ANNUAL EVALUATION AND APPRAISAL FOR CY2021

Evaluation of the Infection Control Program CY2021 based on Surveillance, Prevention and Control Practices

Overview of Program

The Infection Prevention and Control Program at Broward Health Coral Springs (BHCS) is directed by the Clinical Specialist of Epidemiology, under the leadership of the Medical Director of Infection Prevention and Control and Antibiotic Stewardship programs. The Clinical Specialist of Epidemiology reports to the Regional Manager of Quality and Epidemiology, and thereon to the Medical Executive Council and Board. The Infection Control Committee consists of an Infectious Diseases Physician, who is also the Medical Director of the Infection Prevention and Control Program, and serves as the Chairperson of the Committee. The Infection Control Committee is a multidisciplinary committee with representation from, but not limited to, the Medical Staff, Executive Leadership, Nursing, Pharmacy, Laboratory, Surgical Services, Environmental Services, Facilities Management, Employee Health, Ancillary staff, Nutritional Services and other departments of the hospital. The Committee meets on a quarterly basis. In addition, the Clinical Specialist of Epidemiology attends other hospital department meetings to present and review results of surveillance activities and provides infection control education to all employees in Patient Safety Quality Committee meetings, New Hire Orientation, in-services, staff meetings, Grand Rounds, and Healthstream education.

BHCS is a 250 bed multiservice hospital. Adult Medical/Surgical Services, Maternal/Child Services, NICU, PICU, Primary Stroke Care, and Outpatient Services including Wound Care, Women's Health, and Rehabilitation are the predominant service lines offered. The Clinical Specialist of Epidemiology monitors and provides coverage for all services, both inpatient and outpatient, at BHCS.

This Program Evaluation is based in part on outcomes achieved during calendar year 2021. Outcomes are identified through review of performance measurement data, information resulting from Broward Health Coral Springs (BHCS) committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout BHCS and in collaboration with other Broward Health facilities.

The Infection Prevention and Control Program is an organization wide program that provides for surveillance, prevention and control of infections in patients, employees, students, LIPs, physicians, and all visitors to the organization. The Infection Control Plan addresses epidemiologically important issues of infections among patients, employees and non-employees, as well as exposure to communicable disease, device related infections, surgical site infections, healthcare associated infections hospital wide, epidemiologically important and antibiotic resistant organisms, and the reporting of communicable disease to the public health authorities. The plan is comprehensive, appropriate to the size and complexity of the medical center, and is reviewed on a continual basis. It addresses all aspects of Infection Prevention and Control activities and education, includes assessment and prioritization of infection risks, and provides recommendations for the implementation of strategies to reduce or eliminate prioritized risks. Specifically,

- Prospective surveillance is completed by Epidemiology for identification of infections.
- Rates are monitored for trends above the benchmark which would require immediate investigation and/or intense analysis, identification of opportunities for improvement and implementation of corrective action items.
- RCA meetings are held with leaders and staff to identify opportunities and improvements.
- Monthly reports are submitted to Patient Safety Quality Council Committee meeting where infections are discussed and opportunities for improvement are presented.

- Infections, results of ongoing surveillance, and Performance Monitoring Reports (PMR) are also presented at the quarterly Infection Control Committee meeting.
- Priority is given to device related infections based on risk assessment and analysis of collected data, which is evaluated on an ongoing basis to provide immediate intervention when indicated to reduce or prevent infection.
- Priority is also given to Surgical Site Infections based on the risk assessment and analysis of the collected data.
- Epidemiology continually monitors and communicate findings with the appropriate stakeholders on an ongoing basis.

HOUSE WIDE INFECTIONS FOR CY2021

Indicator	Definition	Target	CY 19	CY20	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Central Line Related BSI, laboratory confirmed ALL NHSN Reportable units	# of Infections	0.54	2	4	0	0	1	0	0	0	0	1	1	0	1	0	4
	Line days X 1000		4872	6617	673	482	678	812	749	549	686	953	1,106	821	668	704	8,881
			0.41	0.60	0.00	0.00	1.47	0.00	0.00	0.00	0.00	1.05	0.90	0.00	1.50	0.00	0.45
Catheter Associated UTI ALL NHSN Reportable units	# of CA- UTIs	0.52	5	3	1	0	0	0	1	1	1	0	0	0	0	0	4
	# of foley days x 1000		3746	5241	433	388	450	651	553	414	489	783	887	573	503	477	6,601
			1.33	0.57	2.31	0.00	0.00	0.00	1.81	2.42	2.04	0.00	0.00	0.00	0.00	0.00	0.61
Hospital Onset C-Difficile Infection	# new cases + C-diff	1.91	13	9	1	1	2	0	0	0	0	1	0	0	2	0	7
	# of Patient Days x 10000		40609	42376	4,335	3,906	4,436	5,584	5,611	4,985	5,703	6,303	5,948	5,655	4,895	5,428	62,789
			3.20	2.12	2.31	2.56	4.51	0.00	0.000	0.000	0.000	1.587	0.000	0.000	4.086	0.000	1.115
Hospital Onset MRSA Bacteremia	# of Pts with HA MRSA Bac	0.00	3	0	0	1	0	0	0	0	0	0	1	0	0	0	2
	# of Patient Days x 1000		47988	48568	4,765	4,406	4,912	5,988	6,086	5,523	6,138	6,761	6,438	6,259	5,339	5,943	68,558
			0.06	0.00	0.00	0.23	0.00	0.00	0.00	0.00	0.00	0.00	0.16	0.00	0.00	0.00	0.03

INDICATOR	Definition	Target	CY19	CY20	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct.	Nov	Dec	YTD
SSI Rate, Class I *	# of Class I Infections	0.22	6	3	0	0	1	0	0	0	0	0	1	0	0	0	2
	# of Class I surgeries x 100		1,684	1,251	107	119	127	112	119	104	114	96	134	120	106	112	1,370
			0.36	0.24	0.00	0.00	0.79	0.00	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00	0.15
SSI Rate, Class 2*	# of Class 2 Infections	0.20	13	5	0	0	0	0	0	0	0	0	1	1	2	0	4
	# of Class I surgeries x 100		2,870	2,265	184	193	232	212	219	222	223	227	207	249	227	243	2,638
			0.45	0.22	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.48	0.40	0.88	0.00	0.15
C-section	# of Infections	0.15	7	2	0	1	1	0	1	0	0	0	0	2	0	1	6
	# of surgeries x 100		1,529	1,226	106	94	111	93	93	120	97	125	96	129	101	110	1,275
			0.46	0.16	0.00	1.06	0.90	0.00	1.08	0.00	0.00	0.00	0.00	1.55	0.00	0.91	0.47
Pacer/	# of Infections			1	0	0	0	0	0	0	0	0	0	0	0	0	0
	# of surgeries x 100			17	3	6	5	5	6	3	3	4	4	6	6	3	54
Cardiac Cath				5.88	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Hips	# of Infections	0.00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	# of surgeries x 100		73	55	5	1	6	0	5	2	1	7	8	7	4	2	48
			0.00	0.00	0.00	0.00	0.00	-	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Knees	# of Infections	0.00	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	# of surgeries x 100		78	36	2	1	0	0	0	0	0	0	8	0	0	0	11
			1.28	0.00	0.00	0.00	-	-	-	-	-	-	0.00	-	-	-	0.00
CMS VBP Colon	# of Infections	3.10	7	5	0	1	0	0	0	0	0	0	0	0	0	0	1
	# of surgeries x 100		148	145	14	15	17	6	12	14	12	11	10	8	8	12	139
SSI (rate)			4.73	3.45	0.00	6.67	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.72
CMS VBP	# of Infections	4.09	2	8	0	0	0	0	0	0	0	0	0	0	0	0	0
Abdominal	# of surgeries x 100		313	176	15	12	23	16	16	22	23	25	11	16	10	20	209
Hysterectomies			0.64	4.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Zero Tolerance, Goal of Zero Infections and the Bundle Approach

The Infection Prevention and Control Program has adopted the philosophy of "Zero Tolerance and Goal of Zero" towards healthcare-associated infection. Zero tolerance refers to the ideology that we will work to eliminate every "preventable" healthcare-associated infection. To help achieve this goal, the hospital utilizes the "bundle" approach to help prevent device-related and surgical infections. A bundle is a group of interventions related to a disease process, that when grouped together, result in better outcomes than when implemented individually. Evidence based research has shown that a bundle approach can help to reduce infections.

Benchmarking

BHCS benchmarks infection surveillance numbers utilizing the NHSN (National Healthcare Safety Network, CDC) statistics. The Centers for Disease Control and Prevention provides the national standard measures for healthcare-acquired infections, and CMS requires facilities to utilize the NHSN as our tool for national healthcare data reporting.

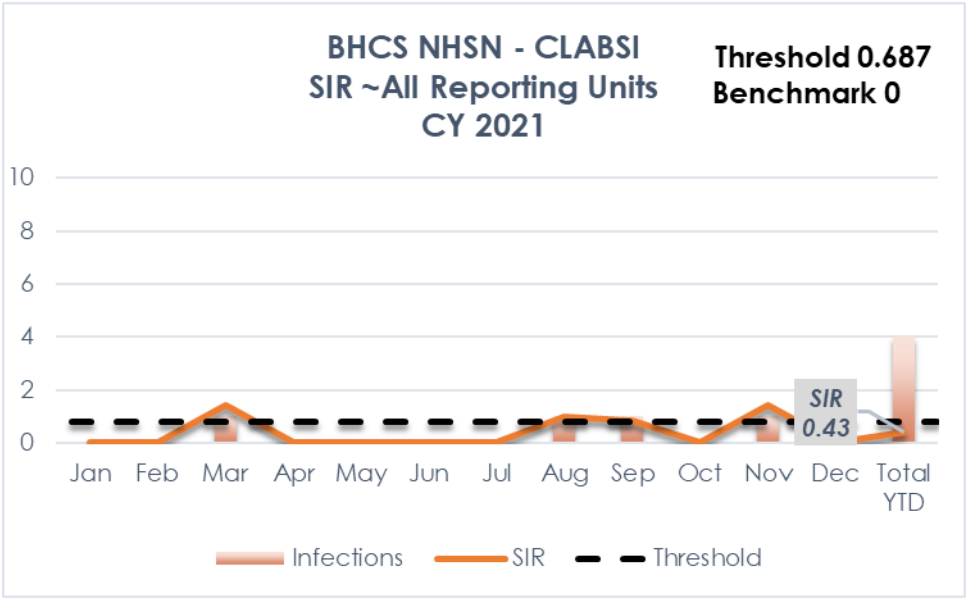
BHCS currently reports through the NHSN: CLABSI, CAUTI, surgical site infections in selected COLO and HYST procedures, lab identified C. difficile and MRSA bacteremia, and influenza vaccination rates.

