

ANNUAL EVALUATION AND APPRAISAL FOR CY2020

Evaluation of the Infection Control Program CY2020 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 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 2020. 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 Broward Health Coral Springs 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.
- 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 CY2020

| INDICATOR | Definition | Target | CY18 | CY19 | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD |
|--------------------------------------|---|--------|--------|--------|------|------|------|------|------|------|------|------|------|------|------|------|-------|
| Central Line Associated BSI | Infections Line days X 1000 | 0.27 | 6 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 4 |
| | | | 6,618 | 6,634 | 544 | 679 | 562 | 785 | 707 | 498 | 846 | 1051 | 709 | 571 | 672 | 854 | 8039 |
| | | | 0.91 | 0.30 | 0.00 | 0.00 | 0.00 | 1.27 | 0.00 | 0.00 | 2.36 | 0.95 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 |
| Catheter Associated UTI | # of CA- UTIs # of Foley days x 1000 | 1.00 | 2 | 6 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 3 |
| | | | 5,553 | 5,425 | 502 | 521 | 500 | 640 | 488 | 433 | 695 | 892 | 644 | 537 | 569 | 734 | 9538 |
| | | | 0.36 | 1.11 | 0.00 | 0.00 | 0.00 | 0.00 | 2.05 | 0.00 | 0.00 | 1.12 | 1.55 | 0.00 | 0.00 | 0.00 | 0.31 |
| Hospital Onset C-Difficile Infection | # new cases + C-diff # of Patient Days x 10000 | 2.88 | 15 | 13 | 2 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 2 | 2 | 0 | 0 | 9 |
| | | | 41,191 | 40,609 | 3764 | 3890 | 3328 | 2908 | 3106 | 2713 | 4096 | 3786 | 3440 | 3507 | 3622 | 4216 | 42376 |
| | | | 0.36 | 3.20 | 5.31 | 0.00 | 0.00 | 0.00 | 3.22 | 3.69 | 2.44 | 0.00 | 5.81 | 5.70 | 0.00 | 0.00 | 2.12 |
| Hospital Onset MRSA Bacteremia | # of Pts with HA MRSA Bac # of Patient Days x 1000 | 0.04 | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | | | 48,066 | 47,962 | 4413 | 4526 | 3852 | 3451 | 3569 | 3094 | 4533 | 4322 | 3886 | 3997 | 4226 | 4699 | 48568 |
| | | | 0.02 | 0.04 | 0.00 | 0.22 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.02 |

| INDICATOR | Definition | Target | CY17 | CY18 | CY19 | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct. | Nov | Dec | YTD |
|--|---|--------|------|-------|-------|------|------|-------|------|--------|--------|----------------|--------------|--------------|--------------|-----------|-----------|---------|
| SSI Rate, Class 1* | # of Class 1 Infections | | | | 6 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 3 |
| | # of Class 1 surgeries x 100 | | | | 1,684 | 113 | 154 | 108 | 49 | 93 | 108 | 72 | 78 | 105 | 135 | 106 | 130 | 1,251 |
| | | | - | - | 0.36 | 0.00 | 0.00 | 0.00 | 0.00 | 2.15 | 0.00 | 0.00 | 0.00 | 0.00 | 0.74 | 0.00 | 0.00 | 0.24 |
| SSI Rate, Class 2* | # of Class 2 Infections | | | | 13 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 5 |
| | # of Class 1 surgeries x 100 | | | | 2,870 | 183 | 203 | 184 | 107 | 139 | 218 | 186 | 134 | 215 | 247 | 202 | 247 | 2,265 |
| | | | - | - | 0.45 | 0.00 | 0.00 | 0.54 | 0.93 | 0.72 | 0.46 | 0.00 | 0.00 | 0.00 | 0.40 | 0.00 | 0.00 | 0.22 |
| C-section | # of Infections | 0.36 | 8 | 5 | 7 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| | # of surgeries x 100 | | 991 | 1,262 | 1,529 | 110 | 120 | 97 | 114 | 83 | 81 | 112 | 111 | 103 | 90 | 97 | 108 | 1,226 |
| | | | 0.81 | 0.40 | 0.46 | 0.00 | 0.00 | 0.00 | 0.88 | 0.00 | 1.23 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.16 |
| Pacer/ Cardiac Cath | # of Infections # of surgeries x 100 | | | | | | | | | 0 0 | 0 0 | 1 5 | 0 4 | 0 3 | 0 3 | 0 2 | 0 0 | 1 17 |
| | | | | | | | | | | 0 0 | 0 0 | 20.00 20.00 | 0.00 0.00 | 0.00 0.00 | 0.00 0.00 | 0.00 - | - 5.88 | |
| Total Hips | # of Infections | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | # of surgeries x 100 | | | | 73 | 5 | 9 | 2 | 3 | 5 | 5 | 5 | 1 | 7 | 8 | 5 | 7 | 62 |
| | | | - | - | 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 | | | | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | # of surgeries x 100 | | | | 78 | 4 | 10 | 5 | 2 | 3 | 4 | 4 | 0 | 2 | 1 | 1 | 0 | 36 |
| | | | - | - | 1.28 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | - | 0.00 | 0.00 | 0.00 | - | 0.00 |
| CMS VBP Colon SSI (rate) | # of Infections | 4.53 | 5 | 7 | 7 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 6 |
| | # of surgeries x 100 | | 123 | 139 | 148 | 15 | 18 | 10 | 8 | 11 | 18 | 12 | 12 | 14 | 16 | 13 | 10 | 157 |
| | | | 4.07 | 5.04 | 4.73 | 6.67 | 5.56 | 0.00 | 0.00 | 9.09 | 5.56 | 0.00 | 0.00 | 6.25 | 7.69 | 0.00 | 3.82 | |
| CMS VBP Abdominal Hysterectomies | # of Infections | 0.00 | 1 | 0 | 2 | 0 | 1 | 2 | 0 | 0 | 3 | 0 | 1 | 0 | 0 | 1 | 0 | 8 |
| | # of surgeries x 100 | | 235 | 259 | 313 | 26 | 25 | 18 | 2 | 7 | 19 | 19 | 8 | 17 | 22 | 14 | 22 | 199 |
| | | | 0.43 | 0.00 | 0.64 | 0.00 | 4.00 | 11.11 | 0.00 | 0.00 | 15.79 | 0.00 | 12.50 | 0.00 | 0.00 | 7.14 | 0.00 | 4.02 |

Zero Tolerance and the Bundle Approach

The *Infection Prevention and Control Program* has adopted the philosophy of “Zero Tolerance” 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.

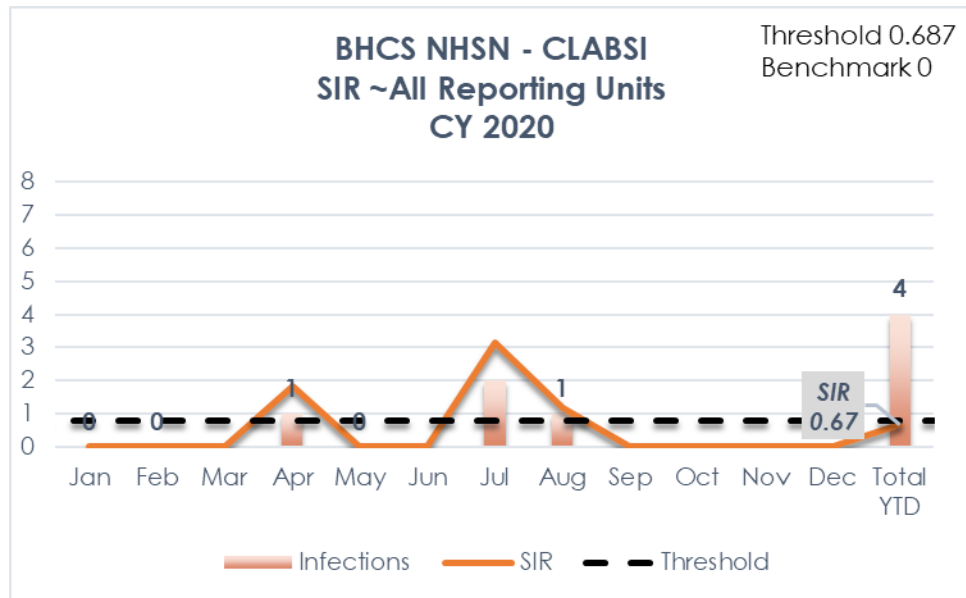
BHCS currently reports through the NHSN: CLABSI, CAUTI, surgical site infections in selected COLO and HYST procedures, lab identified C. difficile and MRSA bacteremia, and influenza vaccination rates.

