

QUALITY REVIEW COMMITTEE

MEETING AGENDA

Wednesday, May 28, 2025
3:00pm

Please see page 2 for meeting location

	<i>The Board may take action on any of the items listed below, including items specifically labeled "Informational Only"</i>	Time	Form A Page	Target
Call To Order				3:00
1.	Establishment of Quorum	1		3:01
2.	Public Comments¹	30		3:31
3.	Action Item(s) (ADD A)	15		3:46
	a. Board Quality Review Committee Meeting Minutes – March 26, 2025 (Pp 6-11)			
	b. Approval of Contracted Services			
	i. BD Carefusion IV Prep Workflow (Pp 12)			
	ii. Corticare Monitoring (Pp 13)			
	iii. Image First Linen (Pp 14)			
	iv. Pharmerica @ The Villas (Pp 15)			
	v. Linde Portable Medical Gas (Pp 16)			
	vi. Premier Laser Services (Pp 17-18)			
4.	Annual Reports – Informational Only (ADD B)	15		4:01
	a. Antibiotic Stewardship Summary (Pp 20-40)			
	b. Infection Prevention and Control (Pp 41-86)			
	c. Radiology & Nuclear Medicine (Pp 87-95)			
	d. Respiratory Services (Pp 96-101)			
	e. Stroke Program (Pp 102-112)			
5.	Adjournment to Closed Session	1		4:02
	<i>Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee</i>	10		4:12
6.	Adjournment to Open Session	1		4:13
7.	Action Resulting from Closed Session	1		4:14
Final Adjournment		1		4:15

Voting Membership	Non-Voting Membership
Linda Greer, RN, Chair	Diane Hansen, CPA, President/Chief Executive Officer
Terry Corrales, RN	Omar Khawaja, MD, Chief Medical Officer
Abbi Jahaaski, MSN, BSN, RN	Andrew Tokar, Chief Financial Officer
Andrew Nguyen, MD, PhD – Chief of Staff-Elect Palomar Medical Center Escondido	Melvin Russell, RN, MSN, Chief Nurse Executive/Chief Operating Officer
Paul Ritchie, MD – Chief of Staff-Elect Palomar Medical Center Poway	Kevin DeBruin, Esq., Chief Legal Officer
	Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director Quality and Patient Safety, Infection Prevention
Laurie Edwards Tate, MS –1st Alternate	

Note: If you need special assistance to participate in the meeting,
please call 760.740.6375, 72 hours prior to the meeting so that we may provide reasonable accommodations.

¹ 3 minutes allowed per speaker. For further details, see Request for Public Comment Process and Policy on page 3 of the agenda.



Board Quality Review Committee Location Options

Linda Greer Board Room

2125 Citracado Parkway, Suite 300, Escondido, CA 92029

- Elected Members of the Palomar Health Board of Directors will attend at this location, unless otherwise noticed below
- Other non-Board member attendees, and members of the public may also attend at this location

<https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting?rtc=1>

Meeting ID: 288 627 823 177

Passcode: De2hx3s3

or

Dial in using your phone at 929.352.2216; Access Code: 871 963 771# ¹

- Non-Board member attendees, and members of the public may also attend the meeting virtually utilizing the above link

¹ New to Microsoft Teams? Get the app now and be ready when your first meeting starts: [Download Teams](#)

DocID: 21790
Revision: 9
Status: Official

Source:
Administrative
Board of Directors

Applies to Facilities:
All Palomar Health Facilities

Applies to Departments:
Board of Directors

Policy: Public Comments and Attendance at Public Board Meetings

I. PURPOSE:

A. It is the intention of the Palomar Health Board of Directors to hear public comment about any topic that is under its jurisdiction. This policy is intended to provide guidelines in the interest of conducting orderly, open public meetings while ensuring that the public is afforded ample opportunity to attend and to address the board at any meetings of the whole board or board committees.

II. DEFINITIONS:

A. None defined.

III. TEXT / STANDARDS OF PRACTICE:

- A. There will be one-time period allotted for public comment at the start of the public meeting. Should the chair determine that further public comment is required during a public meeting, the chair can call for such additional public comment immediately prior to the adjournment of the public meeting. Members of the public who wish to address the Board are asked to complete a [Request for Public Comment form](#) and submit to the Board Assistant prior to or during the meeting. The information requested shall be limited to name, address, phone number and subject, however, the requesting public member shall submit the requested information voluntarily. It will not be a condition of speaking.
- B. Should Board action be requested, it is encouraged that the public requestor include the request on the *Request for Public Comment* as well. Any member of the public who is speaking is encouraged to submit written copies of the presentation.
- C. The subject matter of any speaker must be germane to Palomar Health's jurisdiction.
- D. Based solely on the number of speaking requests, the Board will set the time allowed for each speaker prior to the public sections of the meeting, but usually will not exceed 3 minutes per speaker, with a cumulative total of thirty minutes.
- E. Questions or comments will be entertained during the "Public Comments" section on the agenda. All public comments will be limited to the designated times, including at all board meetings, committee meetings and board workshops.
- F. All voting and non-voting members of a Board committee will be seated at the table. Name placards will be created as placeholders for those seats for Board members, committee members, staff, and scribes. Any other attendees, staff or public, are welcome to sit at seats that do not have name placards, as well as on any other chairs in the room. For Palomar Health Board meetings, members of the public will sit in a seating area designated for the public.
- G. In the event of a disturbance that is sufficient to impede the proceedings, all persons may be excluded with the exception of newspaper personnel who were not involved in the disturbance in question.
- H. The public shall be afforded those rights listed below (Government Code Section 54953 and 54954).
 - 1. To receive appropriate notice of meetings;
 - 2. To attend with no pre-conditions to attendance;
 - 3. To testify within reasonable limits prior to ordering consideration of the subject in question;
 - 4. To know the result of any ballots cast;
 - 5. To broadcast or record proceedings (conditional on lack of disruption to meeting);
 - 6. To review recordings of meetings within thirty days of recording; minutes to be Board approved before release,
 - 7. To publicly criticize Palomar Health or the Board; and
 - 8. To review without delay agendas of all public meetings and any other writings distributed at the meeting. I. This policy will be reviewed and updated as required or at least every three years.

(REFERENCED BY [Public Comment Form](#))

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/dgc-gw.pl?ref=pphealth:21790\\$9](https://www.lucidoc.com/cgi/dgc-gw.pl?ref=pphealth:21790$9).

BOARD QUALITY REVIEW COMMITTEE

Meeting will begin at 3:00 p.m.



Request for Public Comments

If you would like to make a public comment, submit your request by doing the following:

- **In Person: Submit a Public Comment Form, or verbally submit a request, to the Board Clerk**
- **Virtual: Enter your name and “Public Comment” in the chat function**

Those who submit a request will be called on during the Public Comments section and given 3 minutes to speak.

Public Comments Process

Pursuant to the Brown Act, the Board of Directors can only take action on items listed on the posted agenda. To ensure comments from the public can be made, there is a 30 minute public comments period at the beginning of the meeting. Each speaker who has requested to make a comment is granted three (3) minutes to speak. The public comment period is an opportunity to address the Board of Directors on agenda items or items of general interest within the subject matter jurisdiction of Palomar Health.

ADDENDUM A

Board Quality Review Committee Minutes – Wednesday, March 26, 2025

AGENDA ITEM

CONCLUSION/ACTION

FOLLOW UP/RESPONSIBLE PARTY

FINAL?

DISCUSSION

NOTICE OF MEETING

Notice of Meeting was posted at the Palomar Health Administrative Office at 2125 Citracado Parkway, Suite 300, Escondido, CA 92029, as well as on the Palomar Health website, on Friday, March 21, 2025, which is consistent with legal requirements.

CALL TO ORDER

The meeting, which was held in the Palomar Health Administrative Office at 2125 Citracado Parkway, Suite 300, Escondido, CA. 92029, and virtually, was called to order at 3:01 p.m. by Committee Chair Linda Greer.

1. ESTABLISHMENT OF QUORUM

- Quorum comprised of: Director Greer, Nguyen, MD and Ritchie, MD
- Excused Absences: Directors Corrales, and Jahaaski

2. PUBLIC COMMENTS

- None

3. ACTION ITEMS

a. Minutes: Board Quality Review Committee Meeting – November 27, 2024

MOTION by Ritchie, MD, 2nd by Nguyen, MD, to approve the November 27, 2024, Board Quality Review Committee meeting minutes as written.

Roll call voting utilized.
Director Corrales – absent
Director Greer – aye
Director Jahaaski - absent
Nguyen, MD – aye
Ritchie, MD - aye

Three in favor. None opposed. Two absent. None abstain
Motion approved

Discussion:

- No discussion

b. 2025 Board Quality Review Committee Meeting Calendar

MOTION by Ritchie, MD, 2nd by Nguyen, MD, to approve 2025 Board Quality Review Committee Meeting Calendar

Roll call voting utilized.
Director Corrales – absent
Director Greer – aye
Director Jahaaski - absent
Nguyen, MD – aye
Ritchie, MD - aye

Three in favor. None opposed. Two absent. None abstain
Motion approved

Discussion:

- No discussion

<p>c. Board Quality Review Committee Charter</p>	<p>MOTION by Nguyen, MD, 2nd by Ritchie, MD, to approve Board Quality Review Committee Charter</p> <p>Roll call voting utilized. Director Corrales – absent Director Greer – aye Director Jahaaski - absent Nguyen, MD – aye Ritchie, MD - aye</p> <p>Three in favor. None opposed. Two absent. None abstain Motion approved</p>		
<p>Discussion:</p> <ul style="list-style-type: none"> No discussion 			
<p>d. 2025 Board Quality Review Committee Reporting Calendar</p>	<p>MOTION by Ritchie, MD, 2nd by Director Greer to approve 2025 Board Quality Review Committee Reporting Calendar</p> <p>Roll call voting utilized. Director Corrales – absent Director Greer – aye Director Jahaaski - absent Nguyen, MD – aye Ritchie, MD - aye</p> <p>Three in favor. None opposed. Two absent. None abstain Motion approved</p>		
<p>Discussion:</p> <ul style="list-style-type: none"> No discussion 			

<p>e. Approval of Contracted Services</p> <ul style="list-style-type: none"> i. ARUP Reference Laboratory ii. Agiliti iii. San Diego Blood Bank iv. San Diego Urology Mobile Services 	<p>MOTION by Nguyen, MD, 2nd by Ritchie, MD, to approve agenda items 3, e, i-iv.</p> <p>Roll call voting utilized. Director Corrales – absent Director Greer – aye Director Jahaaski - absent Nguyen, MD – aye Ritchie, MD - aye</p> <p>Three in favor. None opposed. Two absent. None abstain Motion approved</p>		
<p>Discussion:</p> <ul style="list-style-type: none"> • Any and all questions by Committee Members were satisfied. 			
<p>4. Annual Reports – Informational Only</p>			

<ul style="list-style-type: none"> a. Emergency Medicine b. Trauma Program c. Rehabilitation and Wound Care Services 	Informational Only		
Discussion: <ul style="list-style-type: none"> All questions by Committee Members were satisfied. 			
5. Adjournment to Closed Session			
<i>Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee</i>			
6. Adjournment to Open Session			
7. Action Resulting from Closed Session			
FINAL ADJOURNMENT			
Meeting adjourned by Committee Chair Linda Greer at 3:28 p.m.			

Signatures:

Committee Chair

Linda Greer, RN

Committee Assistant

Carla Albright

DRAFT

**Palomar Health
Review of Contract Service**

Name of Service: ____BD Carefusion IV Prep _____

Date of Review: _May 2025_____ **Name / Title of Reviewer:** Donna Gelios Director of Pharmacy Services

Nature of Service (describe): _____

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	Met	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	Met	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.		Did Not Meet
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.		Did Not Meet
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	Met	

Performance Metrics

METRIC	_1_ QTR	_2_ QTR	_3_ QTR	_4_ QTR	Cumulative Total
BD IV Workflow	Did Not Meet	Did Not Meet	Discontinued	Discontinued	Did Not Meet

Comments: Due to numerous medication/fluid shortages, the specific gravity component of workflow made system unusable approximately 50% of the time as each medication/fluid has a unique specific gravity.

Conclusion (check one)

Contract service has met expectations for the review period

- ❑ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply:

Monitoring and oversight of the contract service has been increased

Training and consultation has been provided to the contract service

The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care

Penalties or other remedies have been applied to the contract entity

- ❑ The contractual agreement has been terminated without disruption in the continuity of patient care
❑ Other: Discontinuing use and moving to another system.

Corticare Inc.
Review of Contract Service

Name of Service: CortiCare Monitoring Service

Date of Review: 5/15/25 **Name / Title of Reviewer:** Meghan Jaremczuk Director, Progressive & Acute Care

Nature of Service (describe): Continuous Monitoring of EMU patients for seizure activity replacement

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	x	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	x	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	x	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	x	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	x	

Performance Metrics

METRIC	<u>1</u> QTR	<u>2</u> QTR	<u>3</u> QTR	<u>4</u> QTR	Cumulative Total
Continuous Remote monitoring of EMU	100%	100%	100%	100%	100%
Timely notification for any seizure event lasting more than 5 minutes	100%	100%	100%	100%	100%

Comments

Without contracted service we would have to increase the FTE for the EEG department to meet continuous monitoring of the EMU patients.

Conclusion (check one)

☒ **Contract service has met expectations for the review period**

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply:

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: _____

**Palomar Health
Review of Contract Service**

Name of Service: ImageFirst – Linen Management Program / Scrub Management Program

Date of Review: 5/20/2025

Name / Title of Reviewer: Ryan Fearn-Gomez, Vice President of Operations

Nature of Service (describe): Clean linen delivery/Provides for hospital scrubs, picks up and processes soiled linen.

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	X	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	X	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	X	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	X	

Performance Metrics

METRIC	1 st QTR FY 2025	2 nd QTR FY 2025	3 rd QTR FY 2025	4 th QTR FY 2025	Cumulative Total
Percentage of pieces ordered versus percentage of pieces delivered.	MET – 90%	MET – 95%	MET – 95%	MET -100%	95%
Components of Plant Tour Checklist (e.g. Soiled Linen Processing; Clean Linen Processing and/or Sanitization; Pack Room, In-service Programs). If deficiencies are found, Emerald had 30 days to correct deficiencies.	Not MET – 75%	MET – 95%	MET – 95%	MET -95%	90%
Quarterly Scrub Inventory / Replenishment	Not MET – 80%	Not MET – 85%	MET - 95%	MET – 100%	90%

Comments:

We are approaching the end of our first year with ImageFirst as our linen and scrub provider. Throughout this period, they have proven to be a dependable and collaborative partner. Their team has been responsive, solution-oriented, and consistently engaged in supporting our operational needs. Overall, the service has been strong, and the partnership has added value to our organization.

Conclusion (check one)

X - Contract service has met overall expectations for the review period.

- ☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply):
- ☐ Monitoring and oversight of the contract service has been increased
 - ☐ Training and consultation has been provided to the contract service
 - ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
 - ☐ Penalties or other remedies have been applied to the contract entity
 - ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
 - ☐ Other: _____

**Palomar Health
Review of Contract Service**

Name of Service: ___Pharmerica_____

Date of Review: ___May 2025_____ **Name / Title of Reviewer:** Donna Gelios Director of Pharmacy Services

Nature of Service (describe): ___Annual Review_____

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	Met	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	Met	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	Met	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	Met	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	Met	

Performance Metrics

METRIC	___1___ QTR	___2___ QTR	___3___ QTR	___4___ QTR	Cumulative Total
Medication Delivery	90-100%	90-100%	90-100%	90-100%	90-100%
Reporting to P&T	100%	100%	100%	100%	100%
Patient Medication Safety Evaluation	100%	100%	100%	100%	100%

Comments: Medications unavailable from Pharmerica are provided by Palomar Medical Center Poway.

Conclusion (check one)

- ☒ Contract service has met expectations for the review period

Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply:

Monitoring and oversight of the contract service has been increased
 Training and consultation has been provided to the contract service
 The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
 Penalties or other remedies have been applied to the contract entity
 The contractual agreement has been terminated without disruption in the continuity of patient care
 Other:

**Palomar Health
Review of Contract Service**

Name of Service: Linde Gas & Equipment

Date of Review: 5/20/2025 **Name / Title of Reviewer:** Krysti Johnson

Nature of Service (describe): Portable medical gas delivery

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	X	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	X	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	X	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	X	

Performance Metrics

METRIC	_1_ QTR	_2_ QTR	_3_ QTR	_4_ QTR	Cumulative Total
Responsiveness to emergency request for additional O2	100%	100%	100%	100%	100%
Anticipates increase demand for O2	100%	95%	100%	100%	98%
Cleanliness in service units	100%	100%	100%	100%	100%

Comments

Linde (formally PraxAir) continues be valuable partner in providing Palomar Health with a consistent source/supply of portable O2 cylinders.

Conclusion (check one)

☒ **Contract service has met expectations for the review period**

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply:

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: _____

**Premier Laser Services, Inc.
Review of Contract Service**

Name of Service: Premier Laser Services, Inc.

Date of Review: May 15, 2025

Name / Title of Reviewer: Bruce R Grendell
MPH, BSN, RN, Sr. Director, District
Perioperative Services, Palomar Health

Nature of Service (describe): Surgical laser rental services used in the treatment of kidney stones and urological conditions to treat the prostate, Types of lasers and associated peripherals that can be rented include the Holmium laser. Thulium laser, Aloka Ultrasound, Shockpulse, Cyberwand, and KTP laser.

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	√	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	√	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	√	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	√	
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.	√	

Performance Metrics Met and Not Met

METRIC	CY23 Q1	CY23 Q2	CY23 Q3	CY23 Q4	Cumulative Total
Equipment is clean and in good working order	100%	100%	100%	100%	100%
Laser Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%

No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%

Comments: No unusual occurrences documented or communicated by the provider utilizing this contracted purchased service during the contract service evaluation period.

Conclusion (check one)

- ☒ Met Contract service has met expectations for the review period
- ☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:
- ☐ Monitoring and oversight of the contract service has been increased
 - ☐ Training and consultation has been provided to the contract service
 - ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
 - ☐ Penalties or other remedies have been applied to the contract entity
 - ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
 - ☐ Other:

ADDENDUM B

Antimicrobial Stewardship Summary

Presented to Board Quality Review Committee

May 28th, 2025

Sandeep Soni, MD, Chair

Travis Lau, PharmD, BCIDP, Co-Chair

Rachel Lee, PharmD, PGY-2 ID Resident

Antimicrobial Stewardship Program (ASP) - Biannual Report

SITUATION	ASP is essential to ensure antimicrobials are judiciously prescribed so patients receive the most effective antibiotic for the shortest time to improve morbidity and mortality. ASP is required by joint commission and CDPH.
BACKGROUND	Antimicrobial resistance is designated as a major threat by the CDC. Loss of effective antimicrobials will drastically impact medical care and cost. CDC recognizes that one of the biggest threats in the hospital is overuse of carbapenems leading to carbapenem resistant organisms. Another big threat is development of hospital acquired CDI. ASP has been documented to be an effective strategy in minimizing the development of resistance ensuring best care for patients with infectious diseases. All hospitals are required to have an infectious diseases physician and pharmacist to lead ASP. ASP is required to report to the highest level of the organization.
ASSESSMENT	Antimicrobial use, resistance rates, and key quality improvement processes are submitted for review. In summary, antimicrobial usage remains stable based off the standardized antibiotic administration ratio (SAAR). Comparative hospital CDI rates and summary pharmacy antimicrobial interventions are presented.
RECOMMENDATION	The ASP team is monitoring and reviewing appropriate usage of anti-MRSA antibiotics and overall antimicrobial durations. ASP team is continuing to implement OVP to assist in maintaining the CDI goal. ASP interventions remain high and appropriate relative to the previous year. These interventions are estimated to result in significant hospital cost savings. The ASP team will continue focus on these goals for 2025.

ASP – Antimicrobial Stewardship Program; CDI – *Clostridioides difficile* infection; CDPH - California Department of Public Health; OVP – Oral Vancomycin Prophylaxis
 JCAHO - Joint Commission on Accreditation of Healthcare Organizations; QIP – Quality Incentive Pool; CDC – Centers of Disease Control and Prevention

The Threat of Antibiotic Resistance

The Threat of Antibiotic Resistance in the United States

Antibiotic resistance—when germs (bacteria, fungi) develop the ability to defeat the antibiotics designed to kill them—is one of the greatest global health challenges of modern time.

New National Estimate*

Each year, antibiotic-resistant bacteria and fungi cause at least an estimated:



2,868,700
infections



35,900 deaths



*Clostridioides difficile*** is related to antibiotic use and antibiotic resistance:



223,900
cases



12,800 deaths

What is driving the rise in multidrug-resistant superbugs?

The more antibiotics are used, the less effective they become. Unnecessary and inappropriate use accelerates that process.



1 in 3

antibiotic prescriptions written in doctors' offices, emergency rooms, and hospital-based clinics are **unnecessary**—this equals about **47 million prescriptions** each year.

52%



only about half of patients treated with antibiotics for common infections received the recommended antibiotic based on established prescribing guidelines.

The Challenge of Antimicrobial Use in the Era of increasing Antimicrobial Resistance and Cost

- Balance between providing the most effective therapy for individual patients and the overuse of antimicrobials causing ADEs and resistance
- Two most effective tools
 - Best practice in empiric use of antibiotics and rapid diagnostics to ensure rapid effective therapy
 - Effective methods to safely de-escalate antibiotics and limit unnecessary antimicrobial exposure and cost

ADE – Adverse Drug Event

Antimicrobial Stewardship at Palomar

- Mandated by CDPH and JCAHO in all hospitals since 2018. Meeting new standards established in 2023 are now a condition of Medicare participation.
- Effectively and efficiently treating infectious diseases along with control of cost of antimicrobial are a major part of overall provision of care.
- ASP is involved in improvement in key infectious diseases indicators (clostridium difficile rates and surgical site infections) to retrieve full Medi-Cal funds via the QIP program. Meeting these indicators are worth over \$1,000,000.

ASP – Antimicrobial Stewardship Program; CDPH - California Department of Public Health; JCAHO - Joint Commission on Accreditation of Healthcare Organizations;
QIP – Quality Incentive Pool

Palomar Health's ID Team

Mission Infectious Diseases

- Sandeep Soni, MD
- Roger Bitar, MD, MPH
- Jeannette Aldous, MD
- Sarah Ettinger, MD
- Taliha Yasin, MD

Burke Infectious Diseases

- Hayden Burke, MD

Pharmacy

- Travis Lau, PharmD, BCIDP, ID Pharmacist
- Rachel Lee, PharmD, PGY-2 Resident

CDPH ASP Gold Honor Roll Status

- Palomar Health received Gold Status on CDPH's ASP Honor Roll
- Combined designation for both Escondido and Poway
- Designation from 2024-2027



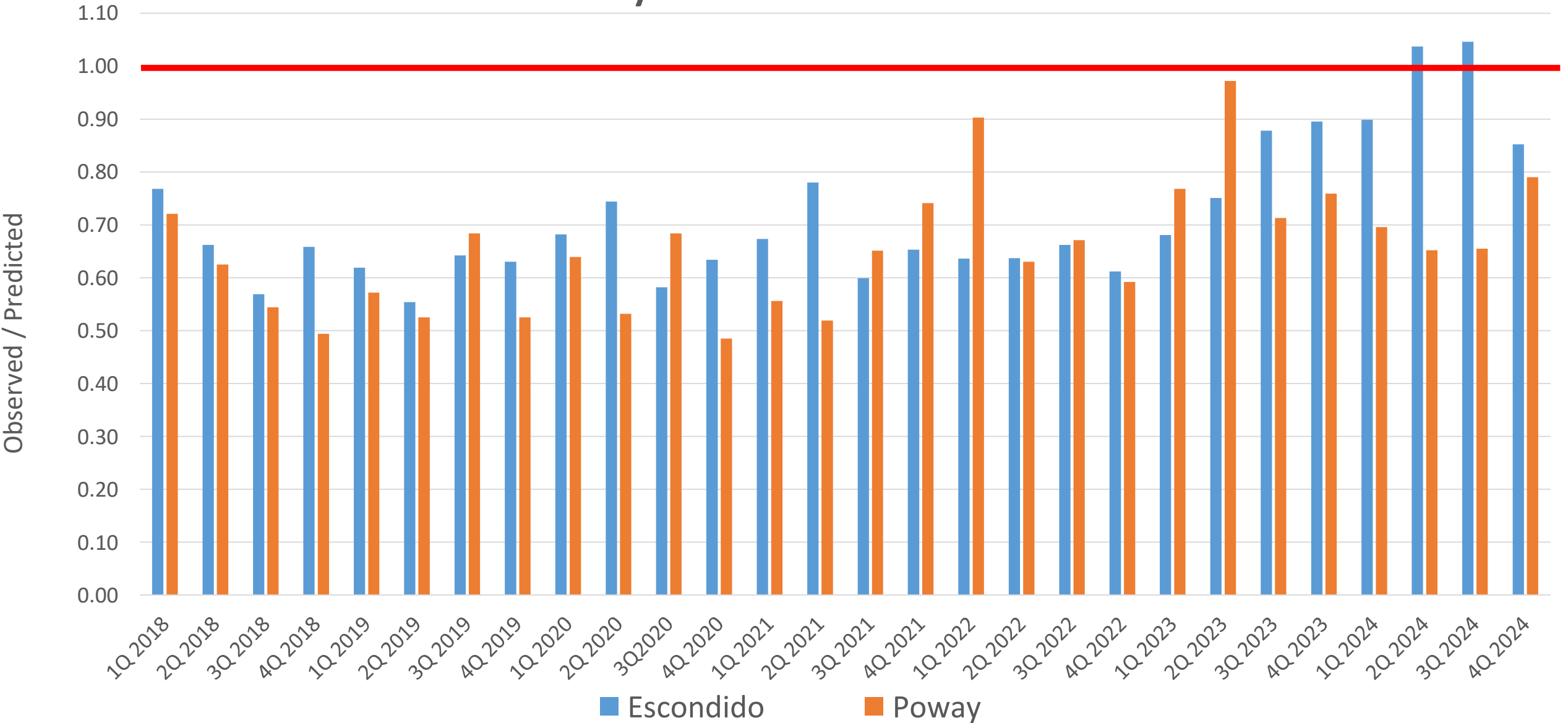
ASP Accomplishments and Goals

2023- 2024 (Completed)	2025 (To Be Completed)
Achieved PGY-2 Infectious Disease Reaccreditation (designated now through 2027 (8/2023))	<i>Staphylococcus aureus</i> Bacteremia Treatment Bundle
CDPH ASP Honor Roll Gold at Poway and Escondido Campus through 2027 (2024)	Submit NHSN Antibiotics Resistance Module data and review and determine best practice
Submit Monthly NHSN Antibiotic Usage and Resistance Module (2024)	Optimize Oral Vancomycin Prophylaxis Criteria Further to Decrease Hospital Acquired CDI Rates
Optimize implementation of oral vancomycin prophylaxis (1/2023)	Optimizing linezolid usage for pneumonias and SSTIs
Meet QIP standard CDI (1/2025)	MRSA nasal screen usage in SSTIs
Review and Respond to CDC Health Alerts on Infectious Diseases (1/2025)	Achieve QIP Goals for CDI and SSI for 2025
Surveyed Best Practice for Preoperative Antibiotic Prophylaxis Administration and Timing (1/2025)	Partnering with CDPH in improving prescribing in treatment of UTIs in nursing homes with emphasis at Villas at Poway (ongoing)
Reviewed Appropriate Prescribing of Restricted Antimicrobials Ceftazidime-Avibactam and Ceftolozane-Tazobactam (2024)	Evaluate additional disease state antimicrobial prescribing (i.e. pyelonephritis/CDI)
Completed Annual Resident ID Projects and Presented at National Conference (7/2025)	Provide Cost Savings Analysis for ASP interventions and Projects (ongoing)
Reimplementation of FMT therapy for fulminant CDI (5/2024)	

CDC - Centers for Disease Control and Prevention; CDI - *Clostridioides Difficile* Infection; CDPH - California Department of Public Health; CRE – Carbapenem Resistant Enterobacterales; PO – Oral; ID – Infectious Diseases; UTI – Urinary Tract Infection; JCAHO – Joint Commission on Accreditation of Healthcare Organizations; NHSN - National Healthcare Safety Network; MDRO – Multi-drug resistant organisms; MRSA – Methicillin Resistant *Staphylococcus aureus*; SSI – Surgical Site Infection; SSTI – Skin Soft Tissue Infection; ASP – Antimicrobial Stewardship Program

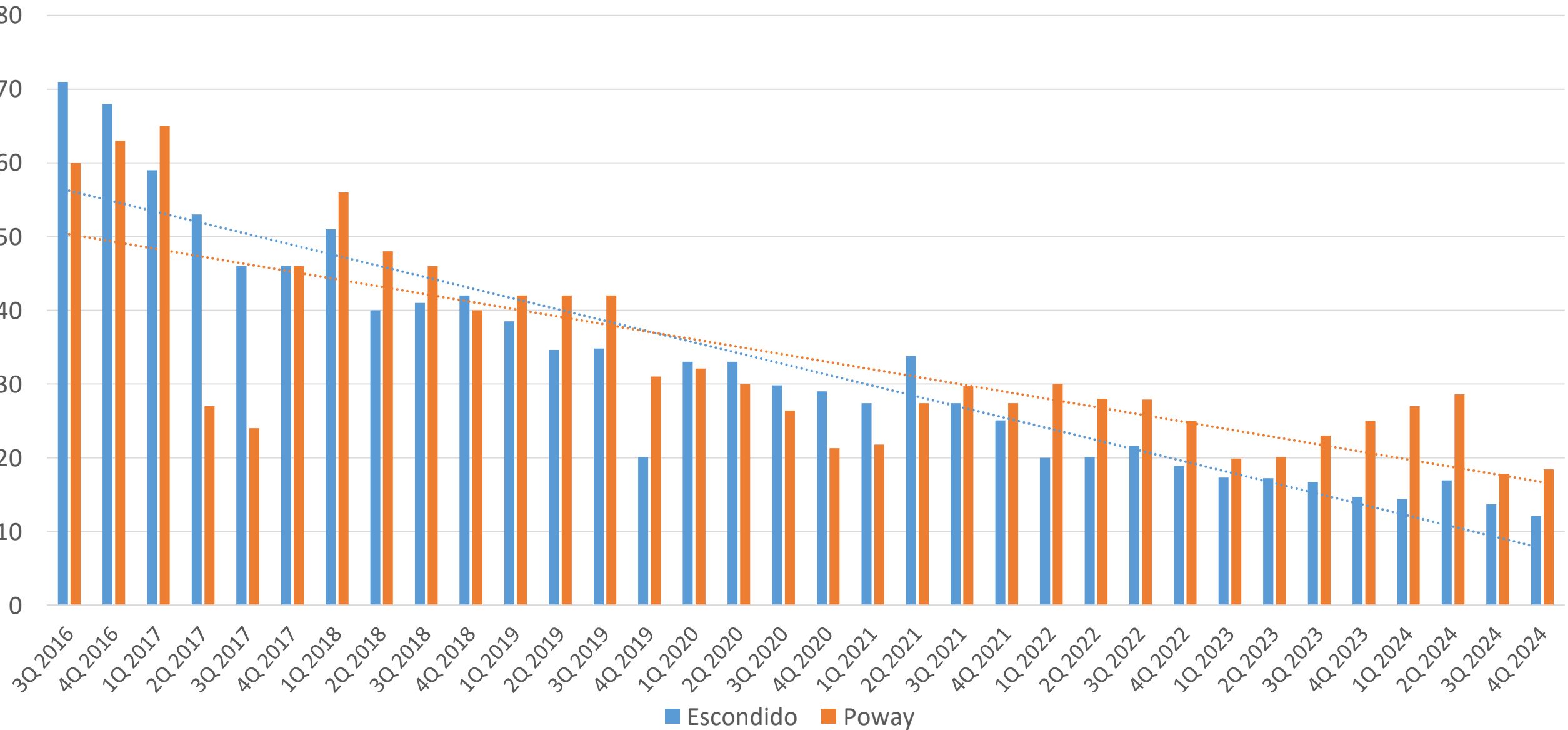
Agent Specific Antimicrobial Analysis 2024 Q3-Q4

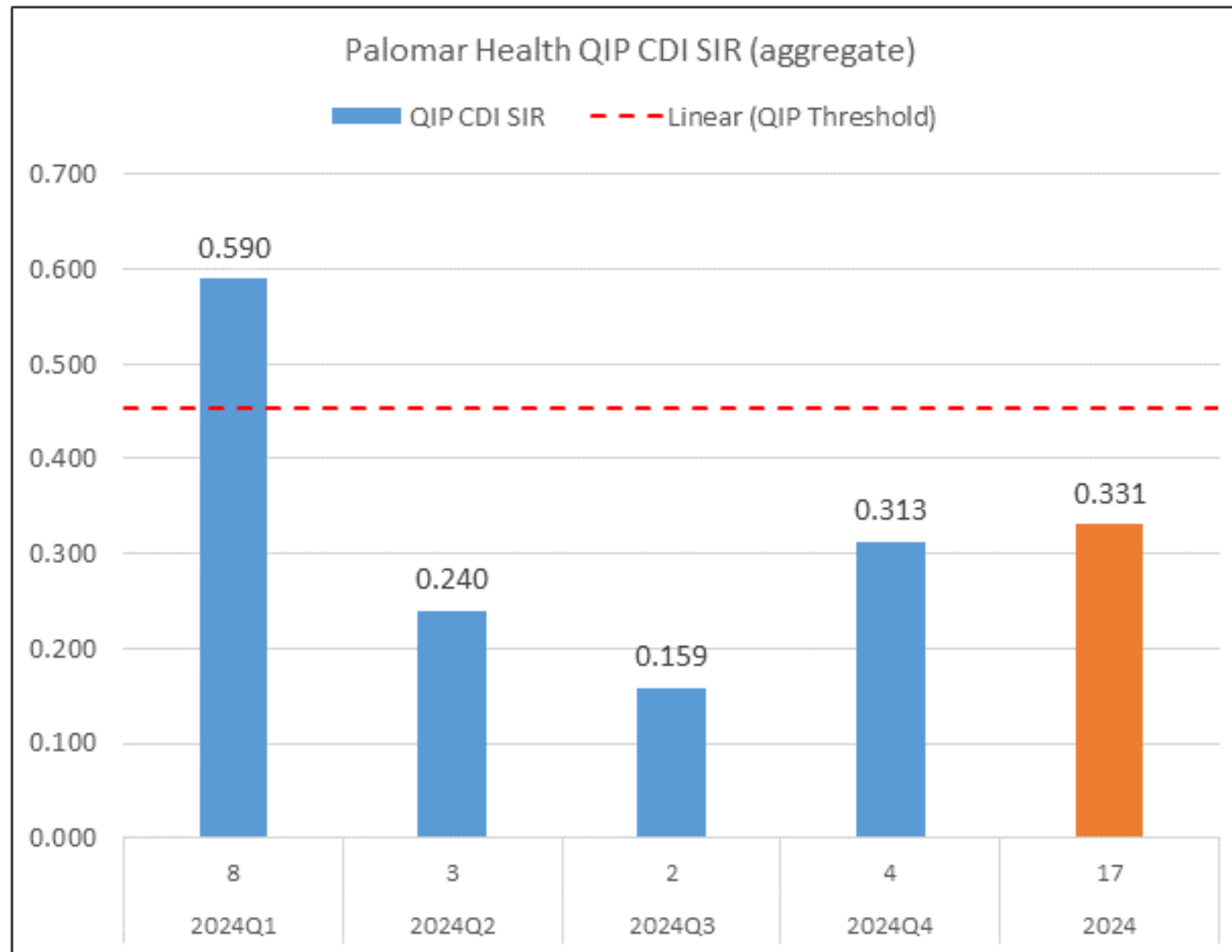
Facility-Wide Anti-MRSA SAAR



CDI Rate Reduction Measures

Facility-Wide Fluoroquinolone Use





C. Difficile Infection Prophylaxis Cost Savings 2024

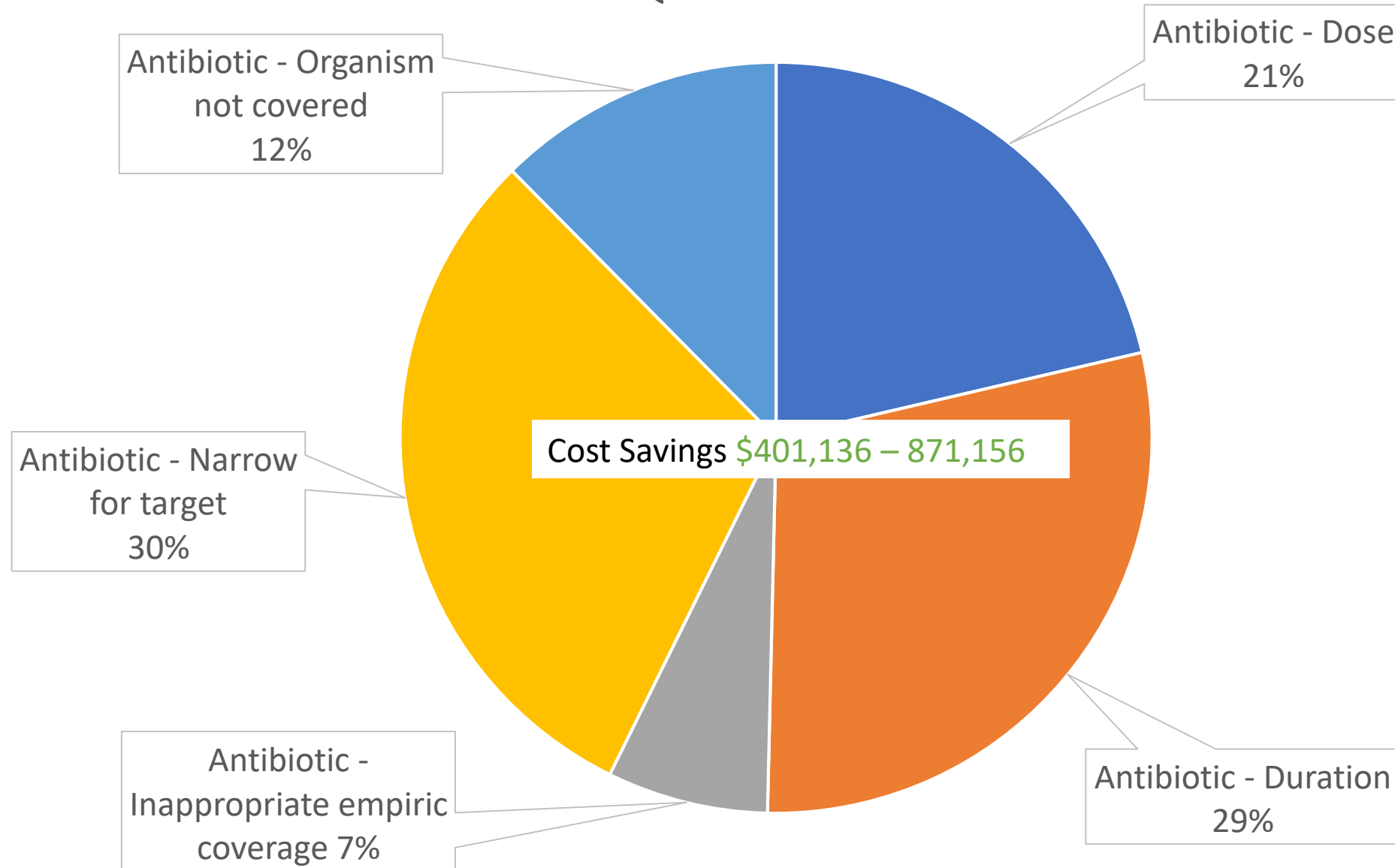
- Residency project in 2024 found that for every 6 high-risk patients treated with OVP would prevent 1 CDI
- 2023 systematic review estimates that 1 CDI episode is associated with healthcare cost of **\$67,837 to \$82,268** per patient¹
- In 2024, ASP Program identified **126 patients** who qualified for OVP
- Prevented $126/6 = 21$ episodes of CDI
- Cost savings of **\$1,424,577 - \$1,727,628** in 2024

OVP – Oral Vancomycin Prophylaxis; CDI – Clostridioides difficile Infection

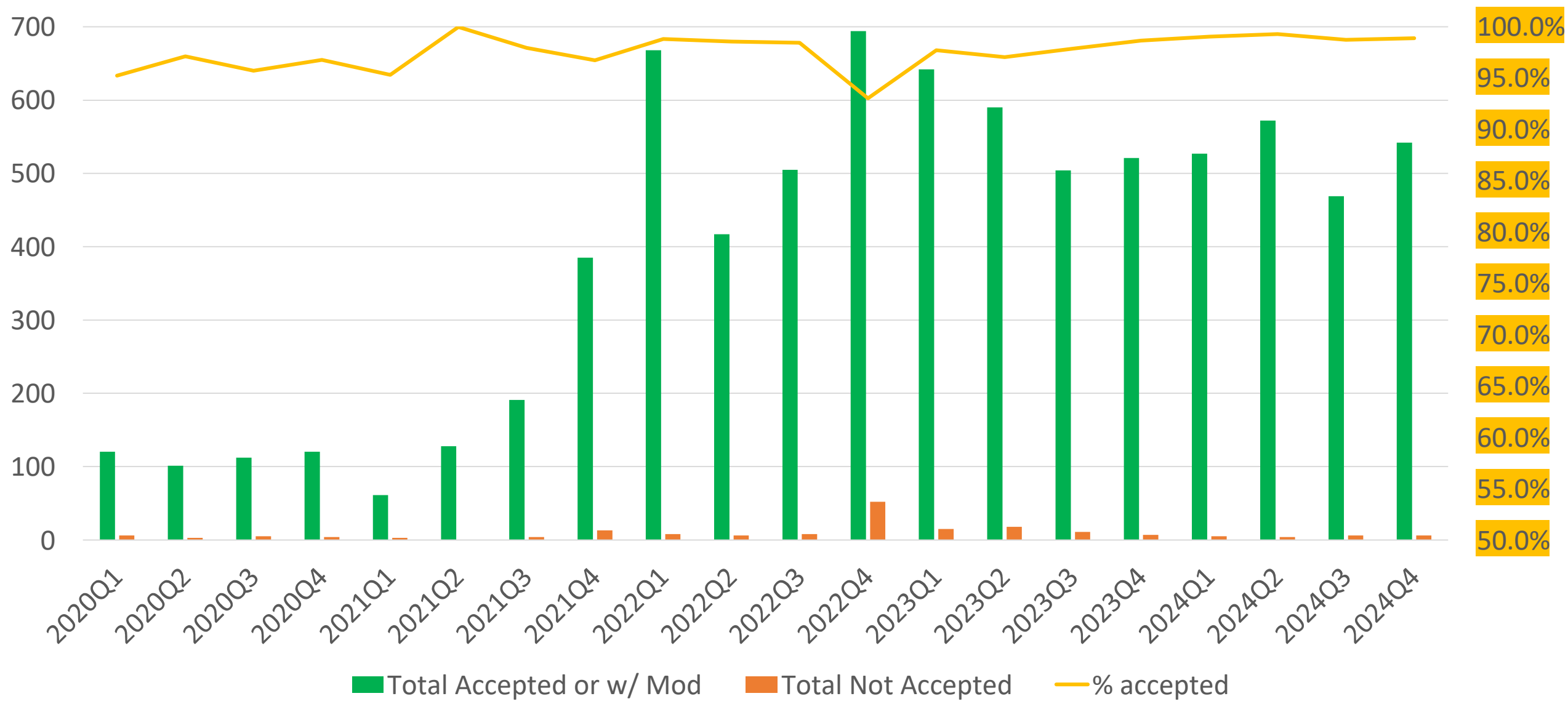
1. Reveles KR, et al. Economic Impact of Recurrent Clostridioides difficile Infection in the USA: A Systematic Literature Review and Cost Synthesis. Adv Ther. 2023 Jul;40(7):3104-3134.

ASP Interventions Data 2020 Q1 to 2024 Q4

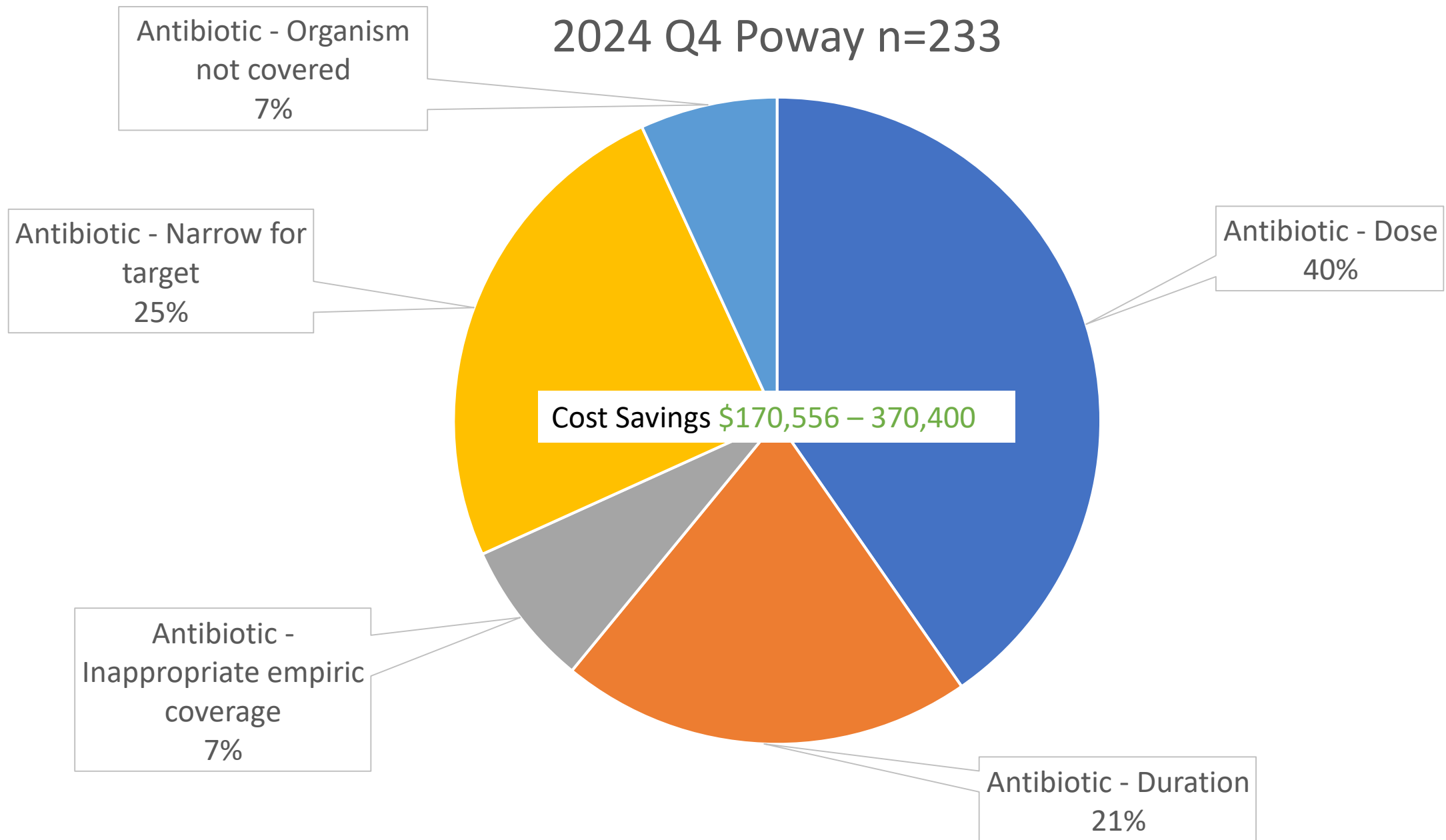
2024 Q4 Escondido n=548



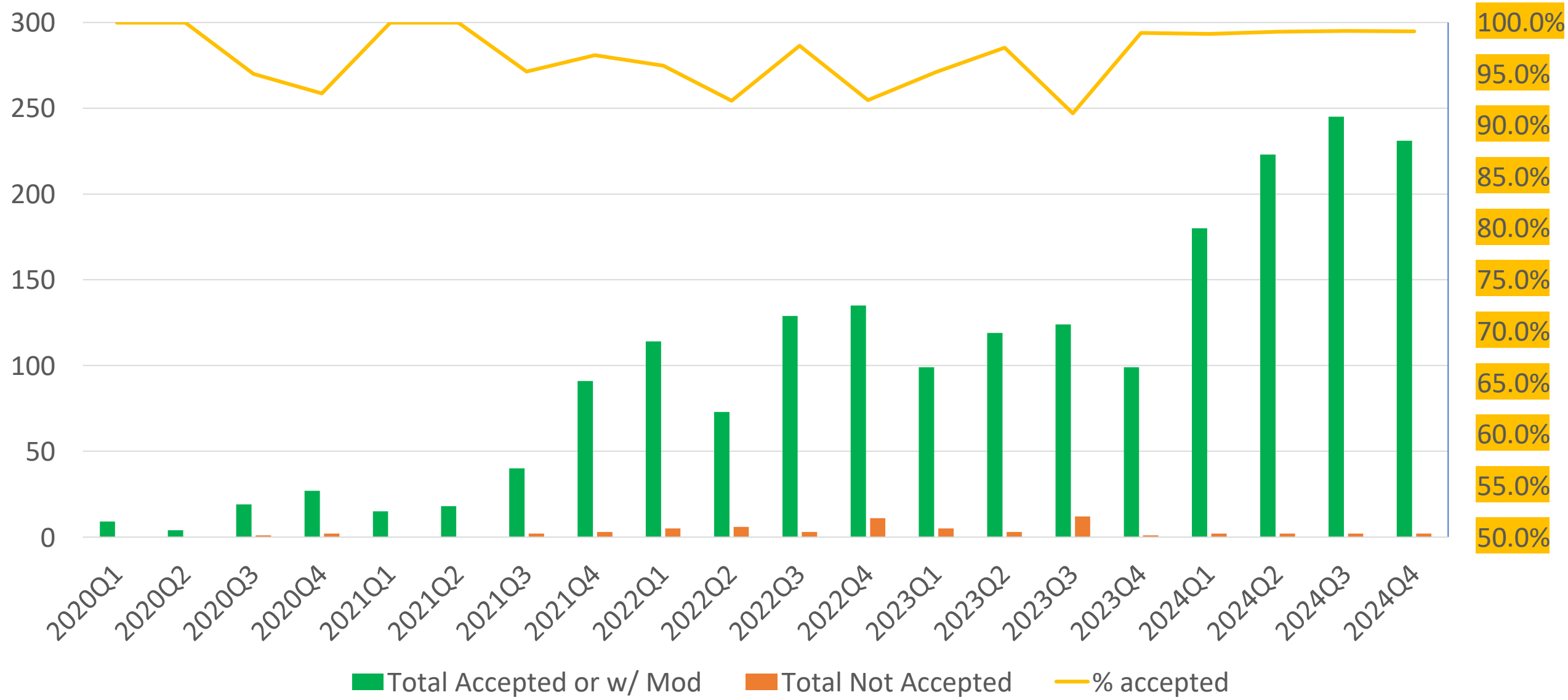
ASP Interventions - Escondido



2024 Q4 Poway n=233



ASP Interventions - Poway



ASP Cost Savings Analysis

Nathwani D, et al (2017)

- Literature search resulted in 221 studies (58 RCTs) in North America and Europe looking at efficacy of ASP interventions to improve antibiotic prescribing in hospital inpatients
- Found ASP interventions reduced length of stay by average **1.12 days** (95% CI 0.7-1.54 days)

Davey P, et al (2019)

- Literature review resulted in 146 studies in North America and Europe evaluating outcomes after implementation of hospital ASPs
- Found majority of studies reduced length of stay and antibiotic expenditure
- Estimated cost savings is **\$732 per patient** intervened on

Nathwani D, et al. Value of hospital antimicrobial stewardship programs [ASPs]: a systematic review. *Antimicrob Resist Infect Control*. 2019;8:35. Published 2019 Feb 12.

Davey P, et al. Interventions to improve antibiotic prescribing practices for hospital inpatients. *Cochrane Database Syst Rev*. 2017;2(2):CD003543. Published 2017 Feb 9.

ASP Cost Savings Analysis

Davey P, et al study found average hospital bed day cost in 2015 in US is \$2,271

Cost savings calculation #1

- 0.7 day reduced length of stay per intervention x 781 interventions x \$2,271 per bed day cost
 - Estimated **\$1,241,555.70** savings per quarter

Cost savings calculation #2

- 781 interventions x \$732 per patient intervened on
 - Estimated **\$571,692.00** savings per quarter

Estimated cost savings from ASP

- **\$571,692.00 - \$1,241,555.70 per quarter**
- **\$2,286,768.00 - \$4,966,222.80 per year**

Nathwani D, et al. Value of hospital antimicrobial stewardship programs [ASPs]: a systematic review. *Antimicrob Resist Infect Control*. 2019;8:35. Published 2019 Feb 12.

Davey P, et al. Interventions to improve antibiotic prescribing practices for hospital inpatients. *Cochrane Database Syst Rev*. 2017;2(2):CD003543. Published 2017 Feb 9.



ANNUAL REVIEW AND ASSESSMENT OF 2024 INFECTION PREVENTION & CONTROL PROGRAM

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Introduction

Annual Review and Program Assessment

The Infection Prevention and Control Program and Plan is evaluated annually. This assessment compares outcome and process measures from calendar year 2023 to 2024, and integrates a comprehensive interdisciplinary risk assessment to prioritize and set goals to minimize the possibility of transmitting infections. The Program assessment includes all surveillance modalities performed by Infection Preventionist (IP). Infection control measures include hand hygiene adherence monitoring, the monitoring of high-level disinfection and sterilization processes, medication preparation, food and nutrition services, construction and renovation, dialysis, and outpatient services. The role of the IP is a department resource and consultant, providing their subject matter-expertise, support, and evidence-based recommendations to ensure the Program and the organization-wide surveillance plan and goals are aligned and met. 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 plans and goals. Information is shared at the Board of Directors, physician, nursing, and support service levels and used to improve patient care. Infection Prevention & Control rounding activities help to identify opportunities for improvement.

Guidance from various regulatory and nationally recognized professional organizations, including but not limited to, The Centers for Disease Control & Prevention (CDC), The Joint Commission (TJC), California Department of Public Health (CDPH), Center for Medicare/Medicaid Services (CMS), and California Occupational Safety and Health Administration (Cal OSHA). These organizations provide direction in identifying indicators or performance measures 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), scientific journals, and continuing education.

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 or transmitting infections among patients, healthcare providers, volunteers, and visitors.

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 prioritized 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 to the Senior Director of Quality, Patient Safety, Infection Prevention, and the Medical Director of Infection Control and Antibiotic Stewardship.

The Infection Control Officers have clinical authority over the infection prevention and control program 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 Officers are qualified through education, training, experience, and certification in infection prevention, control and epidemiology. The officers are appointed by the governing body to be responsible for the infection prevention and control program. This appointment is based on recommendations of the medical staff and nursing leadership. When the Infection Control Officers do not have

expertise in a particular area, they consult with someone who has such expertise in order to make knowledgeable decisions.

The Infection Control Officers are responsible for:

- Developing and implementing hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines
- Documenting infection prevention and control program surveillance, prevention, and control activities
- Communicating and collaborating with the quality assessment and performance improvement program on infection prevention and control issues
- Training and educating staff, including medical staff on the practical applications of infection prevention and control guidelines, policies and procedures, preventing and controlling healthcare associated infections
- Auditing of adherence to infection prevention and control policies and procedures by hospital staff including medical staff, communicating and collaborating with the antibiotic stewardship program

The Infection Prevention & 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.

Access to Information

Patient information used in surveillance is accessed through the Cerner electronic medical record. Cerner also has an Infection Prevention Worklist program, which assists in identifying patients who have communicable reportable diseases, recent discharges, multi-drug resistant organisms, and hospital-associated infections. Cerner analytics reports allow for follow up of patients in isolation precautions, review of abnormal and positive labs, identification of outbreaks, device-associated infections, surgical site infections, and analyze other metrics that aid in infection prevention or epidemiologic investigation.

Equipment and Resources

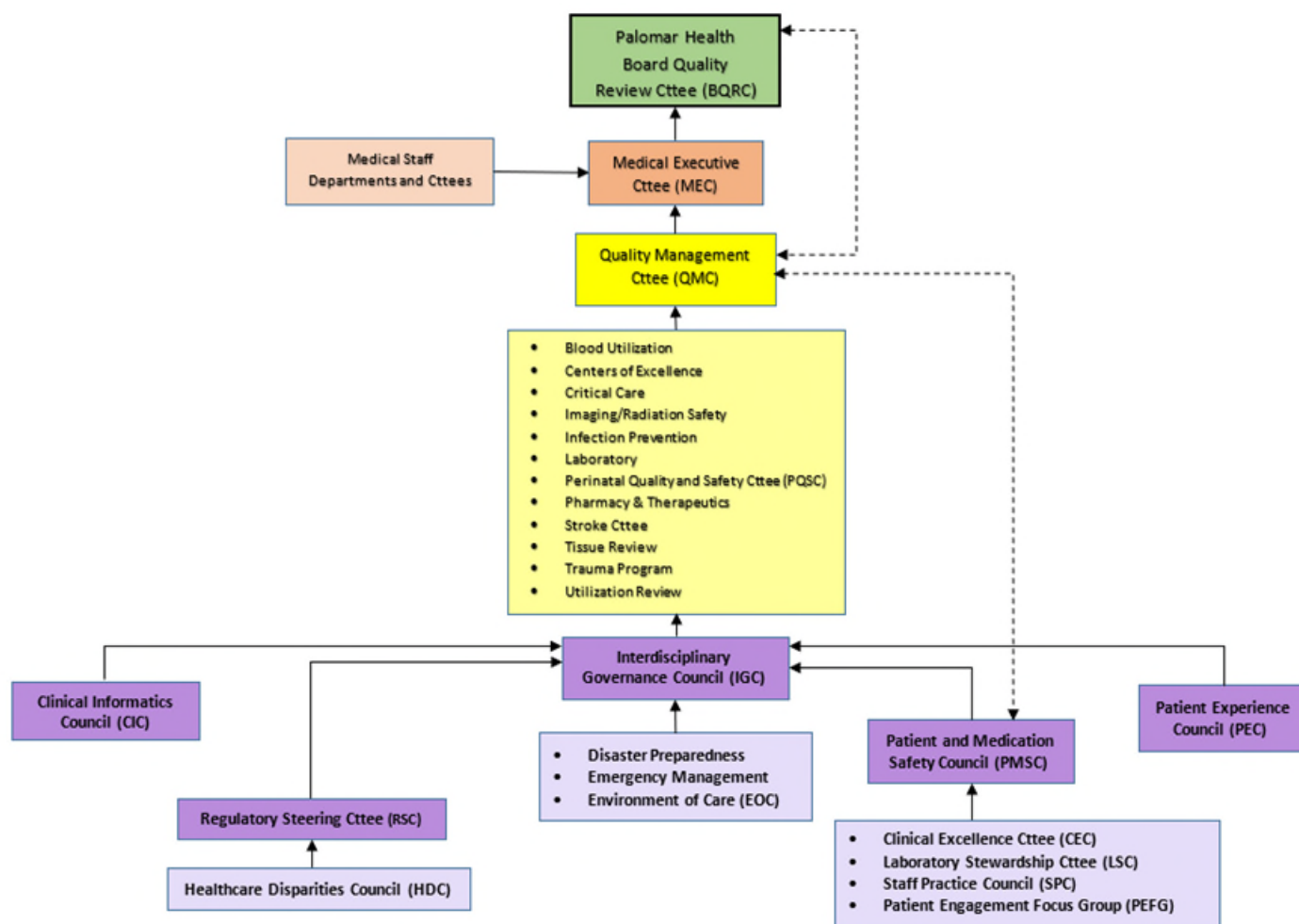
Access to information, laboratory resources, and equipment and supplies are available to support the infection prevention and control program.

Procedure Review

Infection Preventionists worked to review, update and maintain all Infection Control Procedures. The Infection Control Committee reviewed relevant procedures and collaborated with other departments who have procedures that relate to infection control.

Department Structure

The Infection Prevention and Control Department is structured under the Chief Medical Officer and Quality Department. The Infection Prevention and Control Program reports directly to the Quality Management Committee.



Key Definitions

Standardized infection ratio (SIR): a statistical measure used to compare the actual number of healthcare-associated infections (HAIs) observed at a healthcare facility to the predicted number of infections expected based on national baseline data, essentially adjusting for patient risk factors to allow for fair comparisons between different facilities. An SIR greater than 1 indicates more infections than predicted, while an SIR less than 1 indicates fewer infections than predicted.

Standardized utilization ratio (SUR): a metric that compares the actual number of device days to the predicted number of device days. It is used to track device use over time at the facility, state, local, or national level. Having a SUR above 1.0 means the facility or unit utilizes a higher proportion of ventilators than what is predicted for the facility or unit.

IVAC+: is the aggregate SIR calculation of both infection-related ventilator associated condition (IVAC) and possible ventilator associated pneumonia (PVAP).

Complex AR SIR Model: a specific model used to calculate a SIR for surgical site infections (SSIs), where "AR" stands for "Admission/Readmission," meaning the model takes into account the risk factors associated with both the initial admission and any subsequent readmissions when determining the predicted infection rate for a patient.

Hand Hygiene

Overview

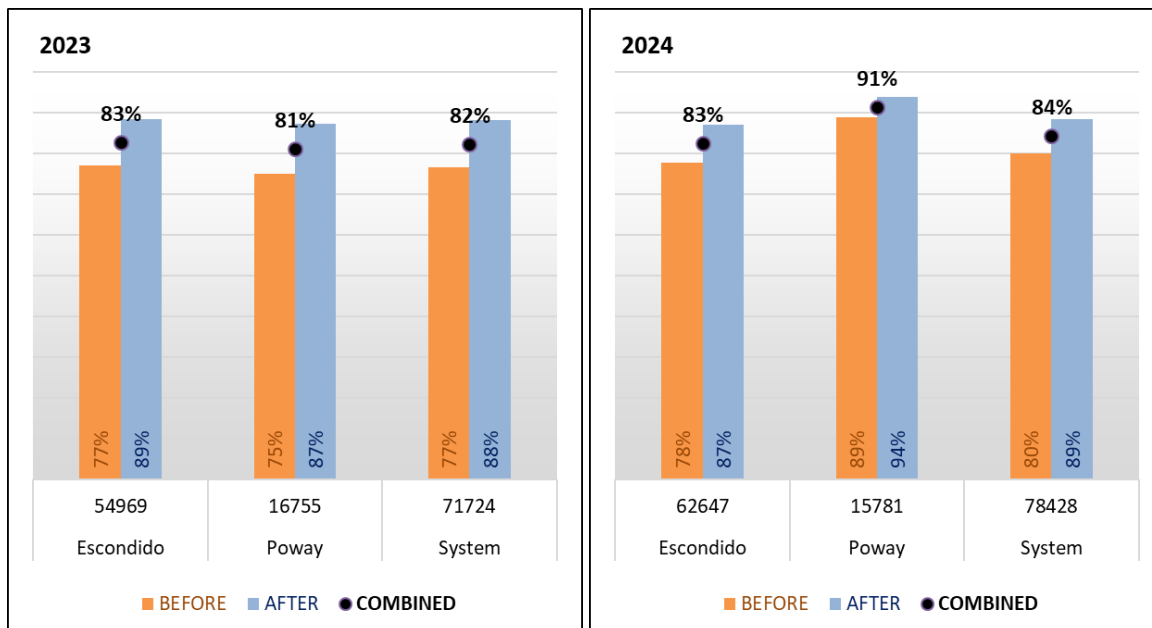
Hand hygiene is crucial in healthcare settings as it significantly reduces the risk of infections by preventing the spread of harmful pathogens. This protects both patients and healthcare providers, and it helps combat antimicrobial resistance by decreasing the need for antibiotics. Studies have shown that proper hand hygiene can prevent up to 50% of healthcare-associated infections, highlighting its importance in maintaining a safe healthcare environment.

Goal

Increase organization-wide (“System”) mean hand hygiene compliance to 95% compliance by end of 2024; measured by Palomar Health Infection Control standardized methods.

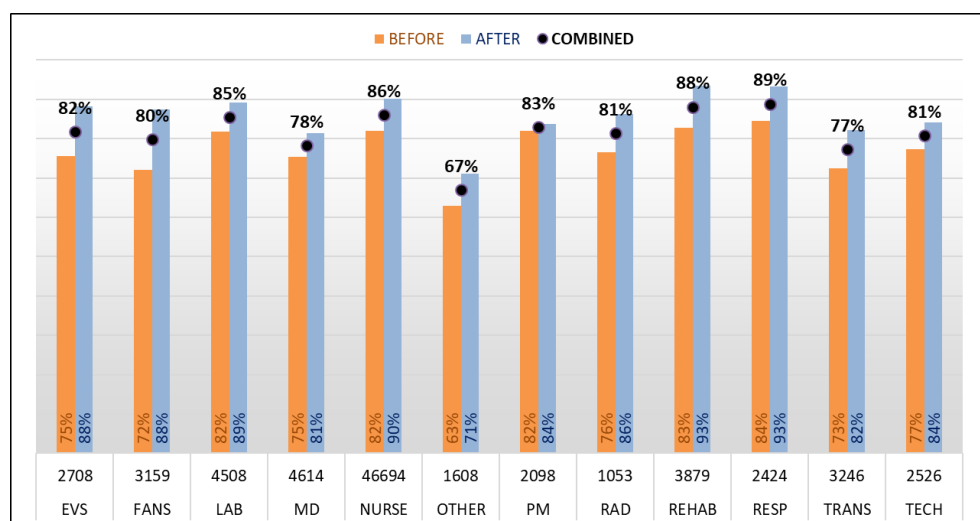
Analysis

Hand Hygiene by System



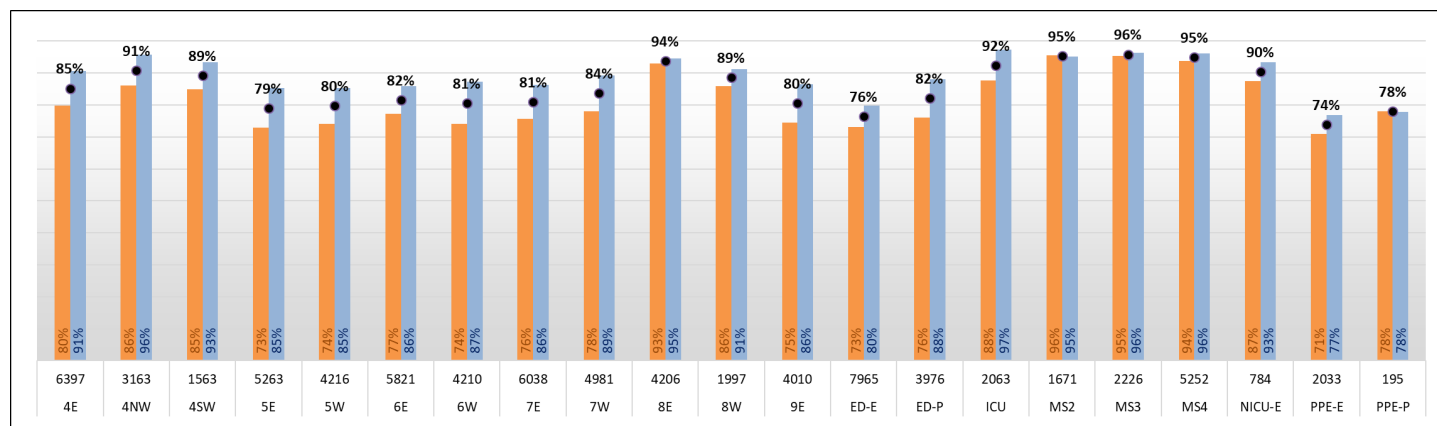
System mean hand hygiene compliance increased 2.4% from previous year, with a 12% improvement at Escondido.

Hand Hygiene Compliance by Discipline



NURSE = RN, CNA; RAD = Radiology/Imaging; MD = MD, OD, PA, NP; FANS = Food service, RD; RESP = Respiratory care practitioners; TRANS = Transport/lift team; EVS = Environmental Service; REHAB = PT, OT, ST; LAB = Phlebotomists; PM = Pathmakers, Volunteers, Students; TECH = ED techs, Cardiology techs, Medical tech/asst.; OTHER = Security, Social worker, Chaplain, etc.

Hand Hygiene Compliance by Unit



Intervention Summary

1. Provide hand hygiene education to employees and medical staff upon hire (physical demonstration), annually, and regularly with units or disciplines as appropriate.
2. Every month, engage department/discipline leaders with low compliance, collaborate to identify specific problems and possible solutions, and request the implementation of a comprehensive action plan with goals and presented at the Infection Control & Prevention Committee.
 - Departments and disciplines identified; PreOP-PACU-Endo Nurses, Escondido ED Nurses and Techs, EVS, FANS, 5W Nurses, Poway ED Nurses and Techs, Radiology, Medical Staff, Pathmakers/Students, Volunteers, Transport/Left Team, 5E Nurses, 5W Nurses, 6E Nurses, 6W Nurses, 7E Nurses, 9E Nurses.
 - Some interventions implemented; staff education and awareness of data at meetings or huddles, real-time auditing and coaching, installing more dispensers on unit, infographic and contact posted in lounges, hand hygiene pledge, explaining data collection methods.

3. Supplement data collection with trained designees among departments. Have a process to evaluate data integrity or a mechanism to omit this supplemental method of data collection from dataset.
4. Provide Leaders with department-level data monthly.
5. Continue to assess accessibility and availability of approved hand hygiene products.
6. An organization-wide conversion of hand hygiene product was implemented end of June. This conversion was an opportunity to safely increase the number of available alcohol-based hand sanitizer dispensers in patient care areas, estimated to be 45% more.

Goal Assessment & Action Plan

Organization did not meet goal. Given the lag effect we may see with this organizational intervention (2) and what can be achieved in a 1-year time scale, the 2025 goal is to increase the System mean hand hygiene compliance to 88% compliance by end of 2025; measured by Palomar Health Infection Control standardized methods.

Central Line-Associated Bloodstream Infection (CLABSI)

Overview

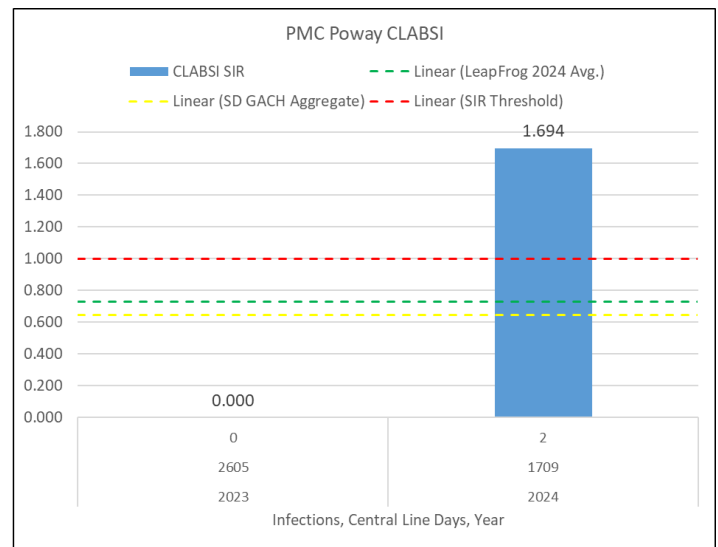
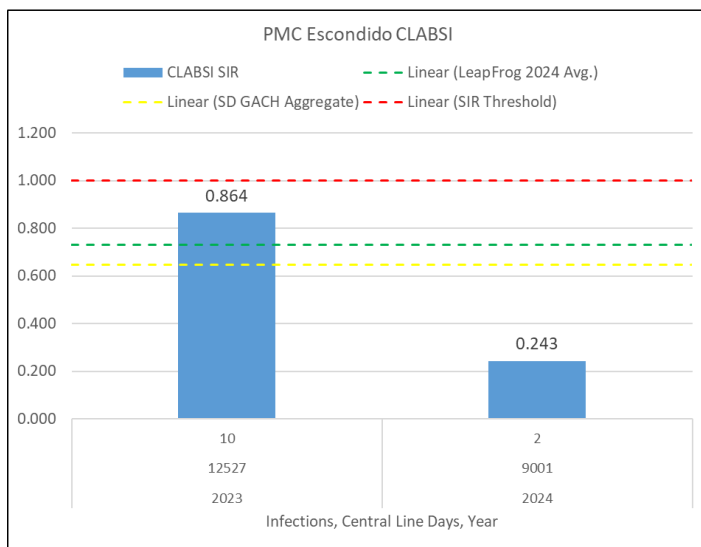
In the US, CLABSIs lead to increased morbidity and mortality, with an estimated 12-25% attributable mortality rate. These infections place a substantial financial burden on the healthcare system, with annual costs ranging from \$60 million to \$460 million. In California, CLABSIs remain a relevant threat to patient safety, particularly in community hospital settings. Studies have shown that CLABSI rates in California hospitals are associated with factors like bed capacity, ownership, and accreditation status. While specific data for San Diego is limited, it is reasonable to expect similar challenges and impacts as seen at the state and national levels, with ongoing efforts focused on prevention and reduction of CLABSIs.

Goal

Facility CLABSI SIR does not exceed established SIR Threshold of 1.0 and a 10% SIR reduction from previous year. This outcome measure is analyzed as a standardized infection ratio (SIR).

Analysis

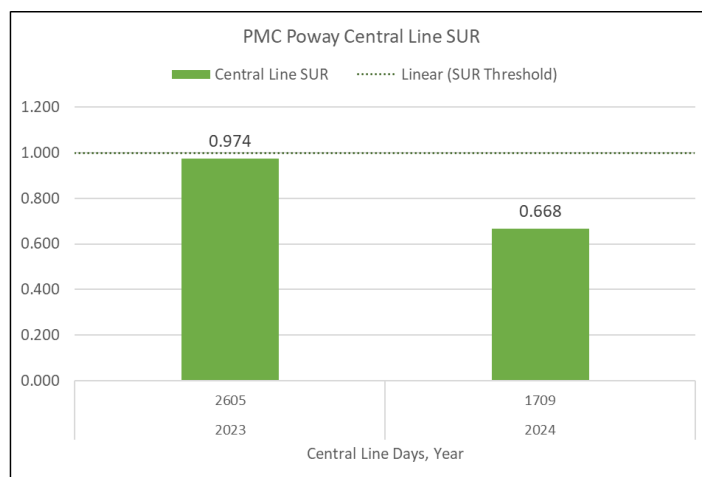
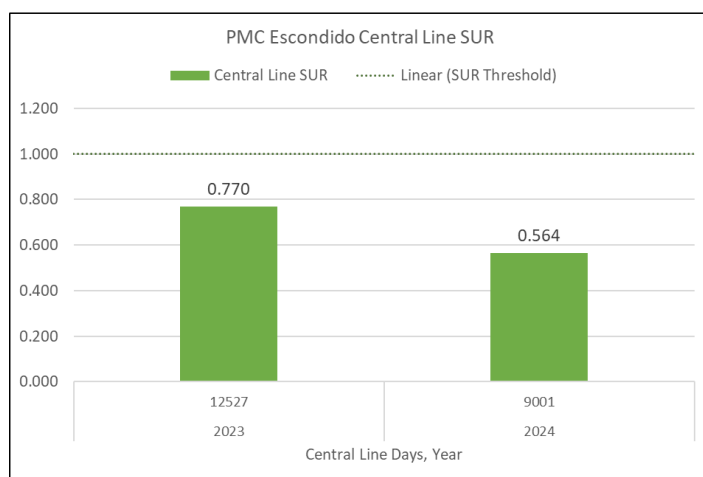
CLABSI SIR



Escondido CLABSI SIR (0.243) is below SIR Threshold and reduced 72% from previous year. No trends found between these two infections. Facility is performing better than the national average (LeapFrog 2024 Avg.) and other general acute care hospitals in San Diego County (SD GACH aggregate 2023Q1-2024Q2).

Poway CLABSI SIR (1.694) is above SIR Threshold and increased from previous year, inversely proportional to less central line days. No trends found between these two infections. Facility is performing worse than the national average and other general acute care hospitals in San Diego County.

CLABSI SUR



The standardized utilization ratio (SUR) for both Escondido and Poway are below SUR Threshold and reduced from previous year.

Intervention Summary

- At the end of 2023 and beginning of 2024, there were three CLABSIs identified in NICU, and addressed by a workgroup among IPs, NICU staff and leaders, NICU providers, Clinical Education, and Rady's IP and Quality partners. Standard precautions was enforced, and best practices and products were shared by our Rady's partners, and implemented within our NICU.
- A critical care workgroup meet monthly to review infections trends and propose solutions in the critical care units.
- Physician documentation of assessing central line necessity daily is monitored monthly, and part of an intensivist medical group performance measure. Intensivist compliance with this metric is 96% (N=2,101 eligible central line days); however, Hospitalist compliance is 67% (N=1,907). This data is reported to the medical directors monthly, with a Hospitalist compliance goal of improving 10% from previous year.
 - This goal was not met (2023=66%).
- A transparent CHG-impregnated dressing was trialed and implemented. The dressing replaced the need for both a CHG-impregnated patch and a transparent dressing, improving the workflow for assessing the site for infection and dressing changes.
- Root cause analyses are performed for all CLABSI events by unit-based leadership.
- A workgroup created in 2023 to reduce blood culture contamination (BCC) rate is still active with an organization-wide goal of 2.0%.
 - This goal was not met, BCC rate=2.5%. Their primary intervention is the routine use of a waste tube, excluding the initial volume of blood that is likely contaminated from a venipuncture "skin plug". The lab will assess the feasibility of a device that diverts this blood without wasting in a tube. It was also reinforced that all blood culture must be drawn or supervised (central line) by a phlebotomist. The lab will continue to monitor this rate and audit phlebotomy blood draw practices.
- Central line insertion practice (CLIP) adherence is monitored quarterly among peripherally inserted central catheters (PICC), measuring full sterile barrier precautions, hand hygiene, and appropriate skin prep, and the use of sterile gel and covers. The organization-wide goal for this performance measure is sustain above 90%. The organization-wide compliance is 100% (N=211 PICC insertions).
 - This goal was met.
- CLABSI bundle compliance is monitored by unit-based leadership through Rounds+, with an annual facility goal of at least 90% among all CLABSI prevention practices, each a sample unit: Antiseptic protector caps are utilized for all line, connectors, CHG-containing bath provided within last 2 nursing shifts, CHG-impregnated dressing is used CVC

dressings clean, dry, and intact (with no additional tape used), CVC dressing is labeled with date and initials, CVC dressing is not past due (i.e. at least Q7 and PRN), CVC has been assessed for necessity, CVC insertion date documented, no visible blood in extension legs or injection caps, and nursing staff can verbalize appropriate CHG bathing. Escondido bundle compliance is 92% (N=52,886). Poway bundle compliance is 96% (N=11,960).

- Escondido goal was met.
- Poway goal was met.

Goal Assessment & Action Plan

Escondido met facility goal. Poway did not meet facility goal. After review of hospital averages at a national and local level, our 2025 CLABSI goal is that each facility does not exceed a SIR threshold of 0.810.

- Maintain Hospitalist central line indication assessment compliance goal of improving 10% from previous year. Work with medical director and hospitalist group to improve this documentation.
- Maintain BCC rate goal of 2.0% with workgroup. Review the Clinical & Laboratory Standards Institute Guidelines for their recommendations on achieving a 1.0% BCC rate, which are the latest practice recommendations. Explore trial of built-in blood diversion technology, or reinforce compliance with waste-tube method.
- Maintain CLIP adherence to above 90%. There may be an opportunity to include non-PICC central lines in this performance measure.
- Maintain CLABSI bundle compliance facility goal of at least 90%.
- Continue to improve hand hygiene compliance.
- Include race-ethnicity with surveillance to analyze possible sources of health inequity.

Catheter-Associated Urinary Tract Infections (CAUTI)

Overview

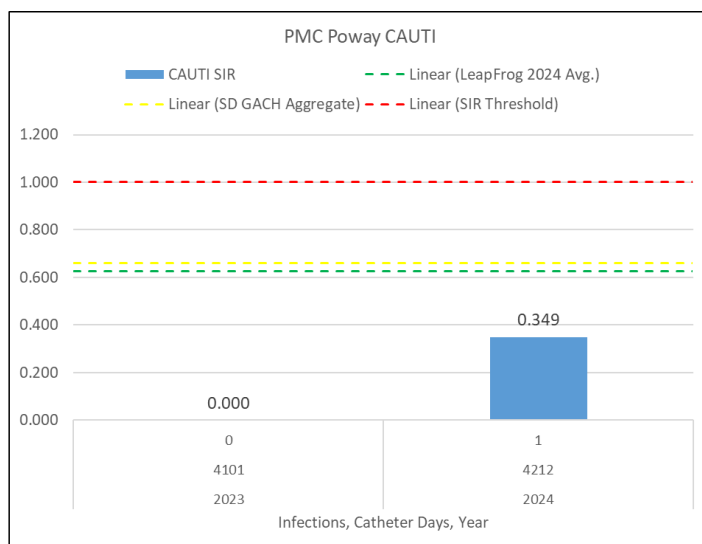
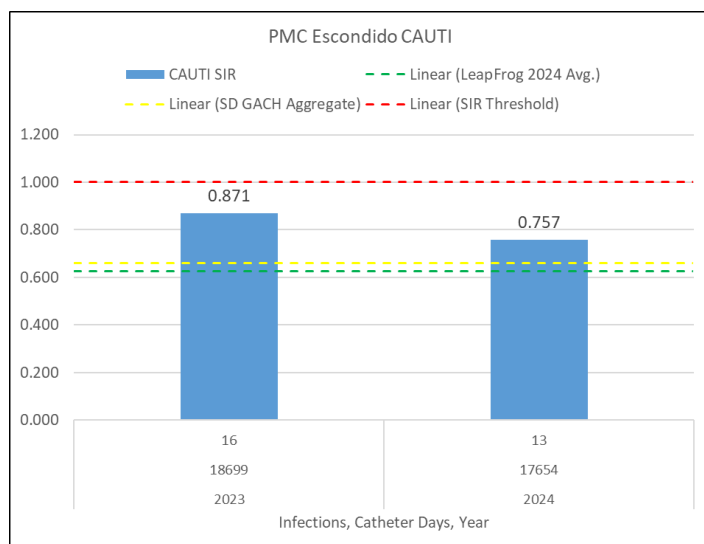
Catheter-associated urinary tract infections (CAUTIs) are a significant public health issue across the United States, with tens of thousands of cases occurring annually, leading to serious complications like sepsis and increased mortality. In California, the Department of Public Health actively works to reduce CAUTI rates through guidelines and resources for healthcare facilities, aiming for a 25% decrease. Locally, San Diego hospitals implement comprehensive programs, including strict adherence to CDC guidelines, use of catheter alternatives, and staff training, to minimize CAUTI incidence and improve patient safety.

Goal

Facility reduces CAUTI SIR by 10% from previous year. This outcome measure is analyzed as a SIR.

Analysis

CAUTI SIR

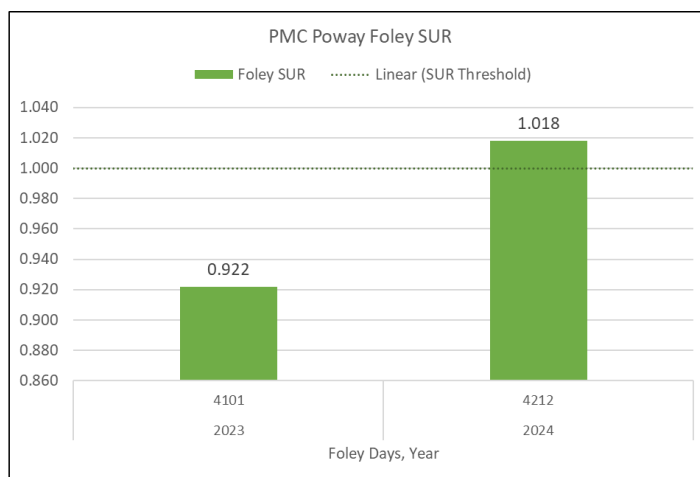
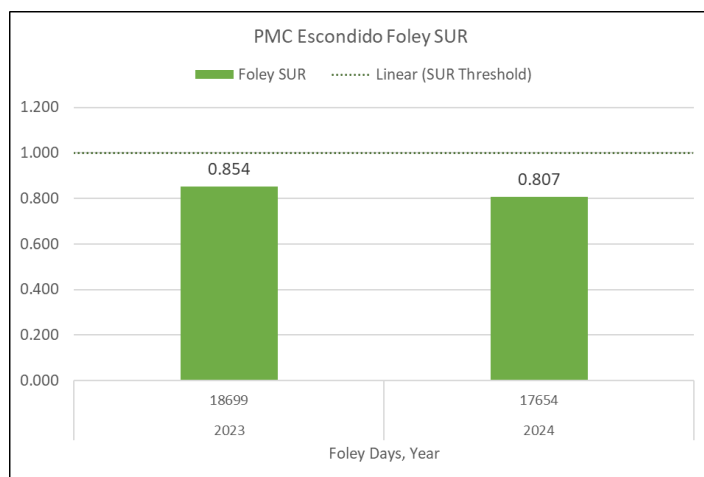


Escondido CAUTI SIR (0.757) is below SIR Threshold and reduced 13% from previous year. Facility is performing worse than the national average and other general acute care hospitals in San Diego County. Ten CAUTI are from 5W, a significant unit-level increase from previous year (one 5W CAUTI in 2023).

Poway CAUTI SIR (0.349) is below SIR Threshold; however, increased from previous year. Facility is performing better than the national average and other general acute care hospitals in San Diego County.

Nearly half of all CAUTI events were within a week of foley insertion, suggesting an opportunity to review insertion practices and products. More than 80% of CAUTI events are from gut or stool flora, suggesting a possible gap with patient hygiene practices like stool management, bathing, and/or peri- and foley care.

CAUTI SUR



Escondido Foley SUR is below SUR threshold. Poway Foley SUR is above SUR threshold. The SUR among all of Poway's' medical-surgical floors (MS2, MS3, MS4) are above SUR threshold.

Intervention Summary

1. Nurse-driven removal protocol are Cerner rules that automatically place an order to discontinue indwelling foleys based on nursing assessment and documentation.
2. A critical care workgroup meet monthly to review infections trends and propose solutions in the critical care units.
3. UA culture reflex change. After robust analyses of patient risks, benefits, and cost avoidance, and much discussion at the workgroup and medical staff committee levels, our laboratory urine diagnostics and antimicrobial therapy practices will be optimized through a small change in urinalysis (UA) orders. Laboratory urinalysis orders will no longer reflex to urine cultures if "WBC >5" by default. The culture reflex threshold will now default to "WBC >10" in all UA orders and those within order sets. Providers will still have the ability to place orders for a urine culture without a UA or within the UA order. Changes will go live February 2025.
4. Nurse skills station for aseptic urine collection from catheter, clean catch, and urostomy at Annual Skills. Issue of poor collection technique was reported through.
5. Removal of redundant and impractical urine culture sources for documentation (e.g. "void") – this documentation correction may help better characterize urine culture contamination.
6. Insertion and maintenance practice assessment (Foley Life Cycle) and virtual reality insertion training provided to critical care nurses.
7. Root cause analyses are performed for all CAUTI events by unit-based leadership.
8. CAUTI bundle compliance is monitored by unit-based leadership through Rounds+, with an annual facility goal of at least 90% among all CAUTI prevention practices, each a sample unit – Appropriate urine specimen collection, Assessed for device necessity, Pericare provided, Properly secured, TES intact, Tubing and reservoir below bladder, Urine flow unobstructed. Escondido bundle compliance is 98% (N=219,000). Poway bundle compliance is 99% (N=20,672). Despite the high bundle compliance for each facility, among the top three missed measures was proper securement, the provision of pericare, and the system remained closed (TES not intact).
 - Escondido goal was met.
 - Poway goal was met.

Goal Assessment & Action Plan

Escondido met facility goal. Poway did not meet facility goal. After review of hospital averages at a national and local level, our 2025 CAUTI goal is that each facility does not exceed a SIR threshold of 0.627.

- Improve hand hygiene compliance.
- Review Diagnostic stewardship recommendations.
 - Improve specimen collection and documentation
 - Reduce urine culture contamination
 - Clinical education on appropriate UA orders
 - Improve collect-to-process time
- Maintain CAUTI bundle compliance facility goal of at least 90%. Work with unit-based leadership to validate this data at least annually.
- Review device utilization and documentation of indications at Poway medical-surgical floors.
- Include race-ethnicity with surveillance to analyze possible sources of health inequity.

Infection-related Ventilator-Associated Complication Plus (IVAC+PVAP)

Overview

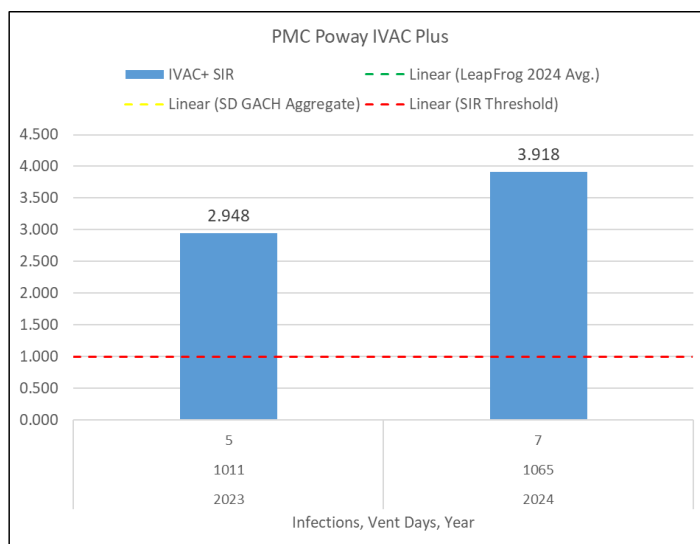
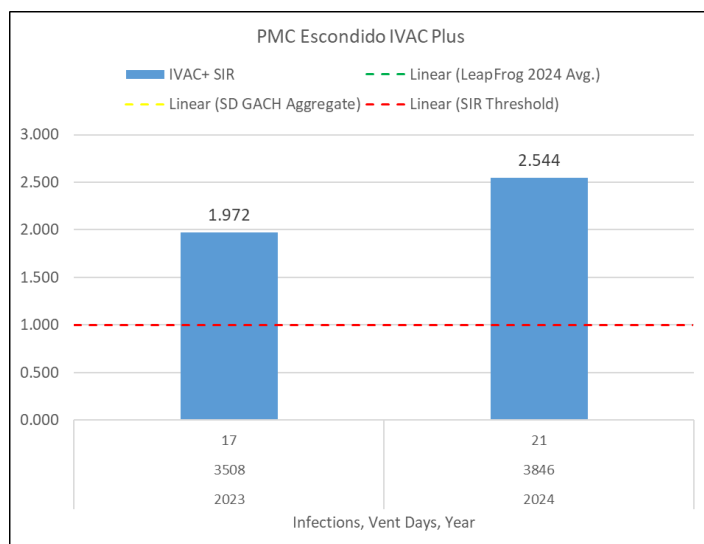
Ventilator-associated pneumonia (VAP) is a serious lung infection that develops in patients who have been on mechanical ventilation for at least 48 hours, posing a significant concern in healthcare settings, particularly ICUs. VAP carries a significant impact, increasing mortality rates (ranging from 10% to 40%), prolonging hospital stays and increasing healthcare costs, and raising the risk of complications like sepsis and acute respiratory distress syndrome (ARDS). The rise of antibiotic-resistant organisms in VAP further complicates treatment and infection control efforts.

Goal

Facility Critical Care Units IVAC+ SIR does not exceed established SIR Threshold of 1.0. This outcome measure is analyzed as a SIR.

Analysis

IVAC+ SIR

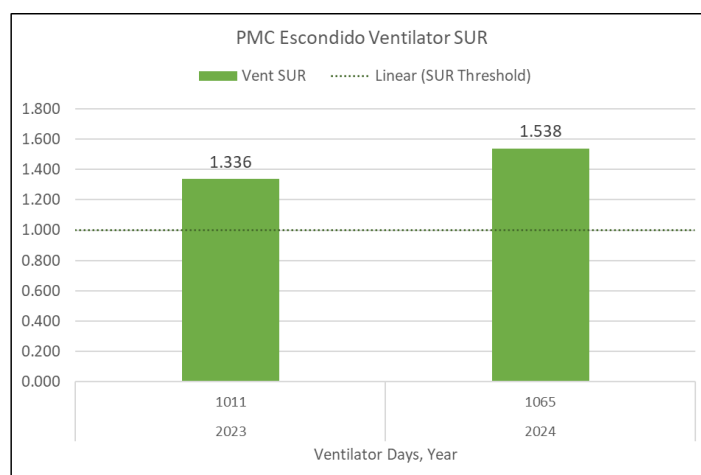
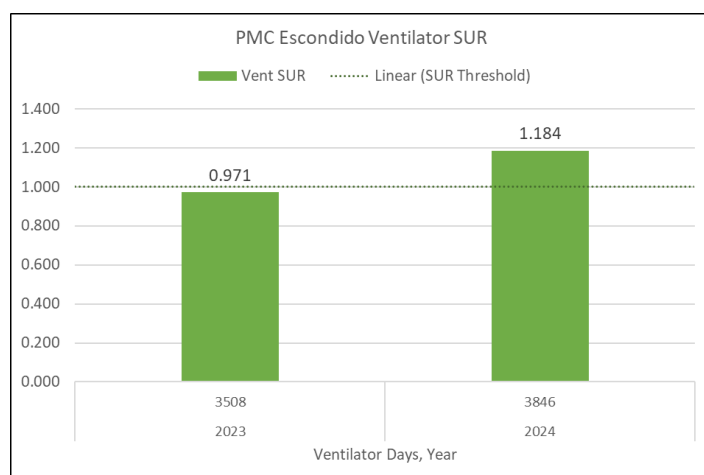


Escondido IVAC+ SIR (2.544), representing both 4SW and 5W, is above SIR Threshold and increased 29% from previous year. Despite this increase, there is evident improvement throughout the year quarter to quarter. In quarter 1, the SIR was 3.77, and trended down every quarter until quarter 4, where the SIR was 1.10.

Poway IVAC+ SIR (3.918), representing ICU, is above SIR Threshold and increased 33% from previous year.

Among 10 reviewed PVAPs, four were infections identified with GI or gut flora, five are from skin or mucus membranes flora, and one from an environmental organism.

IVAC+ SUR



Escondido ventilator SUR is above SUR threshold. Both 4SW and 5W ventilator SURs are above SUR threshold. Poway ventilator SUR (representing only ICU) is above SUR threshold.

Intervention Summary

1. A critical care workgroup meet monthly to review infections trends and propose solutions in the critical care units.
2. Root cause analyses are performed for all IVAC+ events by unit-based leadership.
3. Measures taken during 2023 to decrease ventilator-associated events included a collaborative approach by the ICU medical staff, the Respiratory therapy team, nursing, educators, and Infection Prevention for monitoring the ventilator bundle.
4. The proportion of pathogen sources for PVAPS were presented through Pulmonary Committee with the recommendation to focus clinical education to aspiration prevention (HOB at least >30) and hand hygiene as it relates to ventilator management and oral care.
5. RCP staff took over the responsibility of routine oral care for ventilated patients to standardize practice and the quality of this care.
6. RCP staff improved their organization-wide hand hygiene compliance by 6% (N=2424) compared to previous year. A 10% improvement goal was set for 2024 among this discipline.
 - RCP staff did not meet goal.
7. To standardize practice and ensure every ventilated patient received oral care every 4 hours and oral care with CHG at least every day, the RCP took over all ventilated patient oral care, beginning February 2, 2024.
9. VAP bundle compliance is monitored by RCP and IP leadership through Rounds+, with an annual facility goal of at least 90% among all VAP prevention practices, each a sample unit. Escondido bundle compliance is 94% (N=578). Poway bundle compliance is 92% (N=88).
 - Escondido goal was met. Poway goal was met.

Goal Assessment & Action Plan

Escondido did not meet facility critical care unit goal. Poway did not meet facility critical care unit goal. The facility critical care units will retain the goal of not exceeding a SIR threshold of 1.00, and a 10% reduction from previous year.

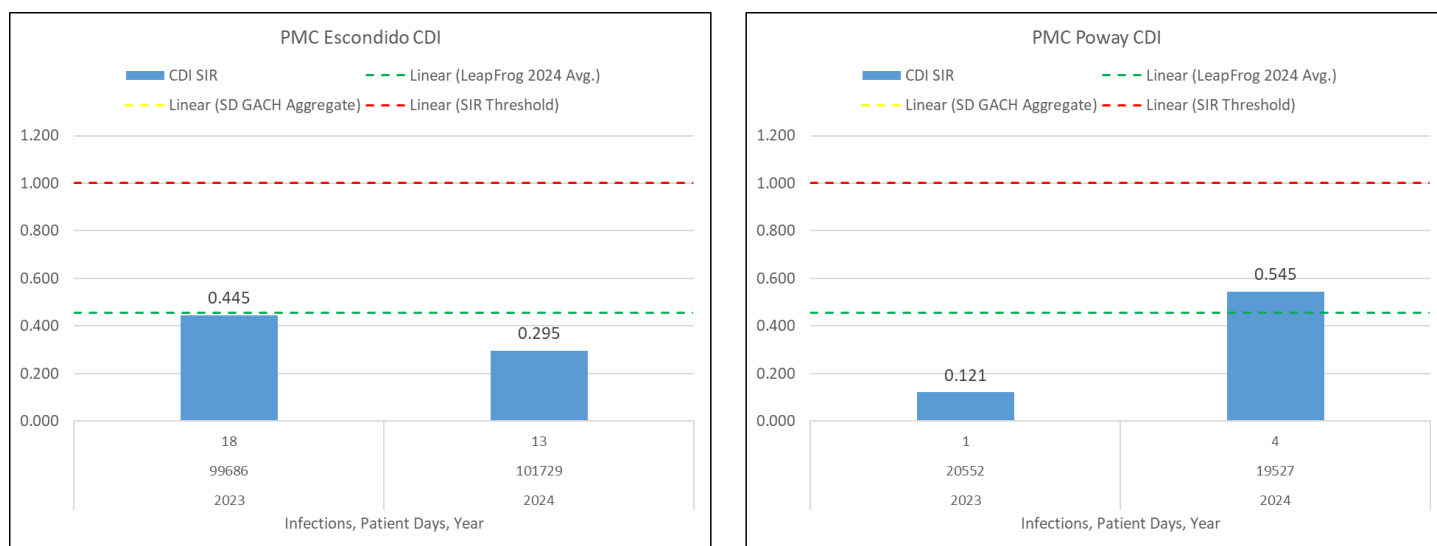
- Improve hand hygiene compliance.
- Considering their compliance of 89% and the rate of improvement, improve mean hand hygiene by 5% among RCPs compared to previous year.
- Maintain VAP bundle compliance facility goal of at least 90%.
- Include race-ethnicity with surveillance to analyze possible sources of health inequity.

Clostridioides difficile Infection (CDI)

Goal

Reduce facility CDI SIR by 10% and below benchmark of 1.0. This outcome measure is analyzed as a SIR.

Analysis



Escondido CDI SIR (0.295) is below SIR Threshold and reduced 34% from previous year. Facility is performing better than the national average.

Poway CDI SIR (0.545) is below SIR Threshold but increased 350% from previous year. Facility is performing slightly worse than the national average.

Among the 17 CDI hospital-onset cases, 88% of stool specimens were collected appropriately by nursing without concurrent laxative-use within 48 hours of collection. The same proportion of cases had at least one risk factor for CDI prior to testing.

Intervention Summary

1. There is a Cerner rule that help identify community-onset CDI early in a patient's admission - A CDI lab order is placed if there is nursing documentation of 3 or more liquid/watery stools within 48 hours of the patient's admission. In 2024, this rule fired 21 times, where 12 stool specimens were collected for testing, and all resulted negative for *C. difficile*.
2. A stool collection algorithm for CDI testing continues to be shared with nurses and is available as a reference text for the lab order and GI assessment.
3. EVS room cleaning validation is performed routinely with a focus on patient in Contact and Contact Plus precautions.
4. Antimicrobial stewardship (see full project list below); vancomycin prophylaxis.
5. Stool specimen validation is a nursing-led collaborative practice of unit leadership reviewing collection practices with their team per stool collection algorithm.
6. Root cause analyses are performed for all CDI events by unit-based leadership.

Goal Assessment & Action Plan

Escondido met facility goal. Poway met facility goal. After review of hospital averages at a national level, our 2025 SIR goal is that each facility does not exceed a SIR threshold of 0.455.

- Distribute provider letter for appropriate CDI testing at least annually or as needed.
- Encourage more provider-to-provider coaching towards improving diagnostic stewardship.

Candida auris

Summary

Candida auris is an emerging and multidrug-resistant yeast, and a contact-transmissible pathogen via hands or environment. Per the local public health jurisdiction, Palomar Health screens admitted patient at risk for *C. auris*. If identified, they will be tested via bilateral swab of axillae and groin. Patients identified within or outside our facility are placed in transmission-based precautions, and investigated for possible hospital transmission or epidemiological linkage to another patient case. A risk group was modified in this screening to focus testing for residents from subacute care facilities versus all skilled nursing facilities.

At the direction of County Public Health Department, a point prevalence survey (PPS) may be performed on a patient census to assess for prevalence in this population. Infection prevention measures are concurrently assessed among affected units. One PPS was performed in April 2024 for the 6W patient population, after a patient from a local long-term care facility tested positive for *C. auris* whom of which was recently discharged from our facility. We tested eight patients for *C. auris* colonization and all resulted negative.

The manufacturer of our bleach wipes (PDI Bleach) used for patients in Contact Plus precautions was identified to not have the EPA kill claim against *C. auris*. We recognized that our general wipes (PDI Super Sani Cloth) had the claim and recommended this wipe for patients suspected or confirmed with *C. auris*. A new bleach wipe manufacturer with the EPA claim was brought into the system as a replacement (Medline Microkill).

Clinical Resource Management implemented the completion of an Inter-facility Transfer Form for patient transfers to other healthcare facilities. Patient isolation status and reasons are documented in this form and communicated to the receiving facility.

Action Plan

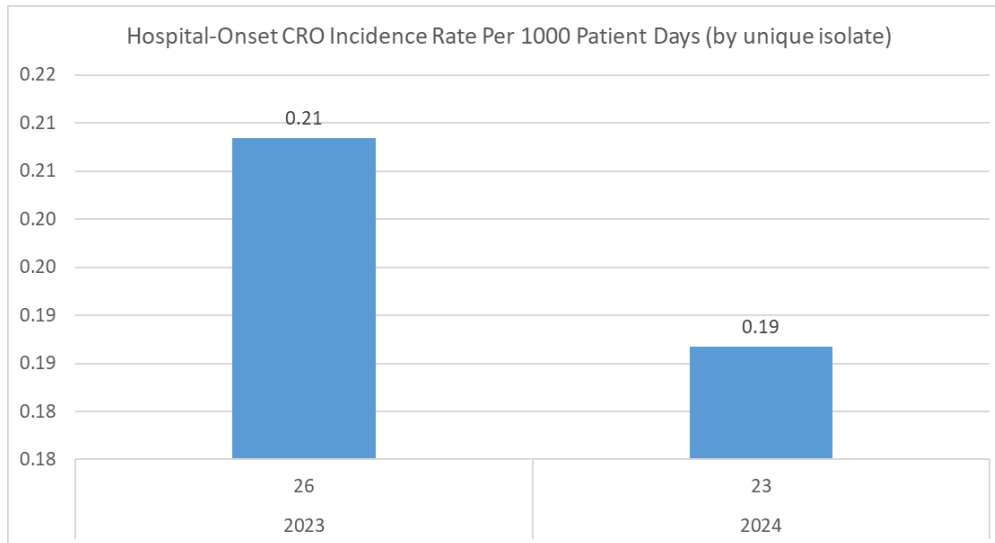
- Monitor and audit screening practice.
- Explore feasibility of a PCR test.

Carbapenem-Resistant Organisms (CRO)

Goal

Decrease organization-wide HO CRO cases by 10% compared to previous year.

Analysis



Healthcare onset is defined as day four or later in the admission, which NHSN definition requires for MDRO LabID cases. All specimen sources are considered. A SIR cannot be calculated because predicted numbers are not available. Hospital-onset cases decreased 12% from previous year.

Intervention Summary

Infection Preventionists identified that EVS cleaning in CRO rooms was performed as routine cleaning and left privacy curtains in the room. There were no trends in location and since the rooms are private at PMC Escondido and Poway, there were no close contacts. Education and monitoring of these rooms for cleaning efficacy was implemented. Early identification and precautions are used for high-risk patients. Patient with any organism with carbapenem resistance, regardless of mechanism, are placed in Contact Precautions to mitigate transmission.

Goal Assessment & Action Plan

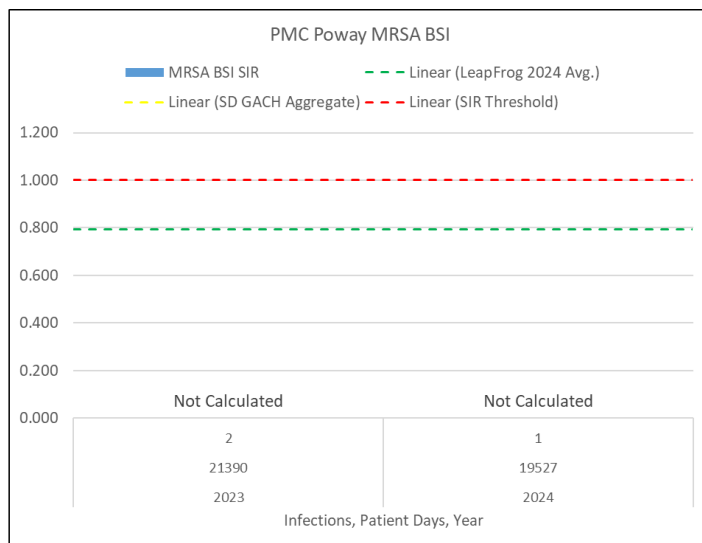
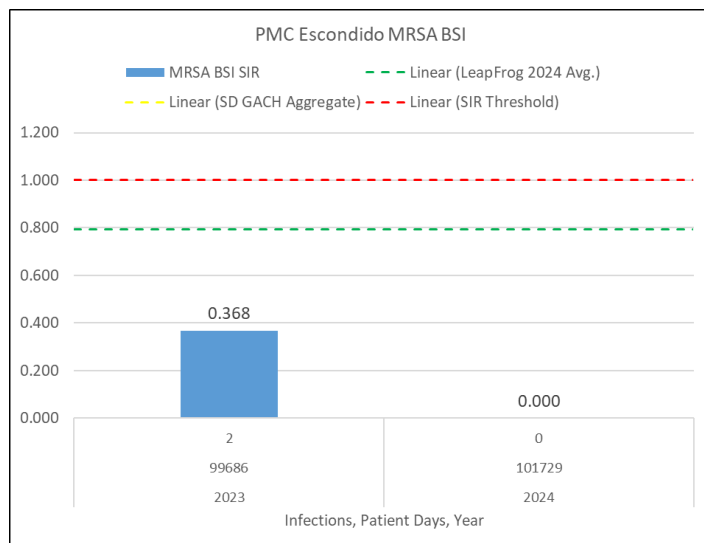
Organization met goal. With a validated report to identify all carbapenem resistant organisms, regardless of mechanism, the organization will reduce the incidence rate of hospital-onset CRO by 10% from previous year.

Methicillin-Resistant *Staphylococcus aureus*. MRSA Bloodstream Infection (BSI)

Goal

Reduce facility MRSA BSI SIR by 10% and below threshold 1.0. This outcome measure is analyzed as a SIR.

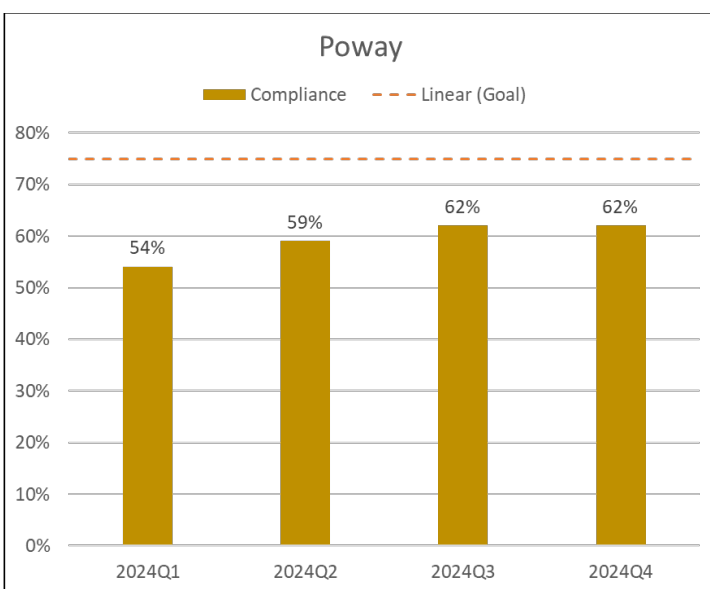
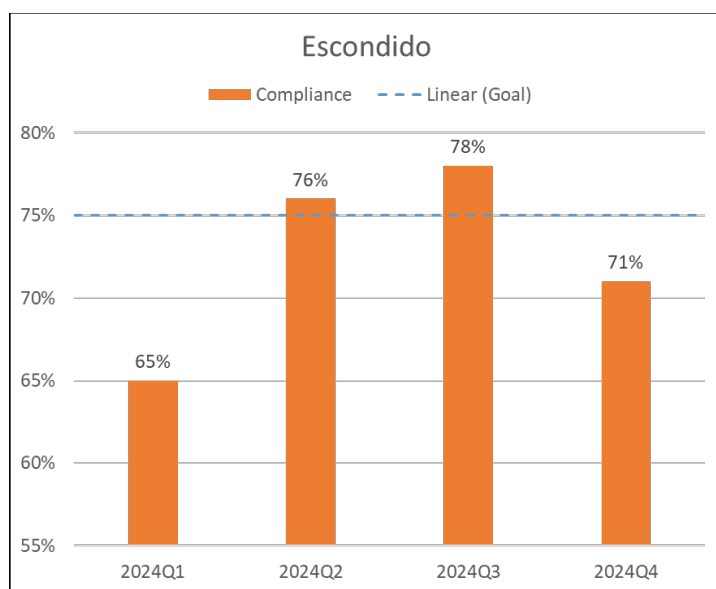
Analysis



Escondido MRSA BSI SIR reduced 100% from previous year and below SIR threshold of 1.0.

Poway MRSA BSI cases reduced by half from previous year, but was above SIR threshold of 1.0.

High-Risk Dialysis MRSA Discharge Screening



The data presented above demonstrates compliance with California mandate for *testing among* a high-risk population. Dialysis patients are the high-risk group that the Infection Control & Prevention Committee identified for testing upon admission and at discharge.

Intervention Summary

Processes that reduce the risk of transmission for MDRO's include; transmission based precautions, patient education, use of the correct precaution signs, ensuring gloves and gowns are available and wearing PPE when it is indicated.

1. Hand Hygiene adherence before and after patient contact (see [Hand Hygiene](#))
2. Transmission-based precautions practices are assessed for compliance routinely with ongoing reinforcement of Standard and Transmission Based Precautions.
3. Follow surveillance testing for MRSA colonization per Senate Bill 1058 of high-risk patients on admission and inpatient dialysis at discharge. Facility compliance goal for screening dialysis patients prior to discharge is at or above 75%.
 - a. Escondido did not meet goal.
 - b. Poway did not meet goal.
4. Continue to use Contact Precautions for infants colonized with MRSA and in NICU.
5. Environmental cleaning validation is performed routinely for patient rooms in Contact and Contact Plus precautions.

Goal Assessment & Action Plan

Escondido met facility goal. Poway did not meet facility goal. Maintain facility goal of a MRSA BSI SIR below threshold of 1.0.

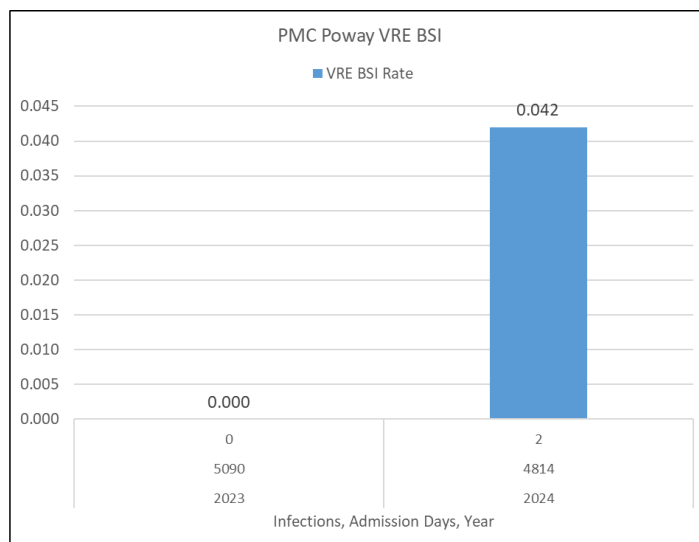
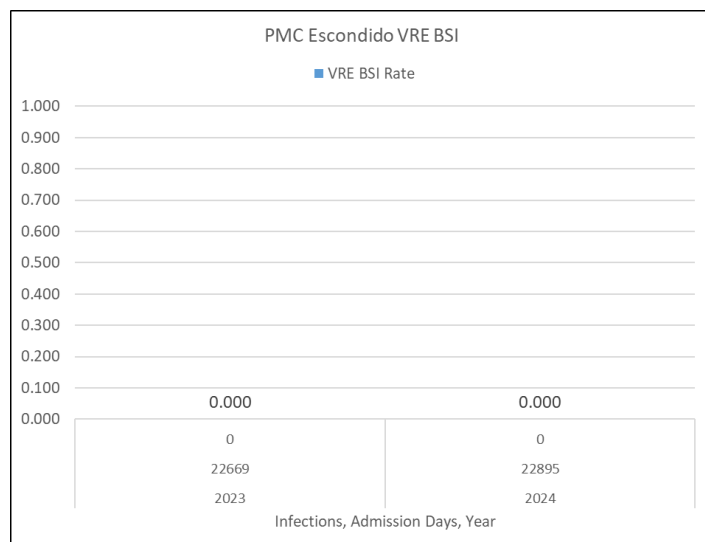
- Improve facility dialysis discharge MRSA screening by 10% from previous year.
- Review toolkits for hospital-onset bacteremia and fungemia prevention.

VRE Bloodstream Infection

Goal

Reduce facility VRE BSI rate by 10% from previous year. This outcome measure is analyzed as a rate per 100 admission days.

Analysis



Escondido VRE BSI rate is 0.00 per 100 admission days and has remained the same from previous year.

Poway VRE BSI rate is 0.042 per 100 admission days and increased from previous year.

Intervention Summary

Processes that reduce the risk of transmission for MDRO's include; transmission based precautions, patient education, use of the correct precaution signs, ensuring gloves and gowns are available and wearing PPE when it is indicated.

1. Hand Hygiene adherence before and after patient contact (see [Hand Hygiene](#))
2. Transmission-based precautions practices are assessed for compliance routinely with ongoing reinforcement of Standard and Transmission Based Precautions.
3. Environmental cleaning validation is performed routinely for patient rooms in Contact and Contact Plus precautions.

Goal Assessment & Action Plan

Escondido met facility goal. Poway did not meet facility goal. Maintain facility goal of a VRE BSI rate of improving by 10% from previous year.

- Review toolkits for hospital-onset bacteremia and fungemia prevention.

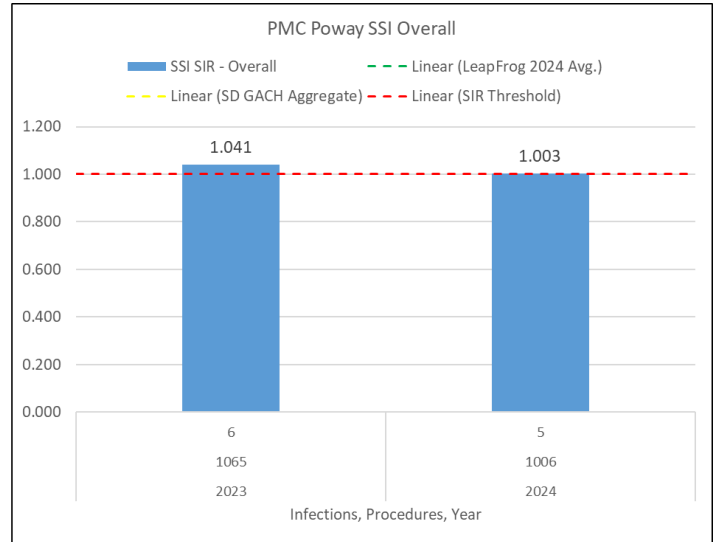
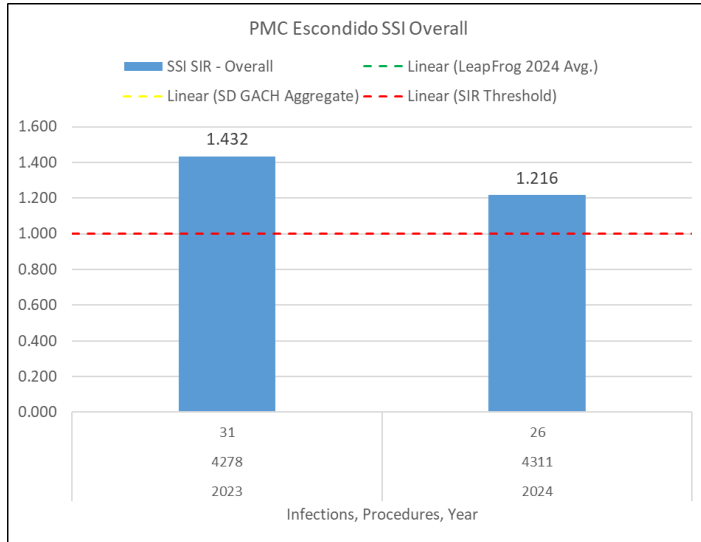
Surgical Site Infections (SSI)

Goal

Reduce facility overall SSI SIR by 10% from previous year and below SIR threshold of 1.0. This outcome measure is analyzed as a SIR using the Complex A/R SIR Model.

Analysis

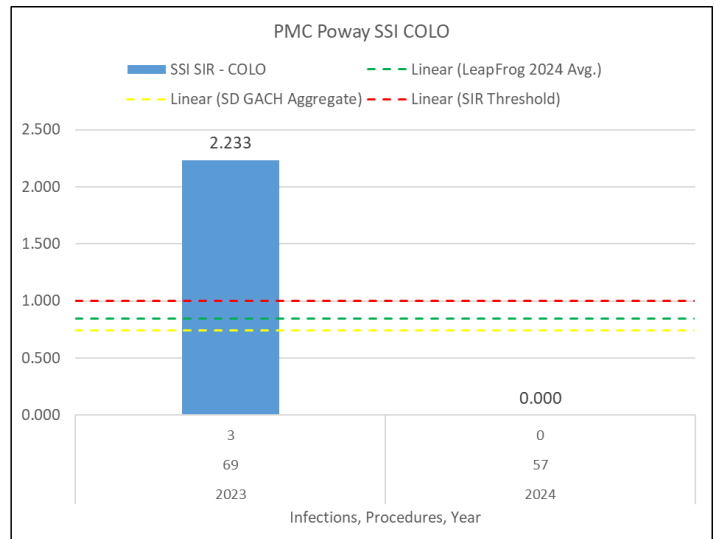
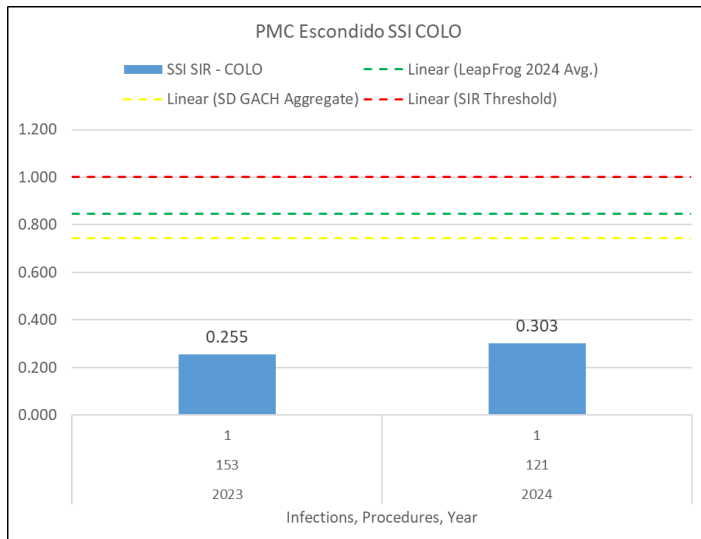
Overall SSI SIR



Escondido Overall SSI SIR (1.216) is above SIR Threshold but reduced 15% from previous year. Trends are identified by procedure type.

Poway Overall SSI SIR (1.003) is above SIR Threshold and decreased 4% from previous year. Trends are identified by procedure type.

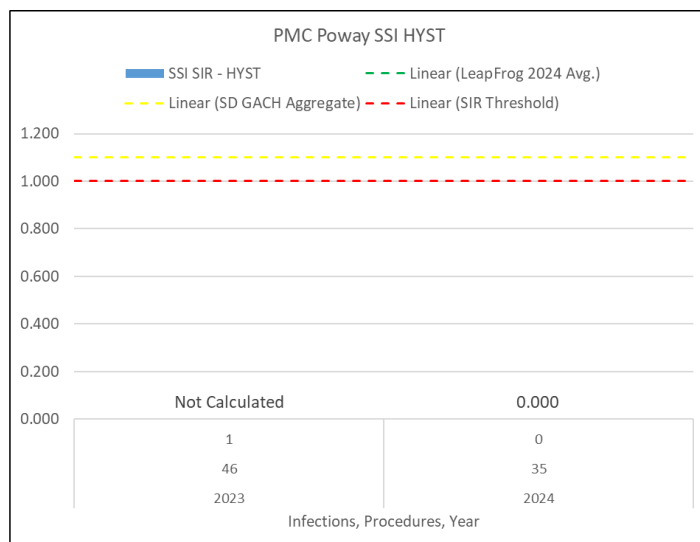
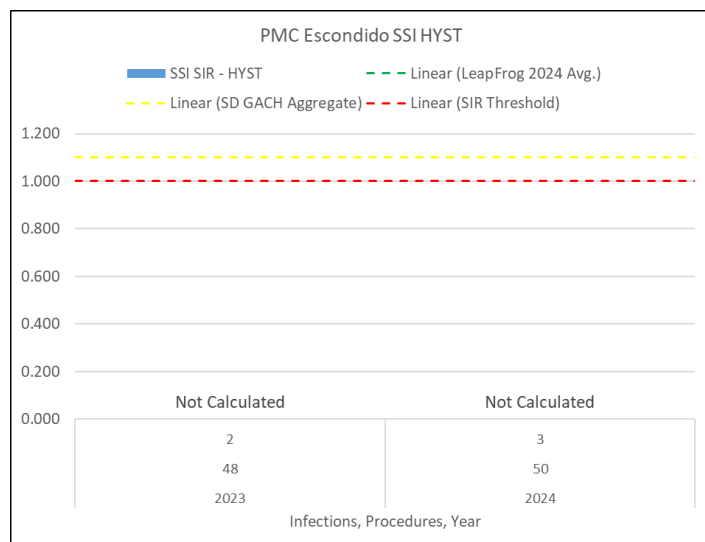
Colon (COLO) SSI SIR



Escondido COLO SSI SIR (0.303) is below SIR Threshold but increased 19% from previous year. There are no trends identified in this single case. Facility is performing better than the national average and other general acute care hospitals in San Diego County.

Poway COLO SSI SIR (0.000) is below SIR Threshold and decreased 100% from previous year. Facility is performing better than the national average and other general acute care hospitals in San Diego County.

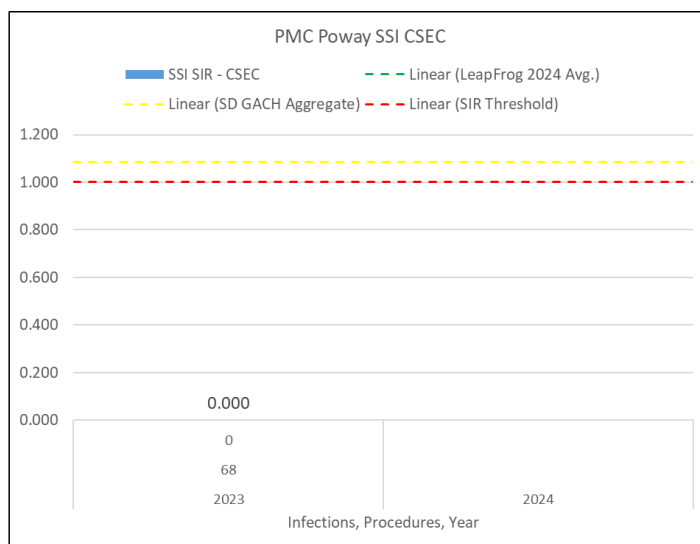
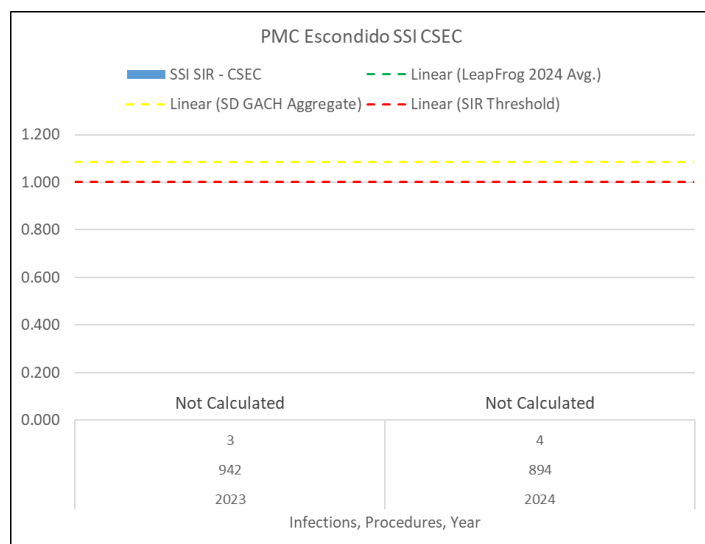
Abdominal Hysterectomy (HYST) SSI SIR



Escondido HYST SSI SIR is not calculated because the predicted value is less than 1.0 but nonetheless above SIR Threshold. There are no trends identified in these three cases. Facility is performing worse than general acute care hospitals in San Diego County.

Poway HYST SSI SIR (0.000) is below SIR Threshold Facility is performing better than other general acute care hospitals in San Diego County.

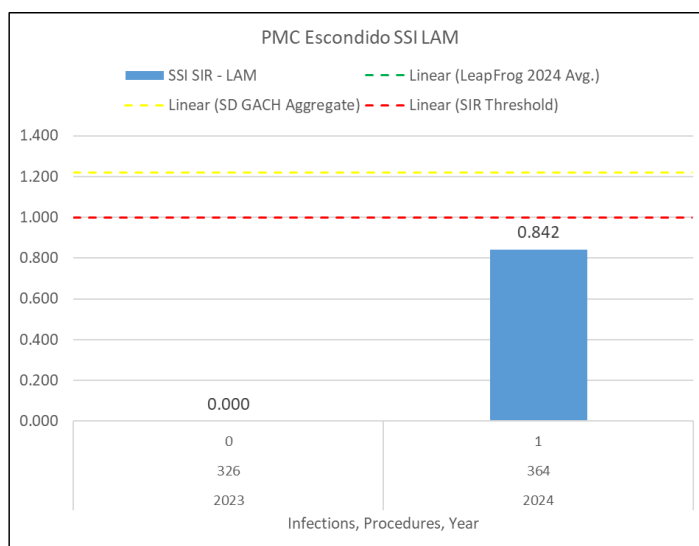
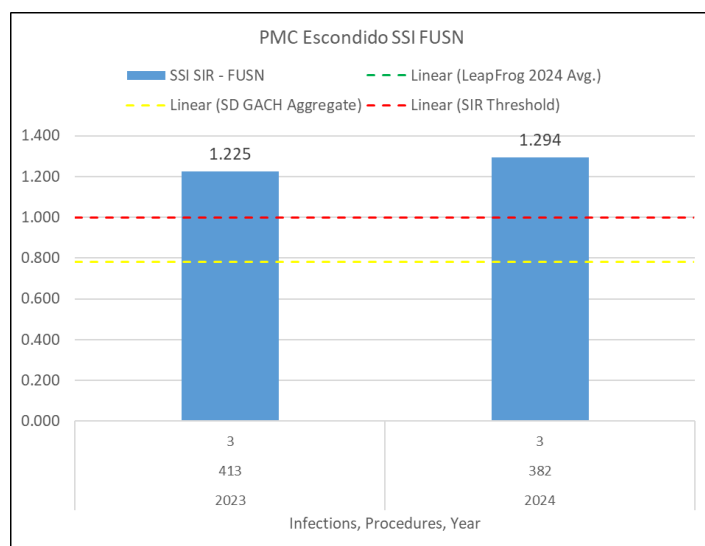
Cesarean Section (CSEC) SSI SIR



Escondido CSEC SSI SIR is not calculated because the predicted value is less than 1.0 but nonetheless above SIR Threshold. There are no trends identified in these four cases. Facility is performing worse than other general acute care hospitals in San Diego County.

No CSEC performed at Poway in 2024.

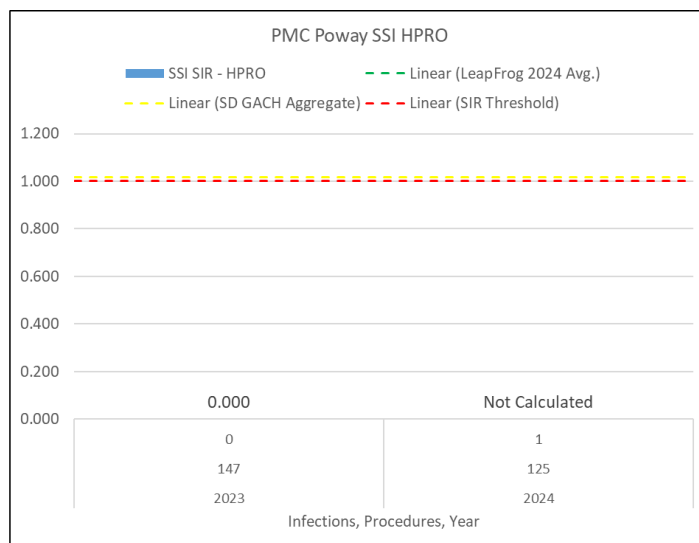
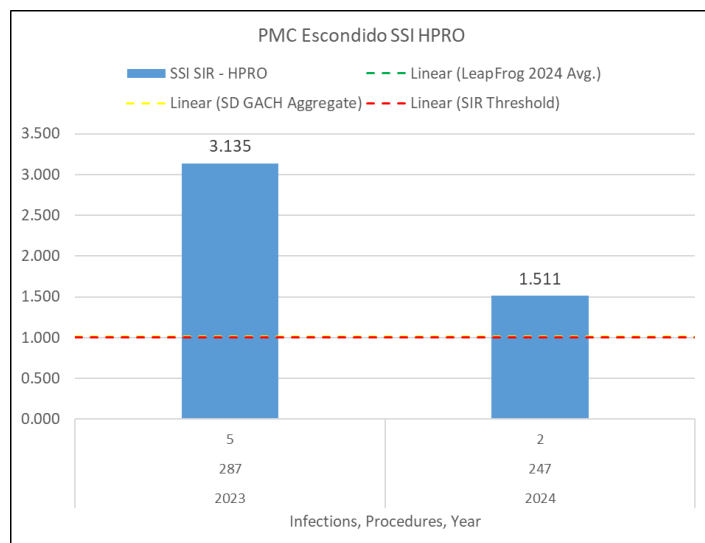
Spinal Fusion (FUSN) and Laminectomy (LAM) SSI SIR



Escondido FUSN SSI SIR (1.294) is above SIR Threshold and increased 6% from previous year. There are no trends identified in these three cases. Facility is performing worse than other general acute care hospitals in San Diego County.

Escondido LAM SSI SIR (0.842) SIR is below SIR Threshold but increased from previous year. Facility is performing better than other general acute care hospitals in San Diego County.

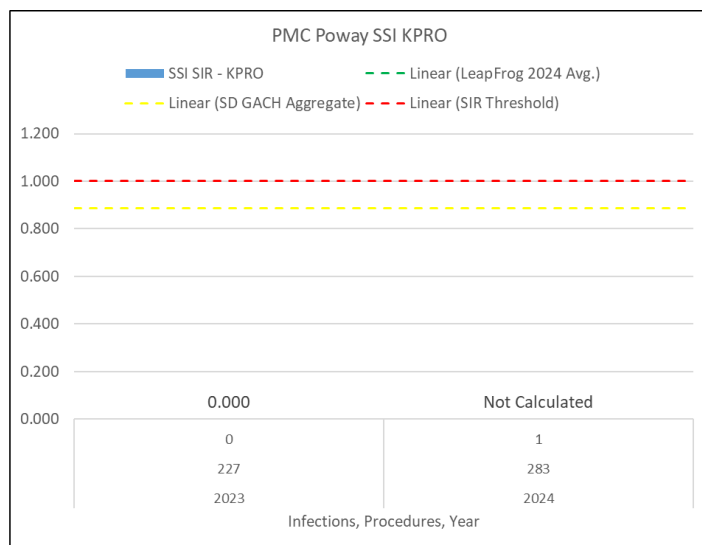
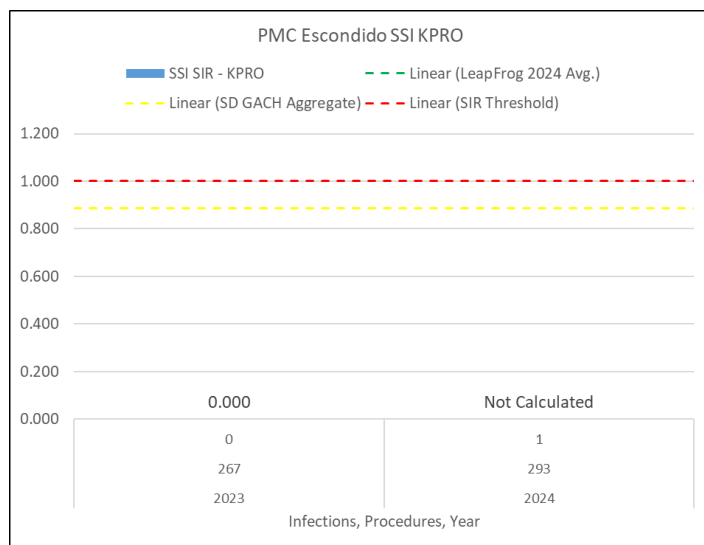
Hip Prosthesis (HPRO) SSI SIR



Escondido HPRO SSI SIR (1.511) is above SIR Threshold but decreased 52% from previous year. There are no trends identified in these two cases. Facility is performing worse than other general acute care hospitals in San Diego County.

Poway HPRO SSI SIR is not calculated because the predicted value is less than 1.0 but nonetheless above SIR Threshold. Facility is performing worse than other general acute care hospitals in San Diego County.

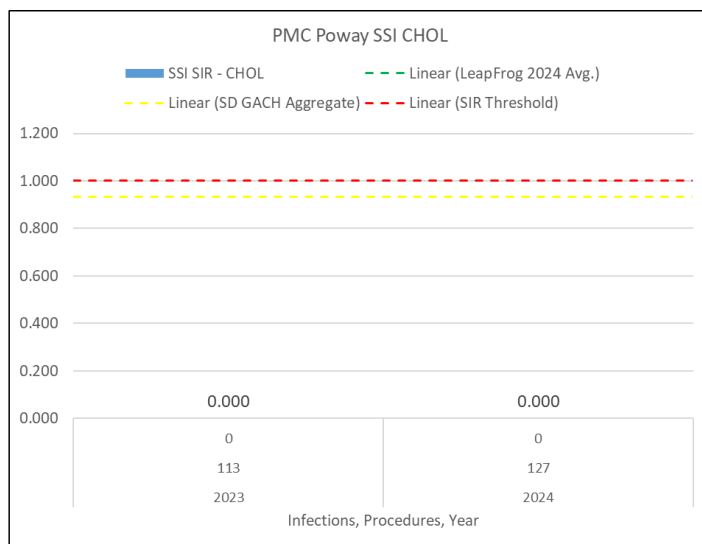
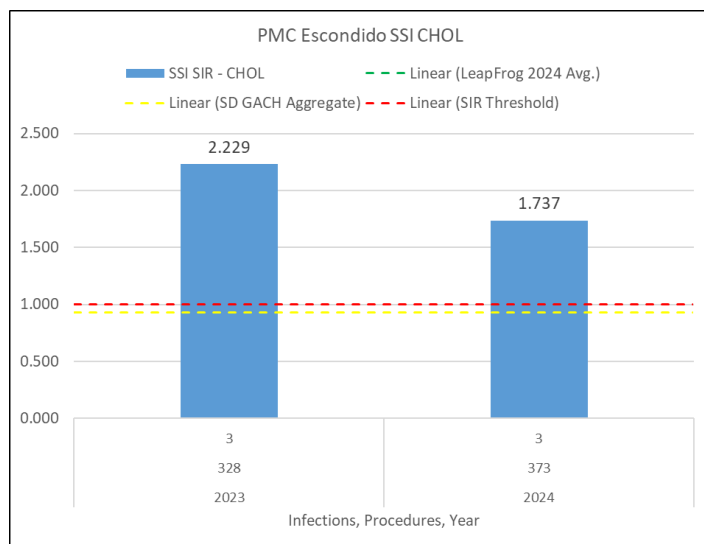
Knee Prosthesis (KPRO) SSI SIR



Escondido KPRO SSI SIR is not calculated because the predicted value is less than 1.0 but nonetheless above SIR Threshold. Facility is performing worse than other general acute care hospitals in San Diego County.

Poway KPRO SSI SIR is not calculated because the predicted value is less than 1.0 but nonetheless above SIR Threshold. Facility is performing worse than other general acute care hospitals in San Diego County.

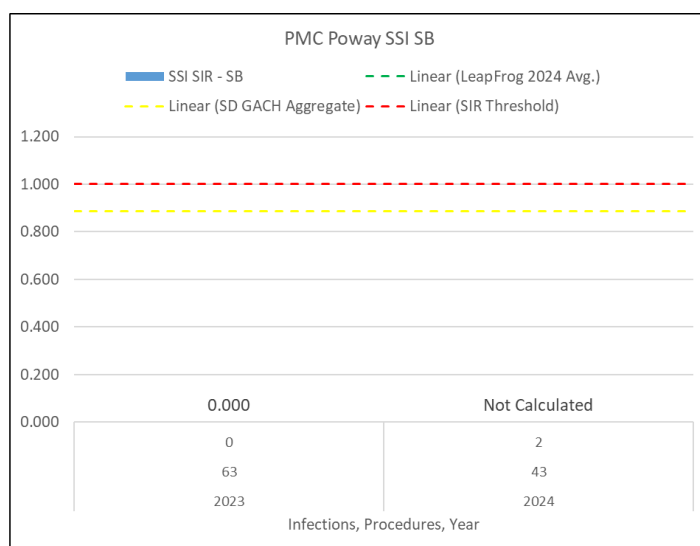
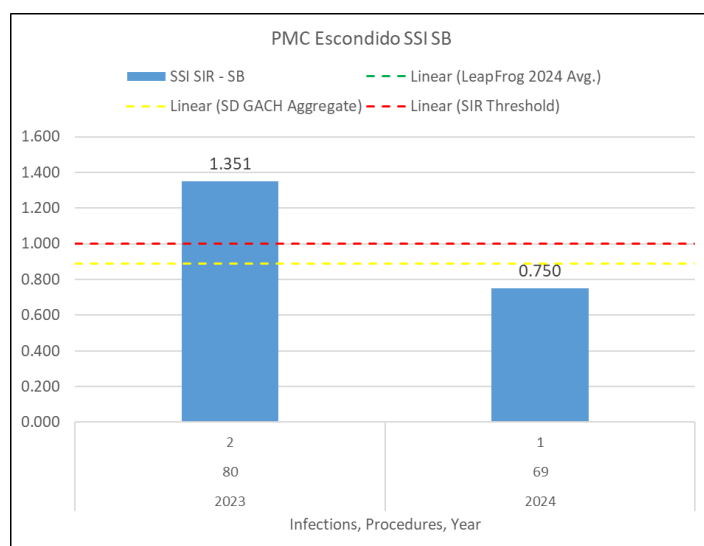
Cholecystectomy (CHOL) SSI SIR



Escondido CHOL SSI SIR (1.737) is above SIR Threshold but decreased 22% from previous year. There are no trends identified among these three cases. Facility is performing worse than other general acute care hospitals in San Diego County.

Poway CHOL SSI SIR (0.000) is below SIR Threshold. Facility is performing better than other general acute care hospitals in San Diego County.

Small Bowel (SB) SSI SIR



Escondido SB SSI SIR (0.750) is below SIR Threshold and decreased 44% from previous year. Facility is performing better than other general acute care hospitals in San Diego County.

Poway SB SSI SIR is not calculated because the predicted value is less than 1.0 but nonetheless above SIR Threshold. Facility is performing worse than other general acute care hospitals in San Diego County.

Intervention Summary

1. Provision of AORN wound classification and PATOS education for surgical services staff and surgical committees. Engaged medical director champions to identify and implement peer-to-peer responses to misses. Wound classification documentation errors are monitored and reported to surgical services.
2. Identifying and implementing surgeon champion for improving provider documentation.
3. RCAs are performed for each SSI for process measure compliance and practice or infection trends.
4. Orthopedic and Spine clinical workgroups review infections, trends, and process measures monthly. Preoperative decolonization (nasal betadine and CHG bathing) are reviewed process measures. Preoperative CHG bathing among this population improved 2% from previous year. Preoperative nasal betadine improved 4% from previous year. This order was standardized to be pre-checked in orthopedic and spine order sets. Issues identified with order or administration of nasal betadine is reviewed and reported back to this workgroup and preop nursing for education.
5. Ensure non-elective caesarian sections were receiving azithromycin.
6. Preoperative nasal betadine is a practice standard for cardiac procedures and improved 27% from previous year.
7. A colon bundle procedure is implemented as a guideline for colorectal surgeries.
8. Vaginal cleansing intervention continued for elective cesarean surgeries. Intervention was re-evaluated and clinical education to surgery staff was implemented. This performance measure will be closely monitored.
9. Antibiotic prophylaxis for surgery and procedures updated to latest standards. Vancomycin prophylaxis for patients with history of MRSA is a practice standard among orthopedic and spine procedures. Ensure non-elective caesarian sections receive azithromycin. Antibiotic choice, dosing and timing is monitored routinely among surgical site infections.
10. Daily between case and terminal cleaning of operating rooms by EVS. EVS leaders perform cleaning validation routinely.
11. Sterile processing of surgical instruments closely follow standards of The Association for the Advancement of Medical Instrumentation (AAMI). These standards are routinely monitored.
12. Environment of care rounds are routinely performed in SPD and surgery.

Goal Assessment & Action Plan

Escondido did not meet facility goal. Poway did not meet facility goal. Maintain facility goal of reducing the overall SSI SIR by 10% from previous year and below SIR threshold of 1.0

- Continue surgical case observations include Anesthesia observation. Develop checklist to standardize audit.
- Improve practice compliance with colon bundle elements like preoperative nasal betadine, CHG bathing, and antibiotic prophylaxis.
- There may be an opportunity to improve preoperative nasal betadine for cardiac procedures. Although compliance improved from previous year, the rate is only 60% (N=82). Explore standardizing order sets.
- Collaborate with the Department of Anesthesia Committee glucose control below 200 for all patients undergoing surgical procedures.
- Quality improvement project for OR room access and exiting.
- Continue wound classification data sharing and education as needed.
- Include race-ethnicity and location (zip code) to surveillance to analyze possible sources of health inequity.

Employee Health - Influenza Vaccination Rates

Goal

Organization influenza vaccination documentation rate >75% by end of 2023-2024 influenza season.

Analysis

Palomar Health District	Employees	LIP	Volunteers/Student	Contract	
Number of Staff	4294	222	81	30	
Count of HCP who received an influenza vaccine at this healthcare facility since influenza vaccine became available this season	1808	66	21	19	
Count of HCP who provided a written report or documentation of influenza vaccination outside this healthcare facility since influenza vaccine became available this season	511	124	45	9	
Count of HCP who have a medical contraindication to the influenza vaccine	15	1	1	0	
Count of HCP who declined to receive the influenza vaccine	725	31	14	2	
Count of HCP with unknown vaccination status (or criteria not met for questions 2-5 above)	1235	0	0	0	
Percent vaccination	54.01%	85.59%	81.48%	93.33%	56.26%
Total percent vaccinated, declined, contraindication	71%	100%	100%	100%	73.31%

The organization's influenza vaccination documentation (vaccinated or declined) rate is 73%. There were 1235 employees with an unknown influenza vaccine status at the time of this report. TJC standard establishing IC Standard for influenza vaccination for staff. California SB 739: annually offer on-site influenza vaccination to all staff. If employee declines vaccination, document why to provide insights for improvement efforts.

Goal Assessment & Action Plan

Organization did not meet goal. Improve vaccine documentation by 10% compared to previous season. Additionally, improve percent vaccination of the organization to 90%.

- Increased roving vaccination sites
- Increased night vaccination sites
- Continue to engage clinical leaders to assist with vaccinations (Villas, night supervisors)
- Employee Health Walk-in vaccinations encouraged
- Dedicated RN to administer Flu vaccinations Monday through Thursday
- Improve denominator by reducing the number of healthcare personnel with an unknown vaccination status.

Employee Health – Needle stick Injuries

Total needle stick injuries Palomar Health is 34

- Escondido Campus 30
- Poway Campus 4

Assessment & Action Plan

- Develop actionable data for needle sticks.
- Perform standard post exposure investigations and implement corrective actions.
- Continue notification by Employee Health and Safety when needle substitutes occur for employee education.
- Employee interview, what happened, why, how to prevent injury going forward.
- Assignment of education module Needle stick Prevention

Employee Health – ATD Exposures

YEAR TO DATE TOTALS	TB	Meningitis	Scabies	Pertussis	Measles	Varicella	Lice	Brucella	Mpox	Mumpa	Covid-19	TOTAL
Total number of exposures:	9			1		3				1	876	890
Number of exposures pending completion:	0			0		0				0	0	0
Number of exposures completed:	53			3		41				4	41	142
Number of employees tested:	1			0		0				0	0	1
Number of employee conversions:	0			0		0				0	0	0
Conversion rate: # conversions/total tested	0%	0%	0%	0%	0%	0%				0%	0%	0%
Number of employees non-compliant with follow up:	0			0		0	0			1	0	0
Comments												
Non Exposures												
- TB: No conversions, one employee non-compliant with f/u												
-Pertussis: All employees potentially exposed seen in EH, antibiotic script given. One exposed MD- will self-evaluate and prescribe antibiotic												
- Mumps: One employee identified as susceptible, non-compliant with f/u												
- Varicella: All employees potentially exposed had immunity either by titer or documented vaccination x2												
- COVID-19: No WC claims												

Assessment & Action Plan

COVID-19 exposures among ED staff remain high. COVID-19 exposures are primarily related to documentation of masking the patient with influenza like illness while under emergency care. In January 2025, Emergency Department leadership was tasked with reducing these exposures. See TB Exposure Plan and Risk Assessment for additional information.

Environment of Care (EOC)

Goal

Maintain facility $\geq 90\%$ compliance.

Analysis

Using the Infection Control EOC rounds survey in Rounds+, compliance with standard and transmission-based precautions, facilities related infection risks, cleanliness, waste disposal, appropriate storage and processing of patient care equipment and devices was measured, and proper decontamination, handling, transport, and storage of reprocessed devices can be measured. There are 63 questions in a survey. Trends of noncompliance in 2024 differed between site locations. Deficiencies are immediately reported to the appropriate leader if not resolved on site.

Escondido compliance rate is 89.33%, with the most deficient survey questions below:

1. Walls intact, free of penetrations, tears in wallpaper, peeling paint, spackling, etc.
2. Environment clean and free of heavy dust (includes high dust areas).
3. Environment and equipment are free of tape.
4. Single use items are disposed of after use.
5. No torn mattresses, gurneys, chairs, patient care equipment found.

Poway compliance rate is 86.99%, with the most deficient survey questions below:

1. Environment clean and free of heavy dust (includes high dust areas).
2. Walls intact, free of penetrations, tears in wallpaper, peeling paint, spackling, etc.
3. Environment and equipment are free of tape.
4. Sink fixtures are free from mineral buildup and visibly clean
5. Supplies are within recommended expiration date.

Goal Assessment & Action Plan

Escondido did not met facility goal. Poway did not meet facility goal. Maintain facility goal of $\geq 90\%$ compliance.

- EVS focus on dust in the environment.
- Multidisciplinary EOC team rounding monthly in scheduled areas.
- Report findings to Department Directors according to urgency of finding.
- Submit tickets through ServiceNow for service/repair requests.
- Infection Control to report trends and data to EOC and Infection Control committee.
- Leadership to develop action plan to address repeated or high-risk findings.

Environmental Cleaning Measures

EVS management validates environmental cleaning using a florescent marker validation tool and reports out at the Infection Prevention and Control Committee. This measure is implemented in accordance California Public Health Department Senate Bill requirement. The goal is 95%. The results are used in real time education and training.

Patient rooms, care areas, and public spaces are cleaned routinely and are scheduled according to time or frequency of use. The EVS Cleaning procedure outlines this cleaning in detail.

Cleaning, Disinfection, & Sterilization

Review of Cleaning and Disinfection Agents

The Infection Prevention and Control Committee reviews and approves all major disinfectants used within the system, and that they are used safely and according to their manufacturer's instructions, and compatible with materials and equipment used. Committee to continue to review with users to optimize disinfectants based on updated or new equipment MIFUs. IPC and EHS to review MIFU and SDS of all disinfection chemistries prior to purchase approval, i.e. follow VIP product review process.

DESCRIPTION	USER
WIPE OXIVIR 1	Cardiology Services, Radiology-Diagnostic
DISINFECTANT OER-PRO ACECIDE-C	Endo Patient Supply
DISINFECTANT PERIDOX RTU 1 GL	Environmental Services
DISINFECTANT VIREX 2.5L	Environmental Services
DISINFECTANT CLEANER OXYCIDE	Environmental Services
GERMICIDE LAB CONTROL III GAL	Microbiology
BLEACH 8.25% CLOROX PRO 121OZ	Microbiology, Laboratory-Clinical, Laboratory-Pathology
WIPE GERMICIDAL AF3 GRY	Patient Care Areas
WIPE DISINFECT BLEACH BLUE	Patient Care Areas
WIPE DISINFECT ALCOHOL PURPLE	Patient Care Areas
WIPE PHARMA WET STR 9X9"	Pharmacy
WIPE PHARMA DRY STRL 9X9"	Pharmacy
ALCOHOL 70% ISOPRP 16OZ SPRAY	Pharmacy
DISINFECTANT PERIDOX RTU 32 OZ	Pharmacy - Infusion Svcs
STERIS S40	Respiratory
CLEANER DISINFECT 10%BLEACH 32	SART/Child Abuse Program, Forensic Health Services, Critical Care
SOL DISINFECT OPA 1 GL	Sterile Processing Department
DISINFECTANT SONEX-HL TROPHON	Ultrasound, Perinatology
WIPE DISINFECTANT PLUS	Wound Care

Review of Patient Care Equipment and Reusable Medical Equipment

The Infection Prevention and Control Committee reviews all new patient care equipment and reusable medical equipment as a standing agenda item. The organization has three Value Improvement Process committees to vet the safety of new or changed patient care equipment and assess the current capacity of cleaning according to the manufacturer's instructions for use (IFU).

Equipment cleaning and disinfection is outlined in a procedure for reducing the risk of transmission of infectious diseases using medical equipment and by way of the environment. A Device Equipment Location and Accountability grid is reviewed annually and as needed as a comprehensive list of reusable medical equipment, its Spaulding classification, location/owner, the person(s) responsible for cleaning, how often it should be cleaned, and the approved cleaner/disinfectant.

Dialysis machines must be cleaned routinely following manufacturer's instructions. Dialysis machine equipment cleaning is audited routinely for appropriate disinfection between patient uses.

Infection Prevention Team and Supply Chain review FDA alerts, such as recalls and outbreaks due to product or medical device routinely.

Environmental Cleaning

EVS management through either direct observations or Florescent Marker Validation routinely monitors environmental cleaning. Cleaning of special rooms or area is audited routinely following the EVS Cleaning Procedure. These rooms include but not limited to, Isolation Rooms, Operating Rooms, Pharmacy IV Compounding, food preparation areas, and the NICU.

Sterilization Rounds

In the context of a Sterile Processing Department (SPD), sterilization is the process of completely destroying or eliminating all forms of microbial life, including bacteria, viruses, and spores, from medical devices and instruments to ensure patient safety and prevent infections. The sterile processing department is robust with engineered redundancies to mitigate infection risk through inappropriately sterilized medical equipment and instruments. SPD is routinely audited using an AAMI rounding tool. Results and deficient findings are reported directly with SPD management.

High-level disinfection Rounds

High-level disinfection (HLD) is a process that eliminates most microorganisms from medical devices and instruments. It is required semi-critical items that come into contact with non-intact skin or mucous membranes, heat-sensitive items that cannot be sterilized, critical ultrasound probes that cannot be sterilized, gastrointestinal endoscopes. All HLD processes and process owners are audited routinely and include but not limited to speech therapy, cardiology, perinatology, endoscopy, respiratory services, and ultrasound. Results and deficient findings are reported directly with department management.

Environmental Testing

Environmental testing is performed in compliance with Infection Control Risk Assessment. Results outside normal parameters are reported directly to the Infection Prevention and Control Committee with a plan of correction. The Water Management Plan outlines testing of water sources on inpatient and outpatient locations. Environmental testing is performed by third-party consultant for identification and control of environmental risks and hazards as indicated. The organization follows recommendations of third-party consultant for remediation and follow up testing. If results exceed threshold, services may be interrupted while investigations and action plans are created and implemented. Dialysis machines are tested monthly testing for bacterial growth, and there has been no growth reported in 2024.

Construction

System provides consultation, perform Infection Control Risk Assessment (ICRA) for construction and renovation projects, and provide education to Facility Operations, Information Technology (I.T) and Construction personnel.

Palomar Health has an Infection Control and Prevention procedure in place for assessing the risk on construction/renovation projects to determine the appropriate barriers needed in order to mitigate the dispersion of dust. In addition, there were no cases associated with construction or renovation projects.

1. Monitor all construction and renovation projects and issue an ICRA.
2. Provide dust mitigation education to Facility Operations, Information Technology and Construction personnel annually and prior to hospital construction and renovation activity.
3. Collaborate with Facility Operations, Construction Project Management, Information Technology (I.T) and Environmental Services (EVS) through virtual meetings.
4. Provide construction and renovation education to new vendors.

Infection Control Education

Among routine New Staff Orientation held monthly the following educational opportunities were offered in real time and otherwise scheduled in-services including:

1. Mask and eye protection as transmission based precaution to prevent COVID-19 exposure
2. Chlorhexidine bathing
3. Automated isolation precautions orders based on lab orders
4. MRSA colonization vs. infection and isolation precautions
5. Pre-treatment and transport of reusable devices
6. Hand Hygiene
7. Trophon 2 implementation
8. Ion device cleaning and disinfection
9. Infection Present at the time of surgery Wound classification
10. Food and Nutrition education is now provided by the department.
11. Annual EVS education for both campuses, and added physical demonstration of hand hygiene.
12. Hand hygiene return demonstration for staff that have contact with patients (Including providers, EVS staff, new clinical staff hires) and Providers during onboarding.
13. CAUTI and CLABSI Risk Reduction Rounds with unit educators, CNS and primary nurses. Just in time, education is provided when needed and unit leaders received a summary of findings with recommendations. CNAs were included in the education.
14. Regular review of C diff testing orders/collection and provided unit feedback when a test appeared not properly collected. Rounded with staff responsible for collecting and documenting stools and reviewing C diff algorithm.
15. Attended unit huddles and provided infection prevention education on different topics.
16. Rounded with staff regularly and reviewed different topics: C diff algorithm, CHG bath, Pericare with Foley and other topics that reduce risk for infections.
17. Provided infection control education with visitors, which included hand hygiene and how to use PPE.
18. EVS cleaning observations with leadership and just in time recommendations when needed including contact plus precautions.
19. Annual Skills station: collected urine aseptically through a catheter and filling urine tubes.

Assessment & Action Plan

Infection Control provided education routinely, upon request and during real time opportunities. Construction and renovation education is ongoing and in virtual format.

1. Update the ready reference site on intranet for Infection Control topics
2. Provide real time education when indicated during Infection Prevention unit/department rounds
3. Provide hand hygiene education addressing non-compliance.

Reportable Communicable Diseases

The organization has a critical role in complying with Title 17 of the California Code of Regulations, particularly concerning Confidential Morbidity Reporting (CMR) requirements from the California Department of Public Health (CDPH).

Here is a summary of the organization's responsibilities:

- **Reporting of Reportable Diseases:** Hospitals, through their healthcare providers, are obligated to report specific diseases and conditions listed in Title 17 to the local health officer. This includes a wide range of communicable diseases, and the urgency of reporting varies depending on the disease.
- **Adherence to Reporting Timeframes:** Title 17 specifies different reporting timeframes. Some diseases require immediate telephone reporting, while others must be reported within one working day or seven calendar days. Hospitals must establish procedures to ensure these deadlines are met.
- **Accurate and Complete Reporting:** Reports must include accurate and complete patient information, such as demographics, diagnosis, and relevant clinical findings. The Confidential Morbidity Report (CMR) form is a key tool for this process.
- **Establishing Internal Procedures:** Hospital administrators are responsible for creating and implementing internal procedures to ensure that all healthcare providers within the facility comply with reporting requirements. This may involve training, clear communication channels, and designated reporting personnel.
- **Confidentiality:** Hospitals must maintain the confidentiality of patient information reported under CMR requirements.
- **Staying Updated:** Hospitals must stay up to date on changes to title 17, and changes to what diseases are reportable, and how they are to be reported.

When emerging infectious diseases are occurring in the community or community at large, infection control and hospital ensure staff and the facilities are prepared for the detection and management of these cases. Infection Control attends a virtual monthly meeting with County Epidemiology on current public health issues, and receives weekly and monthly reports on influenza and communicable diseases in San Diego County, respectively. Infection Prevention continues to report COVID-19 hospitalization data to and healthcare personnel vaccination (HCP) data to NHSN. Infection Prevention routinely works with San Diego County Epidemiology, responding to requests, initiating reports, and outbreak investigations.

Antimicrobial Stewardship/Infectious Diseases Projects

- 2024-2027 California Department of Public Health Healthcare-Associated Infections Antimicrobial Stewardship Program Honor Roll – Gold Status
- Responses to CDC Health Alerts
 - Extension of Long-Acting Benzathine Penicillin G (Bicillin L-A) Shortage
 - Developed IT alerts in Cerner and education to providers on conserving use for treatment of Syphilis
 - New strain of clade I Mpox education and access to Tecovirimat
 - California statewide discontinuation of ciprofloxacin for invasive meningococcal disease post-exposure prophylaxis
- Antimicrobial Committee
 - Meets at least once a quarter (on average every 2 months)
- Quarterly Review of All Surgical Site Infection and *Clostridioides difficile* Infection (CDI) Cases
- Quarterly Review of Facility-Wide Antimicrobial Usage and Resistance Data
- Quarterly Review of Protected/Restricted Antimicrobial Usage
- Quarterly Review of Pharmacist Initiated Antimicrobial Stewardship Interventions
- Annual Review of Influenza Vaccine Efficacy and Cost Analysis
- Joint Commission Response to Pre-Op Antibiotic Administrations
- Provided Memo to Med Staff, Nursing, Pharmacy on National Blood Culture Media Shortage
- Information Technology (IT) projects
 - Add IV Penicillin to Graded Challenge and Desensitization PowerPlan
 - Remove Prevnar 13 order sentences
 - Update PO Vancomycin Order Sentences
 - Update ED Empiric Therapy for Severe Sepsis + Sepsis – Antibiotics PowerPlan Updates
 - Update ED Suspected Sepsis Order Set
 - Update COVID-19 Vaccine Screener to accommodate 2nd dose for ≥ 65 y/o
 - *Clostridioides difficile* Antibiotics PowerPlan – Add Tigecycline as Treatment Option for Fulminant *C. diff* Infection
 - Removing Unasyn from Multiple Intra-Abdominal Treatment PowerPlans
 - Update Unasyn orders in Cellulitis PowerPlans
 - Update Unasyn and Azithromycin Orders in Asthma/COPD Exacerbation PowerPlan
 - Update Weight Based Clindamycin Order Sentences
 - Update Antibiotic Timeout Alert
- Microbiology Collaboration
 - BioFire Pneumonia PCR Panel
 - Nutritionally Variant Streptococci + Gemella Reporting
 - Urine Culture Reporting Updates
 - Susceptibility Testing on Stool Isolates
 - Susceptibility Testing on *Corynebacterium* Species (excluding diphtheria)
 - Susceptible Dose Dependent Reporting for Zosyn and Cefepime
 - *Neisseria Meningitidis* susceptibility Testing & Reporting
 - Amikacin Reporting for *Pseudomonas aeruginosa* Urinary Isolates
 - *Staphylococcus aureus* Susceptibility Reporting – Hide Rifampin and Gentamicin Susceptibilities Unless Requested
 - *Enterobacterales* Susceptibility Reporting – Hide Tetracycline Susceptibilities
 - Yeast Nomenclature Update
 - Update Definition and Reporting of MDRO *Pseudomonas aeruginosa*

- Release Only Oxacillin, Vancomycin, and Daptomycin on MRSA & MSSA Blood Cultures
- Release Daptomycin on All Non-Respiratory MRSA Isolates (exclude urines)
- Release Linezolid on All Wound and Respiratory MRSA Isolates. Hide Linezolid on Blood, Urines, and Sterile Sites
- Hide Tetracycline and Minocycline on *Staphylococcus aureus* Isolates in Respiratory, Blood, and Urine Cultures
- Hide Bactrim (Trimethoprim/Sulfamethoxazole) Susceptibility on All *Staphylococcus aureus* Respiratory and Blood Cultures
- Carbapenem Resistant Organisms Definition/Reporting
- Review and Publication of Annual Antibigram and Letter to Prescribers
- Review of All Blood Polymerase Chain Reaction (PCR) Discordant Results
- Annual Review of Resistance Rates of Multi-Drug Resistant Organisms
- CDI Testing in Patients < 1 Year Old
- Acinetobacter spp. (non-baumannii) Antimicrobial Susceptibility Testing
- Medication Usage Evaluations (MUE)
 - 2023 Case Review of All Patients Receiving Ceftazidime-Avibactam and Ceftolozane-Tazobactam
 - Annual analysis of cost savings from Emergency Department (ED) Callback Program driven by ED pharmacist
 - Quarterly analysis of cost savings from de-escalation of vancomycin by pharmacy
- ASP Updates to Medical, Nursing, and Pharmacy Staff
 - Discontinuation of Ciprofloxacin for Invasive Meningococcal Disease Post-Exposure Prophylaxis
 - Ceftriaxone 1g vs 2g q24h Pharmacokinetics Analysis
 - Developed Post-Splenectomy Vaccine Educational Handout for Nursing and Patients
 - Paxlovid Utilization Update
 - Education to Medical Staff on Best Practices in Antimicrobial Therapy
- Policy and Procedure Updates
 - Aminoglycoside Dosing Service
 - Antibiotic Stewardship Program
 - Restricted Antimicrobial Procedure
 - Standard Adult Antibiotic Doses
 - Antimicrobial Sub-Committee
 - Bioterrorism Employee Prophylaxis Antibiotic Cache Deployment
 - CK Monitoring During Daptomycin Therapy
 - Fecal Microbiota Transplant
 - Drug Dosing by Indication – Weight – Renal Function
 - CK Monitoring During Daptomycin Therapy
- Manage Shortages and offer alternatives
 - Amphotericin B deoxycholate
 - Bicillin L-A
 - Erythromycin Ophthalmic Ointment
 - IV Acyclovir
 - IV Caspofungin
 - IV Ciprofloxacin
 - IV Fluconazole
 - IV Levofloxacin
 - IV Linezolid
 - IV Metronidazole

- Rabies Vaccine (Imovax)
- Formulary Review
 - Cefepime-Enmetazobactam (Exblifep)
 - Add Cefdinir PO Solution to Formulary for NICU
- Guidelines
 - CDPH UTI/SNF County-Wide Initiative Project
 - Developed SNF UTI Guidelines
 - Developed UTI SBAR for Nursing Checklist
 - Updated Palomar Health Outpatient UTI Treatment Guidelines
- Antimicrobial Stewardship Resident Projects
 - Impact of Additional Comments on Microbiology Reporting for AmpC Organisms
 - Evaluating the Negative Predictive Value of MRSA Nares Screen in Skin and Soft Tissue Infections at or Above the Waist
 - Oral Vancomycin for Secondary Prevention of *Clostridioides difficile* Infection

Palomar Health Imaging Services – Radiology and Nuclear Medicine Report

Presented to Board Quality Review Committee
May 28th 2025

Charles McGraw, MD | Chair, Department of Radiology, PMCE

Arian Nasiri, MD | Chair, Department of Radiology, PMCP

Ryan Fearn-Gomez | Vice President of Operations and Support Services

Sims Kendall, MHA-SI | District Senior Director, Imaging Services

Radiology and Nuclear Medicine Annual Report – FY2025

SITUATION	Radiology and Nuclear Medicine evaluates and reports on specific performance metrics to ensure compliance with Palomar Health policies and regulatory requirements.
BACKGROUND	The exceptions noted by Radiology and Nuclear Medicine for FY2025 include partially achieved PI goals, 2 identified safety opportunities. MRI throughput delays are leading to increased backlog of exams periodically.
ASSESSMENT	<p>Process improvement actions were implemented to reduce turn-around-times (TAT) for Emergency Department ordered imaging studies in FY2023 and beyond. The specific actions were developed through bi-weekly (now monthly) intra-departmental leadership meetings between ED and Imaging. Reading delays are now very infrequent to non-existent. MRI throughput is increasing.</p> <p>The radiation dose badge program identified no physician or staff badges which breached the ALARA level 2 range during this reporting period.</p> <p>Women’s Center communication and process errors identified and corrected.</p> <p>Potential burn risk for MRI Poway from EKG improper screening identified and corrected.</p>
RECOMMENDATION	<ol style="list-style-type: none"> 1. Radiology: Continuation of monthly process improvement meetings with ED Leadership, including providers, to reach goal achievement in the targeted period. 2. Radiation Safety: Provide ongoing communication and data to physicians and staff on the radiation dose badge program requirements and results. 3. Women’s Center: Education of staff, restructure of communication process, and documentation revision for clarity with an auditing/reporting period of no less than (6) months. 4. MRI: Education of staff, revision of screening form and policy, and auditing/reporting period of no less than (6) months.

Radiation Safety and Imaging Performance Indicators

- **Process Improvement:** Turn-Around-Times for ED imaging studies
- **MD Dosimetry Badge:** Occupational dose and ALARA* breaches
- **Staff Dosimetry Badge:** Occupational dose and ALARA* breaches
- **Physicist report:** Required annual testing of all Imaging equipment
- **MRI:**
 - Burns
 - Ferrous events
 - Increased throughput
- **Women's Center:**
 - Wrong-site auditing with monthly goal of 100%
- **Nuclear Medicine:** Linearity testing

**ALARA – As Low a Reasonably Achievable*

Imaging Process Improvement Accomplishments

- **Process Improvement:** ED Imaging Median Turn-Around-Times (TAT)
 - CT order to complete (Goal 60 min)
ESC: 48 to 52 min (↑ 8.3%) | POW: 65 to 75 min (15.4↑)
 - US order to complete (Goal 60 min)
ESC: 80 to 75 min (↓ 6.3%) | POW: 53 to 51 min (↓ 3.8%)
 - XR order to complete (Goal 30 min)
ESC: 34 to 33 min (↓ 2.9%) | POW: 20 to 20 min (---)
 - MRI efficiency:
ESC: Daily throughput average has increased to 19 (+5) per day since Sept '24.

Radiology Enhancements

- System-wide radiologist coverage is vastly improved; reading delays are virtually non-existent.
- 24/7 Esco MRI scanning; continued optimization of staff.
 - Transitioned to 12-hour shifts on 04.06.2025.
- Collaboration with Clinical Services for targeted help during peak times has been beneficial.

Radiation Safety (FY2025)

Physician and Staff Dosimetry Badges

- Physician Dosimetry Badges
 - No badges breached ALARA Level 2 range
- Staff dosimetry Badges
 - No badges breached ALARA Level 2 range

* Radiation Protection and Safety Plan, Lucidoc #56232

Annual Testing & Physicist Inspections FY25

Annual Physicist Testing

- 100% compliance with timeliness of inspection.
 - Annual Physicist Inspections are required on all:
 - Ultrasound machines and transducers
 - Magnetic Resonance Imaging Scanners
 - Diagnostic Imaging systems
 - All mobile (trailer) units also have current Physicist inspections

Dose Calibrator Linearity Test

- Tested quarterly.
- Result is pass or fail.
- FY25 to present Dose Calibrator Linearity Testing
 - PMC Escondido: **PASS**
 - PMC Poway: **PASS**

PMCP Women's Center Process Improvement

- Revision of paper order.
- Re-education of staff and radiologists on performing universal timeout and importance of paper order.
- Implementation of daily huddle between staff and radiologist to discuss the day's cases.
- Improvement of communication between providers when discrepancies arise.

Month	# performed correctly	# of procedures time out observed	% Compliance	Goal
Aug 24	11	11	100%	100%
Sep 24	15	15	100%	100%
Oct 24	18	18	100%	100%
Nov 24	11	11	100%	100%
Dec 24	12	12	100%	100%
Jan 25	16	16	100%	100%

Month	Doc consent matches order	Doc IC done	Doc/ consent	Doc side site	# Loc Perf	%	Goal
Aug 24	11	11	11	11	11	100%	100%
Sep 24	15	15	15	15	15	100%	100%
Oct 24	18	18	18	18	18	100%	100%
Nov 24	11	11	11	11	11	100%	100%
Dec24	12	12	12	12	12	100%	100%
Jan 25	16	16	16	16	16	100%	100%

MRI Burns and Ferrous Events:

- **Confirmed MRI Burns:**
 - Escondido: 0
 - Poway: 0
- **Ferrous events:**
 - Escondido
 - With injury: 0
 - Without injury: 0
 - Poway
 - With injury: 0
 - Without injury: 0

PMCP MRI Screening and Documentation Improvement Activity

- Revision of pre-procedure policy.
- Revision of screening form for attestation of “no changes”.
- Re-education of staff to ensure proper screening is taking place.
- Education of nursing staff via iXpand (MRI Safety).

Month Poway	# patients checked for prohibited items	# MRIs / 4 MS	%	Threshold
Nov 24	25	25	100%	100%
Dec 24	63	64	98%	100%
Jan 25	12	12	100%	100%
Feb 25	62*	62*	100%	100%
March25	39	40	98%	100%
April 25				100%

Respiratory Therapy Services Presented to Board Quality Review Committee May 28th 2025

Krysti Johnson, Respiratory Manager



SBAR: Reducing Ventilator Days

SITUATION	Mechanical ventilation is lifesaving therapy in intensive care units but can increase a patients' risk for ventilator-associated events. These events are associated with longer intensive care unit and hospital stays, increased ventilator days, increased risk of infection, which can lead to increased risk of mortality and higher health care costs.
BACKGROUND	Ventilator-associated pneumonia (VAP) is the most common hospital acquired infection in Intensive care units. Ventilator-associated events (VAE) has now replaced traditional VAP Surveillance and is widely used in the USA.
ASSESSMENT	To meet internal and national benchmarks, the number of ventilator days in a intensive care unit needs to be decreased.
RECOMMENDATION	<p>The Respiratory department will utilize the "Plan/Do/Study/Act" framework in this quality improvement project. The project will include 5 West. Evidence-based guidelines for decreasing ventilator days will be incorporated into the interventions. Interventions should include, but are not limited to:</p> <ul style="list-style-type: none"> • Avoid intubation if possible • Utilize the use of non-invasive ventilation and High Flow Therapy to prevent intubation. Also these therapies should be used immediately upon extubation to help prevent reintubation • <u>Paired</u> daily spontaneous awakening and breathing trials (SAT & SBT) • Multidisciplinary rounds, which include current ventilator settings and results of SBT • Staff education • Audits <p>Results: Pre-implementation data will be compared with Post-implementation data</p>

PDSA: Reducing Ventilator Days

- Continue to focus on the use of non-invasive ventilation and High Flow Therapy to prevent intubation and immediately upon Extubation to prevent reintubation.
- Collect data on percentage of eligible patient receiving daily SBT
- Continue to discuss SBT results at rounds

ACT

- Avoid intubation if possible.
- Utilize the use of non-invasive ventilation and High Flow Therapy to prevent intubation.
- These therapies should be used immediately upon extubation to prevent reintubation in high risk patients.
 - Standardize the spontaneous breathing trials (SBT)
- Attendance at Multidisciplinary rounds

PLAN

5W	2023Q4 SUR	2024Q4 SUR
SUR	1.069	0.948
Mean	1.070	0.948
SD	0.06458	0.03107

- Comparing 2023Q4 to 2024Q4 standardized utilization ratio of ventilator days, by conventional criteria, this difference is considered to be statistically significant (p-value=0.0424).
- 95% confidence interval -0.23655 to -0.00678

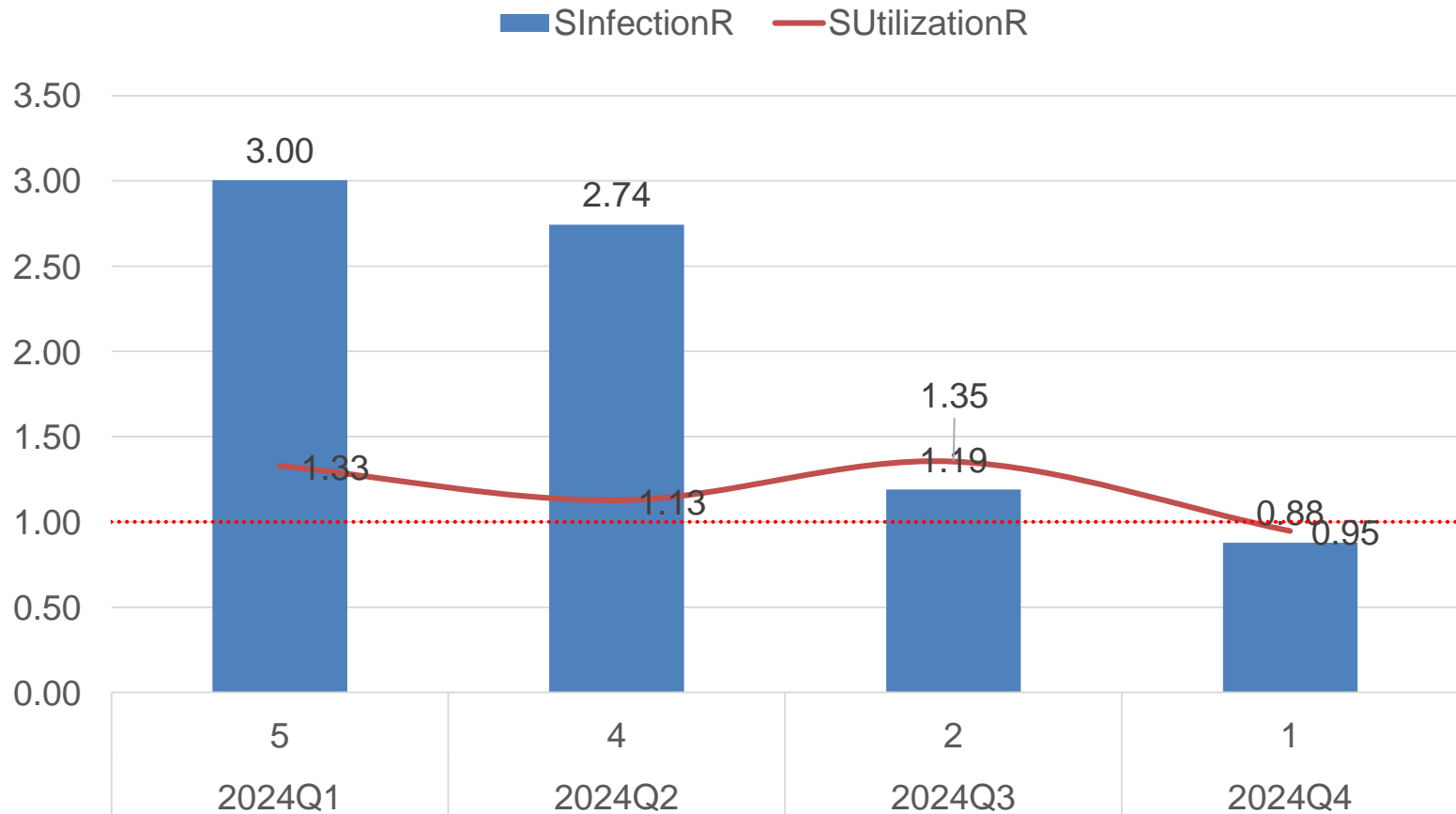
STUDY

Do

- Provide education on the use of non-invasive ventilation device pre and post intubations for high risk patients.
- Perform biweekly audits to ensure compliance with interventions.
- Review data weekly to identify opportunities for improvement.

Standardized Utilization Ratio (SUR)

is the primary summary measure used by the National Healthcare Safety Network (NHSN) to compare device utilization at the national, state, or facility level by tracking ventilator use.



Action Plan with Timeline

- Collect data on percentage of eligible patient receiving daily SBT (Implemented 2/2025)
- Provide education on the use of non-invasive ventilation device pre and post intubations for high risk patients. (Ongoing)
- Perform weekly audits to ensure compliance with interventions. (Ongoing)
- Review data bi-weekly to identify opportunities for improvement. (Ongoing)

What are we working on?

Stewardship of supplies:

- Our goal is to reduce costs for respiratory supplies while maintaining high-quality patient care. We are conducting a cost analysis to identify opportunities for savings and implementing changes where significant cost reductions can be achieved without compromising product quality. As part of this initiative, we will transition our EPAP and Acapella devices to DR Burton products, resulting in an annual cost savings of 16%, approximately \$4,686.
- Nebulizers will be changed out every week and prn instead of every other day, resulting in an annual cost savings of 50%, approximately \$3,039.

Respiratory's efficiency of time management:

- Goal is to identify the areas that no longer require a RT to do the procedure. Over the last few months, we have been able to identify areas of work that can be covered by another discipline.
 - Home Equipment for Non-invasive positive pressure ventilation for OSA will now be managed by nursing after initial set-up. This change in practice requires a multidisciplinary education with Respiratory and nursing. The process change will reduce the RT's workflow and allows the RT to focus on the more critical patients that truly need Respiratory's assessment skills.
 - ABG kits, Bronch Kits, and NICU intubation kits are now being made by our volunteers. This is a huge timesaver for the RT's, allowing them to focus their time on patient care.
- The goal is to identify workflow improvements that will save valuable time, allowing therapists to focus more on patient care.
 - Ventilator data will flow from Mindray to Cerner to assist with ventilator documentation. This will streamline workflow, reduce errors, and enhance data accessibility for respiratory therapists. This change will save valuable time, allowing therapists to focus more on patient care while ensuring accurate and efficient record-keeping.
 - The RTs will now receive patient arrival alerts directly from Cerner, helping to streamline workflow and reduce unnecessary travel between floors. This new feature ensures timely coordination and improved efficiency in patient care.

The Joint Commission Disease Specific Stroke Program Annual Report

Presented to Board Quality Management Committee

Lourdes Januszewicz MSN APRN ACNS-BC SCR N CCRN
Remia Paduga, MD, Stroke Program Medical Director
Valerie Martinez, Sr. Director Quality & Patient Safety
RN, BSN, MHA, CIC, CPHQ, NEA-BC

May 28th, 2025

**PALOMAR
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Reimagining Healthcare

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District Stroke Program

SITUATION	Palomar Health Stroke Program Annual Review
BACKGROUND	Annual Report provides an overview of the success and opportunities for the Stroke Program at Palomar Health. Continuous monitoring of the Stroke Metrics provides opportunities for process improvement.
ASSESSMENT	<ul style="list-style-type: none"> • Joint Commission Stroke Certified Centers at PMC Escondido and PMC Poway with successful Intracycle Call at each stroke center. • Successful completion of the Plan of Correction for fallouts from the 2023 survey. • Full adoption of the Target Stroke Phase III Metrics for monitoring stroke program – JC requirement. • Monitor all “Door to” times for improvement in meeting Thrombolytic and Thrombectomy goals. • Actively participate in the San Diego County Stroke Advisory Committee to share best practices and work on County initiatives to improve stroke care from pre-hospital to hospital acute phase. • PMC Poway has been awarded the Gold Plus Performance Achievement Award from the American Heart Association and American Stroke Association’s “Get with the Guidelines” program for 2024. This also includes recognition of for Target: Stroke Honor Roll Elite for rapid response and treatment times for stroke care and the Target: Type 2 Diabetes Honor Roll.
RECOMMENDATION	<p>Initiatives for 2025:</p> <ol style="list-style-type: none"> 1. Continue to improve the Target Stroke Phase III metrics to meet Door to Drug within 45 min 75% of the time and Door to First Device within 90 minutes for the direct Thrombectomy cases 50% of the time. 2. Continue to work with SD County on EMS Prehospital initiatives: <ol style="list-style-type: none"> a. Use of severity scale to identity potential Large Vessel Occlusion patients prior to arrival which can improve the Door to First Device times; b. Obtain Witness Information on EMS arrivals and document within the hospital record for immediate use by ED and Neurology Providers to improve decision making for interventions. 3. Preparation for 2025 Disease Specific Joint Commission Surveys at PMC Escondido and PMC Poway.

Quality Metrics Adopted: Target Stroke Phase III

“Door to” Measures for Thrombolytic

METRIC	Target Stroke Phase III for Thrombolytic < 60 min	Target Stroke Phase III for Thrombolytic < 45 min	Target Stroke Phase III for Thrombolytic < 30 min
Door to Provider	< 10 min	< 5 min	< 2.5 min
Door to Stroke Code activation	< 15 min	< 10 min	< 5 min
Door to POCT Glucose	< 15 min	< 10 min	< 5 min
Door to NIHSS Begin	< 15 min	< 10 min	< 5 min
Door to CT Begin	< 25 min	< 20 min	< 15 min
Door to CT Results	< 45 min	< 35 min	< 25 min
Door to Needle	< 60 min	NA	NA
Door to Needle Compliance %	85% of the time	NA	NA
Door to Needle Secondary goals	NA	< 45 min	< 30 min
Door to Needle Secondary goals Compliance %	NA	75% of the time	50% of the time

Quality Metrics: Target Stroke Phase III

“Door to” Measures for Thrombectomy

METRIC	Target Stroke Phase III - Direct Cases	Target Stroke Phase III - Transfer Cases
Door to Provider	≤ 5 min	≤ 5 min
Door to Stroke Code activation	≤ 10 min	≤ 10 min
Door to CT Begin	≤ 20 min	≤ 20 min
Door to CT Reported Results	≤ 35 min	≤ 35 min
Door to IR Brain Alert	≤ 40 min	≤ 40 min
Door to Needle (if applicable)	≤ 45 min	≤ 45 min
Door to IR Suite	≤ 60 min	NA
Door IN – Door Out (DIDO)	NA	≤ 75 min
Door to Puncture (Groin Stick	≤ 75 min	≤ 30 min
Door to First Device	≤ 90 min	≤ 60 min
Door to First Device Compliance	50% of the time	50% of the time
Door to Vessel Open with TICI 2b or >	≤ 150 min	≤ 150 min
TICI Score	2b/3 ≥ 80%	2b/3 ≥ 80%

Program Overview: 2024 Summary

2024 Summary	PMC Escondido	PMC Poway
Total Stroke Code Activations: Jan-Dec 2024 <ul style="list-style-type: none"> Total ED SC: 1494 Total IPSC: 92 Total SC Canc: 159 	ED SC: 1083 – 136 cancelled Inpatient SC: 77	ED SC: 411 – 23 cancelled Inpatient SC: 15
Final Diagnosis: 2024 <ul style="list-style-type: none"> Acute Ischemic (AIS) Hemorrhagic Stroke (HS) TIA 	TOTAL: 661 <ul style="list-style-type: none"> AIS: 311 HS: 234 TIA: 116 	TOTAL: 132 <ul style="list-style-type: none"> AIS: 64 HS: 24 TIA: 44
Thrombolytic Administrations: Jan-Dec 2024 <ul style="list-style-type: none"> Total Administrations: 87 Total ED: 83 Total IPSC: 4 	61 Thrombolytic Administrations <ul style="list-style-type: none"> ED: 58 IPSC: 3 	26 Thrombolytic Administrations <ul style="list-style-type: none"> ED: 25 IPSC: 1
Neuro Endovascular Cases: Jan-Dec 2024 <ul style="list-style-type: none"> Total Candidates: 104 Total Thrombectomies: 93 Total Angio/Cancel/ Venous: 11 	Total Cases: 72 <ul style="list-style-type: none"> 67 Thrombectomy <ul style="list-style-type: none"> ED: 61 IPSC: 6 5 Angio/Cancel/Venous 	Total Cases: 32 <ul style="list-style-type: none"> 26 Thrombectomy <ul style="list-style-type: none"> ED: 23 IPSC: 3 6 Angio/Cancel/Venous

Treatment Rate & sICH Rate	2024
Thrombolytic	23% sICH = 2%
Thrombectomy	25% sICH = 5.4%

Program Overview: Summary Metrics

Door to Metrics 2023 & 2024 MEDIAN Minutes	PMC Escondido	PMC Poway	Benchmark
Door to Provider	2023: 7 2024: 6	2023: 4 2024: 4	< 10 min
Door to CT Start	2023: 14 2024: 12	2023: 11 2024: 12	< 15 min
Door to CT Results	2023: 37 2024: 29	2023: 33 2024: 29	< 35 min
Door to POCT Glucose	2023: 10 2024: 6	2023: 4 2024: 4	< 10 min
Door to Needle – Thrombolytic Administration (Median Min)	2023: 41 2024: 37	2023: 42 2024: 37	2023: < 45 min 2024: < 45 min
Door to Needle - % Met	2023: 87% ≤ 60 min 2023: 71% ≤ 45 min 2023: 29% ≤ 30 min 2024: 100% ≤ 60 min 2024: 68% ≤ 45 min 2024: 38% ≤ 30 min	2023: 91% < 60 min 2023: 64% < 45 min 2023: 18% < 30 min 2024: 85% ≤ 60 min 2024: 62% ≤ 45 min 2024: 15% ≤ 30 min	Target Phase 3 (TP3): <ul style="list-style-type: none"> • % < 60 min > 85% • % < 45 min > 75% • % < 30 min > 50%

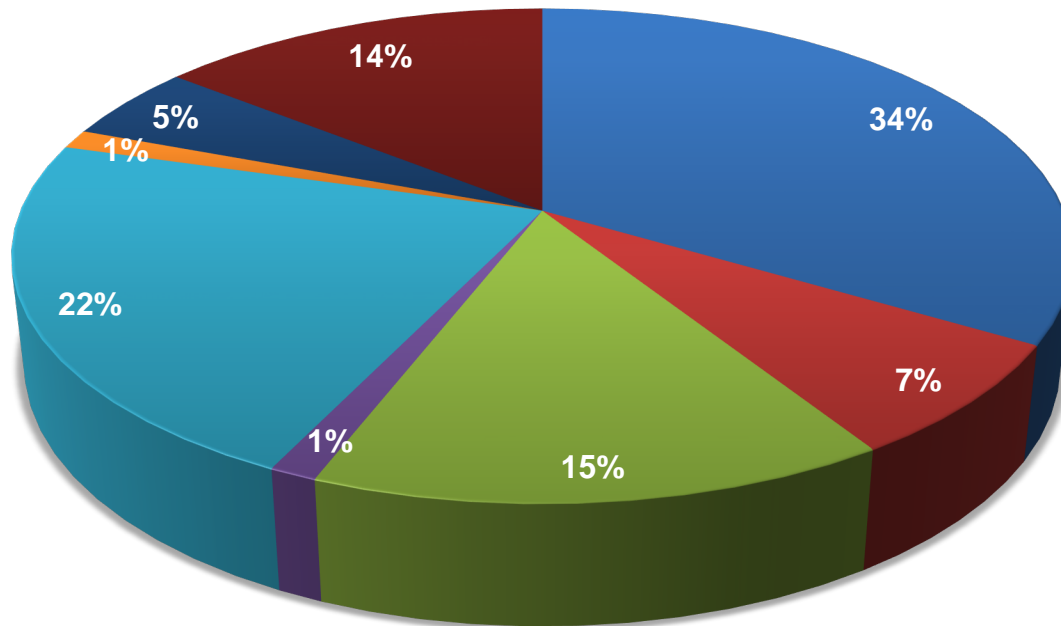
Program Overview: Summary Metrics

Door to Metrics 2023 & 2024 MEDIAN Minutes	PMC Escondido	PMC Poway	Benchmark
Door In – Door Out (DIDO) Transfers	NA	2023 Transfer DIDO: 81 2024 Transfer DIDO: 84	JC: ≤ 120 min PH Goal: ≤ 90 min TP3: ≤ 75 min
Door to IR Brain Alert	2023: 38 2024: 34	2023: 54 2024: 34	< 40 min
Door to Groin Puncture	2023 Direct Cases: 75.0 2024 Direct Cases: 84.0	2023 Transfer Cases: 18.0 2024 Transfer Cases: 15.0	TP3 Direct: ≤ 75 min TP3 Transfer: ≤ 30 min
Door to First Device Pass	2023 Direct Cases: 96.5 2024 Direct Cases: 112.5	2023 Transfer Cases: 39.5 2024 Transfer Cases: 43.0	TP3 Direct: ≤ 90 min TP3 Transfer: ≤ 60 min
Door to First Device Pass - % Met	2023 Direct Cases: 40% 2024 Direct Cases: 23%	2023 Transfer Cases: 94% 2024 Transfer Cases: 92%	TP3 Direct: • $\% \leq 90$ min > 50% TP3 Transfer: • $\% \leq 60$ min > 50%

Program Overview:

2024 Discharge Disposition

Palomar Health 2024 Discharge Disposition
Patients who Received Stroke Intervention
n = 161



■ Home/HH ■ Acute Care Tx ■ Acute Rehab ■ Custodial Care ■ SNF Rehab ■ LTAC ■ Hospice ■ Expired

Program Overview:

2024 Performance Improvement Summary

- Increase use of VIZ AI with all Radiology Provider Groups for Stroke Codes - > 95% compliance.
- Improvement in documentation of Radiology report times to the Stroke Team within the Radiology Reports - > 90% compliance
- Improved compliance using Evidenced-Based YALE Swallow Screen prior to oral intake in the ED - > 90% compliance.
- Improvement in documentation of the Pre and Post assessments of Thrombectomy candidates in the IR arena - > 95% compliance.
- Improvement in the IR Provider Brief –Op Note completion prior to transfer of patient to the next level of care – 100% compliance.
- Improvement in Neurological Assessments documented in required timeframes by Nursing for the Thrombolytic candidates as well as the Hemorrhagic stroke patients - > 90% compliance.
- Improvement in documentation of stroke education including the stroke patient’s individual risk factor - > 95% compliance.
- Improvement in Case Management assessments readiness to discharge for stroke patients - > 90% compliance.
- Stroke Education completed by all new providers onboarding to PH – 100% compliance.

Program Overview:

2024 Performance Improvement Summary

- Pre-Hospital Stroke Code Activation for EMS arrivals at PMCE - > 65% of EMS arrivals
- Pre-Hospital Stroke Code PIT STOP location is direct to CT Scan location
 - Successful administration of thrombolytic in the CT Scan location @ Escondido
- FASTED Stroke Severity Scale used by San Diego County EMS with early notification of severity score to the Stroke Team as part of the Prehospital Stroke Code activation
 - 65% of EMS arrivals with FASTED score provided.
 - Prehospital Stroke Code activations include the FASTED Score in text messages for the team
 - FASTED Scores > 4 with 60% probability of LVO - leads to earlier notification of the IR Team
- Business Hours Mon-Fri: IR Thrombectomy candidates transfer directly to IR Suite versus to ED Room
- Active participation with SD County Stroke Consortium: served as the Chair of the SD County Stroke Advisory Committee 2022 – 2024; acting as Past Chair 2025.
- Successful Community Stroke Awareness Event at the San Diego Padres September 2024
- Successful IT Improvements/Updates in EHR for Stroke Documentation

Program Overview:

2025 Performance Improvement Initiatives

- Continued focus on metrics for Thrombectomy candidates to improve the “Door to 1st Device” for direct cases.
 - Goal: ≤ 90 minutes in 50% of cases
 - Review of fallouts for continued improvements
 - Review of cases to ensure they meet criteria for inclusion in the data.
- Continue to focus on “Door In – Door Out” metrics at Poway for the Thrombectomy candidates and Hemorrhagic strokes patients needing higher level of care.
- Implement the Nurse Careplan that includes Caregiver Readiness Assessment.
- Incorporate the latest Clinical Practice Guidelines of Primary Prevention in the stroke program as applicable.
- Provide Stroke education for the OB Team.
- Active involvement in the SD County QIP for Witness Information with Stroke Codes.
 - Witness information is critical for earlier decision-making for interventions
- Joint Commission Recertification in 2025 for each campus – prep work in progress.