SVHCD QUALITY COMMITTEE MEETING
AGENDA
WEDNESDAY, MARCH 23, 2016
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Gigi Betta at ebetta@svh.com or 707.935.5004 at least 48 hours prior to the meeting.		
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT SECTION At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.	*Hirsch*	
3. CONSENT CALENDAR • QC Minutes, 02.24.16	*Hirsch*	Action
4. **POLICY & PROCEDURES** ✓ PC8610-165 *Sara Lite Sit to Stand* lift (new) ✓ 8640-173 Neutropenic Precautions (new) ✓ 8640-174 Credit Card Use in Café (new) ✓ IC8610-140 Infection Prevention Program (revised) ✓ CE8610-151 Injury Prevention Program (revised) ✓ IC8610-141 Influenza Vaccine Program (revised) ✓ QA8610-106 PI Improvement Plan (revised) ✓ Multiple Pharmacy Policies Feb. 2016 (revised)	*Lovejoy*	Action
5. QUALITY REPORT Quality & Resource Management Report March 2016	*Lovejoy*	Inform/Action
6. INFECTION CONTROL REPORT • Annual Evaluation • Infection Prevention Program • Infection Control Dashboard • Infection Control Risk Assessment	*Mathews*	Inform/Action
7. ANNUAL REPORT OF CONTRACT EVALUATION	*Lovejoy*	Action
8. CLOSING COMMENTS/ANNOUNCEMENTS	*Hirsch*	
9. ADJOURN	*Hirsch*	
10. UPON ADJOURNMENT OF REGULAR OPEN SESSION	*Hirsch*	

11. CLOSED SESSION: • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report • 4th Q 2015 Quality Dashboard	*Dr. Sebastian*	Action
12. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
13. ADJOURN	*Hirsch*	

3.

CONSENT

+

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
Wednesday, February 24, 2016
Schantz Conference Room

Committee Members Present	Committee Members Present cont.	Members Not Present	Admin Staff /Other
Jane Hirsch Brian Sebastian, M.D. Carol Snyder Michael Mainardi Cathy Webber	Ingrid Sheets Susan Idell Kelsey Woodward Joshua Rymer Howard Eisenstark		Leslie Lovejoy Robbie Cohen, M.D. Gigi Betta

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	The meeting was called to order at 5:00pm	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 1.27.16		**MOTION** by Rymer and 2nd by Idell. All in favor.
4. POLICY & PROCEDURES	*Lovejoy*	Action
• Multiple-Feb. 2016: GL8610-190, PC8610-157, UR8610-100 • Multiple-Feb. 2016: IC8610-131, PC8610-120, PC8610136 • Sweet Success Program: PC6171-193	Dr. Cohen will obtain clarification from Dr. Amara on *Procedure: 2.c. and 2.d.* of the Sweet Success Program.	**MOTION** by Idell and 2nd by Mainardi. All in favor.
5. APPROVE 2016 WORK PLAN	*Lovejoy*	Action
	Ms. Lovejoy will invite Dr. DeMartini to present to the Committee on the new 3D mammography equipment.	**MOTION** by Mainardi and 2nd by Rymer to approve work plan. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
6. QUALITY REPORT FEB 2016	*Lovejoy*	Inform/Action
• Quality & Resource Management Report Feb2016 ➢ AHRQ Culture of Safety Survey Report ➢ 3Q 2015 Good Catch Awards Summary ➢ Development of Quality Management Database	Ms. Lovejoy will send the Culture of Safety Survey to the Committee and the discussion may be continued at the next QC meeting.	
7. CLOSING COMMENTS	*Hirsch*	
	No closing comments.	
8. ADJOURN	*Hirsch*	
9. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
10. CLOSED SESSION	*Sebastian*	Action
<u>Calif. Health & Safety Code § 32155</u> • Medical Staff Credentialing & Peer Review Report • Board Quality Dashboard		
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
	The Medical Staff Credentialing & Peer Review Report dated February 17, 2016 was approved.	
12. ADJOURN	*Hirsch*	
	Meeting adjourned at 6:30pm	

4.

POLICY & PROCEDURE

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: **PC8610-165 Sara Lite Sit-to-Stand Lift -New**	
APPROVED BY:	DATE: **2-17-16**
Director's/Manager's Signature	Printed Name **Mark Kobe, RN MPA**

Michael Brown, MD
Chair Surgery Committee

3-9-16
Date

Douglas S Campbell, MD
Chair Medicine Committee

3/10/16
Date

Leslie Lovejoy, RN PhD
Chief Quality Officer

Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **New Organizational Policy**

New Document or Revision written by: **Chelsey Holdsworth, PT**

Date of Document:

Type:	**Regulatory:**
❑ **Revision** X **New Policy**	X **CIHQ** X **CDPH** X **CMS** ❑ **Other:**
Organizational: X **Clinical** X **Non-Clinical**	❑ **Departmental** ❑ **Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

PC8610-165 Sara Lift Sit-to-Stand Lift – New Policy; guidelines for the use of Sara Lite Sit-to-Stand Lift and the applicable slings

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	2/16/2016	Yes	
Surgery Committee	3/02/2016	Yes	Chelsey to present
Medicine Committee	3/10/2016	yes	
P.I. or P. T. Committee	n/a		
Medical Executive Committee	3/17/2016	yes	
Board Quality	3/23/2016		
Board of Directors	4/07/2016		

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SUBJECT: Sara Lite Sit-to-Stand Lift – NEW POLICY	POLICY # PC8610-165
	PAGE 1 OF 5
DEPARTMENT: Rehabilitation	EFFECTIVE: 12/15
APPROVED BY: Director of Ancillary Services	REVISED:

Purpose:

To establish guidelines for use of Sara Lite Sit to Stand Lift and the applicable slings.

Policy:

The Sara Lite Sit-to-Stand Lift is intended for use with patients who:
- Can sit in a wheelchair
- Can bear partial weight through at least one lower extremity
- Has some amount of trunk stability
- Is dependent on caregivers for most situations or is physically demanding for caregivers
- Has a significant need for stimulation outside of bed

Rehab or Nursing staff must evaluate patient's appropriateness for use of lift prior to use. Pts unsuitable for standing transfers or seated positions are not appropriate for use of this device.

Lift Operational Life= 7 years or 10,000 transfers
Lift slings operational life=
- Flites = Disposable sling, 3 weeks of use without being soiled or damaged. 5 years total from manufactured date for unopened, unused disposable slings.
- Active Slings= Reusable sling, 3 years from manufacture date on sling.

Stop use immediately if any sling is damaged (ie. fraying, tearing) or if there is damage (ie. cracking, bending, and breaking) to the attachment clips.

Wt Limits:
- Sara Lite Lift=175 kg or 385 lb
- Active Sling= 175 kg or 385 lb
- Flites Slings= 200 kg or 440 lb

Procedure:

- Hand Control operations
  - Pictures depicted on hand control correspond to the actions for opening and closing the chassis legs
  - Pictures depicted on hand control correspond to the actions for raising and lowering the lift.
- Raising and Lowering a patient

- Patient can be raised or lowered by use of the hand controls or as a secondary by the direct controls on the lift itself.
- The lift will only operate while the buttons are pressed and will stop when released.

- Brake use
  - Foot brakes are located on both rear castors. Push down on rear portion of pad to engage brake, lift up with toe or push down on front portion of pad to disengage brake.
  - Brakes should be used when:
    - Lifting a patient from bed/chair/other
    - When transferring patient and movement stopped.
  - Brakes should NOT be used when:
    - Lowering a patient to maintain proper center of gravity for lift.
- Emergency Shut-off
  - Operator can engage emergency shut-off at any time by pushing the RED button on the lift to stop the lift.
  - Alternately the RED release button on the battery can be pushed to disengage battery power and stop the lift.
  - To reset the lift, push the GREEN button or reinsert the battery.
- System Failure (Emergency Lowering)
  - In the case the Sara Lift has full system failure and the lift becomes stuck in the raised position, pull up on the slide control located on the actuator (hydraulic arm).
  - The lift will only lower while the slide control is being pulled up and suitable force (patient weight, lift operator force) is being pushed down through actuator.
- Transferring a Patient
  - If the patient cannot hold the support arms of the lift have a second person present for transfer.
  - Patient must always be transferred with use of a sling.
  - Lift should never be maneuvered using the support arm, boom or actuator.
- Lifting a Patient
  - Lifting a patient by means of the Sara Lite lift may be done with any seated patient regardless of sitting surface.
  - Standing sling must be applied properly prior to lifting.
  - Sling Application:
    - Pt should be clothed to allow barrier between sling and skin.
    - Top of sling can be identified by the soft padding on the lateral portions of the sling.
    - Place the sling around the patient's lower back and lean pt forward as needed to position sling properly.
    - Position the bottom of the sling horizontally about 2 inches above the waistline, with patient arms outside of the sling.

        - Secure support belt buckles or Velcro so that the support belt is tight, but comfortable for the patient.
    - Align the Sara Lift with the patients sitting surface.
        - Open lift legs as needed to position lift close enough for foot contact with the foot plate.
        - Raise or lower lift support arms as needed for proper height to attach sling clips.
    - Apply sling clips to lift, fasten by pulling down to secure.
      ***Make sure sling clips are securely attached and at proper height for proper sling use. Clips should be at level heights
    - Position feet to foot plate and at knee pad. Adjust knee pad to just below knee or at the height of the inferior pole of the patella. Secure lower legs with Velcro strap.
    - Apply rear castor brakes when ready to lift patient.
      The patient's body should be supported under the armpits, around the chest and lower back. The feet should stay firming supported on foot plate. ***Stop lifting and lower patient if feet rise from foot plate.
    - The patient must hold one or both of the support arms. Encourage patient to assist as much as they can. If they can only hold with one arm, have second caregiver assist with positioning and maintaining safety with hanging arm.
    - If patient can fully stand sufficiently with lift assist, knees may come off of knee support.
    - Use the "up" button on the hand control or lift to raise the patient.
    - Transfer the patient to desired sitting location.
    - Make sure that chassis legs are in fully closed position by using the hand controls to adjust before moving lift.
    - Use the "down" button on the hand control or lift to lower patient to sitting.
      Do not apply rear castor brakes before lowering patient. This allows lift to keep proper center of gravity during patient movement. ***Take care with when lowering patient to keep support arms clear of patient to avoid potential injury.
    - Once patient is seated remove attachment clips from lift and undo chest strap of sling.
- Sara Lift care and maintenance:
    - Battery to be maintained on charging wall unit at all times outside of use. Remove from unit and apply to lift for use. Remove battery from lift by pushing RED release button and reapply to wall unit when finished using lift.
    - Battery to be maintained in REHAB office and Lift to be maintained in REHAB supply room.
    - Slings to be maintained with lift in REHAB supply room.
    - Lift to be inspected by qualified technician once yearly.
    - Lift to be cleaned and inspected for safe working use before each use.

  - Clean lift between patient uses and when visibly soiled with hospital hydrogen peroxide wipes. Use bleach only when required for proper cleaning (IE: precaution room).
  - Slings:
    - Sara Lite Active Sling=Must be machine washed between patient use. Close all buckles and Velcro closures prior to washing. Wash at 158 deg F. Do NOT: wash with other items, tumble dry, use mechanical pressure during drying, use bleach, use gas sterilization, use autoclave, dryclean, steam or iron.
    - Sara Lite Flites Slings=Are not washable and are single patient use only. Dispose of sling after use (IE: patient discharges, sling is used for 3 weeks, sling becomes soiled)
- Sling assignment:
  - ***Active sling*** to be assigned to patient with sticker on pink wrist band on sling and left in patient room. When pt discharges use, wrist band to be removed and sling to be laundered.
  - ***Flites sling*** to be assigned to patient with patient name written on sling tag. Flites to be used with pts on precautions or as alternative to active sling if already in use.