Device- Associated Infections

Central Line Associated Blood Stream Infections (CLABSI)

CLABSI CY2020

| | Target | CY19 | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD |
|--------------|--------|-------|------|------|------|------|------|------|------|-------|------|------|------|------|-------|
| ICU | 0.84 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 4 |
| | | 1,747 | 151 | 135 | 153 | 293 | 151 | 113 | 306 | 339 | 245 | 170 | 195 | 297 | 2548 |
| | | 1.14 | 0.00 | 0.00 | 0.00 | 3.41 | 0.00 | 0.00 | 6.54 | 2.95 | 0.00 | 0.00 | 0.00 | 0.00 | 1.57 |
| 3E | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 1,573 | 136 | 213 | 120 | 143 | 208 | 162 | 97 | 105 | 118 | 85 | 126 | 170 | 1683 |
| | | 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 |
| 3S | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 490 | 33 | 89 | 69 | 59 | 53 | 44 | 48 | 88 | 69 | 96 | 107 | 85 | 840 |
| | | 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 |
| 4EAST PCU | 1.48 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| | | 1,762 | 166 | 117 | 145 | 194 | 212 | 128 | 158 | 141 | 168 | 153 | 148 | 130 | 1860 |
| | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 5.95 | 0.00 | 0.00 | 0.00 | 0.54 |
| 4W | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 242 | 51 | 85 | 54 | 25 | 40 | 41 | 82 | 137 | 31 | 43 | 63 | 74 | 286 |
| | | 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 |
| 4N | 3.81 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 1 | 4 | 22 | 8 | 53 | 43 | 3 | 60 | 35 | 37 | 11 | 9 | 64 | 349 |
| | | 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 |
| NICU | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 86 | 1 | 2 | 5 | 0 | 0 | 6 | 0 | 18 | 2 | 13 | 17 | 5 | 69 |
| | | 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 |
| PICU | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 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 |
| 3W PEDS | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 82 | 2 | 16 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 26 |
| | | 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 |
| ICUO | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 0 | 0 | 0 | 0 | 18 | 0 | 0 | 95 | 188 | 39 | 0 | 7 | 29 | 376 |
| | | 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 |
| BHCS | 0.82 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 5 |
| | | 5,993 | 544 | 679 | 562 | 785 | 707 | 498 | 846 | 1,051 | 709 | 571 | 672 | 854 | 8,039 |
| | | 0.33 | 0.00 | 0.00 | 0.00 | 1.27 | 0.00 | 0.00 | 2.36 | 0.95 | 1.41 | 0.00 | 0.00 | 0.00 | 0.62 |



Analysis:

Hospital associated CLABSI infection rate for 2020 was 0.50, which was an increase from 0.30 in 2019.

BHCS had 5 CLABSIs 2020 (1 was non NHSN reportable) which was an increase from 2 in 2019. 4 out of the 5 CLABSIs were in the ICU. We believe this increase was directly related to the number of our COVID positive patients and the acuity level of the patients. We also had an increase in our central line days. As a result, many action plans were initiated and ongoing efforts to reduce infection continue through staff awareness and education.

Our SIR for 2020 was 0.67 which is more than our SIR for 2019 which was 0.46 per NHSN.

Increase in infection rate from 2019 to 2020 was 67%.

Increase in central line days from CY2019 to CY2020 was 34%

Increase in SIR rate from 2019 to 2020 was 46%.

NICU

The CLABSI rate in the NICU population for CY2020 was 0 per 1000 central line days.

Pediatrics

The CLABSI rate in the pediatric population was 0 per 1000 central line days for CY2020.

- Infections are identified from prospective surveillance by the Clinical Specialist of Epidemiology.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
- Meetings are held with all infections to determine opportunities and action plans for improvement.
- Reports are submitted to BHCS Infection Prevention and Control Committee and Patient Safety Quality Council.

- 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.
- Rates increased and decreased depending on the unit.
- Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.
- Strive for zero infection.

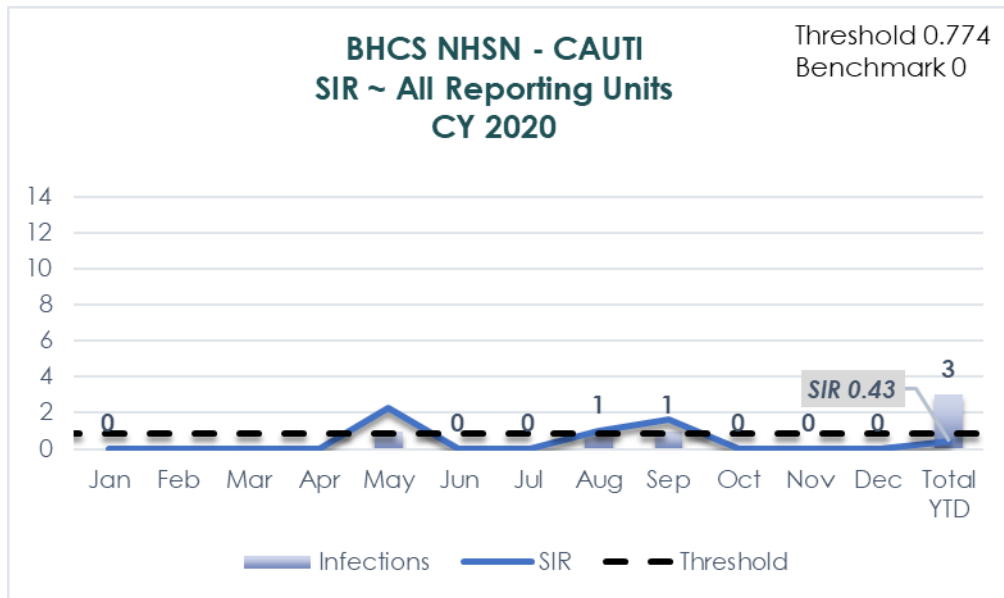
Action Plans

- Continue to monitor central lines for necessity, educate nursing staff and the medical staff, when appropriate.
- BHCS participates in HIIN for best practices.
- Improved awareness and communication which included bedside shift report.
- Daily rounding included ongoing interventions, central line necessity, education and central line bundle compliance during surveillance.
- Daily central line dressing assessment
- Daily chlorhexidine bathing for inpatients on all units, except for the ICU/CCU for patients with central lines.
- Twice bathing, every 12 hours in the ICU/CCU for all patients
- Continued surveillance and enforcement of the central line bundle compliance during rounding.
- Partnership with Clinical Education for collaboration of rounding and just in time education
- Strive for Zero Infection
- 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
- Education provided regarding CLABSI bundles and importance of following.
- Intense analysis of every CLABSI is reviewed 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.
- Meeting with company representative and clinical coordinator to discuss PICC line and best practices.
- Institution of Vascular Access Guidelines for nurses to assist with appropriate line required
- 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.
 - Need to have CMO discuss with primary care physician and other consultants the need for a central line and possibly changing to midline or peripheral line.
 - Ensure Curo caps on all ports
 - Count of central line day similar to vent days on IView.
 - Removal of 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.

Catheter Associated Urinary Tract Infections (CAUTI)

CAUTI CY2020

| | Target Rate | CY18 | CY19 | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD |
|-------------|-------------|-------|-------|------|------|------|------|-------|------|------|------|------|------|------|------|-------|
| ICU | 1.73 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 2 |
| | | 1,939 | 1,563 | 146 | 176 | 214 | 276 | 159 | 129 | 319 | 368 | 260 | 181 | 214 | 267 | 2709 |
| | | 1.03 | 1.92 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 2.72 | 3.85 | 0.00 | 0.00 | 0.00 | 0.74 |
| 3E | 1.37 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | | 711 | 655 | 55 | 40 | 44 | 64 | 88 | 56 | 46 | 56 | 49 | 101 | 74 | 70 | 743 |
| | | 0.00 | 1.53 | 0.00 | 0.00 | 0.00 | 0.00 | 11.36 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.35 |
| 3S | 0.70 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 383 | 1,283 | 128 | 151 | 82 | 91 | 88 | 116 | 84 | 99 | 127 | 103 | 99 | 177 | 1,345 |
| | | 0.00 | 0.78 | 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 |
| 4EAST PCU | 1.17 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 970 | 771 | 74 | 61 | 74 | 104 | 89 | 62 | 69 | 61 | 93 | 58 | 73 | 79 | 897 |
| | | 0.00 | 1.30 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0 | 0 | 0.00 |
| 4W | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 432 | 242 | 38 | 36 | 25 | 8 | 15 | 18 | 17 | 32 | 14 | 29 | 29 | 25 | 286 |
| | | 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 | 0 | 0.00 |
| 4N | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 404 | 0 | 1 | 2 | 3 | 17 | 0 | 0 | 24 | 21 | 27 | 9 | 28 | 24 | 156 |
| | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | - | - | 0.00 | 0.00 | 0.00 | 0.00 | 0 | 0 | 0.00 |
| PICU | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 13 | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| | | 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 | 0.00 |
| 3W PEDS | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 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 | 0.00 |
| Mother Baby | 0.00 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 922 | 908 | 58 | 55 | 58 | 60 | 49 | 52 | 69 | 67 | 57 | 56 | 46 | 60 | 3,070 |
| | | 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 | 0.00 |
| ICUO | 0.00 | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | 20 | 0 | 0 | 67 | 188 | 17 | 0 | 6 | 32 | 330 |
| | | | | | | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| BHCS | 1.00 | 2 | 6 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 3 |
| | | 5553 | 5425 | 502 | 521 | 500 | 640 | 488 | 433 | 695 | 892 | 644 | 537 | 569 | 734 | 9,538 |
| | | 0.36 | 1.11 | 0.00 | 0.00 | 0.00 | 0.00 | 2.05 | 0.00 | 0.00 | 1.12 | 1.55 | 0.00 | 0.00 | 0.00 | 0.31 |



Analysis:

Hospital associated CAUTI infection rate for 2020 was 0.31, which was a decrease from 1.11 in 2019.

Our SIR for 2020 was 0.43 which is less than our SIR for 2019 which was 1.06 per NHSN.

Reduction in infection rate from 2019 to 2020 is 72%.

Reduction in SIR rate from 2019 to 2020 is 59%.

Increase in urinary catheter days from CY2019 to CY2020 is 76%

We had 3 CAUTIs in 2020 which was a reduction of 3 less CAUTIs from 2019. Our improvements were noted in the ICU, which reduced from 3 CAUTIs to 2 CAUTIs in 2020. We also reduced our CAUTIs to zero on our 3 South surgical unit and our 4 East telemetry unit. We instituted many action plans. Continued efforts to reduce infection are through staff awareness and education.

- Infections are identified from prospective surveillance by the Coordinator of Epidemiology.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
- Meetings are held to review all infections to determine opportunities and action plans for improvement.
- Reports are submitted to BHCS Infection Prevention and Control Committee and Patient Safety Quality Council.
- 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.
- Rates increased and decreased depending on the unit.
- Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.
- Strive for zero infection.

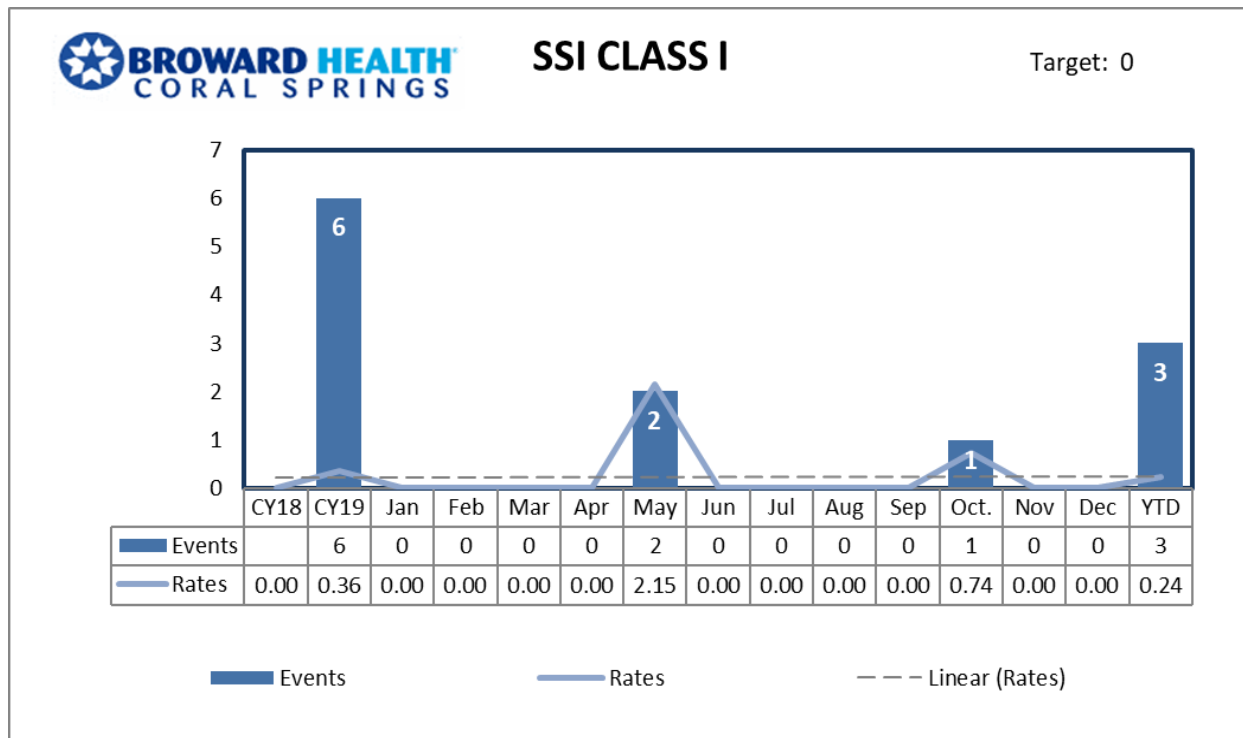
Action Plans

- 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 participates 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 included bedside shift report.
- Daily rounding included ongoing interventions, urinary catheter necessity, education and urinary catheter bundle compliance during surveillance.
- Continued surveillance and enforcement of the urinary catheter bundle compliance during rounding.
- Partnership with Clinical Education for collaboration of rounding and just in time education
- Strive for Zero Infection
- Point Prevalence studies completed with Device Company with feedback to be provided to stake holders and leadership.
- CAUTI mandatory education provided to all staff via Healthstream
- Education provided regarding CAUTI bundles and importance of following.
- Intense analysis of every CAUTI is reviewed 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. Had Bard do observations and training
 - 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
 - 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

Surgical Infections Report

Surgical Site Infections Class I CY2020

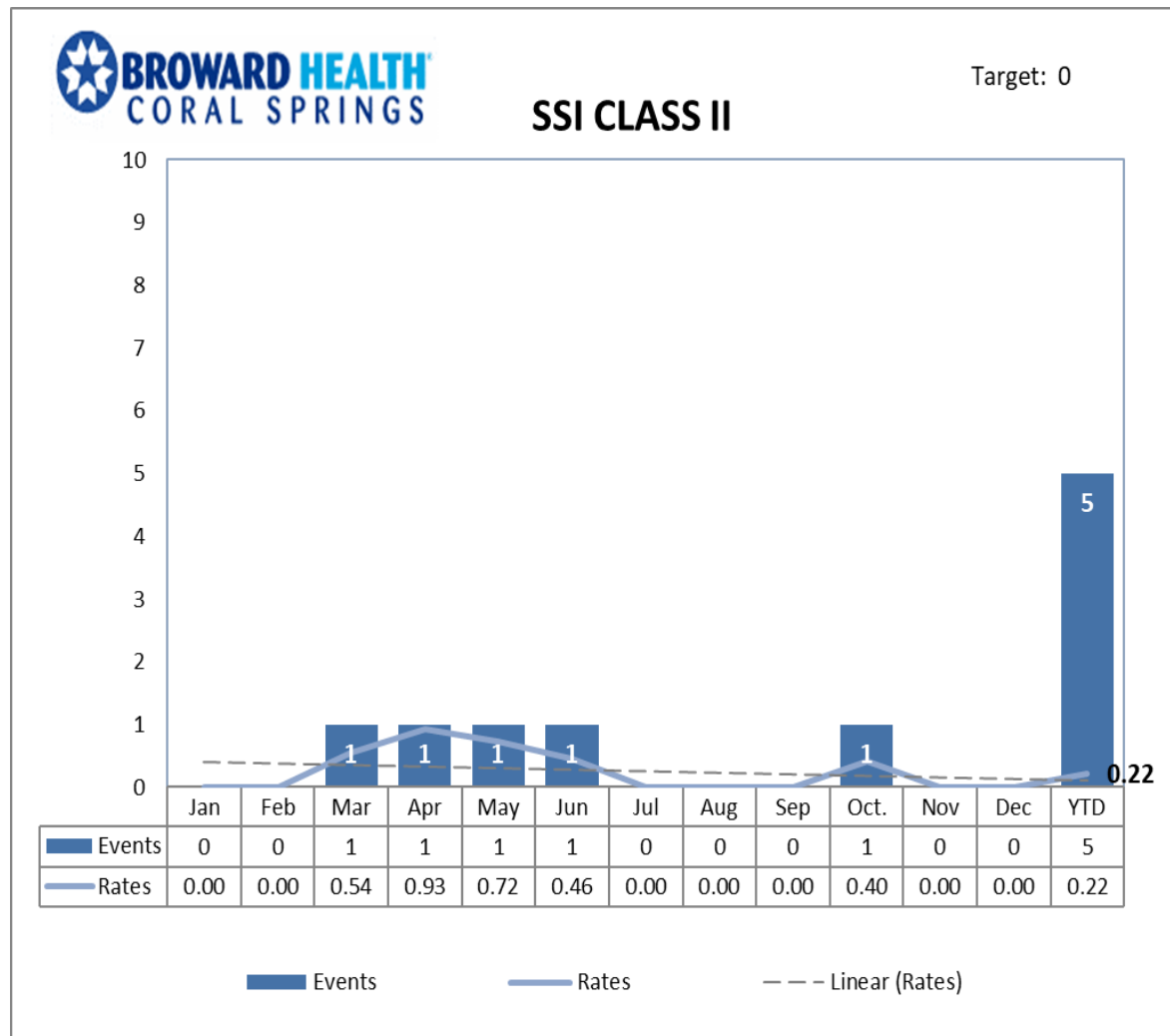


Analysis

Total Class I infections: 3/1214. Rate: 0.24%.

- Reduction in infection rate from CY2019 to CY2020 was 33%.
- A SIR rate is not provided by NHSN.

Surgical Site Infections II CY2020

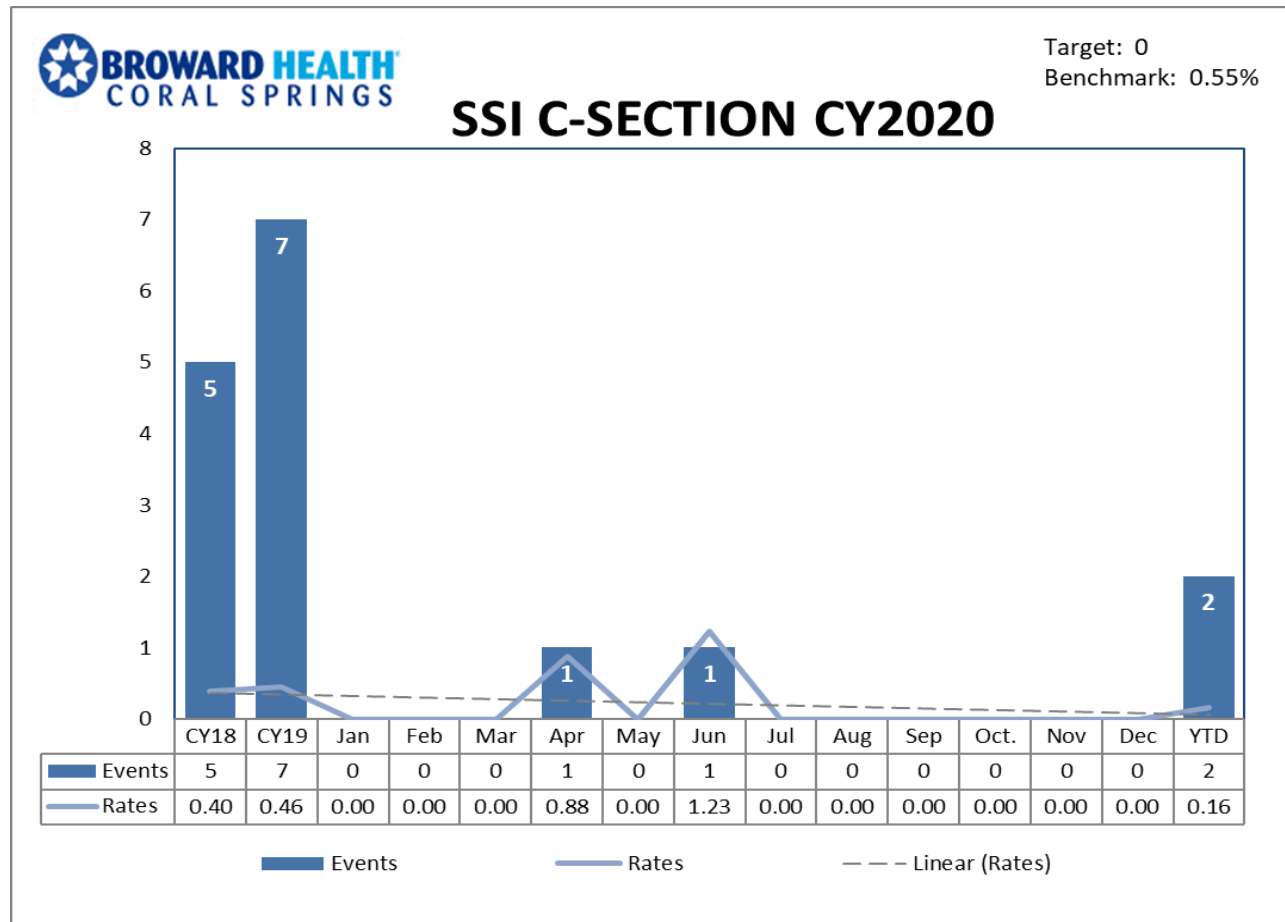


Analysis

Total Class II infections: 5/2265. Rate: 0.22%

- Reduction in infection rate from CY2019 to CY2020 was 39%.
- A SIR rate is not provided by NHSN.

C-section Surgical Site Infections

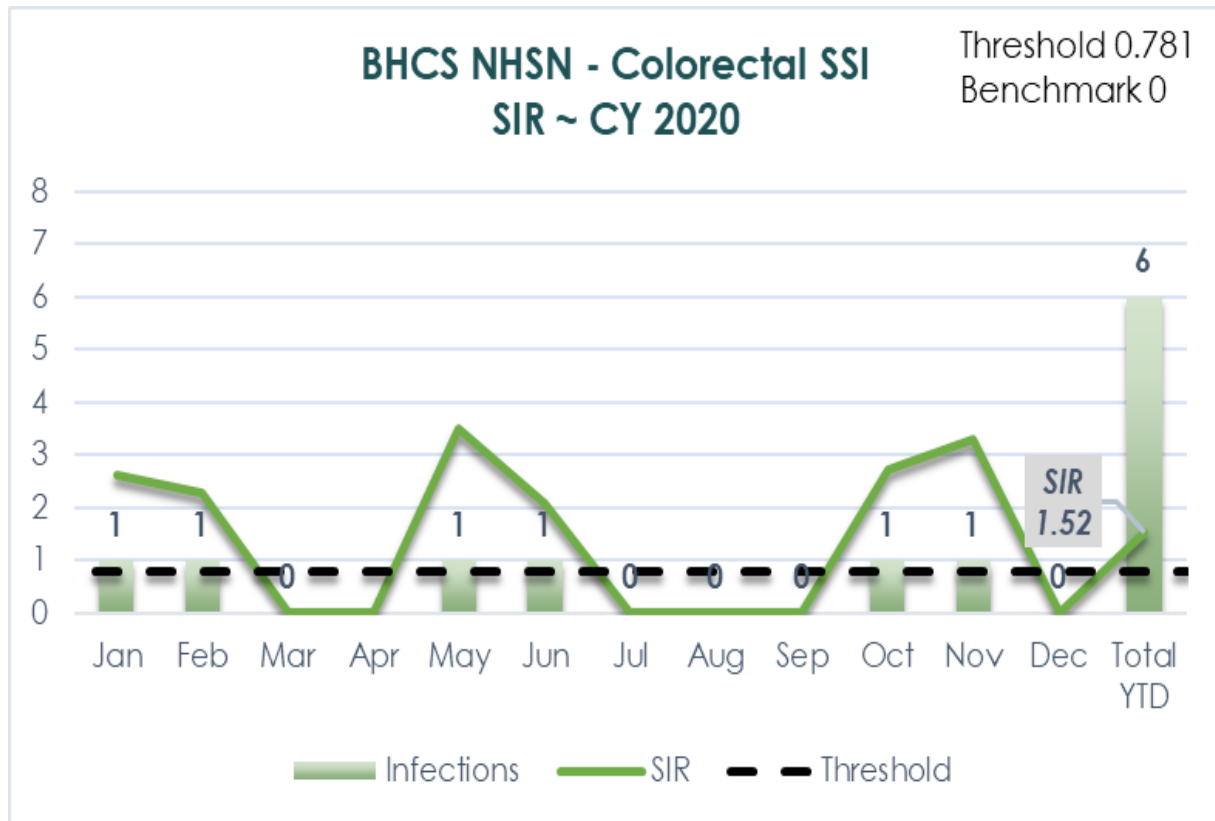


Analysis

Total C-section infection rate: 2/1226. Rate of 0.16

- Reduction in infection rate from CY2019 to CY2020 was 65%.
- A SIR rate is not provided by NHSN.

Colon Surgical Site Infections



Analysis

Total Colon Infection rate: 6/157. Rate of 3.82

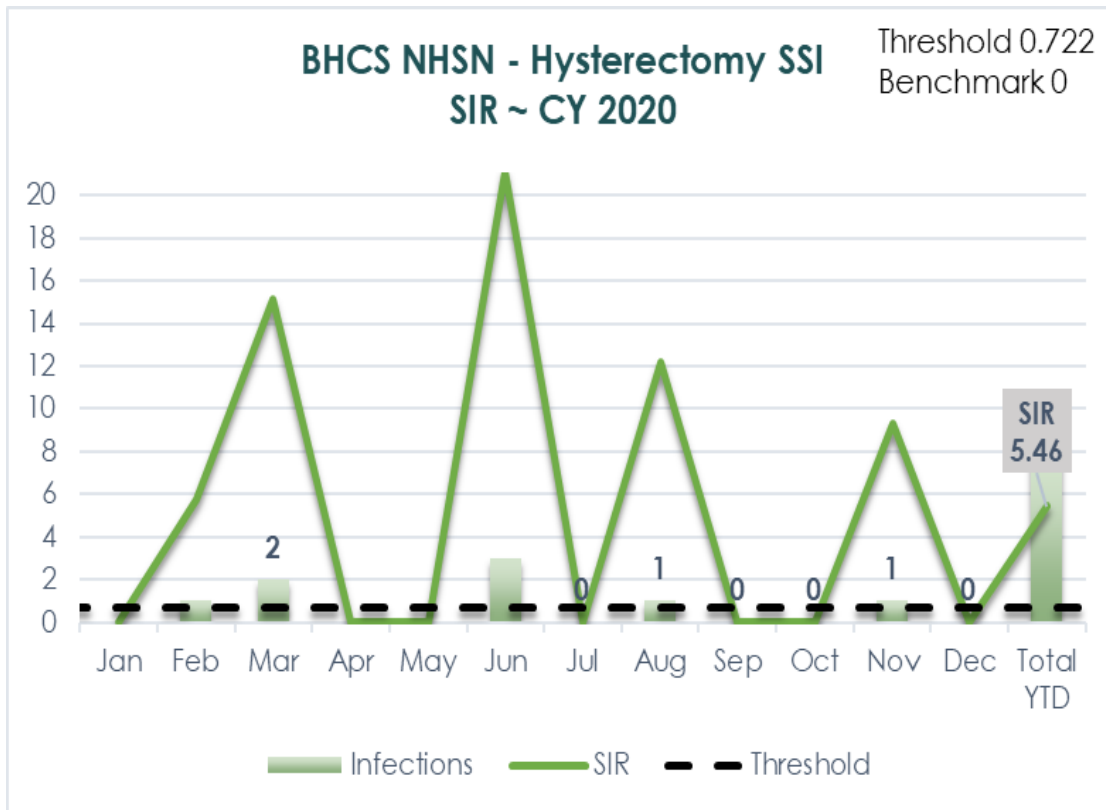
Decrease in infection rate from 2019 to 2020 was 24%.

Decrease in SIR rate from 2019 to 2020 was 20%.

For CY2020, the colon surgical site infection rate was 3.82%. This number represents 6 infections out of 157 colon surgical procedures.

The NHSN SIR for CY2020 was 1.52 which is a decrease from 1.90 in CY2019. The SIR is above 1, which indicated that there were more 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 Infections



Analysis

Total Hysterectomy Infection rate: 8/199. Rate of 4.02

Increase in infection rate from 2019 to 2020 was 474%.

Increase in SIR rate from 2019 to 2020 was 20%.

For CY2020, the hysterectomy surgical site infection rate was 5.46%. This number represents 8 infections out of 199 hysterectomy surgical procedures.

The NHSN SIR for CY2020 was 5.42 which is an increase from 0.82 in CY2019. The SIR is above 1, which indicated that there were more infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

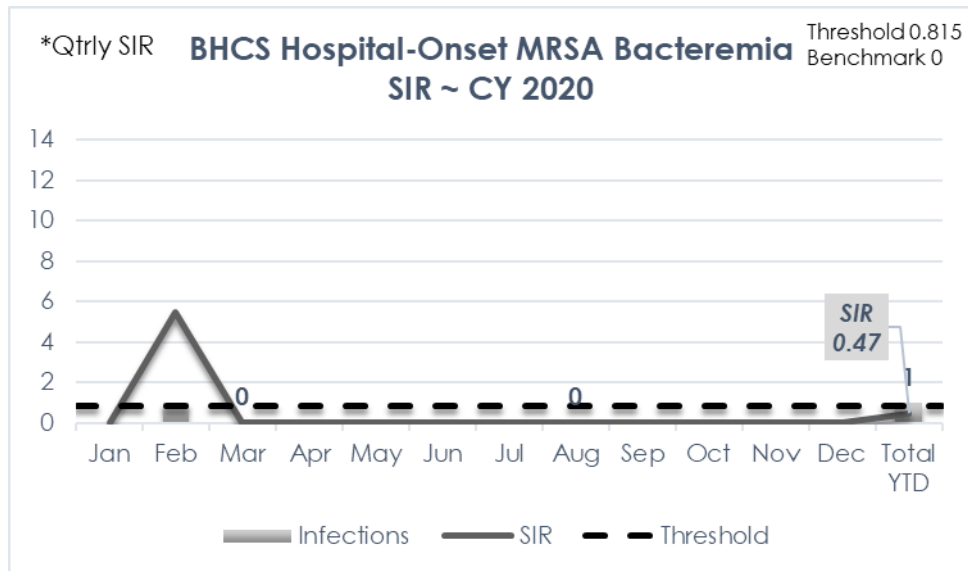
There were no SSIs related to total hip or total knee procedures.

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.
- Presentation of all surgical site infections at the Surgical Site Infection Prevention Committee and the OB/GYN Perinatal Committee meeting with focus on risk factors and adherence to evidence based practice to reduce infections.
- Ongoing education of surgical staff on proper wound classification.
- BHCS participates in HIIN 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 foam 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 for identification of opportunities of improvement.
- Re-establishment of Surgical Site Prevention meeting with gap analysis. Meeting held with key stake holders including frontline staff of the OR.
- Continue to perform surveillance to identify all surgical site infections.
- Rounding in Surgical Services Department, including sterile processing department.
- 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 with Medicine Department Chair, Chairman of OB/GYN and General Surgery 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 = 0.02/1000 patient days. This is a reduction from a rate of 0.04/1000 patient days in 2019.

Our SIR for 2020 was 0.047 which is a reduction from 0.90 in 2019. 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.

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

Reduction in SIR rate from 2019 to 2020 is 48%.

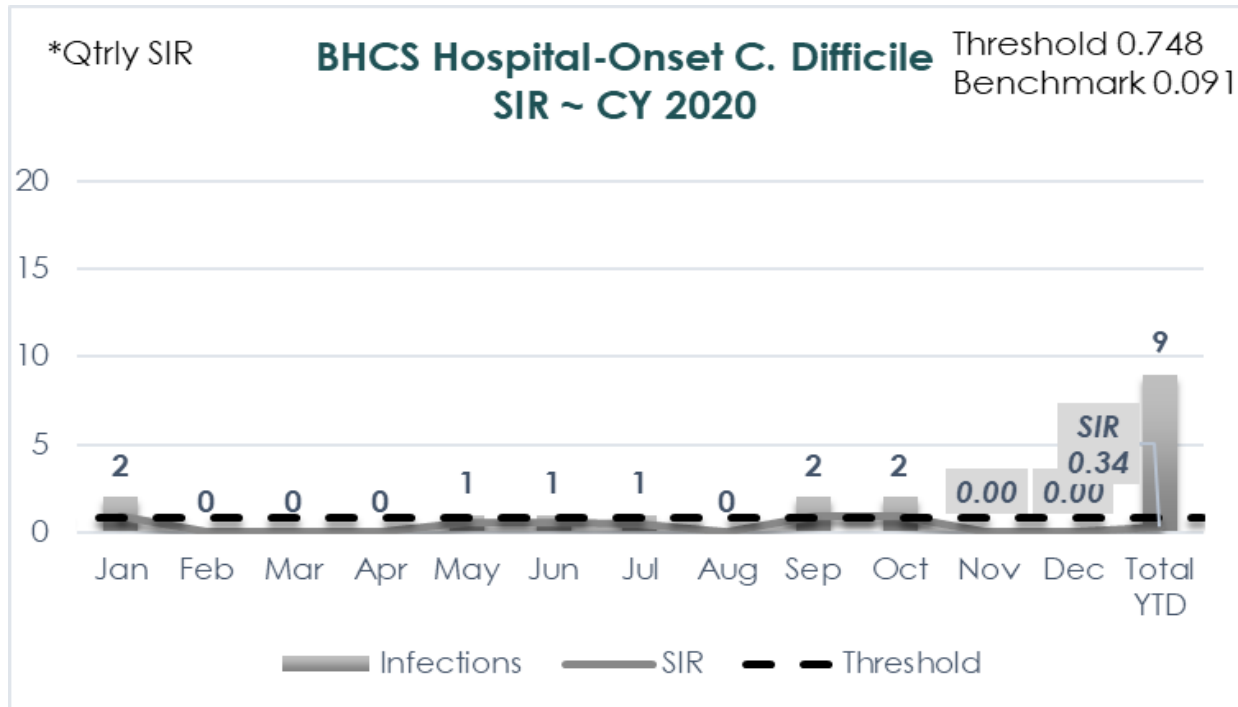
For CY2020, our infection rate for organisms that were culture positive for MDRO was 0.04%. This number represents 2 infections out of 48,568 patient days. For CY2019, our infection rate for organisms that were culture positive for MDROs was 0.17%. This number represented 8 infections out of 50,830 patient days.

For CY2020, our infection rate for MRSA Bacteremia was 0.02%. This number represents 1 infection out 48,568 patient days. For CY2019, our infection rate for MRSA Bacteremia was 0.04%. This number represented 2 infections out of 48,568 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.
- Implementation 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 2.1/10,000 patient days for CY 2020. This is a reduction from a rate of 3.2/10,000 patient days in 2019.

Our SIR for 2020 was 0.34 which is a reduction from 0.51 in 2019.

Reduction in infection rate from 2019 to 2020 is 34%.

Reduction in SIR rate from 2019 to 2020 is 33%.

Our greatest improvement was noted in our 3 East medical unit, which decreased from 5 C. diff infections in 2019 to 3 C. diff infections in 2020. We also had a reduction on our 3 South surgical unit, which reduced from 3 C. diff infections to 2 C. diff infections. 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 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.
- Implementation of 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

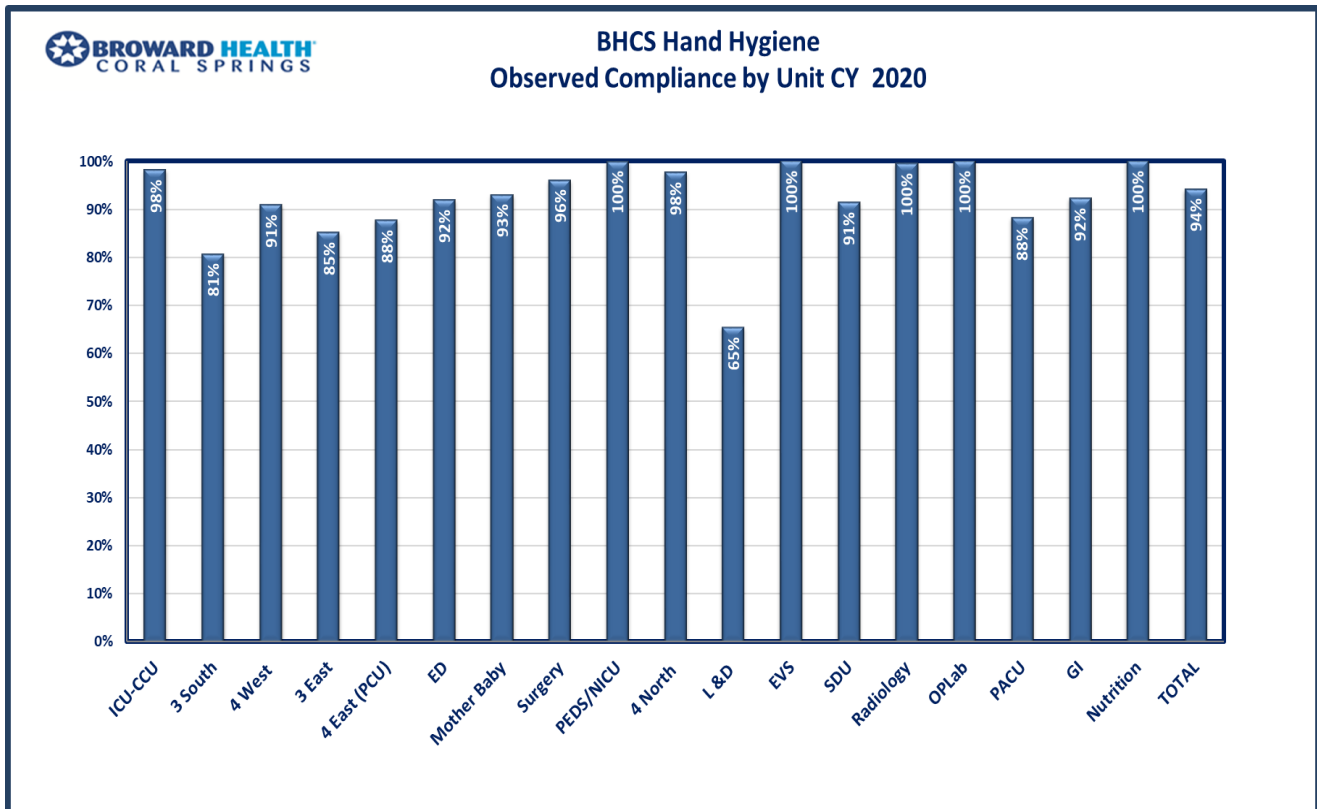
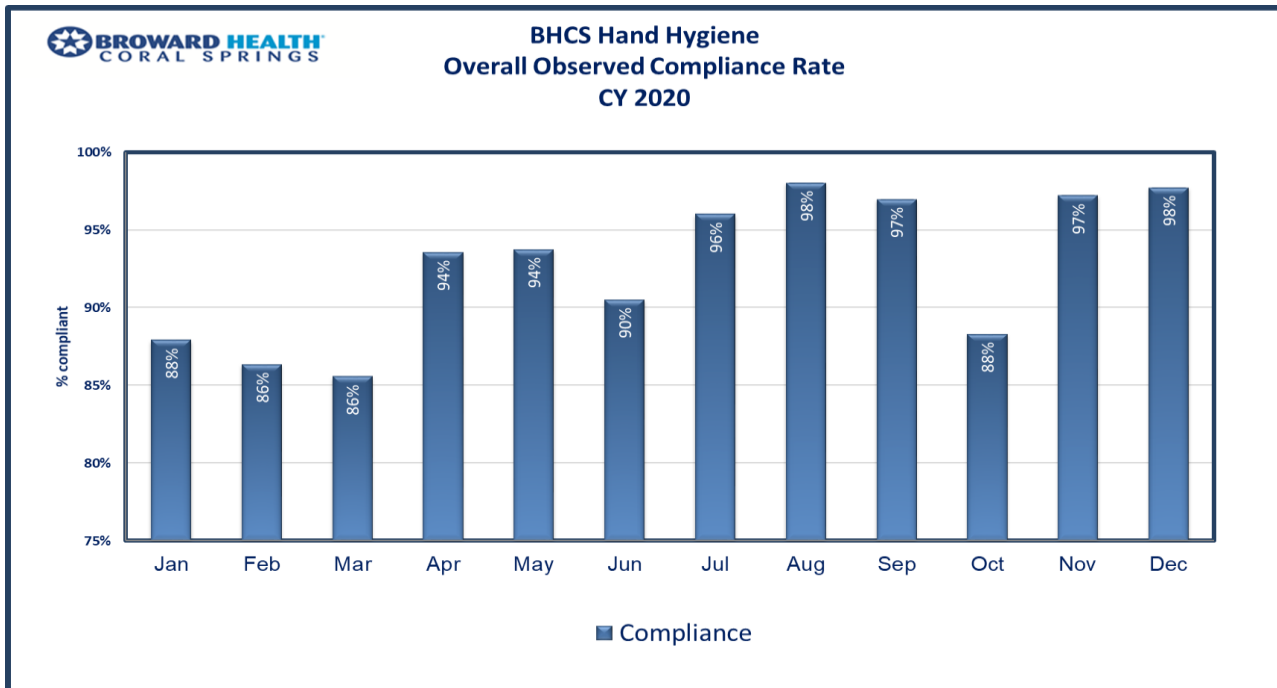
Isolation Precautions Compliance

| Indicator | Definitions | | ACTUAL PERFORMANCE | | | | | | | | | | | | YTD |
|--|--|------|--------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|----------------|
| | | | Jan | Feb | Mar | Apr | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Avg |
| Target | | | | | | | | | | | | | | | |
| Precaution supplies readily available outside patient room | # of Isolation boxes in use transmission based precautions | 100% | 222 of 222 | 171 of 171 | 246 of 246 | 213 of 213 | 114 of 114 | 105 of 105 | 457 of 457 | 113 of 113 | 178 of 178 | 178 of 178 | 219 of 219 | 257 of 257 | 2,473 of 2,473 |
| | | | 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% |
| | | | 222 of 222 | 169 of 171 | 240 of 246 | 213 of 213 | 114 of 114 | 105 of 105 | 457 of 457 | 113 of 113 | 178 of 178 | 178 of 178 | 219 of 219 | 257 of 257 | 2,465 of 2,473 |
| Precaution sign on door matches order | # of Precaution signs on door matches order transmission based precautions | 100% | 222 of 222 | 169 of 171 | 240 of 246 | 213 of 213 | 114 of 114 | 105 of 105 | 457 of 457 | 113 of 113 | 178 of 178 | 178 of 178 | 219 of 219 | 257 of 257 | 2,465 of 2,473 |
| | | | 100.0% | 98.8% | 97.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.7% |
| | | | 197 of 222 | 166 of 171 | 245 of 246 | 213 of 213 | 114 of 114 | 104 of 105 | 450 of 457 | 112 of 113 | 175 of 178 | 177 of 178 | 217 of 219 | 256 of 257 | 2,426 of 2,473 |
| Precaution label on front of chart | # of Precaution labels on front of charts transmission based precautions | 100% | 222 of 222 | 166 of 171 | 245 of 246 | 213 of 213 | 114 of 114 | 104 of 105 | 450 of 457 | 112 of 113 | 175 of 178 | 177 of 178 | 217 of 219 | 256 of 257 | 2,426 of 2,473 |
| | | | 88.7% | 97.1% | 99.6% | 100.0% | 100.0% | 99.0% | 98.5% | 99.1% | 98.3% | 99.4% | 99.1% | 99.6% | 98.1% |
| | | | 221 of 222 | 171 of 171 | 246 of 246 | 213 of 213 | 114 of 114 | 105 of 105 | 457 of 457 | 113 of 113 | 178 of 178 | 178 of 178 | 219 of 219 | 257 of 257 | 2,472 of 2,473 |
| Appropriate PPE used by HCW | # of employee observations # of opportunities | 100% | 222 of 222 | 171 of 171 | 246 of 246 | 213 of 213 | 114 of 114 | 105 of 105 | 457 of 457 | 113 of 113 | 178 of 178 | 178 of 178 | 219 of 219 | 257 of 257 | 2,473 of 2,473 |
| | | | 99.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | | | 222 of 222 | 171 of 171 | 246 of 246 | 213 of 213 | 112 of 114 | 104 of 105 | 457 of 457 | 113 of 113 | 178 of 178 | 178 of 178 | 219 of 219 | 257 of 257 | 2,470 of 2,473 |
| Isolation Order in PowerChart | # observations # of opportunities | 100% | 222 of 222 | 171 of 171 | 246 of 246 | 213 of 213 | 114 of 114 | 105 of 105 | 457 of 457 | 113 of 113 | 178 of 178 | 178 of 178 | 219 of 219 | 257 of 257 | 2,473 of 2,473 |
| | | | 100.0% | 100.0% | 100.0% | 100.0% | 98.2% | 99.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.9% |
| | | | 222 of 222 | 171 of 171 | 246 of 246 | 213 of 213 | 112 of 114 | 104 of 105 | 457 of 457 | 113 of 113 | 178 of 178 | 178 of 178 | 219 of 219 | 257 of 257 | 2,470 of 2,473 |

The number of patients placed on isolation precautions have increased significantly related to the COVID-19 pandemic. In CY2019, 1,653 patients were placed on isolation. In CY2020, that number has increased to 2,473.

On 4/48/20, 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.

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. Initially, testing was only performed by Florida Department State Lab which required permission from the Department of Health. Open communication with staff at the Department of Health was critical. 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 CY2020 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 CY2020 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 2020.
- 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.

CY2020 Epidemiology Accomplishments

Education

- Nursing Grand Rounds on Health Associated Infections
- Education on Healthstream regarding coronavirus and COVID-19
- Creation of guidelines, protocol, monitoring tools, etc. due to the COVID-19 pandemic and implementation of such as updates provided from the CDC
- Participated in Town Halls with Leadership to discuss Coronavirus and effect on hospital and staff
- Met with all departments in Feb 2020 to discuss coronavirus (at that time, the virus was not yet named), PPE and patient safety
- 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
- Creation of Novel Coronavirus Gap Analysis and updated on daily/weekly bases and informed Leadership as needed
- Creation of Influx of Contagious Patients protocol and implemented on 4/4/2021
- 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.
- Reviewed CDC Preparedness Checklist with Leadership to ensure hospital preparedness
- CDC education on NHSN definitions by Epidemiology nurse.
- Continuous education through webinars, attendance at meetings and online education
- Presented Flu Educational Program for all BHCS employees through Healthstream
- Presented Flu Educational Program for Community via Webex.
- Creation of Education board with all HAI information and prevention tips

- Need2Know Education Flyers created on the following topics

| | | |
|---|---|----------------------|
|  | N2K 2019 Novel Coronavirus | 1/30/2020 1:35 PM |
|  | N2K 2019 Novel Coronavirus 1-30-20 | 1/30/2020 1:57 PM |
|  | N2K Flowchart to ID and Assess 2019 Nove... | 2/3/2020 10:21 AM |
|  | N2K Precautions for 2019 Novel Coronavir... | 2/7/2020 9:02 AM |
|  | N2K Precautions for 2019 Novel Coronavir... | 2/18/2020 10:07 AM |
|  | N2K COVID-19 for all BH | 2/18/2020 11:02 AM |
|  | N2K Donning and Doffing for 2019 Novel ... | 2/18/2020 11:10 AM |
|  | N2K Flowchart for COVID-19 2-28-20 | 2/28/2020 7:16 AM |
|  | N2K Flowchart for COVID-19 2-28-2020 | 2/28/2020 8:13 AM |
|  | N2N PPE Picture of HCW 3-16-20 | 3/16/2020 8:24 AM |
|  | N2N Doffing PPE HCW 3-16-20 | 3/16/2020 8:27 AM |
|  | N2N Donning PPE HCW 3-16-20 | 3/16/2020 9:31 AM |
|  | N2K Isolation gowns for CONTACT Isolatio... | 4/3/2020 4:25 PM |
|  | N2N COVID testing for elective surgery wo... | 4/23/2020 2:24 PM |
|  | N2K NASAL SWABBING SPECIMEN COLLE... | 4/30/2020 9:58 AM |
|  | N2N COVID Symptoms | 5/1/2020 11:52 AM |
|  | BHCS COVID 19 Process for Testing and Ba... | 5/5/2020 10:28 AM |
|  | no gloves | 5/21/2020 12:15 PM |
|  | remove your gloves.docx | 5/21/2020 1:05 PM |
|  | Germs and Glove Use | 5/21/2020 1:08 PM |
|  | Please remove your gloves docx | 5/21/2020 2:05 PM |
|  | N2N Masking | 5/28/2020 4:18 PM |
|  | SocialDistancingFlyer-Order2020-12-Perso... | 6/25/2020 2:21 PM |
|  | N2K Consent for Pelvic and Rectal Examin... | 7/7/2020 10:50 AM |
|  | N2N COVID Safety Protocol and PPE updat... | 7/16/2020 1:41 PM |
|  | N2N Donning & Doffing COVID Safety 7-2... | 7/27/2020 12:48 PM |
|  | N2N Donning & Doffing refresher 7-27-20 | 7/27/2020 12:51 PM |
|  | N2N COVID Safety Protocol and PPE updat... | 8/6/2020 2:25 PM |
|  | N2N COVID POC, Panther and Gene Expert... | 9/3/2020 12:16 PM |
|  | N2N COVID POC, Panther and Gene Expert... | 9/3/2020 12:16 PM |
|  | Here | 9/10/2020 8:30 AM |
|  | N2K CAUTI Tips with pics | 10/1/2020 3:25 PM |
|  | BLANK Need2Know.docx | 10/2/2020 9:23 AM |
|  | N2K CAUTI Tips | 10/5/2020 10:56 AM |
|  | N2K CAUTI Tips with pics updated | 10/6/2020 10:08 AM |
|  | N2N COVID Symptoms 10-20-20 -did not s... | 10/20/2020 7:11 AM |
|  | N2N COVID Safety Reminders 10-20-20 | 10/20/2020 7:17 AM |
|  | generic pp presentation | 11/19/2020 4:12 PM |
|  | Flushing protocols for Midlines and Centra... | 11/19/2020 4:43 PM |
|  | N2K Thanksgiving revised | 11/19/2020 4:49 PM |
|  | N2K Standard Precautions 12-2-20 | 12/2/2020 10:37 AM |
|  | N2N Gym Safety | 12/15/2020 10:47 ... |
|  | N2K COVID Symptoms 12-21-20 | 12/21/2020 10:51 ... |
|  | N2K COVID Vaccine 12-17-20 | 1/5/2021 12:33 PM |
|  | N2K COVID Symptom Update 1-29-21 | 1/29/2021 3:29 PM |

Hand Hygiene 2020

- 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.

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

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

- 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 Multidisciplinary 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.
- SSI Gap analysis created to identify areas of opportunity in order to care for patients using best practices
- 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: