Practice Evaluation (OPPE).
      d. Recognize physician excellence in addition to identifying improvement opportunities.
   2. Composition:
      a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the respective Medical Staff Peer Review Charter for each facility.

M. Critical Care Committee (CCC)
   1. Duties: The District wide Critical Care Committee is responsible for:
      a. Identifying indicators for monitoring the important aspects of critical care.
      b. Evaluating results of data collected for these indicators.
      c. Making recommendations for actions to improve care or correct identified problems.
   2. Composition: Co-chairs, both of whom will be Medical Directors of ICU, along with broad representation from appropriate areas of the Medical Staff, Administration, Nursing and other disciplines as appropriate.

N. Imaging Services - District Radiation Safety Committee (RSC): The District wide Palomar Health Imaging Services - District Radiation Safety Committee (RSC) is responsible for carrying out the following:
   1. Duties:
      a. The RSC will regularly review metrics recognized as measurements of quality and safety and safety in radiation safety and protection. Metrics reviewed include, but are not limited to, dosimetry badge readings, medical physicist reports, and fluoroscopy quality assurance.
   2. Composition:
      a. The Committee Chair is the Radiation Safety Officer (RSO). Committee members will include representatives from Imaging Services, Surgical Services, Interventional Radiology, Cath Lab, Environmental Services, Radiation Oncology, Administration, nursing representation and a medical physicist.

O. Infection Prevention and Control Committee (IPCC): The District wide Palomar Health Infection Prevention and Control Committee is responsible for carrying out the following:
   1. Duties:
      b. Develop and maintain an Infection Prevention and Control program that reflects the Mission and Vision of Palomar Health. The program includes Quality and Regulatory Standards developed by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and other nationally recognized organizations.
      c. To ensure implementation of prevention measures, and monitoring outcomes with the ultimate goal of preventing and controlling infection transmission among patients, employees, medical staff, contracted service workers, and volunteers.
      d. The IPCC will report directly to the Quality Management Committee.
      e. To provide structure for an organization-wide, facility specific approach to identify and reduce the risk of endemic and epidemic healthcare-associated infections (HAI). To ensure optimal provision of
services, the management of the infection prevention and control process is assigned to qualified personnel by virtue of education, training, licensure, experience or certification.

i. Application of epidemiological principles, including activities directed at improving patient outcomes using implementation science.

ii. Implementation of changes mandated by regulatory, accrediting, and licensing agencies.

iii. Education efforts directed at interventions to reduce infection risk.

iv. Consultation on risk assessment, prevention, and control strategies (includes activities related to occupational health, construction, and emergency management.


vi. Review and analysis of infection data.

f. The hospital has designated one or more individual(s) as its Infection Control Officer(s). The Infection Control Officer(s) is/are qualified and maintain(s) qualifications through education, training, experience or certification related. The Infection Control Officer(s) have the authority and responsibility for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program. The IPCC through its chairperson and/or Senior Director of of Quality and Infection Prevention and Control Program are the Infection Control Officers, are granted the authority to institute any appropriate emergency measures throughout the health system when there is reasonable risk or danger to any patient, personnel, or visitors as it relates to Infection Prevention and Control.

2. Composition:

a. The Committee is composed of a physician chair who is an infectious disease specialist, and representatives but not limited to: Infection Prevention, Nursing, Administration, and personnel responsible for overseeing facility infection control activities, (e.g., Home Health, Villa Pomerado, Peri-operative Services, Facilities, Environmental Services, Food and Nutrition, Pharmacy and Corporate/Employee Health, Lab, Respiratory Services, and Wound Care).

Pharmacy and Therapeutics Committee (P&T):

1. Duties:

a. Develop and implement written policies and procedures for the establishment of safe and effective systems of procurement, storage, distribution, dispensing and use of medications.

b. Develop and maintain a formulary of drugs throughout the hospitals.

c. Monitor the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition, and clinical dietary consultations.

d. Review Adverse Drug Reaction Event Program.

e. Review Medication Error Reduction Plan at least annually.

f. Make recommendations to improve care or to correct identified problems to the Quality Management Committee based on analysis and evaluation of data collected through indicators.

g. Refer to the Chair of either Palomar Medical Center Escondido (PMCE) or Palomar Medical Center Poway (PMCP) --any matter within the scope of the Medical Staffs' responsibilities for performance improvement as appropriate.

h. The P&T committee will report to the Quality Management Committee.

2. Composition:

a. The minimum committee quorum shall consist of the Physician Chair, the Director of Pharmaceutical Services or representative, the Chief Nursing Officers from PMCE and PMCP or representatives, a System Administrator or representative. Representatives from Medical Staff, Nursing, Laboratory, Nutritional Services and Allied Health care Staff may also participate on the committee.
1. Nutrition and Therapeutics Committee (N&TC): The purpose of the N&TC is to provide appropriate nutrition care to patients using evidenced based information, bridging the gap between research and practice.

   a. Duties: The duties of the Nutrition and Therapeutics Committee include, but are not limited to:
      i. Assisting the pharmaceutical service in maintaining the enteral and parenteral Hospital Formulary.
      ii. Monitoring the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition and clinical dietary consultations.

   b. Composition:
      i. The N&TC is comprised of a multidisciplinary team of health professionals including Nutritional Services, Medical Staff, Pharmacy and Nursing.

2. Antibiotic Stewardship Subcommittee:

   a. Duties: In view of the dramatic increase in antibiotic resistance, the Antibiotic Stewardship Subcommittee's responsibilities include, but are not limited to:
      i. Reviewing new antimicrobial agents.
      ii. Reviewing antibiotic usage and expenditures, including restricted antibiotics.
      iii. Developing empiric treatment guidelines, protocols, and Power Plans to minimize the development of resistance organisms.

   b. Composition:
      i. The Antibiotic Stewardship Subcommittee is comprised of one or more Infectious Disease Physicians, Physicians representing various medical specialties, Antibiotic Stewardship Pharmacist, a Microbiology Representative from the Laboratory and an Infection Preventionist.

R. Centers of Excellence - Bariatric (Palomar Medical Center Poway)

1. Duties:
   a. To achieve and maintain Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care.
   b. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and value.

2. Composition:
   a. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialist's Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other medical directors).

S. Non-Medical Staff QAPI Committees and Functions

1. Centers of Excellence - Cardiovascular and Orthopedics (PMC Escondido and PMC Poway) /Spine (PMC Escondido)
   a. Duties:
      i. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and value.
      ii. To achieve and maintain Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care.

   b. Composition:
      i. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialist's Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other medical directors).
2. **Diabetes Medical Advisory Committee (DMAC):** The purpose of DMAC is to establish, assess and review program procedures governing the scope of diabetes services provided. This committee will report to QMC. Duties: the duties of DMAC include, but are not limited to: Evaluate appropriateness and adequacy through a review of procedures, Power Plans, and clinical practice guidelines and update with the most current recommendations. Participate in the Palomar Health Quality and Performance Improvement program. Composition: The DMAC is comprised of a multidisciplinary team of health professionals including but not limited to: Medical Staff, Diabetes Clinical Nurse Specialist, Pharmacy, Nursing and Nutritional Services.

3. **Stroke Committee:**
   a. Duties:
      i. Provide oversight, coordination and direction to the individuals caring for the stroke patients.
      ii. Evaluate appropriateness and adequacy of the program through a review of clinical practice guidelines, power plans, and procedures.
      iii. Coordinate education programs for staff and the community we serve.
      iv. Monitor, analyze, and evaluate stroke measures; identify opportunities for improvement; share recommendations and outcomes.
      v. Participate in the Palomar Health Quality and Performance Improvement program.
   b. Composition:
      i. The committee is comprised of a multidisciplinary team of health professionals including Administrative Leaders; Medical Staff: Neurology, Neurosurgery, Neuro-Interventionist, Emergency, Critical Care, Anesthesiology, and Hospitalist; Stroke Program Coordinator; Pharmacy; Nursing; Radiology; Laboratory; Rehabilitation Services; Case Resource Management; Patient Access and Quality.

4. **Laboratory Services: Quality**
   a. Duties: Laboratory Services: Lab Quality includes, but are not limited to:
      i. Review and approve monthly Lab Quality indicators and blood bank audits
      ii. Identify opportunities for process improvement from staff feedback, variance reports, QRR reports, and quality indicator results.
      iii. Evaluate results of monthly ED turnaround time report.
      iv. Review for completion of follow up action and plan of corrections.
      v. Review actions and decisions with Medical Laboratory Director.
   b. Composition:
      i. The District Laboratory Director and Laboratory Quality Analyst-Managers chair and co-chair the monthly meeting. Members include the medical laboratory director, laboratory managers, section supervisors, and shift supervisors, and Chairs of the Lab Professional Practice.

5. **Environment of Care (EOC) Committee:**
   a. Duties: Specific responsibilities include, but are not limited to the following:
      i. Development and review of procedures
      iii. Environmental Surveillance, Safety Education and Product Recall Monitoring.
      iv. Monitor the results of regulatory inspections and refer to Regulatory Steering Committee.
      v. Analyze and aggregate data. Recommendations are developed and approved as applicable.
   b. Composition:
      i. The Committee is composed of the Chair and Co-Chair, Facilities, Risk Management, Security, Employee Health, Biomedical Engineering, EVS, Infection Control as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.

6. **Disaster Preparedness Committee (DPC):**
   a. Duties:
      i. The District wide Disaster Preparedness Committee is responsible for ensuring disaster planning and disaster related activities are managed and implemented. It is the responsibility of the
Emergency Management/Safety Program Manager to ensure meetings are scheduled and minutes taken. Information, progress notes, and followup activities from this committee are reported to the Environment of Care Committee.

- This committee will report up through the Interdisciplinary Governance Committee.

b. Composition:

- The Committee is composed of the Chair and Co-chair, Facilities, Risk Management, Security, Infection Control, Emergency Department as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.

Continuum Care Operations Division:

a. Purpose: Under the direction of the Vice President, the Continuum Care Directors, the Continuum Care Operations Division promotes improvement of patient safety and outcomes by providing an organization-wide approach for continually assessing and improving the quality of health services that we provide to our patients, employees, and community outside our acute care facilities. Under the oversight of the Vice President, Continuum Care, the Continuum Directors are responsible for the performance improvement and patient safety program at the departmental level within their respective specialties. The ongoing monitoring and analysis of Quality indicators are based on the following:

- Identification of patient needs and expectations and evaluation of how these needs and expectations are met
- Identification of staff education and training needs and ongoing measurements to demonstrate sustained improvement
- Use of evidence-based data from internal and external sources to improve the quality of care
- Integration and coordination of quality initiatives across the care continuum including: acute care, skilled nursing, home health and ambulatory services
- Analysis of data to establish priorities and identify opportunities for future improvement

b. Entities under the umbrella of the Continuum Care Operations Improvement Function include:

- Villa Pomerado Quality Committee
- Home Health Quality Committee
- Rehabilitation Services
- Ambulatory Specialty Outpatient Services

c. The performance improvement measures that reflect a direct contribution of Continuum Care achieving quality and safe patient care outcomes may include:

- Physician and Employee Engagement
- Patient Experience
- Risk
- Regulatory or accreditation requirements
- Patient and community outcomes
- CMS Quality Indicators for Skilled Nursing and Home Health

METHODS:

A. Understanding that performance improvement and patient safety permeate every level of the organization. The Palomar Health Leadership Team empowers and assigns individuals to lead these by providing time and resources to achieve optimal outcomes.

B. Whenever possible, sound statistical methods and the techniques of continuous quality improvement will be utilized. In most projects, a Plan-Do-Study-Act Cycle (PDSA) methodology model will be used.
c. Prioritization: When selecting Quality Assessment Performance Improvement (QAPI) projects, Palomar Health leaders recognize the importance of using criteria to do ongoing prioritization of Quality Assessment Performance Improvement projects. Therefore, proposed projects will be coordinated to avoid duplication of projects.

d. Designing Processes: When creating or modifying programs and/or processes, consideration is taken to ensure the design:

1. Is consistent with the mission, vision, values, goals, objectives and plans;
2. Meets the needs of individuals served, staff and others;
3. Is clinically sound and current (for instance, use of best practice guidelines, successful practices, information from relevant literature, and clinical standards);
4. Incorporates available information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesign processes, functions, or services;
5. Utilizes tools and methods to proactively identify risk points and eliminate them prior to implementing changes;
6. Includes analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement; and
7. Incorporates the results of Quality Assessment Performance Improvement activities.

data. Data Collection: Data is collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement and sustain improvement. Collected data is used to:

a. Compare performance about processes and outcomes through the use of reference databases.

b. Compare performance data about processes with information from up-to-date sources.

c. Make comparisons of performance of processes and outcomes over time.

d. Data is collected on important processes and outcomes and includes, but is not limited to, key processes related to:
   i. Leadership priorities
   ii. Patient Safety including staff
   iii. Environment of care
   iv. Patient Satisfaction
   v. Pain Management
   vi. Medication Management
   vii. Blood and blood products
   viii. Restraint and seclusion
   ix. Operative and other invasive procedures
   x. Organ procurement
   xi. Resuscitation
   xii. Risk Management
   xiii. Infection Control
   xiv. Imaging Services
Laboratory Services

Patient Grievances

Contracted Services

e. Contracted Services: All contracted services, including one for shared services and joint ventures, patient care services, and all other services, provided under contract are subject to the same hospital wide quality assessment and performance improvement (QAPI) evaluation as other services provided directly by the hospital. The hospital will assess the services furnished directly by hospital staff and those services provided under contract, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities. Benchmarks: Whenever available, benchmarks from local, state and national databases and medical literature will be obtained and used. Available bench marking systems include but are not limited to:

i. The Joint Commission (TJC)
ii. Centers for Medicare & Medicaid Services (CMS) through [HospitalCompare](http://CMS.Gov)
iii. Society of Thoracic Surgeons Cardiac Surgery Database
iv. Center for Disease Control and Prevention (CDC) Database
v. National Database for Nursing Quality Indicators (NDNQI)
vi. Office of Statewide Health Planning and Development (OSHPD) California State Hospital Discharge Annual Database

Palomar Health is a member of the California Hospital Patient Safety Organization (CHPSO) and Health Services Advisory Group (HSAG).

Best Practice Core Measures: Proactively engaged with benchmarking systems performance through their involvement with The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) in order to continuously seek out opportunities to improve our performance based on best practices, such as those promulgated by the National Quality Forum.

Data Assessment: The data is organized for reporting purposes in a manner that allows for analysis of the results. Data is systematically aggregated and analyzed on an ongoing basis:

1. Aggregated data is analyzed to make judgments about:
   a. Whether design specifications for processes were met
   b. The level of performance and stability of important existing processes
   c. Opportunities for improvement
   d. Actions to improve the performance of processes
   e. Whether changes in processes resulted in improvement
2. Appropriate statistical techniques are used to analyze and display data. These techniques include, run charts, control charts, Pareto charts, and other statistical tools as appropriate.

Failure Mode and Effects Analysis (FMEA): involves the prospective evaluation of processes identified by the organization as being vulnerable to risk and the redesign of such processes to build safety in (e.g., through creating redundancies) before an adverse event occurs.

Root Cause Analysis (RCA): When a serious, unexpected adverse outcome or near-miss occurs, the RCA process may be used to determine the most basic or immediate factor(s) or causes of why the event occurred. The RCA process is a systematic approach to understanding the causes of an adverse event and identifying system flaws that can be corrected to prevent the error from happening again. RCAs are retrospective, focus on system issues rather than blame, and are not appropriate in cases of negligence or willful harm. An action plan is then identified and monitored.

Improving and Sustaining Performance: Changes to improve performance are identified, planned, and tested using the PDSA Cycle Model. Effective changes are incorporated into standard operating procedure.

Training and Education: Training and Education in performance improvement/patient safety is provided to every level of throughout the organization.

Communication:

1. Communication of Performance Improvement/Patient Safety activities throughout the Medical Staffs and Hospital Staffs occurs through a variety of means including:
   a. Through the QAPI Committee structure, e.g., the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council,
and Medical Staff Committees.

b. Through newsletters, memos, education programs, educational offerings

2. QAPI reports are communicated to the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and other clinical Committees according to the calendar of reporting.

M. Confidentiality:

1. Data generated by the QAPI Program are considered to be products of the Quality Management Committee of the applicable health facility and are protected from discoverability under Section 1157 of the California Evidence Code. Practitioners and Palomar Health personnel have a duty to preserve this confidentiality.

2. The performance improvement activities must abide by the Confidentiality of Medical Information Act in maintaining the confidentiality of the patient’s medical information. Compliance is also maintained with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

N. Conflict of Interest:

1. A Practitioner may not participate in the review of any case in which he has been or anticipates being professionally involved. Practitioners having either a direct or indirect financial interest in the case(s) being reviewed may not participate in the utilization review activities pertaining thereto.

O. Annual Reappraisal: This QAPI plan is reviewed annually to evaluate the overall effectiveness considering such factors as results achieved, operational problems encountered, and deficiencies noted. The Plan with any amendments will be forwarded to the Board of Directors Quality Review Committee for final approval.
I. PURPOSE:

A. To outline the framework for a leadership driven, systematic, interdisciplinary approach to continuous improvement using our performance improvement model known as Plan, Do, Study, Act (PDSA). Our efforts will focus on all care and service outcomes for our patient populations and meet the mission, vision, and standards of excellence for Palomar Health as follows:

1. Mission: The mission of Palomar Health is to heal, comfort, and promote health in the communities we serve.
2. Vision: Palomar Health will be the health system of choice for patients, physicians, and employees, recognized nationally for the highest quality of clinical care and access to comprehensive services.
4. Palomar Health's Patient Safety Officer/s are the Senior Director of Quality/Patient Safety and the Medical Quality Officer.

II. DEFINITIONS:

A. Quality Assessment Performance Improvement (QAPI) Plan

1. QAPI is the merger of two complementary approaches to quality, namely Quality Assessment (QA) and Performance Improvement (PI). Both involve seeking and using information, but they differ in key ways:
   a. QA is a process of meeting quality standards and assuring that care reaches an exceptional level. Hospitals and health systems typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is the data collection and analysis through which the degree of conformity to predetermined standards and criteria are exemplified. If the quality, through this process is found to be unsatisfactory, attempts are made to discover the reason for this. On the basis of this, remedial actions are instituted and the quality reevaluated after a suitable time period.
   b. PI is a proactive and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches in order to fix underlying causes of persistent/systemic problems. PI in hospitals and health systems across the care continuum aims to improve processes involved in health care delivery and quality of life. PI can make good quality even better.

2. QAPI is a data-driven, proactive approach to improving the quality of care and services across the care continuum. The activities of QAPI engage members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

III. Authority and Responsibility

A. Governing Body

The Governing Body authorizes the establishment of this performance improvement program. This Governing Body is responsible for assuring:

1. An ongoing program for quality improvement is defined, implemented, and maintained.
2. An ongoing program for patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
3. An organization-wide quality assessment and performance improvement efforts address priorities for improved quality of care, and patient safety and that all improvement actions are evaluated.
4. Clear expectations for safety are established.
5. Adequate resources are allocated for measuring, assessing, improving, and sustaining the health system’s performance and patient safety.
6. A determination of the number of distinct improvement projects is conducted annually.
Medical Executive Committee / Quality Management Committee
The Governing Body delegates the development, implementation, and evaluation of this program to the Medical Executive Committee (MEC). The MECs are responsible for monitoring and improving, the quality of care, safety and service provided by its medical staff. The MEC has formed a Quality Management Committee to carry out this responsibility.

Administration & Management
The Governing Body also delegates the development, implementation, and evaluation of this program to the organization's Administrative team. Administration is responsible for improving the quality of care, safety, and service provided by organization staff. The Administrative team has developed structures and processes to carry out this responsibility.

Further Delegation of Authority and Responsibility
The MEC and/or Administration & Management may further delegate aspects of this program as necessary.

Core Components
The following are the core components of the framework:

1. Recognizing that defects are primarily from processes and systems, not people. Performance improvement will focus on systems, processes and outcomes.
2. Leadership driven by a commitment to a culture of safety and transparency that uses a Quality Dashboard as the monitoring tool.
3. Data driven based on evidenced based practices using national benchmarks (when available) and comparative data.
4. Integrated and coordinated processes to engage all levels of leadership, physicians, employee staff, and community members.
5. Proactive by design in order to sustain continuous performance improvement, promote high reliability, quality, safe patient care and services.
6. Communication through a common language created by an ongoing process to prioritize Quality Assessment/Performance Improvement opportunities using consistent methods and statistical tools that are the tenets of PDSA and when appropriate Lean/Six Sigma -- i.e., Define, Measure, Analyze, Improve and Control (DMAIC).
7. A calendar of reporting to ensure ongoing systematic communication to all key constituents, ensure accountability and maintain the ongoing improvement gains for all continuous quality assessment/performance improvement activities.
8. Educational programs and meetings to enhance statistically-based quality assessment/performance improvement tools for every level of leadership, physicians, and staff.
9. Standardized processes for investigation of events and followup on near miss adverse, adverse events and sentinel events. These standardized processes address:
   a. An investigation into the cause of the adverse event may be undertaken pursuant to the Medical Center’s Review Process.
   b. The investigation would be conducted for the purpose of the evaluation and improvement of the quality of care.
   c. What practice / process change is required to prevent recurrence
   d. How the practice/process change will be accomplished
   e. Who is responsible for the practice/process change
   f. Timeline for completion
   g. Description of the monitoring process to prevent a recurrence.
   a. CMS is waiving 482.21(a)-(d) and (f), and 485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program’s performance improvement activities, and integrated QAPI.
   b. Any improvements to the plan must focus on the Public Health Emergency. While this waiver decreases the burden associated with the development of a hospital or QAPI program, the
requirement that hospitals maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain.

c. Upon declaration of end of pandemic, QAPI will return to normal processes.

d. Waivers will be tracked and monitored accordingly throughout Pandemic.

V. Goals

A. As part of the annual evaluation of the Quality Assessment Performance Improvement (QAPI) activities and goals are identified for each calendar year to ensure continuous improvement. The following actions should be taken in forming specific goals:

1. Enhance key processes to ensure that "Evidence Based Practices" are considered in all opportunities for improvement of care and services.

2. Integrate the Quality Assessment/Performance Improvement Plan into a culture of safety that recognizes the key behaviors and attitudes that result in a safe environment for patients, families, employees, and physicians.

3. Create a support structure for data collection and analysis through collaboration with Information Technology, Strategy, and Finance.

4. Review and revise as necessary the peer review methodology to ensure a quality driven process that provides a consistent, objective, data-driven evaluation of physician and nurse performance via their respective peer review programs.

5. Identify core components for Quality Assessment/Performance Improvement methods and tools for the organization.

B. The organization has an effective program that assesses the quality and safety of its services including Local, State, and Federal regulations to identify opportunity for improvement, and works to address those opportunities. Services include but not limited to:

1. Management of the Care Environment
2. Management of the Medical Record
3. Infection Prevention and Control
4. Patient Rights
5. Medication Management
6. Anesthesia Services
7. Dietary Services
8. Discharge Planning
9. Laboratory Services
10. Nuclear Medicine Services
11. Nursing Services
12. Operative and Invasive Services
13. Outpatient Services
14. Radiology Services
15. Rehabilitation Services
16. Respiratory Services
17. Contracted Service: All contracted services, including one for shared services and joint ventures, patient care services, and all other services, provided under contract are subject to the same hospital-wide quality assessment and performance improvement (QAPI) evaluation as other services provided directly by the hospital. The hospital will assess the services furnished directly by hospital staff and those services provided under contract, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities.

18. Patient Grievances - The hospital’s Governing Body has delegated the grievance process to the Quality/Patient Safety Department. The Quality/Safety department receives, reviews, and collaborates with appropriate unit/department leader and/or physician, in addition to, but not limited to; Regulatory, Finance, and Risk Management for review and investigation. Upon completion of the investigation, a letter will be sent to the complainant informing them of the outcome. Outcome data will be presented to various stakeholder meetings including up to the Governing Body.
v. Reporting Structure, Responsibilities, and Constituents of the QAPI Plan

A. Board Quality Review Committee (BQRC):
   1. Duties:
      a. Pursuant to the BQRC bylaws. The Board Quality Review Committee shall also review the prioritized proposed performance improvement projects and patient safety activities and shall report to the governing body.
   2. Composition:
      a. Voting Membership: The committee shall consist of five voting members, including three members of the Governing Body and the Chairs of the Quality Management Committees (QMC) of Palomar Medical Center Escondido and Palomar Medical Center Poway. Nonvoting Members include: The President and Chief Executive Officer; the Chief Operations Officer; the Chief Medical Officer; Medical Quality Officer; the Chief Legal Officer; the Chief Nursing Officers of Palomar Medical Center Escondido and Palomar Medical Center Poway; Vice President of Quality/Patient Safety, Senior Director of Quality/Patient Safety.

B. Medical Staff Executive Committees (MEC):
   1. Duties:
      a. The Medical Executive Committee (MEC) is the primary governance committee for the independent medical staff. The MEC, with input from the medical staff, makes key leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement initiatives. They are also responsible for adopting and implementing medical staff policies and procedures, and creating medical staff appointment and reappointment criteria.
      b. The MECs review and approve all recommendations submitted by the Quality Management Committee and initiate any special studies or recommendations as deemed appropriate to maintain
an effective program.

2. Composition:
   a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the Medical Staff Bylaws.

C. The Quality Management Committee (QMC) of the Medical Staffs:
   1. Purpose:
      a. The Quality Management Committees of the Medical Staffs will regularly review specified performance metrics recognized as measurements of quality and safety, including but not limited to: blood usage, medication usage, pharmacy and therapeutics, nutrition, medical record timeliness, special care review, utilization review, nursing sensitive (e.g., falls, hospital acquired pressure injuries, and medical restraint use) patient outcomes, infection control, patient safety, and other items identified in the body of this plan. Appropriate summaries and recommendations first referred to the appropriate clinical departments and subcommittees are then forwarded to the respective Medical Staff Executive Committees for review and approval.
      b. The QMC reviews and prioritizes proposed performance improvement projects as recommended by the Interdisciplinary Governance Council (IGC).
      c. The QMC provides oversight for the Quality Assessment Performance Improvement (QAPI) activities of medical staff, nursing, and clinical departments and committees.

   2. Composition:
      a. The Committee has Physician Chairs (preferably the Chief of Staff-elect at each licensed acute care facility). Committee members will include the department chairs-elect of the medical staffs or their designee, along with representatives from Medical Staff, Administration, Nursing, Department Directors, and staff responsible for overseeing quality assessment and performance improvement activities.

   3. Voting Membership: Physicians and Executive Leadership Team (VPs, CNOs, Executives) present at time of voting.

D. Interdisciplinary Governance Council (IGC):
   1. Purpose: The Interdisciplinary Governance Council is responsible for providing oversight and approval for all councils in the IGC infrastructure. The Governance Council will work closely with the Regulatory Steering Committee and QMC. The intention is to improve communication, efficiency, and effectiveness in regard to decision making and to provide a mechanism and structure for a communication and approval process that will expedite process improvement changes as well as implementation.

2. Governance: The IGC is the oversight council for Education and Organizational Development Council (EODC), Clinical Informatics Council (CIC), the Patient and Medication Safety Council (PMSC) and the Regulatory Steering Committee. The Staff Practice Council (SPC) will report through the PMSC.

E. Clinical Informatics Council (CIC):
   1. Purpose: The Clinical Informatics Council is an interdisciplinary group that whose purpose is to serve as the oversight body for all clinical Informatics projects. The council discusses and oversee clinical informatics requests, and change orders to determine priority and provide feedback and support to end users. This council is the team that advises on priorities and recommendations regarding electronic health record (EHR) support of safe patient care.

2. Governance: This council will make recommendations for final approval to the Interdisciplinary Governance Council based on the authority level granted. Recommendations regarding project prioritization, strategy, or capital expense will then be referred to the IT Steering Committee.

F. Education/Leadership Development Council (EODC):
   1. Purpose: The purpose of the Education and Leadership Development Council (EODC) is to develop, implement, evaluate, and provide oversight over integrated education and leadership development plan that meets regulatory requirements, as well as to facilitate implementation of strategic initiatives that support a culture of excellence.

2. Governance: The EODC will make recommendations regarding education plans and practices to the IGC for approval.

G. Regulatory Steering Committee:
1. **Purpose:** The purpose of the Regulatory Steering Committee is to provide guidance and oversight for the implementation and monitoring of CMS Conditions of Participation (COP), and the Joint Commission (TJC) accreditation standards for maintaining Medicare Reimbursement and Quality Accreditation approved status as an organization. The oversight and guidance also applies to all applicable local, state, and federal regulatory regulations across the system (i.e. Title 22, OSHA, etc.)

2. **Governance:** The committee will provide a monthly report to the IGC.

### Patient and Medication Safety Council (PMSC):

1. **Purpose:** The purpose of the Patient and Medication Safety Council is to promote a culture of safety through oversight and implementation of the Quality Assessment and Performance Improvement (QAPI) Plan. The council will ensure the development of documents, policies, procedures, and practices that reflect evidence-based practice (EBP) and meet the standards of professional organizations, state and federal professional practice acts, scopes of practice, as well as regulatory standards. Responsibility will include oversight for medication safety and recommendations for process improvement projects that will facilitate an interdisciplinary approach to the Plan, Do, Study, Act (PDSA) model for daily work processes.

2. **Governance:** The Patient and Medication Safety Council will make recommendations for final approval of policies to be sent to specialty committees (e.g. Infection Prevention, QMC) and will refer policies/procedures to IGC for approval for posting. This council will also make recommendations regarding various committee and project proposals to the IGC.

### Patient Experience Council (PEC):

1. **Purpose:** The purpose of the Patient Experience Council is to provide oversight and guidance on achieving and sustaining patient-centered care. The council will oversee the development, implementation and monitoring for all best practices, performance metrics, policies and procedures that enhance and/or promote the ideal patient and family experience while always advocating for the communities we serve, aligning with our mission, vision, and values.

2. **Governance:** The Patient Experience Council will make recommendations regarding performance improvement plans and best practices to the Interdisciplinary Governance Council for approval.

### Staff Practice Council:

1. **Purpose:** The purpose of the Staff Practice Council is to facilitate staff input and feedback from an interdisciplinary perspective into decisions effecting patient care and professional practice. The council also seeks to enhance sharing and reporting of unit/dept. specific work plans related to the Plan for Patient Care Services, the organizational strategic plan related to clinical practice, patient and employee satisfaction, and quality and patient safety. The work, conversations, and recommendations from the council should be based on the Relationship Based Care model. The SPC serves as Interdisciplinary fall team for the system. Teams reporting into SPC include: Nursing Peer Review; Safe Patient Handling and Patient Classification.

2. **Composition:** The Staff practice Council (SPC) will be made up of representatives of the Unit/Department Based Practice Council Chairs, a sponsor from the Patient and Medication Safety Council (PMSC), and staff representatives from teams that have been meeting to make decisions with staff input (e.g. Staff on Safety (SOS), Nursing Peer Review, Patient Classification, and Safe Patient Handling).

3. **Governance:** This council will report to the PMSC. The PMSC will provide guidance and mentoring for professional practice. Sponsors will provide updates from (PMSC) and also the Interdisciplinary Governance Council (IGC).

### Medical Staff Committees:

Pursuant to the Medical Staff Bylaws, Medical Staff departments and committees are responsible for the quality of care, service and safety of patient care delivered by the members of their respective departments. Medical Staff Departments and Committees shall demonstrate quality assurance and performance improvement by:

1. Participating in departmental and quality assessment/performance improvement activities.

2. Utilizing results and recommendations from interdisciplinary performance improvement efforts to improve services.

3. Utilizing information from the Medical Staff Peer Review Committee (MSPRC) and Quality Department that includes data addressing each of the six physician core competencies for credentialing, privileging and the reappointment process.

4. Reviewing and analyzing summary reports of trended data reported out by department and/or by physician for processes dependent primarily on the activities of one or more individuals with clinical privileges.
5. Sharing responsibility for planning, designing, measuring, assessing, and improving the overall safe care of patients.

L. Medical Staff Peer Review Committee (MSPRC):

1. Duties:
   a. Review cases referred by physicians and staff or by screening criteria with the goal of improving physician performance at the individual and aggregate levels, improving patient outcomes, and supporting a culture of compassion and respect.
   b. Promote efficient use of physician and quality staff resources.
   c. Provide accurate and timely performance data as available for physician feedback and Ongoing Professional Practice Evaluation (OPPE).
   d. Recognize physician excellence in addition to identifying improvement opportunities.

2. Composition:
   a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the respective Medical Staff Peer Review Charter for each facility.

M. Critical Care Committee (CCC)

1. Duties: The District wide Critical Care Committee is responsible for:
   a. Identifying indicators for monitoring the important aspects of critical care.
   b. Evaluating results of data collected for these indicators.
   c. Making recommendations for actions to improve care or correct identified problems.

2. Composition: Co-chairs, both of whom will be Medical Directors of ICU, along with broad representation from appropriate areas of the Medical Staff, Administration, Nursing and other disciplines as appropriate.

N. Imaging Services - District Radiation Safety Committee (RSC):

1. Duties:
   a. The RSC will regularly review metrics recognized as measurements of quality and safety and safety in radiation safety and protection. Metrics reviewed include, but are not limited to, dosimetry badge readings, medical physicist reports, and fluoroscopy quality assurance.

2. Composition:
   a. The Committee Chair is the Radiation Safety Officer (RSO). Committee members will include representatives from Imaging Services, Surgical Services, Interventional Radiology, Cath Lab, Environmental Services, Radiation Oncology, Administration, nursing representation and a medical physicist.

O. Infection Prevention and Control Committee (IPCC): The District wide Palomar Health Infection Prevention and Control Committee is responsible for carrying out the following:

1. Duties:
   b. Develop and maintain an Infection Prevention and Control program that reflects the Mission and Vision of Palomar Health. The program includes Quality and Regulatory Standards developed by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and other nationally recognized organizations.
   c. To ensure implementation of prevention measures, and monitoring outcomes with the ultimate goal of preventing and controlling infection transmission among patients, employees, medical staff, contracted service workers, and volunteers.
   d. The IPCC will report directly to the Quality Management Committee.
   e. To provide structure for an organization-wide, facility specific approach to identify and reduce the risk of endemic and epidemic healthcare-associated infections (HAI). To ensure optimal provision of services, the management of the infection prevention and control process is assigned to qualified personnel by virtue of education, training, licensure, experience or certification.
   i. Application of epidemiological principles, including activities directed at improving patient outcomes using implementation science.
a. Implementation of changes mandated by regulatory, accrediting, and licensing agencies.

b. Education efforts directed at interventions to reduce infection risk.

c. Consultation on risk assessment, prevention, and control strategies (includes activities related to occupational health, construction, and emergency management.


e. Review and analysis of infection data.

f. The hospital has designated one or more individual(s) as its Infection Control Officer(s). The Infection Control Officer(s) is/are qualified and maintain(s) qualifications through education, training, experience or certification related. The Infection Control Officer(s) have the authority and responsibility for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program. The IPCC through its chairperson and/or Senior Director of of Quality and Infection Prevention and Control Program are the Infection Control Officers, are granted the authority to institute any appropriate emergency measures throughout the health system when there is reasonable risk or danger to any patient, personnel, or visitors as it relates to Infection Prevention and Control.

2. Composition:

a. The Committee is composed of a physician chair who is an infectious disease specialist, and representatives but not limited to: Infection Prevention, Nursing, Administration, and personnel responsible for overseeing facility infection control activities, (e.g., Home Health, Villa Pomerado, Peri-operative Services, Facilities, Environmental Services, Food and Nutrition, Pharmacy and Corporate/Employee Health, Lab, Respiratory Services, and Wound Care).

P. Pharmacy and Therapeutics Committee (P&T):

1. Duties:

a. Develop and implement written policies and procedures for the establishment of safe and effective systems of procurement, storage, distribution, dispensing and use of medications.

b. Develop and maintain a formulary of drugs throughout the hospitals.

c. Monitor the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition, and clinical dietary consultations.

d. Review Adverse Drug Reaction Event Program.

e. Review Medication Error Reduction Plan at least annually.

f. Make recommendations to improve care or to correct identified problems to the Quality Management Committee based on analysis and evaluation of data collected through indicators.

g. Refer to the Chair of either Palomar Medical Center Escondido (PMCE) or Palomar Medical Center Poway (PMCP) --any matter within the scope of the Medical Staffs' responsibilities for performance improvement as appropriate.

h. The P&T committee will report to the Quality Management Committee.

2. Composition:

a. The minimum committee quorum shall consist of the Physician Chair, the Director of Pharmaceutical Services or representative, the Chief Nursing Officers from PMCE and PMCP or representatives, a System Administrator or representative. Representatives from Medical Staff, Nursing, Laboratory, Nutritional Services and Allied Health care Staff may also participate on the committee.

q. Subcommittees:

1. Nutrition and Therapeutics Committee (N&TC): The purpose of the N&TC is to provide appropriate nutrition care to patients using evidenced based information, bridging the gap between research and practice.
a. Duties: The duties of the Nutrition and Therapeutics Committee include, but are not limited to:
   i. Assisting the pharmaceutical service in maintaining the enteral and parenteral Hospital Formulary.
   ii. Monitoring the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition and clinical dietary consultations.

b. Composition:
   i. The N&TC is comprised of a multidisciplinary team of health professionals including Nutritional Services, Medical Staff, Pharmacy and Nursing.

2. Antibiotic Stewardship Subcommittee:
   a. Duties: In view of the dramatic increase in antibiotic resistance, the Antibiotic Stewardship Subcommittee’s responsibilities include, but are not limited to:
      i. Reviewing new antimicrobial agents.
      ii. Reviewing antibiotic usage and expenditures, including restricted antibiotics.
      iii. Developing empiric treatment guidelines, protocols, and Power Plans to minimize the development of resistance organisms.
   b. Composition:
      i. The Antibiotic Stewardship Subcommittee is comprised of one or more Infectious Disease Physicians, Physicians representing various medical specialties, Antibiotic Stewardship Pharmacist, a Microbiology Representative from the Laboratory and an Infection Preventionist.

R. Center of Excellence - Bariatric (Palomar Medical Center Poway)
   1. Duties:
      a. To achieve and maintain Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care.
      b. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and value.
   2. Composition:
      a. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other medical directors).

S. Non-Medical Staff QAPI Committees and Functions
   1. Centers of Excellence - Cardiovascular and Orthopedics (PMC Escondido and PMC Poway) /Spine (PMC Escondido)
      a. Duties:
         i. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and value.
         ii. To achieve and maintain Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care.
      b. Composition:
         i. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other medical directors).

2. Stroke Committee:
   a. Duties:
      i. Provide oversight, coordination and direction to the individuals caring for the stroke patients.
ii. Evaluate appropriateness and adequacy of the program through a review of clinical practice guidelines, power plans, and procedures.

iii. Coordinate education programs for staff and the community we serve.

iv. Monitor, analyze, and evaluate stroke measures; identify opportunities for improvement; share recommendations and outcomes.

v. Participate in the Palomar Health Quality and Performance Improvement program.

vi. Stroke Committee will report through the Quality Management Committee.

b. Composition:
   i. The committee is comprised of a multidisciplinary team of health professionals including Administrative Leaders; Medical Staff: Neurology, Neurosurgery, Neuro-Interventionist, Emergency, Critical Care, Anesthesiology, and Hospitalist; Stroke Program Coordinator; Pharmacy; Nursing; Radiology; Laboratory; Rehabilitation Services; Case Resource Management; Patient Access and Quality.

3. Laboratory Services: Quality

   a. Duties: Laboratory Services: Lab Quality includes, but are not limited to:
      i. Review and approve monthly Lab Quality indicators and blood bank audits
      ii. Identify opportunities for process improvement from staff feedback, variance reports, QRR reports, and quality indicator results.
      iii. Evaluate results of monthly ED turnaround time report.
      iv. Review for completion of follow up action and plan of corrections.
      v. Review actions and decisions with Medical Laboratory Director.

b. Composition:
   i. The District Laboratory Director and Laboratory Managers chair and co-chair the monthly meeting. Members include the medical laboratory director, laboratory managers, section supervisors, shift supervisors, and Chairs of the Lab Professional Practice.

4. Environment of Care (EOC) Committee:

   a. Duties: Specific responsibilities include, but are not limited to the following:
      i. Development and review of procedures
      iii. Environmental Surveillance, Safety Education and Product Recall Monitoring.
      iv. Monitor the results of regulatory inspections and refer to Regulatory Steering Committee.
      v. Analyze and aggregate data. Recommendations are developed and approved as applicable.
      vi. This committee will report up through the Interdisciplinary Governance Committee.

b. Composition:
   i. The Committee is composed of the Chair and Co-Chair, Facilities, Risk Management, Security, Employee Health, Biomedical Engineering, EVS, Infection Control as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.

5. Disaster Preparedness Committee (DPC):

   a. Duties:
      i. The District wide Disaster Preparedness Committee is responsible for ensuring disaster planning and disaster related activities are managed and implemented. It is the responsibility of the Emergency Management/Safety Program Manager to ensure meetings are scheduled and minutes taken. Information, progress notes, and followup activities from this committee are reported to the Environment of Care Committee.
      ii. This committee will report up through the Interdisciplinary Governance Committee.

b. Composition:
   i. The Committee is composed of the Chair and Co-chair, Facilities, Risk Management, Security, Infection Control, Emergency Department as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.

6. Continuum Care Operations Division:
a. Purpose: Under the direction of the Vice President, the Continuum Care Directors, the Continuum Care Operations Division promotes improvement of patient safety and outcomes by providing an organization-wide approach for continually assessing and improving the quality of health services that we provide to our patients, employees, and community outside our acute care facilities. Under the oversight of the Vice President, Continuum Care, the Continuum Directors are responsible for the performance improvement and patient safety program at the departmental level within their respective specialties. The ongoing monitoring and analysis of Quality indicators are based on the following:
   i. Identification of patient needs and expectations and evaluation of how these needs and expectations are met
   ii. Identification of staff education and training needs and ongoing measurements to demonstrate sustained improvement
   iii. Use of evidence-based data from internal and external sources to improve the quality of care
   iv. Integration and coordination of quality initiatives across the care continuum including: acute care, skilled nursing, home health and ambulatory services
   v. Analysis of data to establish priorities and identify opportunities for future improvement
b. Entities under the umbrella of the Continuum Care Operations Improvement Function include:
   i. Villa Pomerado Quality Committee
   ii. Home Health Quality Committee
   iii. Rehabilitation Services
   iv. Ambulatory Specialty Outpatient Services
c. The performance improvement measures that reflect a direct contribution of Continuum Care achieving quality and safe patient care outcomes may include:
   i. Physician and Employee Engagement
   ii. Patient Experience
   iii. Risk
   iv. Regulatory or accreditation requirements
   v. Patient and community outcomes
   vi. CMS Quality Indicators for Skilled Nursing and Home Health

METHODS:
A. Understanding that performance improvement and patient safety permeate every level of the organization. The Palomar Health Leadership Team empowers and assigns individuals to lead these by providing time and resources to achieve optimal outcomes.
B. Whenever possible, sound statistical methods and the techniques of continuous quality improvement will be utilized. In most projects, a Plan-Do-Study-Act Cycle (PDSA) methodology model will be used.
C. Prioritization: When selecting Quality Assessment Performance Improvement (QAPI) projects, Palomar Health leaders recognize the importance of using criteria to do ongoing prioritization of Quality Assessment Performance Improvement projects. Therefore, proposed projects will be coordinated to avoid duplication of projects.
D. Designing Processes: When creating or modifying programs and/or processes, consideration is taken to ensure the design:
1. Is consistent with the mission, vision, values, goals, objectives and plans;
2. Meets the needs of individuals served, staff and others;
3. Is clinically sound and current (for instance, use of best practice guidelines, successful practices, information from relevant literature, and clinical standards);
4. Incorporates available information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesign processes, functions, or services;
5. Utilizes tools and methods to proactively identify risk points and eliminate them prior to implementing changes;
6. Includes analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement; and
7. Incorporates the results of Quality Assessment Performance Improvement activities.
8. Data Collection: Data is collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement and sustain improvement. Collected data is used to:
   a. Compare performance about processes and outcomes through the use of reference databases.
   b. Compare performance data about processes with information from up-to-date sources.
   c. Make comparisons of performance of processes and outcomes over time.
   d. Data is collected on important processes and outcomes and includes, but is not limited to, key processes related to:
      i. Leadership priorities
      ii. Patient Safety including staff
      iii. Environment of care
      iv. Patient Satisfaction
      v. Pain Management
      vi. Medication Management
      vii. Blood and blood products
      viii. Restraint and seclusion
      ix. Operative and other invasive procedures
      x. Organ procurement
      xi. Resuscitation
      xii. Risk Management
      xiii. Infection Control
      xiv. Imaging Services
      xv. Laboratory Services
      xvi. Patient Grievances
      xvii. Contracted Services
   e. Benchmarks: Whenever available, benchmarks from local, state and national databases and medical literature will be obtained and used. Available bench marking systems include but are not limited to:
      i. The Joint Commission (TJC)
      ii. Centers for Medicare & Medicaid Services (CMS) through CMS.Gov
      iii. Society of Thoracic Surgeons Cardiac Surgery Database
      iv. Center for Disease Control and Prevention (CDC) Database
      v. National Database for Nursing Quality Indicators (NDNQI)
      vi. Office of Statewide Health Planning and Development (OSHPD) California State Hospital Discharge Annual Database
   f. Palomar Health is a member of the California Hospital Patient Safety Organization (CHPSO) and Health Services Advisory Group (HSAG).
   g. Best Practice Core Measures: Proactively engaged with bench marking systems performance through their involvement with The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) in order to continuously seek out opportunities to improve our performance based on best practices, such as those promulgated by the National Quality Forum.
G. Data Assessment: The data is organized for reporting purposes in a manner that allows for analysis of the results. Data is systematically aggregated and analyzed on an ongoing basis:
   1. Aggregated data is analyzed to make judgments about:
      a. Whether design specifications for processes were met
      b. The level of performance and stability of important existing processes
      c. Opportunities for improvement
      d. Actions to improve the performance of processes
      e. Whether changes in processes resulted in improvement
   2. Appropriate statistical techniques are used to analyze and display data. These techniques include, run charts, control charts, Pareto charts, and other statistical tools as appropriate.

H. Failure Mode and Effects Analysis (FMEA): involves the prospective evaluation of processes identified by the organization as being vulnerable to risk and the redesign of such processes to build safety in (e.g., through creating redundancies) before an adverse event occurs.

I. Root Cause Analysis (RCA): When a serious, unexpected adverse outcome or near-miss occurs, the RCA process may be used to determine the most basic or immediate factor(s) or causes of why the event occurred. The RCA process is a systematic approach to understanding the causes of an adverse event and identifying system flaws that can be corrected to prevent the error from happening again. RCAs are retrospective, focus on system issues rather than blame, and are not appropriate in cases of negligence or willful harm. An action plan is then identified and monitored.

J. Improving and Sustaining Performance: Changes to improve performance are identified, planned, and tested using the PDSA Cycle Model. Effective changes are incorporated into standard operating procedure.

K. Training and Education: Training and Education in performance improvement/patient safety is provided throughout the organization.

L. Communication:
   1. Communication of Performance Improvement/Patient Safety activities throughout the Medical Staffs and Hospital Staffs occurs through a variety of means including:
      a. Through the QAPI Committee structure, e.g., the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and Medical Staff Committees.
      b. Through newsletters, memos, education programs, educational offerings
   2. QAPI reports are communicated to the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and other clinical Committees according to the calendar of reporting.

M. Confidentiality:
   1. Data generated by the QAPI Program are considered to be products of the Quality Management Committee of the applicable health facility and are protected from discoverability under Section 1157 of the California Evidence Code. Practitioners and Palomar Health personnel have a duty to preserve this confidentiality.
   2. The performance improvement activities must abide by the Confidentiality of Medical Information Act in maintaining the confidentiality of the patient’s medical information. Compliance is also maintained with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

N. Conflict of Interest:
   1. A Practitioner may not participate in the review of any case in which he has been or anticipates being professionally involved. Practitioners having either a direct or indirect financial interest in the case(s) being reviewed may not participate in the utilization review activities pertaining thereto.

O. Annual Reappraisal: This QAPI plan is reviewed annually to evaluate the overall effectiveness considering such factors as results achieved, operational problems encountered, and deficiencies noted. The Plan with any amendments will be forwarded to the Board of Directors Quality Review Committee for final approval.

Document Owner: Martinez, Valerie A
Approvals:
- Committees: ( 03/10/2021 ) Quality Management (QMC) (joint), ( Not yet approved ) Medical Executive Committee, Escondido, ( Not yet approved ) Medical Executive Committee, Poway
Revision Date: Standards: College of American Pathologists:
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<td>(REFERENCED BY THIS DOCUMENT)</td>
<td>Patient Safety Event Response, Investigation and Follow-Up</td>
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<td><a href="mailto:patientsafetyreport@jointcommission.org">patientsafetyreport@jointcommission.org</a></td>
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<td>Patient Complaint/Grievance Process</td>
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<td>COVID-19 Exposure Control Plan</td>
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*Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at https://www.lucidoc.com/cgi/doc-gw.pl?ref=pphealth:11234$18.*
ADDENDUM D
Plan: Infection Prevention and Control Risk Assessment and Surveillance Plan

Differences between version 21 and 22.

I. Authority Statement:
A. The Infection Control Officers have the authority and responsibility for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program and for acting on the results of the information. The Infection Control Committee, through its chairperson and/or Senior Director of the Infection Prevention and Control Program, are granted authority to institute any appropriate emergency control measures throughout the health system when there is a reasonable risk or danger to any patient or personnel.

II. Purpose:
A. To provide structure for an organization-wide, facility specific approach to identify and reduce the risk of endemic and epidemic healthcare-associated infections (HAI). To ensure optimal provision of services the management of the infection prevention and control process is assigned to qualified personnel by virtue of education, training, certification or licensure, and experience.

III. Mission:
A. To develop and maintain an Infection Prevention and Control program that reflects the Mission and Vision of Palomar Health and includes Quality and Regulatory Standards developed by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS) and other national organizations. To ensure implementation of prevention measures, and monitoring outcomes with the ultimate goal of preventing and controlling infection transmission among patients, employees, medical staff members, contracted service workers, volunteers, students, and visitors.

IV. Scope of Service
A. Interdisciplinary outcomes-based approach to surveillance, prevention, and control of infection. Individual departments develop specific procedures utilizing clinical and practical experience. Procedures are first reviewed by the infection preventionsists for consistent demonstration of sound epidemiological principles prior to submission to the Infection Prevention and Control Committee for final approval.
   1. The infection preventionsists serve as expert consultants, working with individual departments to develop, design and present continuing education programs, and contribute to both department-specific and organization-wide orientation.
   2. Corporate Health Services shares responsibility for educating staff regarding the risks of transmission and appropriate exposure precautions for communicable diseases.
   3. Management systems (including staff and data systems), defined by specific requirements of the healthcare-associated infection risk reduction process of the organization, are available to help achieve this outcome.

B. Fiscal Year 2019 - FY 2020 Top Ten MSDRGs Diagnosis - Related Groups (DRG)

<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>392</th>
<th>766</th>
<th>885</th>
<th>871</th>
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<td>470</td>
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<td>SEPTICEMIA OR SEVERE SEPSIS W/O MV &gt;96 HOURS W/O MCC</td>
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V. Objectives:
A. Direct, coordinate, integrate, and monitor all organizational infection prevention and control activities.
   1. Collect and analyze data in order to identify infection problems or opportunities to improve patient care.
   2. Establish priorities for action based on the following considerations:
      b. Number of patients or health care workers potentially affected.
      c. Duration of problem.
      d. Number of services involved.
      e. Requirements for investigation and resolution.
      f. Resources available.
      g. Mission statement and infection control risk assessment and plan for Palomar Health.
   3. Provide effective communication of appropriate information to the medical staff and Palomar Health care workers related to infection prevention and control and regulatory guidelines.
   4. Provide appropriate infection prevention and control information to individual practitioners as needed.
   5. Document evidence that departments, which perform decontamination and sterilization activities, are consistent in intent and application throughout the organization and follow all manufacturers’ recommendation.

B. Licensed Beds:
   1. ICU
      a. Escondido 24
      b. Poway 12
VI. Risk Assessment Grid:

A. The table below that follows outlines the prioritized risks identified as the result of the assessment and provides a brief description of those risks. A risk level is assigned (low, medium, or high) based on the care setting (outlines in summary form), interventions that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of the interventions.

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B. Legend:

1. I = Inpatient services such as medical surgical, critical care, maternal / child, surgery, behavioral health, and other care units
2. A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department
3. O = Outpatient services including, Wound Care Centers, Outpatient Rehabilitation, Cardiac Rehabilitation, Corporate Health Services, Sleep Lab, Behavioral Health, Retail Pharmacy, Women's outpatient services, Laboratory Medicine Outpatient Building
4. H = Home health, hospice, home pharmacy, DME, and other home health services
5. L = Long-term care, sub-acute care, skilled nursing, and other long term care services

* For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, clinical laboratory, and all other departments and services of the organization.

C. Allocation - Enter the Level of Assessed Risk for Each Care Setting:

1. L = Low risk
2. M = Medium risk
3. H = High risk

---

Legend is apparent & ambiguity. On outpatient high M medium L low (see below for in depth legend) | Prioritized Risk Description | Care Setting | Risk Level | Description
---|---|---|---|---|
I = Inpatient services such as medical surgical, critical care, maternal / child, surgery, behavioral health, and other care units | Care Service Prioritization | Care Setting | Risk Level | Description
A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department | Care Service Prioritization | Care Setting | Risk Level | Description
O = Outpatient services including, Wound Care Centers, Outpatient Rehabilitation, Cardiac Rehabilitation, Corporate Health Services, Sleep Lab, Behavioral Health, Retail Pharmacy, Women's outpatient services, Laboratory Medicine Outpatient Building | Care Service Prioritization | Care Setting | Risk Level | Description
H = Home health, hospice, home pharmacy, DME, and other home health services | Care Service Prioritization | Care Setting | Risk Level | Description
L = Long-term care, sub-acute care, skilled nursing, and other long term care services | Care Service Prioritization | Care Setting | Risk Level | Description

* For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, clinical laboratory, and all other departments and services of the organization.

C. Allocation - Enter the Level of Assessed Risk for Each Care Setting:

1. L = Low risk
2. M = Medium risk
3. H = High risk
<table>
<thead>
<tr>
<th>Prioritized Event Risk Description</th>
<th>Care Setting / Risk Level</th>
<th>Summary of Risk Mitigation Strategies</th>
<th>How Effectiveness of Strategies is Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission of infection through potential non-compliance to CDC guidelines and recommendations for hand hygiene</td>
<td>M</td>
<td>Hand hygiene procedures follow CDC guidance</td>
<td>Standardized observation data, quarterly facility and unit reports, LEM scoring, Medical staff reports</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>Staff education initial and at least annually</td>
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<tr>
<td></td>
<td>M</td>
<td>Observation Data shared at department level</td>
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<tr>
<td></td>
<td>L</td>
<td>Availability of alcohol gel and non-alcohol alternative</td>
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<td></td>
<td>L</td>
<td>Availability of hospital approved hand lotion</td>
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<tr>
<td>Unprotected exposure to pathogens throughout the organization through potential non-compliance with policies addressing category / disease specific isolation and other precautions</td>
<td>M</td>
<td>Staff education (initial and annual)</td>
<td>Staff Education records</td>
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<td></td>
<td>L</td>
<td>Blood borne pathogen exposure control plan</td>
<td>Exposure reports</td>
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<td>M</td>
<td>Annual Transmissible Diseases Control (TB) control plan</td>
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<td>Cough etiquette program</td>
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<td>Isolation procedure</td>
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<td>Personnel and availability</td>
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<td>Infection control protocols</td>
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<tr>
<td></td>
<td>L</td>
<td>Availability of hospital approved hand lotion</td>
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<tr>
<td>Potential for transmission of infection related to procedures, medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment</td>
<td>M</td>
<td>Disinfection and sterilization procedures using manufacturer’s instructions for use (IFU) and CDC guidelines - Spaulding Classification</td>
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<td>Classification System</td>
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<td>Education/Compliance</td>
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<td>Therapy culture</td>
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<td>High level disinfection (HLD) logs, recording and reporting</td>
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<td>Annual Linen Plant tour</td>
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<td>Potential for infection in ambulatory care and outpatient settings due to potential prolonged wait times in common areas and potential exposure to infectious individuals</td>
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<td>Cough hygiene stations located at entries of ED, hospital lobby, and satellite services waiting area</td>
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<td>Patients discouraged from OP units when it</td>
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<td>Cough hygiene stations located at entries of ED, hospital lobby, and satellite services waiting area</td>
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<td>Community-wide outbreaks of communicable diseases that carry the potential of adversely impacting operations and service capabilities</td>
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<td>Emergency Infectious Disease Awareness and Education</td>
<td>Chapter Committee and IPCC agenda and minutes</td>
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<td>Emergency Department (ED) travel screening</td>
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<td>Positive Air Purification Respirator (PAPR) inventory</td>
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<td>Disaster and Surve Plan</td>
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<td>Syndrome Surveillance</td>
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<td>Annual Hazard Vulnerability Analysis</td>
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<td>Long Term Care Risk Assessment and Enhanced Standard Precautions</td>
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<td>Prioritized Event Risk Description</td>
<td>Care Setting</td>
<td>Risk Level</td>
<td>Summary of Risk Mitigation Strategies</td>
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<td>Emergency Preparedness: Infectious Disease Suspect encounter (novel and epidemic), naturally occurring events including: earthquakes, fires and drought and boil water alerts are the top priority followed by an epidemic, human related events such as mass casualty/medical or infectious)</td>
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<td>Daily hand hygiene hold</td>
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<td>Changes to microbiology result interpretation and reflex</td>
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<td>CEP Germ audits</td>
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<td>Device rounding CC</td>
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<td>Alerts to providers to assess necessity</td>
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<td>Ventilator Associated Pneumonia (VAP)</td>
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<td>VAP surveillance</td>
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<td>Pulmonary partnership with units to increase accountability and knowledge</td>
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<td>VAP bundle Data</td>
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</table>
### Surveillance Plan Palomar Health:

**A. 2019-2021 Surveillance Plan**


### Summary of Risk Mitigation Strategies

<table>
<thead>
<tr>
<th>Prioritized Event Risk Description</th>
<th>Care Setting / Risk Level</th>
<th>Summary of Risk Mitigation Strategies</th>
<th>How Effectiveness of Strategies is Evaluated</th>
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<tbody>
<tr>
<td><strong>Catheter Associated UTIs (CAUTI)</strong></td>
<td>Low Risk</td>
<td>CAUTI bundle compliance</td>
<td>CAUTI bundle data</td>
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<td>CAUTI HH NHN</td>
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<td>Alternative products to indwelling catheters</td>
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<td>Vessel rounding CC</td>
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<tr>
<td><strong>Surgical Site Infections Overall (SSI)</strong></td>
<td>Medium Risk</td>
<td>Prevent antimicrobial bathing</td>
<td>Surgical Site Infection HH NHN</td>
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<td></td>
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<td>Appropriate preop antibiotic timing; dosing; dosing</td>
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<td>Core Heater Cooler procedures</td>
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<td>Roundup of SOP; EVS; and EOC</td>
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<td>Preop interventions taskforce</td>
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<td><strong>Colon SSI</strong></td>
<td>Low Risk</td>
<td>Colon bundle initiative has overall measures above</td>
<td>Surgical Site Infection HH NHN</td>
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<td>Developed surgical order set</td>
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<td><strong>Hysterectomy SSI</strong></td>
<td>Low Risk</td>
<td>Overall measure above</td>
<td>Surgical Site Infection HH NHN</td>
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<tr>
<td><strong>Orthopedic SSI</strong></td>
<td>Low Risk</td>
<td>Overall measure above</td>
<td>Surgical Site Infection HH NHN</td>
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</table>

**VII. Surveillance Plan Palomar Health:**

To improve HH rate from 2020. Expand to outpatient services. Patient care task. AMBULATORY: To improve HH rate from 2020. Expand to outpatient services. Patient care task.
<table>
<thead>
<tr>
<th>Case Finding Methodology: Perform surveillance for atypical mycobacterial infections. Review trends to determine if medical equipment is a risk. Perform EOC rounding and report to Stakeholders. EVS collection and reporting of sanitation measures performed.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infection from medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment. Unprotected exposure to pathogens throughout the organization through potential non-compliance with policies addressing category / disease specific isolation and other precautions. Infection associated with potential prolonged wait times in common areas and potential exposure to infectious individuals. MEDIUM RISK INPATIENT AND OUTPATIENT.</strong></td>
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<tr>
<td><strong>Method of Analysis:</strong></td>
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<tr>
<td>CDPH, CMS, and Joint Commission mandatory to have a Hand Hygiene program</td>
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<td><strong>Goal</strong></td>
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**Method of Analysis:**
- Compliant / Observations x 100 – Health Care providers are observed by a "secret shoppers" who are assigned to different units. Data is presented by unit and by discipline to various medical and other committees.

**Case Finding Methodology:**
- **Inpatient, ambulatory, and outpatient:** Implement a Hand Hygiene initiative and educate staff on best practices.
- **Low Risk Ambulatory:**
  - **Infection Control Committee:** Review infection control policies and procedures.
  - **SPD and OR Rounding:** Ensure proper infection control measures are followed.
  - **Follow ANSI and AAMI recommendations:** Utilize approved disinfectants and cleaning supplies.
  - **Follow manufacturer recommendations for reprocessing:** Ensure medical devices are properly cleaned and sterilized.

**Medium Risk Inpatient and Outpatient:**
- **Infection Control Committee, Stakeholder committees, and departments:** Mitigate the risk associated with medical devices and reprocessing.
- **SPD and OR Rounding:** Conduct rounds to monitor compliance with infection control policies.
  - **Follow ANSI and AAMI recommendations:** Utilize approved disinfectants and cleaning supplies.
  - **Follow manufacturer recommendations for reprocessing:** Ensure medical devices are properly cleaned and sterilized.

**High Risk Inpatient and Outpatient:**
- **Infection Control Committee, Stakeholder committees, and departments:** Mitigate the risk associated with medical devices and reprocessing.
- **SPD and OR Rounding:** Conduct rounds to monitor compliance with infection control policies.
  - **Follow ANSI and AAMI recommendations:** Utilize approved disinfectants and cleaning supplies.
  - **Follow manufacturer recommendations for reprocessing:** Ensure medical devices are properly cleaned and sterilized.

**Low Risk Inpatient and Outpatient:**
- **Infection Control Committee, Stakeholder committees, and departments:** Mitigate the risk associated with medical devices and reprocessing.
- **SPD and OR Rounding:** Conduct rounds to monitor compliance with infection control policies.
  - **Follow ANSI and AAMI recommendations:** Utilize approved disinfectants and cleaning supplies.
  - **Follow manufacturer recommendations for reprocessing:** Ensure medical devices are properly cleaned and sterilized.
<table>
<thead>
<tr>
<th>Surveillance Activity (Indicator)</th>
<th>Goal</th>
<th>Actions to Reduce Risk</th>
<th>Patient Population</th>
<th>Actions to Reduce Risk</th>
<th>Data Entry and Reporting</th>
<th>Method of Analysis</th>
<th>Priority Score</th>
<th>Method of Analysis</th>
<th>Priority Score</th>
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<tr>
<td>Surgical Site Infections (SSI) for CDPH targeted 25 Surgical procedures</td>
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<td>Targeted surveillance is performed on SSIs associated with medical procedures performed outside the US</td>
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**Case Finding Methodology:**
Infections identified through microbiology cultures, antibiotics prescribed, readmissions, reports from surgeons, and diagnosis codes. NHSN criteria used. Electronic medical record review. Post-discharge surveillance by PH Home Health.

**CMS mandatory Hysterectomy and Colon**
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<tr>
<td>Central Line-Associated Blood Stream Infections (INPATIENT)</td>
<td>Goal</td>
<td>Aims to reduce risk of infection</td>
<td>Patients with CVC's ICU, Med/Surg, adult, and NCU</td>
<td>Participation in CDC National Healthcare Safety Network (NHSN)</td>
<td>Mandatory requirement by CDPH and CMS; Mandatory requirement by CDPH and CMS; Designated internal committees (at least quarterly) stakeholders when identified</td>
<td>Standardized Infection Ratio (SIR) = # of infections / # of infections predicted</td>
<td>CMS and CDPH mandatory for ICU and all inpatient units</td>
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**Method of Analysis**
- CLIP form
- CMS and CDPH mandatory for ICU and all inpatient units
- CLIP entry into NHSN

**CLABSI Case Finding Methodology**
- Discern analysis. Infections identified through prospective and retrospective review of blood cultures and Electronic Medical Record (EMR). When case meets NHSN definition for CLABSI the case it is entered into NHSN database.

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<tr>
<th>Hospital Onset (HO) MDROs</th>
<th>MDRs</th>
<th>MRSAs</th>
<th>VREs</th>
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<tr>
<td><strong>MRSA</strong> (HO) MDROs</td>
<td>Hand Hygiene CDC</td>
<td>50% reduction from 2015 baseline by 2020</td>
<td>Enter MRSA, VRE, CDI data into NHSN</td>
<td>Incidence and prevalence as calculated by NHSN</td>
<td>CMS and CDPH mandatory reporting</td>
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<td><strong>VRE</strong></td>
<td>HLD rounding</td>
<td>Lab reports to IC all CRE - critical results</td>
<td>Enter MRSA, VRE, CDI data into NHSN</td>
<td>MDRO process measure compliance</td>
<td>Departmental HLD compliance reports</td>
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<td><strong>C. difficile</strong></td>
<td>Glow germ</td>
<td>Endoscope quality marker</td>
<td>Follow county public health guidance for reporting, testing and identification of C. difficile</td>
<td>Antibiotic Use Reduction utilization reports</td>
<td>Follow county public health guidance for reporting, testing and identification of C. difficile</td>
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<td><strong>C. auris</strong></td>
<td>Line List CRE and C. auris cases all clinical cultures</td>
<td>IC Committee and other stakeholder committees</td>
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<td>Channel Check results</td>
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**Central Line-Associated Blood Stream Infections (INPATIENT)**
- System: Eliminate Hospital Onset MDRO CLABSI
- Facility: 50% reduction by 2020

**Low-Risk Inpatient**
- System: Eliminate Hospital Onset MDRs
- Facility: 50% reduction by 2020

**Medium-Risk Outpatient and Ambulatory**
- System: Eliminate Hospital Onset MDRs
- Facility: 50% reduction by 2020

**C. difficile Infection**
- System: Eliminate Hospital Onset MDRs
- Facility: 50% reduction by 2020
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<tr>
<th>Surveillance Activity (Indicator)</th>
<th>Goal</th>
<th>Actions to Reduce Risk</th>
<th>Patient Population</th>
<th>Actions to Reduce Risk Data Entry and Reporting</th>
<th>Method of Analysis</th>
<th>Patient Population Priority Score</th>
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<td>Review of cultures and PCR screens, positive isolates - clinical records, and definitions for healthcare onset from NHSN surveillance definitions</td>
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<td>July 2015 “Go live” with Cerner Infection Control data mining module. This has enhanced case finding and improved efficiencies in data mining.</td>
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<td><strong>Catheter Associated Urinary Tract Infections</strong></td>
<td><strong>System:</strong> Eliminate HO CAUTI</td>
<td><strong>Established Indications:</strong> Catheter</td>
<td><strong>CAUS Bundle Bladder scan</strong></td>
<td><strong>Female alternatives</strong></td>
<td><strong>Nurse Driven Protocol</strong></td>
<td><strong>Departmental HLD compliance reports</strong></td>
<td><strong>Channel Check results</strong></td>
<td><strong>Microbiological</strong></td>
<td><strong>Positive isolates clinical cultures</strong></td>
<td><strong>NHSN surveillance definitions.</strong></td>
<td><strong>July 2015 “Go live” with Cerner Infection Control data mining module. This has enhanced case finding and improved efficiencies in data mining.</strong></td>
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<td><strong>Antimicrobial utilization reports</strong></td>
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<td><strong>60% reduction from 2015 to 2016</strong></td>
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<td><strong>CAUTI Case Finding Methodology:</strong></td>
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<td>Discern analysis. Prospective and retrospective culture and EMR review. When case meets NHSN definition for CAUTI the case it is entered into NHSN database.</td>
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<td><strong>Ventilator-Associated Events</strong></td>
<td><strong>System:</strong> Eliminate IVAC Plus</td>
<td><strong>Discern analysis:</strong> Prospective and retrospective culture and EMR review. Daily assessment of ventilator necessity and weaning</td>
<td><strong>CDC NHSN CAUTI definition</strong></td>
<td><strong>Designated internal committees:</strong> Identify and report</td>
<td><strong>Line lists</strong></td>
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<td><strong>SAUTI Bundle:</strong></td>
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<td><strong>Charge viewer identifies ventilated patients in ICU. Infections are identified through review of positive respiratory and blood cultures, antimicrobial use, clinical record, FiO2, and PEEP. CDC NHSN VAE calculator.</strong></td>
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<td><strong>NHSN analysis reports</strong></td>
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<td><strong>Unusual Organisms</strong></td>
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<td>Surveillance Activity (Indicator)</td>
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<td>Actions to Reduce Risk</td>
<td>Patient Population</td>
<td>Actions to Reduce Risk and Data Entry and Reporting</td>
<td>Method of Analysis</td>
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<td>Influenza Vaccination Activity (Indicator)</td>
<td>Achieve &gt;90% compliance with vaccination following CMS goals.</td>
<td>Continue mandatory mask program</td>
<td>All clinical and non-clinical employees, volunteers, physicians, residents, medical students and anyone working in the facility for at least one day during the influenza season.</td>
<td>Enter data into NHSN National Quality Forum (NQF)</td>
<td>Compliance rate is calculated by number of staff, MDs, students, residents, LPs and contractors divided by 100 for % compliance.</td>
<td>“M”</td>
<td>CDPH and CMS - mandatory</td>
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<td>Employee Health oversight with Infection Control collaboration; Employee Health collaboration with medical staff to improve process for data collection.</td>
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<td>Shrapn/ Blood borne Pathogen (BBP) Exposures</td>
<td>Reduce the number of needle sticks and blood borne pathogen exposures from 2020.</td>
<td>Education safe needle stick and bloodborne pathogen exposures, use of PPE/proper disposal of PPE readily available for immediate use, reported injuries/exposures during daily huddle, encourage correct PPE during splash-producing procedures.</td>
<td>All employees, volunteers, physicians, surgeons, residents, medical students and anyone working in the facility.</td>
<td>OSHA Log Employee Health Log IC Committee and other stakeholder committees and departments at least quarterly.</td>
<td>Needle sticks</td>
<td>CDPH, CMS, and Cal OSHA mandatory to have a BBP plan.</td>
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<td>Case Finding Methodology: All exposures reported through Employee Health with appropriate follow up.</td>
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<td>Tuberculosis Exposures</td>
<td>Reduce the number of TB exposures compared with 2020 data.</td>
<td>Evaluate patient risk on case by case basis; Prolong isolation precautions even if AFB negative x3 in high risk patients.</td>
<td>Inpatients Outpatients</td>
<td>Employee Health Log IC Committee and other stakeholder committees and departments at least quarterly.</td>
<td>Actual TB exposures</td>
<td>OSHA mandate</td>
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<td>Case Finding Methodology: IC Committee and other stakeholder committees and departments at least quarterly. All exposures reported through Employee Health with appropriate follow up.</td>
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<td>Environmental Surveillance</td>
<td>100% participation in EOC rounding</td>
<td>IC rounding</td>
<td>Inpatients, Outpatients</td>
<td>Sentic Reports</td>
<td>CMS CDPH Surveilllance Services USP 793</td>
<td>Medium</td>
<td>Risk</td>
<td>Exposure Community-wide outbreaks of communicable diseases that carry the potential of adversely impacting operations and service capabilities.</td>
<td>COVID-19/ MERS/SARS/ Ebola exposure.</td>
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<td>1. OSHA mandate</td>
<td>2. Improved outcomes in contact reports</td>
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<td>Inpatients, Outpatients</td>
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<td>Percent compliance with rounding observations</td>
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VIII. Performance Improvement Activities/Projects:
A. IC/Employee Health collaboration
1. Case investigation and exposure incidents
2. Influenza immunization program evaluation
B. Infection Control Risk Assessment
1. Palomar Health System
VII. **Emerging Infectious Diseases**

A. Infection Prevention and Control will provide information on emerging infectious diseases to key stakeholders.

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IX. **Infection Control Functions**

A. Take action to solve identified problems which may include:

1. Review and revise procedures
2. Consultation on risk assessment, prevention and control strategies (includes activities related to occupational health, construction, and emergency management
3. Education efforts directed at interventions to reduce infection risk
4. Implementation of changes mandated by regulatory, accrediting and licensing agencies
5. Application of epidemiological principles, including activities directed at improving patient outcomes using implementation science
6. Antimicrobial Stewardship

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7. **Participation in research projects**: Provision of high quality services in a cost efficient manner
8. Fratly ideas of the infection prevention team
9. Members disseminate information discussed in the committee meeting
10. Review equipment or services with appropriate departments.
11. Report information to Administration for action as appropriate
12. Report information to the Infection Prevention and Control Committee, the Quality Management Committee, the Medical Staff departments, and the California Department of Public Health (CDPH), as appropriate.
13. Investigate Epidemics, infection, or colonization caused by unusual pathogens, and look into occurrences of healthcare-associated infection that exceed the baseline. Refer to [Outbreak Investigation](#). Conduct studies, as indicated by the occurrence of health-care associated infection problems, or at the request of a Medical Staff department.
14. Evaluate infection rates/ratios and clinical data and compare with baseline information and published data, as available.
15. Communicate with the Chair of the Infection Prevention and Control Committee, appropriate physicians, administrators, managers and staff regarding infection prevention and control issues.
16. The function of the surveillance, prevention, and control of infection interfaces with the local health department to ensure continuity of care, appropriate followup, and control of infection.

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G. **Biological Monitoring compliance and failure rates** (Surgery, Respiratory Care, SPD, Endoscopy)

H. **Surveillance Definitions**

1. Palomar Medical Center, Palomar Downtown, Pomerado Hospital comply with NHSN Patient Safety Module Definitions and Reporting Requirements
2. Skilled Nursing Facilities use McGeer Criteria
3. NHSN Antibiotic module

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I. **Reporting and using surveillance information**

1. Infection control data is presented at the Infection Prevention and Control Committee (IPCC) and all other stakeholder committees. Recommendations for practice or supply changes are made by the committee and implemented by the infection prevention and Control staff. The results of these recommended changes are reported back to the Infection Prevention and Control Committee, at a time specified by the Committee.
2. IPCC reports up to the Quality Management Committee and, then to the Medical Executive Committee and report out to BORC. Reports are also presented to appropriate Surgical, Nursing and interdisciplinary committees who share the information with the staff.
3. Surveillance data is incorporated into the Infection bundle and posted on the LBM Quality dashboards.
4. Identifying unusual infection related events
   a. When an unexpected influx of patients who require special isolation precautions occurs, the facility Disaster Plan will be activated.
   b. The Infection Prevention and Control Staff will be notified when actual or potential infection related events occur. If necessary, consultation with the chairman of the Infection Surveillance Committee, Infection Control Officer/s, and/or other committee members may be needed. Isolation of an individual patient does not require approval and should be initiated without delay.

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J. **Palomar Health System Wide Surveillance**

1. Ongoing components of Palomar Health system wide surveillance include:
   a. Hand Hygiene observations using CDC indications. Compliance is monitored by designated personnel in departments and rates are communicated to staff by Dept representative.
   b. Periodic alcohol gel purchase data is used as a surrogate marker for compliance monitoring.
   c. Emergency Department Syndromic Surveillance - San Diego Aberration Detection and Incident Characterization (SDADIC)
   d. Tuberculosis trends.
   e. Blood and body fluid exposures.
   f. Environmental safety observations.
   g. **Infection Control**: The Villas at Poway and Home Health site specific surveillance plans are reviewed and updated at least annually.
   h. Post-discharge infections are surveyed through self report from physicians, laboratory and other hospitals.
   i. Review, evaluate, and advise when communicable disease exposure in either patient or employee has occurred. The following are cause for investigation and action:
      i. Gastroenteritis if considered healthcare-associated.
      ii. Exposure to measles, chickenpox, rubella or scabies for followup.
      iii. TB exposure will be investigated for control and followup when isolation procedures are not instituted.
      iv. Exposure to possible HIV for followup.
2. Outpatient Services (listed in grid above)
   a. CDC Infection Prevention Checklist for Outpatient Settings
   b. Environmental rounds are performed in outpatient settings. Feedback is given to the department managers.
   c. Environment and Equipment is assessed for compliance with hospital sanitation standards
   d. Environment of Care records are kept by the Safety Officer in the appropriate database and monitored by EOC and IPCC as appropriate
   e. Outpatient Departments participate in the system wide hand hygiene compliance monitor
   f. Home Health surveillance includes:
      i. UTI with and without catheter
      ii. Wound infection
      iii. SSI
      iv. CLABSI

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**References**

- [Outbreak Investigation](#)
- [CDC Infection Prevention Checklist for Outpatient Settings](#)
- [SDADIC](#)
- [Gastroenteritis](#)
- [TB](#)
- [Exposure to measles, chickenpox, rubella or scabies](#)
- [Exposure to possible HIV](#)
- [Home Health surveillance](#)
- [UTI](#)
- [Wound infection](#)
- [SSI](#)
- [CLABSI](#)
B. Infection Control Committee will review details of emerging infectious diseases.
C. Infection Preventionists will assist leaders of special populations with interpretation and implementation of recommendations for emerging infectious diseases (e.g., Zika, COVID-19).

VIII. Performance Standards:
A. Staff knowledge and skill requirements are assessed at orientation, annual skill days, self-assessments, annual safety test, and through performance evaluation.
B. Monitoring and inspection activities:
1. Aggregate data measures effectiveness of infection surveillance by evaluating rates/ ratios and infection trends that exceed thresholds.
2. Safety inspection lists from department, as required.
C. Estimate of the need for and recommendations for additional resources for Infection Prevention and Control Program:
1. The healthcare system currently has five full-time employees as Infection Preventionists. The Program also benefits from an Infection Control Committee Chair/Medical Director for our current licensed beds.

IX. Methods, Indicators and Threshold for Evaluation:
A. Focused or targeted surveillance is conducted as appropriate on patients or procedures to identify healthcare-associated infections and infection risks. This may include clinical indicators, patient care areas and/or patient population. Methods include epidemiological and statistical techniques with the application of evidence-based practice research principles to evaluate processes and trends for quality improvement. Results will be presented in a report format with the annual summary. The methods reflect established industry standards, guidelines and approved organizational procedures.
B. In collaboration with Employee Health Services, and as part of the Environment of Care Safety Committee, Patient Safety Committee activities, surveillance include data on:
   1. Employee exposure to blood and body fluids.
   2. TB conversion rates
   3. Needle stick and other puncture incidents.
   4. Clusters or outbreak investigation is the immediate priority at the time an unexpected occurrence or frequency of infections become evident. See Outbreak Investigation procedure. Indicators for increased incidence may include:
      a. Clustering of surgical site infections from a specific surgeon or related to a specific activity.
      b. A cluster of infections involving the same resistant organism.
      c. Unusual organisms.
   5. Case findings include:
      a. Use of electronic medical record Infection Control software.
      b. Chart review, including microbiology, serology and radiology reports.
      c. Review of microbiology reports.
      d. Referral and input from physicians and other healthcare personnel.
      e. Review of autopsy reports.

X. Criteria for Plan Application:
A. The Infection Prevention and Control Plan apply to all health care workers, volunteers, students, contracted services, and physicians who utilize Palomar Health facilities.

XI. Roles and Responsibilities:
A. Responsibility for the overall Infection Prevention and Control Program rests with the Board of Directors. The Board of Directors delegates responsibility and accountability for the ongoing operation of the program to the Administration and the organized Medical Staff.
B. The program is directed by the Infection Prevention and Control Committee, which operates under the auspices of the Medical Staff bylaws. The Committee has a strong support from the infectious disease specialist who serves as the chairperson.
C. The Infection Control District Director has responsibility for oversight and coordination of the development, testing and implementation of the Infection Prevention and Control Risk Assessment and Surveillance plan as it pertains to regulatory and accreditation standards.
D. The Infection Control Director is designated Infection Control Officers for the system.
E. Coverage will be maintained for oversight and intervention by designated departmental staff.
F. Infection Preventionists disseminate public health information as it becomes available to key stakeholders.

XII. Orientation, Education, Training:
A. Infection Prevention and Control information is presented to all new employees and volunteers during orientation, and on an annual basis and as needed.

XIII. Annual Evaluation:
A. The effectiveness of the Infection Prevention and Control Plan is assessed annually using defined performance standards. Results of summary data are reported to appropriate committees, not limited to the Infection Prevention and Control, Quality Management and Patient Safety, and Board Quality Review Committees.

XIV. Methods of Surveillance:
A. Surveillance for infections is conducted using the following methods:
1. Targeted and focused surveillance based on results of annual risk assessment and significant epidemiological events are chosen and prioritized based on high risk, high/low volume and or problem-prone criteria designated by the Infection Prevention and Control Committee.
2. Use of ECHOView and Cerner IP list.
B. Additional established standards, benchmarks and/or evidence-based practice guidelines include but are not limited to the following:
1. CDC and National Healthcare Safety Network (NHSN) definitions and reporting requirements.
2. Senate Bill 739, 158, 1058 regulations.
3. Utilize Plan Do Check Act for Infection Control improvement projects.
5. Compile data annually on patients with active TB and employee conversions. Use data to plan protective controls as appropriate.
6. Review Palomar Health Healthcare worker influenza vaccination compliance, provide expert consultation for compliance improvement and reporting methodology.
7. Compile data on employee blood and body fluid exposures this data is used to evaluate safe work practices and safety devices.
8. Survey hospital areas with members of the Environment of Care Safety Committee to ensure that protective devices and garments are available and used by staff. Report results to the committee and assist in the formulation of action plans.
9. Each department performing decontamination and sterilization will, in the event of sterilizer failure, present data to the Infection Prevention and Control and Department who will assist in the formulation of action plans if sterilizers fail expected outcomes.
10. Involvement in planning and monitoring construction and renovation activities to reduce the risk of infection to patients, staff, and visitors. Ensure infection control concerns are addressed and precautions are established prior to, during and following construction/renovation activities to minimize infection risks.
11. Provide plans and resources to respond to potential emergency, pandemic and bioterrorism events.

C. San Diego County Demographics:
2. Of residents under 18, 35% are Hispanic, and the Hispanic population is expected to continue to grow at a rapid rate.
3. Approximately 21.5% of the county's population is immigrants, including refugees, who come from other countries, speak 68 different languages, and have a variety of backgrounds as they assimilate into their new environment.
4. The senior and disabled populations are growing disproportionately compared to the rest of the population.
5. Second-most populous county in California and fifth-most populous in the US.
6. Part of the San Diego-Tijuana metropolitan area.
7. Naval and Marine Corps bases.
8. Desert locations.
9. 1,700,000 individuals who migrated to the US without authorization living in the region.
<table>
<thead>
<tr>
<th>Document Owner:</th>
<th>Martinez, Valerie A</th>
</tr>
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<tbody>
<tr>
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<td>Comparison of National, State and County Data for Tuberculosis, 201</td>
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<td>County of San Diego HIV, STD Hepatitis Report</td>
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<td>Outbreak Investigation</td>
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<td>Preventing Transmission of Zika Virus in Labor and Delivery Settings Through Implementation of Standard Precautions United States, 2016</td>
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<td>San Diego Demographics from the US Census Bureau</td>
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<tr>
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<td>Ebola Donning Doffing PPE</td>
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<td>Ebola Plan</td>
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Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at https://www.lucidoc.com/cgi/doc-gw.pl?ref=pphealth:15412$21&ref2=pphealth:15412$22.
I. Authority Statement:
   A. The Infection Control Officers have the authority and responsibility for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program and for acting on the results of the information. The Infection Control Committee, through its chairperson and/or Senior Director of the Infection Prevention and Control Program, are granted authority to institute any appropriate emergency control measures throughout the health system when there is a reasonable risk or danger to any patient or personnel.

II. Purpose:
   A. To provide structure for an organization-wide, facility specific approach to identify and reduce the risk of endemic and epidemic healthcare-associated infections (HAI). To ensure optimal provision of services the management of the infection prevention and control process is assigned to qualified personnel by virtue of education, training, certification or licensure, and experience.

III. Mission:
   A. To develop and maintain an Infection Prevention and Control program that reflects the Mission and Vision of Palomar Health and includes Quality and Regulatory Standards developed by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS) and other national organizations. To ensure implementation of prevention measures, and monitoring outcomes with the ultimate goal of preventing and controlling infection transmission among patients, employees, medical staff members, contracted service workers, volunteers, students, and visitors.

IV. Scope of Service
   A. Interdisciplinary outcomes-based approach to surveillance, prevention, and control of infection. Individual departments develop specific procedures utilizing clinical and practical experience. Procedures are first reviewed by the infection preventionists for consistent demonstration of sound epidemiological principles prior to submission to the Infection Prevention and Control Committee for final approval.
      1. The infection preventionists serve as expert consultants, working with individual departments to develop, design and present continuing education programs, and contribute to both department-specific and organization-wide orientation.
      2. Corporate Health Services shares responsibility for educating staff regarding the risks of transmission and appropriate exposure precautions for communicable diseases.
      3. Management systems (including staff and data systems), defined by specific requirements of the healthcare-associated infection risk reduction process of the organization, are available to help achieve this outcome.
   B. FY 2020 Top Ten MSDRGs Diagnosis - Related Groups (DRG)

<table>
<thead>
<tr>
<th>MSDRG</th>
<th>#Encounters</th>
<th>Days</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>807 VAGINAL DELIVERY W/O STERILIZATION/D&amp;C W/O CC/MCC</td>
<td>2,229</td>
<td>4,238</td>
<td>51,911,142</td>
</tr>
<tr>
<td>795 NORMAL NEWBORN</td>
<td>1,790</td>
<td>2,936</td>
<td>9,542,028</td>
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<tr>
<td>871 SEPTICEMIA OR SEVERE SEPSIS W/O MV &gt;96 HOURS W MCC</td>
<td>1,633</td>
<td>8,305</td>
<td>171,312,093</td>
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<tr>
<td>794 NEONATE W OTHER SIGNIFICANT PROBLEMS</td>
<td>1,178</td>
<td>2,040</td>
<td>7,358,158</td>
</tr>
<tr>
<td>885 PSYCHOSES</td>
<td>1,038</td>
<td>7,454</td>
<td>38,240,815</td>
</tr>
<tr>
<td>470 MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY</td>
<td>929</td>
<td>1,450</td>
<td>64,634,101</td>
</tr>
<tr>
<td>788 CESAREAN SECTION W/O STERILIZATION W/O CC/MCC</td>
<td>636</td>
<td>1,636</td>
<td>24,921,747</td>
</tr>
<tr>
<td>291 HEART FAILURE &amp; SHOCK W MCC</td>
<td>621</td>
<td>2,523</td>
<td>47,282,507</td>
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<tr>
<td>872 SEPTICEMIA OR SEVERE SEPSIS W/O MV &gt;96 HOURS W/O MCC</td>
<td>609</td>
<td>1,854</td>
<td>35,168,448</td>
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<tr>
<td>392 ESOPHAGITIS, GASTROENT &amp; MISC DIGEST DISORDERS W/O MCC</td>
<td>404</td>
<td>1,022</td>
<td>20,627,172</td>
</tr>
</tbody>
</table>

**DRG Code within limits** 11,067 33,458 470,998,211

V. Objectives:
   A. Direct, coordinate, integrate, and monitor all organizational infection prevention and control activities.
      1. Collect and analyze data in order to identify infection problems or opportunities to improve patient care.
2. Establish priorities for action based on the following considerations:
   b. Number of patients or health care workers potentially affected.
   c. Duration of problem.
   d. Number of services involved.
   e. Requirements for investigation and resolution.
   f. Resources available.
   g. Mission statement and infection control risk assessment and plan for Palomar Health.
3. Provide effective communication of appropriate information to the medical staff and Palomar Health care workers related to infection prevention and control and regulatory guidelines.
4. Provide appropriate infection prevention and control information to individual practitioners as needed.
5. Document evidence that departments, which perform decontamination and sterilization activities, are consistent in intent and application throughout the organization and follow all manufacturers’ recommendation.

B. Licensed Beds:
1. ICU
   a. Escondido 24
   b. Poway 12
   c. NICU Poway 4
2. Escondido total - 287
3. Poway - 107
4. Villa Pomerado - 129
5. Acute Rehabilitation - 15
6. Poway Psychiatric - 46

C. Out Patient Visits:
1. ED Escondido - 80,612
2. ED Poway - 26,248
3. Home Health, - 62,932
4. Employee Health Services - 20,945

VI. Risk Assessment Grid:
A. The table that follows outlines the prioritized risks identified as the result of the assessment and provides a brief description of those risks. A risk level is assigned (low, medium, or high) based on the care setting (outlines in summary form), interventions that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of the interventions.

B. Legend*
1. I = Inpatient services such as medical surgical, critical care, maternal / child, surgery, behavioral health, and other care units
2. A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department
3. O = Outpatient services including, Wound Care Centers, Outpatient Rehabilitation, Cardiac Rehabilitation, Corporate Health Services, Sleep Lab, Behavioral Health, Radiation Oncology, Woman's outpatient services, Laboratory Medicine Outpatient Building.
4. H = Home health, hospice, home pharmacy, DME, and other home health services
5. L = Long-term care, sub-acute care, skilled nursing, and other long term care services.
6. * For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, clinical laboratory, and all other departments and services of the organization.

C. Allocation – Enter the Level of Assessed Risk for Each Care Setting:
1. L = Low risk
2. M = Medium Risk
3. H = High Risk

<table>
<thead>
<tr>
<th>Prioritized Event Risk Description</th>
<th>Care Setting / Risk Level</th>
<th>Summary of Risk Mitigation Strategies</th>
<th>How Effectiveness of Strategies is Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission of infection through potential non-compliance to CDC guidelines and recommendations for hand hygiene</td>
<td>M M M</td>
<td>Hand hygiene procedures follow CDC guidance</td>
<td>Standardized observation data, quarterly facility and unit reports, LEM scoring, Medical Staff reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff education initial and at least annually</td>
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<tr>
<td></td>
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<td>Observation Data shared at department level</td>
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<td></td>
<td></td>
<td>Availability of alcohol gel, and non-alcohol alternative</td>
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<td></td>
<td></td>
<td>Availability of hospital approved hand lotions</td>
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</tr>
<tr>
<td>Prioritized Event Risk Description</td>
<td>Care Setting / Risk Level</td>
<td>Summary of Risk Mitigation Strategies</td>
<td>How Effectiveness of Strategies is Evaluated</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
</tbody>
</table>
| Unprotected exposure to pathogens throughout the organization through potential non-compliance with policies addressing category / disease specific isolation and other precautions. | M M M                    | Staff education (initial and annual)  
Blood borne pathogen exposure control plan  
Aerosol Transmissible Diseases Control/TB control plan  
Cough etiquette program  
Visitation procedure  
PPE storage and availability  
IC Isolation list/rounds  
Influenza vaccination program  
Immunity verification  
MDRO flags in EMR  
Patient education  
MRSA screening and testing | Staff education records  
Exposure reports  
MDRO process measures  
Influenza Vaccination data  
Isolation report  
MRSA screening compliance |
| Potential for transmission of infection related to procedures, medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment. | M L L                    | Disinfection and Sterilization procedures using manufacturer’s Information for Use (IFU) and CDC guidance - Spaulding Classification system  
Value Improvement Process (VIP) Team  
Education/competency  
Dialysis cultures  
High level disinfection (HLD) logs, rounding and reporting  
Immediate use steam sterilization (IUSS) monitoring  
Biological Indicator monitoring (BI)  
Intradepartmental sterilizations surveys  
EVS cleaning observation audits  
Equipment cleaning procedures  
Conveniently located Germicide wipes  
Oxycide with C. difficile claim  
Staff awareness of wet contact times  
Clean and dirty transport procedures  
Sure Step – Endoscopy  
Glow Germ – EVS  
Annual Linen Plant tour | Environment of Care Rounds  
BI and sterilization compliance reporting  
HLD compliance reporting  
IUSS compliance monitoring  
Data submission to VIP team  
Sure Step process report  
Glow Germ Report  
Surveillance data |
| Potential for infection in ambulatory care and outpatient settings due to potential prolonged wait times in common areas and potential exposure to infectious individuals. | L M M                    | Cough Etiquette stations located at entries of ED, hospital lobby, and satellite services waiting areas.  
Patients discouraged from OP visits when ill | Exposure Reports |
| Community-wide outbreaks of communicable diseases that carry the potential of adversely impacting operations and service capabilities | M M M                    | Emerging Infectious Disease awareness and education.  
Emergency Department (ED) travel screening.  
Positive Air Purifying Respirator (PAPR) inventory  
County Cache  
Disaster and Surge Plan  
Syndromic Surveillance  
Initial and annual training  
Annual Hazard Vulnerability Analysis  
Long Term Care Risk Assessment and Enhanced Standard Precautions  
California Healthcare Alert Network | Disaster Committee and IPC Committee agenda and minutes  
Drills and tabletop exercises and debriefs  
Surveillance Data |
<table>
<thead>
<tr>
<th>Prioritized Event Risk Description</th>
<th>Care Setting / Risk Level</th>
<th>Summary of Risk Mitigation Strategies</th>
<th>How Effectiveness of Strategies is Evaluated</th>
</tr>
</thead>
</table>
| Potential for a bioterrorism event that would require specific responses from the organization to successfully meet the threat. | L M L | PAPR inventory  
County Cache  
Disaster and Surge Plan  
Decontamination Procedures  
Initial and annual training | Disaster Committee  
Hazard Vulnerability |
| Emergency Preparedness Infectious Disease Suspect encounter (novel and epidemic), naturally occurring events including; earthquakes, fires and drought and boil water alerts are the top priority followed by an epidemic. Human related events such as mass casualty (medical or infectious). | L M L | Disaster Committee  
Staff education  
Management of influx of infectious patients  
Erecting isolation barriers including appropriate PPE  
Disaster plan  
IC procedures  
Disaster drills  
Supply chain – VIP attendance | Annual Hazard Vulnerability Assessment  
Disaster and IPC minutes |
| MRSA and VRE bloodstream infection (BSI) | M M L | Hand Hygiene - CDC  
Standard and Transmission Based Precautions  
Cart and sign system  
Reflex isolation orders  
Rounding  
Cerner Medical Record flagging  
Antibiotic Stewardship  
Review of PICC line indications for antibiotics  
TPN procedure review  
MRSA Screening  
CHG bathing ICU  
Selected surgical procedures of Pre-op CHG bathing  
Glow germ audits  
Certified Pet therapy Program | MDRO Process Measures  
MRSA Screening Compliance  
MRSA BSI SIR NHSN  
Antibiotic utilization reports  
Glow germ reports  
Pet therapy attestation records  
Antibiograms |
| Clostridium difficile infection | M M L | Standard and Transmission Based Precautions  
Reflex isolation orders  
Isolation rounding  
Antibiotic Stewardship with specific focus on usage of fluoroquinolones  
Acid suppressive therapy reduction (PPI)  
Rectal tubes for incontinence  
Fecal microbiota transplant  
Stool collection procedures  
Daily Huddle case reporting  
Changes to microbiology result interpretation and reflexing  
Glow Germ audits  
Automated triggers in EMR  
Medical staff education, “Guidance to Providers” | MDRO Process Measures CDI  
SIR NHSN  
Antibiotic Utilization Reports  
Glow germ reports  
Fluoroquinolone usage  
PPI usage |
<table>
<thead>
<tr>
<th>Prioritized Event Risk Description</th>
<th>Care Setting / Risk Level</th>
<th>Summary of Risk Mitigation Strategies</th>
<th>How Effectiveness of Strategies is Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbapenem-resistant <em>Enterobacteriaceae</em> (CRE)</td>
<td>L L L</td>
<td>Standard and Transmission Based Precautions</td>
<td>MDRO Process Measures</td>
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<td>Reflex isolation orders</td>
<td>CRE incidence</td>
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<td></td>
<td>Rounding</td>
<td>Antibigram</td>
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<td>Antibiotic Stewardship</td>
<td>Endo round results</td>
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<td>Control of carbapenem usage</td>
<td>Channel check logs</td>
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<td>Rectal tubes for incontinence</td>
<td>NHSN analysis reports</td>
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<td>Glow Germ</td>
<td>Antibiotic Utilization – carbapenem Reports</td>
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<td>Automated triggers in EMR</td>
<td>Glow germ reports</td>
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<td>Endoscope Hang time risk assessment</td>
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<td>Channel Check and quality review of HLD process.</td>
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<td>Double disinfection of endoscopes.</td>
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<td>Central Line Associated Bloodstream Infections (CLABSI)</td>
<td>M L L</td>
<td>Dressing change training</td>
<td>CLIP compliance</td>
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<td>Unit Based Champions</td>
<td>AllPoints Training attendance</td>
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<td>Daily CHG bathing</td>
<td>CLABSI SIR NSHN</td>
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<td></td>
<td>Central Line Insertion Practices (CLIP)</td>
<td>Nursing Skills Day topics</td>
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<td></td>
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<td>TPN practice in pharmacy</td>
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<td></td>
<td></td>
<td>Device rounding CC</td>
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<td></td>
<td></td>
<td>Alerts to providers to assess necessity</td>
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<tr>
<td>Ventilator Associated Pneumonia (VAP)</td>
<td>M L L</td>
<td>VAP bundle compliance</td>
<td>VAP bundle Data</td>
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<td>VAP surveillance</td>
<td>VAP SIR NSHN</td>
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<td>Pulmonary partnership with units to increase accountability and knowledge</td>
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<td>Catheter Associated UTIs (CAUTI)</td>
<td>L L L</td>
<td>CAUTI Bundle compliance</td>
<td>CAUTI bundle Data</td>
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<td></td>
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<td>CAUTI Surveillance</td>
<td>CAUTI SIR NSHN</td>
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<td>Alternative products to indwelling catheters</td>
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<td>Device rounding CC</td>
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<tr>
<td>Surgical Site Infections Overall (SSI)</td>
<td>L M L</td>
<td>Preop antiseptic bathing</td>
<td>Surgical Site Infection SIR NSHN</td>
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<tr>
<td></td>
<td></td>
<td>Appropriate preop antibiotic timing, dosing, redosing</td>
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<td>Sorin Heater Cooler procedures</td>
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<td>Rounding of SPD, EVS, and EOC</td>
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<td></td>
<td>Perioperative glycemic control</td>
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<td>Normothermia</td>
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<td>Preop interventions taskforce</td>
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<tr>
<td>Colon SSI</td>
<td>L L L</td>
<td>Colon Bundle initiative (has overall measures above)</td>
<td>Surgical Site Infection SIR NSHN</td>
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<td></td>
<td>Developed surgeon order sets</td>
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<td>Hysterectomy SSI</td>
<td>L L L</td>
<td>Overall measure above</td>
<td>Surgical Site Infection SIR NSHN</td>
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<tr>
<td>Orthopedic SSI</td>
<td>L M L</td>
<td>Overall measures above</td>
<td>Surgical Site Infection SIR NSHN</td>
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<tr>
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<td>Nasal decolonization</td>
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<tr>
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<td>Case observations and stakeholder review of cases</td>
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VII. **Surveillance Plan Palomar Health:**
A. 2021 Surveillance Plan
<table>
<thead>
<tr>
<th>Surveillance Activity (Indicator)</th>
<th>Goal</th>
<th>Actions to Reduce Risk</th>
<th>Patient Population</th>
<th>Data Entry and Reporting</th>
<th>Method of Analysis</th>
<th>Priority Score “M”</th>
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</thead>
<tbody>
<tr>
<td>Hand Hygiene (HH) CDC System:</td>
<td></td>
<td>Adherence to CDC Hand Hygiene recommendations</td>
<td>Inpatient and ED Expand to outpatient services</td>
<td>IC Committee, Stakeholder committees and departments</td>
<td>Percent compliance: Before and after patient/environmental contact Discipline Patient care task</td>
<td>CDPH, CMS and Joint Commission mandatory to have a Hand Hygiene program</td>
</tr>
<tr>
<td>90% Compliance Facility:</td>
<td></td>
<td>Triclosan soap alcohol based hand sanitizer</td>
<td></td>
<td></td>
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<tr>
<td>To improve HH rate from 2020.</td>
<td></td>
<td>Conveniently located dispensers</td>
<td></td>
<td></td>
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<tr>
<td>Expand to outpatient services</td>
<td></td>
<td>Working group for stakeholders to provide what is going well and identify what can be improved</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Case Finding Methodology: $(#\text{compliant} / #\text{observations}) \times 100$ – Health Care providers are observed by a “secret shoppers” who are assigned to different units. Data is presented by unit and by discipline to various medical and other committees.

| Infection from medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment. Unprotected exposure to pathogens throughout the organization through potential non-compliance with policies addressing category / disease specific isolation and other precautions. Infection associated with potential prolonged wait times in common areas and potential exposure to infectious individuals. | System: Zero Harm Facility: Mitigate risk associated with devices, and reprocessing and waiting areas. | Follow ANSI and AAMI recommendations Provide Infection Control Committee approved disinfectants Follow manufacturer recommendations for reprocessing. SPD and OR rounding HLD Rounding Florescent marker EVS environmental measures designated waiting for patients with undiagnosed respiratory symptoms. Respiratory etiquette/patient masking. | Inpatient, ambulatory and outpatient | IC Committee, Stakeholder committees and departments | HLD BI monitoring attestation. SPD and OR EOC rounds. | CDPH, CMS and Joint Commission |

Case Finding Methodology: Perform surveillance for atypical mycobacterial infections. Review trends to determine if medical equipment is a risk. Perform EOC rounding and report to Stakeholders. EVS collection and reporting of sanitation measures performed. |
<table>
<thead>
<tr>
<th>Surveillance Activity (Indicator)</th>
<th>Goal</th>
<th>Actions to Reduce Risk</th>
<th>Patient Population</th>
<th>Data Entry and Reporting</th>
<th>Method of Analysis</th>
<th>Priority Score &quot;M&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Site Infections (SSI)</td>
<td></td>
<td>SCIP recommendations</td>
<td>Colorectal, Hip Prosthesis, Knee Prosthesis, Fusion, Re-fusion, Laminectomy, Fracture, Abdominal, Hysterectomy, Vaginal, Hysterectomy, Ovary, C-section, AAA</td>
<td>Enter procedures by ICD10, Mandatory requirement by CDPH and CMS, Data downloaded for internal dissemination, IC Committee and other stakeholder committees and departments, Graphic presentation and line listings shared with medical director of Ortho/Spine COE</td>
<td>SIR 2021 NHSN definition</td>
<td>CDPH mandatory for 26 surgical procedures, CMS mandatory Hysterectomy and Colon</td>
</tr>
<tr>
<td>Colorectal and Orthopedic/Spine</td>
<td></td>
<td>Evidence based practices for joint replacement</td>
<td></td>
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</tr>
<tr>
<td>Targeted surveillance is performed on SSI associated with medical procedures performed outside the US</td>
<td>Surgical Attire</td>
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<tr>
<td>Disinfection and Sterilization standards; AORN, AAMI, ANSI, CDC</td>
<td>Departmental rounding</td>
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<tr>
<td>Central Line-Associated Blood Stream Infections</td>
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</tr>
<tr>
<td>System: Eliminate Hospital Onset (HO) CLABSI</td>
<td>CLIP form</td>
<td>Patients with CVC's ICU Med/Surg, adult, and NICU</td>
<td>Participation in CDC National Healthcare Safety Network (NHSN), Mandatory requirement by CDPH and CMS, Designated internal committees (at least quarterly) stakeholders when identified</td>
<td>Standardized Infection Ratio (SIR) = # of infections / # of predicted 2021 NHSN definitions, NHSN analysis reports Line lists CLIP data analysis</td>
<td>CMS and CDPH mandatory for ICU and all inpatient units, CDPH mandatory CLIP entry into NHSN.</td>
<td></td>
</tr>
<tr>
<td>Facility: 10% reduction from 2021 by 2022.</td>
<td>CLABSI CAUTI prevention</td>
<td>Minimize the use of Central Venous Catheters (CVC) by using only when indicated CHG impregnated patch Care and maintenance assessment Unit based champions, skills day requirement CVC dressing kits</td>
<td></td>
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</tr>
<tr>
<td>CLABSI Case Finding Methodology:</td>
<td>Discern analysis. Infections identified through prospective and retrospective review of blood cultures and Electronic Medical Record (EMR). When case meets NHSN definition for CLABSI the case it is entered into NHSN database.</td>
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</tbody>
</table>

Case Finding Methodology:
Infections identified through a microbiology cultures, antibiotics prescribed, readmissions, reports from surgeons, and diagnosis codes. NHSN criteria used. Electronic medical record review. Post discharge surveillance by PH Home Health.
<table>
<thead>
<tr>
<th>Surveillance Activity (Indicator)</th>
<th>Goal</th>
<th>Actions to Reduce Risk</th>
<th>Patient Population</th>
<th>Data Entry and Reporting</th>
<th>Method of Analysis</th>
<th>Priority Score “M”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Onset (HO) MDROs MRSA BSI VRE BSI C. difficile Infection CRE C.auris</td>
<td>System: Eliminate Hospital Onset MRSA and VRE BSI C. difficile 10% reduction from 2021 by 2022. Zero CRE HO cases.</td>
<td>Hand Hygiene CDC Evidence-based practice strategies using APIC, HICPAC AORN AAMI, ANSI, SGNA EVS cleaning practices Channel Check Endoscopy quality marker Risk assessment for endoscope hang time (7 days) HLD rounding Glow germ Antibiotic Use Reduction</td>
<td>Patients with MRSA VRE BSI, CRE or C. auris clinical culture and CDI</td>
<td>Enter MRSA, VRE, CDI data into NHSN Mandatory requirement by CDPH and CMS. Lab reports to IC all CRE C. auris - critical results Data downloaded for internal dissemination. Line List CRE and C. auris cases all clinical cultures IC Committee and other stakeholder committees Antibiotic utilization reports Follow county public health guidance for reporting, testing and identification of C. auris</td>
<td>Incidence and prevalence as calculated by NHSN for MRSA and VRE BSI Hand hygiene data MDRO process measure compliance Departmental HLD compliance reports Channel Check results</td>
<td>CMS and CDPH mandatory reporting</td>
</tr>
<tr>
<td>Catheter Associated-Urinary Tract Infections</td>
<td>System: Eliminate HO CAUTI Facility: 10% reduction from 2021 by 2022.</td>
<td>Established Indications IC catheter CAUTI Bundle Bladder scanner Nurse Driven Protocol Female alternatives Foley Assessments</td>
<td>Patients with urinary catheters (ICU and adult Med/Surg)</td>
<td>CDC NHSN CAUTI Unit based case review Designated internal committees stakeholders when identified</td>
<td>SIR 2021 NHSN definition NHSN analysis reports Line lists CAUTI Bundle Discern analysis</td>
<td>CMS mandatory for ICU and all inpatient units</td>
</tr>
<tr>
<td>Ventilator- Associated Events</td>
<td>System: Eliminate IVAC Plus Facility: IVAC Plus SIR below 1.0</td>
<td>Bundle measures and compliance on all ventilated patients in intensive care CHG oral care Daily assessment of ventilator necessity and weaning</td>
<td>All adult (&gt;18 yrs.) Ventilated patients in intensive care</td>
<td>CDC NHSN (not in plan) Identify and report IVAC Plus Designated internal committees Stakeholders when identified Not publically reportable</td>
<td>SIR 2021 NHSN definition NHSN analysis reports Line lists Bundle compliance</td>
<td>Not Mandatory</td>
</tr>
</tbody>
</table>

Case Finding Methodology:
- Review of cultures and PCR screens, positive isolates, clinical records, and definitions for healthcare onset from NHSN surveillance definitions.
- July 2015 "Go live" with Cerner Infection Control data mining module. This has enhanced case finding and improved inefficiencies in data mining.

CAUTI Case Finding Methodology:
- Discern analysis. Prospective and retrospective culture and EMR review. When case meets NHSN definition for CAUTI the case it is entered into NHSN database.
<table>
<thead>
<tr>
<th>Surveillance Activity (Indicator)</th>
<th>Goal</th>
<th>Actions to Reduce Risk</th>
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<td><strong>Surveillance Activity (Indicator)</strong></td>
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<td><strong>Patient Population</strong></td>
<td><strong>Data Entry and Reporting</strong></td>
<td><strong>Method of Analysis</strong></td>
<td><strong>Priority Score &quot;M&quot;</strong></td>
</tr>
<tr>
<td>VAC Plus Case Finding Methodology:</td>
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<tr>
<td>Charge viewer identifies ventilated patients in ICU. Infections are identified through review of positive respiratory and blood cultures, antimicrobial use, clinical record, FiO2, and PEEP. CDC NHSN VAE calculator.</td>
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<tr>
<td>Unusual Organisms</td>
<td>Review all unusual organism including but not limited to: Aspergillus Legionella</td>
<td>Water sampling</td>
<td>Inpatients</td>
<td>Line listing</td>
<td>Record Review Line listing</td>
<td>CDC recommendations</td>
</tr>
<tr>
<td>Case Finding Methodology:</td>
<td></td>
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<tr>
<td>Discern analysis. Routine culture review and culture look back.</td>
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<tr>
<td>Influenza Vaccination</td>
<td>Achieve &gt;90% compliance with vaccination following CMS goals.</td>
<td>Continue mandatory mask program</td>
<td>All clinical and non-clinical employees, volunteers, physicians, students, contractors, working in the facility for at least one day during the influenza season.</td>
<td>Enter data into NHSN National Quality Forum (NQF) IC Committee and other stakeholder committees and departments</td>
<td>Compliance rate is calculated by number of staff, MDs, students, residents, LIP's and contractors divided by 100 for % compliance.</td>
<td>CDPH and CMS-mandatory</td>
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<tr>
<td>Employee Health oversight with Infection Control collaboration. Employee Health collaboration with medical staff to improve process for data collection.</td>
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<tr>
<td>Sharp/ Blood borne Pathogen (BBP) Exposures</td>
<td>Reduce the number of needle sticks and blood borne pathogen exposures from 2020</td>
<td>Education safe needle practices, use of PPE/proper disposal: PPE readily available for immediate use Report injuries/exposures during daily huddle Encourage correct PPE during splash-producing procedures</td>
<td>All employees, volunteers, physicians, surgeons, residents, medical students and anyone working in the facility</td>
<td>OSHA Log</td>
<td># needle sticks #blood/body fluid exposures</td>
<td>CDPH, CMS, and Cal OSHA mandatory to have a BBP plan</td>
</tr>
<tr>
<td>Case Finding Methodology:</td>
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<tr>
<td>All exposures reported through Employee Health with appropriate follow up.</td>
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<tr>
<td>Tuberculosis Exposures</td>
<td>Reduce the number TB Exposures compared with 2020 data</td>
<td>Evaluate patient risk on case by case basis. Prolong isolation precautions even if AFB negative x3 in high risk patients.</td>
<td>Outpatients</td>
<td>Employee Health Log</td>
<td># Actual TB exposures</td>
<td>OSHA mandate</td>
</tr>
<tr>
<td>Case Finding Methodology:</td>
<td></td>
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<tr>
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<tr>
<td>Environmental Surveillance</td>
<td>100% participation in EOC rounding</td>
<td>IC rounding: EOC HLD Pharmacy IP/OP USP 797 garbing Environmental air quality testing in pharmacy compounding area EVS Observations Surgical Services FANS Gift Shop Dialysis Linen Plant Tours Satellite Services</td>
<td>Inpatients Outpatients</td>
<td>Sentact Reports EOC committee IC committee Pharmacy culture results</td>
<td>Percent compliance with rounding observations Third party vendor, environmental testing</td>
<td>CMS CDPH USP 797</td>
</tr>
<tr>
<td>COVID-19/ MERS/SARS/Ebola Measles Exposure Community-wide outbreaks of communicable diseases that carry the potential of adversely impacting operations and service capabilities. Potential for bioterrorism event.</td>
<td>Minimize Exposure Risk</td>
<td>Adherence to CDC guidance, identify, Isolate, inform, signage at entrances ED patient X surveys Communication with SD County Public Health, local healthcare providers, and outpatient draw stations. Quickview identification of possible measles Auto order for airborne isolation for anyone with fever and rash Corporate Health proactive identification of susceptible healthcare workers and vaccine offer Local outpatient draw stations Refer to COVID-19 Exposure Control Plan Ebola Plan and PPE donning and doffing During surges FMS unit may be deployed</td>
<td>Inpatients Outpatients</td>
<td>County Public Health mandated reporting. Exposure Report</td>
<td>CDPH</td>
<td></td>
</tr>
</tbody>
</table>

VIII. Performance Improvement Activities/Projects:

A. IC/Employee Health collaboration
   1. Case investigation and exposure incidents
   2. Influenza immunization program evaluation

B. Infection Control Risk Assessment
   1. Palomar Health System
   2. The Villas at Poway (Villa Pomerado) (refer to their plan and assessment)
   3. Home Health (refer to their plan and assessment)

C. Respiratory Etiquette Program
   1. Staff and patient education
   2. Respiratory/Hygiene stands at ED and main entrances
   3. Signage posted
   4. ED triage patient assessment and masking of suspect Aerosol Transmissible Disease (ATD) cases
   5. Transmission based precautions as indicated

D. Bundle compliance monitor
   1. VAP bundle
2. CAUTI bundle
3. CLIP
4. Colorectal Surgery Bundle

E. High level disinfection process audits (Department based compliance monitoring).
F. Immediate Use Steam Sterilization rates Surgical Services procedure based rates.
G. Biological Monitoring compliance and failure rates (Surgery, Respiratory Care, SPD, Endoscopy)

H. Surveillance Definitions
1. Palomar Medical Center, Palomar Downtown, Pomerado Hospital comply with NHSN Patient Safety Module Definitions and Reporting Requirements
2. Skilled Nursing Facilities use McGeer Criteria
3. NHSN Antibiotic module

I. Reporting and using surveillance information
1. Infection control data is presented at the Infection Prevention and Control Committee (IPCC) and all other stakeholder committees. Recommendations for practice or supply changes are made by the committee and implemented by the Infection prevention and Control staff. The results of these recommended changes are reported back to the Infection Prevention and Control Committee, at a time specified by the Committee.
2. IPCC reports up to the Quality Management Committee, then to the Medical Executive Committee and report out to BQRC. Reports are also presented to appropriate Surgical, Nursing and interdisciplinary committees who share the information with the staff.
3. Surveillance data is incorporated into Quality dashboards.
4. Identifying unusual infection related events
   a. When an unexpected influx of patients who require special isolation precautions occurs, the facility Disaster Plan will be activated.
   b. The Infection Prevention and Control Staff will be notified when actual or potential infection related events occur. If necessary, consultation with the chairman of the Infection Surveillance Committee, Infection Control Officer/s, and/or other committee members may be needed. Isolation of an individual patient does not require approval and should be initiated without delay.

J. Palomar Health System Wide Surveillance
1. Ongoing components of Palomar Health system wide surveillance include:
   a. Hand Hygiene observations using CDC indications. Compliance is monitored by designated personnel in departments and rates are communicated to staff by Dept representative.
   b. Periodic alcohol gel purchase data is used as a surrogate marker for compliance monitoring
   c. Emergency Department Syndromic Surveillance - San Diego Aberration Detection and Incident Characterization (SDADIC)
   d. Tuberculosis trends.
   e. Blood and body fluid exposures.
   f. Environmental safety observations.
   g. The Villas at Poway and Home Health site specific surveillance plans are reviewed and updated at least annually.
   h. Post-discharge infections are surveyed through self report from physicians, laboratory and other hospitals.
      i. Review, evaluate, and advise when communicable disease exposure in either patient or employee has occurred. The following are cause for investigation and action:
         i. Gastroenteritis if considered healthcare-associated.
         ii. Exposure to measles, chickenpox, rubella or scabies for followup.
         iii. TB exposure will be investigated for control and followup when isolation procedures are not instituted.
         iv. Exposure to possible HIV for followup,
2. Outpatient Services (listed in grid above)
   a. CDC Infection Prevention Checklist for Outpatient Settings
   b. Environmental rounds are performed in outpatient settings. Feedback is given to the department managers.
   c. Environment and Equipment is assessed for compliance with hospital sanitation standards
   d. Environment of Care records are kept in the appropriate database and monitored by EOC and IPCC as appropriate.
   e. Outpatient Departments participate in the system wide hand hygiene compliance monitor
   f. Home Health surveillance includes:
      i. UTI with and without catheter
      ii. Wound infection
      iii. SSI
      iv. CLABSI

IX. Infection Control Functions:
A. Take action to solve identified problems which may include:
   1. Review and revise procedures
   2. Consultation on risk assessment, prevention and control strategies (includes activities related to occupational health, construction, and emergency management
   3. Education efforts directed at interventions to reduce infection risk
   4. Implementation of changes mandated by regulatory, accrediting and licensing agencies
   5. Application of epidemiological principles, including activities directed at improving patient outcomes using implementation science
   6. Antimicrobial Stewardship
   7. Provision of high quality services in a cost efficient manner
   8. Ratify ideas of the infection prevention team
   9. Members disseminate information discussed in the committee meeting
   10. Review equipment or services with appropriate departments.
   11. Report information to Administration for action as appropriate
   12. Report information to the Infection Prevention and Control Committee, the Quality Management Committee, the Medical Staff departments, and the California Department of Public Health (CDPH), as appropriate.
A. Investigate Epidemics, infection, or colonization caused by unusual pathogens, and look into occurrences of healthcare-associated infection that exceed the baseline. Refer to Outbreak Investigation. Conduct studies, as indicated by the occurrence of health-care associated infection problems, or at the request of a Medical Staff department.

B. The Infection Control Committee will review details of emerging infectious diseases.

C. Infection Preventionists will assist leaders of special populations with interpretation and implementation of recommendations for emerging infectious diseases (e.g. Zika, COVID-19)

VIII. Performance Standards:
A. Staff knowledge and skill requirements are assessed at orientation, annual skill days, self-assessments, annual safety test, and through performance evaluation.

B. Monitoring and inspection activities:
   1. Aggregate data measures effectiveness of infection surveillance by evaluating rates/ratios and infection trends that exceed thresholds.
   2. Safety inspection lists from department, as required.

C. Estimate of the need of and recommendations for additional resources for Infection Prevention and Control Program
   1. The healthcare system currently has five full time employees as Infection Preventionists. The Program also benefits from an Infection Control Committee Chair/Medical Director for our current licensed beds.

IX. Methods, Indicators and Threshold for Evaluation:
A. Focused or targeted surveillance is conducted as appropriate on patients or procedures to identify healthcare-associated infections and infection risks. This may include clinical indicators, patient care areas and/or patient population. Methods include epidemiological and statistical techniques with the application of evidence-based practice research principles to evaluate processes and trends for quality improvement. Results will be presented in a report format with the annual summary. The methods reflect established industry standards, guidelines and approved organizational procedures.

B. In collaboration with Employee Health Services, and as part of the Environment of Care Safety Committee, Patient Safety Committee activities, surveillance include data on:
   1. Employee exposure to blood and body fluids.
   2. TB conversion rates
   3. Needle stick and other puncture incidents.
   4. Clusters or outbreak investigation is the immediate priority at the time an unexpected occurrence or frequency of infections become evident. See Outbreak Investigation procedure. Indicators for increased incidence may include:
      a. Clustering of surgical site infections from a specific surgeon or related to a specific activity.
      b. A cluster of infections involving the same resistant organism.
      c. Unusual organisms.

C. Case findings include:
   a. Use of electronic medical record Infection Control software.
   b. Chart review, including microbiology, serology and radiology reports.
   c. Review of microbiology reports.
   d. Referral and input from physicians and other healthcare personnel.
   e. Review of autopsy reports.

X. Criteria for Plan Application:
A. The Infection Prevention and Control Plan apply to all health care workers, volunteers, students, contracted services, and physicians who utilize Palomar Health facilities.

XI. Roles and Responsibilities:
A. Responsibility for the overall Infection Prevention and Control Program rests with the Board of Directors. The Board of Directors delegates responsibility and accountability for the ongoing operation of the program to the Administration and the organized Medical Staff.

B. The program is directed by the Infection Prevention and Control Committee, which operates under the auspices of the Medical Staff bylaws. The Committee has a strong support from the infectious disease specialist who serves as the chairperson.

C. The Infection Control District Director has responsibility for oversight and coordination of the development, testing and implementation of the Infection Prevention and Control Risk Assessment and Surveillance plan as it pertains to regulatory and accreditation standards.

D. The Infection Control Committee will review details of emerging infectious diseases.

E. Coverage will be maintained for oversight and intervention by designated departmental staff.

F. Infection Preventionists disseminate public health information as it becomes available to key stakeholders.

XII. Orientation, Education, Training:
A. Infection Prevention and Control information is presented to all new employees and volunteers during orientation, on an annual basis and as needed.

XIII. Annual Evaluation:
A. The effectiveness of the Infection Prevention and Control Plan is assessed annually using defined performance standards. Results of summary data are reported to appropriate committees, not limited to the Infection Prevention and Control, Quality Management and Patient Safety, and Board Quality Review Committees.

XIV. Methods of Surveillance
A. Surveillance for infections is conducted using the following methods:
1. Targeted and focused surveillance based on results of annual risk assessment and significant epidemiological events are chosen and prioritized based on high risk, high /low volume and or problem-prone criteria designated by the Infection Prevention and Control Committee. 

2. Use of ECHOView and Cerner IP list.

B. Additional established standards, benchmarks and/or evidence-based practice guidelines include but are not limited to the following:

1. CDC and National Healthcare Safety Network (NHSN) definitions and reporting requirements.
2. Senate Bill 739, 158, 1058 regulations.
3. Utilize Plan Do Check Act for Infection Control improvement projects.
5. Compile data annually on patients with active TB and employee conversions. Use data to plan protective controls as appropriate.
6. Review Palomar Health Healthcare worker influenza vaccination compliance, provide expert consultation for compliance improvement and reporting methodology.
7. Compile data on employee blood and body fluid exposures this data is used to evaluate safe work practices and safety devices.
8. Survey hospital areas with members of the Environment of Care Safety Committee to ensure that protective devices and garments are available and used by staff. Report results to the committee and assist in the formulation of action plans.
9. Each department performing decontamination and sterilization will, in the event of sterilizer failure, present data to the Infection Prevention and Control Department who will assist in the formulation of action plans if sterilizers fail expected outcomes.
10. Involvement in planning and monitoring construction and renovation activities to reduce the risk of infection to patients, staff, and visitors.
    Ensure infection control concerns are addressed and precautions are established prior to, during and following construction/renovation activities to minimize infection risks.
11. Provide plans and resources to respond to potential emergency, pandemic and bioterrorism events.

C. San Diego County Demographics

1. Population - 3.1 million
2. Of residents under 18, 37% are Hispanic, and the Hispanic population is expected to continue to grow at a rapid rate.
3. Approximately 21.5% of the county's population is immigrants, including refugees, who come from other countries, speak 68 different languages, and have a variety of needs as they assimilate into their new environment.
4. The senior and disabled populations are growing disproportionately compared to the rest of the population.
5. Second-most populous county in California and fifth-most populous in the US
6. Part of the San Diego-Tijuana metropolitan area
7. Naval and Marine Corps bases
8. Desert locations
9. 170,000 individuals who migrated to the US without authorization living in the region

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**Document Owner:** Martinez, Valerie A

**Approvals**
- Committees:

**Revision Date:**

**Standards:**
(WHICH REFERENCE THIS DOCUMENT)

**The Joint Commission:**
- Infection Prevention and Control - IC.01.05.01
- Infection Prevention and Control - IC.01.04.01
- Infection Prevention and Control - IC.01.03.01
- Infection Prevention and Control - IC.01.01.01
- Infection Prevention and Control - IC.01.01.01
- Infection Prevention and Control - IC.01.03.01
- Infection Prevention and Control - IC.01.04.01
- Infection Prevention and Control - IC.01.05.01
- Infection Prevention and Control - IC.02.03.01

**Attachments:**
(REFERENCED BY THIS DOCUMENT)
- Comparison of National, State and County Data for Tuberculosis, 201
- County of San Diego HIV, STD Hepatitis Report
- Preventing Transmission of Zika Virus in Labor and Delivery Settings Through Implementation of Standard Precautions United States, 2016
- San Diego Demographics from the US Census Bureau
- Ebola Donning Doffing PPE
- Ebola Plan
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Introduction

Annual Review and Program Assessment

The Infection Prevention and Control program is evaluated annually. This assessment compares outcomes from 2019 to 2020. The assessment includes all surveillance modalities, both process and outcome measures, performed by the various disciplines including the Infection Preventionists (IP). In addition to infection control measures, ongoing monitoring of processes involving high-level disinfection, Sterile Process Department, medication preparation, food and nutrition services, construction, and satellite services are included. The IP staff use their role as department resources to provide their expertise, support, and evidence-based recommendations to ensure the program and the system wide surveillance plan is followed. The program assessment provides information to steer the Infection Prevention and Control Department’s focus for the upcoming year. Each measure is evaluated for effectiveness and is considered a driver for departmental and unit based action planning. Process and outcome measures are shared at the physician, nursing and support service levels and used to sustain or improve patient care activities. Infection Control rounding activities help to identify opportunities for improvement. Liaisons for Infection Prevention provide an extension of the Infection Prevention and Control Department with collaboration and implementation of program activities in specialty areas.

Guidance from various regulatory and nationally recognized professional organizations including but not limited to are The Centers for Disease Control (CDC), The Joint Commission (TJC), California Department of Public Health (CDPH), Center for Medicare/Medicaid Services (CMS), and California Occupational Health and Safety Administration (Cal OSHA). These organizations provide direction in identifying indicators and implementation of the plan. The program is fluid and can change based on emerging infectious diseases or new risks associated with the provision of care. The Infection Prevention and Control Department keeps abreast of these through the media, participation in the San Diego County Emerging Infectious diseases community meetings, Association of Professionals in Infection Control (APIC), and scientific journals. This assessment provides the reader with information on the status of the Infection Prevention and Control Plan.

Infection Prevention Mission

Develop and maintain an Infection Prevention and Control program that reflects the Mission, Vision, and Values of Palomar Health. The program promotes patient safety by reducing the risk of acquiring and transmitting infections among patients, healthcare providers, volunteers, and visitors. The program is guided by Quality and Regulatory Standards developed by TJC, CDC, CMS, CDPH, Cal OSHA and other nationally recognized organizations.

Purpose

This document provides information to establish a framework and structure for Palomar Health’s organization-wide, facility specific approach in identifying and reducing the risk of endemic and epidemic healthcare-associated infections (HAI). To ensure optimal provision of
services, the management of infection prevention and control processes are assigned to qualified personnel by virtue of education, training, licensure, experience and/or certification.

Authority Statement

Palomar Health has designated the Infection Control Officers per CMS to the Senior Director of Quality, Patient Safety, Infection Prevention, and the Chair of the Infection Prevention and Control Committee.

The Infection Control Officers are qualified and maintain qualifications through education, training, experience and certification related to infection control.

The Infection Control Officers have the authority and responsibility for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program. The Infection Control Committee, through its chairperson and/or Senior Director of the Infection Prevention and Control Program, are granted authority to institute any appropriate emergency control measures throughout the health system when there is a reasonable risk or danger to any patient, healthcare provider, volunteer, or visitor.
Department Structure

The Infection Prevention and Control Department is structured under the Operations Division. The Infection Prevention and Control Program reports directly to the Quality Management Committee.
Hand Hygiene

Goal: Increase facility before patient contact (orange) hand hygiene compliance by $\geq 10\%$ or maintain above 85% compliance from 2019; measured by Palomar Health Infection Control standardized methods.

2020

Hand Hygiene by Facility and N

- Esccondido: 15563
- Poway: 6364
- Vista: 591
- Grand Total: 22518

Hand Hygiene by Discipline and N

- EVS: 5357
- NURSE: 1404
- MD: 2262
- OTHER: 758
- PM: 472
- RAD: 1083
- RESP: 1559
- TRANS: 1594

Hand Hygiene by Unit and N

- 2021: 1202
- 2020: 1370
- 2019: 2071
- 2018: 2134
- 2017: 2299
- 2016: 2252
- 2015: 2248
- 2014: 2195
- 2013: 205
- 2012: 46

NURSE=RN, LVN, CNA, HCA; RAD=Imaging; TRANS=Transporters, Lift team; RENUM=OT, PT, ST; FANS includes RD; PM=Pathmaker, Student, Volunteer.
“COMBINED” is the mean rate of before and after patient contact values, and associated with LEM.

**Summary Analysis:** during 2020, Palomar Health System maintained focus on increasing hand hygiene *before patient contact* yet did not achieve this at 71% compliance ($N=22,646$) compared to 2019 82% compliance ($N=32,518$). At the facility level, overall combined measures decreased at Escondido (92% vs. 84%), and the Villas at Poway (97% vs. 95%). Poway stayed the same at 92%. ARU increased compliance from 83% to 93% during 2020. Notable gains were made by the following departments with increases at or above the stated goal; 5E 16.2%, 8E 13.4%, 8W 15.2%, ED Escondido 50%, IR Escondido 102% and IR Poway increased from zero to 87% compliance.

**Goal Met/Unmet:**

PMC Escondido - Goal Unmet

PMC Poway – Goal Met

The Villas at Poway – Goal Met

ARU – Goal Met

**Action Plan:**

1. Re-evaluate unit-based interventions/action plans. Share successful strategies across units/departments and district
2. Explore electronic technology to measure hand hygiene vs observation
3. Medical staff engagement - trained observers will continue to notate physician names on observation worksheets and be shared with Medical Director leaders for peer follow up
4. Continue to provide quarterly facility and unit-level data (report cards)
5. Continue to provide list of interventions and assistance with implementing to unit leaders
6. Continue to provide transparency to data collection methods and expectations
7. Continue to provide hand hygiene education to employees upon hire, annually, and regularly with units or disciplines
8. Work with employee health to accommodate non-alcohol formula for reported sensitivities
9. Explore logistics and compatibility with Human Resources’ HALO recognition program
10. Improve product accessibility with pilot unit, infection control, unit leader, facilities, and EVS
Home Health Hand Hygiene Compliance

**Goal:** Facility maintain above 90% compliance, measured through Sentact Survey

**Summary Analysis:** With hand hygiene rates above 90% in home health, Infection Control focused on COVID-19 training including hand hygiene, equipment cleaning, and donning doffing PPE. Infection Control Home health audits were put on hold in order to meet the needs of the Home Health staff and patients during the pandemic.

**Action Plan:**

1. Reinitiate observed hand hygiene compliance monitoring using Sentact Survey by designating an onsite observer during 2021.
Central Line-Associated Bloodstream Infection (CLABSI)

CLABSI Standardized Infection Ratio (SIR)

**Goal:** Facility does not exceed established threshold 1.0, analyzed by NHSN.

**Summary Analysis:** Among 14 CLABSI events (13 at Escondido, 1 at Poway), ten (77%) cases occurred greater than 7 days from when the central line was inserted. This suggests the CLABSI risk may have arisen from a lapse in line maintenance interventions versus insertion, as Central Line Insertion Practices (CLIP) adherence has remained above 90% (Figure 1). Senate Bill requirements mandate that providers have assessed the necessity of a central line at least daily (Figure 2). A reduction in the central line Standardized Utilization Ratio (SUR) at PMCE during 2020 is temporally, associated with necessity compliance monitoring tool implementation. Universal decolonization could not be implemented as planned for 2020 due to the impact of COVID-19. However, the staff was able to implement daily CHG bathing for patients who have central venous catheters, which was only 57% compliant among cases. Reminders communicated to nursing and referred to our Infection Control intranet resources for wipe-based bathing instructions. The Vascular Access team routinely changes dressings for Peripherally Inserted Central Catheters (PICC) lines; however, during surge capacity when PICC team resources were exhausted, there was a shift of awareness and responsibility to primary care nursing when dressings were lapsing their appropriate change times. Nine of 13 cases were PICCs. The Vascular Access team produced a clinical aid to encourage the use of midlines. Ten of the 13 cases tested for COVID-19 and 4 were positive.

**Goal Met/Unmet:**

PMC Escondido – Goal Unmet

PMC Poway – Goal met
Action Plan:

1. Continue case reviews with units leaders and evaluate process measures
2. Continue to provide device utilization data to unit Medical Directors, involving hospitalist and intensivists in device reduction strategies (Figure 3)
3. Daily CHG bathing for patients with central venous catheters – evaluate process and provide educational needs
4. Explore designated maintenance days for 7 day dressing, caps and IV tubing changes.
5. Encourage provider use of midlines – work with vascular access team to produce clinical aid/flyer to promote midlines versus PICCs
6. Explore universal decolonization in the intensive care units
7. Assess operations and IC practices under surge capacity

**CLABSI Process Measures – Central Line Insertion Practices (CLIP)**

![CLABSI Process Measures Chart](image)

*Figure 1 System CLIP adherence, measuring full sterile barrier precautions, hand hygiene, and appropriate skin prep.*

**Palomar Health Central Line Indication Documentation Percent Compliance**

![Palomar Health Central Line Indication Documentation Chart](image)
Figure 2. Adherence to evaluation of necessity for central venous catheters is measured by physician response to a prompt in Cerner to evaluate the current need for a central venous catheter. Physician compliance with this process has increased during 2020 by 24%, indicating the necessity of the catheter has been assessed and confirmed on a daily basis.

Central Venous Catheter Standardized Utilization Ratio (SUR)

Figure 3. Central line use is measured by NHSN as the number of observed catheter days / the number of predicted catheter days. Overall system SUR for central lines is below threshold. PMC Poway increased utilization by 7% PMC Escondido decreased utilization by 16%, and ARU increased utilization by 76% compared to the previous year. All locations campuses are below threshold.
Catheter-Associated Urinary Tract Infections (CAUTI)

CAUTI Standardized Infection Ratio

**Goal:** Reduce facility CAUTI SIR from previous year, analyzed by NHSN.

![CAUTI SIR by Facility](image)

**Summary Analysis:** There is an increased number of cases, 25 (Escondido 23, Poway 1, ARU 1), compared to the previous year with 18, system-wide. See CAUTI bundle measures for prevention compliance (Figure). No common trends in insertion or maintenance risks. More than half of cases was *E. coli* and other gut flora; however, pericare was documented in all cases. Average utilization of pericare products was performed and demonstrated an increase in utilization by 169%, since product use initiated during 2019. The system is continuing to promote the use of alternatives instead of indwelling catheters and daily device necessity assessments. Twenty of the twenty-five cases were tested for COVID-19 and 6 were positive.

**Goal Met/Unmet:**

PMC Escondido – Goal Unmet

PMC Poway – Goal Met

ARU – Goal Met

**Action Plan:**

1. Continue providing education and promote use for alternatives (e.g. external catheter)
2. Re-assess insertion techniques and maintenance, among non-ED staff (February 2020)
3. Continue Hospitalist involvement in CAUTI reduction
4. Continue device rounds and evaluate process measures
5. Workgroup to update nurse-driven removal protocol. Focus on a more robust bladder scanning protocol, get bladder scanning procedure approved by leaders and committees
with our MD champions, submit a change request in Cerner, update procedures, provide RN education, and go live.
6. Continue daily Quality huddle to ensure accountability for necessary catheters
7. Observe pericare technique and evaluate training for wipes
8. Assess operations and IC practices under surge capacity

**CAUTI Process Measures - CAUTI Bundle Monitoring**

*Figure 4. CAUTI Bundle compliance is a measure of 6 maintenance intervention elements: tamper seal intact (ensures closed system), securement device, unobstructed urine flow, drainage tubing/bag off floor, drainage tubing/bag below bladder, indication for catheter documented if not discontinued.*

**Indwelling Urinary Catheter Standardized Utilization Ratio (SUR)**

*Figure 5. Indwelling urinary catheter use is measured by NHSN as the number of observed catheter days / the number of predicted catheter days. PMC Escondido decreased by 7%, PMC Poway decreased by 10%, and ARU decreased by 5%.*
**Ventilator-Associated Pneumonia (VAP)**

Infection Related Ventilator-Associated Complications Plus (IVAC Plus) SIR

**Goal:** Facility ICUs to reduce IVAC Plus SIR from previous year.

**Summary Analysis:** The total cases of IVAC plus for PMCE and Poway is 29. 5W had (14), 4SW (9) and Poway (6). IVAC Plus data includes IVAC (infection-related ventilator complication) and PVAP (probable ventilator associated pneumonia), and the SIR is the number of observed / number of predicted IVAC and PVAPs in intensive care units. PMCE increased IVAC SIR by 67% PMCP increased by 179% Measures taken during 2020 to decrease ventilator associated events included a collaborative by the ICU medical staff and the Respiratory therapy team monitoring for the ventilator bundle. (Figure 3). All measures of VAP bundle have improved throughout the year at both campuses with the exception of Daily Spontaneous Breathing Trial Initiated. A workgroup formed to standardize process and documentation of daily awakening, sedation vacation, and readiness to extubate. Twenty-eight of 29 patients/cases tested for COVID-19 and 12 were positive.

**Goal Met/Unmet:**

PMC Escondido (5W & 4SW) – Goal Unmet

PMC Poway (ICU) – Goal Unmet

**Action Plan:**

1. Continue to report cases to unit and Respiratory and Unit leaders
2. Maintain device rounds and planning strategy with pulmonary care
3. Continue to engage Intensivists in reducing Standardized Utilization Ratio (Figure 4), and assessing device necessity
4. Continue to report all IVAC Plus and Standardized Infection Ratio outcomes to various committees indicating areas of opportunity.
5. Infection Control, Critical Care and Pulmonary committee review of data and drill down on cases as appropriate, including device utilization.
6. Workgroup to standardize process and documentation for daily awakening, sedation vacation, and assessing readiness to extubate.

**VAP Process Measures – Ventilator Bundle Monitoring**

![Figure 2 Ventilator Bundle Compliance, Escondido 4SW & 5W](image)

![Figure 3 Ventilator Bundle Compliance, Poway ICU](image)
Mechanical Ventilator Standardized Utilization Ratio (SUR)

Figure 4. Mechanical ventilator use is measured by NHSN as the number of observed vent days / the number of predicted vent days.
Multi-Drug Resistant Organism (MDRO) Lab-Identified Event

Clostridioides difficile Infection (CDI) Standardized Infection Ratio

**Goal:** Reduce facility hospital-onset (HO) CDI SIR below benchmark of 1.0.

**Summary Analysis:** The 2019 data was validated during 2020, and found to have one case that did not meet healthcare onset (HO) CDI LABID definition and this case was revised and subsequently removed from HO events. This revision changed the SIR for CDI from 0.615 to 0.589 for 2019 overall. SIR data for all facilities have remained under 1.0. During 2020, PMC Escondido reduced CDI SIR by 22% compared to previous year, and PMC Poway and ARU have decreased by 41% and 100%, respectively. Re-education was initiated and using a testing algorithm and provided on intranet.

**Goal Met/Unmet:**

PMC Escondido – Goal Met
PMC Poway – Goal Met
PMC ARU – Goal Met

**Action Plan:**

1. Continue to notify unit leaders of HO-cases to review
2. Collaborative with antibiotic stewardship subcommittee – goal to reduce fluoroquinolone use to address antibiotic-associated diarrhea/CDI
MRSA Bloodstream Infection (BSI)

**Goal:** (1) Reduce facility MRSA BSI SIR from previous year and (2) below threshold 0.75.

![MRSA BSI SIR by Facility](image)

*SIRs cannot be calculated when the predicted value is < than 1.0

**Summary Analysis:** PMC Escondido showed a 9% increase from previous year, however it was below the 1.0 SIR threshold. This reflects an increase of one case. PMC Poway had one MRSA BSI event during 2020 for a SIR of 0.9 this is a 14% increase from 2019. PMC ARU had zero events.

**Goal Met:**

PMC Escondido – Goal Met

PMC Poway – Goal Met

PMC ARU – Goal Met

**Action Plan:**

1. Unit based review of all Healthcare Onset (HO) cases with feedback from Pharmacy
2. Timely reporting of all HO cases to the Unit for review and education
3. Redistribute “Isolation precautions at a glance” with updates
4. Continue to round and follow up with unit isolation precaution compliance (Figure 5)
5. Continue with hand hygiene program (Hand Hygiene Table of Contents)
6. Review needs and protocol for universal decolonization in ICUs (nasal and full body)
7. Continue surveillance testing for MRSA colonization per Senate Bill 1058 of high risk patients on admission and inpatient dialysis at discharge. Compliance for MRSA testing of high risk group at discharge is at or above 90% at PMC Escondido and Poway (Figure 61)
MDRO Process Measures – Isolation Precautions Compliance

Figure 5. Processes that reduce the risk of transmission for MDRO’s include; Isolation initiation, patient education, use of the correct signs, ensuring gloves and gowns are available and wearing them when it is indicated.

Figure 6. 2019 analysis demonstrated gaps in compliance with testing dialysis patients at discharge. This was a focus for improvement during 2020. The figure presented above shows compliance for that group.
Surgical Site Infections (SSI)

**Goal:** (1) Reduce facility overall SSI SIR from previous year and (2) below SIR threshold of 1.0

**Summary Analysis:** Targeted surgical site infection surveillance is performed routinely, with 25 surgical procedures that are mandatory to report. The overall SSI SIR represents the 25 reported procedure events.

PMC Escondido overall SSI SIR increased 3% from previous year, from 39 with predicted 62.494 in 2019 to 33 with predicted 50.903 this year. PMC Poway SIR decreased by 34% from previous year, from 13 to 8 cases.

**Goal Met:**

PMC Escondido – Goal Met

PMC Poway – Goal Met

**Action Plan:**

1. Continue to collaborate with Physician liaison when opportunity identified for risk adjustment documentation.
2. Various multidisciplinary workgroups formed to address procedure-specific trends  
   a. Colon Bundle (**Colon Surgery**)  
   b. Perioperative Glycemic Control  
      i. Focused on perioperative glucose control <200 mg/dl for the diabetic patient within multidisciplinary group: preop and PACU nurse, anesthesiology, diabetes services, and infection control  
   c. Pre-op Interventions (**Orthopedic Surgery**)  
3. Continue to notify surgeons and OR leaders of SSI events

**Colon Surgery**

![COLO SSI SIR by Year](image)

**Summary Analysis:** With multiple interventions, PMC Escondido decreased COLO SSI SIR by 71% compared to previous year, from 11 to 8 SSI events. PMC Poway reduced SSI events from two to one, improving 61%. A taskforce was formed to address Colon SSI and reduce infection risk among elective cases. The task force developed a colon intervention bundle with pre-, intra-, and post-operative interventions. Order sets updated with bundle initiatives made available. A general surgeon champion identified to provide appropriate wound and present-infection classification in intraoperative documentation

**Abdominal Hysterectomy**

**Summary Analysis:** There are no HYST SSI events during 2020.
**Summary Analysis:** PMC Escondido reduced orthopedic SSI SIR by 6% compared to previous year, while PMC Poway decreased by 36%. Although there was a significant decrease in overall SIR for Poway. Knee replacement surgery (KPRO) is above threshold with a SIR of 2.720. This consists of three infections (2 January, 1 November) All are different surgeons, and there was not a common organism. Since two cases were S. aureus (one MRSA), preoperative interventions focused on decolonization protocols using nasal betadine and full-body CHG bathing.

Compliance with CHG bathing is reported high, but questionable as the data is dependent on patient responses. Poway has agreed to model that all elective orthopedic procedures receive a CHG waterless bath regardless of patient responses to normal CHG bathing.
Environment of Care (EOC)

EOC Rounds

Goal: Maintain facility ≥90% compliance

Summary Analysis: Using the infection control EOC rounds within Sentact, compliance with standard and transmission-based precautions, facilities related infection risks, cleanliness, waste disposal, and appropriate storage and processing of patient care equipment and devices was measured. Also observed is the proper decontamination, handling, transport, and storage of sterilized devices. Trends included visibly dusty environment, cleaning of glucometers, left open disinfectant wipes, and bins, microwaves and refrigerator cleaning reinforcement.

Goal Met/Unmet:

PMC Escondido – Goal Unmet
PMC Poway – Goal Met
PMC Downtown Escondido – Goal Unmet (1st Quarter only)
Villas at Poway – Goal Unmet

Action Plan:

1. EVS focus on dust in the environment.
2. Continue EOC team rounding performed monthly in scheduled areas.
3. Continue reporting findings to Department Directors according to urgency of finding
4. Infection Control to report trends and data to EOC and Infection Control committee
5. Leadership to develop action plan to address repeated or high-risk findings.
**Environmental Sanitation Measures**

Florescent Marker Validation of Environmental Cleaning

**Goal:** Facility to maintain compliance ≥95%.

**Summary Analysis:** This measure is implemented in accordance California Public Health Department Senate Bill requirement. During 2020, florescent marker tool was used and represented by the above data. Compliance for PMC Escondido and Poway has increased from previous year, so has the sample size.

**Goal Met/Unmet:**

PMC Escondido – Goal Met

PMC Poway – Goal Met

**Action Plan:**

1. Continue to monitor observations and use as a practice enhancement tool
2. Routine reporting through Infection Control Committee by EVS Leadership
3. Explore use of florescent markers in outpatient settings.
Environmental Testing

**Goal:** Periodic environmental testing with certification where applicable. Action planning and resolution expected when tests are out of range.

**Summary:** Environmental testing is performed routinely on air pressure differentials, potable water, the pharmacy compounding spaces, laboratory fume hoods, dialysis machine and water, and Infection Control Officer-approved environmental fomites and Class IV construction. Results outside normal parameters are reported directly to the Infection Prevention and Control Committee with a plan of correction.

**Action Plan:**

1. Continue environmental testing via 3rd party vendors for identification and control of environmental hazards
2. If results exceed threshold services may be interrupted while investigations and action plans are created and implemented

Construction

**Goal:** System provides consultation, perform Infection Control Risk Assessment (ICRA) for construction and renovation projects, and provide education to facility and construction personnel

**Summary Analysis:** Palomar Health has an infection control procedure in place for assessing the risk of construction/renovation jobs to determine the appropriate barriers for mitigating dust dispersion. There were no outbreaks associated with construction. The infection control class for construction and renovation was moved to a digital format due to COVID-19.

**Goal Met:**

Palomar Health – Goal Met
Action Plan:

1. Continue to monitor all construction activities and issue ICRA
2. Continue to submit request for baseline air particulate measurements for Class IV activities, if assessed to be needed
3. Continue to provide dust-mitigation education to facility and construction personnel annually and before hospital construction and renovation activity
## Infection Control Education

**Goal:** Provide Infection Prevention education to Palomar Health staff on areas of focus

**Summary Analysis:** During 2020, IP staff provided information to staff regarding multiple primarily focusing on COVID-19 precautions. These included; routine, just in time education, and scheduled inservices. Monthly in person education is provided for Nursing Services and New Leader orientation.

<table>
<thead>
<tr>
<th>Month</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>Initiated daily huddle topic about novel coronavirus in Wuhan China. Distributed three I’s information for ED. Lab Specimen collection, ED coronavirus information collected and placed in ED project drive. Coronavirus precautions memorandum to medical staff and hospital staff. ED communication for isolation precautions. PUI definition to medical staff. Coronavirus update #1.</td>
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<tr>
<td>Mar</td>
<td>Update on screening, inventory, visitation, and planning and education. Public health and CDC guidance on visitors, volunteers, school closings, surge tent, student rotations, meetings, isolation locations, supply inventory. PPE usage guidance and building access. Surge tent, parking, shuttle, PPE usage, exposure, work from home, elective surgery postponement, grab and go food. PPE utilization update and conservation, visitation and donations, stay at home order. Social distancing lab results, train the trainer N-95 reuse. N-95 reuse announcement, isolation requirements and exposure information, pregnant staff information, staffing ratios. Airborne vs. Droplet precautions, PPE guidance and daily masking. FAQ Process for de-escalation, donning PPE, disinfectant wipe use, chaplaincy.</td>
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<tr>
<td>Apr</td>
<td>COVID-19 Update – testing turnaround, first death. COVID-19 Update – donated mask distribution, pharmacy alcohol gel distribution. COVID-19 Update – N-95 reprocessing prospect, Federal Medical Station (FMS) information, birth center protocols and use of PMCDT facility, cases reported. COVID-19 Update – cohorting, SNF transfers, antibody testing, second death, FMS.</td>
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<td>July</td>
<td>Transporter update, phlebotomy reinforcement of reuse and storage of N-95. COVID-19 therapy grand rounds. COVID-19 Update. Masking patients, testing guidelines.</td>
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<td>Oct</td>
<td>COVID-19 Update – respiratory protection – new PAPRs,</td>
</tr>
<tr>
<td>Dec</td>
<td>COVID-19 Update – PPE conservation using reusable respirators and PAPR’s, exposures vaccine information and weekly testing of HCW’s. COVID-19 Update – vaccination. COVID-19 Update – administration plan and process. FMS use, visitation, experimental treatments, weekly testing plan, exposures. FMS opens, FMS staff education.</td>
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**Interventions:** Infection Control provided education routinely, upon request and during real time opportunities.

**Goal:**

PMC Escondido - Goal Met

PMC Poway – Goal Met

PMC Downtown Escondido – Goal Met

**Action Plan:**

1. Update the ready reference site on intranet for IC topics
2. Provide real time education when indicated during IP unit/department rounds
3. Provide hand hygiene education addressing non-compliance
4. Focus on Standard Precautions during 2021
5. Perform gap analysis and educational needs assessment with focus on high risk units
Reportable Diseases & Emerging Infections

Maintain compliance with Title 17, California Code of Regulations, CDPH Confidential Morbidity Reporting (CMR) Requirements. When emerging infectious diseases are occurring in the community or community at large, infection control and hospital ensure staff and facility is prepared for the detection and management of these cases. Infection Control attends a monthly meeting with County Epidemiology on current public health issues, and receive weekly and monthly reports on influenza and communicable diseases in San Diego County, respectively. Infection Control may use the information and data to identify unusual clusters in the patient population. IP’s routinely work with San Diego County Epidemiology staff, responding to requests and initiating reports.
Employee Health

Influenza Vaccination Compliance

Goal: System and facility above 90% compliance with immunization program by end of 2019-2020 influenza season.

### System summary

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<th>SYSTEM</th>
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**Summary Analysis:** Overall compliance is at the threshold of 90%. Escondido met the compliance at 90%, Poway at 91%, ARU at 96% and the Villas at Poway had a compliance rate of 95%. Home Health was below compliance at 79%. Staff awareness and participation in the program is encouraged. Mandated masking breaks the chain of transmission of those who may unknowingly be contagious. Influenza vaccination among healthcare workers was promoted through a disaster preparedness fair with the Del Lagos Senior mentorship program and during the International Infection Control Week.

Palomar Health – Goal Met

PMC Escondido – Goal Met

PMC Poway – Goal Met

PMC ARU – Goal Met

Villa Pomerado and Subacute - Goal Met

Home Health – Goal Unmet
Action Plan:

1. Focus on Influenza vaccination education during Infection Control Week 2021
2. Include education on common reasons for influenza vaccination declination
Palomar Health Staff Exposures

**Goal:** Continue to assess and mitigate exposure risk

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<th>YEAR TO DATE TOTALS</th>
<th>TB</th>
<th>Scabies</th>
<th>Pertussis</th>
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</tbody>
</table>

**Summary Analysis:** During 2020, there were 1394 exposures. The majority of which unprotected exposures to COVID contacts prior to initiation of isolation precautions. Exposures are based on the use of PPE during contact and isolation precautions initiated. Measures were put into place to identify, isolate and inform. There were no TB conversions identified.

**Goal Met:**

Palomar Health – Goal Met

First Responder Exposures

**Goal:** Comply with Ryan White Law and Senate Bill 432 exposure to bloodborne pathogens and Cal OSHA Aerosol Transmissible Disease Regulations

**Analysis:** There were 650 pre-hospital exposures for the Palomar Health system, all associated with patients confirmed with COVID-19, and a 2,995% increase from the previous year. All exposures were handled in accordance with established processes. Notification given to the appropriate Infection Control Medic contact for all potential exposures, County notification sent for confirmed exposures.

**Goal Met:**

Palomar Health – Goal Met
Summary of Infection Control Interventions

- “Identify, isolate, inform” at ED triage using electronic charting triggers for isolation orders.
- Order and charting-based triggers for isolation orders through system
- Provided staff training for PPE use, limited reuse, and extended use
  - Training provided to EVS to return to routine cleaning procedures for patients in isolation
- PPE supplies were routinely monitored by supply chain, and strategies to optimize and conserve were implemented throughout the pandemic
  - New PPE introduced in system
- Hand hygiene is routinely monitored through trained observation
• Exposure and transmission mitigation through universal [source control measure] masking of patients and staff, and staff eye protection recommendation, if patients cannot tolerate face covering while provided care
• Visitation restrictions
• Physical distancing, cancellation of in-person meetings and hospital gatherings, breakroom capacity assessments and notice
• Evolving testing capacity, turnaround time and targeting, universal testing of all admissions (varied adoption periods), evolving testing algorithms and workflows
• Maintained ‘airborne & contact’ isolation status and patient placement (in AIIR) for COVID-19, but developed de-escalation protocol for downgrading to enhanced droplet precautions (private room with standard ACH) reviewing patient clinical presentation and anticipation of aerosol-generating procedures
• Using guidance adapted from CDC, developed protocol to safely discontinue isolation precautions
• Evolving process to respond to patient and staff exposures from any sources in and out of facility, plan for standardized contact tracing, outbreak investigation and reporting
• Optimize engineering controls and modification of rooms and space to pull negative, totaling 132 negative pressure rooms between both campuses. Negative pressure is monitored routinely by facilities and nursing
• Developed process and work flow with volunteer services and supply chain to safely assemble alternative disinfectant wipes to supplement low supply of hospital-approved product.
• Executive newsletter to communicate policy or practice changes surrounding COVID-19
• Surge Tent & Field Medical Station Infection Control Preparation: Review of infection control processes and procedures, training of staff, staging of PPE, and rounding of hospital surge tent and government-launched field medical station on the 10th and 11th floor at PMC Escondido.
• Infection Control COVID-19 Rounding Aids: A team of Pathmakers were trained and tasked to supplement rounding. This was done to ensure staff and patient safety during the COVID-19 pandemic. Appropriate infection control practices and COVID-19 protocols were monitored and support was provided.
• Maintained communication with local hospitals and California Department of Public Health and local health department
• Employee vaccination and community vaccination roll out
Summary of Projects

Antibiotic Stewardship

- Performed a detailed analysis of CDI cases and presented to committee.
- Reported four quality measures of Antibiotic stewardship every meeting – achieved predetermined goals in all categories.
  - Avoidance of Antibiotics in acute bronchitis
  - Percentage of Anti-pseudomonas Beta-lactams and Anti-MRSA agents as a percentage of days present
  - CDI rates
  - Use of Post op Antibiotics in clean contaminated surgery
- Developed order sets update for Pneumonia
- Reviewed goals for 2021 at last meeting of year
- Reviewed guidelines for MDRO published by IDSA and revised practice
- Reviewed Influenza vaccine and therapy
- Revised information for medical staff orientation.
- Presented Antifungal gram
- Developed guidelines for asymptomatic bacteriuria
- Updated Antiibiogram for 2020 and sent best practice recommendations to all members of the medical staff.
- Developed COVID working task force and updated committee on best therapeutic approach and guidelines
- Tracked pharmacist interventions
- Revised guidelines for Linezolid usage and potential interactions
- Revised antibiotic power plans on Amphotericin B
- Revised Vancomycin dosing based on AUC
- MUE on Ceftaroline, Meropenem, Remdesivir
- Revised various policies and procedures
- Formulary Review

Junior Mentorship Program

As part of the Del Lagos Junior and Senior Mentorship Program, two high school students were assigned an internship with Infection Control with the following objectives:

- Understand the chain of transmission and the role of infection prevention and control
- Develop and submit an education module for all clinical staff through Palomar Health’s online employee education portal, Healthstream
- Collect, input, and analyze healthcare worker hand hygiene data at each facility and develop recommendations for unit-based interventions
• Collaborate with Administration and Marketing to develop a semi-self-sustaining IC department newsletter for Palomar Health

Unfortunately, the program was temporarily discontinued due to COVID-19 pandemic.

**Hand Hygiene Accessibility Trial**

Using 2019 hand hygiene compliance data, a unit was selected to trial increased accessibility to hand sanitizer, with the understanding that increasing accessibility and visibility of hand hygiene product would increase hand hygiene compliance. New installation points for wall dispensers was identified with the unit leaders, facilities, and EVS. The trial was suspended due to the COVID-19 pandemic’s strain on these supplies.

**Product Review**

Members of the Infection Prevention and Control team participate in the Value Improvement Process at Palomar Health. Several interventions for improving infection outcomes were approved by the VAT during 2020 as noted. The team also functions as gatekeepers for products that are reprocessed by validating that there is an infrastructure in place to properly clean and disinfect or sterilize items purchased.

**Procedure Review**

IP’s worked to update and maintain all Infection Control Procedures in Lucidoc. IC reviewed nineteen procedures and collaborated with other departments who have procedures that relate to infection control.
References

1. The Direct Medical Costs of Healthcare-Associated Infection in U.S. Hospitals and the Benefits of Prevention  R. Douglas Scott II, Economist Division of Healthcare Quality Promotion National Center for Preparedness, Detection, and Control of Infectious Diseases Coordinating Center for Infectious Diseases Centers for Disease Control and Prevention March 2009


ADDENDUM F
Palomar Home Health Services
2021 Infection Control Surveillance Plan

Palomar Home Health Services provides intermittent nursing care, physical therapy, speech therapy, occupational therapy, medical social work, and home health aides to adult and geriatric patients. The primary need must be for skilled care as ordered by a physician.

Assessing the population

Palomar Home Health Services serves patients that are newborn, adult, and geriatrics. The agency serves a large area of San Diego County and parts of Temecula area. Most of the area that is served is urban and we serve some outlying areas that are rural.

The number of unduplicated persons seen by the agency during 2020 is 4,230 patients for the certified skilled home health. A breakdown of skilled services provided shows the following based on visit volume of 63,319 visits in 2020.

Skilled nursing 46%
Physical therapy 38%
Occupational therapy 7%
Speech Pathology 2%
Social Worker 1%
Certified Home Health Aide 6%

Selecting the outcome or process for surveillance

Services provided by Palomar Home Health Services:

<table>
<thead>
<tr>
<th>Home IV Therapy</th>
<th>Personal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Infant Program</td>
<td>Patient Caregiver Education</td>
</tr>
<tr>
<td>Behavioral Health Nursing</td>
<td>Rural Health Care</td>
</tr>
<tr>
<td>Respiratory Care</td>
<td>Hourly Care</td>
</tr>
<tr>
<td>Cardiac Care</td>
<td>Intermittent Care</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>Managed Care Specialists</td>
</tr>
<tr>
<td>Wound Care</td>
<td>24-hour R.N. Availability</td>
</tr>
<tr>
<td>Diabetic Management</td>
<td>Social Workers</td>
</tr>
</tbody>
</table>

Indicators are also selected based on current science based recommendations, problems identified in the community or within the healthcare system, and results of previous indicators.
The top five admission diagnoses’ illness class for Palomar Home Health Services for 2020 is as follows:

Factors Influencing health status and contact with health services (high volume, mod risk)
Injury, poisoning and certain other consequences of external cause (high volume, mod risk)
Not available with Hemiplegia following Cerebral Infarct affecting left non dominant side and Pneumonia, unspecified organism (high volume, mod risk)
Diseases of Circulatory system (moderate volume, high risk)
Diseases of the skin and subcutaneous tissue (moderate volume, mod risk)

When selecting infection indicators we considered the following: Are there guidelines for the prevention of this infection? Are there evidence-based national guidelines? Can a change in practice decrease the risk of infection? Can the data be collected? Is there a valid comparison group?

Based on this information, analysis of the infection trends at the home health department in 2020, and the care, treatment and services provided by the home health agency, we have selected the following indicators and goals for 2020 that will be reported to the Infection Control Committee as part of our Quality Assurance and Performance Improvement Plan.

- Hand Hygiene Monitor reported quarterly based on home visits observations with the goal of 100%.
- Flu vaccination of Home Health personnel reported annually with the vaccination goal of 90%.

The following additional indicators will be tracked, audited, aggregated and monitored monthly and reported quarterly to the Infection Control Committee that show trends at the home health department.

- Urinary Tract Infection
- CAUTI – Catheter Associated Urinary Tract Infection
- Wound Infections
- Surgical Infections
- PICC line Infections
- Central Line Infections

Methicillin-resistant *Staphylococcus aureus* (MRSA) infections and Clostridium-Difficile infections will be noted and precautions will be taken in the home setting. The agency performs a risk assessment hazard scoring tool annually. The tool looks at elements at related to home health, probability of occurrence, risk/impact severity rating and preparedness, risk factor severity of effect and regulatory requirement, monitoring, mitigation & remediation activities. The hazard tool is part of this risk assessment.
Surveillance Activities & Evaluation at Infection Control Committee

- The Division of Healthcare Quality Promotion of the Center for Disease Control has not developed guidelines for infection control in home care settings.
- Association for Professional in Infection Control and Epidemiology, Inc. (APIC) has surveillance definitions for home health care infections that are utilized at the agency.
- Problem oriented surveillance is utilized in the home health department. Data is collected from the clinical staff and is reported utilizing an infection log. Any patients that show on our CMS Potentially Avoidable Events Report for development of Urinary Tract Infection and emergent care for wound infections will also be audited. All patients that have a suspected or identified infection three days or 72 hours after the start of care are analyzed through chart review. This is documented on an Infection Review form.
- Appropriate statistic techniques will be used to determine if the infection rates are higher or lower than expected. Currently utilize reported infections via log reports and microbiology reports as the numerator (site-specific type of infection). The denominator is per measured patient days as required by the Infection Control Committee.
- The infection rates are calculated monthly by site-specific rates and a quarterly and annual report is generated. Infection rates are reported to the Palomar Health Infection Control Committee per the reporting grid for Home Health.
- Definitions of infections for purposes of review have been identified for the following:
  1. Skin infections – surgical site, soft tissue, wound, decubitus ulcers, cellulitis, IV site, fungal skin, and herpes simplex or zoster infections.
  2. Urinary tract infection
  3. Primary Bloodstream Infections
  4. Respiratory infections
  5. Osteomyelitis
  6. Eye, ear, nose, mouth infections
  7. Gastrointestinal infections.

The following definitions are from APIC February 2008 article that outlines the definitions for surveillance of infections in the home care setting. All surveillance activities, including data collection and analysis, are used to identify infection prevention and to control risks pertaining to patients and families, staff, volunteers, and students. All reporting of diseases to public health are done per the Palomar Health procedure.

The home health department will be evaluated annually and will redesign the infection control interventions if necessary. The home health infection control representative presents the home health data at minimum quarterly to the committee. The committee will address any changes in the scope of the Infection Control Program, evaluate the risk assessment and analysis by department, address any emerging problems in the health care community that potentially affect the organization, address the assessment of the success or failure of interventions for preventing and controlling infection, addresses concerns raised by
leadership and others in the organization, and addresses the evolution of relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus.

**Home Health Infection Control Goals and Risk Assessment**

The home health agency sets goals to minimize the possibility of infection. A hazard risk scoring tool is provided in this risk assessment. The goals are based on prioritized risks in the home health department as well as limiting the unprotected exposure to pathogens; the spread of infections associated with procedures and the use of medical equipment, devices, and supplies.

**Focused Indicators with Goals:**

- **Enhanced hand hygiene** – Hand hygiene monitoring will be observed when clinical field staff has supervisory or competency visits in the home setting. The clinicians are observed for the appropriate compliance to hand hygiene indications and procedures. Clinicians are provided with feedback regarding performance. The agency’s goal is to be at 100% compliance. A hand hygiene monitor is filled out and outcomes are analyzed and aggregated and reported to the infection control committee. A non-home health member of the Infection Control Committee performs hand hygiene and equipment cleaning observations on a quarterly basis and reports to the committee. The 2019 hand hygiene results is 99%, with 71 home visits and 271 opportunities for hand hygiene with 2 breaks.

- **Improved compliance with seasonal flu vaccination** – The vaccines are available to all home health employees through Palomar Health to limit exposure. Palomar Health requires that employees have a flu shot sticker on their name badge when they receive the flu vaccine. If the employee refused vaccination, they must wear a mask when visiting patients in their home and when going into Palomar Health facilities where patients are present. Employee health monitors how many employees receive or decline the flu vaccine on an annual basis and report it to the infection control committee. The agency’s goal is 90% of employees to receive the vaccine. The 2020 flu vaccination rate is reported to the IC Committee by Employee Health.

- **Enhanced droplet precautions for COVID-19** - On March 13, 2020, the U.S.A. declared a Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak. On March 30, 2020, The Center for Medicare and Medical (CMS) issued Home Health Agency guidelines and flexibilities to fight COVID-19. The agency follows the Center for Disease Control (CDC) guidelines for droplet precautions. All staff wear a mask in the office during working hours. All clinical staff wear a surgical mask and gloves at all visits. Patients are asked to wear a mask during the home visit. COVID-19 positive patients are seen in the home with additional Personal Protective Equipment (PPE) of face shield, shoe coverings, full disposable gown when entering the home. COVID-19 Start of Care kits include single user blood pressure cuff and plastic stethoscope.
Infrared thermometers take temperature and are cleaned per manufacturer’s instructions. A Powered Air Purifying Respirator (PAPR) is issued to clinicians upon request. The agency’s goal is no cross contamination between patients and clinical staff. At the end of 2020, there was no evidence of cross contamination between clinicians and patients served.

Home Health staff intrinsically has an increased risk of infection due to potential exposure in the community. Palomar Health has implemented strict guidance for asymptomatic Health Care Provider (HCP) who were exposed to individuals with confirmed COVID-19. Employee Health is notified of any potential exposure and CDC Exposure Assessment Criteria is followed. Agency staff are quarantined based on the guidance. The agency recognizes that a comprehensive infection control program plays a major role in improving patient safety and quality of care. Education is provided annually and just in time that stresses adherence to hand hygiene, consistent and proper use of Personal Protective Equipment, PAPR and influenza vaccination annually. All staff are encouraged to take the COVID-19 vaccination.

**Reporting and using surveillance information**

Infection control indicator data is presented at the Infection Surveillance Committee by a home health representative utilizing a written report. A calendar reporting schedule determines when the department reports to the committee. Recommendations for practice or supply changes are made by the committee and implemented by the Home Health agency. The results of these recommended changes are reported back to the Infection Surveillance Committee, at a time specified by the Committee.

Infection Control Committee reports are submitted to the Quality Management Committee and then to the Medical Executive Committee.

**Identifying unusual infection related events**

The District Nurse Epidemiologist will be notified when actual or potential infection related events occur. If necessary, consultation with the chairman of the Infection Surveillance Committee or other committee members may be needed. Isolation or quarantine of an individual patient requires a physician’s order. When an unexpected influx of patients who require special isolation precautions occurs, the facility Disaster Plan may be activated. Patient care areas can be isolated are at Palomar Medical Center Escondido and Poway.

It is the home health agencies responsibility to provide a safe and healthful workplace. When a patient is transferred with an infection requiring monitoring, the agency informs office and clinical staff involved on the case. The office staff prescreen all patients prior to admission with COVID-19 screening questions that are on the referral form. If the agency receives a patient from another organization who has an infection requiring action and the infection was not communicated by the referring organization, the agency informs the referring
The Palomar Health system nurse epidemiologist is also notified and training is provided when indicated.

Planning for pandemic influenza is critical. The agency has taken into account that the potential exists for an infection outbreak so extensive that it overwhelms the organization’s resources. In the event of a pandemic influenza outbreak, home health agencies in the surrounding area will likely be called upon to provide care for patients who do not require hospitalization for pandemic influenza, or for who hospitalization is not an option because hospitals have reached their capacity to admit patients. The home health agency has the potential to become overburdened quickly and shortages of personnel and supplies for providing home health care may occur. The agency reserves the right not to accept patients based on its ability to care for those patients based on staffing.

As a hospital based home health agency that is a department of Palomar Health, our agency has access to the entire health system, and in the event of a pandemic, will have the availability of all of the resources of Palomar Health. The home health agency is included in the Infection Prevention and Control Risk Assessment and Surveillance Plan for Palomar Health. The infection control committee regularly updates any critical information about emerging infections that could cause an increased number of potentially infectious patients. The Disaster Plans of the home health agency and Palomar Health will be implemented in the event of a pandemic influenza outbreak as well as the Disaster Centers in San Diego County. The department monitors illness of employees and all employees at home health are highly encouraged annually through Employee Health to get the Seasonal Flu Vaccine. The home health department utilizes the Pandemic Influenza Preparedness and Response Guidelines for Healthcare Workers and Healthcare Employers prepared by the Occupational Safety and Health Administration (OSHA). Specific guidelines are available in this document that specifically addresses the home health department. The guidelines outline the common symptoms, supplies to have on hand, caring for a person with influenza, and when to seek additional medical advice. This document is in the Pandemic Response Guideline Book that resides in the Quality Manager’s office. A supply of masks, gowns, gloves, and hand washing gel are kept aside in the event of pandemic response.

In the event that a home health patient needs to be isolated the following precautions will be followed:

- Assess the suitability of the residential setting for care at home.
- Patients should be stable enough to receive care at home. Patient should not leave the home for the duration of the isolation period, except as necessary for follow-up medical care. When movement outside of the home is necessary, the patient should wear a mask, if tolerated, and should not use public transportation.
- Appropriate caregivers are available at the home.
- Separate the patient from other persons in the household to the extent possible. Use a separate room and bathroom if available.
• Limit the number of persons in the household to those who are essential for patient support. Other household members should either be relocated or minimize contact with patient in the home.
• When airborne or droplet precautions are required, home health clinicians have access to a Positive Airway Pressure Respirator (PAPR) for use during the home visit.
• Unexposed persons who do not have an essential need to be in the home should not visit.
• Towels and bedding should not be shared. Laundry may be washed in a standard washing machine with warm water and detergent; bleach may be added but is not necessary. Gloves should be worn when handling soiled laundry, and care should be use when handling soiled laundry to avoid contact of skin and/or clothing with contaminated material. Soiled laundry should not be shaken or otherwise handled in a manner that may aerosolize infectious particles.
• Objects used for eating should not be shared. Soiled dishes and eating utensils should be washed either in a dishwasher or by hand with warm soap and water. Disposable dishes and eating utensils can also be utilized and double bagged and disposed of.
• Gloves, tissues, and other waste generated in the care of a patient should be double bagged and place in another container for disposal with other household waste.
• Environmental surfaces that are frequently touched by the patient or are soiled with body fluids should be cleaned and disinfected with a household disinfectant. The bathroom used by the patient should be cleansed daily, if possible. Household utility gloves should be worn during the cleaning process.
ADDENDUM G
The Villas at Poway Skilled Nursing Facility
2021 Infection Control Surveillance Plan

I. Infection Control Plan Purpose:
   The Villas at Poway will maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection.

II. Components of the Infection Control Program
   Infection Control Committee (ICC) oversight
   The Villa at Poway QAPI committee oversight
   Procedure development and approval by ICC
   Infection Preventionist(s)
   Surveillance
   Documentation
   Monitoring
   Data analysis
   Communicable Disease Reporting
   Education
   Antibiotic Stewardship

   Responsibility for implantation of the program components:
   A. The Villas at Poway Infection Control Coordinator(s) monitor the routine implementation of the program, responds to errors, problems or other identified issues and reports findings and action planning to the Infection Control Department
   B. The Palomar Health Infection Control Department and the Infection control Committee chairperson responds to outbreak of communicable disease, episodes of infection or threat, of bio-hazard attack.

III. Authority Statement:
   The Palomar Health Infection Control Officers have the authority and responsibility for ensuring the implementation of a planned systematic process for monitoring and evaluating the equality and appropriateness of the Infection Prevention and Control Program and for acting on the results of the information. The Infection Control Committee, through its chairperson and/or designee are granted authority to institute any appropriate emergency control measures at The Villas at Poway when there is a reasonable risk or danger to any resident or personnel.
IV. **Objectives:**

Prevent, investigate, and control infection and or outbreaks. Collect and maintain records of infections. Analyze data regarding infections present on admission or infections acquired in the facility.

V. **The Villas at Poway Risk Assessment:**

<table>
<thead>
<tr>
<th>Prioritized Risk/Description</th>
<th>Summary of strategies to mitigate the risk</th>
<th>How effectiveness of Action is Evaluated</th>
<th>2021 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Geographic location Risks</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Earthquakes:</td>
<td>The Disaster committee and the Infection coordinate implementation of Disaster planning for The Villas at Poway. Recommendations are based on recommendations and mandates issued by California Public Health, San Diego Public Health, and Emergency Management Departments. PH district Corporate Health provides annual TB testing of employees.</td>
<td>Emergency preparedness drills. Disaster Committee minutes. Tuberculosis/COVID19 screening rates among patients. Annual staff TB testing.</td>
<td>Develop a method for documenting resident compliance. Goal: 100% compliance with staff and resident TB testing.</td>
</tr>
<tr>
<td>Drought</td>
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<tr>
<td>Wild Fire</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis: Proximity regions with endemic TB</td>
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<td></td>
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<tr>
<td><strong>Community</strong></td>
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<tr>
<td>Poway:</td>
<td>Cough etiquette supplies in lobby. CDC recommendations for Hand Hygiene. Resident admission TB testing. Staff annual TB testing. Isolation procedures for patients with signs and symptoms of possible infection. Personal Protective Equipment Supplies. Annual influenza vaccination program for staff and residents. Reportable Disease Process – CMR.</td>
<td>Influenza vaccination rates (staff and residents). TB testing (staff and residents). Hand Hygiene compliance rates. Annual Summary Report.</td>
<td>100% of residents will be screened for influenza vaccination and TB testing requirements. 100% of staff will participate in influenza program. Increase vaccine rate from previous year.</td>
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<tr>
<td>Rancho Bernardo</td>
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<tr>
<td>Population: 47,811 Area: 39.1 sq miles Median age: 37.5</td>
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### Programs and Services

The Villas at Poway is a 129 bed skilled nursing facility, located next to and affiliated with Pomerado Hospital. The Villas at Poway, offers a continuum of care for a variety of adult patients with post-acute, orthopedic, trauma, deconditioning, and long-term needs; rehabilitation, antibiotic administration, respite and hospice care. All services are provided in a home-like atmosphere.

<table>
<thead>
<tr>
<th>Prioritized Risk/Description</th>
<th>Summary of strategies to mitigate the risk</th>
<th>How effectiveness of Action is Evaluated</th>
<th>2021 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Representatives of IPPC Hand Hygiene recommendations (CDC)</td>
<td>ICC Minutes</td>
<td>Increase hand hygiene before entering room compliance by 5% by quarter 2 and 10% by quarter 4</td>
</tr>
<tr>
<td></td>
<td>Annual Infection Control Staff Education</td>
<td>IC Program Annual summary</td>
<td>Decrease CAUTI by 10%</td>
</tr>
<tr>
<td></td>
<td>CDPH Enhanced Standard Precautions</td>
<td>Hand Hygiene rates</td>
<td>Explore use of NHSN in 2019 with new software</td>
</tr>
<tr>
<td></td>
<td>Personal Protective Equipment (PPE) provision</td>
<td>Multi Drug Resistant Organisms (MDRO) process measures</td>
<td>New EMR software to aid in antibiotic utilization. Focus on decreasing antibiotic use for asymptomatic bacteriuria.</td>
</tr>
<tr>
<td></td>
<td>Routine assessment of patients with indwelling urinary and central venous catheters for necessity</td>
<td>PPE compliance</td>
<td>Develop process for identifying inappropriate antibiotic use.</td>
</tr>
<tr>
<td></td>
<td>Transmission based precautions when indicated</td>
<td>NHSN</td>
<td></td>
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<tr>
<td></td>
<td>Catheters Associated Urinary Tract Infection (CAUTI) bundle</td>
<td>CAUTI bundle and infection rates</td>
<td></td>
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<tr>
<td></td>
<td>Routine Infection Control</td>
<td>UTI rates</td>
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<td></td>
<td>Environmental rounding</td>
<td>MDRO Lab ID rates</td>
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<tr>
<td></td>
<td>Antibiotic Stewardship Program</td>
<td>Sentact Reports</td>
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<tr>
<td></td>
<td>Environmental Services Sanitation Measures</td>
<td>Antibiotic utilization</td>
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<td></td>
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<td>EVS schedules</td>
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</tbody>
</table>

### Special Populations Served

The facility also has a sub-acute unit for patients whose complex needs cannot be met in an acute hospital or in a community skilled nursing facility.

<table>
<thead>
<tr>
<th>Prioritized Risk/Description</th>
<th>Summary of strategies to mitigate the risk</th>
<th>How effectiveness of Action is Evaluated</th>
<th>2021 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Representatives of ICC Hand Hygiene recommendations (CDC)</td>
<td>ICC minutes</td>
<td>CAUTI bundle implemented and audited in 2019</td>
</tr>
<tr>
<td></td>
<td>Ventilator Associated Pneumonia (VAP) bundle</td>
<td>Hand Hygiene (HH) compliance NHSN</td>
<td>VAP bundle implemented and audited in 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MDRO process measures</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>PPE compliance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHSN</td>
<td></td>
</tr>
<tr>
<td>Patients with Multi-drug Resistant Organisms (MDRO’s)</td>
<td>Routine assessment of residents for necessity of indwelling urinary and central venous catheters</td>
<td>VAP bundle and infection rates CLABSI rates CAUTI bundle and infection rates UTI rates MDRO Lab ID rates Antibiotic utilization data</td>
<td></td>
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</tr>
<tr>
<td><strong>Prioritized Risk/Description</strong></td>
<td><strong>Summary of strategies to mitigate the risk</strong></td>
<td><strong>How effectiveness of Action is Evaluated</strong></td>
<td></td>
</tr>
<tr>
<td><strong>High Risk Residents</strong></td>
<td></td>
<td>2021 Goal</td>
<td></td>
</tr>
<tr>
<td>Individual Factors:</td>
<td>Observe Standard Precautions at all times</td>
<td>McGeer’s criteria reports: UTI, CAUTI, CLABSI rates MDRO rates Surgical Site Infection (SSI) reports</td>
<td></td>
</tr>
<tr>
<td>Immune compromised residents receiving corticosteroids, chemotherapy, impaired responses to infection, declining liver and kidney function</td>
<td>No signage needed</td>
<td>Continue to utilize McGeer Criteria and explore NSHN utilization for UTI and MDRO data collection</td>
<td></td>
</tr>
<tr>
<td>Residents with invasive devices. Decreased or absent cough reflex, thinning skin, decreased tear production vascular insufficiency, coexisting chronic disease (DM, cancer arthritis, COPD, anemia)</td>
<td>No one who is ill should enter the resident’s room Clean fresh fruit and vegetables No flowers or plants Special Environments are not necessary</td>
<td>Compare McGeer’s and Loeb’s Criteria for the 2019 year for significant differences.</td>
<td></td>
</tr>
<tr>
<td>Post-surgical resident</td>
<td>Assess routinely for necessity of the device: Ventilator – readiness to wean Foley – still meets criteria for insertion Central Venous Catheter – still indicated</td>
<td>Ventilator Days data Central Line Days data Urinary Catheter Days data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daily personal hygiene Assess the wound for redness, pain, tenderness, and drainage</td>
<td></td>
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<td></td>
<td>McGeer’s and Loeb’s Criteria use Report changes indicative of infection Report Surgical Site Infections to Pomerado IP and throughout the resident’s stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prioritized Risk/Description</td>
<td>Summary of strategies to mitigate the risk</td>
<td>How effectiveness of Action is Evaluated</td>
<td>2021 Goal</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td><strong>Frequently Occurring and Commonly Occurring Infections</strong></td>
<td>Following recognized Infection Control practices&lt;br&gt;McGeer’s Criteria&lt;br&gt;Loeb’s Criteria&lt;br&gt;Recognizing and managing infections at the time of admission</td>
<td>Surveillance Data and Action Planning Reports</td>
<td>Utilize McGeer’s Criteria&lt;br&gt;Utilize Loeb’s Criteria</td>
</tr>
<tr>
<td>Conjunctivitis&lt;br&gt;Gastroenteritis&lt;br&gt;Influenza&lt;br&gt;Urinary Tract Infection&lt;br&gt;Respiratory Infection&lt;br&gt;Skin and Soft Tissue Infection</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Epidemiology:</strong></td>
<td>Routine review Clinical Microbiology Report&lt;br&gt;McGeer’s Criteria use&lt;br&gt;Loeb’s Criteria use&lt;br&gt;California Confidential Morbidity Reporting (CA CMR)&lt;br&gt;Antibiotic Utilization&lt;br&gt;Enhanced Standard Precautions&lt;br&gt;Transmission Based Precautions as indicated&lt;br&gt;Outbreak Investigation procedures&lt;br&gt;NHSN MDRO Lab ID participation&lt;br&gt;Hand Hygiene and PPE compliance monitoring</td>
<td>ICC minutes&lt;br&gt;Antibiotic Utilization Reports&lt;br&gt;Outbreaks investigation documents&lt;br&gt;NHSN MDRO data report&lt;br&gt;Surveillance reports&lt;br&gt;Hand Hygiene and PPE compliance data</td>
<td>Annual</td>
</tr>
<tr>
<td>MDRO’s&lt;br&gt;Norovirus&lt;br&gt;Influenza&lt;br&gt;Mycobacterium tuberculosis&lt;br&gt;Microbiological trends&lt;br&gt;Clinically significant organisms including but not limited to: Group A Streptococcus&lt;br&gt;Aspergillus&lt;br&gt;Legionella&lt;br&gt;Coronavirus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unprotected exposure to pathogens:</strong></td>
<td>Staff education (initial and annual)&lt;br&gt;Proper CDC recommended hand hygiene&lt;br&gt;Proper food handling&lt;br&gt;Staff presenting with symptoms of communicable illness including: infected skin lesions, are prohibited from direct resident contact, or contact with resident food.&lt;br&gt;Enhanced Standard Precautions&lt;br&gt;Transmission Based Precautions&lt;br&gt;Aerosol Transmissible Disease Control</td>
<td>ICC Corporate Health reports&lt;br&gt;Staff education records&lt;br&gt;Hand hygiene rates&lt;br&gt;FANS Rounds&lt;br&gt;Occupational Health reports&lt;br&gt;TB testing rates of staff and patients&lt;br&gt;Influenza vaccination rates (staff and residents)</td>
<td>Early identification of Risk for Exposure</td>
</tr>
<tr>
<td>Prioritized Risk/Description</td>
<td>Summary of strategies to mitigate the risk</td>
<td>How effectiveness of Action is Evaluated</td>
<td>2021 Goal</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------</td>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>Communication:</td>
<td>IC reporting to The Villas at Poway</td>
<td>QAPI minutes</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>QAPI Committee</td>
<td>ICC minutes</td>
<td></td>
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<tr>
<td></td>
<td>24 hour Infection Control coverage</td>
<td>Sentact Reports</td>
<td></td>
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<td></td>
<td>Lucidoc procedures – online</td>
<td>Employee education records</td>
<td></td>
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<td></td>
<td>Palomar Health Intranet</td>
<td></td>
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<td></td>
<td>Printed and video materials</td>
<td></td>
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<tr>
<td></td>
<td>Cough etiquette posters</td>
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<tr>
<td></td>
<td>Live inservice education</td>
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<td></td>
<td>Computer based education</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>IC seminars</td>
<td></td>
<td></td>
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<td></td>
<td>New employee orientation process</td>
<td></td>
<td></td>
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<td></td>
<td>IC environmental rounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutional Factors:</td>
<td>Infection Control Risk Assessment (ICRA)</td>
<td>ICRA</td>
<td>All construction jobs will have an ICRA</td>
</tr>
<tr>
<td></td>
<td>Contractors and staff education</td>
<td>ICC minutes</td>
<td></td>
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<tr>
<td></td>
<td>Construction/renovation site rounds</td>
<td>Facilities reports</td>
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<td></td>
<td>Competency verification badges for</td>
<td>EVS reports</td>
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<tr>
<td></td>
<td>contractors</td>
<td>Sentact reports</td>
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<td></td>
<td>Influenza vaccination for contracted</td>
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<tr>
<td></td>
<td>services</td>
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<tr>
<td></td>
<td>Environmental cleaning schedules</td>
<td></td>
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<tr>
<td></td>
<td>EVS staff competencies</td>
<td></td>
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<tr>
<td></td>
<td>Environmental Sanitation measures</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>include high touch surfaces</td>
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<tr>
<td></td>
<td>Dressings and supplies are properly</td>
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<tr>
<td></td>
<td>stored</td>
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</tr>
</tbody>
</table>

TB control plan
Cough etiquette program
Visitation procedures
PPE storage and availability
Pneumococcal immunization
Annual mandatory influenza vaccination program
Immunity verification
Patient education

Prioritized Risk/Description

Summary of strategies to mitigate the risk

How effectiveness of Action is Evaluated

2021 Goal

Communication:

IC reporting to The Villas at Poway QAPI Committee
24 hour Infection Control coverage
Lucidoc procedures – online
Palomar Health Intranet
Printed and video materials
Cough etiquette posters
Live inservice education
Computer based education
IC seminars
New employee orientation process
IC environmental rounds

Institutional Factors:

Building maintenance, renovation, and construction.
Water intrusion
Environmental Sanitation – handrails
Common air circulation
Direct and indirect contact staff or visitors/other residents
Transferring residents to and from hospitals or other settings

Infection Control Risk Assessment (ICRA)
Contractors and staff education
Construction/renovation site rounds
Competency verification badges for contractors
Influenza vaccination for contracted services
Environmental cleaning schedules
EVS staff competencies
Environmental Sanitation measures include high touch surfaces
Dressings and supplies are properly stored

ICRA
ICC minutes
Facilities reports
EVS reports
Sentact reports

All construction jobs will have an ICRA
### Equipment and Devices:

**Risk of exposure to pathogens and infection due to contaminated medical equipment, devices, supplies, or environmental surfaces.**

- Spaulding Classification – standard definition for devices which come into contact with skin (non-critical); mucous membranes (semi-critical); or sterile body sites (critical)
- Single use devices are disposed of after use and never used for more than one resident
- EVS Infection Control Procedure
- EPA approved ICC approved disinfectants are used
- EVS cleaning observation audits
- Equipment cleaning procedure
- Routine Environmental Rounds
- Physical separation of clean and dirty equipment.
- Germicide wipes education – wet contact time
- Use of Bleach impregnated wipes for equipment or surfaces that may be contaminate with *C. difficile*
- Glucometer decontamination procedures
- Single use lancets

<table>
<thead>
<tr>
<th>Prioritized Risk/Description</th>
<th>Summary of strategies to mitigate the risk</th>
<th>How effectiveness of Action is Evaluated</th>
<th>2021 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Linen Handling:</strong></td>
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<tr>
<td>Linen handling shall meet regulatory mandates</td>
<td>Resident linens are process by a professional laundry facility. Linen facilities are evaluated initially by Palomar Health Infection Preventionists. Temperatures are validated during these visits. The Villas at Poway staff handle, stores, and transports linens so as to prevent the spread of infection</td>
<td>Linen facility inspection records Sentact Reports</td>
<td>Annual site visit by IC</td>
</tr>
</tbody>
</table>
Contaminated linens are handled using Standard Precautions, no additional labeling is needed

Emergency Preparedness

COVID19
Natural occurring events:
Earthquakes and fires are the top priority followed by an epidemic.
Human related event:
Mass casualty (medical or infectious)
Boil water alerts
Drought advisory

Consultant to the Disaster Committee
Staff education for PPE use
Influx of infectious patients procedures
Triaging patients
Erecting isolation barriers
Appropriate PPE available
Annual Hazard Vulnerability Analysis
Follow FDA recommendations for drinking water
Disaster plan
IC procedures
Disaster drills
Supply chain collaboration

Disaster Committee minutes
QAPI Committee minutes
ICC minutes
Drill findings

IC attendance on committee

2020 Significant Events:

1. December 2020 COVID19 Outbreak

VI. Sureillance Plan The Villas at Poway Skilled Nursing Facility

The Surveillance Plan is ongoing and includes systematic collection, analysis, interpretation, and dissemination of data to identify infections and infection risks, to try to reduce morbidity and mortality and to improve resident health status. Surveillance is used to improve processes and outcomes through corrective actions.

A. VACCINATION COMPLIANCE

- □ Pneumococcal – Residents
- □ Influenza
  - o Staff
  - o Residents
- □ COVID19
  - o Staff
  - o Residents
B. TB SCREENING COMPLIANCE
   □ Admitted residents screened for TB (# of screened residents/# of resident admissions)

C. RESPIRATORY TRACT INFECTIONS (RTIs)
   □ Common Cold Syndromes/Pharyngitis
   □ Influenza – Like Illness
   □ Pneumonia (no ventilator)
   □ Pneumonia (ventilator)
   □ Lower Respiratory Tract (bronchitis/tracheobronchitis)
   □ COVID19

D. URINARY TRACT INFECTIONS (UTIs) – NHSN
   □ Resident WITHOUT indwelling urinary catheter
   □ Resident WITH indwelling urinary catheter (excludes suprapubic, urostomy, and intermittent catheters)

E. SKIN, SOFT TISSUE AND MUCOSAL INFECTIONS
   □ Cellulitis, soft tissue or wound infection (including surgical site infection)
   □ Scabies
   □ Herpesvirus skin infection
      ○ Herpes simplex infection
      ○ Herpes zoster infection

F. GASTROINTESTINAL (GI) TRACT INFECTIONS
   □ Gastroenteritis
   □ Norovirus gastroenteritis
   □ Clostridium difficile infection

G. LABORATORY-CONFIRMED BLOODSTREAM INFECTION (LCBI) WITH AND WITHOUT CENTRAL VENOUS CATHETER
   □ LCBI 1
   □ LCBI 2

H. LABORATORY IDENTIFIED MULTI-DRUG RESISTANT ORGANISMS – NHSN
   □ Staphylococcus aureus, methicillin- resistant (MRSA)
   □ Vancomycin-Resistant Enterococcus spp. (VRE)
   □ Carbapenem-Resistant Klebsiella spp. (CRE)
   □ Carbapenem-Resistant E. coli (CRE-E.coli)
   □ Multidrug-Resistant Acinetobacter spp (MDR-Acinetobacter)
I. **CLINICALLY SIGNIFICANT MICROORGANISMS**
   - Influenza
   - Acid Fast Bacilli (AFB)
   - *Streptococcus pneumoniae*
   - *Parainfluenza*
   - *Respiratory Syncytial Virus (RSV)*
   - *Chlamydia pneumonia*
   - *Aspergillus*
   - Group A *Streptococcus* infection
   - *Viral hepatitis*
   - *Legionella*
   - *Coronavirus*

J. **NUMBERATOR DATA COLLECTION – PER MONTH**
   - Daily Microbiology Reports
   - Pharmacy Drug Usage Reports
   - Physician Orders
   - Nursing reports and documentation
   - Resident Record Review

K. **DENOMINATOR DATA COLLECTION – PER MONTH**
   - Total Residents Days
   - Total Resident Admissions
   - Central Line Days
   - Foley Catheter Days
   - Ventilator Days (Subacute Unit)

L. **CALCULATING AND ANALYZING INFECTION RATES**
   - McGeer’s Criteria met - # site-specific infection/total resident days x 1000
   - Bloodstream Infection (BSI) in residents with central venous catheters (CVC) - #BSI/#CVC days x1000
   - BSI in residents without central venous catheter - # BSI in residents without CVC/# residents days - # CVC days x 1000
   - Urinary Tract Infection (UTI) in residents with urinary catheters (excluding straight, suprapubic, and condom catheters) – UTI/#urinary catheters days x 1000
   - UTI in residents without urinary catheters - # UTI/#resident days – urinary catheter days x 1000
   - Skilled Nursing – Pneumonia in residents without ventilators - # pneumonia/# residents days x 1000
   - Subacute Unit – Pneumonia in residents with ventilators - # pneumonia/# residents days x 1000
Subacute Unit – Pneumonia in residents without ventilator - 
# pneumonia/#resident days - # ventilator days x 1000

MDRO LabID NHSN reporting calculated by the Centers for Disease Control’s National Healthcare Safety Network (CDC NHSN)

M. **CALCULATING ANTIBIOTIC USE**

- Specific types of antibiotics used and:
  - # of doses or
  - # of treatment days or
  - Costs
- When possible link this data with MDRO LabID data

---

**References:**

**Centers for Disease Control Tuberculosis demographics:**

**Centers for Medicare and Medicaid Services**
483.65 Infection Control Tag (F441)

**SHEA Position Paper Antimicrobial Use in Long-Term Care Facilities**
Lindsay E. Nicolle, MD; David W. Bentley, MD; Richard Garibaldi, MD; Ellen G. Neuhaus, MD; Philip W. Smith, MD; the SHEA Long-Term Care Committee

**Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria**
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836
ADDENDUM H
Trauma Service Annual Report
Presented to Board Quality Review Committee

Melinda Case, RN, MSN – Manager of Trauma Program
John Steele, MD – Medical Director of Trauma

April 2021
## Trauma Services

| **SITUATION** | Trauma Services is tracking progress towards successful re-verification of Level II Trauma Program which was scheduled for May 2021. Due to the pandemic and ongoing effects of COVID-19; the ACS and San Diego County have adjusted reviews to extend through another year. All Trauma Centers in San Diego County will undergo virtual site surveys in the year 2022. Palomar Medical Center-Escondido is on track for a virtual site survey in May of 2022. The index year of data for this upcoming review will be 2021. In particular, February 1, 2021 through January 31, 2022. |
| **BACKGROUND** | The Palomar Medical Center Trauma Program is subject to an annual review as reflected in the San Diego EMS County Trauma agreement; the ACS-COT has recently changed from an on-site 2-day review of the trauma program, to a virtual process; now scheduled for May of 2022. |
| **ASSESSMENT** | Palomar Trauma Service continues to assess, monitor, and evaluate for any ACS Criteria Deficiencies. The Trauma Program monitors, collects data, and evaluates over 250 data points and audit filters mandated by the ACS-COT and the San Diego Trauma/EMS System. Annually, the Trauma Program reviews and strategizes to focus on the top 3-4 audits that currently demonstrate opportunities for improvement and meet the criterion for a Level II Trauma Center. |
| **RECOMMENDATION** | Trauma continues to monitor audits that were considered opportunities in our 2018 ACS Review and our internal concurrent review process to meet the current ACS criteria put forth in the upcoming 2021 version of the Resources for Optimal Care of the Injured Patient by the Committee on Trauma-American College of Surgeons. |
Palomar Trauma Services

- Trauma continues to monitor audits that were considered opportunities in 2018 ACS Review & our internal concurrent review audit process:
  - Days to trach in severe TBI
  - CAGE audits
  - Time to antibiotics in open fractures
  - Review of MTP in trauma
  - Ortho & Neuro time to consult

- Days to trach average: 7.5
- CAGE Audits:

- All audit filters are monitored currently and retrospectively for fallouts with action plans implemented to address particulars
  - Discussed in Peer Review; individual practitioners and units/departments as needed

- All cases requiring review are presented at monthly Trauma Committee Peer Review; cases requiring specialty input are forwarded to the appropriate medical peer review committee and the overall Hospital Quality Committee

PASSION. PEOPLE. PURPOSE.
Overall Trauma Volume Statistics

**2020 Activation Levels**

- Full Activations
- Partial Activations
- Trauma Consults

**2019 & 2020 Trauma Level of Care Admissions Comparisons**

**2019 & 2020 Trauma Patient Volume Comparisons**
Total 2019: 1696 2020: 1626

**2020 Blunt vs Penetrating Injuries by Percentage**
Average Penetrating Injury is 8%
Days to Tracheostomy in Severe TBI

CY 2020 Days to Trach

Target Days to Trach
Average
Days to Trach

Days to Trach

# of Trachs

Trach 1 Trach 2 Trach 3 Trach 4 Trach 5 Trach 6 Trach 7 Trach 8 Trach 9 Trach 10 Trach 11

Days to Trach

0 2 4 6 8 10 12 14

Trach 1 Trach 2 Trach 3 Trach 4 Trach 5 Trach 6 Trach 7 Trach 8 Trach 9 Trach 10 Trach 11

# of Trachs
CAGE Audit

CY 2020 CAGE Audit

% of CAGE completed

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec 2020

Benchmark

100% 90% 94% 95% 95% 95% 91% 90% 92% 93% 83% 57%
Time to Antibiotics in Open Fractures

CY 2020 Counts of Open Fractures with Time to ABX Administration

- Time to ABX
- 1 Hour Benchmark
- Average

# of Open Fractures, n = 74
Massive Transfusion Protocol

CY 2020 MTP Initiated with RBC:FFP Ratio

<table>
<thead>
<tr>
<th>MTP Count</th>
<th>Ratio</th>
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<tbody>
<tr>
<td>1</td>
<td>1.50</td>
</tr>
<tr>
<td>2</td>
<td>1.00</td>
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<tr>
<td>3</td>
<td>1.00</td>
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<tr>
<td>10</td>
<td>1.00</td>
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<tr>
<td>11</td>
<td>2.00</td>
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</table>

RBC:FFP Ratio

Average

Std Dev
Ongoing Neurosurgical & Orthopedic Consult Times

**CY 2020 Orthopedic Arrival Times**
Documented n = 393
- Yes: 63%
- No: 37%

**CY 2020 Neurosurgeon Arrival Times**
Documented n = 529
- Yes: 63%
- No: 37%
Action Plan with Timeline

- All Trauma Centers in San Diego County will undergo virtual site surveys in the year 2022. Palomar Medical Center-Escondido is on track for a virtual site survey in May of 2022.
- Each week, trauma services reviews all the above outliers and any other trauma audit outlier. This year, these are the focus for our American College of Surgeon-Committee on Trauma index year.
- All cases with outliers without an identified rationale are reviewed at the monthly Trauma Peer Review Committee and discussed with both the multi-disciplined trauma team members and individual practitioner. Cases requiring further review are sent to the overall Medical Peer Review
ADDENDUM I
The Joint Commission Disease Specific Stroke Program Annual Report

Presentation to Board Quality Review Committee
April 2021

Lourdes Januszewicz MSN APRN ACNS-BC SCRN CCRN
Jasmina Namenyi, MSN, APRN, ACCNS-AG, CDE
Remia Paduga, MD, Medical Director
Valerie Martinez, Sr. Director Quality RN, BSN, MHA, CIC, CPHQ, NEA-BC
# District Stroke Program

<table>
<thead>
<tr>
<th><strong>Situation</strong></th>
<th>PMC Escondido and PMC Poway Annual Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>Annual Report provides an overview of the success and opportunities for the Stroke Program at Palomar Health. To maintain certification as an Advanced Primary Stroke Center the following metrics are monitored for compliance and improvement.</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>Overall, the Stroke Program continues to show improvement with the Joint Commission Metrics. As a result of the focus for Stroke Care, the outcomes for those treated with Alteplase and/or Neuro Endovascular therapy shows success.</td>
</tr>
</tbody>
</table>
| **Recommendation** | 1. 2020: Full implementation of Target Stroke Phase 3 Goals  
   a. Alteplase administration within 60 min 85% of the time  
2. 2020: Improving metrics for Neuro Endovascular Program  
   a. Door to Groin Puncture within 90 min 50% of the time— Direct  
   b. Door to Groin Puncture within 60 min 50% of the time - Transfers  
3. 2020: Launch Tele Neurology  
4. 2020: PMC Poway Stroke Transfer Process Grid  
5. 2020: Business Plan for Joint Commission Thrombectomy Capable Stroke Certification for PMC Escondido |
Program Overview

• Established the program in 2008.
• First certified in 2009
• PMC Poway Primary Stroke Certification (PSC) Recertification:
  – Window opens 4/10/2021 through 7/10/2021
• PMC Escondido Thrombectomy Capable Stroke Certification
  – Application submitted and accepted by JC
Total Volume of Stroke
(Acute Ischemic Stroke and Hemorrhagic Stroke)

COVID 19 Pandemic
Palomar Health Program Status: Volume

Total Volume of Transient Ischemic Attacks (TIA)

COVID 19 Pandemic

<table>
<thead>
<tr>
<th>Year</th>
<th>PMC Escondido TIA</th>
<th>PMC Poway TIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>237</td>
<td>77</td>
</tr>
<tr>
<td>2014</td>
<td>273</td>
<td>68</td>
</tr>
<tr>
<td>2015</td>
<td>274</td>
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<td>2016</td>
<td>261</td>
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<td>2017</td>
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<td>2018</td>
<td>225</td>
<td>64</td>
</tr>
<tr>
<td>2019</td>
<td>237</td>
<td>65</td>
</tr>
<tr>
<td>2020</td>
<td>232</td>
<td>43</td>
</tr>
</tbody>
</table>
Palomar Health Program Status: Alteplase

Total Number of Patients receiving tPA (Tissue Plasminogen Activator)

- PMC Escondido
- PMC Poway

Years: Program Start to Present

COVID 19 Pandemic
Palomar Health Program Status: Neuro IR

Mechanical Endovascular Revascularization 2018-2020

- Total Cases
- PMC Escondido Cases
- PMC Poway Cases
Palomar Health: Outcomes Alteplase (tPA) 2020

Palomar Health Discharge Disposition
Patients treated with Alteplase 2020
n = 94

- Home/HH: 53%
- Home/Facility with Hospice: 6%
- Acute Rehab: 13%
- SNF Rehab: 20%
- Tx Acute Care: 2%
- Expired: 6%
Palomar Health: Outcomes Neuro IR 2020

Palomar Health Discharge Disposition
Neuro IR Thrombectomy 2020
n = 55

- Home/HH: 27%
- Home with Hospice: 5%
- Acute Rehab: 11%
- SNF Rehab: 24%
- Acute Care Tx: 2%
- Expired: 31%
Palomar Health Joint Commission Metrics

Joint Commission Cycle May 2019 – April 2021: 56/71 = 79%

Alteplase % Compliance ≤ 60 min 50% of the time
PMC Escondido 2019-2021

50% 67% 67% 67% 71% 71% 71% 80% 80% 100% 100% 100%
Palomar Health Joint Commission Metrics

Alteplase % Compliance ≤ 60 min 50% of the time
PMC Poway: 2019-2021

Joint Commission Cycle May 2019 – April 2021: 19/22 = 86%
### Palomar Health Joint Commission Metrics

#### Performance Improvement PMC Escondido:

**Door to Provider < 10 Minutes**
- 2016 MED: 7 minutes
- 2017 MED: 5 minutes
- 2018 MED: 4 minutes
- 2019 MED: 4 minutes
- **2020 MED: 5 minutes**

**Door to CT Begin < 25 Minutes (Goal: 15 minutes)**
- 2016 MED: 21 minutes
- 2017 MED: 11 minutes
- 2018 MED: 13 minutes
- 2019 MED: 12 minutes
- **2020 MED: 13 minutes**

**Door to CT Results < 45 Minutes (Goal: 30 minutes)**
- 2016 MED: 31 minutes
- 2017 MED: 24 minutes
- 2018 MED: 26 minutes
- 2019 MED: 25 minutes
- **2020 MED: 28 minutes**

*COVID 19 Pandemic
Palomar Health Joint Commission Metrics

Performance Improvement PMC Poway:
**Door to Provider < 10 Minutes**
- 2016 MED: 6 minutes
- 2017 MED: 5 minutes
- 2018 MED: 3 minutes
- 2019 MED: 3 minutes
- **2020 MED: 3.5 minutes***

Performance Improvement PMC Poway:
**Door to CT Begin < 25 Minutes (Goal: 15 minutes)**
- 2016 MED: 17 minutes
- 2017 MED: 17 minutes
- 2018 MED: 13 minutes
- 2019 MED: 15 minutes
- **2020 MED: 14 minutes***

Performance Improvement PMC Poway:
**Door to CT Results < 45 Minutes (Goal: 30 minutes)**
- 2016 MED: 30 minutes
- 2017 MED: 29 minutes
- 2018 MED: 24 minutes
- 2019 MED: 27 minutes
- **2020 MED: 26.5 minutes***

*COVID 19 Pandemic
2020 Door to Groin (DTG) Puncture Trend

2020 D2P Average Min: 120  2020 D2P Median Min: 119

Target Stroke Phase 3 Goal: ≤ 90 minutes - Direct; ≤ 60 minutes Transfers

PMC Escondido DTG ≤ 90 min 50% of the time = < 50% at present time
PMC Poway DTG ≤ 60 min 50% of the time = 10/10 cases = 100%
Palomar Health:  
2020 Performance Improvement Project Summary

**PI Initiatives: affected by COVID-19**

- TeleStroke Consultation for Neurology – Stroke Codes  
  – Go-live April 2020
- Poway Stroke Code Transfer Process Grid  
  – Go-Live August 2020
- 24 Hour Stroke Code Activation  
  – Go-Live December 2020*
- IR Brain Alert for Emergency Brain Thrombectomy  
  – Go-Live December 2020*
- Updated ED Stroke Related Powerplans  
  – Go-Live December 2020*
- Business Plan for Thrombectomy Capable Stroke Center Certification  
  – Presented and accepted Executive Committee October 2020*

*Delayed due to COVID 19 Pandemic*
Palomar Health PI Project: PMC Poway Transfers

Jan 2020 – July 2020 Stroke Activations Requiring Transfer

2020 PMCP Door In - Door Out Transfer Times - Pre Stroke Transfer Process Go-Live

- All Stroke n=36: Average Minutes 218, Median Minutes 186
- tPA Only n=15: Average Minutes 231, Median Minutes 206
- tPA & IR Candidate n=4: Average Minutes 95, Median Minutes 92
- IR Candidate Only n=3: Average Minutes 105, Median Minutes 89
- Hemorrhagic Stroke n=10: Average Minutes 211, Median Minutes 190
- Insurance Purposes n=4: Average Minutes 0, Median Minutes 0

Door in - Door Out Metric ≤ 120 minutes
Palomar Health PI Project: PMC Poway Transfers

Aug 2020 – Dec 2020 Stroke Activations Requiring Transfer

2020 PMCP Door In - Door Out Transfer Times - Post Stroke Transfer Process Go-Live

<table>
<thead>
<tr>
<th>Category</th>
<th>Average Minutes</th>
<th>Median Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Stroke n=35</td>
<td>247</td>
<td>206</td>
</tr>
<tr>
<td>tPA Only Tx to PMCE n=2</td>
<td>125</td>
<td>125</td>
</tr>
<tr>
<td>tPA Only Tx to Other facility n=1</td>
<td>274</td>
<td>274</td>
</tr>
<tr>
<td>tPA &amp; IR Candidate n=2</td>
<td>141</td>
<td>141</td>
</tr>
<tr>
<td>IR Candidate Only n=3</td>
<td>95</td>
<td>84</td>
</tr>
<tr>
<td>Hemorrhagic Stroke PMCE n=4</td>
<td>95</td>
<td>101</td>
</tr>
<tr>
<td>Hemorrhagic Stroke tx other facility n=2</td>
<td>201</td>
<td>201</td>
</tr>
<tr>
<td>Insurance Purposes n=18</td>
<td>324</td>
<td>206</td>
</tr>
<tr>
<td>Other n=4</td>
<td>275</td>
<td>255</td>
</tr>
</tbody>
</table>

Door In - Door Out Metric ≤ 120 minutes

Key Cases: Improved Transfer times
Palomar Health:

2021 Performance Improvement Initiatives

**PI Initiatives:**

- Inpatient Stroke Powerplans: currently in approval process with MEC
  - IT Build in progress & Go-live TBD
- Joint Commission Thrombectomy Capable Stroke Certification
  - Application submitted January 2021
  - Request for JC Survey Review August 2021
- Joint Commission PSC Recertification PMC Poway
  - Window for Review: April 10 2021 – July 10 2021
- Neuro Interventional Radiology PI for Stroke
  - Monitor improvements with Door to Groin times with addition of 2nd Stroke Alert
    - Door to Groin times ≤ 90 minutes 50% of the time for Direct
    - Door to Groin times ≤ 60 minutes 50% of the time for Transfers
- Stroke Handbook – Patient Education
  - In final review with Patient Family Advisory Committee; will be available in English and Spanish
  - Distribution Goal 2nd quarter 2021
- Community Education-work with Marketing for different venue to present classes
Questions
ADDENDUM J
Infection Prevention and Control Annual Report

Hospital-Associated Infections

Presented to Board Quality Review Committee

Valerie Martinez RN, BSN, MHA, CIC, CPHQ, NEA-BC
Senior Director of Quality/Patient Safety/Infection Prevention

Sandeep Soni MD, CIC
Medical Director Infection Control

April 2021
<table>
<thead>
<tr>
<th><strong>SITUATION</strong></th>
<th>Surveillance of hospital-associated infections (HAI) part of The Joint Commission's Annual National Patient Safety Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND</strong></td>
<td>HAIs associated with central lines, urinary catheters, mechanical ventilation, multi-drug resistant organisms (MDRO), and SSI expressed as a standardized infection ratio (SIR), which is the number of observed infections divided by predicted infections</td>
</tr>
</tbody>
</table>
| **ASSESSMENT** | • **PMC Escondido:** CAUTI=24, SIR>1; CLABSI=13, SIR>1; IVAC Plus=23, SIR>1; HO-CDI=17, SIR<1; MRSA BSI=3, SIR<1; SSI=33, SIR<1  
• **PMC Poway:** CAUTI=1, SIR<1; CLABSI=1, SIR<1; IVAC Plus=6, SIR>1; HO-CDI=3, SIR<1; MRSA BSI=1, SIR<1; SSI=8, SIR<1 |
| **RECOMMENDATION** | • Continue to assess device necessity and appropriate removal  
• Review pericare training and technique among RN and CNA. Finalize updated nurse-driven removal protocol  
• Explore moving towards day of week to change of dressing. Encourage providers to use midlines instead of PICCs.  
• Ongoing focus on VAP bundle and weaning protocols, workgroup.  
• Assess and address challenges with COVID-19 co-infections. |
Infection Control Cycle

**Plan**
- Reinforce prevention measures and bundles with nurses and physicians
- Review risks for cases with stakeholders to identify opportunities for improvement

**Act**
- Collaborate with Learning and development for reinforcement of prevention measures
- Collaborate with nursing and other patient care staff to identify risk factors and provide education as indicated

**Do**
- HAIs and bundle data
- Evidenced-based interventions
- Community standards
- CDC recommendations

**Study**
- HAI outcome and process surveillance
- Report HAI to stakeholders for input and parallel review
- Monitor bundles
**Summary:** PMC Escondido had a total of 13 CLABSIIs in 2020. The 2020 SIR is 1.264 and above threshold. Twelve cases occurred greater than 7 days from when the central line was inserted. Documented CHG bathing among cases was only 57%. Eight of 13 cases were PICCs. Nine of 13 cases were within the ICU. Central line indication compliance among cases was 72%. The 7-day dressing change compliance among cases was 82%. Out of 13 CLABSI, 12 were tested for COVID-19 and 5 were positive.
Summary: PMC Poway had a total of 1 CLABSI in 2020. The SIR 2020 is 0.803 and below threshold.
Summary: PMC Escondido had a total of 24 CAUTIs in 2020. The 2020 SIR is 1.051 and slightly above threshold. Among 24 CAUTIs in 2020, 14 occurred greater than 7 days from when the foley was inserted. *E. coli* and other gut flora was isolated in more than half of the cases; however, pericare was documented in all cases. Twelve of 24 cases were within the ICU (TICU 2/CCU 10). Out of 24 CAUTI, 19 were tested for COVID-19 and 5 were positive.
CAUTI SIR  PMC Poway

Summary: PMC Poway had a total of 1 CAUTI in 2020. The SIR 2020 is 0.292 and below threshold.
Summary: Escondido and Poway had a total of 29 IVAC/VAPs in 2020. Both their SIRs are above threshold. 4SW had 5 IVACs and 4 VAPs. 5W has 12 IVACs and 2 VAPs.

- All measures of VAP bundle has improved throughout the year at both campuses
- 12 of 28 cases were tested for COVID-19 and were positive.
- Ongoing focus on VAP bundle weaning protocols – formation of workgroup.
Summary: PMC Poway had a total of 6 IVAC/VAPs in 2020. The 2020 SIR is 3.285 and above threshold. Four out of 6 tested were COVID-19 positive.
CDI SIR  PMC Escondido

Summary: PMC Escondido had a total of 17 HO-CDIs in 2020. The 2020 SIR is 0.458 and below threshold.
Summary: PMC Poway had a total of 3 HO-CDIs in 2020. The 2020 SIR is 0.402 and below threshold.
Summary: PMC Escondido had a total of 3 MRSA BSIs in 2020. The 2020 SIR is 0.781 and below threshold.
Summary: PMC Poway had a total of 1 MRSA BSIs in 2020. The 2020 SIR is 0.900 and below threshold.
Summary: PMC Escondido had a total of 33 SSIs in 2020. The 2020 SIR is 0.648 and below threshold.
Summary: PMC Poway had a total of 8 SSIs in 2020. The 2020 SIR is 0.652 and below threshold.
Action Plan with Timeline

1. **CAUTI:** Review pericare training and technique among RN and CNA. Finalize new nurse-driven removal protocol, and education. Assess and address challenges with COVID-19 co-infections. Charge RN report to better monitor unit devices and real-time practices.

2. **CLABSI:** Explore moving towards day of week to change dressing. Encourage providers to use midlines instead of PICCs. Assess and address challenges with COVID-19 co-infections. By April 2021. Develop and perform audits of appropriate dressing changes. Charge RN report to better monitor unit devices and real-time practices.

3. **IVAC Plus:** Ongoing focus on VAP bundle weaning protocols – formation of workgroup to standardize process to assess readiness to extubate. Assess and address challenges with COVID-19 co-infections.

4. **CDI:** Continue antimicrobial stewardship program. Continue to monitor and report inappropriate stool collection events - and provide education and resources.

5. **MRSA BSI:** Continue to monitor. Explored annual IC education requirements to include deep-dive of standard precautions for all staff.

6. **SSI:** Reported compliance data for pre-operative IC measures to periop SSI reduction taskforces. Continue to review SSI case trends with surgeons and periop leaders. Summarize actions completed by other working groups (e.g. Orthopedic COE, diabetes, Antimicrobial Stewardship).
ADDENDUM K
Regulatory Update
Presented to Board Quality Review Committee

Jami Piearson, RN, MSN, MBA
Manager of Regulatory

Tricia Kassab, EdD., RN, FACHE, CPHQ, HACP
Vice President Quality/Patient Safety

April 2021
### Situation

Ongoing Survey Readiness

### Background

**Palomar Health:**
- **Pending:** General Acute Care licensing Palomar Poway
- **Pending:** Joint Commission Infusion Specialty Pharmacy at Escondido
- **Audits:** Were performed to ensure compliance with standards for Joint Commission, Center for Medicare Services and California Department of Public Health

### Assessment

**Escondido:**
- Chart audits for Joint Commission and CDPH concluded November 2020
- Based on influx of COVID patients chart audits were not done for the month of January and February 2021
- Chart Audits resumed March 2021. Data to be presented to leaders April 2021
- PI team in place for IPOCs with ongoing education to ensure compliance
- ER chart audits initiated October 2020. Compliance for November and December for completing them not achieved at 30 cases. Focus on ED triage. Resumed March 2021

**Poway:**
- Chart audits for Joint Commission and CDPH concluded April 2020
- Ongoing chart audits initiated May 2020
- Based on influx of COVID patients chart audits were not done for the month of January and February 2021
- Chart Audits resumed March 2021. Data to be presented to leaders April 2021
- ER chart audits initiated October 2020. Compliance for November and December for completing them not achieved at 30 cases. Focus on ED triage. Resumed March 2021

### Recommendation

- O₂ sensor documentation per policy / RNs documentation inconsistency noted. Nursing to review April data for noted improvements. Pending further education until next set of data
- Incentive Spirometer documentation for patients with an order for Incentive Spirometer/following surgery documentation per shift remains inconsistent. Modified chart audit for only those patients with IS order and monitor for compliance initiated March 2021
# PMC Escondido Summary 2020

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2020 Compliance</th>
<th>Expected Goal Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Tube output</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>Medication orders followed</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>Titration follow MD order</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>Family /others notified as requested/Pt</td>
<td>96%</td>
<td>90%</td>
</tr>
<tr>
<td>Temperature documented/vital signs</td>
<td>97%</td>
<td>90%</td>
</tr>
<tr>
<td>Care plan updated</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Incentive spirometer documented use per standards</td>
<td>76%</td>
<td>90%</td>
</tr>
<tr>
<td>Care plan individualized</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Pain meds followed per MD order</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>SAS documented/ICU</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>O2 sensor rotated per policy</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>O2 sensor documented per policy</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Was the O2 sensor location documented</td>
<td>80%</td>
<td>90%</td>
</tr>
</tbody>
</table>
# PMC Poway Summary 2020

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2020 Compliance</th>
<th>Expected Goal Compliance</th>
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<tbody>
<tr>
<td>Anesthesia</td>
<td>81%</td>
<td>90%</td>
</tr>
<tr>
<td>ED</td>
<td>77%</td>
<td>90%</td>
</tr>
<tr>
<td>Chart audit/acute care</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Chart audit/mother/baby</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Chart audit /Operating Room</td>
<td>97%</td>
<td>90%</td>
</tr>
<tr>
<td>Operating room / interventional radiology / cath lab observation</td>
<td>97%</td>
<td>90%</td>
</tr>
<tr>
<td>Pre-op/PACU</td>
<td>96%</td>
<td>90%</td>
</tr>
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</table>
## Palomar Health Policy Update

<table>
<thead>
<tr>
<th>Total Clinical Documents</th>
<th>Reviews Current</th>
<th>Reviews Due</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,077</td>
<td>2,077</td>
<td>206</td>
<td>90%</td>
</tr>
<tr>
<td>Excludes Laboratory</td>
<td></td>
<td>Completed within the Accreditation Manager</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Standardized Procedures</th>
<th>Reviews Current</th>
<th>Reviews Due</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Non-Clinical Documents</th>
<th>Reviews Current</th>
<th>Reviews Due</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>428( current ) up-to-date</td>
<td>95</td>
<td></td>
<td>82%</td>
</tr>
<tr>
<td>Excludes HR</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Palomar Health Regulatory Goals 2021**

- Continue with audits for 6 consecutive months to ensure compliance overall compliance of 90%....Monthly results to leaders
- Enabling clinicians to collaborate, lead, in chart review to ensure all aspects of patient care are documented
- **CHANGE;** is another important aspect of regulatory strategy. If a process is not working encourage flexibility and resiliency into clinical documentation plans and establish multidisciplinary teams to organize response by clinicians.
- By engaging all stakeholders – including front-line workers – in the process, regulatory rounding with nursing and other leaders
- Encourage the next level of compliance, which includes adopting policies and practices directed at protecting patients, staff and physicians....Build the framework within Policies and Procedures
- Regulatory to ensure new standards disseminated as needed and work with other teams to ensure process in place
- Ongoing successful licensing as needed