Reference:

- ArjoHuntleigh
www.ArjoHuntleigh.com
- Sara Lite Instructions for use, March 2014
http://www.arjohuntleigh.us/products/download-document/?docid=d653f120-68c3-4a4f-b935-da358ca57513&name=Sara-Lite-Instruction-for-Use---001.20058.XX-rev.-10#.VmcxVeLpAzI.email
- Sara Lite Active Sling Instructions for use, October 2014
- Flites Sara Instructions for use, November 2011

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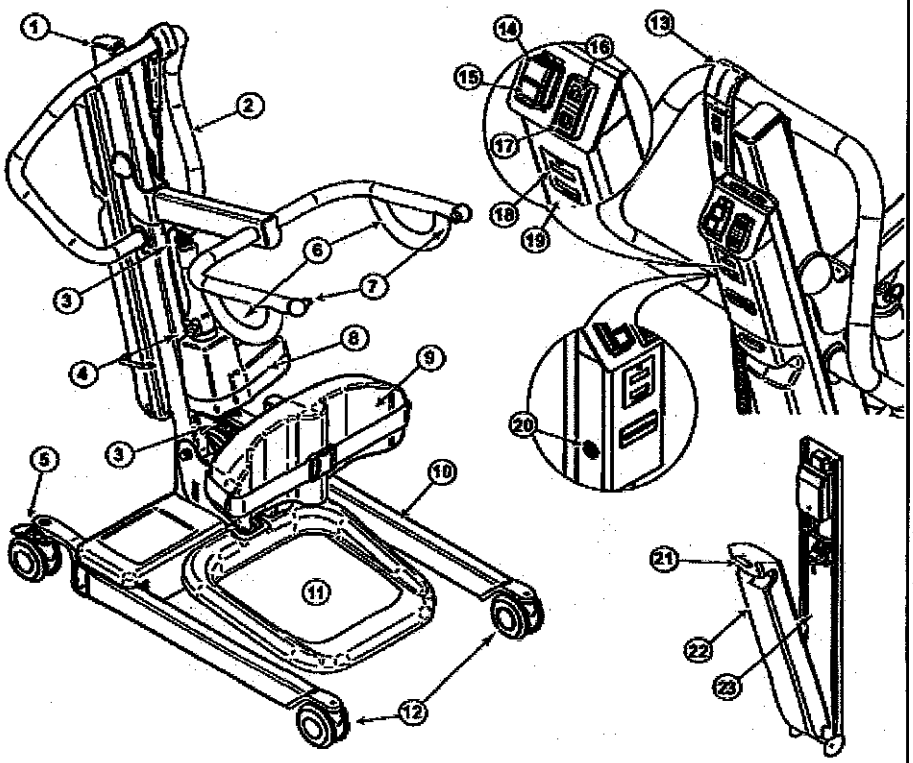
SUBJECT: Sara Lite Sit-to-Stand Lift – NEW POLICY	POLICY # PC8610-165
	PAGE 5 OF 5
DEPARTMENT: Rehabilitation	EFFECTIVE: 12/15
APPROVED BY: Director of Ancillary Services	REVISED:

Part Designation

SARA LITE Floor Lift and Battery Station



Legend

1) Mast
2) Maneuvering handle
3) Splitrings
4) System failure lower override
5) Rear castors with brakes
6) Patient support arms
7) Clip attachment points
8) Motor/actuator
9) Knee support
10) Adjustable chassis legs
11) Footsupport
12) Front castors
13) Hand control
14) Emergency stop button (red)
15) Power button (green)
16) Raise button
17) Lower button
18) Hour meter
19) Battery charge indicator
20) Hand control connector
21) Battery release button
22) Battery pack
23) Battery charger

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

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- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Departmental: **8640-173 Nutritional Services Neutropenic Precautions –New Policy** **8640-174 Credit Card Use in the Cafe**	
APPROVED BY:	DATE: **2-17-16**
Director's/Manager's Signature Robert Harrison	Printed Name **Robert Harrison, CDM CFPP**

Douglas S Campbell, MD
Chair Medicine Committee

3/17/16
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff

3/17/16
Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Food & Nutrition Department Policy**

New Document or Revision written by: **Allison Evanson, MS RD**

Date of Document: **1-26-16**

Type:	**Regulatory:**
❑ **Revision** X **New Policy**	❑ **CIHQ** X **CDPH** X **CMS** ❑ **Other:**
Organizational:	X **Departmental**
X **Clinical** X **Non-Clinical**	❑ **Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

8340-173 Nutritional Services Neutropenic Precautions- New Policy; to provide standards for food preparation and delivery for patients with "neutropenic" precautions as part of their diet order. This will be accompanied by the addition of a "neutropenic" precautions diet order as part of the physician diet order set

8340-174 Credit Card Use in the Café- New Policy; Credit card purchases will not need a signature unless the transaction is greater than or equal to $15.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	**1/19/2016**	Yes	
Surgery Committee	n/a		
Medicine Committee	**3/10/2016**	Yes	Allison to present
P.I. or P. T. Committee	n/a		
Medical Executive Committee	**3/17/2016**	Yes	
Board Quality	**3/23/2016**		
Board of Directors	**4/07/2016**		

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SUBJECT: Credit Card Use in the Cafe	POLICY #8340-173
	PAGE 1 OF 1
DEPARTMENT: Food and Nutrition Services	EFFECTIVE: 2//16
APPROVED BY: Food and Nutrition Services Manger	REVIEW/REVISED:

Purpose:

This policy will define the process for accepting Credit Cards for payment in the Café.

Policy:

It is the policy of the Food and Nutrition Services department to accept Credit Card Payments for purchases in the Café. Security of patron's information is the highest priority and FNS will follow the recommendations of Payment Card Industry Data Security Standards (PCI DSS)

Procedure:

When patrons present credit cards for payment the cashier will swipe the card through the card reader on the cash register monitor. Any transactions over $15.00 will require the patron to sign the receipt. The receipt is sent to Finance at the end of the day. Any card purchase under $15.00 does not require a signature. The Food and Nutrition Services Manager will handle all discrepancies brought to the department's attention. Resolution of discrepancies will be done on an individual basis. The Food and Nutrition Services Department does not accept Debit Cards and cannot include cash back with transactions.

Reference:
PCI DSS v3.1 SAQ A, Rev. 1.1 July 2015

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SUBJECT: Nutritional Services Neutropenic Precautions	POLICY # 8340-173
	PAGE 1 OF 2
DEPARTMENT: Food and Nutrition Services	EFFECTIVE: 1/16
APPROVED BY: Food & Nutritional Services Manager	REVISED:

Purpose:
To provide a standardized method for preparing and serving meals with Neutropenic precautions ordered as part of the diet order.

Policy:
Provide meals appropriate for clients with Neutropenia in accordance with guidelines on Neutropenic precautions. Neutropenia results in a weakened immune system and increased risk for food borne illness. The patients most at risk include patients: cancer, severe infection, bone marrow disorders, autoimmune disorders, viral infections that disrupt bone marrow, and use of drugs that destroy bone marrow or neutrophils.

Procedure:
1. The Diet Clerk will identify the patient with a diet order for 'Neutropenic Precautions' prior to tray line.
2. The Diet Clerk will alert all kitchen staff that this meal will be prepared first.
3. All kitchen staff will follow the proper Hazard Analysis Critical Control Point (HACCP) food safety protocol: discard products past the expiration date, cook all foods to standards temperatures, and practice proper hygiene.
4. Delivery:
    a. This tray will be delivered solo, in its own tray cart, by a designated staff member.
    b. The staff member will deliver the tray immediately after it is ready, and will wear gloves during the delivery.
    c. On the floor, the staff member will check in at the nurse's station and allow them to pass the tray.
    d. The staff member will return the cart to the kitchen and resume normal tray line duties.

Foods to Avoid For Patients with Neutropenic Diet Order:
1. Raw, uncooked fruit
    a. House made fruit cups
    b. Sliced fruit
2. Raw, uncooked vegetables
    a. Salad
    b. Raw vegetable snacks
3. Live culture yogurt
4. Garnishes
    a. Flowers
    b. Herbs
    c. Raw fruit
5. Bulk Items

   a. Anything scooped out of a large bag, tub, carton or box
   b. Examples: nuts, cottage cheese from the carton, iced tea, smoothies

Foods Permitted for Patients with Neutropenic Diet Order:

1. Anything individually sealed or vacuum packed and intended for single serving use
   a. Juices
   b. Milk cartons
   c. Assorted cereals
   d. Pre-packaged fruit cups
   e. Pudding cups
2. Pasteurized, individually sealed dairy products
   a. Except yogurt, as stated above.
3. Pasteurized eggs with yolks fully cooked
   a. Scrambled eggs
   b. Hard boiled eggs
4. Hot items cooked to standard temperature
   a. Hot entrees
   b. Soups
   c. Breakfast cereals
   d. Coffee
   e. Hot tea, NO LEMON

Reference:

- http://www.mayoclinic.org/symptoms/neutropenia/basics/definition/sym-20050854
- www.nutritioncaremanual.org

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: **IC8610-140 Infection Prevention Program, Annual Evaluation IC Program 2015 Infection Prevention Risk Assessment and Goals for 2016**	
APPROVED BY:	DATE: **2-11-16**
Director's/Manager's Signature Kathy Mathews RN, CIC	Printed Name **Kathy Mathews, RN CIC**

Brian Sebastian, MD
Chair, P.I. & P.T. Committees

2/25/16
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff

3/17/16
Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

New Document or Revision written by: **Kathy Mathews, RN CIC**

Date of Document: **2-11-16**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational: **X Clinical** **X Non-Clinical**	**❑ Departmental** **❑ Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

IC8610-140 Infection Prevention Program –
- Revised; no substantive changes in 2016.

Annual Evaluation of the Infection Prevention Program 2015 –.
- the initiatives attempted in 2015 and the evaluation of effectiveness

Infection Prevention Risk Assessment and Goals for 2016 – includes:
- a table with quantitative assessment of the components of the Infection Prevention Program for 2016
- goals of the program for 2016

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a		
Surgery Committee	n/a		
Medicine Committee	n/a		
P.I. Committee	**2/25/2016**	yes	Kathy to present
Medical Executive Committee	**3/17/2016**	yes	
Board Quality	**3/23/2016**		
Board of Directors	**4/07/2016**		

Sonoma Valley Hospital
ANNUAL EVALUATION OF THE INFECTION PREVENTION PROGRAM 2015

PURPOSE
To evaluate the effectiveness of the infection prevention program and to identify those activities that are effective, as well as those activities which require modification so as to improve care and services in 2016.

PROGRAM GOALS
The goals of the 2015 infection prevention program were:

- Prevention or reduction of risk from unprotected exposure to pathogens throughout the hospital
- Preparing for possible Ebola Viral Disease in Sonoma County
- Reinforcing appropriate hand hygiene practices by staff, patients and visitors
- Promoting cough etiquette and influenza prevention
- Annual influenza immunization campaign results in improved immunization compliance
- Minimizing the risk of transmitting infections with the use of procedures, medical equipment and medical devices
- Maintaining a sanitary environment to reduce the risk of fomite-associated infections and communicable diseases
- Implement a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel including Central Line Associated Bloodstream Infection (CLABSI), Ventilator Associated Events(VAE), Symptomatic Urinary Tract Infection (SUTI), Catheter Associated Urinary Tract Infection (CAUTI), Multi-drug Resistant Organism (MDRO), and hospital-acquired pneumonia in accordance with California Department of Public Health (CDPH), National Health and Safety Network (NHSN), and CIHQ requirements
- Ensuring that the hospital-wide quality, performance improvement and training programs address problems identified by infection prevention personnel, and that subsequent corrective action plans are successfully implemented
- Participation in the Performance Improvement poster session with the focus of Ebola preparation.
- Implementing Hospital Acquired Infection (HAI) prevention measures in accordance with SB 739, SB 158, SB1058 and CIHQ standards
- Complying with Cal/OSHA regulations including Bloodborne Pathogen and Aerosol Transmissible Disease Standards

PROGRAM SCOPE
The scope of the infection prevention program addresses all pertinent services and sites of care in the organization. The scope of the program in 2016 will include the Cancer Support Services.

INFECTION CONTROL RISK ASSESSMENT
The organization conducts a periodic assessment of the risk(s) for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.
2. The results of the organization's infection prevention and control data.
3. The care, treatment, and services provided.

The risk analysis is conducted / reviewed at least annually and whenever there is a significant change in any of the above factors. The most recent risk assessment required the following changes in the infection control program:

Assessed Risk	Changes to Program Activities
Hospital onset CDI risk increased in Nov/Dec 2015	Education, early implementation of contact/enteric isolation, routine disinfection using bleach (ICU), Xenon robot disinfection for all discharges in ICU

Multiple unprotected exposures in the ED prior to influenza diagnostic testing results	Inservice education for ED and nursing staff on use of empiric Droplet Isolation precautions for all pts with influenza like illness during influenza season. Counseling by nurse manager on appropriate documention in EMR of droplet isolation.
Hand hygiene audits revealed a need for improvement	Provide a hand hygiene campaign in 2016. Continue tracking and trending hand hygiene compliance and report back to all stakeholders and pertinent committees.
CDI rate in 2015 above benchmark in acute care. (SNF was well below benchmark.)	Continued vigilance and communication about appropriate antibiotic, PPI and probiotic use with through the Antimicrobial Stewardship Program and alerts in the EMR. Promote ingestion of live culture yogurt or probiotics for patients receiving antimicrobials. Inform physicians about risk of PPI drugs taken with antimicrobials.

EMERGING / REEMERGING PROBLEMS IN THE HEALTHCARE COMMUNITY
The organization keeps abreast of infection control related issues occurring in the healthcare community. This is accomplished by reviewing the following:

1. Notices from the public health department
2. Notices and recommendations from the Center for Disease Control
3. Current literature and recommendations from professional organization's as well as accrediting and regulatory agencies.

Based on this review, the following infection control issues were identified in the healthcare community. The organization's response to these issues is also noted below.

Issue Identified	Organization Response
Sonoma Co. ID Task Force focusing on CDI rates. Establishing a work group. CalHEN has a CDI collaborative	Participate in Sonoma DPH CDI project and the Cal HEN CDI collaborative.
Community outbreaks of pertussis in recent years. Tdap recommended not required at SVH. ED and Birthplace compliant.	PI Committee suggested that Tdap be required for health care workers in patient care. Employee Health plans to implement for all patient care staff in 2016.

SUCCESS OF INFECTION CONTROL INTERVENTIONS
The organization undertook several initiatives to prevent and control infection during the evaluation period. A summary of the effectiveness of significant interventions is noted below.

Initiative / Intervention	Determination of Effectiveness
Clostridium difficile infection prevention project	Improvement in CDI evident until Nov. Goal=CDI rate at or below 7.4. SNF CDI rate 2. Acute 12 and above benchmark due to cluster in 4th quarter
CAUTI prevention	Revised P&P, education of staff, improved EMR for foley necessity check. CAUTI rate above benchmark. Retain as an initiative in 2016
Continued central line infection prevention procedures and monitored CLIP forms for consistent practice	Zero CLABSI in 2015. Very effective program.
Reduce the risk of MRSA and VRE BSI. Maintain an active Antimicrobial Stewardship Program.	Zero HA MRSA or VRE BSI in 2015. Antibiogram stable. Very effective program.
Low SSI rates. Surgeon reporting of SSIs. Participate in CDPH SSI validation study.	Overall SSI rate < 1%. 50% fewer SSIs in 2015. No total hip SSIs. Total knee SSI rate 2%. Surgeon reporting 100% in 4th quarter. Implement

	CHG wipes vs Hibiclens shower for all total joint pts in 2016.
Reduce Immediate Use Steam Sterilization	Got new IUSS trays. Rate decreased from18% in 1st quarter to 4% in 4th quarter. Very effective in reducing IUSS.
VAP prevention	No VAP in 2015.

INFECTION PREVENTION AND CONTROL GUIDELINES
The organization evaluates relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus. This is accomplished by reviewing:

1. Notices from the public health department
2. Notices and recommendations from the Center for Disease Control
3. Current literature and recommendations from professional organization's as well as accrediting and regulatory agencies.

Based on this review, the following relevant guidelines were reviewed. The organization's response is also noted below.

Guideline Evaluated	Actions Taken
SB 739, SB 158, SB 1058	Compliance with all CDPH requirements.
Prevention of MDRO, CLASBI, SSI	Compliance with all CIHQ met. MRSA + nares patients no longer being isolated. No clusters of MRSA noted.
HAI reporting	Reporting required data to NHSN/CDPH on a quarterly basis and influenza immunization annually

DETERMINATION OF EFFECTIVENESS
Based on the information noted above, the infection prevention program was determined to be effective in implementing its activities during the evaluation period. Activities which require improvement will be addressed by the program during the upcoming evaluation period.

WHERE THIS REPORT WILL GO
This report will be submitted to the Performance Improvement Committee. This committee is charged with overseeing the infection control program as well as the patient safety program.

REFERENCES
CIHQ Standards, CDC guidelines

Sonoma Valley Hospital
Infection Prevention Risk Assessment and 2016 Goals

BACKGROUND
As part of its commitment to quality care and service, Sonoma Valley Hospital, conducts a risk assessment for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.
2. Analysis of surveillance activities and the results of the organization's infection prevention and control data.
3. Infection prevention standards recommended by Center for Improvement in Healthcare Quality (CIHQ), CDPH. Cal/OSHA, CDC and other regulatory bodies.
4. The patient care, treatment, and other services provided by SVH and the inherent risk therein.

SCOPE OF ASSESSMENT
This risk assessment is organization-wide in scope. It covers inpatient acute medical/surgical, emergency, intensive care, maternal/newborn and skilled nursing units, ancillary services, as well as ambulatory care settings, Cancer Support, outpatient care settings and Healing at Home.

PROCESS
The risk analysis is conducted at least annually and whenever there is a significant change in the scope or services. The assessment is facilitated by the Infection Preventionist and presented to the Performance Improvement Committee for review and approval.

Once risks are identified, the organization prioritizes those risks that are of epidemiological significance. Certain risks are automatically prioritized based on their nature, scope, and impact on the care, treatment, and services provided. These risks are outlined in this document as well.

Specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure establishment, surveillance and monitoring activities, education and training programs, environmental and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application, and/or duration depending on the specific risk issue, the care setting(s), and environment involved,

ASSESSMENT FINDINGS / MITIGATION STRATEGIES
The table below outlines the prioritized risks identified as the result of the assessment; provides a brief description of those risks, assigns a risk level (L=low, 1point., M=medium, 5 points., or H=high, 10 points) based on the care setting*, outlines – in summary form – actions that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of actions taken:

Care Settings Legend*
I = Inpatient services including medical surgical, critical care, maternal / child, surgery, and other care units
A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department
O = Outpatient services including rehabilitation clinics and other services
H = Home Health
L = Skilled Nursing Facility

Prioritized Risk Description	Care Setting / Risk Designation (See legend)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	L		
Transmission of infection associated with non-compliance with CDC guidelines and CIHQ recommendations for hand hygiene (HH). 50 points	H	H	H	H	H	Information given to patients on admission on the importance of HH. HH education included in hospital and nursing orientation and annual Healthstream education. HH compliance rounds conducted by Infection Preventionist and department champions to obtain hospital-wide compliance data.	Goal is >90% compliance Assess compliance rate and report to PI committee, department managers and staff during hospital orientation.
Unprotected exposure to pathogens throughout the organization through potential non-compliance with standard precautions, empiric precautions, transmission-based precautions or other infection prevention measures e.g., breach in aseptic technique in Surgery, vaccination non-compliance (influenza, Tdap). 35 points	M	H	M	M	H	Staff confirm immunity status at time of hire (MMR, varicella, hepatitis B). TB testing annually. Infection Prevention training provided during orientation and annually through Healthstream. Inservice education to physician and nursing staff prior to influenza season to prevent exposures. Post appropriate posters during influenza season. Promote respiratory hygiene and cough etiquette in waiting areas and lobby. Patient education given on admission on 'covering your cough'. Monitor isolation practices for appropriate placement, precautions and adherence to policies.	Goal: 1.90% Influenza immunization compliance by staff and physicians. 2. Zero cases of HAI influenza. 3.Require Tdap immunization pt. care providers 3.Influenza immunization compliance is reported to CDPH and the aforementioned committees. 4. 100% compliance with masks for epidural placement. Hospital-acquired infections are reported to Medicine, Surgery, Quality Board, P&T as needed and PI committee. Communicable disease exposures and clusters of infection are investigated, tracked and reported to PI

						Masks are worn by Anesthesia when performing epidurals. Investigate exposures and/or clusters of infections. Process in place for notification of patients placed in isolation.	Committee and other committees as appropriate.
Potential for transmission of infection related to procedures, medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment. 35 points	H	H	M	N A	H	Central Sterile Processing monitors QA logs on autoclaves, immediate use sterilizer, temperature logs, and the endoscope processing equipment on a daily basis. Medical Imaging utilizes the Trophon disinfection system. Endoscopy equipment is reprocessed in accordance with manufacturer's recommendation EVS training on IC for proper daily, OR, and terminal room cleaning.	Goal: 1. Reduce 2015 rate of immediate use sterilization. 2. Confirm compliance with Endoscope reprocessing. Quarterly Immediate Use Sterilization report submitted to PI committee and Surgery Committee. Check for ongoing compliance with maintaining QA logs, appropriate cleaning, storage, disinfection, sterilization, reuse, and/or disposal of waste, supplies and equipment during Infection Prevention rounds.
Multi use vials (MUV) have the potential risk of contamination without proper handling 25 points	M	M	M	M	M	MUVs must be kept in the medication prep area rather than the pts room. MUVs are dated when opened and discarded by day 28.	Infection Prevention rounds to confirm that there is compliance with strategies by Nursing, Anesthesia, OR. Report to PI Committee.
Potential for infection in ambulatory care and outpatient settings due to potential prolonged wait times in common areas and potential exposure to infectious individuals. 21 points	N A	H	H	L	N A	Respiratory hygiene and cough etiquette signage posted in all inpatient, ambulatory care and outpatient waiting areas (including offsite radiology and outpatient	Goal: 100% of patient waiting areas have signage and supplies to promote cough etiquette. Monitor for evidence of exposures to infectious

						rehab services). Alcohol gel, face masks, and facial tissues available to patients in waiting areas and lobby. ED patients are screened for obvious signs of contagious disease and appropriate control measures are taken for those who may present a risk of transmission of infectious agents.	individuals and follow up as appropriate. Outpatient departments are responsible for reporting any noncompliance issues to infection preventionist for follow up as appropriate. Issues may be identified during Infection Prevention rounds as well.
Community-wide outbreaks of communicable diseases e.g., pandemic influenza, pertussis, that carry the potential of adversely impacting operations and service capabilities 50 points	H	H	H	H	H	The Infection Preventionist is an active member of the Infectious Disease Task Force facilitated by the Deputy Health Officer of Sonoma County on a bi-monthly basis. Health alerts are received from the Public Health Department. On email lists and CAHAN for notification of any potential emergencies. Remain in close communication with the communicable disease control nurses at the Sonoma County Public Health Department. Policies/Guidelines in place for outbreak management. Recommendations and guidelines set forth by the DPH for various diseases (e.g. Norovirus, Influenza, Pertussis, possible EVD) are available and	Goal: 1. Infection Preventionist attends 90% of ID Task Force meetings and shares health alerts and other pertinent information with appropriate staff. 2. Evaluate all infectious clusters or outbreaks in a timely manner. Assess compliance with public health guidelines and recommendations. Prepare an action plan to interrupt the cluster/outbreak. Tdap, Hepatitis B, Influenza, MMR, and Varicella vaccination required for employees in accordance with Cal/OSHA regulations and CDC recommendations. Staff Influenza vaccination rates monitored and reported to NHSN as required by Ca law. TB testing performed annually and as needed post exposure.

						followed during an outbreak.	
Potential for a bioterrorism (BT) event that would require specific responses from the organization to successfully meet the threat. 25 points	M	M	M	M	M	BT response plan and the plan to manage an influx of infectious patients are included in the Emergency Operations Plan for SVH. Maintain communication with CDPH for updates and alerts.	Goal: 1. IP attends 90% of Emergency Management Committee meetings and actively participates in emergency preparedness 2. Evaluate and update plans as necessary.
Acquisition and transmission of multi-drug resistant bacteria that carry the potential for healthcare associated MDRO infections among patients and staff. • MRSA 25 points	M	M	M	M	M	Contact precautions initiated for all patients currently infected or with a history of MRSA (not required for nares colonization). Patients are flagged in the system for identification and isolation on subsequent admissions. Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing. . Hospital Acquired MRSA cases are tracked and reported. Active surveillance cultures for MRSA obtained on designated "high risk" patients as required by SB 1058.	Goal: 1. Hospital Acquired MDRO cases are identified and reported quarterly to PI and appropriate medical staff committees. 2. 100% of HAI MRSA bacteremia cases are reported to CDPH including all cases identified in the ED in 2015. 3. Monitor for any clusters of MDRO infections associated with changes in isolation practices. 6. Pts colonized with MRSA are informed in accordance with SB 1058.
• VRE 25 points	M	M	M	M	M	Contact precautions initiated for all patient infected or colonized with VRE. Patients are flagged in the system for	Goal: 1. 100% of HAI VRE bacteremia cases are reported to CDPH including all cases identified in the ED. Hospital Acquired

						identification and isolation on subsequent admissions. Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing. This will need review and approval by PI Committee and other committees as appropriate. Hospital Acquired VRE cases are tracked and reported. VRE bacteremia that is detected in the ED as well as after admission is required reporting to NHSN in 2015.	MDRO cases are identified and reported quarterly to PI and appropriate medical staff committees.
• ESBL 25 points	M	M	M	M	M	Contact precautions initiated for all patients infected or colonized with ESBL. Patients are flagged in the system for identification and isolation on subsequent admissions. Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing. This will need review and approval by PI Committee and other committees as appropriate. ESBL cases are tracked and reported.	Goal: 1. Monitor for any clusters of MDRO infections associated with changes in isolation practices . 2. Assess the cost savings realized by decreasing use of isolation supplies in 2015. ESBL rates are reported quarterly to PI and appropriate medical staff committees.
• CDI	M	M	M	M	H	Contact/Enteric precautions initiated for	Goal: 7.4 CDI per 10,000 patient days.

25 points						all patient with diarrhea until cause is determined to be noninfectious, or pt. completes treatment for CDI and symptoms subside. Environmental disinfection of the isolation room utilizing bleach. Use of handwashing rather than alcohol-based hand sanitizer. Daily antibiotic rounds by Dietary, live culture yogurt/probiotics administered until 48 hours after antibiotics are discontinued and recommend DC PPI for patients on antibiotics. Encourage patient education for patients prescribed antibiotics in the Emergency Department. Review of cases of concern in ASP weekly with MDs. Hospital Acquired CDI cases are tracked, trended, and reported.	The ASP program includes weekly review of pts on antibiotics, annual antibiogram and preoperative antibiotic recommendations to promote antimicrobial stewardship and CDI prevention. Hospital Acquired CDI cases are identified and reported quarterly to PI and appropriate medical staff committees. CDI cases are reported to CDPH including cases identified in ED (new 2015).
• Infection Prevention policies and procedures reflect current CIHQ standards. 25 points	M	M	M	M	M	Allocate adequate time to review and revise IP policies and procedures by 2016.	Goal: Review and revise IP policies and procedures as required. Introduce new policies and procedures as indicated by IP literature, changes in the law or community standard.
Potential for the following based on the results of surveillance and other data, review of the literature, patient population, and scope of services provided.							
• Central line associated bloodstream infections	M	M	L	M	M	Central line bundle in place, including	Goal: Review 100% of CLIP forms and follow

(CLABSI) 21 points						Biopatch. CLIP monitoring for ICU central line insertions and reported to NHSN. Daily review of line necessity and line removal asap.	with clinician whenever CLIP is not performed correctly. Goal: CLABSI rates at or below NHSN benchmarks. CLABSI rates are reported quarterly to PI committee and appropriate medical staff committees.
• Ventilator Associated Event (VAE) 9 points	M	L	L	L	L	VAP bundle in place in ICU in collaboration with RT.	Goal: VAE are below NHSN benchmark. Reported quarterly to PI committee and appropriate medical staff committees.
• Catheter associated UTI (CAUTI) 21 points	M	M	L	M	M	Daily review of catheter necessity to remove asap based on criteria. Include criteria in EMR. Vitamin C given to appropriate patients to reduce risk of UTI.	Goal: Reduce CAUTI rates to NHSN benchmarks. Reported quarterly to PI committee and appropriate medical staff committees.
• Surgical Site Infections (SSI) 21 points	M	M	L	M	M	SCIP bundle measures in place Elevated SSI rates (by procedure group) are investigated and action plans developed to reduce rates to baseline. CHG protocol in place for elective total joint patients. Consider change to CHG wipes. SSI outcomes (HAI report) are shared with OR staff.	Goal: 1. Overall SSI rate <1% in 2016. 2. 80% SSI report compliance by surgeons . 3. SSI rates by procedure do not exceed the NHSN benchmarks. Report SSI rates quarterly to Surgery Committee and PI committee.
Potential for transmission of infection related to noncompliance with hospital sanitation measures. 21 points	M	M	M	L	M	Quarterly meetings conducted with the EVS manager, the Nutritional services manager, and the Chief engineer and inservices provided on a prn basis to ensure maintenance of a sanitary environment. Infection control training	Track patient satisfaction survey feedback on cleanliness of the hospital. EVS provides cleanliness data to IP on a quarterly basis (TBD). Isolation carts are disinfected and

						of EVS staff on hire and annually thereafter to educate on maintenance of a sanitary environment. Policy on Cleaning of patient care equipment in place for a clear delineation of responsibility for cleaning specific areas of the hospital and equipment.	restocked following discharge of patient's on isolation. Medication preparation is performed >3 feet from a sink or a splash guard is installed. (CIHQ)
Infection Prevention and Control involvement in construction activities 15 points	M	M	N A	N A	M	Infection Control Risk Assessment completed for all construction activities. Construction workers educated on IC practices via an APIC video during safety orientation.	Goal: 100% compliance with Infection Control Risk Assessment (ICRA) and compliance checklist completed before initiating any construction projects. Documentation kept in Engineering.

Legend*
I = Inpatient services including medical surgical, critical care, maternal / child, and surgery
A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department
O = Outpatient services such as primary and specialty care clinics, wellness centers, infusion centers, rehabilitation clinics, and other services
H = Home health
L = skilled nursing
* For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, clinical laboratory, and all other departments and services of the organization.
Risk Designation – Enter the Level of Assessed Risk for Each Care Setting:
L = Low risk (1 point)
M = Medium Risk (5 points)
H = High Risk (10 points)

REFERENCEs: CIHQ Standards, CDC guidelines, AORN.

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Policy and Procedure - Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: CE8610-151 Injury & Illness Prevention Program; LB8610-106 Formalin Spill	
APPROVED BY:	DATE: **10-20-15**
Director's/Manager's Signature	Printed Name **Kimberly Drummond**

Kimberly Drummond
Chair, Safety Committee

1/28/16
Date

Brian Sebastian, MD
Chair, P.I./P.T. Committee

2/25/16
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff

3/17/16
Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

New Document or Revision written by: **Paula Davis**

Date of Document: **10-21-15**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational:	**❑ Departmental**
X Clinical	**❑ Interdepartmental** (list departments effected)
X Non-Clinical	

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

CE8610-151- Injury, Illness and Prevention Program-Revised; policy was ECSAF8610-105; The IIPP was updated and replaced the old program policy due to obsolete and missing information.

LB8610-106 Formalin Spill Cleanup-Revised; designated staff with be trained annually as part of the Hazardous Material Spill Response Team; procedure for calling Code Orange for large volume spills.

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	10/20/2015	Yes	
Safety Committee	10/28/2015	No	Due to time will review next meeting
Safety Committee	1/27/2016	Yes	
Medicine Committee	n/a		
P. I. Committee 2/25/2016	2/25/2016	OK YES	
Medical Executive Committee	3/17/2016	YES	
Board Quality	3/23/2016		
Board of Directors	4/07/2016		

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: **IC8610-141 Influenza Vaccination Program for Staff and Licensed Independent Practitioners**	
APPROVED BY:	DATE: **1-30-16**
Director's/Manager's Signature Kathy Mathews RN CIC	Printed Name **Kathy Mathews, RN CIC**

Michael Brown, MD
Chair Surgery Committee — Date 3/9/16

Douglas S Campbell, MD
Chair Medicine Committee — Date 3/10/16

Brian Sebastian, MD
Chair, P.I. / P. T. Committee — Date 3/10/16

Leslie Lovejoy, RN PhD
Chief Quality Officer — Date

Kelly Mather
Chief Executive Officer — Date

Jane Hirsch
Chair, Board of Directors — Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies**

New Document or Revision written by: **Kathy Mathews, RN CIC**

Date of Document: **1-30-2016**

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational: **X Clinical** **X Non-Clinical**	**❑ Departmental** **❑ Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

IC8610-141 Influenza Vaccination Program for Staff and Licensed Independent Practitioners-Revised;

Expanded upon previous policy and procedure and added appendices i.e., consent and declination form.

Influenza Vaccine Consent Form – updated for 2015-2016 season

Influenza Vaccine Declination Form – updated for 2015-2016 season

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	n/a		
Surgery Committee	2/03/2016	YES	
Medicine Committee	2/11/2016	YES	
P.I. or P. T. Committee	2/25/2016	YES	
Medical Executive Committee 3/17	~~3/10~~/2016	YES	
Board Quality 3/23	~~3/17~~/2016		
Board of Directors	4/07/2016		

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Policy and Procedure - Approvals Signature Page

Review and Approval Requirements

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- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: QA8610-102 Performance Improvement Plan, QA8610-104 Department Specific P. I., QA8610-106 Reporting of Quality Monitoring and Performance Improvement	
APPROVED BY: **Chief Quality Officer**	DATE: **2-20-16**
Director's/Manager's Signature Leslie Lovejoy	Printed Name **Leslie Lovejoy, RN PhD**

Brian Sebastian, MD
Chair, P.I./P.T. Committee

2/25/16
Date

KJC MD MBA

Keith J. Chamberlin, MD MBA
President of Medical Staff

3/17/16
Date

Kelly Mather
Chief Executive Officer

Date

Jane Hirsch
Chair, Board of Directors

Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policies-Information Management**

New Document or Revision written by: **Fe Sendaydiego**

Date of Document:

Type:	**Regulatory:**
X Revision **❑ New Policy**	**X CIHQ** **X CDPH** **X CMS** **❑ Other:**
Organizational: **X Clinical** **X Non-Clinical**	**❑ Departmental** **❑ Interdepartmental** (list departments effected)

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

QA 8610-102 Performance Improvement Plan: revised; changed heading to comply with CIHQ, no other changes

QA 8610-104 Department Specific Performance Improvement: revised; changed heading to comply with CIHQ; deleted annual review with senior leader but added participation in the annual PI Fair and periodic reviews of department specific PI/QC programs at PI Committee of Quality Committee of the Board.

QA 8610-106 Reporting of Quality Monitoring and Performance Improvement: Revised; changed heading to comply with CIHQ

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	**2/16/2016**	Yes	
Surgery Committee	n/a		
Medicine Committee	n/a		
P.I. or P. T. Committee	**2/25/2016**	Yes	
Medical Executive Committee	**3/17/2016**	Yes	
Board Quality	**3/23/2016**		
Board of Directors	**4/07/2016**		

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POLICY AND PROCEDURE
Approvals Signature Page

Review and Approval Requirements

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- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Organizational: Pharmacy Policies Feb List 2016	
APPROVED BY: **Director of Pharmacy**	DATE: **2-17-16**
Director's/Manager's Signature	Printed Name **Chris Kutza**

Brian Sebastian, MD
Chair, P.I. & P.T. Committees
2/25/14
Date

Leslie Lovejoy, RN
Chief Quality & Nursing Officer
2-25-16
Date

MD MBA
Keith J. Chamberlin, MD MBA
President of Medical Staff
3-17-16
Date

Kelly Mather
Chief Executive Officer
Date

Jane Hirsch
Chair, Board of Directors
Date

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Policy Submission Summary Sheet

Title of Document: **Organizational Policy**
New Document or Revision written by: **Chris Kutza**
Date of Document: **02-16-16**

Type:	**Regulatory:**
X **Revision** ☐ **New Policy**	X **CIHQ** X **CDPH** X **CMS** ☐ **Other:**
Organizational:	☐ **Departmental** ☐ **Interdepartmental** (list departments effected)
X **Clinical** ☐ **Non-Clinical**	

Please briefly state changes to existing document/form or overview of new document/form here:
(include reason for change(s) or new document/form)

MM8610-101 Look Alike / Sound Alike Medications—Reviewed; no changes

MM8610-104 Lipid Rescue for Local Anesthetic Toxicity—Reviewed; no changes

MM8610-105 Malignant Hyperthermia, Management of Patient with—Reviewed; no changes

MM8610-106 Administration of Medications—Reviewed; no changes

MM8610-107 Drug Regimen Review for Skilled Nursing Facility—Reviewed; no changes

MM8610-108 Controlled Substance Distribution for Anesthesia—Reviewed; no changes

MM8610-109 Pharmaceutical Care Consulting for Skilled Care Facility—Reviewed; no changes

MM8610-110 Piperacillin-Tazobactam Extended Infusion Dosing—Revised; Updated to reflect the CPOE process

MM8610-112 Warming Fluids for IV and Irrigation Purposes, Storage and Handling of—Reviewed; no changes

MM8610-113 Labeling Medications On and Off Sterile Field—Reviewed; no changes

MM8610-114 Vaccine Screening-Pneumococcal and Influenza—Reviewed; no changes

MM8610-115 Self Administration of Medications—Reviewed; no changes

MM8610-117 Sterile Compounding—Reviewed; no changes

MM8610-118 IV Compounding Outside of the Pharmacy—Reviewed; no changes

MM8610-119 Pharmacist Review of Medication Orders—Reviewed; no changes

MM8610-120 Access to Patient Information for Medication Management—Reviewed; no changes

MM8610-121 Floorstock Medications—Reviewed; no changes

MM8610-151 Parenteral Nutrition Protocol—Revised; Updated to reflect new laboratory reference ranges

Reviewed; no changes by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	02/16/2016	Yes	
Surgery Committee	n/a		
Medicine Committee	n/a		
P.I. or P. T. Committee	02/25/2016	Yes	
Medical Executive Committee 3/17	~~03/10~~/2016	Yes	
Board Quality	03/23/2016		
Board of Directors	04/07/2016		

5.

QUALITY REPORT

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: Sonoma Valley Healthcare District Board Quality Committee
From: Leslie Lovejoy
Date: 03/23/16
Subject: Quality and Resource Management Report

March Priorities:

1. Orientation of new team members
2. CALHEN project team development
3. Performance Evaluations
4. "PRIME" Grant application

1. *Orientation of new team members*

A great deal of my focus has been on the orientation of two new team members for the Case Management Department. I hired an experienced LVN Certified Case Manager for the Skilled Nursing Facility and a new per diem RN Acute Case Manager to cover both acute and the navigator role for Pre-op. In addition, I have hired a per diem RN for Pre-op Navigation in order to begin to expand their role into simple surgical case management (pre-op through discharge). This will also address the anticipated retirement of 1, possibly 2 staff members from this team in the next year or two. In addition, case management duties will expand in FY 2016 to include post discharge care coordination from the acute and the emergency department side.

2. *CALHEN project team development*

We have decided to work on three projects this year in this collaborative and have formed our teams, found physician champions and nurse project leaders. The projects are expected to be completed by the end of this year. CALHEN is creating data tracking reports and benchmarking reports to assist in monitoring our progress. The three performance improvement projects are: Improving outcomes for Severe Sepsis and Septic Shock; reducing the risk of Iatrogenic Delirium ; and reducing the risk of C. Difficile hospital acquired infections. As we are a small hospital, we have decided to work on these projects organization-wide rather than department specific.

In addition, the Patient Experience Team is involved in the ENGAGE program which focuses on best practices in improving the patient and family experience. One of the goals is to develop an interview, application and criteria for identifying potential patient/family advisors for hospital committees. Mark Kobe is working on this project with the team. This is an important initiative within the Leapfrog Action Plan.

3. *Performance Evaluations*

The whole organization has been completing annual performance evaluations for all staff members by the end of March. Performance evaluations have been amended to include the following statement: **Actively takes responsibility for improving gaps in performance metrics to ensure a safe patient care and employee environment.** It has been added to the

Accountability core value to complete a Leapfrog Action item that involves including a statement regarding patient safety within the core values of the organization.

4. *PRIME Grant application*

It is time to put all the work we have been doing with the development of a Community Care Network (CCN) and building infrastructure for more advanced care transitions planning into the CMS funded, State monitored program. The grant is over a five year period and is expected to move the organization towards the new healthcare delivery system involving population health and complex care coordination on an outpatient setting. The Steering Committee decided to begin with a modest project of post-discharge care transitions management as we continue to build the CCN. There are three elements that will be part of this project:

- One full time ED RN Case Manager who will provide follow up phone calls to patients discharged from the acute setting and for ED patients meeting criteria for post ED discharge follow-up. In addition, this position will do a initial home visit as indicated and work with the health coach, home care, the community clinic etc. to ensure access and transition linkages are in place.
- Purchase of a software product that links our hospital with all pharmacy providers for real time medication histories; medication reconciliation and medication administration compliance such that we will be able to track this data for at least 30 days post discharge.
- Building of the health coach role and infrastructure to support a Community Care Network.

The grant application is due to the CDPH on April 4th.

Topic for discussion this meeting:

- Annual Contract Review
- Annual Infection Control Report

6.

INFECTION CONTROL REPORT

Sonoma Valley Hospital
ANNUAL EVALUATION OF THE INFECTION PREVENTION PROGRAM
2015

PURPOSE
To evaluate the effectiveness of the infection prevention program and to identify those activities that are effective, as well as those activities which require modification so as to improve care and services in 2016.

PROGRAM GOALS
The goals of the 2015 infection prevention program were:

- Prevention or reduction of risk from unprotected exposure to pathogens throughout the hospital
- Preparing for possible Ebola Viral Disease in Sonoma County
- Reinforcing appropriate hand hygiene practices by staff, patients and visitors
- Promoting cough etiquette and influenza prevention
- Annual influenza immunization campaign results in improved immunization compliance
- Minimizing the risk of transmitting infections with the use of procedures, medical equipment and medical devices
- Maintaining a sanitary environment to reduce the risk of fomite-associated infections and communicable diseases
- Implement a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel including Central Line Associated Bloodstream Infection (CLABSI), Ventilator Associated Events(VAE), Symptomatic Urinary Tract Infection (SUTI), Catheter Associated Urinary Tract Infection (CAUTI), Multi-drug Resistant Organism (MDRO), and hospital-acquired pneumonia in accordance with California Department of Public Health (CDPH), National Health and Safety Network (NHSN), and CIHQ requirements
- Ensuring that the hospital-wide quality, performance improvement and training programs address problems identified by infection prevention personnel, and that subsequent corrective action plans are successfully implemented
- Participation in the Performance Improvement poster session with the focus of Ebola preparation.
- Implementing Hospital Acquired Infection (HAI) prevention measures in accordance with SB 739, SB 158, SB1058 and CIHQ standards
- Complying with Cal/OSHA regulations including Bloodborne Pathogen and Aerosol Transmissible Disease Standards

PROGRAM SCOPE
The scope of the infection prevention program addresses all pertinent services and sites of care in the organization. The scope of the program in 2016 will include the Cancer Support Services.

INFECTION CONTROL RISK ASSESSMENT
The organization conducts a periodic assessment of the risk(s) for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.
2. The results of the organization's infection prevention and control data.
3. The care, treatment, and services provided.

The risk analysis is conducted / reviewed at least annually and whenever there is a significant change in any of the above factors. The most recent risk assessment required the following changes in the infection control program:

Assessed Risk	Changes to Program Activities
Hospital onset CDI risk increased in Nov/Dec 2015	Education, early implementation of contact/enteric isolation, routine disinfection using bleach (ICU),

	Xenon robot disinfection for all discharges in ICU
Multiple unprotected exposures in the ED prior to influenza diagnostic testing results	Inservice education for ED and nursing staff on use of empiric Droplet Isolation precautions for all pts with influenza like illness during influenza season. Counseling by nurse manager on appropriate documention in EMR of droplet isolation.
Hand hygiene audits revealed a need for improvement	Provide a hand hygiene campaign in 2016. Continue tracking and trending hand hygiene compliance and report back to all stakeholders and pertinent committees.
CDI rate in 2015 above benchmark in acute care. (SNF was well below benchmark.)	Continued vigilance and communication about appropriate antibiotic, PPI and probiotic use with through the Antimicrobial Stewardship Program and alerts in the EMR. Promote ingestion of live culture yogurt or probiotics for patients receiving antimicrobials. Inform physicians about risk of PPI drugs taken with antimicrobials.

EMERGING / REEMERGING PROBLEMS IN THE HEALTHCARE COMMUNITY
The organization keeps abreast of infection control related issues occurring in the healthcare community. This is accomplished by reviewing the following:

1. Notices from the public health department
2. Notices and recommendations from the Center for Disease Control
3. Current literature and recommendations from professional organization's as well as accrediting and regulatory agencies.

Based on this review, the following infection control issues were identified in the healthcare community. The organization's response to these issues is also noted below.

Issue Identified	Organization Response
Sonoma Co. ID Task Force focusing on CDI rates. Establishing a work group. CalHEN has a CDI collaborative	Participate in Sonoma DPH CDI project and the Cal HEN CDI collaborative.
Community outbreaks of pertussis in recent years. Tdap recommended not required at SVH. ED and Birthplace compliant.	PI Committee suggested that Tdap be required for health care workers in patient care. Employee Health plans to implement for all patient care staff in 2016.

SUCCESS OF INFECTION CONTROL INTERVENTIONS
The organization undertook several initiatives to prevent and control infection during the evaluation period. A summary of the effectiveness of significant interventions is noted below.

Initiative / Intervention	Determination of Effectiveness
Clostridium difficile infection prevention project	Improvement in CDI evident until Nov. Goal=CDI rate at or below 7.4. SNF CDI rate 2. Acute 12 and above benchmark due to cluster in 4th quarter
CAUTI prevention	Revised P&P, education of staff, improved EMR for foley necessity check. CAUTI rate above benchmark. Retain as an initiative in 2016
Continued central line infection prevention procedures and monitored CLIP forms for consistent practice	Zero CLABSI in 2015. Very effective program.
Reduce the risk of MRSA and VRE BSI. Maintain an active Antimicrobial Stewardship Program.	Zero HA MRSA or VRE BSI in 2015. Antibiogram stable. Very effective program.
Low SSI rates. Surgeon reporting of SSIs.	Overall SSI rate < 1%. 50% fewer SSIs in 2015.

Participate in CDPH SSI validation study.	No total hip SSIs. Total knee SSI rate 2%. Surgeon reporting 100% in 4th quarter. Implement CHG wipes vs Hibiclens shower for all total joint pts in 2016.
Reduce Immediate Use Steam Sterilization	Got new IUSS trays. Rate decreased from18% in 1st quarter to 4% in 4th quarter. Very effective in reducing IUSS.
VAP prevention	No VAP in 2015.

INFECTION PREVENTION AND CONTROL GUIDELINES
The organization evaluates relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus. This is accomplished by reviewing:

1. Notices from the public health department
2. Notices and recommendations from the Center for Disease Control
3. Current literature and recommendations from professional organization's as well as accrediting and regulatory agencies.

Based on this review, the following relevant guidelines were reviewed. The organization's response is also noted below.

Guideline Evaluated	Actions Taken
SB 739, SB 158, SB 1058	Compliance with all CDPH requirements.
Prevention of MDRO, CLASBI, SSI	Compliance with all CIHQ met. MRSA + nares patients no longer being isolated. No clusters of MRSA noted.
HAI reporting	Reporting required data to NHSN/CDPH on a quarterly basis and influenza immunization annually

DETERMINATION OF EFFECTIVENESS
Based on the information noted above, the infection prevention program was determined to be effective in implementing its activities during the evaluation period. Activities which require improvement will be addressed by the program during the upcoming evaluation period.

WHERE THIS REPORT WILL GO
This report will be submitted to the Performance Improvement Committee. This committee is charged with overseeing the infection control program as well as the patient safety program.

REFERENCES
CIHQ Standards, CDC guidelines

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APPROVED BY: CQO/ Performance Improvement Committee	REVISED: 8/92 3/94 7/98 10/01 9/04 9/07 12/07 5/10 2/11 3/12 2/13 2/14 5/15, 2/16

Purpose:
To codify the components of Sonoma Valley Hospital's Infection Prevention program and the mission to identify, prevent and control the spread of infections in accordance with all applicable regulatory standards and requirements..

Policy:

Scope & Applicability
This is an organization-wide program. As such, it applies to all services and settings including inpatient, outpatient, Healing at Home, SNF and all healthcare providers, including physicians, licensed independent practitioners (LIP), staff, students, trainees, volunteers, and as appropriate, visitors, and patients.

Secondary Policy & Procedure
Unless otherwise noted herein, additional policies and procedures may be developed to address specific infection control and prevention issues on an organization-wide and/or department specific basis. In these instances, such policies and procedures must be consistent with the policy statements established in this document. These policies and procedures are – by this reference – incorporated into the scope of the Infection Prevention Program.

Goals
The 2016 goals of the infection prevention program include, but are not necessarily limited to:
- Preventing or reducing the risk of unprotected exposure to pathogens throughout the organization.
- Hand hygiene performed in accordance with hospital policy
- Minimizing the risk of transmitting infections via medical equipment and medical devices
- Maintaining a sanitary environment to reduce the risk of fomite-associated infections and communicable diseases
- Ongoing implementation of a system for identifying, reporting, investigating, and controlling infections and communicable diseases in patients and personnel including Central Line Associated Bloodstream Infection (CLABSI), Ventilator Associated Events(VAE), Symptomatic Urinary Tract Infection (SUTI), Catheter Associated Urinary Tract Infection (CAUTI), Multi-drug Resistant Organism (MDRO), and hospital-acquired pneumonia in accordance with California Department of Public Health (CDPH), National Health and Safety Network (NHSN), and the Center for Improvement in Healthcare Quality (CIHQ).
- Ensuring that the hospital-wide quality, performance improvement and training programs address problems identified by the Infection Control Officer i.e., Infection Preventionist, and that subsequent corrective action plans are successfully implemented

- Implementing Hospital Acquired Infection (HAI) prevention measures in accordance with SB 739, SB 1058 and CIHQ.
- Complying with the MRSA active surveillance requirements of SB 158.
- Complying with Cal/OSHA regulations including Bloodborne Pathogen and Aerosol Transmissible Disease Standards.

The 2016 goals of the Healing at Home infection prevention program include, but are not necessarily limited to:

- To maintain low infection rates through a surveillance plan that includes monitoring and reporting surgical site infections (SSI) and home health associated infections including Central line associated bloodstream infections (CLABSI), Symptomatic urinary tract infections (SUTI), Catheter associated urinary tract infections (CAUTI), Multi-drug resistant organisms (MDRO), and pneumonia) as well as outbreak investigation and communicable disease exposures.
- Enhancing hand hygiene in the home setting.

Structure of the Infection Control Program

INFECTION CONTROL OFFICER

Sonoma Valley Hospital has an Infection Control Officer i.e., Infection Preventionist (IP) to oversee the development and day-to-day implementation of the infection prevention plan. This individual is qualified by virtue of her training, education, and experience to perform this function. The IP is expected to maintain her qualifications through ongoing education and training, which can be demonstrated by participation in infection prevention courses, or in local and national meetings organized by recognized professional societies (e.g. APIC) and certification.

In determining the number of infection prevention personnel and support staff, the organization considers patient census, characteristics of the patient population, and complexity of the healthcare services to assure that resources are adequate to accomplish the tasks required for the implementation of the goals of the infection prevention program.

Responsibilities of the infection preventionist include, but are not necessarily limited to:

- Develop and implement policies and procedures governing the prevention and control of infections and communicable diseases.
- Develop, implement and evaluate systems and measures governing the identification, investigation, reporting, prevention and control of infections and communicable diseases within the hospital, including both healthcare–associated infections and community-acquired infections.

- Take necessary steps to prevent or control the acquisition and transmission of infectious agents
- Coordinate all infection prevention and control activities within the hospital
- Facilitate ongoing monitoring of the effectiveness of prevention and/or control activities
- Perform all the required reporting to NHSN, CDPH, Sonoma County DPH, CIHQ and other regulatory bodies as required.

PERFORMANCE IMPROVEMENT COMMITTEE
The Performance Improvement Committee is a multi-disciplinary body composed of representatives from Infection Prevention, medical staff, nursing, and other direct and indirect care staff and oversees the Infection Control Program. For the purposes of this document, the term “committee” may mean a distinct and stand-alone entity, or a function of an entity.

Composition of the committee ensures – through either membership or invitee – that administration, building maintenance/engineering, emergency, food service, Healing at Home, housekeeping, laboratory, pharmacy, SNF, sterilization services, and surgery are represented as applicable and necessary.

The functions of the Performance Improvement (PI) Committee include, but are not necessarily limited to:

- Provide a forum for departments and services to effectively collaborate in developing, implementing, and evaluating the infection prevention program plan.
- Develop strategies for each component/function in the program
- Assess the adequacy of the human, information, physical, and financial resources allocated to support infection prevention and control activities
- Review and revise the program as warranted to improve outcomes
- Monitor compliance with all policies, procedures, protocols and other infection control program requirements
- Provide mechanisms for integration of the infection prevention program into the organization’s quality assurance and improvement, environment of care, and safety programs.
- The committee maintains a record of, and reports a summary of its activities to the Medical Executive Committee.

Management of Infectious Risk
IDENTIFICATION OF RISK
The organization identifies risks for transmission and acquisition of infectious agents throughout the hospital based on the following factors:

- The geographic location and community environment of the hospital, program/services provided, and the characteristics of the population served, including Sonoma Developmental Center and Napa State Hospital patients.
- The results of the analysis of the hospital's infection prevention and control data
- The care, treatment, and services provided

This risk analysis is formally reviewed at least annually and whenever significant changes occur in any of the above factors. The infection preventionist performs the risk assessment and presents the results to the PI Committee.
Review of the risk assessment including significant changes that may occur from one formal review period to the next, may be codified in reports to the PI Committee or in other documents that provide evidence the risk was identified and addressed.

PRIORITIZATION OF RISK
Once risks are identified, the organization prioritizes those risks that are of epidemiological significance. Certain risks are automatically prioritized based on their nature, scope, and impact on the care, treatment, and services provided. These risks include, but are not necessarily limited to:

- Transmission of infection through potential non-compliance to CDC guidelines and recommendations for hand hygiene.
- Unprotected exposure to pathogens throughout the organization through non-compliance with policies addressing universal precautions, transmission-based precautions and other infection prevention measures.
- Potential for transmission of infection related to procedures, medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment.

STRATEGIES TO ADDRESS THE PRIORITIZED RISKS
Specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure establishment, surveillance and monitoring activities, education and training programs, environmental and engineering controls, or combinations thereof.

Strategies may differ in approach, form, scope, application, and/or duration depending on the specific risk issue, the care setting(s), and environment involved.

A complete description of prioritized risks and subsequent mitigation strategies from the most recent formal risk assessment is by reference incorporated herein.

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General Scope and Activities of the Infection Control Program

MAINTENANCE OF A SANITARY PHYSICAL ENVIRONMENT
The organization has developed specific policies, procedures, or other codified work processes that address the following:

- Ventilation, temperature, humidification and water quality control issues, including measures taken to maintain a safe environment during internal or external construction / renovation.
- Maintaining safe air handling systems in areas of special ventilation, such as operating rooms, intensive care units, and airborne isolation rooms
- Safe food storage, preparation, and handling
- Appropriate cleaning and disinfecting of environmental surfaces, carpeting, furniture, common areas, and medical equipment including a clear description of responsibility for cleaning the specific areas.
- Sanitary textile reprocessing, storage, and distribution
- Safe storage and disposal of regulated and non-regulated waste
- Adequate pest or vector control
- Procedures for animal visitation

MANAGEMENT OF STAFF, PHYSICIANS, AND OTHER PERSONNEL
The organization has developed specific policies, procedures, or other codified work processes that address the following:

- Communication with licensed independent practitioners (LIP), staff, students, trainees, volunteers, and as appropriate, visitors, patients, and families about infection control issues, including their responsibilities in preventing the spread of infection.
- New employee and annual training in preventing and controlling healthcare associated infections and methods to prevent exposure to and transmission of infections and communicable diseases;
- Screening for exposure and/or immunity to infectious diseases that LIP, staff, students, trainees, and volunteers may come in contact in their work including:
  - Policies articulating the authority and circumstances under which the hospital screens hospital staff for infections likely to cause significant infectious disease or other risk to the exposed individual, and for reportable diseases, as required under local, state, or federal public health authority
  - Measures –and authority - for ensuring that hospital staff have documented immunity to designated infectious diseases, as recommended by the CDC and its Advisory Committee on Immunization Practices (ACIP)

- Referral for assessment, potential testing, immunization, and/or prophylaxis/treatment and counseling, as appropriate, of LIP, staff, students, trainees, and volunteers who are identified as potentially having an infectious disease or risk of infectious disease that may put the population they serve at risk including policies articulating when infected hospital staff are restricted from providing direct patient care and/or are required to remain away from the healthcare facility entirely;
- Referral for assessment, potential testing, immunization, and/or prophylaxis/treatment, and counseling, as appropriate of patients, students, trainees, and volunteers who have been exposed to infectious diseases in the organization, and LIP or staff who are occupationally exposed.

MITIGATION OF RISK ASSOCIATED WITH PATIENT INFECTIONS PRESENT ON ADMISSION
The organization has developed specific policies, procedures, or other codified work processes that address the following:

- Measures for the early identification of patients who require isolation in accordance with CDC guidelines;
- Appropriate use of standard precautions with all patients including personal protective equipment i.e., gowns, gloves, masks and eye protection devices;
- Transmission –based "isolation" precautions as recommended by the CDC for patients with suspected or confirmed communicable diseases.

MITIGATION OF RISKS CONTRIBUTING TO HEALTHCARE ASSOCIATED INFECTIONS
The organization has developed specific policies, procedures, or other codified work processes that address the following:
Surgery-related infection risk mitigation measures:

- Implementing appropriate prophylaxis to prevent surgical site infection (SSI). Staff adhere to a protocol to assure that antibiotic prophylaxis to prevent surgical site infection for appropriate procedures is administered at the appropriate time, done with an appropriate antibiotic, and discontinued appropriately after surgery;
- Addressing aseptic technique practices used in surgery and invasive procedures performed outside the operating room, including sterilization of instruments;

Other hospital healthcare-associated infection risk mitigation measures:

- Promotion of hand washing/ hygiene among staff and employees, including utilization of alcohol-based hand sanitizers;
- Measures specific to prevention of infections caused by organisms that are antibiotic-resistant i.e., the Antimicrobial Stewardship Program and Contact Isolation.

- Measures specific to prevention of device-associated bloodstream infection (CLABSI),
- Measures specific to prevention of other device-associated infections, e.g., those associated with ventilators, tube feeding, indwelling urinary catheters, etc;
- Isolation procedures and requirements for highly immuno-suppressed patients who require a protective environment.
- Care techniques for tracheostomy care, respiratory therapy, burns and other situations that reduce a patient's resistance to infection;
- Requiring disinfectants, antiseptics, and germicides to be used in accordance with the manufacturers' instructions;
- Appropriate use of facility and medical equipment, including negative and positive pressure air flow room systems, portable air filtration equipment, treatment booths and enclosed beds, UV lights, and other equipment used to control the spread of infectious agents;
- Adherence to nationally recognized infection prevention and control precautions, such as current CDC guidelines and recommendations, for infections/communicable diseases identified as present in the organization based on the following:
  - The potential for transmission
  - The mechanism of transmission
  - The care, treatment, and service setting
  - The emergence or reemergence of pathogens in the community that could affect the organization.
- Educating patients, visitors, caregivers, and staff, as appropriate, about infections and communicable diseases and methods to reduce transmission in the hospital and in the community;

ACTIVE SURVEILLANCE
The organization has developed specific policies, procedures, or other codified work processes that address the following:

- Methods for obtaining and reviewing data on infections/communicable diseases selected for monitoring;
- Methods for monitoring and evaluating practices of asepsis;
- Authority and indications for obtaining microbiological cultures from patients and the environment as indicated.

Active surveillance consists of both targeted surveillance of selected patient populations or procedures, as well as organization-wide surveillance designed to identify infectious risks or communicable disease issues in any department or care setting.

The selection of patient populations and/or procedures for targeted surveillance is based on the following criteria:

- There is internal or external data and evidence that designates the patient population / procedure at a high risk of infection.
- The patient population / procedure ties directly to an issue or need identified in the organization
- There is internal data and evidence demonstrating a historical unacceptable rate of infection tied to a patient population / procedure.

When targeted surveillance is utilized, appropriate data definitions, surveillance methodologies, internal or external benchmarks, monitoring frequencies, and display tools are developed.

Organization-wide surveillance does not imply or require total surveillance of all patients, and care settings. Instead the organization has developed the following mechanisms:

- Positive cultures on patients from any location in the organization are reviewed by either the infection preventionist or appropriate LIP.
- Adherence to infection prevention related quality control / assurance processes are monitored by management personnel in all applicable locations.
- Facilities personnel monitor environmental infection control processes related to air exchanges, temperature, humidity, and isolation rooms throughout the organization
- Infection preventionist or designee(s) conducts rounds throughout the organization to identify and correct practice or environmental issues.

COMMUNICATION / COORDINATION WITH OUTSIDE AGENCIES

The organization has developed specific policies, procedures, or other codified work processes that address the following:

- Coordination with federal, state, and local emergency preparedness and health authorities to address communicable disease threats, bioterrorism, and outbreaks, including a plan to manage an influx of potentially infectious patients.
- Systems for reporting infection surveillance, prevention, and control information to the following:
  - The appropriate staff within the organization
  - Federal, state, and local public health authorities in accordance with law and regulation
  - Accrediting bodies
  - The referring or receiving organization, when a patient was transferred or referred and the presence of a healthcare acquired infection was not known at the time of transfer or referral

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APPROVED BY: CQO/ Performance Improvement Committee	REVISED: 8/92 3/94 7/98 10/01 9/04 9/07 12/07 5/10 2/11 3/12 2/13 2/14 5/15, 2/16

Integration of the Infection Prevention Program Into the Performance Improvement Program

The activities of the Infection Prevention Program fall under the umbrella and auspices of the organization's Performance Improvement Program. Issues or problems noted are to be addressed through corrective action plans. These action plans are to include – when appropriate – education and training of staff.

Adherence to corrective action plans will be monitored, to assess the effectiveness of actions taken, with implementation of revised corrective actions as needed.

Evaluation of the Infection Prevention Program

The organization formally evaluates and revises the goals and program (or portions of the program) at least annually and whenever risks significantly change

- The evaluation addresses changes in the scope of the program
- The evaluation addresses changes in the results of the program risk analysis
- The evaluation addresses emerging and re-emerging problems in the health care community that potentially affect the hospital
- The evaluation addresses the assessment of the success or failure of interventions for preventing and controlling infection
- The evaluation addresses responses to concerns raised by leadership and others within the organization
- The evaluation addresses the evolution of relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus

The infection preventionist facilitates the program evaluation and submits the evaluation to the Performance Improvement Committee for review and approval.

Reference:

1. The Center for Improvement in Healthcare Quality
2. CMS Conditions of Participation for Acute Care Hospitals, §482.42
3. CDC Guidelines

Infection Prevention HAI Report

Indicator	Comparison 2013 /2014 rates	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Benchmarks/Actions/Comments
National Healthcare Safety Network (NHSN) indicator data are a requirement of California Department of Public Health (CDPH) and Senate Bill 1058 mandated reporting Data are entered into the National Healthcare Safety Network (NHSN) system for public reporting by CDPH. Overall SSI rate includes all SSIs identified regardless of wound class. There is no NHSN benchmark. NHSN risk stratefies SSI rates by procedure therefore a range is provided. Green indicates no action, yellow indicates above benchmark, red indicates greater than the NHSN 90th percentile or internal benchmark. Action is recommended when rates exceed the 90th percentile. New Requirements in 2015: All MRSA and VRE bacteremia identified in Emergency Department, all SSIs acquired from Outpatient surgeries.						
CLABSI (NHSN) (CMS Never Event) *# Central Line Associated Bloodstream Infections (CLABSI)/1000 central line days*	**0** 0	**0** 0/162	**0** 0/125	**0** 0/71	**0** 0/117	**NHSN Benchmark: 0.8 per 1,000 central line days(ICU). SVH (acute units) have not had a CLABSI since 2011! Practitioner CLIP practices remain excellent and reported to CDPH. Nurses received CL inservice at Skills Fair.**
CDI (NHSN) *#Inpatient Hospital Acquired infections due to C. difficile per 10,000 patient days*	**2.1** 7.2	**0** 0/1072	**9.0** 1/1108	10.8 **1/924**	**30** 3/992	**NHSN median rate 7.4/10,000 patient days . 1 pt. expired. Case review by PI Committee. Annual rate 12 (acute). ASP review. PPIs. IP Education 1/22/16. Bleach disinfection + Xenex robot ICU/2So. Isolate 48 hrs after formed stools.**
MRSA Bloodstream Infections (NHSN) *#bloodstream infections due to MRSA per 1000 pt. days*	**1.3** 0	**0** 0/1072	**0** 0/1108	**0** 0/924	**0** 0/992	**SVH Benchmark: 1 per 1,000 patient days. 2015 New requirement: Report ED and acute care unit infections to NHSN. No cases in 2015.**
VRE Bloodstream Infections (NHSN) *#Hospital Acquired bloodstream infections due to VRE per 1000 pt. days*	**0** 0	**0** 0/1072	**0** 0/1108	**0** 0/924	**0** 0/992	**SVH Benchmark: 1 per 1,000 patient days. 2015 New Requirement report ED and acute care unit infections to NHSN. No cases in 2015.**
Hip: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Hip Cases x 100*	**0** 1.8%	**0** 0/12	**0** 0/4	**0** 0/9	**0** 0/8	**NHSN Benchmark: Risk stratified. Rate range 0.67% (0 risk index) to 2.40% (higher risk index). No SSIs in 2015.**
Knee: Deep or Organ/Space Surgical Site Infections (NHSN) *# infections/ # Total Knee Cases x 100*	**0** 1.7%	**0** 0/17	**6.25** 1/16	**0** 0/4	**0** 0/12	**NHSN Benchmark: Risk stratefied. Rate range 0.58% (0 risk index) to 1.60 (higher risk index). Annual rate 2%.**
Overall Surgical Site Infections (SSI) *Total # SSI/Total # surgeries x 100*	**0.2% (3 SSIs)** 0.7%(12 SSIs)	0.2% 1/402	**0.5** 2/386	**0.53** 2/373	**0.23** 1/427	**<1% (SVH trended data). No NHSN benchmark for all surgeries. Annual rate <1%. 50% fewer SSIs in 2015.**
Class I SSI rate	0.2 % 0.8%	0/332	0.7 2/289	0		**4th quarter 0.3% (1/298) Benchmark 1.2-2.9 . Annual rate <1%**
Class II SSI rate	0 0	0 0/55	0 0/72	3.2 2/63	0/166	**Benchmark 2.4-7.7 3rd quarter revised. Annual <1%**
Total Joint SSI rate	**0** **0.8%**	**0 /33**	9.0% 2/22	0/27	0	**No NHSN benchmark for combined total joint cases. Annual rate 1.9%. Increase from 2014.**
Post discharge surveillance surgeon compliance	57% July-Dec	41% Jan-Feb	24%	84% July-Sept	100%	**2014 Surgery Committee approved post discharge surveillance plan with reporting by surgeons monthly, to promote accurate SSI reporting. Significant improvement in 2015.**

Infection Prevention HAI Report

Indicator	Comparison 2013 /2014 rates	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Benchmarks/Actions/Comments
National Healthcare Safety Network (NHSN) indicator data are a requirement of California Department of Public Health (CDPH) and Senate Bill 1058 mandated reporting Data are entered into the National Healthcare Safety Network (NHSN) system for public reporting by CDPH. Overall SSI rate includes all SSIs identified regardless of wound class. There is no NHSN benchmark. NHSN risk stratefies SSI rates by procedure therefore a range is provided. Green indicates no action, yellow indicates above benchmark, red indicates greater than the NHSN 90th percentile or internal benchmark. Action is recommended when rates exceed the 90th percentile. New Requirements in 2015: All MRSA and VRE bacteremia identified in Emergency Department, all SSIs acquired from Outpatient surgeries.						
Immediate Use Steam Sterilization *# of IUSS/total number of procedures*	**12%** 9.3%	**18%**	**16%**	**19.5**	**4%**	**Internal Benchmark 12%. CIHQ Mid-cycle survey recommendation: do not use IUSS as routine method for sterilization. 4th quarter new product intervention results in significant improvement.**
Ventilator Associated Event (VAE): Pneumonia *# Ventilator Associated Pneumonia/ # vent days x 1000*	**0** 0	**0** 0/46	**0** 0/79	**0** 0/19	**0** 0/26	**NHSN Benchmark: 1.1 per 1,000 ventilator days. No cases in 2015.**
Hospital Acquired Pneumonia (HAP) *# hospital acquired pneumonia/# patient days*	**0.2** 0.47	**0.9** 1/1072	**0.9** 1/1109	**1** 1/924	**1** 1/992	**5-15 cases per 1,000 admissions (3) (NOTE: Influenza-no HAI but 4 exposures/20 staff/MDs. Droplet Isolation required. Education staff x 2 in ED)**
Inpatient Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) (CMS Never Event) *# inpatient CAUTI/# catheter days x 1000*	**0.7** **0**	**0** 0/112	**2.4** 1/403	**0** **0/309**	**2.8** **1/351**	**NHSN Benchmark: 1.3 per 1,000 catheter days. CAUTI prevention education completed on acute units 3rd quarter. Revised P&P and EMR to include daily assessment for foley necessity. Annual rate 1.7**
SNF Hospital Acquired Catheter Associated Urinary Tract Infections (CA-UTI) *# SNF CAUTI/# catheter days x 1000*	**2.6** **3.3**	**13.8** 4/288	**0** 0/279	5.5 **2/358**	**0** 0/113	**NHSN Benchmark: 1.5 per 1,000 catheter days. Multiple patients with bacteriuria (>100,000 col. / ml) however zero met NHSN criteria for CAUTI. 3rd quarter rate revised. Annual rate 5.7. Increased from 2014. Education provided 2nd qtr.. P&P revised. Daily assessment for foley necessity in EMR.**
SNF Hospital Acquired *C. Difficile* Infections (CDI) *# SNF CDI/# patient days x 10,000*	**20.4** 11.7	**0** 0/1930	**0** 0/1782	**0** 0/1860	**5.3** 1/1858	**NHSN Benchmark: 7.4 per 10,000 patient days. Significant overall decrease in CDI rate in 2015. 1 case in Dec! Infection Control investigation. Annual rate 2.0.**
SNF Central line associated bloodstream infections (CLABSI) *# Central Line Associated Bloodstream Infections (CLABSI)/central line days x 1000*	**1** 0	0 0/184	0 0/115	0 0/107	0 0/179	**NHSN Benchmark: 0.8 per 1,000 central line days (SNF). No cases in 2015.**
Healing at Home Associated Infections *# of infections/Total visits x 1000*	**0.3** 0.6	**0** 0/3438	**0** 0/3131	**0** 0/ 2844	**0** 0/ 3844	**SVH Benchmark: 1.5 per 1,000 home care visits (SVH Trended Data). Cases representing >10% of the average daily census are randomly selected for review.**
MRSA Active Surveillance Cultures (nares cultures only) *# positives/total screened x 100*	**14%** 20%	**6%** 5/82	**10.6%** 7/66	**5.8%** 4/69	**2.7%** 2/75	**Patients have a nasal screen for MRSA in accordance with California law. They are notified and provided with patient education. MRSA is 26% of all S. A cultures this quarter. 6.1% annual rate and decreased from last two years.**
% ESBL(E. coli;K. pneumoniae, K. oxytoca,	2%	5%	3.10%	1.6%	4.4%	**ASP monitors antibiogram and updates annually. Rate ESBL slightly higher in 2015.**
# CRE	0	0	0	0	0	**No action required. Track and trend.**

References: 1.) Device-associated Module, AJIC2015; 43:206-221 2.) MMWR, Vital Signs: Preventing Clostridium difficile Infections, March 9, 2012/61 (09); 157-162 3.) 2.Klevens RM, Edwards JR, Richards CL Jr, et al. Estimating health care-associated infections and deaths in U.S. hospitals, 2002. Public Health Rep 2007; 122:160–166

Sonoma Valley Hospital
Infection Prevention Risk Assessment and 2016 Goals

BACKGROUND
As part of its commitment to quality care and service, Sonoma Valley Hospital, conducts a risk assessment for transmission and acquisition of infectious agents. This risk assessment incorporates an analysis of the following:

1. The geographic location and community environment of the organization, the programs and services provided, and the characteristics of the population served.
2. Analysis of surveillance activities and the results of the organization's infection prevention and control data.
3. Infection prevention standards recommended by Center for Improvement in Healthcare Quality (CIHQ), CDPH. Cal/OSHA, CDC and other regulatory bodies.
4. The patient care, treatment, and other services provided by SVH and the inherent risk therein.

SCOPE OF ASSESSMENT
This risk assessment is organization-wide in scope. It covers inpatient acute medical/surgical, emergency, intensive care, maternal/newborn and skilled nursing units, ancillary services, as well as ambulatory care settings, Cancer Support, outpatient care settings and Healing at Home.

PROCESS
The risk analysis is conducted at least annually and whenever there is a significant change in the scope or services. The assessment is facilitated by the Infection Preventionist and presented to the Performance Improvement Committee for review and approval.

Once risks are identified, the organization prioritizes those risks that are of epidemiological significance. Certain risks are automatically prioritized based on their nature, scope, and impact on the care, treatment, and services provided. These risks are outlined in this document as well.

Specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure establishment, surveillance and monitoring activities, education and training programs, environmental and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application, and/or duration depending on the specific risk issue, the care setting(s), and environment involved,

ASSESSMENT FINDINGS / MITIGATION STRATEGIES
The table below outlines the prioritized risks identified as the result of the assessment; provides a brief description of those risks, assigns a risk level (L=low, 1point., M=medium, 5 points., or H=high, 10 points) based on the care setting*, outlines – in summary form – actions that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of actions taken:

Care Settings Legend*
I = Inpatient services including medical surgical, critical care, maternal / child, surgery, and other care units
A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department
O = Outpatient services including rehabilitation clinics and other services
H = Home Health
L = Skilled Nursing Facility

Prioritized Risk Description	Care Setting*/ Risk Designation (See legend)					Summary of Risk Mitigation Strategies	Goals/How the Effectiveness of the Strategies is Evaluated
	I	A	O	H	L		
Transmission of infection associated with non-compliance with CDC guidelines and CIHQ recommendations for hand hygiene (HH). 50 points	H	H	H	H	H	Information given to patients on admission on the importance of HH. HH education included in hospital and nursing orientation and annual Healthstream education. HH compliance rounds conducted by Infection Preventionist and department champions to obtain hospital-wide compliance data.	Goal is >90% compliance Assess compliance rate and report to PI committee, department managers and staff during hospital orientation.
Unprotected exposure to pathogens throughout the organization through potential non-compliance with standard precautions, empiric precautions, transmission-based precautions or other infection prevention measures e.g., breach in aseptic technique in Surgery, vaccination non-compliance (influenza, Tdap). 35 points	M	H	M	M	H	Staff confirm immunity status at time of hire (MMR, varicella, hepatitis B). TB testing annually. Infection Prevention training provided during orientation and annually through Healthstream. Inservice education to physician and nursing staff prior to influenza season to prevent exposures. Post appropriate posters during influenza season. Promote respiratory hygiene and cough etiquette in waiting areas and lobby. Patient education given on admission on 'covering your cough'. Monitor isolation practices for appropriate placement, precautions and adherence to policies.	Goal: 1.90% Influenza immunization compliance by staff and physicians. 2. Zero cases of HAI influenza. 3.Influenza immunization compliance is reported to CDPH and the aforementioned committees. 4. 100% compliance with masks for epidural placement. Hospital-acquired infections are reported to Medicine, Surgery, Quality Board, P&T as needed and PI committee. Communicable disease exposures and clusters of infection are investigated, tracked and reported to PI Committee and other committees as appropriate.

						Masks are worn by Anesthesia when performing epidurals. Investigate exposures and/or clusters of infections. Process in place for notification of patients placed in isolation.	
Potential for transmission of infection related to procedures, medical equipment, and medical devices related to appropriate storage, cleaning, disinfection, sterilization, reuse and/or disposal of supplies and equipment, as well as use of personal protective equipment. 35 points	H	H	M	NA	H	Central Sterile Processing monitors QA logs on autoclaves, immediate use sterilizer, temperature logs, and the endoscope processing equipment on a daily basis. Medical Imaging utilizes the Trophon disinfection system. Endoscopy equipment is reprocessed in accordance with manufacturer's recommendation EVS training on IC for proper daily, OR, and terminal room cleaning.	Goal: 1. Reduce 2015 rate of immediate use sterilization. 2. Confirm compliance with Endoscope reprocessing. Quarterly Immediate Use Sterilization report submitted to PI committee and Surgery Committee. Check for ongoing compliance with maintaining QA logs, appropriate cleaning, storage, disinfection, sterilization, reuse, and/or disposal of waste, supplies and equipment during Infection Prevention rounds.
Multi use vials (MUV) have the potential risk of contamination without proper handling 25 points	M	M	M	M	M	MUVs must be kept in the medication prep area rather than the pts room. MUVs are dated when opened and discarded by day 28.	Infection Prevention rounds to confirm that there is compliance with strategies by Nursing, Anesthesia, OR. Report to PI Committee.
Potential for infection in ambulatory care and outpatient settings due to potential prolonged wait times in common areas and potential exposure to infectious individuals. 21 points	NA	H	H	L	NA	Respiratory hygiene and cough etiquette signage posted in all inpatient, ambulatory care and outpatient waiting areas (including offsite radiology and outpatient	Goal: 100% of patient waiting areas have signage and supplies to promote cough etiquette. Monitor for evidence of exposures to infectious

						rehab services). Alcohol gel, face masks, and facial tissues available to patients in waiting areas and lobby. ED patients are screened for obvious signs of contagious disease and appropriate control measures are taken for those who may present a risk of transmission of infectious agents.	individuals and follow up as appropriate. Outpatient departments are responsible for reporting any noncompliance issues to infection preventionist for follow up as appropriate. Issues may be identified during Infection Prevention rounds as well.
Community-wide outbreaks of communicable diseases e.g., pandemic influenza, pertussis, that carry the potential of adversely impacting operations and service capabilities 50 points	H	H	H	H	H	The Infection Preventionist is an active member of the Infectious Disease Task Force facilitated by the Deputy Health Officer of Sonoma County on a bi-monthly basis. Health alerts are received from the Public Health Department. On email lists and CAHAN for notification of any potential emergencies. Remain in close communication with the communicable disease control nurses at the Sonoma County Public Health Department. Policies/Guidelines in place for outbreak management. Recommendations and guidelines set forth by the DPH for various diseases (e.g. Norovirus, Influenza, Pertussis, possible EVD) are available and	Goal: 1. Infection Preventionist attends 90% of ID Task Force meetings and shares health alerts and other pertinent information with appropriate staff. 2. Evaluate all infectious clusters or outbreaks in a timely manner. Assess compliance with public health guidelines and recommendations. Prepare an action plan to interrupt the cluster/outbreak. Tdap, Hepatitis B, Influenza, MMR, and Varicella vaccination required for employees in accordance with Cal/OSHA regulations and CDC recommendations. Staff Influenza vaccination rates monitored and reported to NHSN as required by Ca law. TB testing performed annually and as needed post exposure.

						followed during an outbreak.	
Potential for a bioterrorism (BT) event that would require specific responses from the organization to successfully meet the threat. 25 points	M	M	M	M	M	BT response plan and the plan to manage an influx of infectious patients are included in the Emergency Operations Plan for SVH. Maintain communication with CDPH for updates and alerts.	Goal: 1. IP attends 90% of Emergency Management Committee meetings and actively participates in emergency preparedness 2. Evaluate and update plans as necessary.
Acquisition and transmission of multi-drug resistant bacteria that carry the potential for healthcare associated MDRO infections among patients and staff. • MRSA 25 points	M	M	M	M	M	Contact precautions initiated for all patients currently infected or with a history of MRSA (not required for nares colonization). Patients are flagged in the system for identification and isolation on subsequent admissions. Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing. . Hospital Acquired MRSA cases are tracked and reported. Active surveillance cultures for MRSA obtained on designated "high risk" patients as required by SB 1058.	Goal: 1. Hospital Acquired MDRO cases are identified and reported quarterly to PI and appropriate medical staff committees. 2. 100% of HAI MRSA bacteremia cases are reported to CDPH including all cases identified in the ED in 2015. 3. Monitor for any clusters of MDRO infections associated with changes in isolation practices. 6. Pts colonized with MRSA are informed in accordance with SB 1058.
• VRE 25 points	M	M	M	M	M	Contact precautions initiated for all patient infected or colonized with VRE. Patients are flagged in the system for	Goal: 1. 100% of HAI VRE bacteremia cases are reported to CDPH including all cases identified in the ED. Hospital Acquired

						identification and isolation on subsequent admissions. Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing. This will need review and approval by PI Committee and other committees as appropriate. Hospital Acquired VRE cases are tracked and reported. VRE bacteremia that is detected in the ED as well as after admission is required reporting to NHSN in 2015.	MDRO cases are identified and reported quarterly to PI and appropriate medical staff committees.
• ESBL 25 points	M	M	M	M	M	Contact precautions initiated for all patients infected or colonized with ESBL. Patients are flagged in the system for identification and isolation on subsequent admissions. Develop a policy, consistent with CDC MDRO recommendations to discontinue isolation following appropriate testing. This will need review and approval by PI Committee and other committees as appropriate. ESBL cases are tracked and reported.	Goal: 1. Monitor for any clusters of MDRO infections associated with changes in isolation practices . 2. Assess the cost savings realized by decreasing use of isolation supplies in 2015. ESBL rates are reported quarterly to PI and appropriate medical staff committees.
• CDI	M	M	M	M	H	Contact/Enteric precautions initiated for	Goal: 7.4 CDI per 10,000 patient days.

25 points						all patient with diarrhea until cause is determined to be noninfectious, or pt. completes treatment for CDI and symptoms subside. Environmental disinfection of the isolation room utilizing bleach. Use of handwashing rather than alcohol-based hand sanitizer. Daily antibiotic rounds by Dietary, live culture yogurt/probiotics administered until 48 hours after antibiotics are discontinued and recommend DC PPI for patients on antibiotics. Encourage patient education for patients prescribed antibiotics in the Emergency Department. Review of cases of concern in ASP weekly with MDs. Hospital Acquired CDI cases are tracked, trended, and reported.	The ASP program includes weekly review of pts on antibiotics, annual antibiogram and preoperative antibiotic recommendations to promote antimicrobial stewardship and CDI prevention. Hospital Acquired CDI cases are identified and reported quarterly to PI and appropriate medical staff committees. CDI cases are reported to CDPH including cases identified in ED (new 2015).
• Infection Prevention policies and procedures reflect current CIHQ standards. 25 points	M	M	M	M	M	Allocate adequate time to review and revise IP policies and procedures by 2016.	Goal: Review and revise IP policies and procedures as required. Introduce new policies and procedures as indicated by IP literature, changes in the law or community standard.
Potential for the following based on the results of surveillance and other data, review of the literature, patient population, and scope of services provided.							
• Central line associated bloodstream infections	M	M	L	M	M	Central line bundle in place, including	Goal: Review 100% of CLIP forms and follow

(CLABSI) 21 points						Biopatch. CLIP monitoring for ICU central line insertions and reported to NHSN. Daily review of line necessity and line removal asap.	with clinician whenever CLIP is not performed correctly. Goal: CLABSI rates at or below NHSN benchmarks. CLABSI rates are reported quarterly to PI committee and appropriate medical staff committees.
• Ventilator Associated Event (VAE) 9 points	M	L	L	L	L	VAP bundle in place in ICU in collaboration with RT.	Goal: VAE are below NHSN benchmark. Reported quarterly to PI committee and appropriate medical staff committees.
• Catheter associated UTI (CAUTI) 21 points	M	M	L	M	M	Daily review of catheter necessity to remove asap based on criteria. Include criteria in EMR. Vitamin C given to appropriate patients to reduce risk of UTI.	Goal: Reduce CAUTI rates to NHSN benchmarks. Reported quarterly to PI committee and appropriate medical staff committees.
• Surgical Site Infections (SSI) 21 points	M	M	L	M	M	SCIP bundle measures in place Elevated SSI rates (by procedure group) are investigated and action plans developed to reduce rates to baseline. CHG protocol in place for elective total joint patients. Consider change to CHG wipes. SSI outcomes (HAI report) are shared with OR staff.	Goal: 1. Overall SSI rate <1% in 2016. 2. 80% SSI report compliance by surgeons . 3. SSI rates by procedure do not exceed the NHSN benchmarks. Report SSI rates quarterly to Surgery Committee and PI committee.
Potential for transmission of infection related to noncompliance with hospital sanitation measures. 21 points	M	M	M	L	M	Quarterly meetings conducted with the EVS manager, the Nutritional services manager, and the Chief engineer and inservices provided on a prn basis to ensure maintenance of a sanitary environment. Infection control training	Track patient satisfaction survey feedback on cleanliness of the hospital. EVS provides cleanliness data to IP on a quarterly basis (TBD). Isolation carts are disinfected and

						of EVS staff on hire and annually thereafter to educate on maintenance of a sanitary environment. Policy on Cleaning of patient care equipment in place for a clear delineation of responsibility for cleaning specific areas of the hospital and equipment.	restocked following discharge of patient's on isolation. Medication preparation is performed >3 feet from a sink or a splash guard is installed. (CIHQ)
Infection Prevention and Control involvement in construction activities 15 points	M	M	N A	N A	M	Infection Control Risk Assessment completed for all construction activities. Construction workers educated on IC practices via an APIC video during safety orientation.	Goal: 100% compliance with Infection Control Risk Assessment (ICRA) and compliance checklist completed before initiating any construction projects. Documentation kept in Engineering.

Legend*
I = Inpatient services including medical surgical, critical care, maternal / child, and surgery
A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department
O = Outpatient services such as primary and specialty care clinics, wellness centers, infusion centers, rehabilitation clinics, and other services
H = Home health
L = skilled nursing
* For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, clinical laboratory, and all other departments and services of the organization.
Risk Designation – Enter the Level of Assessed Risk for Each Care Setting:
L = Low risk (1 point)
M = Medium Risk (5 points)
H = High Risk (10 points)

REFERENCEs: CIHQ Standards, CDC guidelines, AORN.