Device- Associated Infections

Central Line Associated Blood Stream Infections (CLABSI)

CLABSI CY2021

	Target	CY20	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
ICU	1.41	4			1					1	1				3
		2,548	262	231	253	390	251	255	253	426	544	326	266	259	3716
		1.57			3.95					2.35	1.84				0.81
3E													1		1
		1,683	165	115	114	147	167	121	188	225	211	138	165	171	1927
													6.06		0.52
3S		840	76	66	155	89	92	39	84	107	84	74	58	79	1003
4EAST PCU	0.48	1				1						1			2
		1,860	157	112	159	199	227	163	234	121	125	178	187	209	2071
		0.54				5.03						5.62			0.97
4W		286	81	55	87	64	81	74	74	17	75	75	68	84	835
4N		349	38	15	63	21	41	19	42	31	48	69	34	50	471
NICU		69	33				34	12	9	6	41	21	20	7	183
				-	-	-									
PICU															
		-	-	-	-	-	-	-	-	-	-	-	-	-	-
3W PEDS		26				1									1
			-	-	-		-	-	-	-	-	-	-	-	
ICUO		376	18		6	100	83	29	36	141	103	118	57	54	745
				-											
BHCS	0.56	5			1	1				1	1	1	1		6
		8,039	830	594	837	1,011	976	712	920	1,074	1,231	999	855	913	10,952
		0.62			1.19	0.99				0.93	0.81	1.00	1.17		0.55
Adult Only		5			1	1				1	1	1	1		6
		7,566	779	594	831	910	859	671	875	927	1,087	860	778	852	10,023
		0.661			1.20	1.10				1.08	0.92	1.16	1.29		0.60



Analysis:

HAI CLABSI infection rate for 2021 was 0.55, which was an increase from 0.50 in 2020.

BHCS had 6 CLABSIs 2021 (2 were on non NHSN reportable units) which was an increase from 4 in 2020. Although we had 3 CLABSI in our ICU, this is a decrease from 4 compared to 2020. We also had an increase in central line days from 8,039 to 10,952, which is over 2,900 days when compared to 2020. As a result, many action plans were initiated and ongoing efforts to reduce infection continue through staff awareness, education and meetings to identify any opportunities for improved care.

Our SIR for 2021 was 0.43 which is less than our SIR for 2020 which was 0.67 per NHSN.

Increase in infection rate from 2020 to 2021 was 10%.

Increase in overall central line days from 2020 to 2021 was 36%

Decreased in SIR rate from 2020 to 2021 was 46%

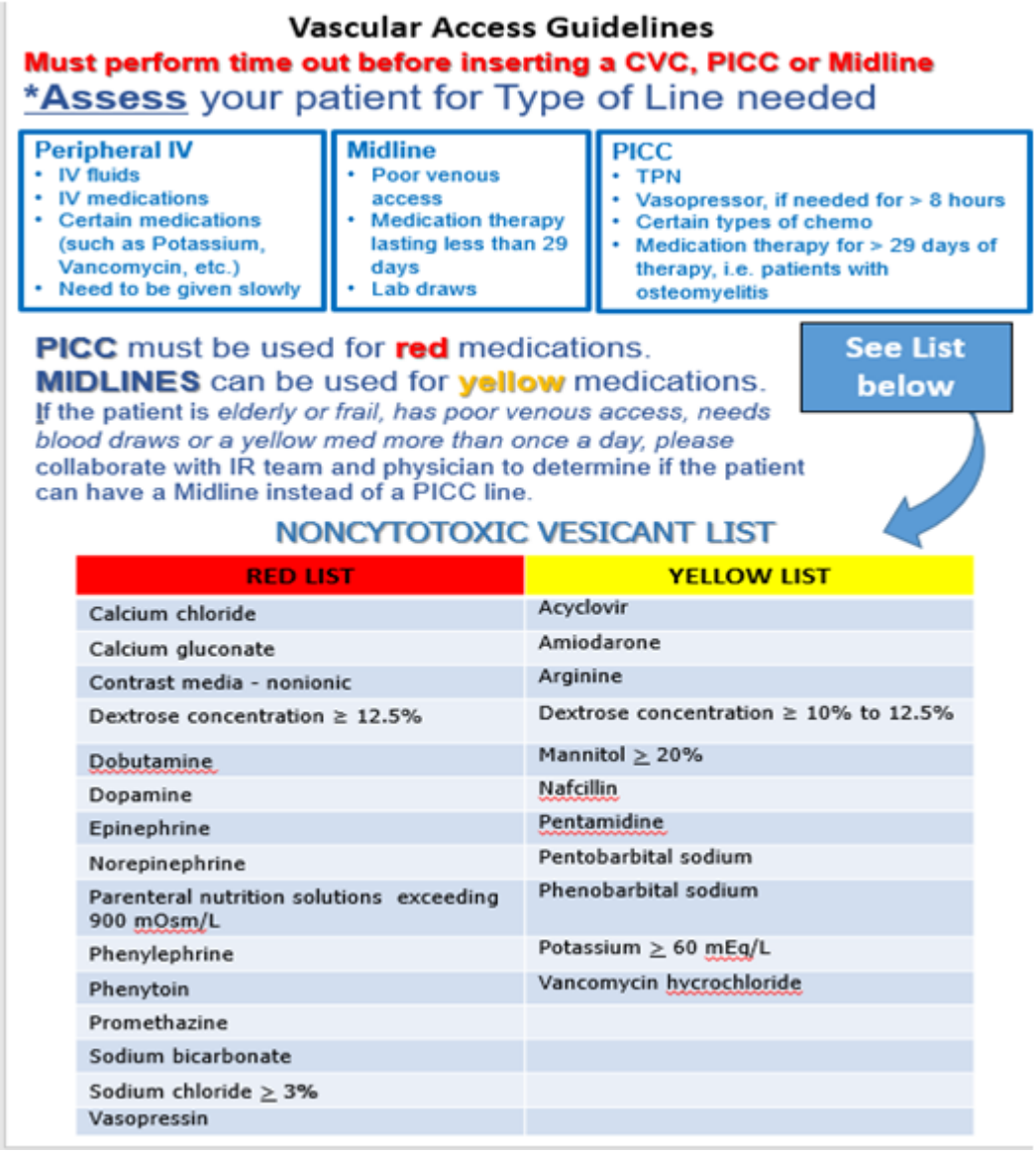
NICU
The CLABSI rate in the NICU population for 2021 was 0 per 1000 central line days.

Pediatrics
The CLABSI rate in the pediatric population was 0 per 1000 central line days for 2021.

Action Plans

- Continue to monitor central lines for necessity, educate nursing staff and the medical staff, when appropriate.
- BHCS continues to utilize the HIIN for best practices.
- Improved awareness and communication which included bedside shift report.
- Daily rounding includes ongoing interventions, central line necessity, education and central line bundle compliance during surveillance.
- Daily central line dressing assessment
- Daily chlorhexidine bathing for all inpatients that have a central line.
- Continue surveillance and enforcement of the central line bundle compliance during rounding.
- Partnership with Clinical Education for collaboration of rounding and just in time education
- Always strive for Zero Infections
- Point Prevalence studies completed with Device Company with feedback provided to stake holders and leadership: on hold due to the pandemic
- CLABSI mandatory education provided to all staff via Healthstream on annual basis and for all new hires
- Education provided regarding CLABSI bundles and importance of following.
- Intense analysis of every CLABSI within two weeks of identification of infection, including the nurse manager, CNO and Regional Quality Manager. Opportunities for improvement are identified and shared at Patient Safety Quality Committee meetings.
- Updated Fast Facts for CLABSI Prevention and distributed to NM for sharing at huddles.
- Continue to utilize Vascular Access Guidelines for nurses to assist with appropriate line placement
- Review of all CLABSI prevention plan and discussion with NM to be sure that staff are adhering to best practices:
    - Buy in from PCP and consultants
    - Continue to assess need for central line and possibly change to midline or peripheral line
    - MDR need to include lines and need for them

- Share data with nursing staff: in the lounges, med room, etc. review CLABSI and reason, document number of central lines every day on the unit, review number of days each patient has central line, list reason for central line. List on white board.
- CMO discusses with primary care physician and other consultants the need for a central line and possibly changing to midline or peripheral line.
- Ensure Curos caps on all ports
- Continue to remove central line prior to leaving the ICU if no longer needed.
- Stop review sheet prior to transfer to another nursing unit (ICU to floor)
- Monitor the number of midline insertions and PICC line insertions on daily basis.



Vascular Access Guidelines

Must perform time out before inserting a CVC, PICC or Midline

***Assess your patient for Type of Line needed**

Peripheral IV
- IV fluids
- IV medications
- Certain medications (such as Potassium, Vancomycin, etc.)
- Need to be given slowly

Midline
- Poor venous access
- Medication therapy lasting less than 29 days
- Lab draws

PICC
- TPN
- Vasopressor, if needed for > 8 hours
- Certain types of chemo
- Medication therapy for > 29 days of therapy, i.e. patients with osteomyelitis

PICC must be used for **red** medications.
MIDLINES can be used for **yellow** medications.
If the patient is *elderly or frail, has poor venous access, needs blood draws or a yellow med more than once a day, please* collaborate with IR team and physician to determine if the patient can have a Midline instead of a PICC line.

See List below

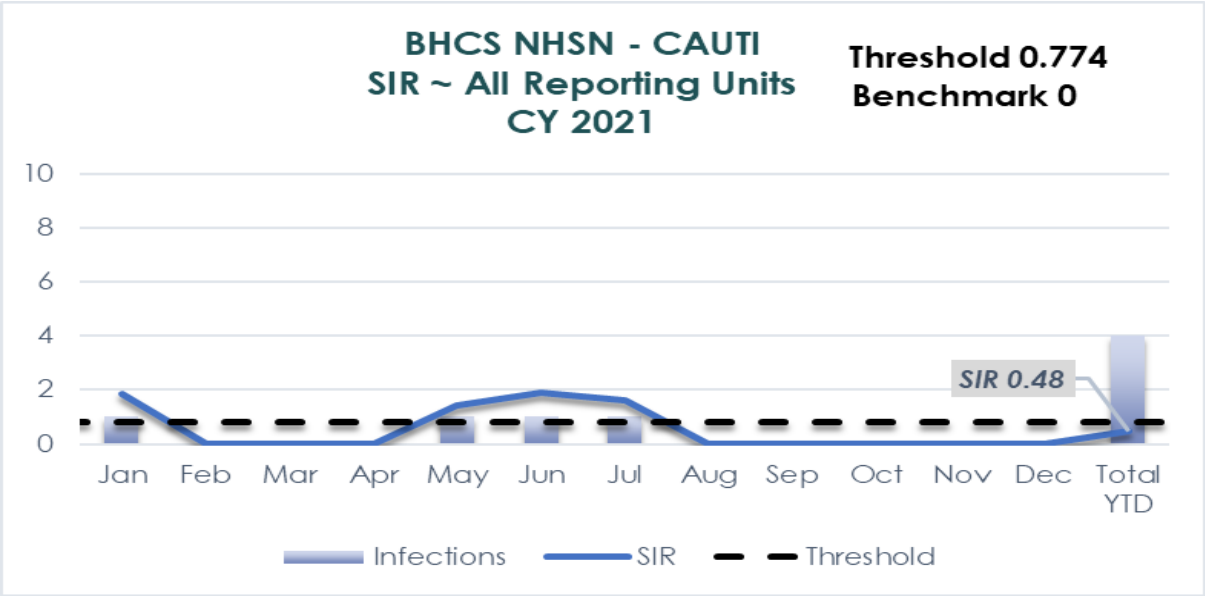
NONCYTOTOXIC VESICANT LIST

RED LIST	YELLOW LIST
Calcium chloride	Acyclovir
Calcium gluconate	Amiodarone
Contrast media - nonionic	Arginine
Dextrose concentration ≥ 12.5%	Dextrose concentration ≥ 10% to 12.5%
Dobutamine	Mannitol ≥ 20%
Dopamine	Nafcillin
Epinephrine	Pentamidine
Norepinephrine	Pentobarbital sodium
Parenteral nutrition solutions exceeding 900 mOsm/L	Phenobarbital sodium
Phenylephrine	Potassium ≥ 60 mEq/L
Phenytoin	Vancomycin hydrochloride
Promethazine	
Sodium bicarbonate	
Sodium chloride ≥ 3%	
Vasopressin	

Catheter Associated Urinary Tract Infections (CAUTI)

CAUTI CY2021

	Target Rate	CY20	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
ICU	0.66	2					1		1						2
		2,709	232	189	224	376	280	216	218	412	539	238	253	247	3424
		0.74					3.57		4.59						0.58
3E	1.21	1	1												1
		743	33	81	65	84	86	64	82	116	56	67	74	62	870
		1.35	30.30												1.15
3S								1							1
		1,345	119	82	125	63	67	94	107	93	135	114	109	80	1,188
								10.64							0.84
4EAST PCU						1						1			2
		897	81	43	109	132	110	74	102	101	98	110	69	108	1,137
						7.58						9.09			2
4W															
		286	18	30	23	39	55	22	43	5	36	10	7	49	337
4N															
		156	20	6	9		13	1	5	20	28	11	7	11	131
			-	-	-	-	-	-	-	-	-	-	-	-	-
PICU															
		2			1		1			2					4
			-	-		-		-	-		-	-	-	-	
3W PEDS															
		-													
Mother Baby															
		3070	48	64	57	57	44	68	63	65	47	63	47	51	674
ICUO															
		330	11		3	89	51	17	34	135	93	133	53	28	647
				-											
BHCS	0.28	3	1			1	1	1	1			1			6
		9538	562	495	616	840	707	556	654	949	1,032	746	619	636	8,412
		0.31	1.78			1.19	1.41	1.80	1.53			1.34			0.71



Analysis:

HAI CAUTI infection rate for 2021 was 0.71, which was an increase from 0.31 in 2020.

BHCS had 6 CAUTIs in 2021 (2 were on non NHSN reportable units) which is an increase from 3 CAUTIs 2020. We had 2 CAUTIs in our ICU for both 2020 and 2021, had 1 CAUTI on our medical unit (3 East) for both 2020 and 2021, and we had a CAUTI on our surgical unit (3 South). We also had a decrease in urinary catheter days from 9538 to 8412. We instituted many action plans. Continued efforts to reduce infection are through staff awareness and education and meetings to identify any opportunities for improved care.

Our SIR for 2021 was 0.48, which was more than our SIR for 2020 which was 0.43 per NHSN.

Increase in infection rate from 2020 to 2021 was is 129%.

Increase in SIR rate from 2020 to 2021 is 12%.

Decreased in urinary catheter days from CY2020 to CY2021 by 12%.

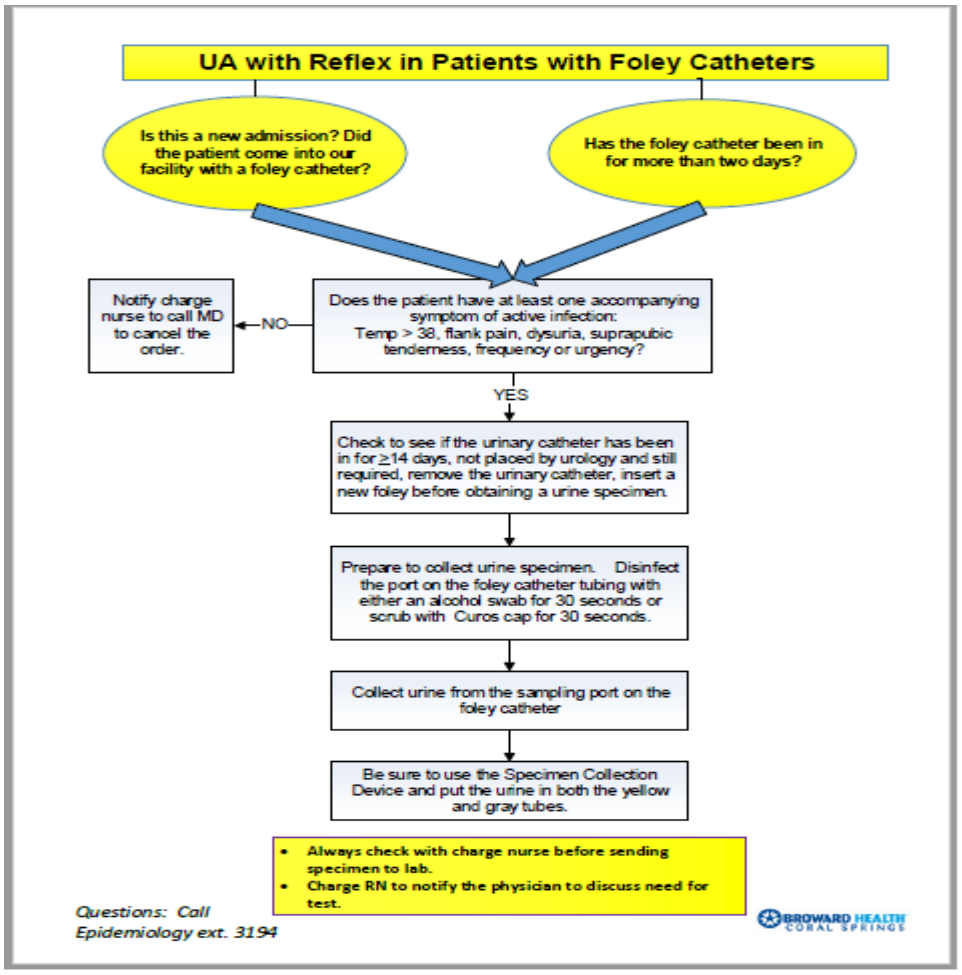
Action Plans

- Continue to monitor urinary catheter for necessity, educate nursing staff and the medical staff, when appropriate.
- Continue to utilize the HOUDINI protocol for indications for urinary catheter.
- BHCS utilizes in HIIN for best practices.
- Daily assessment of the urinary catheter included line necessity and discontinuation of the urinary catheter utilizing the HOUDINI protocol.
- Improved awareness and communication which includes bedside shift report.
- Daily rounding includes ongoing interventions, urinary catheter necessity, education and urinary catheter bundle compliance during surveillance.
- Continue surveillance and enforcement of the urinary catheter bundle compliance during rounding.
- Partnership with Clinical Education for collaboration of rounding and just in time education
- Always strive for Zero Infection
- Point Prevalence studies completed with Device Company with feedback to be provided to stake holders and leadership on hold due to pandemic.
- CAUTI mandatory education provided to all staff via Healthstream on an annual basis and for all new hires
- Education provided regarding CAUTI bundles and importance of following.
- Intense analysis of every CAUTI within two weeks of identification of infection, including the nurse manager, CNO and Regional Quality Manager. Opportunities for improvement are identified and shared at Patient Safety Quality Committee meetings.
- Updated Fast Facts for CAUTI Prevention and distributed to NM for sharing at huddles.
- Changed all stock urinary insertion kits to all 14 French, instead of 16 French. Will still have 16 French in Materials Management for specific patient needs.
- Review of all CAUTI prevention plan and discussion with NM to be sure that staff are adhering to best practices:
    - HOUDINI policy

- Opportunities noted in the past with insertion.
- Use smallest bore possible
- Need protocol regarding retention
- Buy in from nephrologist and urologist
- Use closed system, if system opened, then replace catheter
- Two nurse foley insertion, if available.
- Continue to assess need for foley
- MDR need to include lines and need for them
- Encourage removal of foley catheter and utilization of Purewick for urine output.
- Share data with nursing staff: in the lounges, med room, etc. review CAUTI and reason, document number of Foleys every day on the unit, review number of days each patient has indwelling, list reason for foley. List on white board.
- Need to have CMO discuss with Nephrologist, primary care physicians and other consultants the benefits of Purewick and daily weights to monitor I&O
- Need specific reason to order urinalysis with reflex to culture: (new or worsening fever, rigors, altered mental status, malaise or lethargy with no identified cause, flank pain, CVA tenderness, acute hematuria, pelvic discomfort, and when foley removed: dysuria, urgent or frequent urination or suprapubic pain or tenderness.
- Ensure that collection devices clean and for specific patient
- Ensure that spigot wiped with alcohol after drainage each time
- Will plan for automatic alerts for physician regarding removal at day 2
- Will plan for automatic alerts for physician regarding removal q5 days
- Will plan to include pop up question prior to urine analysis: does your patient have a follow catheter for greater than 14 days? If yes, then order to remove, reinsert and then obtain urinalysis with reflex
- Will plan for count of foley catheter similar to vent days on IView.
- Removal of foley prior to leaving the ICU as strict I&O will not occur on nursing unit and patients are not on Levophed, etc.
- Stop review sheet prior to transfer to another nursing unit (ICU to floor)

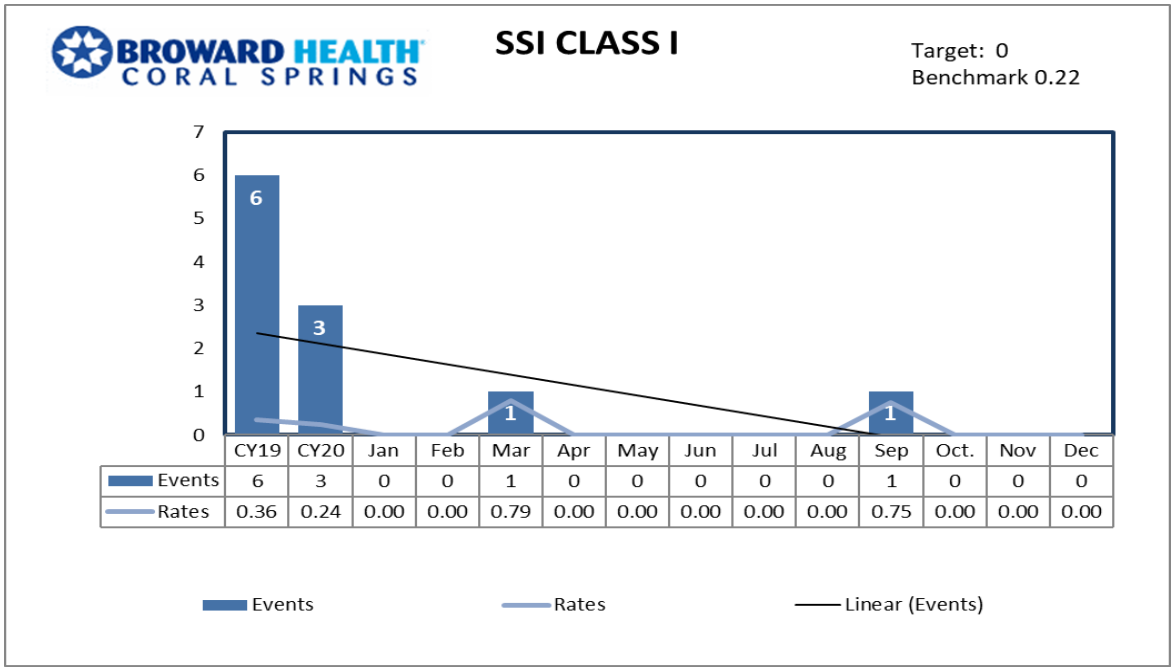
- CAUTI prevention education provided to all nursing unit utilizing Wheel of Bugs, questions regarding CAUTI prevention and provided educational flyers.
- Continue to have Material Management place Stop sign on foley kits prior to stocking on unit.
- Changed urinalysis to reflex culture: removed findings of the following: leukocyte esterase, nitrates and epithelial cells so that reflex culture is not performed. Reflex culture will be performed with findings of moderate or many urine bacteria/yeast and WBC count ≥ 10.


STOP
Could you use a Purewick or Condom Cath instead of a foley?


UA with Reflex in Patients with Foley Catheters
Is this a new admission? Did the patient come into our facility with a foley catheter?
Has the foley catheter been in for more than two days?
Does the patient have at least one accompanying symptom of active infection: Temp > 38, flank pain, dysuria, suprapubic tenderness, frequency or urgency?
NO
Notify charge nurse to call MD to cancel the order.
YES
Check to see if the urinary catheter has been in for ≥14 days, not placed by urology and still required, remove the urinary catheter, insert a new foley before obtaining a urine specimen.
Prepare to collect urine specimen. Disinfect the port on the foley catheter tubing with either an alcohol swab for 30 seconds or scrub with Curos cap for 30 seconds.
Collect urine from the sampling port on the foley catheter
Be sure to use the Specimen Collection Device and put the urine in both the yellow and gray tubes.
Always check with charge nurse before sending specimen to lab.
Charge RN to notify the physician to discuss need for test.
Questions: Call Epidemiology ext. 3194
BROWARD HEALTH CORAL SPRINGS

Surgical Infections Report

Surgical Site Infections Class I CY2021



	CY19	CY20	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct.	Nov	Dec
Events	6	3	0	0	1	0	0	0	0	0	1	0	0	0
Rates	0.36	0.24	0.00	0.00	0.79	0.00	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00

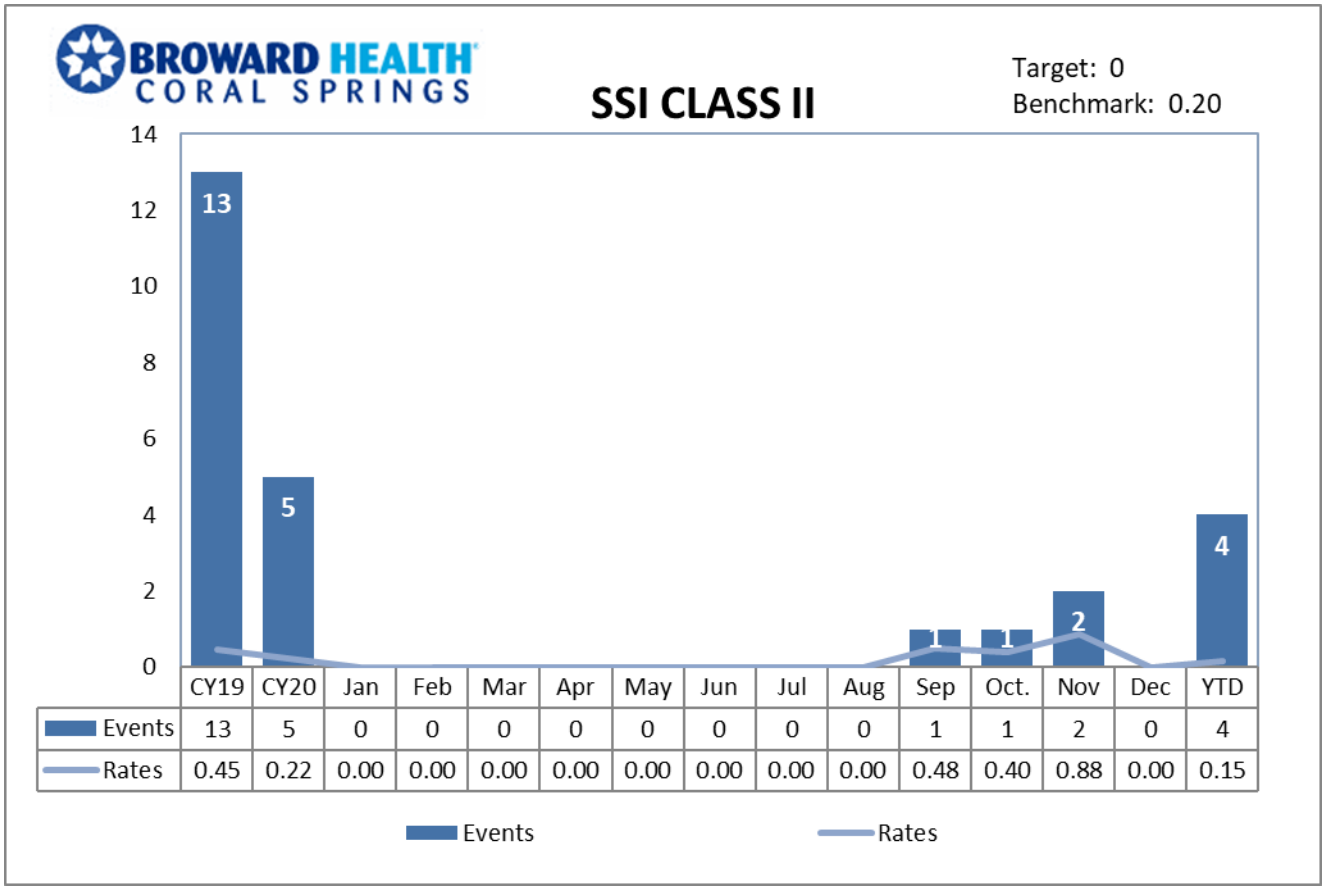
Analysis

Total Class I infections: 2/1,370. Rate: 0.15%

Analysis

- **Reduction in infection rate from CY2020 to CY2021 was 38%.**
- **A SIR rate is not provided by NHSN.**

Surgical Site Infections II CY2021



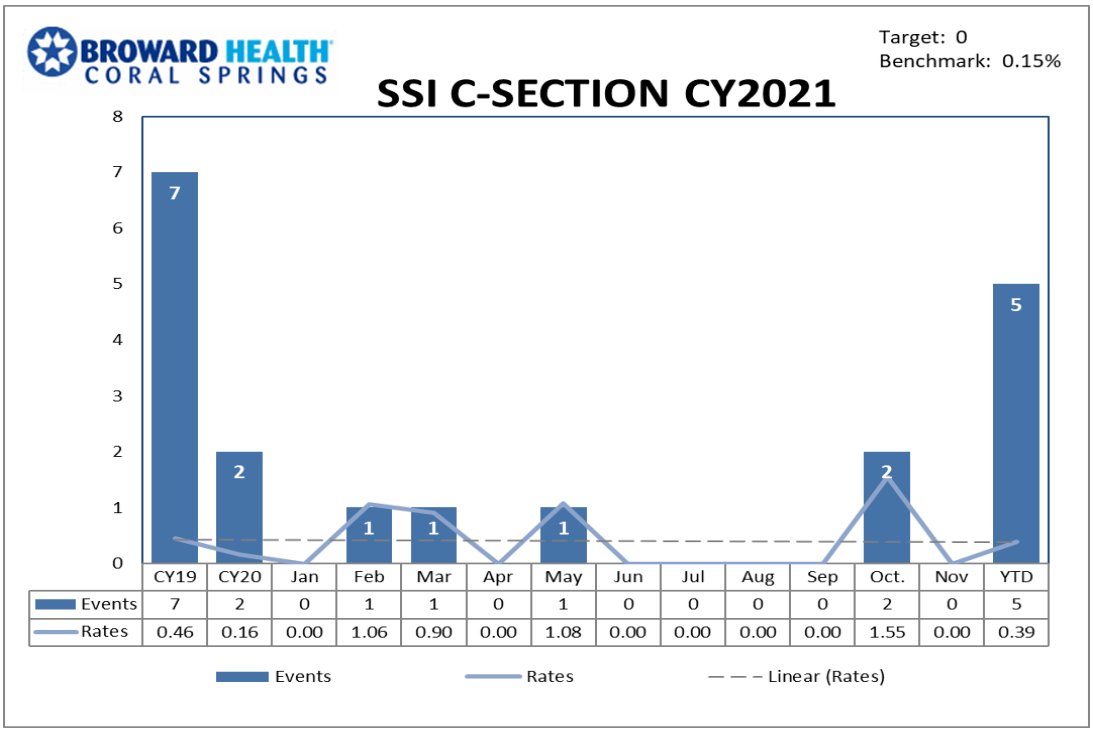
	CY19	CY20	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct.	Nov	Dec	YTD
Events	13	5	0	0	0	0	0	0	0	0	1	1	2	0	4
Rates	0.45	0.22	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.48	0.40	0.88	0.00	0.15

Analysis

Total Class II infections: 4/2,638. Rate: 0.15%

- **Reduction in infection rate from CY2020 to CY2021 was 38%.**
- **A SIR rate is not provided by NHSN.**

C-section Surgical Site Infections



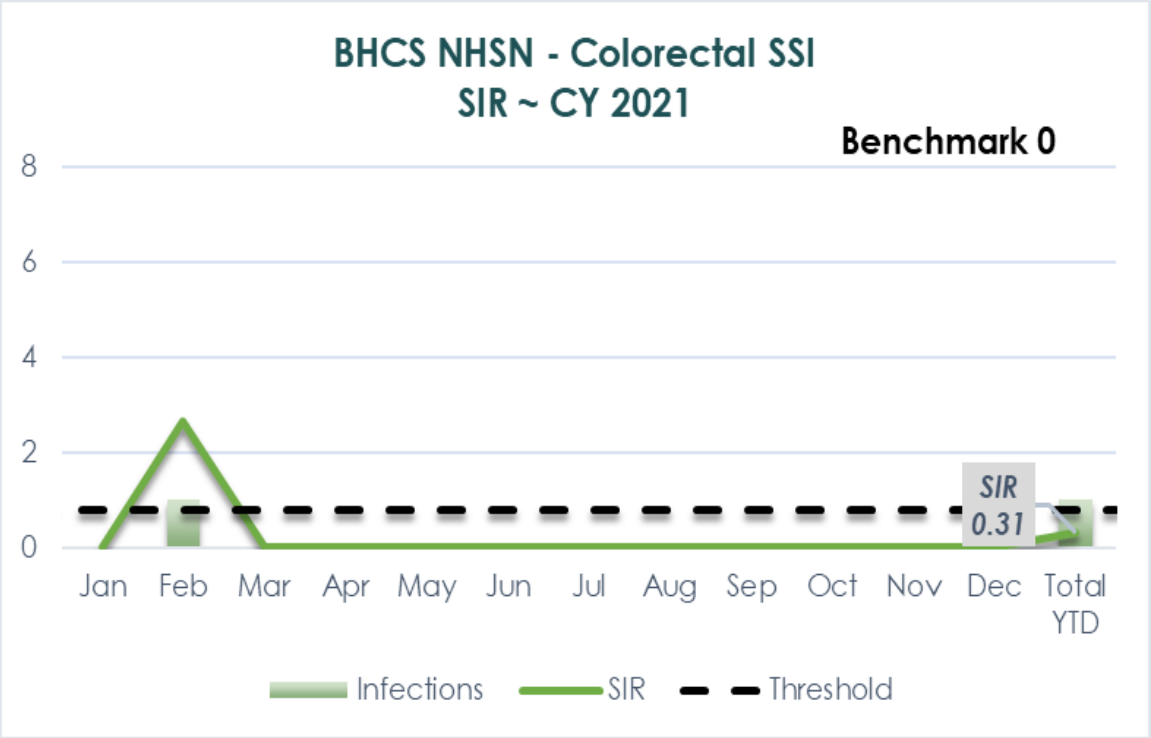
	CY19	CY20	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct.	Nov	YTD
Events	7	2	0	1	1	0	1	0	0	0	0	2	0	5
Rates	0.46	0.16	0.00	1.06	0.90	0.00	1.08	0.00	0.00	0.00	0.00	1.55	0.00	0.39

Analysis

C-Section Infections: 6/1,275. Rate of 0.47

- **Increase in infection rate from CY2020 to CY2021 was 194%.**
- **A SIR rate is not provided by NHSN.**

Colon Surgical Site Infections



Analysis

Colon Surgical Site Infection: 1/139. Rate of 0.72

Analysis

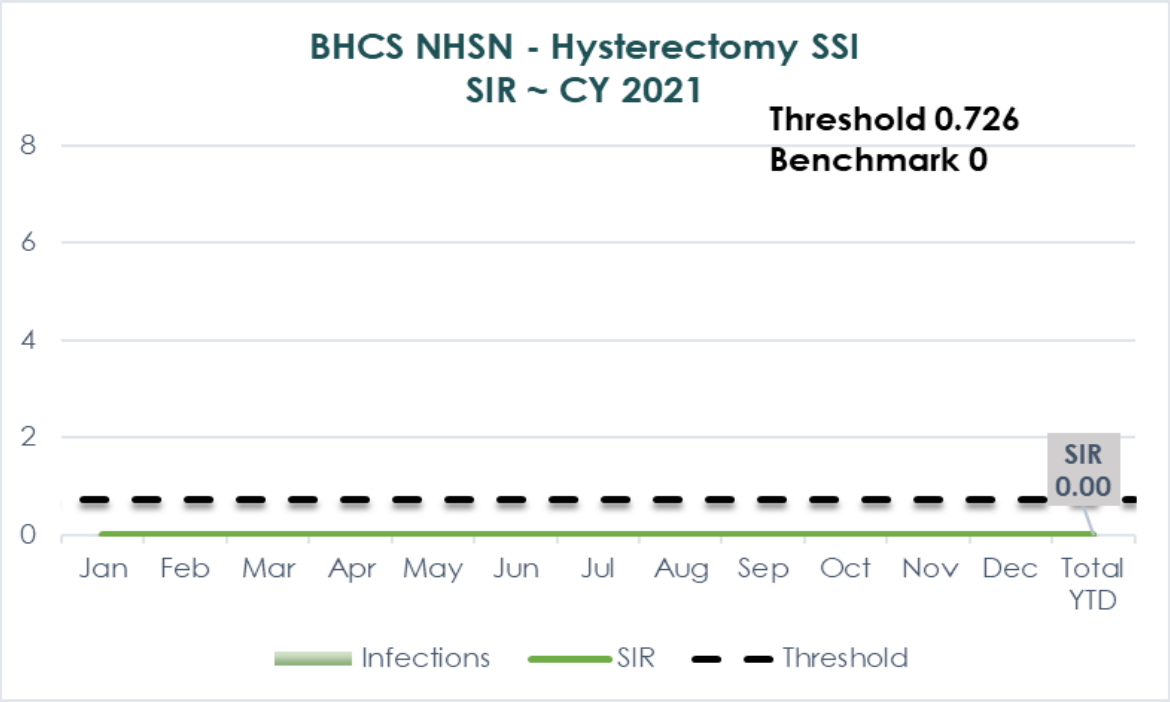
Decrease in infection rate from 2020 to 2021 was 79%.

Decrease in SIR rate from 2020 to 2021 was 82%.

For CY2021, the colon surgical site infection rate was 0.72%. This number represents 1 infections out of 139 colon surgical procedures.

The NHSN SIR for CY2021 was 0.72 which is a decrease from 3.45 in CY2020. The SIR is 0.2831, which is below 1, which indicated that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

Hysterectomy Surgical Site Infection: 0/209. Rate of 0.00



Analysis

Decrease in infection rate from 2020 to 2021 is 100%.

Decrease in SIR rate from 2020 to 2021 100%.

For CY2021, the hysterectomy surgical site infection rate was 0%. This number represents 0 infections out of 209 hysterectomy surgical procedures.

The NHSN SIR for CY2021 was 0.00 which is a decrease from 4.55 in CY2020. The SIR is below 1, which indicated that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

There were no SSIs related to total hip or total knee procedures.

Action Plans for All Surgical Site Infections

- Continue to monitor all class I, II, colon, hysterectomy and C-section surgical procedures for development of surgical site infection. In addition, total knee and total hip surgical procedures are also monitored. This is for standardization of internal reporting mandated by Broward Health.

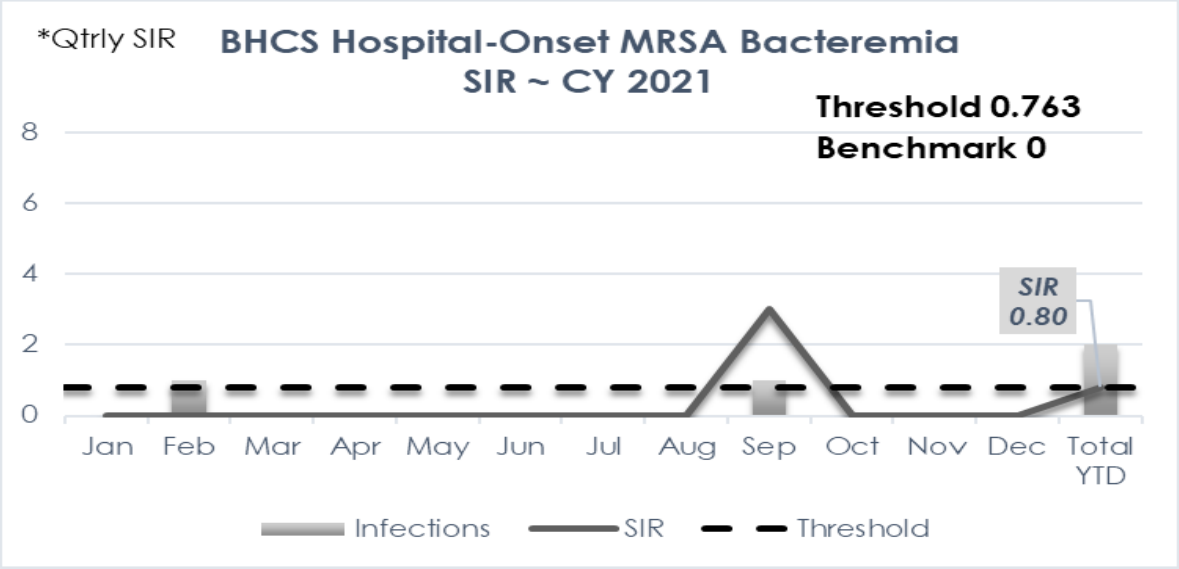
- Continue to report surgical infections to Patient Safety and Quality Council Committee meeting, Department of Surgery Committee meeting and Infection Control Committee meeting.
- Ongoing education of surgical staff on proper wound classification.
- Continue to review wound classification for accuracy.
- BHCS utilizes all evidence-based guidelines for best practices.
- Preoperative education prior to surgery is provided to all patients regarding the importance of preoperative bathing with either soap or water or an antiseptic which is to be completed at home the night before surgery and the morning of surgery before coming to the hospital.
- CHG is provided to all patients that attend preoperative education classes. This information was communicated to the medical staff.
- Meetings with Surgical Services Director, Nurse Manager of the Operating and Nurse Manager of Surgical Unit, CNO, Director of Women's and Children's Services, Nurse Manager for Labor and Delivery for identification of opportunities of improvement with review of every surgical site infection to ensure that all surgical site infection prevention bundles are implemented.
- Continue to perform surveillance to identify all surgical site infections.
- Continue rounds in Surgical Services Department, including sterile processing department.
- Ensure staff are utilizing additional medical equipment to assist with cleaning and disinfection, which included a borescope, lighted magnifiers, a new case cart system.
- Additional education was provided by DaVinci regarding cleaning and disinfection procedures.
- Meetings with frontline staff in Surgical Services and Sterile Processing Department to identify opportunities and improvements for best practices.
- Purchasing of additional equipment for cleaning and disinfection best practices.
- Rounding in GI suite, radiology and cardiology departments to ensure that high level disinfection processes are followed.
- Meetings held with Medical Director of Infection Control and with Chairman of the Department of Surgery to review every surgical site infection to identify opportunities for improvement.

- Meetings held, if needed, with Chairman of OB/GYN to identify opportunities for improvement specifically due to the increased number of hysterectomy infections.

- Ensure adherence to BH Hand Hygiene Plan.

Multi-drug Resistant Organisms (MDRO) and C. Difficile Infections

MDRO Infections



BHCS Tracks and trends all Resistant Organisms (i.e. MRSA, VRE, CRE, and ESBL) cultured from patients to determine if they are community acquired versus hospital acquired. We also track and trend all MRSA bacteremia as per the NHSN guidelines.

Analysis
Hospital-onset MRSA Bacteremia rate is based on 1000 patient days = 0.03/1000 patient days. This is an increase from a rate of 0.02/1000 patient days in 2020.

Our SIR for 2021 was 0.80 which is an increase from 0.00 in 2020. The SIR is below 1, which indicated that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

Increase in infection rate from 2020 to 2021 is 50%.

Reduction in SIR rate from 2019 to 2020 is 49%.

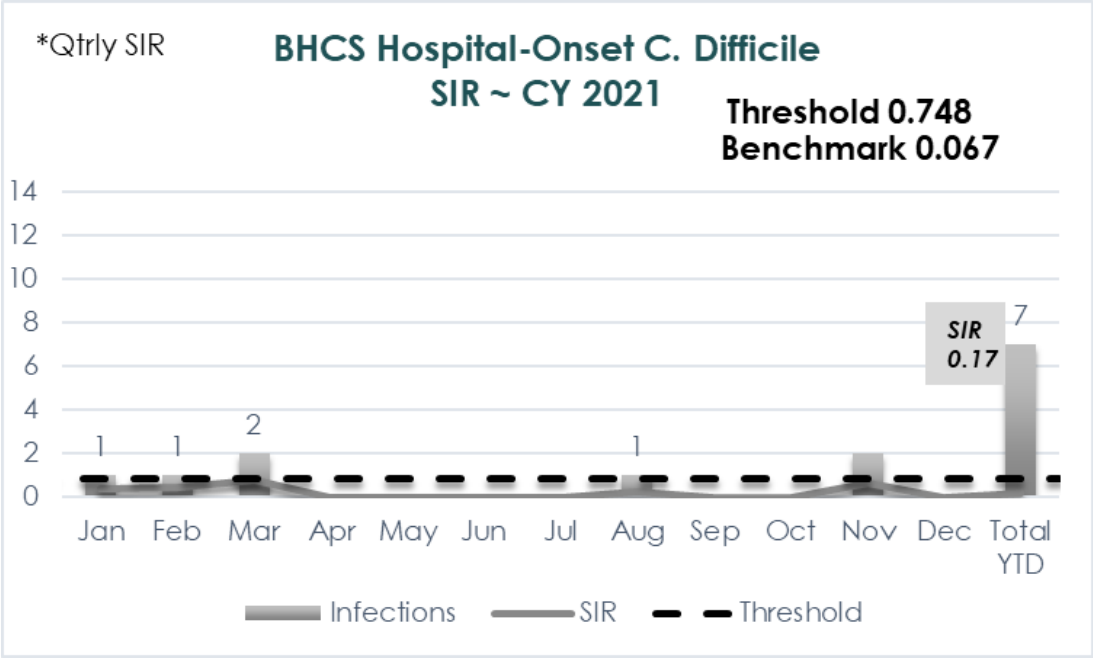
For CY2021, our infection rate for organisms that were culture positive for MDRO was 0.01%. This number represents 1 infection out of 68,558 patient days.
For CY2021, our infection rate for MRSA Bacteremia was 0.03%. This number represents 2 infections out 68,558 patient days.

Action Plans for All MDRO Infections

- Continue to implement hand hygiene, at the bedside, for all visitors to the NICU. Implementation of permanent signs for outside of all NICU patient rooms.
- Continue to maintain NICU eye care, which includes documentation in the EMR and date and time on eye shield used during phototherapy.
- Continue to ensure of use of nonsterile gloves for all contact with NICU babies.
- Early identification of patients colonized or infected with resistant organisms or other infectious organisms and immediate transmission based isolation of these patients reduced and prevented further transmission.
- Daily surveillance of cultures from patients admitted with or developing infection.
- Individual patient positive MDRO results were entered into an ALERT data base system which is activated to display with subsequent patient visits. The ALERT screen enabled hospital staff to imitate transmission based precautions as indicated from the screen information.
- Daily monitoring of ED visit log, admission log, disease alert log and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms to allow Epidemiologist to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission based precautions.
- Focused isolation rounds to ensure strict adherence to contact precautions.
- The CDC isolation precautions are uploaded to the general Broward Health intranet website as a resource for all staff to have access to.
- Education provided at New Hire Orientation with focus on transmission based precautions and patient to patient transmission.
- Participation in Antimicrobial Stewardship Program
- Enforcing strict hand washing with soap and water when exiting rooms with patients on Enhanced Contact Isolation
- Adherence to high touch surface cleaning with hypochlorite based solution for those patients that are on enhanced contact isolation precautions.
- Continue to monitor Transmissions-Based Precautions and Standard Precautions, Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical and nursing departments and Epidemiology.
- Ongoing education to all staff regarding importance of hand hygiene.
- BHCS participates in HIIN for best practices.
- Adherence to BH Hand Hygiene Plan.
- Provide education during new hire orientation, staff meetings/huddles and during rounding.
- Implemented a recognition program to identify HCWs who perform hand hygiene by providing a business card with a life saver candy and a “thank you for being a life saver”.
- Provided education during Infection Prevention and Control Week.

- Education provided to all nursing unit utilizing Wheel of Bugs, questions regarding HAI and provided education flyers from CDC.

C. Difficile



Hospital Onset C. difficile is tracked as per the NHSN guidelines and tracked for rates as well as by unit to identify locations for potential issues with patient to patient transmission.

Analysis:

Hospital-acquired C. difficile case rate is 1.11/10,000 patient days for CY2021. This is a reduction from a rate of 2.12/10,000 patient days in 2020.

Our SIR for 2021 was 0.17 which is a reduction from 0.34 in 2020.

Reduction in infection rate from 2020 to 2021 is 48%.

Reduction in SIR rate from 2019 to 2020 is 50%.

Our greatest improvement was noted in our 3 East medical unit, which decreased from 3 C. diff infections in 2020 to 1 C. diff infection in 2021. We continued to have the same amount of 2 infections on our 3 South surgical unit. We did have one C. diff infection on our Pediatric unit, which was very unusual for our population. Continued efforts to reduce infection are through staff awareness, education, strict enforcement of enhanced contact precautions and hand-hygiene. Strict adherence to Enhanced Contact Precautions guidelines has resulted in 0 cases of patient to patient transmission.

Action Plans

- Question on ED triage regarding loose stools in order to identify a patient with a risk for C. difficile early on admission to limit risk of hospital transmission.
- Automatic placement of C. diff collection if patient complains of diarrhea on presentation to the ED.
- Automatic discontinuation of C. diff order if specimen has not been collected in 24 hours to limit the identification of C. diff colonization.
- Indication required for Proton Pump Inhibitor order
- Indication required for antibiotic treatment and duration.
- Education with nursing staff regarding indications for C. diff.
- Partnership with pharmacy on the antimicrobial stewardship program.
- Intense analysis of every C. diff HAI is reviewed within two weeks of identification of infection, including the nurse manager, CNO, Regional Quality Manager and Clinical Coordinator of Pharmacy. Opportunities for improvement are identified and shared at Patient Safety Quality Committee meetings.
- A pending C. diff report is automatically generated every morning. All pending orders for C. diff are reviewed and nurse managers are notified during the daily morning huddle report. Opportunities for intervention have been identified with the implementation of this report.
- C. diff education provided to all nursing unit utilizing Wheel of Bugs, questions regarding C. diff, provided updated algorithm, education flyers from CDC.
- Continue to utilize stop sign in clean supply room near specimen containers to alert staff.
- Updated C. diff education algorithm to
    - RN discussion with charge nurse, ANM/NM or Clinical Specialist prior to collection of stool specimen.
    - Use chain of command including charge nurse, ANM/NM/Epi when needed.
    - Daily huddle to include patients with diarrhea and number of days since admission.

Healthcare Worker Risks

- Provide education during new hire orientation, staff meetings/huddles and during rounding with focus on disease transmission and prevention.
- Implemented a recognition program to identify HCWs who perform hand hygiene by providing a business card with a life saver candy and a “thank you for being a life saver”.
- Provided education during Infection Prevention and Control Week.
- Isolation Precautions compliance is monitored on a monthly basis by Epidemiology and presented at the Infection Control Committee meeting. Compliance with PPE is over 99%.
- In-services and education provided to individual departments during their staff meetings to include Environmental Services and Nutritional Services.
- All hospital staff and LIPs are required to comply with mandatory in-service education about the prevention of health care associated infections, multi-drug resistant organisms, and prevention strategies, at hire and annually thereafter**.**
- All nursing staff are required to complete education about prevention of central line associated blood stream infections, catheter associated urinary tract infections, and ventilator associated pneumonia, surgical site infections, and transmission of multidrug-resistant organisms.
- Education is provided to all patients and families who are infected or colonized with a multidrug-resistant organism about health care associated infection prevention strategies.

- Surveillance plan based on prioritized risk of transmission of diseases identified in our community and from the characteristics of the population served was developed and approved by the Infection Prevention and Control Committee.
- Surveillance plan is carried out by the Epidemiology on an ongoing basis resulting in prevention of disease transmission to patients, hospital staff, LIPs, students, volunteers and visitors.
- Epidemiology identifies risks for acquisition and transmission of infectious agents on an ongoing basis (MDROs, C. difficile, TB, Influenza) and annual risk assessments.
- There is a high incidence of TB in Broward County which requires constant surveillance to identify suspect cases. This is included in the risk analysis of reported data as high risk and requires close monitoring to prevent transmission.
- Continue to actively track and trend the traffic of patients for any increase influx of patients and/or need to implement the Pandemic Plan.
- Epidemiology performed daily ongoing surveillance through the monitoring of ED logs, microbiology candidate reports and rounding helped identify influx of infectious patients.
- The ESSENCE reporting system that identifies syndromic trends through the ER is used to coordinate surveillance with the Broward County Department of Health.
- A database for TB reporting to the Health Dept. was utilized to maintain a record of communication.
- Early identification of patients colonized or infected with resistant organisms, TB, influenza or other infectious organisms and immediate transmission based isolation of these patients reduced and prevented further transmission.
- Individual patient positive MDRO results were entered into an ALERT data base system which is activated to display with subsequent patient visits. The ALERT screen enabled hospital staff to imitate transmission based precautions as indicated from the screen information.
- Increased surveillance, monitoring, tracking and trending of COVID-19 related infections for patients and staff.
- Increased rounding and on the spot education provided specifically based on the COVID-19 pandemic.
- Increased education regarding PPE and reinforcement of donning and doffing, including

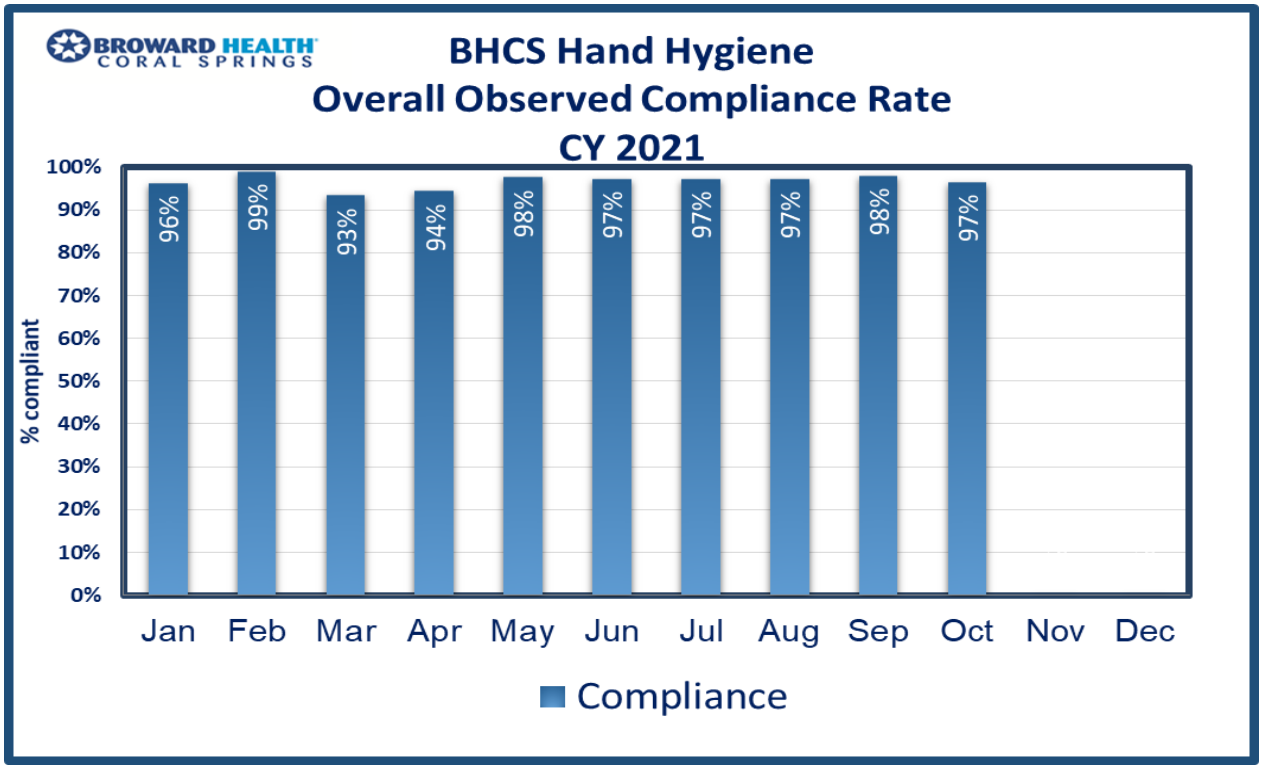
Isolation Precautions Compliance

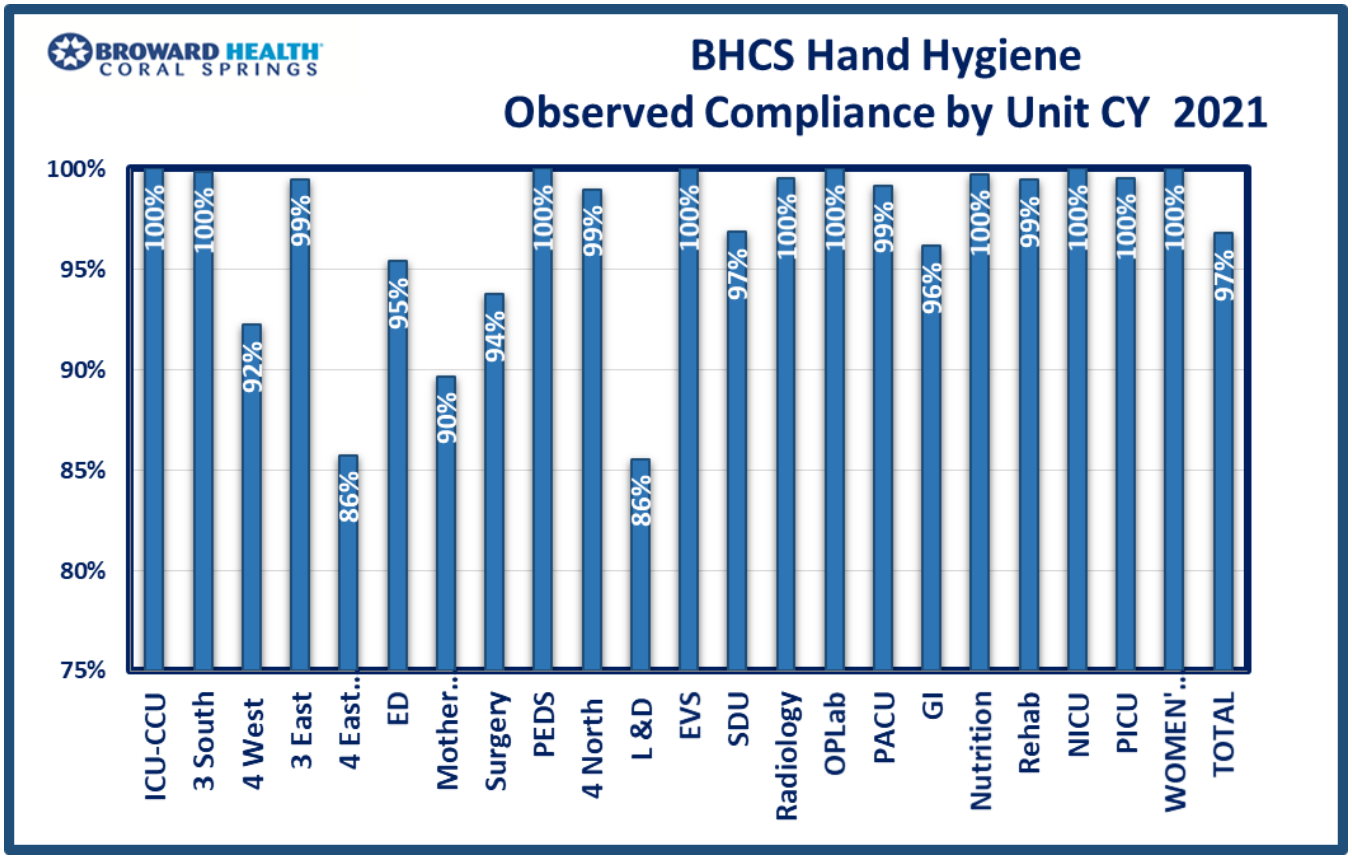
Indicator	Definitions		CY2019	CY2020	ACTUAL PERFORMANCE Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	YTD Avg
Target																	
Precaution supplies readily available outside patient room	# of Isolation boxes in use	100%	1,653	2,473	358	301	309	311	274	205	443	635	428	294	271	367	4,196
	transmission based precautions		of 1,653	of 2,473	of 358	of 301	of 309	of 311	of 274	of 205	of 443	of 635	of 428	of 294	of 271	of 367	of 4,196
			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Precaution sign on door matches order	# of Precaution signs on door matches order	100%	1,642	2,465	358	301	301	311	272	204	440	635	428	294	271	367	4,182
	transmission based precautions		of 1,653	of 2,473	of 358	of 301	of 309	of 311	of 274	of 205	of 443	of 635	of 428	of 294	of 271	of 367	of 4,196
			99.3%	99.7%	100.0%	100.0%	97.4%	100.0%	99.3%	99.5%	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%
Precaution label on front of chart	# of Precaution labels on front of charts	100%	1,425	2,426	343	298	306	309	270	200	441	633	424	293	270	365	4,152
	transmission based precautions		of 1,653	of 2,473	of 358	of 301	of 309	of 311	of 274	of 205	of 443	of 635	of 428	of 294	of 271	of 367	of 4,196
			86.2%	98.1%	95.8%	99.0%	99.0%	99.4%	98.5%	97.6%	99.5%	99.7%	99.1%	99.7%	99.6%	99.5%	99.0%
Appropriate PPE used by HCW	# of employee observations	100%	1,629	2,472	358	301	309	311	274	205	443	635	427	294	271	367	4,195
	# of opportunities		of 1,653	of 2,473	of 358	of 301	of 309	of 311	of 274	of 205	of 443	of 635	of 428	of 294	of 271	of 367	of 4,196
			98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%
Isolation Order in PowerChart	# observations	100%	1,652	2,470	358	301	309	311	274	205	443	635	428	294	271	367	4,196
	# of opportunities		of 1,653	of 2,473	of 358	of 301	of 309	of 311	of 274	of 205	of 443	of 635	of 428	of 294	of 271	of 367	of 4,196
			99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The number of patients placed on isolation precautions have increased significantly related to the COVID-19 pandemic. In CY2020, 2,473 patients were placed on isolation. In CY2021, that number has increased to 4,196.

On 4/18/20, mandatory masks for all staff was implemented. On 4/18/20, mandatory mask was implemented for all patients and visitors. In addition, eye protection was mandated for all staff in patient facing encounters as of 6/29/20. We continue to maintain these practices.

Hand Hygiene Compliance





Communicable Diseases

The Clinical Specialist of Epidemiology reports all required reportable diseases in to the Broward County Health Department. Sexually transmitted diseases comprise the predominance of the reporting: Gonorrhea and Chlamydia are the most frequently reported STDs.

Antibodies to Hepatitis C virus, and various gastrointestinal diseases such as Salmonella and Shigella were the top reported communicable diseases other than STDs.

Due to the COVID-19 pandemic, there has been unprecedented reporting to the Broward County Department of Health. Currently, all positive COVID-19 patients are reported to the Department of Health. In addition, all expirations are also reported. Of great importance to the Department of Health is the notification of patients who presented to the emergency department that came from assisted living facilities, skilled nursing homes, or other group settings.

Education

- Annual infection control education completed for all departments at BHCS via Healthstream. Attendance lists are on file in the Education office.
- Education provided at New Hire Orientation, during the height pandemic in-person was suspended.

- Formal in services as well as Just in Time education provided by Clinical Specialist of Epidemiology throughout CY2021 focused on Hand hygiene, multidrug resistant organisms, C. difficile, CAUTI bundle practices, and isolation precautions.
- Presentations at various hospital unit staff meetings conducted throughout the year.
- Epidemiology is available for consultation 24 hours a day, seven days a week.
- Support and enhance public relations through community interactions and educational programs on BHCS campus and at various community centers throughout the county.

Trials / New Products

- All products that are introduced to Broward Health Coral Springs must first go through the Value Analysis Committee for approval which includes updates on trials of the product to ensure proper function and safety.
- When indicated, presentations are first given to the Regional Epidemiologists prior to being presented at Value Analysis Committee.

Evaluation

The BHCS Infection Control Risk Assessment for CY2020 was presented to the Infection Control Committee for review, recommendations and approval.

- The annual appraisal CY2021 was presented for approval to the Infection Control Committee and will be presented to the Medical Executive Committee.
- The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified.
- The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- The Infection Control Committee meets quarterly. The Committee structure includes the Committee chair, who is the Medical Director of the Infection Control Program, staff physicians, administration, nursing, pharmacy, lab, nutritional services, environmental services, surgery, safety, facilities and other departments as needed.
- PMR and other reports are indicated are provided to the Patient Safety Quality Council Committee meeting on a monthly basis.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.
- All areas surveyed for construction were found to be fully ICRA compliant during CY 2021 and if there were any deficiencies noted, these were corrected immediately or work was stopped.
- All of the prioritized risks were reviewed and evaluated. Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- Epidemiology monitored sterilization and high level disinfection processes within the hospital. Ongoing review of the monitoring reports submitted by all departments are also presented at the Environment of Care Committee meeting and Infection Control Committee meeting.
- The Clinical Specialist of Epidemiology maintains membership of national and local chapters of their professional organizations, to include APIC and AORN, in order to receive education and competency related to Epidemiology/ Infection Prevention and Control on an ongoing basis.

CY2021 Epidemiology Accomplishments

Education

- Nursing Grand Rounds on Health Associated Infections
- Creation of guidelines, protocol, monitoring tools, etc. due to the COVID-19 pandemic and implementation of such as updates provided from the CDC
- Reviewed CDC, TJC, SHEA, APIC and other regulatory agencies on daily basis to keep informed of any changes and provided information to Leadership as needed
- Updated different departments as needed with updates to included Surgical Services, OB/GYN, and Children's Services
- Updated Medical Staff as new information received including information from DOH.
- CDC education on NHSN definitions by Epidemiology nurse.
- Continuous education through webinars, attendance at meetings and online education
- Creation of Education board with all HAI information and prevention tips
- Maintains excellent relationships with all epidemiologists at hospitals in tri-county area in order to share information regarding Infection Prevention and Control and reporting of infections.
- Attendance at Association for Professional in Infection Control and Epidemiology (APIC) Chapter meeting for continuing education and network with Miami/Dade, Broward and West Palm Beach counties for updates on infection prevention and control. Participated in weekly calls with local APIC chapter for information sharing with tri-county hospitals specifically regarding COVID protocols.
- Presented Flu education to community as requested by Community Education via TEAMS in October.
- Always available to nursing supervisors, NM, staff and physicians, even when not on call in order to maintain good communication and patient safety.
- Bylaws Chairperson for Broward County APIC chapter.
- Assisted with development of additional infection prevention protocols for Women's Services. Ensured proper technique during set up, breakdown and transfer of vaginal delivery instruments.
- Rounding in Surgical Services with education provided in SPD for evidence based practices and following AORN and AMMI guidelines. Education provided to SSAs regarding room turnover. Rounds in OR assess terminal cleaning in order to reduce SSIs.

- Focused rounds in SPD to identify opportunities for improvement and recommendations made for borescope in an effort to reduce SSIs, lighted magnifier in order to visualize instruments when putting trays together.

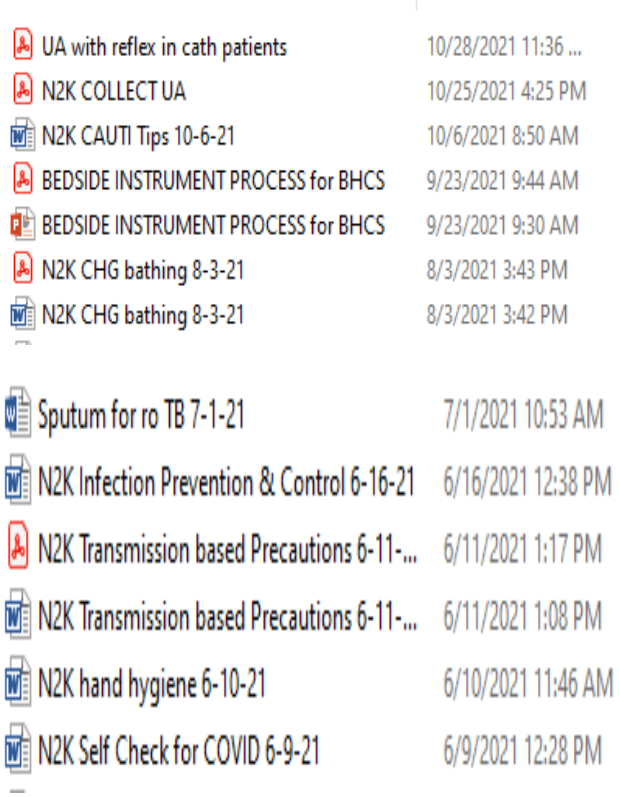
- Additional education provided regarding quality strips for washer and recommended to display instructions. Identification of requirement to perform quality indicators on Ultrasonic machine for cleaning DaVinci instruments. Recommendations regarding documentation of control and biological checks for Sterrad sterilization.

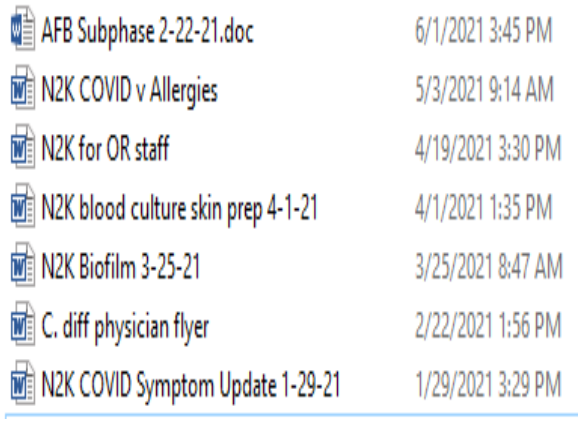
- Rounding individually and with CNO in SPD continued on weekly, then monthly basis to ensure compliance with standards.

- Identification of back order of Sure step foley catheter trays and replacement by Materials Management Corporate with foley and insertion separate trays which can be high risk for infection. Spoke directly with company rep to identify back order and replacements that are available. Forwarded information to VP of Quality and able to obtain Sure step foley insertion tray with different size foley, due to back order and able to use these trays system wide with a lower risk for infection.
- Worked closely with Corporate IT to create a daily am C. diff and C. AFB report regarding pending studies in order to review and potentially ensure that patients are on appropriate isolation.

- Presented at EBCC to place all patients pending a respiratory viral panel on both airborne and contact isolation while pending results as this testing also includes COVID PCR.
- Presented to EBCC that all C. diff orders include enhanced contact isolation. Created UA to reflex culture algorithm in order to ensure that urine specimen are obtained when appropriate.
- Created “yellow” form checklist for nursing staff to use prior to sending C. diff specimen to the lab, created letter for physicians regarding C. diff and sent out to all medical staff.
- Created stop sign and placed on all carts in clean supply rooms near specimen containers for nursing to review prior to collecting specimen.
- Created UA and culture algorithm in cathed patients for nursing to review prior to collecting specimen. Urinary Cath patient education flyer,
- Updated Fast Facts for CAUTI prevention for BHCS. Updated CHG bathing as requested by Clinical Education for Healthstream upload and nursing education.

- Need2Know Education Flyers created on the following topics





Hand Hygiene 2021

- Continued to utilize a recognition program to identify HCWs who perform hand hygiene by providing a business card with a life saver candy and a "thank you for being a life saver"
- Stress importance at New Hire Orientation
- Just in time education provided whenever opportunity arises
- Participation in multiple committee meetings discussing the importance of hand hygiene.
- Monthly presentation of hand hygiene compliance at Patient Safety Quality Committee meeting.
- Focused hand hygiene education in NICU with education and return demonstration.

CAUTI

- Changed standard foley catheter insertion kits to all 14 French instead of 16 French. Continue to stock 16 French in Material Management and maintenance of urology cart.
- Updated Fast Fact for CAUTI Prevention for nursing
- Updated Urinary Catheter Flyer for Patient Education
- CAUTI prevention education provided to all staff via Health stream.
- Continued education on NHSN and surveillance definitions
- Rounding on maintenance and care related to urinary catheters as well as reminders for removal
- House wide collection of line days
- Striving for zero infections
- Pericare/foley care and CAUTI prevention provided to all staff
- Continue to ensure that all urinary catheters inserted with urimeters to prevent breaking closed system
- CAUTI rate graphs provided monthly at Patient Safety Quality Council meetings
- Point Prevalence rounding with Device Representative. Results presented to stake holders and leadership for evaluation
- Prevalence rounding by Epidemiology
- Intense drill down and analysis of every infection with key stake holders
- Urine collection algorithm
- Ensure that the laboratory is utilizing advanced urine reflex protocols as approved by Corporate Medical Director of Infection Control and the Corporate Pathologist.

CLABSI

- Updated Fast Facts for CLABSI Prevention for nursing
- Vascular Access Line Use Flyer for nursing education regarding lines
- Continue education on NHSN and surveillance definitions
- CHG bathing techniques were monitored and re-education was provided to all nursing staff
- Created mandatory online education was provided through Healthstream.
- Continued use of disinfectant caps on all IV tubing access ports on all adult inpatient nursing units
- Rounding on the unit questioning the necessity of lines and observing dressings has contributed to the overall decline in CLABSI rates
- CLABSI rate graphs provided monthly at Patient Safety Quality Council meetings.
- Discussion of CLABSI in at Patient Safety Quality Council meetings.
- Prevalence rounding by Epidemiology
- Intense drill down and analysis of every infection with key stake holders

SSI

- Continued use of updated BHCS Antimicrobial Surgical Prophylaxis Guidelines, with assistance from pharmacy, for use in surgery
- Education on NHSN and surveillance definitions
- Daily surveillance of cultures to identify any surgical site infections
- Attendance at Multidisplinary Rounding for all patients who are part of the Joint Commission Disease Specific Minimally Invasive program, initially on hold due to pandemic
- Presentation of all surgical site infections at the Surgical Site Infection Prevention Committee meeting with focus on risk factors and adherence to evidence based practice to reduce infections
- SSI rate graphs provided monthly at Patient Safety Quality Council meetings, Department of Surgery and OB/GYN Perinatal Committee meetings
- Discussion of SSI at Patient Safety Quality Council meetings
- Continued weight based dosing for pre op antibiotics as per evidence based practice.
- Intense drill down and analysis of every infection with key stake holders
- Review of all SSIs with Medical Director of Infection Control and Department Chair of Surgery
- Focus group meeting to discuss increase in hysterectomy infections and changes made, including additional education from DaVinci regarding reprocessing of instrumentation

VAE

- Education in NHSN and surveillance definitions.
- Surveillance through rounding (both Epi and managers) observing for compliance to VAE bundles.

MDRO and C. Difficile

- Updated C. diff algorithm to include chain of command to follow prior to collection of stool specimen
- Created stop sign with symptoms of C. diff and attached to all par carts near specimen containers to provide additional education to nursing
- EVS in-services
- Nutritional Services in-services
- Use of Medmined data mining system to capture any trends related to MDRO's and CDI
- Recognizing the importance of antimicrobial stewardship in decreasing the rates of MDROs, the Epidemiology Department continues to work with Pharmacy

- Continued to implement Transmissions-Based Precautions and Standard Precautions
- Hand Hygiene education
- MDRO admission alerts, and frequent communication between clinical and nursing departments and Epidemiology
- Continued use of Respiratory Viral Panel/Biofire technology to decrease antibiotic use when viruses are identified

Clinical Specialist of Epidemiology: _____

CNO, COO, or CFO: _____

Infection Control Committee Chairman: _____

Date: