# Quality Assessment & Oversight Committee Meeting

*Jul 24, 2019 5:30 PM EDT*

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NOTICE OF MEETING

A Quality Assessment and Oversight Committee meeting will be held on Wednesday, July 24th, 2019, immediately following the Human Resource Committee meeting, at the Broward Health Corporate Spectrum Location: 1700 Northwest 49 Street, Fort Lauderdale, Florida, 33309. The purpose of this committee meeting is to review and consider any matters within the committee’s jurisdiction.

Persons with disabilities requiring special accommodations in order to participate should contact the District by calling 954-473-7100 at least 48 hours in advance of the meeting to request such accommodations.

Any person who decides to appeal any decision of the District’s Board with respect to any matter considered at these meetings will need a record of the proceedings, and for such purpose, may need to ensure that a verbatim record of the proceedings is made which record includes testimony and evidence upon which the appeal is to be based.
CALL TO ORDER 5:32 pm

COMMITTEE MEMBERS

✔ Commissioner Nancy W. Gregoire/Chair
✔ Commissioner Ray T. Berry
✔ Commissioner Stacy L. Angier

PRESENT Commissioner Andrew M. Klein, Commissioner Christopher T. Ure, Commissioner Marie C. Waugh, Gino Santorio/President/CEO, Alan Goldsmith/Acting CAO, Alex Fernandez/CFO, Marian Wossum/Interim General Counsel Designee, Jerry Del Amo/Managing Senior Associate, Nigel Crooks/Chief Internal Auditor

PUBLIC COMMENTS None

APPROVAL OF MINUTES

1. Approval of Quality Assessment and Oversight Committee meeting minutes, dated November 26, 2018

MOTION It was moved by Commissioner Berry, seconded by Commissioner Angier, to:

APPROVE THE QUALITY ASSESSMENT AND OVERSIGHT COMMITTEE MEETING MINUTES, DATED NOVEMBER 26, 2018.

Motion carried unanimously.

TOPIC OF DISCUSSION

Note: Mr. Barry Gallison informed the Committee that tabs two through thirteen (2-13) in the packet were quarterly reports on the QAOC Consent Agenda. Being there were no questions, Mr. Gallison stated he would move on to present items fourteen through seventeen (14-17), starting with the Infection Control Update.

Quarterly Reports: Data Q4 CY2018 (tabs 1-12)

2. Population Health
3. Ambulatory
4. Antimicrobial Stewardship
5. Medicare Readmission & Performance Improvement
6. Medicare Mortalities
7. Environment of Care
8. Sepsis Prevention by Region & Sepsis Performance Improvement
9. Infection Prevention
10. Hospital Acquired Pressure Injury
11. Grievances
12. Risk Management Quarterly Reports
13. HCAHPS (Patient Satisfaction)
Before Mr. Gallison continued with his report, he introduced the quality managers and infection control practitioners from each region. The staff stood to greet the committee as their names and titles were called out.

**Quality and Safety Agenda**

14. Infection Control System Update
   Barry Gallison reported

15. Value Based Purchasing Update
   Lee Ghezzi reported

   Barry Gallison reported

17. Gold Coast Home Health & Hospice
   Debora Shockley reported

**ADJOURNMENT** 6:11 pm

**MOTION** It was *moved* by Commissioner Angier, *seconded* by Commissioner Berry, to:

ADJOURN THE QUALITY ASSESSMENT AND OVERSIGHT COMMITTEE MEETING.

Motion *carried* unanimously.

Respectfully submitted,
Commissioner Ray T. Berry
Secretary / Treasurer
HUMANA – 2018 4TH QUARTER RESULTS

Finalized 2018 scores to be released June 2019

<table>
<thead>
<tr>
<th>Measures Title 2018</th>
<th>Benchmark</th>
<th>2018 Q 1</th>
<th>2018 Q 2</th>
<th>2018 Q 3</th>
<th>2018 Q 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>86%</td>
<td>68.89%</td>
<td>78.64%</td>
<td>81.58%</td>
<td>81.19%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>84%</td>
<td>58.55%</td>
<td>62.33%</td>
<td>77.09%</td>
<td>73.30%</td>
</tr>
<tr>
<td>Adult Body Mass Index (BMI) Assessment</td>
<td>96%</td>
<td>91.07%</td>
<td>93.91%</td>
<td>93.63%</td>
<td>98.42%</td>
</tr>
<tr>
<td>Diabetes Care - Blood Sugar Controlled</td>
<td>86%</td>
<td>35.71%</td>
<td>83.33%</td>
<td>92.31%</td>
<td>82.35%</td>
</tr>
<tr>
<td>Diabetes Care - Monitoring Diabetic Nephropathy</td>
<td>99%</td>
<td>71.43%</td>
<td>88.89%</td>
<td>98.08%</td>
<td>96.08%</td>
</tr>
<tr>
<td>Diabetic Eye Exam</td>
<td>83%</td>
<td>47.62%</td>
<td>57.41%</td>
<td>73.08%</td>
<td>72.55%</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>80%</td>
<td>71.69%</td>
<td>91.33%</td>
<td>87.90%</td>
<td>96.25%</td>
</tr>
</tbody>
</table>
HUMANA – 2018 4TH QUARTER RESULTS

HEDIS 2018

- Breast Cancer Screening
- Colorectal Cancer Screening
- Adult Body Mass Index (BMI) Assessment
- Diabetes Care - Blood Sugar Controlled
- Diabetes Care - Monitoring Diabetic Nephropathy
- Diabetic Eye Exam
- Depression Screening

Legend:
- Benchmark
- 2018 Quarter 1
- 2018 Quarter 2
- 2018 Quarter 3
- 2018 Quarter 4
AVMED MEDICARE QUALITY OUTCOMES

Avmed Hedis 2018

<table>
<thead>
<tr>
<th>Measures Title</th>
<th>Benchmark</th>
<th>Prior-end 2017</th>
<th>Q1 2018</th>
<th>Q2 2018</th>
<th>Q3 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>82%</td>
<td>67.90%</td>
<td>75.30%</td>
<td>73.00%</td>
<td>72.10%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>65%</td>
<td>61.40%</td>
<td>58.90%</td>
<td>58.60%</td>
<td>56.00%</td>
</tr>
<tr>
<td>Use of High Risk Medications in Elderly</td>
<td>7.50%</td>
<td>4.00%</td>
<td>3.80%</td>
<td>3.50%</td>
<td>2.80%</td>
</tr>
<tr>
<td>Use of RAS Antagonist in Hypertensive Diabetic Members</td>
<td>88.50%</td>
<td>81.40%</td>
<td>82.70%</td>
<td>88.80%</td>
<td>86.50%</td>
</tr>
<tr>
<td>Adult Body Mass Index (BMI) Assessment</td>
<td>74%</td>
<td>32.80%</td>
<td>37.40%</td>
<td>39.70%</td>
<td>40.70%</td>
</tr>
<tr>
<td>Diabetes HbA1c Less Than 8 Percent</td>
<td>88%</td>
<td>74.50%</td>
<td>65.60%</td>
<td>69.60%</td>
<td>71.10%</td>
</tr>
<tr>
<td>Diabetes Microalbumin Test for Nephropathy</td>
<td>90%</td>
<td>94.70%</td>
<td>93.30%</td>
<td>94.60%</td>
<td>87.80%</td>
</tr>
</tbody>
</table>

- Reports from payers are 90 days or more delayed before data is posted.
- The current collected data shows slight variation.
- Use of high risk medications in the elderly consistently maintained below benchmark.
AVMED UTILIZATION

• Annual Exam noted to be a deficiency as members engage the practices on sick visits. Updated membership distributed in January to assure members engaged for annual care visits.
• Coding for E&M (Evaluation and Management) with Himagine company for some Primary care offices at Broward Health Physician Group (phased approach)
• HRA’s: as of last data from Avmed 96.3%. Actual end of year submission 181 out of 184 HRA’s.
• ER visits dropping as members engaged back into office setting or urgent care as appropriate based on symptomology
• Noted just below benchmark for generic dispensing rate

<table>
<thead>
<tr>
<th>MEASURES TITLE</th>
<th>BENCHMARK</th>
<th>Prior</th>
<th>Q1 2018</th>
<th>Q2 2018</th>
<th>Q3 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Exam</td>
<td>90%</td>
<td>13.80%</td>
<td>15.30%</td>
<td>18.30%</td>
<td>21.30%</td>
</tr>
<tr>
<td>HRA</td>
<td>90%</td>
<td>97%</td>
<td>68.20%</td>
<td>77.70%</td>
<td>96.3</td>
</tr>
<tr>
<td>HOSPITAL ADMITS PER 1,000 - less than 276</td>
<td>276</td>
<td>263.6</td>
<td>263.4</td>
<td>252.3</td>
<td>235.9</td>
</tr>
<tr>
<td>ER VISITS PER 1,000 - less than 225</td>
<td>225</td>
<td>344.8</td>
<td>358.2</td>
<td>349.5</td>
<td>322.6</td>
</tr>
<tr>
<td>GENERIC DISPENSING RATE</td>
<td>85.00%</td>
<td>85.13%</td>
<td>84.94%</td>
<td>84.90%</td>
<td>85.11</td>
</tr>
</tbody>
</table>
MY BLUE - QUALITY OUTCOMES

- Increased focus on care of diabetics. Category 11 coding will assist with closure of gaps via claims process.
- Re-education to provider and mid levels in practices
MY BLUE - QUALITY OUTCOMES - UTILIZATION

Utilization is split.......CHS and BHPG as of 3/31/2018

<table>
<thead>
<tr>
<th></th>
<th>BHPG Benchmark</th>
<th>3/31/2018</th>
<th>6/30/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Utilization - visits per 1000</td>
<td>344.00%</td>
<td>335%</td>
<td>318%</td>
</tr>
<tr>
<td>IP Utilization - visits per 1000</td>
<td>60.40%</td>
<td>68%</td>
<td>61%</td>
</tr>
<tr>
<td>New patients seen w/90 dys</td>
<td>50%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>Existing patients seen</td>
<td>75%</td>
<td>63%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>CHS Benchmark</th>
<th>3/31/2018</th>
<th>6/30/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Utilization - visits per 1000</td>
<td>346.00%</td>
<td>429%</td>
<td>435%</td>
</tr>
<tr>
<td>IP Utilization - visits per 1000</td>
<td>77.00%</td>
<td>76%</td>
<td>61%</td>
</tr>
<tr>
<td>New patients seen w/90 dys</td>
<td>50%</td>
<td>39%</td>
<td>47%</td>
</tr>
<tr>
<td>Existing patients seen</td>
<td>75%</td>
<td>62%</td>
<td></td>
</tr>
</tbody>
</table>

- Increasing education to patients on ED utilization. Flexibility being offered by offices for appointments for transition of care and new patients.
- As of June reports received 10/31/2018 IP utilization decreased to 61 for both parties. Insufficient data for new versus existing patients.
• Further education to providers on use of Category 11 codes. This assists to communicate closure of gaps on claims.
• Strategic Planning in process to use Care Coordination personnel across the spectrum of ambulatory.
Quality Team continues to work closely with CCP representative to turn in any supplemental data for this Medicaid population. Pending final 2018 scores June 2019
COMMUNITY CARE PLAN (CCP)

Quality Team continues to work closely with CCP representative to turn in any supplemental data for this Medicaid population. Pending final 2018 scores June 2019

Members have been noted to consistently refuse preventative care.
ACTION PLAN

- Continued ancillary coding through provider education. Primary Care HEDIS education provided to Internal Medicine/Family Practice March 2018 followed by education on value based purchasing education on October 31st 2018.
- Standard of Practice review for workflow of reviewing clinical reports outside date of service
- Restructure of Ambulatory Quality Department to support the cohesiveness and standardization of the ambulatory practices (BHPG/CHS/UC)
- Reconstruct care coordination and ambulatory quality teams to support a Patient Centered Medical Home Model.
- Offices templates restructured for Primary Care to provide access for post E.R and Inpatient hospitalizations (Transition of Care)
- Continue strategy meetings with payers.
- Continue working with payers to provide more meaningful reports to support care and gap closure.
- Tips and tricks quality corner correspondence to providers and coordinators of Primary Care Practices under development. Example: Difference between Annual Well Visit and Physical
- Strategize with quality representatives from payer organizations to set up educational sessions for coordinators at practices.
PATIENT CENTERED MEDICAL HOME MODEL

Patient:
Patient Medical Home (PCP)
- ARNP
- RN
- MA
- POS
- Social Workers

- Medical Specialties
- Ancillary Care (Imaging, Lab, Testing)
- Inpatient
- Behavioral Health
- Telemedicine
- Pharmacy
- Skilled Nursing
- Home Health, Hospice
- Emergency Care, Urgent Care
- Patient Navigation
- Surgical Care
- Community Services (Bus, etc.)

BROWARD HEALTH
BROWARD HEALTH
GOLD COAST HOME HEALTH

IMPROVEMENT IN AMBULATION
DRUG EDUCATION
RE-HOSPITALIZATION
HHCAHPS

JUNE 2019
Improvement in Ambulation/Locomotion

CMS Target 73.1%  CY 2019 YTD

1st quarter data not yet available from McKesson/Netsmart EMR.

Action Plan:
- Analysis of all negative outcome indicators
- Education of qualifying clinicians
- OASIS scoring accuracy
- OASIS Walk
- Monitor Care Coordination
Drug Education on All Medications
During All Episodes of Care

CMS Target 97.9%  CY 2019 YTD

1st quarter data not yet available from McKesson/Netsmart EMR.

Action Plan
• Analysis for all negative outcome reports
• Education of qualifying clinicians in OASIS data:
• QI Developed & implemented visit guideline tool – initial visit
• QI Developed discharge audit tool - OASIS
GOLD COAST HOME HEALTH

Re-hospitalizations

CMS Target 15.9%  

<table>
<thead>
<tr>
<th>Preventing Unplanned Hospital Care</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Risk Adjusted Hospitalizations</td>
<td></td>
<td></td>
<td>21.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Action Plan:
- Re-admission Prevention Program
- Analysis performed for all re-admissions
- Patient Hi-Risk Stratification developed & implemented
- Assess for additional programs: Tele-Monitoring & Palliative Care
- Exchange of re-admission information within Broward Health System
- Weekly review with staff at Clinical Staff Meeting
- Explore & develop provider home visits in disease management/chronic care
GOLD COAST HOME HEALTH

HHCAHPS - Patients who gave Agency rating of 9 or 10

CMS Rolling Target - 83%  

|-------------|------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|---------|
| HHCAHPS % of patients who gave their HH agency a rating of 9 or 10 | CMS Target Rolling 83% | 87.5 | 100 | 100 | | | | | 96 |}

Action Plan:
- Initiating Leadership follow-up calls to patients
- All staff educated in AIDET
- QI developed & implemented visit guidelines
- Implemented follow up phone calls after Admission to Home Health
- Patients encouraged to complete surveys of their home care experience
- Follow-up calls initiated during episode of care
HOSPICE OF GOLD COAST

CMS HIS – Hospice Information Set
CMS Group National Average  97.1%

<table>
<thead>
<tr>
<th>Hospice-Level Quality Measures</th>
<th>HIS</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Group National Average (3.1.2018 – 2.28.2019)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beliefs / Values</td>
<td>97.1%</td>
<td>99.2</td>
<td>99.2</td>
<td>99.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

CY 2019 YTD 99.2%
HOSPICE OF GOLD COAST

CMS HIS – Hospice Information Set
(Home Hospice Patients only)
CMS Group National Average 82.21%
CY 2019 YTD 86.6%

<table>
<thead>
<tr>
<th>Hospice-Level Quality Measures</th>
<th>HIS</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Hospice Visits when Death is Imminent - Measure 1</td>
<td>82.2%</td>
<td>86.4</td>
<td>86.4</td>
<td>87</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>86.6</td>
</tr>
</tbody>
</table>

**Action Plan**

- Hire ARNP / provider for home hospice visits
**HOSPICE OF GOLD COAST**

**HSCAHPS Target 85%**

CY 2019  YTD 83%

<table>
<thead>
<tr>
<th><em>HSCAHPS</em></th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
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<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend Hospice</td>
<td>85%</td>
<td>100</td>
<td>100</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>83</td>
</tr>
</tbody>
</table>

**Action Plan:**

- HSCAHPS education provided to Hospice staff
- Patient’s families/primary caregivers encouraged to complete survey of Hospice experience.
BH ASP UPDATE

• ASP Interventions

<table>
<thead>
<tr>
<th></th>
<th>July 2018</th>
<th>October 2018</th>
<th>February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimize therapy</td>
<td>49</td>
<td>68</td>
<td>111</td>
</tr>
<tr>
<td>Renal dosing adjustment</td>
<td>120</td>
<td>168</td>
<td>462</td>
</tr>
<tr>
<td>Bug-Drug mismatch</td>
<td>3</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>IV to PO conversion</td>
<td>5</td>
<td>28</td>
<td>38</td>
</tr>
<tr>
<td>Therapeutic duplication</td>
<td>7</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>Unnecessary order</td>
<td>0</td>
<td>7</td>
<td>25</td>
</tr>
</tbody>
</table>

• ASP policies & procedures updates
  – Antimicrobial renal dosing policy currently under revision
  – Anti-biogram enhancement (addition of breakpoint MICs and inclusion of Stenotrephomonas data)

• Additions to Formulary: Zerbaxa and Biktarvy
BH ASP UPDATE

• ASP Steering Committee – March/June meeting
  – Approved ASP Initiatives
    • Extended infusion of piperacillin-tazobactam and meropenem pilot program in the ICU
      – Annual Cost Savings: $20,876
      – Mortality benefit
    • Beta lactam continuous infusion pilot program in the ICU
    • Duration and indication requirement for all antifungal and antiviral orders
    • Daptomycin restricted prescribing criteria for utilization & daptomycin subphase
    • Linezolid/Meropenem restricted prescribing criteria for utilization – pending IT implementation
Medicare Readmissions

Medicare Average:

BHMC worse than National Average for COPD

No difference from National Average for other hospitals and diagnoses: HF, COPD, PN, AMI, TH/TK or CABG

Readmissions 07/01/2014 – 06/30/2017
Readmission Rates – All Payer (Crimson)
BHMC
National LCY Jan-18 Feb-18 Mar-18
HF
21.6% 17.2% 31.2% 27.6% 21.3%
COPD
19.8% 17.2% 8.7%
5.9% 10.3%
Pneumonia 16.9% 10.4% 10.7% 10.6% 9.3%
AMI
16.3% 10.2% 12.0% 2.5% 15.2%
Hip/Knee
4.4%
3.1% 7.7%
2.6%
2.3%
CABG
13.8% 6.7% 12.5% 10.0% 13.8%

Apr-18
25.0%
25.0%
11.1%
9.1%
0.0%
25.0%

May-18
20.4%
16.7%
5.4%
9.5%
2.7%
15.0%

Jun-18
20.8%
19.1%
15.2%
19.2%
8.8%
30.8%

Jul-18 Aug-18 Sep-18
26.1% 28.3% 28.0%
13.6% 17.7% 18.2%
4.9%
9.4% 10.0%
5.7%
6.3%
3.3%
3.2%
2.7%
2.5%
4.6%
8.7%
0.0%

Oct-18 Nov-18 Dec-18
19.6% 31.7% 10.6%
4.6% 23.5% 12.5%
14.9% 7.5% 13.8%
3.6% 14.3% 3.6%
0.0%
0.0%
3.9%
17.4% 0.0%
7.1%

2018
24.6%
14.2%
10.4%
9.8%
3.0%
11.8%

2018 n
153
43
55
42
13
27

BHN
National LCY Jan-18 Feb-18 Mar-18
HF
21.6% 24.8% 41.2% 7.7% 22.5%
COPD
19.8% 19.2% 16.3% 28.6% 18.9%
Pneumonia 16.9% 11.9% 8.5% 17.7% 14.0%
AMI
16.3% 8.5% 27.8% 10.0% 0.0%
Hip/Knee
4.4%
1.6% 1.6%
3.1%
0.0%

Apr-18
34.3%
11.5%
14.6%
7.4%
1.6%

May-18
23.5%
33.3%
11.6%
16.7%
0.0%

Jun-18
13.8%
18.8%
21.2%
11.1%
3.5%

Jul-18 Aug-18 Sep-18
29.6% 17.2% 34.2%
24.1% 16.7% 40.0%
15.4% 15.9% 22.2%
22.2% 12.5% 6.3%
0.0%
2.9%
0.0%

Oct-18 Nov-18 Dec-18
37.1% 15.9% 38.9%
20.0% 35.5% 26.9%
10.7% 34.5% 6.4%
13.0% 8.3% 13.0%
3.0%
0.0%
6.8%

2018
27.3%
23.3%
13.4%
13.2%
1.8%

2018 n
110
75
70
23
14

BHIP
HF
21.6% 21.2% 22.2% 7.1% 33.3% 8.3% 20.0% 0.0%
COPD
19.8% 22.5% 38.9% 23.8% 9.1%
0.0%
6.7% 14.3%
Pneumonia 16.9% 13.2% 22.2% 12.1% 13.0% 16.7% 0.0%
6.2%
AMI
16.3% 18.2% 0.0% 100.0% 0.0%
0.0%
0.0%
0.0%
Hip/Knee
4.4%
2.1% 17.7% 11.1% 0.0%
7.1%
0.0%
0.0%

7.1% 11.8% 0.0% 11.1% 25.0% 10.0%
30.8% 29.4% 9.5%
7.7% 14.3% 33.3%
20.0% 10.7% 19.0% 20.0% 17.7% 30.8%
0.0%
0.0%
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0.0%
0.0%
0.0%
0.0%
0.0%
6.7%
0.0%
0.0%
0.0%

2018
12.8%
17.5%
15.6%
10.0%
4.7%

2018 n
18
35
38
1
10

BHCS
National LCY Jan-18 Feb-18 Mar-18 Apr-18 May-18
HF
21.6% 21.5% 20.8% 26.7% 13.3% 5.9% 26.4%
COPD
19.8% 20.2% 10.0% 34.8% 26.1% 50.0% 33.3%
Pneumonia 16.9% 7.5% 8.6%
8.1%
4.6%
5.7%
7.9%
AMI
16.3% 31.3% 50.0% 0.0%
0.0% 100.0% 0.0%
Hip/Knee
4.4%
7.5% 14.3% 16.7% 0.0%
0.0% 33.3%

25.0% 18.2% 18.2% 8.3% 20.0% 26.1%
27.3% 14.3% 23.1% 5.0%
6.7%
4.0%
17.5% 14.3% 5.4%
8.1% 15.2% 2.6%
0.0%
0.0%
0.0%
0.0%
0.0%
0.0%
0.0% 25.0% 11.1% 0.0% 10.0% 33.3%

2018
19.9%
20.1%
8.3%
22.2%
10.6%

2018 n
41
45
41
2
7

Jun-18
25.0%
10.5%
3.0%
0.0%
25.0%

30


# Readmission Rates – Medicare (Crimson)

## BHMC

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<tbody>
<tr>
<td>HF</td>
<td>21.6%</td>
<td>11.4%</td>
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<td>25.0%</td>
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<td>23.1%</td>
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<td>16.9%</td>
<td>12.2%</td>
<td>6.3%</td>
<td>18.2%</td>
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<td>16.7%</td>
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<tr>
<td>AMI</td>
<td>16.3%</td>
<td>3.5%</td>
<td>23.1%</td>
<td>0.0%</td>
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<tr>
<td>Hip/Knee</td>
<td>4.4%</td>
<td>2.7%</td>
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## BHN

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<td>21.4%</td>
<td>36.4%</td>
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## BHIP

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## BHCS

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<tr>
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<td>19.8%</td>
<td>22.0%</td>
<td>33.3%</td>
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<td>83.3%</td>
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<td>Hip/Knee</td>
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North Broward Hospital District
AMI Medicare Mortalities 1st Q 2019
Hospital Compare CMS benchmark 13.6%

- BHMC: 2/29
- BHN: 0/11
- BHIP: NA
- BHCS: 0/0
North Broward Hospital District
HF Medicare Mortalities 1st Q 2019

Hospital Compare CMS benchmark 12.0%

BHMC

BHN

BHCS

BHIP
North Broward Hospital District
COPD Medicare Mortalities 1st Q 2019

Hospital Compare CMS benchmark 8.1%

BHMC: 
Mortality Rate (Excluding Hospice) - System-All Physicians

BHNC: 
Mortality Rate (Excluding Hospice) - System-All Physicians

BHLP: 
Mortality Rate (Excluding Hospice) - System-All Physicians

BHCS: 
Mortality Rate (Excluding Hospice) - System-All Physicians
North Broward Hospital District
PN Medicare Mortarities 1st Q 2019

Hospital Compare CMS benchmark 16.0%
North Broward Hospital District
CABG Medicare Mortalities 1st Q 2019
Hospital Compare CMS benchmark 3.3%
Jointly and regionally, Broward Health continues to experience OSHA Recordable Injury rate that exceed the targeted threshold of 6.01; additionally, during Q1, 2019 Broward Health experienced a 0.15 rate increase in the performance of the OSHA Recordable Injury monitor. steady downward trend in its OSHA Recordable Injury Rate.

Directly related to the increase in the OSHA Recordable Injury Rate is the number of exposures that were reported to Worker Comp. During Q1CY’19, The worker’s comp department received reports of 100 employees expose to patients with highly communicable illnesses.

Additional Analysis showed that of the total reports received by worker’s comp, only 10% came into contact with the patients; Broward Health policy requires any employee within the vicinity of the ill patient to report to worker comp for monitoring.
BHN Variance Location
Jan thru March 2019

IP, 11, 38%

ED, 18, 62%
BHCS SEPSIS ANALYSIS

Fallouts by Bundle Jan 2019- Mar 2019
- Severe Sepsis 6 hr Bundle 32%
- Severe Sepsis, 3 hr Bundle 57%
- Septic Shock 11%

Fallouts All Causes Jan 2019- Mar 2019
- No Initial LA: 3
- Delayed Initial LA: 0
- Delayed ABX: 1
- ABX not administered: 5
- No BC: 1
- BC after ABX: 1
- Vasopressor not administered: 2
- Missed VS: 0
- No Repeat LA: 0
- Delayed Repeat LA: 0
- Incorrect Fluid: 0
- No reassessment: 8
- Reassessment: 3

Severe Sepsis 3 hr Bundle Failouts Jan 2019- Mar 2019
- No Initial LA: 6%
- Delayed Initial LA: 20%
- Delayed ABX: 6%
- Incorrect ABX: 0%
- Vasopressor not administered: 0%
- Missed VS: 0%
- No Repeat LA: 31%
- Delayed Repeat LA: 6%
- Incorrect Fluid: 6%
- No BC: 0%

Severe Sepsis 6 hr Bundle Failouts Jan 2019- Mar 2019
- No Initial LA: 20%
- Delayed Initial LA: 0%
- Delayed ABX: 0%
- ABX not administered: 0%
- No BC: 0%
- BC after ABX: 80%
- Vasopressor not administered: 0%
- Missed VS: 0%
- No Repeat LA: 0%
- Delayed Repeat LA: 0%
- Incorrect Fluid: 0%
- No BC: 0%

Septic Shock 6 hr Assessment Jan 2019- Mar 2019
- No reassessment: 0%
- Reassessment: 100%
BHCS VARIANCE LOCATION
JAN THRU MARCH 2019

ED - 48%
IP - 52%
BHIP Q1 FALLOUT ANALYSIS SEPSIS

SEPSIS - 3 HOUR BUNDLE
- Blood Culture after Antibiotics ≤ 1 34%
- No Antibiotics Ordered 1 33%
- No Blood Culture 1 33%

SEPSIS - 6 HOUR BUNDLE
- Vasopressor Administration, 1 13%
- No Repeat Lactated 3 37%
- Wrong Fluid Amount, 4 50%

FALLOUTS BY BUNDLE - Q1 2019
- 6 HR Total Fallouts 8 73%
- Total Shock Fallouts 0 0%
- 3 HR Total Fallouts 3 27%
BHIP Variance Location
January 2019-March 2019

ED
6
55%

IP
5
45%
Comparative Report: Quality Performer-Wide for Proportion Measures
Facility: 11366
Interval of Analysis: Quarter
Discharge Dates: 01/01/2016 to 03/31/2019
Measure: SEP-1
Measure Description: Sepsis

Facility #11366  SEP-1: Sepsis

- Facility Rate
- 95th Percentile
- 90th Percentile
- 75th Percentile
- 50th Percentile
- 25th Percentile

Time Period:
- Q1 2016
- Q2 2016
- Q3 2016
- Q4 2016
- Q1 2017
- Q2 2017
- Q3 2017
- Q4 2017
- Q1 2018
- Q2 2018
- Q3 2018
- Q4 2018
- Q1 2019
BHMC

Fallouts by Bundle January 2019- March 2019

- Septic shock: 0%
- Severe Sepsis 3 hr Bundle: 14%
- Severe Sepsis 6 hr Bundle: 86%

Severe Sepsis 3 hrs. Bundle Fallouts

- No Initial LA: 36%
- Delayed Antibiotic: 27%
- Incorrect Antibiotic: 14%
- No Antibiotic administered: 9%
- Blood culture after Antibiotic: 9%
- Less fluid given: 5%

Severe Sepsis 6 hrs. Bundle Fallouts

- No Repeat lactic acid: 50%
- Vasopressor: 50%

Fallouts All Causes January 2019- March 2019

- No initial LA: 8
- Delayed Antibiotic: 2
- Incorrect Antibiotic: 1
- No Antibiotic: 2
- Blood culture after Antibiotic: 3
- Less fluid given: 2
- No repeat lactic: 6
- Late vasopressor: 2
INFECTION PREVENTION
NHSN – CLABSI ~ ALL REPORTING UNITS

BHCS NHSN - CLABSI
SIR ~ All Reporting Units
CY 2019

Threshold 0.784
Benchmark 0

BHIP NHSN - CLABSI
SIR ~ All Reporting Units
CY 2019

Threshold 0.784
Benchmark 0

BHN NHSN - CLABSI
SIR ~ All Reporting Units
CY 2019

Threshold 0.784
Benchmark 0

BHMC NHSN - CLABSI
SIR ~ All Reporting Units
CY 2019

Threshold 0.784
Benchmark 0
NHSN – CLABSI ~ PEDIATRIC

BHCS NHSN - CLABSI
SIR ~ Pediatric (incl. NICU, PICU, Peds)
CY 2019

BHMC NHSN - CLABSI
SIR ~ Pediatric (incl. NICU, PICU, Peds)
CY 2019
NHSN – CAUTI ~ ALL REPORTING UNITS

BHCS NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019
Threshold 0.828
Benchmark 0

BHN NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019
Threshold 0.828
Benchmark 0

BHIP NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019
Threshold 0.828
Benchmark 0

BHMC NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019
Threshold 0.828
Benchmark 0
NHSN – CAUTI ~ PEDIATRIC

**BHCS NHSN - CAUTI**
**SIR ~ Pediatric (incl. PICU, Peds)**
**CY 2019**

Threshold 0.828
Benchmarks 0

**BHMC NHSN - CAUTI**
**SIR ~ ALL Pediatric**
**CY 2019**

Threshold 0.828
Benchmarks 0
HOSPITAL-ONSET MRSA BACTEREMIA

BHCS Hospital-Onset MRSA Bacteremia
SIR ~ CY 2019

*Qtrly SIR

BHN Hospital-Onset MRSA Bacteremia
SIR ~ CY 2019

*Qtrly SIR

BHIP Hospital-Onset MRSA Bacteremia
SIR ~ CY 2019

*Qtrly SIR

BHMC Hospital-Onset MRSA Bacteremia
SIR ~ CY 2019

*Qtrly SIR
NHSN – COLORECTAL SSI

BHCS NHSN - Colorectal SSI
SIR ~ CY 2019
Threshold 0.781
Benchmark 0

BHIP NHSN - Colorectal SSI
SIR ~ CY 2019
Threshold 0.781
Benchmark 0

BHN NHSN - Colorectal SSI
SIR ~ CY 2019
Threshold 0.781
Benchmark 0

BHMC NHSN - Colorectal SSI
SIR ~ CY 2019
Threshold 0.781
Benchmark 0
NHSN – HYSTERECTOMY SSI

BHCS NHSN - Hysterectomy SSI
SIR ~ CY 2019
Threshold 0.722
Benchmark 0

BHN NHSN - Hysterectomy SSI
SIR ~ CY 2019
Threshold 0.722
Benchmark 0

BHIP NHSN - Hysterectomy SSI
SIR ~ CY 2019
Threshold 0.722
Benchmark 0

BHMC NHSN - Hysterectomy SSI
SIR ~ CY 2019
Threshold 0.722
Benchmark 0
HOSPITAL ACQUIRED PRESSURE INJURY
HOSPITAL ACQUIRED PRESSURE INJURY

BHCS HAPI: Stage III, Stage IV, Unstageable
CY 2019

BHN HAPI: Stage III, Stage IV, Unstageable
CY 2019

BHIP HAPI: Stage III, Stage IV, Unstageable
CY 2019

BHMC HAPU: Stage III, Stage IV, Unstageable
CY 2019
GRIEVANCES
COMPLAINTS & GRIEVANCES

• All Grievances follow policy GA 001-010 Complaint/Grievance Management

• Monthly Grievance Committee meetings represented by Customer Service Manager, Administration, Risk and Quality
Q1 2019 BHCS CAPTURED COMPLAINTS & GRIEVANCES

Attitude/Respect, 36, 21%
Delay/process/financial issues, 24, 14%
Appropriateness of Care/Instructions, 39, 23%
Communication, 48, 28%
Responsiveness, 6, 3%
Skill of Staff, 13, 8%
Environment/Nutritional, 6, 3%
Q1 2019 BHMC CAPTURED COMPLAINTS & GRIEVANCES

- Attitude/Respect: 8, 27%
- Delay/process/financial issues: 3, 10%
- Appropriateness of Care/Instruction: 5, 17%
- Communication: 4, 13%
- Environment/Nutritional: 1, 3%
- Safety Issues/Concerns: 4, 13%
- Responsiveness: 2, 7%
- Skill of Staff: 3, 10%

Total: 46, 100%
Q1 2019 BHN CAPTURED COMPLAINTS & GRIEVANCES

- Attitude/Respect, 16, 25%
- Delay/process/financial issues, 8, 12%
- Appropriateness of Care/Instructions, 6, 9%
- Communication, 17, 26%
- Environment/Nutritional, 1, 1%
- Safety Issues/Concerns, 11, 17%
- Responsiveness, 3, 5%
- Skill of Staff, 3, 5%
Q1 2019 BHN CAPTURED COMPLAINTS & GRIEVANCES
HACHPS SCORES
<table>
<thead>
<tr>
<th>Category</th>
<th>CMS 75%tile</th>
<th>CMS CY 2018</th>
<th>CY 2019 to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to Recommend This Hospital</td>
<td>79.00</td>
<td>73.90</td>
<td>70.00</td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
<td>79.00</td>
<td>72.20</td>
<td>70.00</td>
</tr>
<tr>
<td>Communication with Nurses</td>
<td>84.00</td>
<td>78.60</td>
<td>75.00</td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>85.00</td>
<td>78.90</td>
<td>75.00</td>
</tr>
<tr>
<td>Communication about Medicines</td>
<td>80.00</td>
<td>76.00</td>
<td>64.00</td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td>76.00</td>
<td>67.00</td>
<td>58.00</td>
</tr>
<tr>
<td>Discharge Information</td>
<td>84.00</td>
<td>84.90</td>
<td>90.00</td>
</tr>
<tr>
<td>Care Transition</td>
<td>57.00</td>
<td>48.00</td>
<td>53.40</td>
</tr>
<tr>
<td>Clean and Quiet Combined</td>
<td>71.70</td>
<td>64.00</td>
<td>63.40</td>
</tr>
<tr>
<td>Cleanliness of Hospital Environment</td>
<td>81.00</td>
<td>69.00</td>
<td>67.80</td>
</tr>
<tr>
<td>Quietness of Hospital Environment</td>
<td>68.00</td>
<td>59.00</td>
<td>59.10</td>
</tr>
</tbody>
</table>

Responses: 785
CY 2019 to Date
BHN CMS HCAHPS CY 2019 to 07/01/2019

- Willingness to Recommend This Hospital: 79.00
- Overall Rating of Hospital: 76.10
- Communication with Nurses: 85.00
- Communication with Doctors: 79.60
- Communication about Medicines: 79.00
- Responsiveness of Hospital Staff: 76.00
- Discharge Information: 88.30
- Care Transition: 71.70
- Clean and Quiet Combined: 81.00
- Cleanliness of Hospital Environment: 74.50
- Quietness of Hospital Environment: 59.60

Responses: 739
CY 2019 to Date
<table>
<thead>
<tr>
<th>Category</th>
<th>2018</th>
<th>2019</th>
<th>2019 to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to Recommend This Hospital</td>
<td>79.00</td>
<td>77.80</td>
<td>76.00</td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
<td>74.00</td>
<td>77.60</td>
<td>74.00</td>
</tr>
<tr>
<td>Communication with Nurses</td>
<td>84.00</td>
<td>78.00</td>
<td>78.00</td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>85.00</td>
<td>79.70</td>
<td>80.00</td>
</tr>
<tr>
<td>Communication about Medicines</td>
<td>70.00</td>
<td>61.80</td>
<td>67.00</td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td>58.10</td>
<td>64.00</td>
<td>76.00</td>
</tr>
<tr>
<td>Discharge Information</td>
<td>90.00</td>
<td>84.00</td>
<td>84.00</td>
</tr>
<tr>
<td>Care Transition</td>
<td>57.00</td>
<td>53.00</td>
<td>53.30</td>
</tr>
<tr>
<td>Clean and Quiet Combined</td>
<td>71.70</td>
<td>67.00</td>
<td>62.70</td>
</tr>
<tr>
<td>Cleanliness of Hospital Environment</td>
<td>72.00</td>
<td>68.30</td>
<td>68.00</td>
</tr>
<tr>
<td>Quietness of Hospital Environment</td>
<td>57.10</td>
<td>63.00</td>
<td>68.00</td>
</tr>
</tbody>
</table>

Responses: 346
CY 2019 to Date
Finalized 2018 scores to be released June 2019

<table>
<thead>
<tr>
<th>Measures Title 2018</th>
<th>Benchmark</th>
<th>2018 Q 1</th>
<th>2018 Q 2</th>
<th>2018 Q 3</th>
<th>2018 Q 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>86%</td>
<td>68.89%</td>
<td>78.64%</td>
<td>81.58%</td>
<td>81.19%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>84%</td>
<td>58.55%</td>
<td>62.33%</td>
<td>77.09%</td>
<td>73.30%</td>
</tr>
<tr>
<td>Adult Body Mass Index (BMI) Assessment</td>
<td>96%</td>
<td>91.07%</td>
<td>93.91%</td>
<td>93.63%</td>
<td>98.42%</td>
</tr>
<tr>
<td>Diabetes Care - Blood Sugar Controlled</td>
<td>86%</td>
<td>35.71%</td>
<td>83.33%</td>
<td>92.31%</td>
<td>82.35%</td>
</tr>
<tr>
<td>Diabetes Care - Monitoring Diabetic Nephropathy</td>
<td>99%</td>
<td>71.43%</td>
<td>88.89%</td>
<td>98.08%</td>
<td>96.08%</td>
</tr>
<tr>
<td>Diabetic Eye Exam</td>
<td>83%</td>
<td>47.62%</td>
<td>57.41%</td>
<td>73.08%</td>
<td>72.55%</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>80%</td>
<td>71.69%</td>
<td>91.33%</td>
<td>87.90%</td>
<td>96.25%</td>
</tr>
</tbody>
</table>
HUMANA – 2018 4TH QUARTER RESULTS

HEDIS 2018

- Breast Cancer Screening
- Colorectal Cancer Screening
- Adult Body Mass Index (BMI) Assessment
- Diabetes Care Blood Sugar Controlled
- Diabetes Care Monitoring Diabetic Nephropathy
- Diabetic Eye Exam
- Depression Screening

Benchmark
2018 Quarter 1
2018 Quarter 2
2018 Quarter 3
2018 Quarter 4
AVMED MEDICARE QUALITY OUTCOMES

Avmed Hedis 2018

<table>
<thead>
<tr>
<th>MEASURES TITLE</th>
<th>BENCHMARK</th>
<th>Prior-end 2017</th>
<th>Q1 2018</th>
<th>Q2 2018</th>
<th>Q3 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>BREAST CANCER SCREENING</td>
<td>82%</td>
<td>67.90%</td>
<td>75.30%</td>
<td>73.00%</td>
<td>72.10%</td>
</tr>
<tr>
<td>COLORECTAL CANCER SCREENING</td>
<td>65%</td>
<td>61.40%</td>
<td>58.90%</td>
<td>58.60%</td>
<td>56.00%</td>
</tr>
<tr>
<td>USE OF HIGH RISK MEDICATIONS IN ELDERLY</td>
<td>7.50%</td>
<td>4.00%</td>
<td>3.80%</td>
<td>3.50%</td>
<td>2.80%</td>
</tr>
<tr>
<td>USE OF RAS ANTAGONIST IN HYPERTENSIVE DIABETIC</td>
<td>88.50%</td>
<td>81.40%</td>
<td>82.70%</td>
<td>88.80%</td>
<td>86.50%</td>
</tr>
<tr>
<td>MEMBERS</td>
<td>74%</td>
<td>32.80%</td>
<td>37.40%</td>
<td>39.70%</td>
<td>40.70%</td>
</tr>
<tr>
<td>ADULT BODY MASS INDEX (BMI) ASSESSMENT</td>
<td>88%</td>
<td>74.50%</td>
<td>65.60%</td>
<td>69.60%</td>
<td>71.10%</td>
</tr>
<tr>
<td>DIABETES HbA1c LESS THAN 8 PERCENT</td>
<td>90%</td>
<td>94.70%</td>
<td>93.30%</td>
<td>94.60%</td>
<td>87.80%</td>
</tr>
</tbody>
</table>

• Reports from payers are 90 days or more delayed before data is posted.
• The current collected data shows slight variation.
• Use of high risk medications in the elderly consistently maintained below benchmark.
AVMED UTILIZATION

- Annual Exam noted to be a deficiency as members engage the practices on sick visits. Updated membership distributed in January to assure members engaged for annual care visits.
- Coding for E&M (Evaluation and Management) with Himagine company for some Primary care offices at Broward Health Physician Group (phased approach)
- HRA’s: as of last data from Avmed 96.3%. Actual end of year submission 181 out of 184 HRA’s.
- ER visits dropping as members engaged back into office setting or urgent care as appropriate based on symptomology
- Noted just below benchmark for generic dispensing rate

<table>
<thead>
<tr>
<th>MEASURES TITLE</th>
<th>BENCHMARK</th>
<th>Prior</th>
<th>Q1 2018</th>
<th>Q2 2018</th>
<th>Q3 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Exam</td>
<td>90%</td>
<td>13.80%</td>
<td>15.30%</td>
<td>18.30%</td>
<td>21.30%</td>
</tr>
<tr>
<td>HRA</td>
<td>90%</td>
<td>97%</td>
<td>68.20%</td>
<td>77.70%</td>
<td>96.3%</td>
</tr>
<tr>
<td>HOSPITAL ADMITS PER 1,000 - less than 276</td>
<td>276</td>
<td>263.6</td>
<td>263.4</td>
<td>252.3</td>
<td>235.9</td>
</tr>
<tr>
<td>ER VISITS PER 1,000 - less than 225</td>
<td>225</td>
<td>344.8</td>
<td>358.2</td>
<td>349.5</td>
<td>322.6</td>
</tr>
<tr>
<td>GENERIC DISPENSING RATE</td>
<td>85.00%</td>
<td>85.13%</td>
<td>84.94%</td>
<td>84.90%</td>
<td>85.11%</td>
</tr>
</tbody>
</table>
• Increased focus on care of diabetics. Category 11 coding will assist with closure of gaps via claims process.
• Re-education to provider and mid levels in practices
MY BLUE - QUALITY OUTCOMES- UTILIZATION

Utilization is split......CHS and BHPG as of 3/31/2018

<table>
<thead>
<tr>
<th></th>
<th>BHPG</th>
<th>Benchmark</th>
<th>3/31/2018</th>
<th>6/30/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Utilization - visits per 1000</td>
<td>344.00%</td>
<td>335%</td>
<td>318</td>
<td></td>
</tr>
<tr>
<td>IP Utilization - visits per 1000</td>
<td>60.40%</td>
<td>68%</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>New patients seen w/90 dys</td>
<td>50%</td>
<td>41%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existing patients seen</td>
<td>75%</td>
<td>63%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>CHS</th>
<th></th>
<th>3/31/2018</th>
<th>6/30/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Utilization - visits per 1000</td>
<td>346.00%</td>
<td>429%</td>
<td>435%</td>
<td></td>
</tr>
<tr>
<td>IP Utilization - visits per 1000</td>
<td>77.00%</td>
<td>76%</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>New patients seen w/90 dys</td>
<td>50%</td>
<td>39%</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>Existing patients seen</td>
<td>75%</td>
<td>62%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Increasing education to patients on ED utilization. Flexibility being offered by offices for appointments for transition of care and new patients.
- As of June reports received 10/31/2018 IP utilization decreased to 61 for both parties. Insufficient data for new versus existing patients.
• Further education to providers on use of Category 11 codes. This assists to communicate closure of gaps on claims.
• Strategic Planning in process to use Care Coordination personnel across the spectrum of ambulatory.
### COMMUNITY CARE PLAN (CCP)

#### HEDIS 2018 CHS

<table>
<thead>
<tr>
<th>Measures Title 2018</th>
<th>Benchmark</th>
<th>Score 2017</th>
<th>Claims to Dec. 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>70.29%</td>
<td>71.43%</td>
<td>69.12%</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>93.68%</td>
<td>54.10%</td>
<td>62.70%</td>
</tr>
<tr>
<td>Diabetes HBAIC less than 8%</td>
<td>59.12%</td>
<td>29.07%</td>
<td>34.15%</td>
</tr>
<tr>
<td>Diabetic Eye Exam</td>
<td>68.33%</td>
<td>66.28%</td>
<td>52.44%</td>
</tr>
<tr>
<td>Children's Access to Primary Care - Members 12 to 19 yrs of age</td>
<td>94.72%</td>
<td>64.73%</td>
<td>69.46%</td>
</tr>
<tr>
<td>Children's Access to Primary Care - Members 12 to 24 months of age</td>
<td>97.89%</td>
<td>91.04%</td>
<td>84.91%</td>
</tr>
<tr>
<td>Children's Access to Primary Care - Members 2 to 6 yrs of age</td>
<td>93.16%</td>
<td>70.25%</td>
<td>69.47%</td>
</tr>
<tr>
<td>Children's Access to Primary Care - Members 7 to 11 yrs of age</td>
<td>70.31%</td>
<td>75.30%</td>
<td>74.58%</td>
</tr>
</tbody>
</table>

- Quality Team continues to work closely with CCP representative to turn in any supplemental data for this Medicaid population. Pending final 2018 scores June 2019
Quality Team continues to work closely with CCP representative to turn in any supplemental data for this Medicaid population. Pending final 2018 scores June 2019

Members have been noted to consistently refuse preventative care.
ACTION PLAN

- Continued ancillary coding through provider education. Primary Care HEDIS education provided to Internal Medicine/Family Practice March 2018 followed by education on value based purchasing education on October 31st 2018.
- Standard of Practice review for workflow of reviewing clinical reports outside date of service
- Restructure of Ambulatory Quality Department to support the cohesiveness and standardization of the ambulatory practices (BHPG/CHS/UC)
- Reconstruct care coordination and ambulatory quality teams to support a Patient Centered Medical Home Model.
- Offices templates restructured for Primary Care to provide access for post E.R and Inpatient hospitalizations (Transition of Care)
- Continue strategy meetings with payers.
- Continue working with payers to provide more meaningful reports to support care and gap closure.
- Tips and tricks quality corner correspondence to providers and coordinators of Primary Care Practices under development. Example: Difference between Annual Well Visit and Physical
- Strategize with quality representatives from payer organizations to set up educational sessions for coordinators at practices.
PATIENT CENTERED MEDICAL HOME MODEL

Patient:
Patient Medical Home (PCP)
- ARNP
- RN
- MA
- POS
- Social Workers

Medical Specialties
Ancillary Care (Imaging, Lab, Testing)
Inpatient
Behavioral Health
Teledmedicine
Pharmacy
Skilled Nursing
Home Health, Hospice
Emergency Care, Urgent Care
Patient Navigation
Community Services (Bus, etc.)
Surgical Care

BROWARD HEALTH
BROWARD HEALTH
GOLD COAST HOME HEALTH

IMPROVEMENT IN AMBULATION
DRUG EDUCATION
RE-HOSPITALIZATION
HHCAHPS

JUNE 2019
Improvement in Ambulation/Locomotion

CMS Target 73.1%  

1st quarter data not yet available from McKesson/Netsmart EMR.

Action Plan:
• Analysis of all negative outcome indicators
• Education of qualifying clinicians
• OASIS scoring accuracy
• OASIS Walk
• Monitor Care Coordination
Drug Education on All Medications
During All Episodes of Care

CMS Target  97.9%  

1st quarter data not yet available from McKesson/Netsmart EMR.

Action Plan
- Analysis for all negative outcome reports
- Education of qualifying clinicians in OASIS data:
  - QI Developed & implemented visit guideline tool – initial visit
  - QI Developed discharge audit tool - OASIS
GOLD COAST HOME HEALTH

Re-hospitalizations

<table>
<thead>
<tr>
<th>Preventing Unplanned Hospital Care</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>YTD</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CMS Risk Adjusted Hospitalizations</th>
<th>CMS Target 15.9% (CY 2017)</th>
<th>21.9</th>
</tr>
</thead>
</table>

Action Plan:
- Re-admission Prevention Program
- Analysis performed for all re-admissions
- Patient Hi-Risk Stratification developed & implemented
- Assess for additional programs: Tele-Monitoring & Palliative Care
- Exchange of re-admission information within Broward Health System
- Weekly review with staff at Clinical Staff Meeting
- Explore & develop provider home visits in disease management/chronic care
GOLD COAST HOME HEALTH

HHCAHPS - Patients who gave Agency rating of 9 or 10

CMS Rolling Target - 83%

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HHCAHPS % of patients who gave their HH agency a rating of 9 or 10</td>
<td>CMS Target Rolling 83%</td>
<td>87.5</td>
<td>100</td>
<td>100</td>
<td>96</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Action Plan:
• Initiating Leadership follow-up calls to patients
• All staff educated in AIDET
• QI developed & implemented visit guidelines
• Implemented follow up phone calls after Admission to Home Health
• Patients encouraged to complete surveys of their home care experience
• Follow-up calls initiated during episode of care
HOSPICE OF GOLD COAST

CMS HIS – Hospice Information Set
CMS Group National Average  97.1%
CY 2019 YTD 99.2%

<table>
<thead>
<tr>
<th>Hospice-Level Quality Measures</th>
<th>HIS</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>YTD</th>
</tr>
</thead>
</table>

Beliefs / Values
HOSPICE OF GOLD COAST

CMS HIS – Hospice Information Set
(Home Hospice Patients only)
CMS Group National Average  82.21%

<table>
<thead>
<tr>
<th>Hospice-Level Quality Measures</th>
<th>HIS</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
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*Hospice Visits when Death is Imminent - Measure 1

| 82.2% | 86.4 | 86.4 | 87 |

Action Plan

• Hire ARNP / provider for home hospice visits
HOSPICE OF GOLD COAST

HSCAHPS Target 85%  CY 2019  YTD 83%

**Recommend Hospice**

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Action Plan:

- HSCAHPS education provided to Hospice staff
- Patient’s families/primary caregivers encouraged to complete survey of Hospice experience.
ANTIMICROBIAL STEWARDSHIP
BH ASP UPDATE

- ASP Interventions

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- ASP policies & procedures updates
  - Antimicrobial renal dosing policy currently under revision
  - Anti-biogram enhancement (addition of breakpoint MICs and inclusion of Stenotrophomonas data)

- Additions to Formulary: Zerbaxa and Biktarvy
BH ASP UPDATE

- ASP Steering Committee – March/June meeting
  - Approved ASP Initiatives
    - Extended infusion of piperacillin-tazobactam and meropenem pilot program in the ICU
      - Annual Cost Savings: $20,876
      - Mortality benefit
    - Beta lactam continuous infusion pilot program in the ICU
    - Duration and indication requirement for all antifungal and antiviral orders
    - Daptomycin restricted prescribing criteria for utilization & daptomycin subphase
    - Linezolid/Meropenem restricted prescribing criteria for utilization – pending IT implementation
Medicare Readmissions

Medicare Average:

BHMC worse than National Average for COPD

No difference from National Average for other hospitals and diagnoses: HF, COPD, PN, AMI, TH/TK or CABG

Readmissions 07/01/2014 – 06/30/2017
## Readmission Rates – All Payer (Crimson)

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<td>Hip/Knee</td>
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</table>
MEDICARE MORTALITIES
North Broward Hospital District
AMI Medicare Mortalities 1st Q 2019

Hospital Compare CMS benchmark 13.6%

BHMC

BHN

BHCS

BHIP

NA

0/0

0/0

0/5

0/11

2/29

-0.26σ

-0.63σ

-0.21σ

0.0

1.0

1.0

1.0
North Broward Hospital District
HF Medicare Mortalities 1st Q 2019

Hospital Compare CMS benchmark 12.0%

BHMC

BHN

BHIP

BHCS

0/53

0/12

0/25

0/26
North Broward Hospital District
COPD Medicare Mortalities 1st Q 2019

Hospital Compare CMS benchmark 8.1%

BHMC
-0.43σ
0/27

BHN
-0.39σ
0/34

BHIP
-0.32σ
0/13

BHCS
-0.31σ
0/14
North Broward Hospital District
PN Medicare Mortarities 1st Q 2019

Hospital Compare CMS benchmark 16.0%
ENVIRONMENT OF CARE
Jointly and regionally, Broward Health continues to experience OSHA Recordable Injury rate that exceed the targeted threshold of 6.01; additionally, during Q1, 2019 Broward Health experienced a 0.15 rate increase in the performance of the OSHA Recordable Injury monitor. Steady downward trend in its OSHA Recordable Injury Rate.

Directly related to the increase in the OSHA Recordable Injury Rate is the number of exposures that were reported to Worker Comp. During Q1CY'19, The worker’s comp department received reports of 100 employees expose to patients with highly communicable illnesses.

Additional Analysis showed that of the total reports received by worker’s comp, only 10% came into contact with the patients; Broward Health policy requires any employee within the vicinity of the ill patient to report to worker comp for monitoring.
BHN SEPSIS BUNDLE COMPLIANCE

Comparative Report: Quality Performer-Wide for Proportion Measures
Facility: 11367
Interval of Analysis: Quarter
Discharge Dates: 01/01/2016 to 03/31/2019
Measure: SEP-1
Measure Description: Sepsis
BHN Variance Location
Jan thru March 2019

IP, 11, 38%

ED, 18, 62%
BHCS VARIANCE LOCATION
JAN THRU MARCH 2019

ED - 48%
IP - 52%
BHIP Q1 FALLOUT ANALYSIS

Comparative Report: Quality Performer-Wide for Proportion Measures
- Facility: 11368
- Interval of Analysis: Quarter
- Discharge Dates: 01/01/2016 to 03/31/2019
- Measure: SEP-1
- Measure Description: Sepsis

Facility #11368  SEP-1: Sepsis

- Facility Rate
- 99th Percentile
- 90th Percentile
- 75th Percentile
- 50th Percentile
- 25th Percentile

Time Period:
- Q1 2016
- Q2 2016
- Q3 2016
- Q4 2016
- Q1 2017
- Q2 2017
- Q3 2017
- Q4 2017
- Q1 2018
- Q2 2018
- Q3 2018
- Q1 2019
BHLP Q1 FALLOUT ANALYSIS SEPSIS

SEPSIS - 3 HOUR BUNDLE
- Blood Culture after Antibiotics Ordered 1 (34%)
- No Blood Culture 1 (33%)

SEPSIS - 6 HOUR BUNDLE
- Vasopressor Administration 1 (13%)
- No Repeat Lactated 3 (37%)
- Wrong Fluid Amount, 4 (50%)

FALLOUTS BY BUNDLE - Q1 2019
- 6 HR Total Failouts 8 (73%)
- Total Shock Failouts 0 (0%)
- 3 HR Total Failouts 3 (27%)
BHIP Variance Location
January 2019-March 2019

ED
6
55%

IP
5
45%
Comparative Report: Quality Performer-Wide for Proportion Measures
Facility: 11366
Interval of Analysis: Quarter
Discharge Dates: 01/01/2016 to 03/31/2019
Measure: SEP-1
Measure Description: Sepsis
Fallouts by Bundle January 2019 - March 2019

- **Septic shock**: 0%
- **Severe Sepsis 3 hr Bundle**: 14%
- **Severe Sepsis 6 hr Bundle**: 86%

Severe Sepsis 3 hrs. Bundle Fallouts

- No Initial LA: 36%
- Delayed Antibiotic: 27%
- Incorrect Antibiotic: 14%
- No Antibiotic administered: 9%
- Blood culture after Antibiotic: 9%
- Less fluid given: 5%

Severe Sepsis 6 hrs. Bundle Fallouts

- No Repeat lactic acid: 50%
- Vasopressor: 50%
BHMC
Variance Location
January 2019-March 2019

- ED: 72%
- Inpatient: 28%
NHSN – CLABSI ~ ALL REPORTING UNITS

BHCS NHSN - CLABSI
SIR ~All Reporting Units
CY 2019
Threshold 0.784
Benchmark 0

BHN NHSN - CLABSI
SIR ~All Reporting Units
CY 2019
Threshold 0.784
Benchmark 0

BHIP NHSN - CLABSI
SIR ~All Reporting Units
CY 2019
Threshold 0.784
Benchmark 0

BHMC NHSN - CLABSI
SIR ~All Reporting Units
CY 2019
Threshold 0.784
Benchmark 0
NHSN – CLABSI ~ PEDIATRIC

**BHCS NHSN - CLABSI**
SIR ~ Pediatric (incl. NICU, PICU, Peds)
CY 2019

Threshold 0.784
Benchmark 0

**BHMC NHSN - CLABSI**
SIR ~ Pediatric (incl. NICU, PICU, Peds)
CY 2019

Threshold 0.784
Benchmark 0
NHSN – CAUTI ~ ALL REPORTING UNITS

BHCS NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019

Threshold 0.828
Benchmark 0

BHN NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019

Threshold 0.828
Benchmark 0

BHIP NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019

Threshold 0.828
Benchmark 0

BHMC NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019

Threshold 0.828
Benchmark 0
NHSN – CAUTI ~ PEDIATRIC

BHCS NHSN - CAUTI
SIR ~ Pediatric (incl. PICU, Peds)
CY 2019

Threshold 0.828
Bench 0

BHMC NHSN - CAUTI
SIR ~ ALL Pediatric
CY 2019

Threshold 0.828
Bench 0
HOSPITAL-ONSET C. DIFFICILE

BHCS Hospital-Onset C. Difficile
SIR ~ CY 2019

Threshold 0.852
Benchmark 0.091

*Bqtrly SIR

Infections SIR Threshold

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

1 2 0
SIR 0.49

BHIP Hospital-Onset C. Difficile
SIR ~ CY 2019

Threshold 0.852
Benchmark 0.091

*Bqtrly SIR

Infections SIR Threshold

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

0 1 0
SIR 0.22

BHN Hospital-Onset C. Difficile
SIR ~ CY 2019

Threshold 0.852
Benchmark 0.091

*Bqtrly SIR

Infections SIR Threshold

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

0 3 0
SIR 0.25

BHMC Hospital-Onset C. Difficile
SIR ~ CY 2019

Threshold 0.852
Benchmark 0.091

*Bqtrly SIR

Infections SIR Threshold

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

1 1 2
SIR 0.17

130
HOSPITAL-ONSET MRSA BACTEREMIA

BHCS Hospital-Onset MRSA Bacteremia
SIR ~ CY 2019

*Qtrly SIR

Infections  SIR  Threshold

BHIP Hospital-Onset MRSA Bacteremia
SIR ~ CY 2019

*Qtrly SIR

Infections  SIR  Threshold

BHN Hospital-Onset MRSA Bacteremia
SIR ~ CY 2019

*Qtrly SIR

Infections  SIR  Threshold

BHMC Hospital-Onset MRSA Bacteremia
SIR ~ CY 2019

*Qtrly SIR

Infections  SIR  Threshold
NHSN – HYSTERECTOMY SSI
HOSPITAL ACQUIRED PRESSURE INJURY
HOSPITAL ACQUIRED PRESSURE INJURY

BHCS HAPI: Stage III, Stage IV, Unstageable
CY 2019

BHN HAPI: Stage III, Stage IV, Unstageable
CY 2019

BHIP HAPI: Stage III, Stage IV, Unstageable
CY 2019

BHMC HAPU: Stage III, Stage IV, Unstageable
CY 2019

- BHCS HAPI: Shows a trend over the year from January to December. The graph indicates the number of cases for each stage from Stage 3 to Unstageable.
- BHN HAPI: Similar trend as BHCS HAPI, showing a decrease in cases from January to November, with a slight increase in December.
- BHIP HAPI: Shows a gradual increase from January to November, with a peak in December.
- BHMC HAPU: Displays a significant increase in cases from January to December, with a particular spike in November.
**COMPLAINTS & GRIEVANCES**

- All Grievances follow policy GA 001-010 Complaint/Grievance Management

- Monthly Grievance Committee meetings represented by Customer Service Manager, Administration, Risk and Quality
Q1 2019 BHCS CAPTURED COMPLAINTS & GRIEVANCES

- Attitude/Respect, 36, 21%
- Delay/process/financial issues, 24, 14%
- Appropriateness of Care/Instructions, 39, 23%
- Communication, 48, 28%
- Skill of Staff, 13, 8%
- Responsiveness, 6, 3%
- Environment/Nutritional, 6, 3%
Q1 2019 BHMC CAPTURED COMPLAINTS & GRIEVANCES

- Attitude/Respect, 8, 27%
- Delay/process/financial issues, 3, 10%
- Appropriateness of Care/Instructions, 5, 17%
- Communication, 4, 13%
- Environment/Nutritional issues, 1, 3%
- Safety Issues/Concerns, 4, 13%
- Responsiveness, 2, 7%
- Skill of Staff, 3, 10%
Q1 2019 BHN CAPTURED COMPLAINTS & GRIEVANCES

- Attitude/Respect, 16, 25%
- Delay/process/financial issues, 8, 12%
- Appropriateness of Care/Instructions, 6, 9%
- Communication, 17, 26%
- Safety Issues/Concerns, 11, 17%
- Environment/Nutritional, 1, 1%
- Responsiveness, 3, 5%
- Skill of Staff, 3, 5%
Q1 2019 BHN CAPTURED COMPLAINTS & GRIEVANCES

- **Attitude/Respect**: 16, 25%
- **Delay/process/financial issues**: 8, 12%
- **Appropriateness of Care/Instructions**: 6, 9%
- **Communication**: 17, 26%
- **Responsiveness**: 3, 5%
- **Skill of Staff**: 3, 5%
- **Safety Issues/Concerns**: 11, 17%
- **Environment/Nutritional**: 1, 1%
- **Responsiveness**: 3, 5%
- **Skill of Staff**: 3, 5%
- **Safety Issues/Concerns**: 11, 17%
- **Environment/Nutrition**: 1, 1%
BHN CMS HCAHPS CY 2019 to 07/01/2019

Responses: 739
CY 2019 to Date
BHCS CMS HCAHPS CY 2019 to 07/01/2019

- WILLINGNESS TO RECOMMEND THIS HOSPITAL: 66.00 (79.00), 73.80
- OVERALL RATING OF HOSPITAL: 64.00 (79.00), 72.20
- COMMUNICATION WITH NURSES: 58.00 (70.00), 60.40
- COMMUNICATION WITH DOCTORS: 60.00 (76.00), 62.30
- COMMUNICATION ABOUT MEDICINES: 61.00 (71.70), 68.40
- RESPONSIVENESS OF HOSPITAL STAFF: 66.00 (83.00), 80.40
- DISCHARGE INFORMATION: 56.00 (81.00), 63.60
- CARE TRANSITION: 46.00 (57.00), 51.80
- CLEAN AND QUIET COMBINED: 65.00 (68.00), 73.20
- CLEANLINESS OF HOSPITAL ENVIRONMENT: 66.00 (68.00), 73.20
- QUIETNESS OF HOSPITAL ENVIRONMENT: 66.00 (68.00), 73.20

Responses: 486
CY 2019 to Date

CMS 75%tile, CMS CY 2018, CY 2019 to Date
Q1 2019 – No Reportable or SE.

Total of 58 occurrences reported (6 GCHH, 14 GC Hospice). Gradual increase in number of reports per quarter (44, 46, 48 and 58).

Falls included: 3 GCHH, 9 Hospice (one nasal bone fracture), one patient near miss fall due to dizziness after Glucola, one employee fall due to oil on floor, door release mechanism replaced.

Patient reported ED visit due to angioedema related to Lisinopril. Medication variances included duplicate therapy due to dispensing error, wrong med bag handled to patient by cashier, 2 wrong frequencies on label (one from outside CHS pharmacy), one wrong frequency on label due to transcribing and dispensing error, wrong med administered (lidocaine with epinephrine used to dilute ceftriaxone instead of plain lidocaine). No adverse effects to patients. Implement physician order for diluting medication with other medication.

Three events reporting narcotic count discrepancy at hospice home, one patient transferred to inpatient hospice, other discharged from home hospice due to non-compliance. Nine AMAs. One physician-patient relationship terminated due to threat of violence and safety of staff/physician. One student sharps exposure. One near miss related to PPID. One specimen collection error.
Patient transferred to ED due to vasovagal reaction after Solumedrol injection. Eleven AMAs. Lab specimen mislabeled. Ongoing staff education implemented.

Two near miss falls at radiology. Patients felt dizzy after test and were assisted by staff present.

Delay in appropriately addressing bug infestation caused by patient. Process reviewed, after-hours emergency contact list created and distributed to UCCs. Facilities contacted exterminator services.
Q1 2019 – No Reportable or SE.

Two employee related reports (fall and safety).

HIPAA occurrences related to physician IPad stolen and wrong bill mailed to patient.

Physician office received call from ME regarding patient recently seen with history of seizures. Flu vaccine ordered and administered to 2 month old patient. Disclosure by physician. No harm to patient but parents verbalized concern and dissatisfaction. PCE completed. Charges carved out. Case referred for medical review. Two reports related to positive pediatric depression screenings. Referred to medical review. Policy and process being developed to address positive screenings as well as how to proceed if risk of suicide is identified.

One physician-patient relationship terminated due to threat of violence and physician safety concerns. One physician received threats of violence from patient’s son requiring further intervention from security and safety.
Broward Health Ambulatory Services - Risk Management Quarterly Report - 1st Quarter 2019

Q1 2019 – No Reportable or SE.

Total of 13 occurrences reported. Number of reports increased when compared to previous quarters (6, 2 and 2). Increase in HIPAA/PHI events. Medicaid Managed Care plans are now requiring Early Steps to submit its Individual Family Service Plans (IFSP) to them and to patient’s parents in order to coordinate care. Tremendous volume of IFSPs sent via email increased the number of PHI related events. Information Security team is working to implement an easier and secure system to submit these forms.

Falls included one employee accidental fall, one child at play and one due to patient syncope who was transferred to ED. Minor injuries.

Flu vaccine and Pneumococcal 23 administered to the wrong adult patient. Issues identified with PPID, process reviewed with staff. Physician disclosed error to patient.
Q1 2019 – No Reportable or SE.

Two employee related occurrences. Fall without injury and accident while crossing street. Employee health and worker’s compensation aware.

One visitor walked over yellow cone and fell. Welcome mat did not cause visitor to fall but facilities had it replaced with a heavier base mat. This should prevent the need to place caution sign as a result of rolled up mat edge at times.

Patient care event reported by information services, related to spelling errors on discharge template during 2018 upgrade which was fixed.
Broward Health Coral Springs  
Overall Occurrence Report  
Quarter 1 CY 2019

<table>
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<tr>
<th>Occurrence Category Q1 CY19</th>
<th>Total</th>
<th>Percentage</th>
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<tr>
<td>ADR Total</td>
<td>9</td>
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<tr>
<td>FALL Total</td>
<td>33</td>
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<tr>
<td>HIPAAPHI Total</td>
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<td>0.69%</td>
</tr>
<tr>
<td>MEDICATION Total</td>
<td>50</td>
<td>11.47%</td>
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<tr>
<td>OBDELIVER Total</td>
<td>22</td>
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<tr>
<td>PATCARE Total</td>
<td>259</td>
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<tr>
<td>PATRIGHT Total</td>
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<tr>
<td>SAFETY Total</td>
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<tr>
<td>SECURITY Total</td>
<td>37</td>
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<tr>
<td>SURGERY Total</td>
<td>18</td>
<td>4.13%</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>436</strong></td>
<td><strong>100%</strong></td>
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During the *1st Quarter CY 2019*, there were a total of *436 Occurrence Variance Reports* compared to *440 for Q4 2018*. This reflects a decrease by *0.5%* for Q1 2019.

The overall **Near Miss Occurrences** for *1st Quarter CY 19* was *22* compared to *36 for 4th Quarter CY 18*. This represents a decrease in reporting by *24.13 % for Quarter 1 CY 2019*. This reflects a downward trend in reporting of this type of event. The areas that reflected a higher increase were **Pyxis Miss Fill, Allergy**, and **Prescriber Error**. The overall goal is to increase reporting which can be achieved through staff education and encouragement. An increase in reporting, allows us the opportunity to implement measures, to improve patient safety as well as to track and trend events.
AMAs are the highest reported events in Patient Care Occurrences totaling **50.24%** for **Q1 2019**. This represents an increase in this category by **0.5%** when compared to **Q4 2018** at **49.76%**. Reasons as noted above; **Personal Reasons/Family Choice** and **Refused Treatment, Noncompliance** were listed as the highest causes. Patients are assessed for vulnerability including the ability to make informed decisions. Risks and benefits are explained to the patient prior to signing the AMA form and physicians are informed.

The following grid below reflects AMAs by department.

**3 East, PCU and 4 West are identified as having the highest occurrences.**

<table>
<thead>
<tr>
<th>Department</th>
<th>1st Quarter 2019</th>
<th>%</th>
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<tbody>
<tr>
<td>3 South Tower</td>
<td>3</td>
<td>2.88%</td>
</tr>
<tr>
<td>3E-Medical/ Surgical</td>
<td>17</td>
<td>16.35%</td>
</tr>
<tr>
<td>4W-Medical/Surgical</td>
<td>49</td>
<td>47.12%</td>
</tr>
<tr>
<td>Critical Care - CCU</td>
<td>2</td>
<td>1.92%</td>
</tr>
<tr>
<td>Critical Care- SICU</td>
<td>1</td>
<td>0.96%</td>
</tr>
<tr>
<td>Delivery Room</td>
<td>2</td>
<td>1.92%</td>
</tr>
<tr>
<td>ER</td>
<td>4</td>
<td>3.85%</td>
</tr>
<tr>
<td>Pediatrics ER</td>
<td>2</td>
<td>1.92%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1</td>
<td>0.96%</td>
</tr>
<tr>
<td>Progressive Care</td>
<td>23</td>
<td>22.12%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>104</td>
<td>100%</td>
</tr>
</tbody>
</table>
The total Fall Events for 1st Quarter CY 2019 were 33. This reflects a decrease by 2 resulting in 2.94% from Q4 2018.

- The trend continues to be “Patients Found on Floor.” Patients are given education on fall precautions and encouraged to call for assistance. However, patients are not compliant with instructions given. Patients are assessed upon admission and given a Morse Fall Score that determines fall category. Precautions are established based on the fall category or at the nurse’s discretion.
- Majority of the fall events (24) were listed as no injuries, (8) were minor injuries, and (1) Moderate. No Major Fall events were identified in this Quarter. Appropriate assessment on admission and purposeful rounding is encouraged to decrease these events.
There are a total of 2 incidents for 1st Quarter CY 2019. There were no reported HAPI for February and March. Results decreased by 1 when compared to Q4 2018 with 3 incidents. There was no stage 1 injury reported, but 1 Decubitus-stage II and Deep Tissue Injury for the month of January.

Wound Care committee is formed to review and identify opportunities for improvement. The Unit Managers continues to educate staff regarding proper skin assessment on admission and initiation of wound care for any identified skin integrity changes.
Medications Events Q1, 2019

In Q1 CY 2019, there was total of 57 Medication Occurrences. This reflects an increase by 7 resulting in a 6.54% from Q4 2018. The following categories identified as causes are: Delayed Dose, Omitted Dose, Pyxis Miss Fill, Other and Wrong Drug or IV Fluid. All Medication Variances are reviewed at the Medication Safety Committee and the P& T Committee. The Committee reviews for quality improvement opportunities and recommendations are addressed collectively by all Regions.

ADR Q1, 2019

<table>
<thead>
<tr>
<th>ADR</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>2</td>
</tr>
<tr>
<td>Cardio</td>
<td>3</td>
</tr>
<tr>
<td>Dermatological</td>
<td>1</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>0</td>
</tr>
<tr>
<td>Metabolic/Endocrine</td>
<td>1</td>
</tr>
<tr>
<td>Hematological / Blood Disorder</td>
<td>0</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>0</td>
</tr>
<tr>
<td>Neuro</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total ADR</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

There were 9 ADR’s reported for Q1 2019, this reflects a decrease by 4, resulting in 18.18% when compared to Q4 2018. The ADR events are reviewed for Hospital related versus Present on Admission. ADR’s are reported to the P& T Committee and are tracked and trended. Any incidence related to Anesthesia is referred to the Chief of Anesthesia for further review. If an allergic reaction is confirmed, the patient’s record is updated in Cerner to reflect allergy.
### OB Delivery Q1, 2019

<table>
<thead>
<tr>
<th>OB</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Trauma</td>
<td>0</td>
</tr>
<tr>
<td>Emergency C-Section &gt;3 0 min</td>
<td>0</td>
</tr>
<tr>
<td>Fetal Distress</td>
<td>0</td>
</tr>
<tr>
<td>Maternal complications</td>
<td>6</td>
</tr>
<tr>
<td>Neonatal complications - Admit NICU</td>
<td>1</td>
</tr>
<tr>
<td>Neonatal complications - Apgar &lt;5 @5 min</td>
<td>0</td>
</tr>
<tr>
<td>Neonatal complications – Impaired Skin Integrity</td>
<td>0</td>
</tr>
<tr>
<td>OB Alert</td>
<td>0</td>
</tr>
<tr>
<td>RN Attended Delivery (0 events &gt;30 mins)</td>
<td>13</td>
</tr>
<tr>
<td>Shoulder Dystocia</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

Q1 2019 there were 22 reported occurrences for OB. This reflects an increase by 2, resulting in **4.76%** from Q4 2018. **RN attended Deliveries** remain the highest incidence for this category. Rapid progression of delivery is identified as the root cause for this occurrence. MD’s are contacted, but are not present in time for delivery. For delay greater than 30 minutes, a referral is sent to Quality for tracking and trending. Maternal complications are referred and reviewed by Quality Management/Peer Review for Quality of Care concerns.

### Surgery Q1, 2019

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Issues</td>
<td>2</td>
</tr>
<tr>
<td>Sponge/Needle/Instrument Issues</td>
<td>3</td>
</tr>
<tr>
<td>Sterile field contaminated</td>
<td>1</td>
</tr>
<tr>
<td>Surgery Delay</td>
<td>5</td>
</tr>
<tr>
<td>Surgery/Procedure Cancelled</td>
<td>4</td>
</tr>
<tr>
<td>Surgical Complication</td>
<td>0</td>
</tr>
<tr>
<td>Unplanned Return to OR</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

Q1 2019 there were 20 reported incidences which reflect a decrease by 10 resulting in 20% from Q4 2018. During this Quarter, there was an increase in events related to **Surgery Delay** and **Unplanned Return to OR**. These events are tracked and trended.
### SAFETY AND SECURITY Q1 2019

#### Security Q1, 2019

<table>
<thead>
<tr>
<th>SECURITY</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access control</td>
<td>1</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>4</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>1</td>
</tr>
<tr>
<td>Code Assist</td>
<td>9</td>
</tr>
<tr>
<td>Code Elopement</td>
<td>3</td>
</tr>
<tr>
<td>Code Stork</td>
<td>1</td>
</tr>
<tr>
<td>Contraband</td>
<td>9</td>
</tr>
<tr>
<td>Property Damaged/Missing</td>
<td>10</td>
</tr>
<tr>
<td>Security Presence Requested</td>
<td>1</td>
</tr>
<tr>
<td>Security Transport</td>
<td>0</td>
</tr>
<tr>
<td>Threat of violence</td>
<td>2</td>
</tr>
<tr>
<td>Trespass</td>
<td>0</td>
</tr>
<tr>
<td>Vehicle Accident</td>
<td>0</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>41</strong></td>
</tr>
</tbody>
</table>

During **Q1, 2019**, Security Events decreased by **9** resulting in **9.89%** when compared to **50** events for **Q4 2018**. **Property Damaged/Missing** is the highest category for security occurrences.

- Property Damaged/Missing decreased by **23.08%**. Staff provides education to patients on securing their personal property, and they are also encouraged to send them home. The Education Department has distributed a flyer for all Units titled **“Facts about Patients’ Belongings.”**
- Staff is encouraged to speak up on any form of abuse lateral or horizontal.

#### Safety Q1, 2019

<table>
<thead>
<tr>
<th>SAFETY</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Red</td>
<td>1</td>
</tr>
<tr>
<td>Elevator entrapment</td>
<td>0</td>
</tr>
<tr>
<td>Safety Hazard</td>
<td>6</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>0</td>
</tr>
<tr>
<td><strong>Safety Total</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

**Q1 2019**, Safety Events decreased by **25**, resulting in **64.10%** from **Q4 2018**. There was a decrease in the number of **Code Red** and **Safety Hazards**. Occurrences related to staff and LIP is referred to Employee Health for further management.
I. BHCS Falls Safety Measures

- Identify patients at risk for falls to ensure Patient Safety
- Neon “Alarm In Use” signs for high risk patients with bed/chair alarms
- Yearly competency to also include definitions
- Hand-off of high risk pts to the RN/PCA by transporters
- Fall Response process; “Code Autumn” implemented Feb 2017
- Falls Committee – meets every 3rd Thursday of the Month.
- Post Fall Huddle form for an Intense Analysis of the fall
- Include patient assisted to bathroom and visible to staff Jan 2018
- Use the Explorer Morse Fall Risk Report as an audit tool
- Bed alarms to be checked during bed-side shift exchange report. Assess functional bed alarm
- Medication post fall review by decentralized pharmacist to provide real time review
- Refusal form required if patient declines bed alarm
- Health Stream Education “Evaluating Fall Risk with Morse fall Score “added as an educational tool.
- Integration of Bed Alarm into Call Light System
- Developing Fall Risk Assessment competency for RNs ad PCAs
- Lippincott Education –Fall prevention and Fall management
- Fall Champions validate that all fall prevention steps are in place-Q shift
- Fall Champions rounding on each unit implemented Oct 2017
- Radiology department implementation: mirrors in ultrasound, signs in bathroom – “Call Don’t Fall”, and call bells for patients in the inpatient and outpatient CT hallway. Evaluation of specialty beds and mattresses to identify its impact on fall prevention-ex: Bariatric beds without bed alarms will require the use of portable long mattress pads.
Q1 CY 2019
OVERALL SUMMARY OF REPORTED EVENTS

Total Occurrences Reported:

<table>
<thead>
<tr>
<th>Occur Category</th>
<th>Number of Incidents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Issues</td>
<td>355</td>
<td>61.85%</td>
</tr>
<tr>
<td>Security</td>
<td>102</td>
<td>17.77%</td>
</tr>
<tr>
<td>Falls</td>
<td>44</td>
<td>7.67%</td>
</tr>
<tr>
<td>Surgery Issues</td>
<td>40</td>
<td>6.97%</td>
</tr>
<tr>
<td>Medication Variance</td>
<td>12</td>
<td>2.09%</td>
</tr>
<tr>
<td>Adverse Drug Reaction</td>
<td>9</td>
<td>1.57%</td>
</tr>
<tr>
<td>Safety</td>
<td>6</td>
<td>1.05%</td>
</tr>
<tr>
<td>Patient Rights</td>
<td>3</td>
<td>0.52%</td>
</tr>
<tr>
<td>HIPAA/PHI</td>
<td>3</td>
<td>0.52%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>574</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Total number of reported incident reports increased by 18% from the prior quarter. 205 out of the 574 are AMA’s. Patients fill out AMA form and decline further treatment. Categorized by risk severity we had a total of 414 Level 1, 145 Level 2, 13 Level 3 and 2 Level 4 incidents reported and investigated.

Q1 CY 2019 Leaving Against Medical Advice by Cause:

- REFUSED TREATMENT, NONCOMPLIANCE (45%)
- FAMILY/PERSONAL REASON/EMERGENCY/WORK/TRAVEL (6%)
- REFUSED ADMISSION (3%)
- PATIENT FEELS FINE/BETTER (19%)
- PT PREFERS OWN PHYSICIAN/FACILITY (8%)
- DISSATISFIED WITH CARE/TREATMENT (9%)
- NO REASON/EXPLANATION GIVEN (1%)
- PT REFUSED TO WAIT FOR D/C PAPERS (2%)
- SMOKING ISSUE (2%)
- FINANCIAL REASONS (1%)
- NO PRIVATE ROOM (1%)
Q1 CY 2019 Inpatient Falls:

<table>
<thead>
<tr>
<th>Patient Falls</th>
<th>Subcategory</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Found on floor</td>
<td></td>
<td>11</td>
<td>29.73%</td>
</tr>
<tr>
<td>From chair</td>
<td></td>
<td>5</td>
<td>13.51%</td>
</tr>
<tr>
<td>Patient States</td>
<td></td>
<td>4</td>
<td>10.81%</td>
</tr>
<tr>
<td>Slip</td>
<td></td>
<td>3</td>
<td>8.11%</td>
</tr>
<tr>
<td>From Bed</td>
<td></td>
<td>3</td>
<td>8.11%</td>
</tr>
<tr>
<td>While ambulating</td>
<td></td>
<td>3</td>
<td>8.11%</td>
</tr>
<tr>
<td>Trip</td>
<td></td>
<td>2</td>
<td>5.41%</td>
</tr>
<tr>
<td>From Bedside Commode</td>
<td></td>
<td>2</td>
<td>5.41%</td>
</tr>
<tr>
<td>From equipment, i.e stretcher, table, etc.</td>
<td></td>
<td>2</td>
<td>5.41%</td>
</tr>
<tr>
<td>From Toilet</td>
<td></td>
<td>1</td>
<td>2.70%</td>
</tr>
<tr>
<td>Eased to floor by employee</td>
<td></td>
<td>1</td>
<td>2.70%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>37</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

We had an increase of 54% in inpatient falls. Trends identified were patients found on floor, decline to call for assistance, fall preventions were in place. Out of the 37 falls 12 were behavioral health patients. The Falls Committee has provided valuable feedback, which initiated a changed in HAS to add more detail for Managers specific to be able to better trend and obtain data electronically.

Q1 CY 2019 HAPI Events:

There are a total of 3 HAPIs reported for Q1 FY 2019 an increase from the prior quarter. No identified trends for this category. Intense Analysis were conducted by the departments. Stage 4 HAPI, was not documented until after 24 hours of admission, staff was re-educated on the importance of documentation upon admission.
Q1 CY 2019 Adverse Drug Reactions:

Broward Health Imperial Point
Adverse Drug Reaction
Q1 CY 2019

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Hematological / Blood Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q1 CY 2019 Medications Variances:

Broward Health Imperial Point
Q1 CY 2019
Medication Variances

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra Dose</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Omitted dose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrong Drug or IV Fluid</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Wrong time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improper Monitoring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriber Error</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No significant trends identified.
Q1 CY 2019 Surgery Related:

<table>
<thead>
<tr>
<th>Surgery Category</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Complication</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Surgery/Procedure Cancelled</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Consent Issues</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Sponge/Needle/Instrument Issues</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Unplanned Return to OR</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>14</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>

Surgical Complications and Unplanned Return to ORs are being tracked and trend by Quality and Risk and prepare an action plan if necessary.

Q1 CY 2019 Security Related:

<table>
<thead>
<tr>
<th>Security Category</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Assist</td>
<td>12</td>
<td>6</td>
<td>19</td>
<td>37</td>
</tr>
<tr>
<td>Contraband</td>
<td>6</td>
<td>7</td>
<td>11</td>
<td>24</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>10</td>
<td>2</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>Property Damaged/Missing</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Security Presence Requested</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Code Elopement</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Code Strong</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Access control</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Threat of violence</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Trespass</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Vehicle Accident</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Break-in</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Smoking Issues</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40</td>
<td>24</td>
<td>38</td>
<td>102</td>
</tr>
</tbody>
</table>

Q1 CY 2019 Safety Related:

<table>
<thead>
<tr>
<th>Safety Category</th>
<th>Jan</th>
<th>Feb</th>
<th>Feb</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Hazard</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Electrical Hazard</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>
Q1 CY 2019 Lab Related:

<table>
<thead>
<tr>
<th>Lab Related</th>
<th>Occur Sub Category</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlabeled Specimen</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Labeling Error</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Wasted blood product</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Critical Results</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Not Scanned</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

*Reporting has increased in this category due to education provide to staff.*

Q1 CY 2019 AHCA Annual Reportable Events:

*Three AHCA Annual reportable event occurred during Q1 CY 2019.*

Q1 CY 2019 Code 15 Reported:

No Code 15s reported for Q1 CY 2019.
Overall Occurrence Report
Quarter 1 CY 2019

<table>
<thead>
<tr>
<th>Occurrence Category Q1 CY19</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADR</td>
<td>3</td>
<td>0.17%</td>
</tr>
<tr>
<td>Falls</td>
<td>102</td>
<td>5.84%</td>
</tr>
<tr>
<td>HIPAA PHI</td>
<td>6</td>
<td>0.34%</td>
</tr>
<tr>
<td>Medication Variance</td>
<td>59</td>
<td>3.38%</td>
</tr>
<tr>
<td>OB/Delivery</td>
<td>78</td>
<td>4.47%</td>
</tr>
<tr>
<td>Patient Care Issues</td>
<td>887</td>
<td>50.80%</td>
</tr>
<tr>
<td>Patient Rights</td>
<td>2</td>
<td>0.11%</td>
</tr>
<tr>
<td>Safety</td>
<td>51</td>
<td>2.92%</td>
</tr>
<tr>
<td>Security</td>
<td>519</td>
<td>29.73%</td>
</tr>
<tr>
<td>Surgery Issues</td>
<td>39</td>
<td>2.23%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>1746</td>
<td>100%</td>
</tr>
</tbody>
</table>

During the 1st Quarter CY 2019 there were a total of 1746 occurrence variance reports compared to 1438 during the 4th Quarter CY 2018 reflecting a 21.50% increase in reporting. Since the standardization of login in HAS and security’s response to clinical codes, there has been an increase in reporting in patient care issues.

Inpatient Fall Q1 CY19

<table>
<thead>
<tr>
<th>Incident</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child fall during play</td>
<td>2</td>
</tr>
<tr>
<td>Eased to floor by employee</td>
<td>7</td>
</tr>
<tr>
<td>Found on floor</td>
<td>35</td>
</tr>
<tr>
<td>From bed</td>
<td>6</td>
</tr>
<tr>
<td>From bedside commode</td>
<td>1</td>
</tr>
<tr>
<td>From chair</td>
<td>8</td>
</tr>
<tr>
<td>From equipment, i.e stretcher, table, etc.</td>
<td>1</td>
</tr>
<tr>
<td>Patent States</td>
<td>9</td>
</tr>
<tr>
<td>Slip</td>
<td>1</td>
</tr>
<tr>
<td>Trip</td>
<td>1</td>
</tr>
<tr>
<td>While ambulating</td>
<td>10</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>81</td>
</tr>
</tbody>
</table>

There were 82 falls reported during the 1st Quarter of 2019, a 7.8% decrease from Q4 CY18 - 89. The CNO is reinstituting the Falls Committee so our leadership team can evaluate each fall and establish actions plan to implement house-wide. The incidents occurred on the following departments: 3NT (6), 3ST (2), 4NT (1), 4NWW (8), 4ST (3), 4SWW (17), 4Atrium (11), 5NT (4), 5ST (6), 5Atrium (8), 6NT (1), 6ST (7), CVICU (1), CCU (1), L&D (2) RCU (2), and PICU (1).

There was nine falls with injuries reported during the 1st Quarter 2019 – (1) fall requiring sutures; (1) Fall with fracture; (4) falls with abrasions; and (4) falls with lacerations.
Broward Health Medical Center

OB/Delivery Q1 CY19

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Trauma</td>
<td>3</td>
</tr>
<tr>
<td>CPOE issue</td>
<td>1</td>
</tr>
<tr>
<td>Fetal Distress</td>
<td>3</td>
</tr>
<tr>
<td>Maternal complications</td>
<td>7</td>
</tr>
<tr>
<td>Neonatal complications - Admit NICU</td>
<td>51</td>
</tr>
<tr>
<td>Neonatal complications - Apgar &lt;5 @5 min</td>
<td>1</td>
</tr>
<tr>
<td>Neonatal complications - IV Infiltrate</td>
<td>1</td>
</tr>
<tr>
<td>OB Alert</td>
<td>1</td>
</tr>
<tr>
<td>RN Attended Delivery</td>
<td>6</td>
</tr>
<tr>
<td>Shoulder Dystosia</td>
<td>4</td>
</tr>
<tr>
<td>Grand Total</td>
<td>78</td>
</tr>
</tbody>
</table>

OB/Delivery: All NICU admissions were unrelated to an adverse event but due to the infants’ condition and MD requesting infants’ to be transferred to NICU for closer observations.
**Broward Health Medical Center**

**AMAs:** 25% Refusal of Treatment followed by 14% Family/Personal Reasons and 12% Refused to Wait for D/C Papers. 66% of the AMAs were unrelated to patient care issues.

**HAPU:** Education with critical care unit has been effective as seen from the decrease from Q4 CY18 - 5 to Q1 CY19 – 3 ~ 40% decrease. Wound Care boot camp has been restructured to provide more hands on experience with the nursing staff.

**Medication Variances:** 31% increase in medication variances from 45 Q4 CY18 to 59 Q1 CY19 of which 20 were near misses. No Adverse Outcomes. 5 of the 9 wrong drug occurrences were near misses. 32 occurrences were on the Adult units and 14 on the Pediatric units and 9 in Retail Pharmacy. Retail pharmacy is aware and are tracking and trending incidents.
## ADR Q1 CY19

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>2</td>
</tr>
<tr>
<td>Dermatological</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

**ADR:** 3 ADRs reported. No adverse events.

### SURGERY Q1 CY19

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Issue</td>
<td>4</td>
</tr>
<tr>
<td>Sponge/Needle/Instrument Issues</td>
<td>17</td>
</tr>
<tr>
<td>Sterile field contaminated</td>
<td>4</td>
</tr>
<tr>
<td>Surgery Delay</td>
<td>5</td>
</tr>
<tr>
<td>Surgery/Procedure Cancelled</td>
<td>2</td>
</tr>
<tr>
<td>Surgical Complication</td>
<td>4</td>
</tr>
<tr>
<td>Unplanned Return to OR</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

**Surgery:** 3 Sponge/Needle/Instrument Issues were related to trauma patients who were taken emergently to the OR and initial count could not be completed; 3 were related to needle sticks during the procedure; 4 related to final count were incorrect, all x-rays came back negative. No trends identified.

### MISLABELS Q1 CY19

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mislabeled Specimen</td>
<td>5</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

**Mislabels:** No trend identified. Employees involved will be attending lab school.

### SECURITY Q1 CY19

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive behavior</td>
<td>21</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>18</td>
</tr>
<tr>
<td>Break-in</td>
<td>1</td>
</tr>
<tr>
<td>Code Assist</td>
<td>103</td>
</tr>
<tr>
<td>Code Black</td>
<td>1</td>
</tr>
<tr>
<td>Code Elopement</td>
<td>12</td>
</tr>
<tr>
<td>Code Green</td>
<td>1</td>
</tr>
<tr>
<td>Contraband</td>
<td>39</td>
</tr>
<tr>
<td>Property Damaged/Missing</td>
<td>17</td>
</tr>
<tr>
<td>Security Presence Requested</td>
<td>295</td>
</tr>
<tr>
<td>Security Transport</td>
<td>1</td>
</tr>
<tr>
<td>Threat of violence</td>
<td>3</td>
</tr>
<tr>
<td>Trespass</td>
<td>2</td>
</tr>
<tr>
<td>Vehicle Accident</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>4</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>519</strong></td>
</tr>
</tbody>
</table>
Security: Security reporting has increased from 459 – Q4 CY18 to 519 – Q1 CY19. Most of the increase coming from Security Presence Requested - a 49.7% increase. Decrease noted in assaults from Q4 CY18 -21 vs. Q1 CY19 -18. Increase in Code Assist from Q4 CY18 – 78 vs. Q1 CY19 – 103 ~ a 32% increase. Our PI team continues to review the data and address this issue.

<table>
<thead>
<tr>
<th>SAFETY Q1 CY19</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Biohazard Exposure</td>
<td>2</td>
</tr>
<tr>
<td>Code Red</td>
<td>3</td>
</tr>
<tr>
<td>Electric Hazard</td>
<td>1</td>
</tr>
<tr>
<td>False Alarm</td>
<td>1</td>
</tr>
<tr>
<td>Safety Hazard</td>
<td>35</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>6</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>51</td>
</tr>
</tbody>
</table>

Safety: No trends identified.

Serious Incidents

This event involved a 52 y/o male patient who was admitted on 3/29/2019 for left total knee arthroplasty. His past medical history included hypertension, dyslipidemia, osteoarthritis, and morbid obesity. He previously had Right knee arthroplasty in November of 2018. During the patient’s admission, nursing staff noticed the patient snoring when he slept. He was asked if he had sleep apnea. The patient said he had not been diagnosed with sleep apnea. On the night of 3/30/2019, going into the morning of 3/31/19 the patient was medicated multiple times with PO percocet and IV Dilaudid. At 0745, the PCA entered to room to take the patient’s vital signs. She found the patient lying on his side, snoring and not responding to his name or touch. She went for help, and the responding providers could not detect a pulse, and ACLS was started. There was return of spontaneous circulation, and the patient was intubated and transferred to the intensive care unit. Subsequent EEG’s performed on the patient showed severe abnormal record, cerebral dysfunction with a poor prognosis in the setting of anoxic encephalopathy. The wife elected for hospice care and the patient was transferred to an inpatient hospice at another facility on 4/12/19.
During the 1st Quarter CY 2019, there were a total of 991 occurrence variance reports compared to 883 during the 4th Quarter CY 2018, reflecting a 12% increase in reporting. The overall Near Miss Occurrences during the 1st Qtr. CY 19 were 35 or 3.53% of overall occurrences ~ a positive trend. The goal continues to be increased reporting to discern trends in order to place risk reduction measures in place.

### Inpatient Fall Q4 CY18

<table>
<thead>
<tr>
<th>Occurrence Category</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADR</td>
<td>6</td>
<td>1%</td>
</tr>
<tr>
<td>FALLS</td>
<td>45</td>
<td>5%</td>
</tr>
<tr>
<td>HIPAA PHI</td>
<td>4</td>
<td>0%</td>
</tr>
<tr>
<td>MEDICATION</td>
<td>65</td>
<td>7%</td>
</tr>
<tr>
<td>PATIENT CARE</td>
<td>590</td>
<td>60%</td>
</tr>
<tr>
<td>PATIENT RIGHT</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>SAFETY</td>
<td>9</td>
<td>1%</td>
</tr>
<tr>
<td>SECURITY</td>
<td>227</td>
<td>23%</td>
</tr>
<tr>
<td>SURGERY</td>
<td>40</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>991</strong></td>
<td><strong>102%</strong></td>
</tr>
</tbody>
</table>

**Inpatient Fall(s)** (Including Rehab): **32** or rate of 1.5 with a benchmark of 2.61 (YTD 1.5). Robust Fall Prevention Action Plan in place by Nursing.

5th FL - 1
3 SE - 5
6th FL - 3
4th FL Rehab - 5
9th FL - 3
3NE - 3
CICU - 1
8th FL - 3
7E - 7
MICU - 1

**Inpatient Fall(s) with Injury:** (0)

**ED Falls:** - (3) No injuries
Outpatient Fall(s): (0)

Outpatient Fall(s) with injury: N/A

AMA: The total number of AMAs was 195. The majority of AMAs 75% are unrelated to care and treatment, 17% healthcare related; and 8% no reason given. Continue to track and trend AMA’s and encourage patients to stay in hospital to continue their care and treatment.
Broward Health North

BHN HAPI CY19 Q1

HAPI: No trends identified.
Medication Variances: 61 (Near Miss 20 vs. Actual 41). Rate of 0.02%. No Adverse Outcomes/Trends.

Identified a trend with variances related to medication history/reconciliation. Recommended ER staff to refer to patient’s external medication history to ensure accuracy. Process has been initiated and ongoing. Monitoring in progress.

ADR Q4 CY18

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>4</td>
</tr>
<tr>
<td>Dermatological</td>
<td>1</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

ADR: 6 Rate of 0% No Adverse outcomes/trends.

SURGERY Q4 CY18

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Issues</td>
<td>20</td>
</tr>
<tr>
<td>Sponge/Needle/Instrument Issues</td>
<td>6</td>
</tr>
<tr>
<td>Sterile field contaminated</td>
<td>2</td>
</tr>
<tr>
<td>Surgery Delay</td>
<td>6</td>
</tr>
<tr>
<td>Surgery/Procedure Cancelled</td>
<td>3</td>
</tr>
<tr>
<td>Surgical Complication</td>
<td>1</td>
</tr>
<tr>
<td>Unplanned Return to OR</td>
<td></td>
</tr>
</tbody>
</table>
**Broward Health North**

**Grand Total** | 40
---|---

**Consent issues**: Increase in number of consent issues from 4th quarter 1 vs. 20 in the 1st quarter. Surgical staff increased reporting of all physician consent issues. Many incidents were related to two physicians due to incorrect times written on consent by physician or consent not signed prior to patient going to OR suite. RMO has reviewed with OR director. RMO will review and discuss at Department of Surgery meeting.

No adverse outcomes/trends related to surgical complications or unplanned return to surgery.

**Mislables**

No mislabeled specimens for the quarter which is a positive trend.

One unlabeled specimen for quarter. No trends identified.

<table>
<thead>
<tr>
<th><strong>SECURITY Q4 CY18</strong></th>
<th><strong>Percentage</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access control</td>
<td>1 0%</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>10 4%</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>4 2%</td>
</tr>
<tr>
<td>Break-in</td>
<td>1 0%</td>
</tr>
<tr>
<td>Code Assist</td>
<td>124 55%</td>
</tr>
<tr>
<td>Code Elopement</td>
<td>20 9%</td>
</tr>
<tr>
<td>Contraband</td>
<td>28 12%</td>
</tr>
<tr>
<td>Property Damaged/Missing</td>
<td>23 10%</td>
</tr>
<tr>
<td>Security Presence Requested</td>
<td>9 4%</td>
</tr>
<tr>
<td>Threat of violence</td>
<td>3 1%</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>3 1%</td>
</tr>
<tr>
<td>Arrest</td>
<td>1 0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>227 98%</strong></td>
</tr>
</tbody>
</table>

Security: 226 Security occurrences in Q4 vs 227 in Q1. 5-10 patients had multiple code assists called from 2-5 times. Behavior exhibited ranged from extremely violent such as kicking/hitting staff to elderly confused patients. Several occurrences involved visitor altercations.

Consider development/implementation of acute care behavioral IPOC.

<table>
<thead>
<tr>
<th><strong>SAFETY Q4 CY18</strong></th>
<th><strong>Percentage</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Biohazard Exposure</td>
<td>3</td>
</tr>
<tr>
<td>Code Red</td>
<td>1</td>
</tr>
<tr>
<td>Safety Hazard</td>
<td>4</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

**Safety**: No trends identified.
Opportunity:

- Breakdown in process regarding retained guidewire from CVC insertion. (Wire was successfully removed with no surgical intervention during CVC replacement).

Actions:

- RN will assist radiology tech to remove wires over chest while performing CXR in ICUs.
- Reinforce clear handoff between anesthesia and OR RN at end of case.
- Reinforce removal of distractions during procedures with anesthesia providers.
- Provider who inserts central line in OR will place order for CXR.
- Reinforce documentation of lines in OR by nursing.

Monitor:

- No further incident reports related to similar occurrences
- Staff have not reported any similar occurrences to OR leadership
ANNUAL APPRAISAL FOR CY2019

I. Overview of Program

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

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

This Program Evaluation is based in part on outcomes achieved during calendar year 2018. Outcomes are identified through review of performance measurement data, information resulting from Broward Health Coral Springs (BHCS) committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Broward Health Coral Springs and in collaboration with other Broward Health facilities.

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

- Prospective surveillance is completed by Epidemiology for identification of infections.
- Rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
- Monthly reports are submitted to Patient Safety Quality Council Committee meeting where infections are discussed and opportunities for improvement are presented.
- Infections, results of ongoing surveillance, and Performance Monitoring Reports (PMR) are also presented at the quarterly Infection Control Committee meeting.
- Priority is given to device related infections based on risk assessment and analysis of collected data which is evaluated on an ongoing basis to provide immediate intervention when indicated to reduce or prevent infection.
- Priority is also given to Surgical Site Infections based on the risk assessment and analysis of the collected data.
Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.

3 South Surgical Unit was added for public reporting.

HOUSE WIDE INFECTIONS FOR CY2018

Zero Tolerance and the Bundle Approach

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

Benchmarking

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

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

II. Device-Associated Infections

Central Line Associated Blood Stream Infections (CLABSI)

<table>
<thead>
<tr>
<th>CLABSI CY2018</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>1st Qtr</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>2nd Qtr</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>3rd Qtr</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>4th Qtr</th>
<th>YTD CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>C criterial</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>3 EAST</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>3 SOUTH</td>
<td>0</td>
<td>0</td>
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Total Cases: 1
Total Line Days: 7941
Analysis

Adults
The CLABSI rate in the adult population for CY2018 was 0.91 per 1000 central line days. This is a reduction from a rate of 0.97 per 1000 central line days in CY2017. We also had a reduction in line days from 7,341 in CY2017 to 6,669 in CY2018.

The NHSN SIR for CY2018 was 1.16 which is a reduction from 1.26 in CY2017. The SIR is still above 1, which is more than expected based on the NHSN definition, but it is still a reduction. The SIR is a standardized infection ratio which is risk adjusted based on national data.

- Reduction in infection rate from CY2017 to CY2018 was 6%.
- Reduction in central line days from CY2017 to CY2018 was 9%.
- CY2018 SIR: 1.16
- CY2018 Threshold: 0.784
- Reduction in SIR rate from CY2017 to CY2018 was 8%.

NICU
The CLABSI rate in the NICU population for CY2018 was 0 per 1000 central line days.

Pediatrics
The CLABSI rate in the pediatric population was 0 per 1000 central line days for CY2018.

Action Plans
- We continue to monitor central lines for necessity, educate nursing staff and the medical staff on the use of midlines, when appropriate.
- BHCS participates in HIIN for best practices.
- Daily assessment of the central line included line necessity, discontinuation of the central line or change the central line to a midline when appropriate, improved awareness and communication which included bedside shift report.
- Rounding included ongoing interventions; line necessity, education and line dressing surveillance.
- Daily chlorhexidine bathing for inpatients on all units, except for the ICU/CCU for patients with central lines.
- Implementation of daily CHG bathing for all ICU/CCU patient, as part of nursing action plans.
- Bathing techniques were monitored and re-education was provided to all nursing staff. In addition, mandatory online education was provided through Healthstream.
- Continued use of antimicrobial product, Theraworx, for all patients every 12 hours in the ICU/CCU.
- Continued use of disinfectant caps on all IV tubing access ports on all adult inpatient nursing units.
- Continued education of all new hire RNs with the use of the Guardian Angel Program with validation and competency.
- Central line bundle compliance monitoring completed by Epidemiology on a monthly basis to include review of EMR to reflect the following at every insertion: hands washed prior to procedure, use of CHG antiseptic at the procedure site, maximal barrier used, use of hat, mask, sterile gown, sterile gloves, number of additional line attempts, application of antimicrobial patch, if indicated, number of femoral central venous catheter insertions,
number of femoral line insertions. This data is reported at the quarterly Infection Control Committee meeting.

Catheter Associated Urinary Tract Infections (CAUTI)

CAUTI CY2018

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<th>Indicator</th>
<th>Stretch Goal</th>
<th>Target</th>
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<th>3rd Qtr</th>
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Analysis

Adults

The CAUTI rate in the adult population at BHCS for CY2018 was 0.36 per 1000 urinary catheter days. This is a decrease from the previous CY2017 rate of 0.95 per 1000 urinary catheter days. We also had a reduction in urinary catheter days from 6,341 in CY2017 to 5,769 in CY2018.

The NHSN SIR for CY2018 was 0.73 which is a reduction from 1.30 in CY2017. The SIR is now below 1, which is less than expected based on the NHSN definition. The SIR is a standardized infection ratio which is risk adjusted based on national data.

- Reduction in infection rate from CY2017 to CY2018 was 62%.
- Reduction in urinary catheter days from CY2017 to CY2018 was 9%
- CY2018 SIR: 0.73
- CY2018 Threshold: 0.828
- Reduction in SIR rate from CY2017 to CY2018 was 44%
Pediatrics
The CAUTI rate in the pediatric population at BHCS was 0 per 1000 urinary catheter days for CY2017.

Action Plans
- Continue to monitor urinary catheter for necessity, educate nursing staff and the medical staff, when appropriate.
- Continue to utilize the HOUDINI protocol for indications for urinary catheter.
- BHCS participates in HIIN for best practices.
- Daily assessment of the urinary catheter included line necessity and discontinuation of the urinary catheter utilizing the HOUDINI protocol.
- Improved awareness and communication which included bedside shift report.
- Daily rounding included ongoing interventions, urinary catheter necessity, education and urinary catheter bundle compliance during surveillance.
- Antimicrobial bathing with Theraworx and following the manufacturer’s instructions for use, for all patients with urinary catheters.
- Education and reinforcement regarding appropriate use of antimicrobial product completed on a quarterly basis.
- Continued surveillance and enforcement of the urinary catheter bundle compliance during rounding.

Ventilator Associated Pneumonia

Adults
The VAP rate in the adult population at BHCS for CY2018 was 0 which is a reduction from 2.28% in CY2017. As a result of the increase in CY2017, the pharmacy added CHG to the medication administration record profile and this was also included this on the Ventilator Power plans for physician ease in compliance with the VAP bundles. We has also had a reduction in ventilator days from 878 days in CY2017 to 867 ventilator days to 867 in CY2018.

- Reduction in infection rate from CY2017 to CY2018 was 100%.
- Reduction in ventilator days from CY2017 to CY2018 was 1%.

PICU/NICU
The PediVAP rate in the pediatric population at BHCS for CY2017 was zero per 1000 ventilator days.

Action Plan
The VAP bundle continues to be utilized as well as rounding to ensure that the bundle measures are in place.
III. Surgical Infections Report

Surgical Site Infections Class I and Class II CY2018

Overall Class I and Class II

For CY2018, the overall surgical site infection rate was 0.4% for Class I and Class II infections. This number represents 20 infections out of 4,505 of Class I and Class II surgical procedures combined. For CY2017, the overall surgical site infection rate was 0.6%. This number represents 28 infections out of 4,872 of Class I and Class II surgical procedures combined.

- Reduction in infection rate from CY2017 to CY2018 was 33%.
- The rate of infection from CY2016 to CY2017 remained the same.
- A SIR is not provided by NHSN.
Colon Surgical Site Infections

For CY2018, the colon surgical site infection rate was 9.2%. This number represents 13 infections out of 142 colon surgical procedures. For CY2017, the colon surgical site infection rate was 8.1%. This number represents 10 infections out of 124 colon surgical procedures.

The NHSN SIR for CY2018 was 2.04 which is an increase from 1.56 in CY2017. The SIR is above 1, which indicated that there were more infections identified than predicted based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

- Increase in infection rate from CY2017 to CY2018 was 14%.
- Reduction in infection rate CY2016 to CY2017 was 30%.
- CY2018 SIR: 2.04
- CY2018 Threshold: 0.781
- An increase in the SIR was 31%.
**Hysterectomy Surgical Site Infections**

**Analysis**

**Hysterectomy Surgical Site Infections**

For CY2018, the hysterectomy surgical site infection rate was 0.4%. This number represents 1 infection out of 263 hysterectomy surgical procedures. For CY2017, the hysterectomy surgical site infection rate was 0.8%. This number represents 2 infections out of 237 hysterectomy surgical procedures.

The NHSN SIR for CY2018 was 0 which is a decrease from 0.55 in CY2017. The SIR is below 1, which indicated that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

- Decrease in infection rate from CY2017 to CY2018 was 50%.
- Slight increase in the infection rate from CY2016 to CY2017 was 5%.
- CY2018 SIR: 0.
- CY2018 Threshold: 0.722
- A decrease in the SIR was 100%.
C-section Surgical Site Infections

For CY2018, the C-section surgical site infection rate was 0.4%. This number represents 5 infections out of 1,262 C-section surgical procedures. For CY2017, the C-section surgical site infection rate was 0.8%. This number represents 8 infections out of 991 C-section surgical procedures.

- Decrease in infection rate from CY2017 to CY2018 was 50%.
- Increase in infection rate from CY2016 to CY2017 was 33%.
- A SIR is not provided by NHSN.

Action Plans for All Surgical Site Infections

- Continue to monitor all class I, II, colon, hysterectomy and C-section surgical procedures for development of surgical site infection.
- Infections also be identified separately based on the following: Class I, Class II, total hip and total knee replacements. This is for standardization of internal reporting mandated by Broward Health.
- Continue to report surgical infections to Patient Safety and Quality Council Committee meeting, Department of Surgery Committee meeting, OB/GYN Perinatal Committee and Infection Control Committee meeting.
- A Surgical Site Prevention Committee meeting was established in November 2017 with the intent to focus the CDC Guidelines for Prevention of Surgical Site Infections, 2017 and institute those measures, a focus on all colon and hysterectomy infections, which are reportable to NHSN and focus on all C-section infections as well as all Class I and Class II surgical site infections.
- Multidisciplinary rounding is also completed for all patients who are part of the Joint Commission Disease Specific Minimally Invasive program with Epidemiology in attendance.
- Communication regarding infections occurred with all nurse managers and administration during one-to-one meetings, at Nurse Leadership Committee on lessons learned to prevent infection.
- Presentation of all surgical site infections at the Surgical Site Infection Prevention Committee meeting with focus on risk factors and adherence to evidence based practice to reduce infections.
- Ongoing education of surgical staff on proper wound classification.
- BHCS participates in HIIN for best practices.
- Based on the CDC Guidelines for Prevention of Surgical Site infections, the Department of Surgery decided to discontinue utilization of CHG wipes on all surgical patients immediately prior to surgery in December 2017.
- The Department of Surgery decided to discontinue utilization of CHG bathing for all inpatients in August 2018. This information was communicated to our medical staff.
- Preoperative education prior to surgery is provided to all patients regarding the importance of preoperative bathing with either soap or water or an antiseptic which is to be completed at home the night before surgery and the morning of surgery before coming to the hospital.
- CHG foam is provided to all patients that attend preoperative education classes. This information was communicated to the medical staff.
- Information from the CDC Guidelines for the Prevention of Surgical Site Infections, 2017 was shared with medical staff, included that the performance of an intraoperative skin preparation with an alcohol-based antiseptic agent unless contraindicated is a Category A1-strong recommendation; high quality evidence. This information was communicated to the medical staff.
- Re-evaluation and implementation of CHG bathing preoperatively for all patients.

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

MDRO Infections
BHCS Tracks and trends all Resistant Organisms (i.e. MRSA, VRE, CRE, and ESBL) cultured from patients to determine if they are community acquired versus hospital acquired. We had a slight increase in MDROs, but we had a reduction in VRE and ESBL hospital acquired infections. We also track and trend all MRSA bacteremia as per the NHSN guidelines.

Analysis
For CY2018, our infection rate for organisms that were culture positive for MRSA and ESBL was 0.12%. This number represents 6 infections out of 48,066 patient days. For CY2017, our infection rate for organisms that were culture positive for MRSA, CRE, and VRE was 0.25%. This number represents 13 infections out of 50,830 patient days.

For CY2018, our infection rate for MRSA Bacteremia was 0.02%. This number represents 1 infection out 48,066 patient days. For CY2017, our infection rate for MRSA Bacteremia was 0%. 
The NHSN SIR for CY2018 was 0.52, which is an increase from 0 in CY2017. The SIR is below 1, which indicated that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

- Decrease in overall MDRO infection rate from CY2017 to CY2018 was 52%.
- Increase in MRSA Bacteremia infection rate was 100%; however, this is based on one positive.
- CY2018 SIR: 0.52
- CY2018 Threshold: 0.815
- Increase in SIR.

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

Analysis
For CY2018, our infection rate for hospital onset C. difficile infection 4.13%. This number represents 17 infections out of 41,191 patient days. For CY2017, our infection rate for hospital onset C. difficile infections was 2.97%. This number represents 13 infections out of 43,798 patient days.

The NHSN SIR for CY2018 was 0.56. The NHSN SIR rate for CY2017 was 0.45, which is an increase in CY2017. The SIR is below 1, which indicated that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

There were 17 cases of hospital acquired C. difficile with no commonalities as to time and location.

- Increase in C. difficile infection rate from CY2017 to CY2018 was 39%.
- CY2018 SIR: 0.56
- CY2018 Threshold: 0.852
- Increase in SIR from CY2017 to CY2018 was 24%.

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

V. Healthcare Worker Risks

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

Surveillance plan is carried out by the Epidemiology nurses on an ongoing basis resulting in prevention of disease transmission to patients, hospital staff, LIPs, students, volunteers and visitors.

Epidemiology identifies risks for acquisition and transmission of infectious agents on an ongoing basis (MDROs, C. difficile, TB, Influenza) and annual risk assessments.

There is a high incidence of TB in Broward County which requires constant surveillance to identify suspect cases. This is included in the risk analysis of reported data as high risk and requires close monitoring to prevent transmission.

Continue to actively track and trend the traffic of patients for any increase influx of patients and/or need to implement the Pandemic Plan.

Epidemiology nurses performed daily ongoing surveillance through the monitoring of ED logs, microbiology candidate reports and rounding helped identify influx of infectious patients.

The ESSENCE reporting system that identifies syndromic trends through the ER is used to coordinate surveillance with the Broward County Department of Health.

A database for TB reporting to the Health Dept. was utilized to maintain a record of communication.

Early identification of patients colonized or infected with resistant organisms, TB, influenza or other infectious organisms and immediate transmission based isolation of these patients reduced and prevented further transmission.

Individual patient positive MDRO results were entered into an ALERT data base system which is activated to display with subsequent patient visits. The ALERT screen enabled hospital staff to imitate transmission based precautions as indicated from the screen information.

All exposures are reported to Employee Health. Employee Health tracked for any trends and all reports are presented to Environment of Care Committee meeting and the quarterly Infection Control Committee meeting.

### Isolation Precautions Compliance

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### VI. Communicable Diseases

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

Antibodies to Hepatitis C virus, and various gastrointestinal diseases such as Salmonella and Shigella were the top reported communicable diseases other than STD’s.
VII. Education

- Annual infection control education completed for all departments at BHCS via Healthstream. Attendance lists are on file in the Education office.
- Education provided at New Hire Orientation.
- Formal in services as well as Just in Time education provided by Coordinator of Epidemiology throughout CY2017 focused on Hand hygiene, multidrug resistant organisms, C. difficile, CAUTI bundle practices, and isolation precautions.
- Presentations at various hospital units staff meetings conducted throughout the year.
- Epidemiology is available for consultation 24 hours a day, seven days a week.
- Support and enhance public relations through community interactions and educational programs on BHCS campus and at various community centers throughout the county.

VIII. Trials / New Products

- All products that are introduced to Broward Health Coral Springs must first go through the Value Analysis Committee for approval which includes updates on trials of the product to ensure proper function and safety.
- When indicated, presentations are first given to the Regional Epidemiologists prior to being presented at Value Analysis Committee.
- Implementation of Purewick, which is an alternative for urinary catheters.
- Implementation of the new urinary catheter tray to aid in aseptic technique during insertion.
- Implementation of 7mm Biopatch availability for use in patients with hemodialysis catheters when appropriate.
- Implementation of the TEGO caps for use in patients with hemodialysis catheters which will allow use of the disinfection caps.

IX. Evaluation

- The BHCS Infection Control Risk Assessment for CY2019 was presented to the Infection Control Committee for review, recommendations and approval.
- The annual appraisal CY2019 was presented for approval to the Infection Control Committee and will be presented to the Medical Executive Committee.
- The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified.
- The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- The Infection Control Committee meets quarterly. The Committee structure includes the Committee chair (Infectious Disease physician), staff physicians, administration, nursing, pharmacy, lab, nutritional services, environmental services, surgery, safety, facilities and other departments as needed.
- PMR and other reports are indicated are provided to the Patient Safety Quality Council Committee meeting on a monthly basis.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.
- All areas surveyed for construction were found to be fully ICRA compliant during CY 2018.
• All of the prioritized risks were reviewed and evaluated. Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
• Epidemiology monitored sterilization and high level disinfection processes within the hospital. Ongoing review of the monitoring reports submitted by all departments are also presented at the Environment of Care Committee meeting and Infection Control Committee meeting.
• The Coordinator of Epidemiology maintains membership of national and local chapters of their professional organizations, to include APIC and AORN, in order to receive education and competency related to Epidemiology/Infection Prevention and Control on an ongoing basis.

**CY2018 Epidemiology Accomplishments**

**Education and Celebration**
• Implemented Zero Hero program to recognize nursing units with Zero infections.
• Celebrated Infection Prevention and Control week with Wheel of bug, (similar to Wheel of Fortune) with questions for staff related to Infection Prevention and Control. Provided Germ Matching game and Infection Control Word Search game. Provided coloring page with crayons for staff to bring home to their children related to importance of hand hygiene. Engaged staff during meal times and at Town Hall and went to every department and the Women’s Center during day and night shift to be sure to capture as much staff as possible during the week. Also provided information from APIC on ways to protect patients, breaking the chain of infection and infection prevention.
• During the month of November provided C. diff education as it was C. diff awareness month. Created Wheel of Bugs with specific questions geared to C. diff education. Created “What’s the Scoop on Poop” word search, created C. diff algorithm for nursing education, created Need2Know on C. diff based on CDC guidelines. Provided one-on-one education including to, but not limited to each nursing unit, Nutritional Services, EVS services, and Rehab and physicians to almost 200 staff.
• Nursing Grand Rounds on Health Associated Infections

**Hand Hygiene 2018**
• Implemented a recognition program to identify HCWs who perform hand hygiene by providing a business card with a life saver candy and a “thank you for being a life saver”.
• Recognized during the Joint Commission Survey 2018 as a best practice with recommendation to submit to Joint Commission National Leading Practice Library.
• Created flyer on Hand Hygiene for all departments based on CDC guidelines and presented at departmental huddles.
• Implementation of PDI patient hand sanitizing wipes for improvement of hand hygiene for patient use.
• Updated BH Corporate Hand Hygiene Assessment and Competency Validation Tool.

**CAUTI**
• Continued education on NHSN and surveillance definitions.
• Rounding on maintenance and care related to urinary catheters as well as reminders for removal.
• House wide collection of line days.
• Striving for zero infections.
• Pericare/foley care and CAUTI prevention provided to all staff.
• Introduction of new urinary catheter tray to aid in aseptic technique during insertion.
Continue to ensure that all urinary catheters inserted with urimeters to prevent breaking closed system.

- CAUTI rate graphs provided monthly at Patient Safety Quality Council meetings.
- In-services provided in the use of Theraworx.

**CLABSI**

- Education on NHSN and surveillance definitions
- CHG bathing techniques were monitored and re-education was provided to all nursing staff.
- Created mandatory online education was provided through Healthstream.
- Continued use of disinfectant caps on all IV tubing access ports on all adult inpatient nursing units.
- Continued education of all new hire RNs with the use of the Guardian Angel Program with validation and competency.
- Rounding on the unit questioning the necessity of lines and observing dressings has contributed to the overall decline in CLABSI rates.
- CLABSI rate graphs provided monthly at Patient Safety Quality Council meetings.
- Discussion of CLABSI in at Patient Safety Quality Council meetings.
- Prevalence rounding by Epidemiology.
- Implementation of TEGO caps and availability of 7mm Biopatch.
- Biopatch in-services provided hospital wide, including the ED.

**SSI**

- Education on NHSN and surveillance definitions.
- Daily surveillance of cultures to identify any surgical site infections.
- A Surgical Site Prevention Committee meeting was established in November 2017 with the intent to focus the CDC Guidelines for Prevention of Surgical Site Infections, 2017 and institute those measures.
- Attendance at Multidisplinary Rounding for all patients who are part of the Joint Commission Disease Specific Minimally Invasive program.
- Communication regarding infections occurred with all nurse managers and administration during one-to-one meetings, at Nurse Leadership Committee on lessons learned to prevent infection.
- Presentation of all surgical site infections at the Surgical Site Infection Prevention Committee meeting with focus on risk factors and adherence to evidence based practice to reduce infections.
- SSI rate graphs provided monthly at Patient Safety Quality Council meetings, Department of Surgery and OB/GYN Perinatal Committee meetings.
- Discussion of SSI at Patient Safety Quality Council meetings.
- Continued weight based dosing for pre op antibiotics as per evidence based practice.
- Identification of the need and creation of signs required for the entrances to the Surgical Suite in the new South Tower building.

**VAE**

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

**MDRO and C. Difficile**

- EVS in-services.
- Implementation of the use of Viresep, a bleach product, for EVS to use for daily cleaning and terminal cleaning for those patients on Enhanced Contact Isolation.
• Nutritional Services in-services
• Use of Medmined data mining system to capture any trends related to MDRO’s and CDI.
• Recognizing the importance of antimicrobial stewardship in decreasing the rates of MDROs, the Epidemiology Department continues to work with Pharmacy.
• Continued to implement Transmissions-Based Precautions and Standard Precautions
• Hand Hygiene education
• MDRO admission alerts, and frequent communication between clinical and nursing departments and Epidemiology.
• Continued use of Respiratory Viral Panel/Biofire technology to decrease antibiotic use when viruses are identified.
• Presented Grand Rounds Education on ESBL in the Pediatric Patient.

New policies, committees and initiatives
• System wide High Level Disinfection policy created.
• High Level Disinfection Committee created to standardize practices across departments according to best practices from Joint Commission BoosterPak and in line with AORN guidelines and SGI guidelines.
• Implementation of liners to be used in order to refill the BH patient water pitchers.

Education
• CDC education on NHSN definitions by Epidemiology nurse.
• Certification in Infection Control obtained by Coordinator of Epidemiology
• Attendance at FHA Infection Control Boot Camp
• Continuous education through webinars, attendance at meetings and online education.

Coordinator of Epidemiology: ________________________________

CNO, COO, or CFO: ________________________________

Infection Control Committee Chairman: ________________

Date: ________________________________
INFECTION CONTROL PLAN
POLICIES AND PROCEDURE MANUAL-
BHCS ADDENDUM TO SYSTEM IC PLAN

<table>
<thead>
<tr>
<th>POLICY #:</th>
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<tbody>
<tr>
<td>PURPOSE:</td>
<td>Broward Health Coral Springs (BHCS) has developed and implemented an effective Infection Control Program for the surveillance, prevention and control of infection.</td>
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<tr>
<td>APPROVED BY:</td>
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<td></td>
<td>Chairman, Infection Control Committee</td>
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<td>Chief Executive Officer, BHCS</td>
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<td>Chief Nursing Officer, BHCS</td>
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**Purpose:** Broward Health has developed and implemented an effective system-wide Infection Prevention and Control Program for the surveillance, prevention and control of infection. This is the BHCS specific addendum to the plan.

**I. Description of Population**
Broward Health Coral Springs is a 250 bed community hospital located in Coral Springs, in Northwest Broward County. BHCS provides comprehensive care across the continuum of care for all age groups. Patient populations include: medical-surgical specialties, including but not limited to intensive care, general surgery and medicine, gastroenterology, women and children, neonatology Level II, pediatrics, orthopedics and other services which are delineated in the Scope of Program section. In addition, the adult and pediatric emergency departments are very busy and treated over 66,000 patients in CY2018.
Per Fiscal Year 2018 statistics, our payer mix was Medicare 15.4%, Medicaid 8.9%, Commercial (includes HMO/PPO, Managed Care Medicaid, Managed Care Medicare) 63.9%, Charity & Selfpay 11.8%.

According to the Broward County Health Department, there are high numbers of infectious diseases reported. These primarily include HIV/AIDS, Hepatitis C, STD’s, and Tuberculosis.

The Top 10 adult principle surgical procedures performed in CY2018 include: laparoscopic gastrectomy sleeve; laparoscopic cholecystectomy with cholangiogram; cystoscopy with retrograde ureteroscopy; laparoscopic appendectomy; Davinci laparoscopic hysterectomy; incision and drainage; inguinal herniorrhaphy; dilatation and curettage suction; dilatation and curettage with hysteroscopy; and total abdominal hysterectomy.

The Top 10 adult inpatient principle diagnosis for CY2018 include: sepsis unspecified organism; maternal care for low transverse scar from previous cesarean delivery; morbid obesity due to excess calories; post-term pregnancy; pneumonia, unspecified organism; acute kidney failure, unspecified; chronic obstructive pulmonary disease with acute exacerbation; urinary tract infection, site not specified; Sickle cell disease with crisis, unspecified, and first degree perineal laceration during delivery.

The Top 10 adult emergency department diagnosis for CY2018 include: other chest pain; urinary tract infection, site not specified; headache; chest pain, unspecified; threatened abortion; low back pain; unspecified abdominal pain; essential (primary) hypertension; bronchitis, not specified as acute or chronic; and dizziness and giddiness.

The Top 10 pediatric principle surgical procedures for CY2018 include: circumcision; laparoscopic appendectomy; periodontal surgery; tonsillectomy and adenoidectomy; myringotomy insertion of PE tubes; adenoidectomy; myringotomy insertion of PE tubes and adenoidectomy; inguinal herniorrhaphy and umbilical herniorrhaphy.

The Top 10 pediatric inpatient principle diagnosis for CY2018 include: acute upper respiratory infection, unspecified; viral infection, unspecified; vomiting, unspecified; constipation, unspecified, noninfective gastroenteritis and colitis, unspecified, fever unspecified; acute bronchiolitis, unspecified, otitis media, unspecified, bilateral; unspecified injury of the head, initial encounter, otitis media, unspecified left ear.

The Top 10 pediatric emergency department diagnosis for CY2018 include: acute upper respiratory infection, unspecified; viral infection, unspecified; vomiting, unspecified; constipation, unspecified; noninfective gastroenteritis and colitis, unspecified; unspecified injury of head, initial encounter; fever, unspecified; otitis media, unspecified, bilateral; and otitis media, unspecified, left ear.

Conditions such as cancer, HIV/AIDS, indwelling medical devices, disorders that affect the immune system, alcoholism, drug abuse, diabetes and renal failure can also increase an individual’s risk for acquiring infections.

II. Scope of Program
   a. BHCS is a 250 bed facility that provides care across the continuum of care for all age groups and includes a variety of inpatient, outpatient, rehabilitative, and emergency services for both adult and pediatric populations.
b. The patient population at Broward Health Coral Springs consists of a majority of obstetric/pediatric patients, adult medical/surgical patients and a large number of geriatric cardiac patients. The needs of the geriatric patient population are influenced by an increased potential for complications due to pre-existing conditions and therapy; i.e., long term steroid use, financial constraints in a retirement community, increasing anxiety with potential impact on the timeliness of seeking medical care and compliance with instructions and medications pre and post hospitalization; compromised nutritional status; limited mobility; diminished sensory perception and a greater complexity of discharge planning needs due to length of stay and reimbursement constraints placed upon the hospital by Medicare, Managed Care and other healthcare insurers. Pediatric patients with the potential of acquiring and spreading communicable diseases (i.e., varicella, measles, mumps, pertussis, meningococcal disease, etc.) must be monitored to terminate spread of disease. Immunization status of all hospitalized children is evaluated upon admission. Low-income families run the potential risk of not having up-to-date immunizations. Neonates and newborns having compromised immune systems place them at risk for developing infections.

c. Patient care units include:

1. A thirty-four (34) bed Adult Emergency Department and a ten (10) bed Pediatric Emergency Department that includes four (4) observation beds which treats both adult and pediatric patients and also includes one (1) critical care/trauma bed for adults and one (1) critical care/trauma bed for pediatrics. Approximately 3,800 adult patient and approximately 1,600 pediatric patients are seen on a monthly basis presenting with cardio-respiratory, surgical, and neurovascular disorders. Minimal trauma cases are received. There are five (5) AII (Airborne Infection Isolation) rooms are available on the adult side 13, 14, 20, 34, 35. If needed, room 13 would be used for a pediatric patient.

2. A sixteen (16) bed Adult Critical Care Unit (separated into two units). The patient population is generally adult, geriatric and both antepartum and postpartum patients with cardiopulmonary, surgical, neurovascular disorders, hypertensive crisis and septic patients. Two rooms, in the Intensive Care Unit and Cardiac Care Unit, are AII rooms (ICU 1 and 8, CCU 1 and 8). This unit is located on the 2nd floor in the Legacy Building

3. A thirty-five (35) bed Progressive Care Unit with primarily adult and geriatric patients with cardiopulmonary conditions. Dialysis patients are also treated. Two AII rooms are available (Room 438 and 452). Telemetry monitoring available. This unit is located on the 4th floor in the Legacy Building

4. A thirty-three (33) bed Medical Unit with primarily adult and geriatric patients with respiratory conditions, including suspected and active tuberculosis patients. There is one (1) permanent AII room (Room 401). There are currently 11 rooms which can be converted into AII rooms (409, 410, 411, 412, 415, 416, 417, 418, 423, 424, 425). All types of medical conditions are serviced and some surgical patients may be admitted here. There is remote telemetry monitoring available. This unit is located on the 4th floor in the Legacy Building.

5. A thirty-three (33) bed Med-Surg Unit with primarily adult and geriatric patients. There is one AII room available (Room 352). There is remote telemetry monitoring available. This unit is located on the 3rd floor in the Legacy Building.

6. A twenty-eight (28) Surgical Unit dedicated to bariatric, urological, orthopedic, colorectal, gynecological and general surgical patients with two AII rooms (381 and 395). There is remote telemetry monitoring available. This unit is located on the 3rd floor in the South Tower.

7. A ten-(10) bed Level II Neonatal/Intensive Care Unit is available. The majority of the neonates are premature, hypoglycemic, or rule-out sepsis cases. There are no AII rooms available. This unit is located on the 2nd floor in the South Tower.
8. A twenty (20) bed Pediatric Unit, with patients aged newborn to eighteen (18) years old with all medical and surgical conditions serviced. There is one AII room in the unit. (301). There is remote telemetry available for 7 beds. This unit is located on the 3rd floor in the Legacy Building.

9. There is a 5 bed PICU with one AII room (PICU #5). This is located inside the Pediatric Unit. The majority of the patients are treated for respiratory related conditions with some surgical patients. This unit is located on the 3rd floor in the Legacy Building.

10. The Surgical Services Unit has eight (8) surgical suites including one cystoscopy room with a population of primarily adult, geriatric, and pediatric patients. Surgical Services include general orthopedics, cardiovascular, urology, ENT, gynecology, neurovascular and general surgery. Approximately five thousand two hundred surgical procedures are performed annually. This departmet is located on the 2nd floor in the Legacy Building.

11. An eleven (11) bed Post Anesthesia Care Unit (PACU) provides care for the post-operative patient recovering from general or regional anesthesia or receiving monitored anesthesia care for epidural pain control. This department is located on the 2nd floor in the Legacy Building, adjacent to the Surgical Services unit.

12. A twenty-eight (28) bed Mother-Baby Unit with 28 bassinet newborn nurseries and a five (5) bay virtual nursery area. The unit provides total mother-baby couplet care. Broward Health Coral Springs delivers approximately twenty-two hundred (2,200) live births annually. There are two AII rooms are available (212 and 228). This unit is located on the 2nd floor in the South Tower.

13. An twelve-(12) bed Labor Delivery Unit is available with three (3) Caesarian Section operative suites and five (5) recovery rooms. A five (5) bed exam room area is available there is one AII room available (5 room).This unit is located on the 1st floor in the South Tower.

13. A six (6) bed Antepartum Unit provides care for high-risk pregnancies, located in the Mother-Baby Unit. This is unit is on the 2nd floor in the South Tower.

14. A twenty-four (24) bed Same Day Surgery Unit provides care to pediatric, adult and geriatric patients. Services include care of the surgical patient before surgery and following recovery in the PACU, care of patients receiving other interventional/diagnostic procedures in Radiology and Cardiopulmonary, and the administration of intravenous medications, blood and blood products to outpatients. Two (2) reclining chairs are reserved for administration of intravenous medication, blood and blood products to outpatients. This unit is located on the 2nd floor in the Legacy Building.

15. A four (4) room Endoscopy Unit is available with one AII room used for bronchoscopies. This unit is located on the 2nd floor in the Legacy Building adjacent to the Same Day Surgery Unit.

d. Services provided at BHCS include but are not limited to:

**Adult & Pediatric Care**

a. Emergency Department  
b. Pediatric Emergency Department  
c. Labor and Delivery Unit  
d. Maternity Unit  
e. Nursery  
f. Level II Neonatal Intensive Care Unit  
g. Pediatric Unit  
h. Pediatric Acute Care Unit  
i. Pediatric Intensive Care Unit  
j. Pediatric Sedation
k. Surgical Services Department  
l. Minimally Invasive Colorectal Services  
m. Endoscopy Unit  
n. Interventional Radiology  
o. Primary Stroke Center  
p. Inpatient Dialysis  
q. Cardiopulmonary Services  
r. Center for Wound Care  
s. Sleep Disorders Center  
t. Orthopedic Services  
u. Women’s Center  
v. Rehabilitation Center  
w. Community Health Services

III. At Risk Patient Populations  
The Infection Control Committee at Broward Health Coral Springs has identified the following patient populations as being at higher risk for healthcare associated or transmissible community acquired infections:  
a. Patients undergoing mechanical ventilation  
b. Postpartum patients  
c. Patients undergoing surgical & invasive procedures  
d. Patients with indwelling medical devices (urinary catheters and peripheral and central venous catheters)  
e. Employees at risk for occupational exposure to tuberculosis, blood borne pathogens, and other communicable diseases  
f. Patients with immunosuppression due to chronic illness (diabetes, ESRD, HIV disease, COPD, sickle cell disease and drug and alcohol abuse)  
g. Patients with significant pathogens (i.e., multidrug resistant organisms, including *C. difficile*)  
h. Patients with limited mobility, compromised nutritional status, and diminished sensory perception  
i. Patients with chronic conditions with recurrent hospitalizations (i.e., CHF, COPD)  
j. NICU patients  
k. Pediatric patients with potential of acquiring and spreading communicable diseases (i.e. varicella, measles, mumps, pertussis, meningococcal disease, etc.)

IV. Roles and Responsibilities of the Infection Control Committee (ICC)  
a. The ICC is a multidisciplinary committee with representation from but not limited to Medical Staff, Executive Leadership, Nursing, Pharmacy, Laboratory, Surgical Services, Environmental Services, Facilities Management, Employee Health, Ancillary staff, and other departments of the hospital. The role of the ICC is to oversee the BHCS Infection Prevention and Control Program.  
b. Responsibilities of the Infection Control Committee include but are not limited to the following:  
i. Recommends the minimum amount of time allocated to the Infection Prevention and Control Program based on the needs of the population served.  
ii. Requests changes to the allocation of time as needs change or program goals cannot be met.  
iii. Facilitates the allocation of resources needed to access information, supplies, equipment and laboratory services.
iv. Approves the Infection Control Plan, Annual Appraisal, Risk Assessments, BHCS IC Program revisions, and Infection Control new policies/revised policies and the BHCS Hand Hygiene Plan.

v. Initiates recommendations based on mandatory reporting data, surveillance findings, epidemiological investigations and performance indicator trends.

c. The multidisciplinary Infection Control Committee meets quarterly. The Chairman of the ICC, has the authority of the Chief of Staff and Chief Executive Officer of Broward Health Coral Springs to oversee the Infection Prevention and Control Program. The Coordinator of Epidemiology serves as the facilitator. All hospital departments are encouraged to participate in the ICC and contribute to the infection prevention and control objectives of the program.

d. Employee Health functions relating to Infection Control are conducted by the Employee Health Practitioner. Employee Health trends are reviewed and analyzed by the Infection Control Committee, to include the following:

e. Employee blood and body fluid exposures and follow up with each occurrence reviewed to identify high-risk procedures and/or products. Based on the evaluations, corrective actions can be developed and implemented. Summary evaluations are presented to the Infection Control Committee and Environment of Care Committee.

f. Employees are screened for TB at least annually. Employees with skin test conversions are referred for evaluation and follow-up. TB screenings and conversions are tracked monthly by department and for the facility as a whole. An annual summary is presented to the Infection Control Committee.

g. Infections of epidemiologic significance among employees are reported along with any control measures instituted, follow-up required, or cases of secondary spread.

1. Pre-employment screening is completed by the Employee Health Practitioner to evaluate immunity to certain infectious diseases. Vaccines are offered when indicated.

2. The Employee Health Practitioner or designee coordinates and performs initial fit test and annual fit-checks for N-95 Respirators.

3. The Employee Health Practitioner will perform surveillance of employee illnesses and monitor and report any significant communicable disease. This will also be reported at the Infection Control Committee.

**Information generated by Infection Control activities is confidential and all individuals having knowledge of this information will maintain confidentiality of privileged health information. Results of infection control findings will be presented only to committees and/or personnel responsible for conducting or monitoring the quality of patient care, or to appropriate public health personnel.

V. Objectives
Objectives for the Epidemiology department are as follows:

Please see Appendix A: Goals and Objectives CY2019

Organizations referenced:

1. Centers for Disease Control and Prevention (CDC)

2. The Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)

3. Association of peri-Operative Registered Nurses (AORN)

4. Association for the Advancement of Medical Instrumentation (AAMI)
5. The Society for Healthcare Epidemiology of America (SHEA).

REFERENCES:

6. The Joint Commission Infection Prevention and Control Standards

Related Policies: Broward Health Infection Control Plan (System), Broward Health Epidemiology and Department Specific Infection Control Policies.

Authors: Broward Health Coral Springs Epidemiology Department

Reviewed/Approved: BHCS Infection Control Committee, BHCS CNO

Date: 3/14/2019

A risk assessment guides prioritization of infection prevention and control goals and objectives and is completed by the Infection Control Committee. BHCS identifies the risks for acquiring and transmitting infections based on its geographical location, community findings, care, treatment and services provided, healthcare worker risks, and environmental risks.

The Risk Assessment is conducted annually and/or whenever risks change significantly. Scoring of the Risk Assessment is approved by the Infection Control Committee (ICC) to ensure a multidisciplinary approach to assess the needs of the population served at Broward Health Coral Springs.
Appendix A
Goals and Objectives CY 2019
*Based on Risk Assessment of Events
*Will review monthly
*Target goals based on 10% reduction in harm events from LCY and VBP achievement threshold using NHSN SIR data.

Hospital Acquired Infection (HAI)/Admission Related Risks
Goal # 1: Overall reduction of hospital acquired infections.
*Pareto Analysis reveals multi drug resistant organisms (MDRO) and surgical site infections (SSI) both constitute the highest risk percent at 56% each in the HAI/Admission risk portion of the risk assessment. The top 5 risks identified in the Pareto analysis were MDROs, surgical site infections, central line blood stream infection (CLABSI), catheter associated urinary tract infection (CAUTI), and C-Difficile infections. All HAI are of concern and we strive in chasing zero.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDRO (including MRSA bacteremia) and C. diff</td>
<td>All patients</td>
<td>1. Determine risk factor for HAI</td>
<td>BHCS: Target Rates</td>
<td>IP</td>
<td>1. Daily review of surveillance including ED visit log, review of all microbiology results/monitor labs, identify and verify infections, analyze data.</td>
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<tr>
<td></td>
<td></td>
<td>2. Decrease HAI</td>
<td>MRSA: 0.06</td>
<td>Nurses</td>
<td>2. Utilize MedMined data mining program to assist with identifying potential clusters.</td>
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<tr>
<td></td>
<td></td>
<td>3. Decrease sepsis</td>
<td>VRE: 0.00</td>
<td>Physicians</td>
<td>3. Review Antibiogram and discuss at ICC and Antimicrobial Stewardship committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Continue participating in FHA HIIN</td>
<td>CRE: 0.00</td>
<td>Pharmacists</td>
<td>4. Continue contact precautions for active infection and 6 month history of infection.</td>
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<tr>
<td></td>
<td></td>
<td>5. Decrease readmissions</td>
<td>ESBL : 0.0</td>
<td></td>
<td>5. Utilize Respiratory Viral Panel (Biofire) to prevent antibiotics for viruses.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CDIFF: 3.28</td>
<td></td>
<td>6. C. diff: Place patient on enhanced contact precautions per policy and monitor compliance with bleach based disinfection.</td>
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<td></td>
<td></td>
<td></td>
<td>SIR</td>
<td></td>
<td>7. Cohort if necessary on case by case basis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MRSA bac: 0.815</td>
<td></td>
<td>8. Intense analysis of all C. diff and MRSA</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CDIFF: 0.852</td>
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</table>
| SSI | Patients who had surgery | 1. Determine risk factors for HAI | BHCS target rate: SIR hyst: 0.784 colo: 0.781 | 1. Monitor infection rates for all class I and II surgeries and report to appropriate stakeholders.  
2. Monitor all total hip and total knee surgeries and report to appropriate stakeholders.  
3. Monitor colon, abdominal hysterectomy and C-section infections and report to NHSN and stakeholders.  
4. Daily surveillance of ED log, micro reports, OR schedule.  
5. Review for weight based dosing for antibiotics, redosing as necessary.  
6. Review to ensure glycemic monitoring is performed in all surgical cases.  
7. Discuss each SSI during Patient Safety Quality Council meeting  
8. Discuss in depth SSI at monthly SSI Prevention meeting to determine lessons learned.  
9. Creation of Ad Hoc SSI team to create drill down checklist to review for SSI opportunities preoperatively, intraoperatively and postoperatively with NMs from Surgical Services, Women’s Services and Inpatient Surgical Nurse Units. | 9. IP rounds facility wide.  
10. IP rounds for isolation, PPE use, equipment disinfection compliance.  
11. Nurse driven action plans.  
12. All infections reviewed by Chief of Infection Prevention and Epidemiology.  
13. Infections are reviewed by RMO if indicated. |
10. Review to ensure FIO2 increases upon extubation and during transport to PACU.
11. Review patient temperatures to ensure normothermia during surgery and upon admission to PACU.
12. Review to monitor for appropriate administration of antibiotic prophylaxis prior to surgery.
13. All infections reviewed by Chief of Infection Prevention and Epidemiology.
14. Infections are reviewed by RMO if indicated.
15. Audits completed with medical device company and report findings back to stakeholders.
16. Create action plans based on results of audits.
17. Surgeon Champion.

<table>
<thead>
<tr>
<th>CLABSI</th>
<th>Inpatients with central lines</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>1. Determine risk factor for HAI</td>
</tr>
<tr>
<td></td>
<td>2. Decrease HAI</td>
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<tr>
<td></td>
<td>3. Decrease sepsis</td>
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<tr>
<td></td>
<td>4. Continue participating in FHA HIIN</td>
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<tr>
<td></td>
<td>5. Decrease line days</td>
</tr>
<tr>
<td></td>
<td>1. IP rounds facility wide.</td>
</tr>
<tr>
<td></td>
<td>2. Daily surveillance to monitor labs, identify and verify infections, analyze data.</td>
</tr>
<tr>
<td></td>
<td>3. Collect patient demographic data, line days</td>
</tr>
<tr>
<td></td>
<td>4. Identify risks, assess daily need/removal</td>
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<tr>
<td></td>
<td>7. Nurse driven action plans, include use of CHG bathing in the ICU</td>
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<tr>
<td></td>
<td>8. CHG bathing at PM for all nursing unit. Continued use of Theraworx every 12 hours in ICU/CCU.</td>
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<tr>
<td></td>
<td>10. Discuss each CLABSI with nurse manager to determine opportunities/lessons learned.</td>
</tr>
<tr>
<td></td>
<td>11. Discuss each CLABSI infection in Patient</td>
</tr>
</tbody>
</table>
| CAUTI | Inpatients with Foley catheters | 1. Determine risk factor for HAI  
2. Decrease HAI  
3. Decrease sepsis  
4. Continue participating in FHA HIIN  
5. Decrease foley days | BHCS target rate: 0.65  
SIR: 0.822 | IP  
Nurses  
Physicians  
Pharmacists  
Clinical Education | 1. IP rounds facility wide.  
2. Daily surveillance to monitor labs, identify and verify infections, analyze data.  
3. Collect patient demographic data, line days  
4. Identify risks, assess daily need/removal  
6. Monitor bundle compliance including foley below level of bladder, not on floor, foley bag not more than ½ full, secured to thigh, etc.  
7. Educate on best practices in nursing orientation and rounding.  
8. Nurse driven action plans.  
9. Education through Webinar and the HIIN.  
10. Discuss each CAUTI with nurse manager to determine opportunities/lessons learned.  
11. Discuss each CAUTI infection in Patient Safety Quality Council meeting.  
12. Perform RCA on all infections  
13. All infections are reviewed by Chief of Infection Prevention and Epidemiology.  
14. Infections are reviewed by the RMO if indicated. |

---

- Safety Quality Council meeting.
- All infections are reviewed by Chief of Infection Prevention and Epidemiology.
- Infections are reviewed by the RMO if indicated.
- Participate in the AHRQ Safety Program for ICUs: Preventing CLABSI and CAUTI.
- Audits completed with medical device company and report findings back to stakeholders.
- Create action plans based on results of audits.
| VAE | Inpatients on a ventilator | 1. Determine risk factor for HAI  
  2. Decrease HAI  
  3. Decrease sepsis  
  4. Continue participating in FHA HIIN  
  5. Decrease vent days | BHCS target rate: VAP: 0.00 | IP Respiratory Nurses  
 Physicians Pharmacists | 1. Daily surveillance to monitor labs, identify and verify infections, analyze data.  
  2. Utilize NHSN definition and report to appropriate stakeholders.  
  3. Educate staff on best practices.  
  4. IP rounds facility wide to ensure VAP bundle compliance.  
  5. All infections are reviewed by Chief of Infection Prevention and Epidemiology.  
  6. Infections are reviewed by the RMO if indicated. |}

### Other Identified Events:

**Active TB, unknown at time of admission**
1. All patients with signs and symptoms or questionable TB disease may be placed on airborne isolation by nursing without a physician’s order per airborne isolation policy.  
2. Reeducation of nursing and physicians mandatory ED assessment for potential TB.  
3. Review of Transmission based precautions, included difference between droplet and airborne isolation during New Hire Orientation and as needed.  
4. Meeting with Clinical Specialist of the ED, ED ANM, and Patient Access Manager to review process of registration and admission in order to quickly identify those high risk patients.

**Notification of Community Acquired Infections**
1. Continue to utilize admit alert system and communicate with nursing and outside facilities as needed when patient admitted with a community acquired infection.
Outbreak
1. Monitor daily surveillance for any unusual organisms or clusters of organisms.
2. Initiate infection control measures based on CDC guidelines or other evidence based recommendations.
3. Consult with Florida Department of Health as necessary.
4. Educate healthcare staff on organism identified in outbreak and measures to prevent spread of further infections.
5. Utilize Outbreak procedure policy during any outbreak identified.
6. Report clusters/outbreaks to necessary stakeholders and committees.

Notification of Internal HAIs
1. Continue to utilize admit alert system and communicate with internal departments and bed control as needed when patient is admitted or transferred in the hospital with an MDRO.
2. Review of isolation log and review patient diagnosis to ensure accurate transmission based precautions are in use and education staff as needed.
3. Utilize HAS report system to track and trend occurrences and follow up with managers and conduct education as needed.

Community Risks
Goal # 2: Reduction of community risk.
*Pareto analysis reveals emerging infectious disease and long term care patients constitute the highest risk percent at 44% each for community related risks. The rest of the top 4 risks identified in the Pareto Analysis were seasonal flu, pandemic flu, and community acquired MDROs. All risks from the community are evaluated and Epidemiology works closely with the Health Department.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
</table>
| Emerging infectious disease/other epidemics/influx of infectious patients | All patients       | BHCS will be prepared for an emerging infectious disease or influx of infectious patients. | EM Drills 100% | IP ED EP Nursing | 1. Continue utilizing infectious disease screening tool for all patients during triage to screen for all potentially infectious patients.  
3. Communicate with the Florida Department of Health as necessary.  
4. Continue with established drills and EM updates and education.  
5. Consult with Chief of Infection Prevention and |
<table>
<thead>
<tr>
<th>Long term patients</th>
<th>All patients</th>
<th>BHCS has nearby high admitting SNFs.</th>
<th>Length of stay</th>
<th>IP Nursing Case management Physicians</th>
<th>Epidemiology as needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Active surveillance for incoming patients include blood and urine cultures as indicated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Communication with physicians and transferring/accepting facilities to identify infections.</td>
<td></td>
</tr>
<tr>
<td>Seasonal flu and pandemic flu</td>
<td>All patients</td>
<td>BHCS will offer influenza vaccination to all qualified patients.</td>
<td>BHCS target: 90%</td>
<td>IP Nursing Quality</td>
<td>1. Inpatients vaccinated during flu season per Centers for Medicaid and Medicare Services (CMS) protocol unless contraindicated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Patients with influenza placed on Droplet isolation precautions per policy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. If pandemic flu, work with Florida Department of Health and Emergency Preparedness.</td>
</tr>
<tr>
<td>Community acquired MDRO</td>
<td>All patients</td>
<td>Identify community onset infections for prompt isolation. Placing patients on transmission based precautions.</td>
<td>BHCS target: 90%</td>
<td>IP Nursing Physicians Case management</td>
<td>1. Identification of patients through daily surveillance admitted with MDROs and alert tab.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Assess staff need for education.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Communication with SNF and LTC admitters.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Education for staff and physicians about HO and CO C. diff and MRSA bacteremia to identify community onset MDRO as early as possible and within the first 3 days of admission based on the NHSN definition.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. Education at New Hire Orientation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6. Review of daily isolation log and review of patient diagnosis to ensure that patient is placed on correct transmission based precautions.</td>
</tr>
</tbody>
</table>

**Other Identified Events**

**Displaced person**

1. Work with case management and social services to assist in timely discharge of patients with hospital acquired infections or multi drug resistant organisms as needed.

**Active TB admissions**
1. Continue to follow IC TB Plan.

**HIV/AIDS**
1. Continue to work with Florida Department of Health as necessary.

**Bioterrorism/Ebola and Hemorrhagic Fever Diseases**
1. Work with Emergency Preparedness with drills and PPE training.
2. Communicate with Florida Department of Health as necessary
3. Continue with established drills and EM updates and education.

**Flood**
2. Yearly hurricane drills.

**Waterborne Outbreak**
1. Continue to monitor for waterborne organisms through Medmined and daily surveillance.
2. Work with facilities and consultant to identify risks in water management system.
4. Report to Florida Department of Health as necessary.

**Food Associated Outbreaks**
1. Adhere to established outbreak policy and procedure for outbreak management.
2. Continue to report positive cultures to Florida Department of Health.

**Healthcare Worker Risks**

**Goal #3: Reduction of healthcare worker risk of infection secondary to injury and/or exposure.**

*Pareto Analysis reveals non-compliance with hand hygiene and failure to follow protocols and use safety devices or PPE as the two top highest risk percent at 26% each for healthcare worker related risks. The remaining 4 risks identified in the Pareto analysis were non-compliance with hand hygiene for independent healthcare workers, non-compliance with hand hygiene for HCWs, non-compliance with isolation precautions, and blood and body fluid exposure. All risks to healthcare workers are followed by both Employee Health and Epidemiology and presented at Environment of Care Committee.*
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-compliance with hand hygiene for independent HCWs</td>
<td>All LIPs</td>
<td>Strive for 100% of hand hygiene compliance.</td>
<td>BHCS</td>
<td>IP</td>
<td>1. Monitor compliance in all areas of hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>target: 90%</td>
<td>Administration RMO</td>
<td>2. Updated poster campaign by corporate marketing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chief of Staff</td>
<td>3. Compliance reported at Patient Safety Quality Council monthly meetings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Compliance reported at the quarterly ICC meeting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. Updated BHCS Hand Hygiene plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6. Continue to use recognition program to identify HCWs who perform hand hygiene by providing a business card with a lifesaver candy and a “thank you for being a life saver” note.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7. Just in time education and reinforcement.</td>
</tr>
<tr>
<td>Non-compliance with hand hygiene for staff HCWs</td>
<td>All employees, physicians, students, volunteers</td>
<td>Strive for 100% of hand hygiene compliance.</td>
<td>BHCS</td>
<td>IP</td>
<td>1. Monitor compliance in all areas of hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>target: 90%</td>
<td>Administration</td>
<td>2. Updated poster campaign by corporate marketing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td>3. Compliance reported at Patient Safety Quality Council monthly meetings.</td>
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<td>4. Compliance reported at the quarterly ICC meeting.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. Updated BHCS Hand Hygiene plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td>6. Continue to use recognition program to identify HCWs who perform hand hygiene by providing a business card with a lifesaver candy and a “thank you for being a life saver” note.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7. Just in time education and reinforcement.</td>
</tr>
</tbody>
</table>
### Hand Hygiene Education at Every New Hire Orientation

| Failure to follow protocols and use safety devices or PPE | All employees, physicians, students, volunteers | Decrease needle sticks, splashes, other preventable exposures. | BHCS target: 90% | IP EH Administration | 1. IP rounds to reinforce protocols, use of safety devices, proper PPE.  
2. Revised isolation signs to standardize with rest of Broward Health. Signs to include new recommendations for transport of patients on isolation as well as PPE requirements in 3 different languages.  
3. Reeducation of PPE requirements for visitors of patients on Airborne Isolation and provided sign to put on door specifically for visitors.  
4. Just in time education and remediation as needed. |
|---|---|---|---|---|---|
| Non-compliance with isolation precautions | All employees, physicians, students, volunteers | Decrease time to place patients on transmission based precautions. | BHCS target: 90% | IP Administration | 1. Monitor disease alert and evaluate timeliness of implementation of transmission based precautions.  
2. Monitor isolation log, chart for sticker, sign and PPE on door. |
| Blood and body fluid exposure | All employees, physicians, students, volunteers | Decrease needle sticks, splashes, other preventable exposures. | BHCS target: 90% | IP EH Administration | 1. Monitored by Employee Health.  
2. EH to continue to monitor and report to ICC and EOC.  
3. IP rounding.  
4. Just in time education and remediation as needed. |

**Other Identified Events:**

**Non-compliance with standard precautions**

1. Continue to educate nursing at orientation and periodically on standard precautions according to policy.  
2. IP rounding.
3. Just in time education and remediation as needed.

**Employee Knowledge Deficit of Disease Transmission and Prevention**
1. Coordinate with Clinical Education on utilization of the Need-2-know forum.
2. Continue to present relevant education on disease transmission in nursing orientation.

**Failure to recognize employee outbreak**
1. Utilize HAS reports with risk management, Patient and Medication Safety meeting, and Nurse Practice Council to address any staff infection control issues.
2. IP rounds to engage and education staff.

**Delay in Proper Isolation Precautions**
1. Patients placed on isolation by nursing, but it has been observed that there are times where there is no order for isolation in the patients chart. Infection control and Clinical Education to educate all nursing on the need to place order for isolation in computer system.
2. Daily review of isolation log. Will educate nursing on a case by case basis on the requirements for isolation.

**Environmental Risks**

*Goal #4: Reduction of environmental risk.*

*Pareto analysis reveals improper cleaning as the highest risk percent at 26%. The remaining top 4 risks identified in the Pareto Analysis were: inadequate supplies of personal protective equipment, improper sharps handling, improper disinfection of equipment, and improper handling of biohazardous waste.*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper environmental cleaning</td>
<td>EVS staff</td>
<td>Compliance with proper cleaning protocols and products.</td>
<td>BHCS target: 90%</td>
<td>EVS</td>
<td>1. Partnership with epidemiology and EVS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. EVS maintains pivotal role in Infection Prevention and Control Committee.</td>
</tr>
</tbody>
</table>
PPE in all departments.

2. Utilize new PPE calculator from the CDC to assess PPE based on Ebola admission or PUI
3. (Persons under investigation)

Improper sharps handling

All staff
Reduce incidence of employee injury due to improper sharps handling.

BHCS target: 90%
All employees
1. Education at general orientation by EH and Epi.

Improper disinfection of equipment

All staff
Compliance with proper disinfection protocols and products.

BHCS target: 90%
All employees
1. IP rounds and educates on PDI wipe products.
2. Education on hospital approved disinfectants in New Hire Orientation, in-services, during rounding

Improper handling of biohazardous waste

All staff
Reduce misuse of red bag biohazard waste.

BHCS target: 90%
All employees
1. EOC rounds to check biohazard waste.
2. DOH inspections.

Other Identified Events

Improper Sterilization or High Level Disinfection of Equipment
1. Central processing department to monitor biological pass/fail. Monthly report sent to IC. IC to be identified immediately of failed biological. Procedure for failed biological to be carried out per policy.
2. Immediate use steam sterilization report sent monthly to Infection Control by Central Processing Department
3. Infection Control to investigate any cases reported of improper sterilization.
4. Monitor for High Level Disinfection adherence with Trophon use for all vaginal probes, Reset for all TEE probes and MedEvator AER (automatic endoscope reprocessor) for all endoscopes and bronchoscopes.

Failure of Negative Pressure Ventilation
1. Adhere to existing process for failure of negative pressure ventilation. Refer to Infection Control Policy # 21 Isolation Room Checks.
2. Facilities to ensure compliance with monthly temp and humidity measures in surgical environment per standards.
Tuberculosis (TB) risk assessment worksheet CY2019

This model worksheet should be considered for use in performing TB risk assessments for health-care facilities and nontraditional facility-based settings. Facilities with more than one type of setting will need to apply this table to each setting.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>√ or Y = Yes</th>
<th>X or N = No</th>
<th>NA = Not Applicable</th>
</tr>
</thead>
</table>

1. Incidence of TB

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.

<table>
<thead>
<tr>
<th>Broward County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community rate:</td>
</tr>
<tr>
<td>↓ 3.2 (2017) 3.5 (2016)</td>
</tr>
<tr>
<td>State rate:</td>
</tr>
<tr>
<td>↓ 2.7 (2017) 3.2 (2016)</td>
</tr>
<tr>
<td>National rate:</td>
</tr>
<tr>
<td>↓ 2.8 (2017) 2.9 (2016)</td>
</tr>
</tbody>
</table>

Facility rate: CY 2017
(# of confirmed diagnosed cases of TB/number of admissions)
2/175000=11.42 per 100,000-2018
3/18657 = 16.1 per 100,000=2017

<table>
<thead>
<tr>
<th>Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)?
Review laboratory data, infection-control records, and databases containing discharge diagnoses.

<table>
<thead>
<tr>
<th>Suspected</th>
<th>Confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018: 16</td>
<td>2</td>
</tr>
<tr>
<td>2017: 17</td>
<td>3</td>
</tr>
<tr>
<td>2016: 20</td>
<td>2</td>
</tr>
<tr>
<td>2015: 15</td>
<td>2</td>
</tr>
</tbody>
</table>

Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?

| No |

2. Risk Classification

### Inpatient settings

<table>
<thead>
<tr>
<th>How many inpatient beds are in your inpatient setting?</th>
<th>250</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many patients with MTB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.</td>
<td>CY2018 2</td>
</tr>
<tr>
<td>CY 2017 3</td>
<td></td>
</tr>
<tr>
<td>CY2013 9</td>
<td></td>
</tr>
</tbody>
</table>

Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting (≥200 beds)? (See Appendix C.)
According to the CDC guidelines 2005, a “low risk” facility has less than 6 TB patients a year. A “medium risk” facility has greater than or equal to 6 confirmed cases of tuberculosis annually.

In CY 2018, there were two confirmed MTB patient cases; therefore BHCS is classified as a “low risk” facility.
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease? | Yes

### 3. Screening of HCWs for *M. tuberculosis* Infection

<table>
<thead>
<tr>
<th>Does the health-care setting have a TB screening program for HCWs?</th>
<th>Yes</th>
</tr>
</thead>
</table>
| If yes, which HCWs are included in the TB screening program? (Check all that apply.) | ✓ Physicians  
✓ Mid-level practitioners (nurse practitioners [NP] and physician’s assistants [PA])  
✓ Nurses  
✓ Administrators  
✓ Laboratory workers  
✓ Respiratory therapists  
✓ Physical therapists  
✓ Contract staff (Required by the contracting department. Records kept in contracting department)  
✓ Construction or renovation workers (same as contract workers)  
✓ Service workers  
✓ Janitorial staff  
✓ Maintenance or engineering staff  
✓ Transportation staff  
✓ Dietary staff  
✓ Receptionists  
✓ Trainees and students (Medical students-under GME; Nursing and Allied under Learning/Nursing department. Records and compliance are managed by the above departments)  
✓ Volunteers  
✓ Others__________________ |
| Is baseline skin testing performed with two-step TST (Tuberculin Skin Test) for HCWs? | Yes |
| Is baseline testing performed with QFT (Quantiferon) or other BAMT (Blood Assay for Mycobacterium Tuberculosis) for HCWs? | No |
| How frequently are HCWs tested for *M. tuberculosis* infection? | Annually during their anniversary hire period.  
2018: 762 TST administered  
2017: 507 TST administered |
| Are the *M. tuberculosis* infection test records maintained for HCWs? | Yes |
| Where are the *M. tuberculosis* infection test records for HCWs maintained? Who maintains the records? | Employee Health Department |
| If the setting has a serial TB screening program for HCWs to test for *M. tuberculosis* infection, what are the conversion rates for the previous years?† | (2018): 0%  
(2017): 0%  
(2016): 0%  
(2015): 0.3%  
(2014): 0.3%  
(2013): 0.8% |
| Has the test conversion rate for *M. tuberculosis* infection been increasing or decreasing, or has it remained the same over the previous 5 years? (check one) | Decreasing. |
| Do any areas of the health-care setting (e.g., waiting rooms or clinics) or any group of HCWs (e.g., lab workers, emergency |

No. |
department staff, respiratory therapists, and HCWs who attend bronchoscopies) have a test conversion rate for *M. tuberculosis* infection that exceeds the health-care setting’s annual average?

For HCWs who have positive test results for *M. tuberculosis* infection and who leave employment at the health setting, are efforts made to communicate test results and recommend follow-up of latent TB infection (LTBI) treatment with the local health department or their primary physician?

Not applicable.

Plan for positive: New hire positive skin test results are screened with a chest x-ray and are referred to their PCP or community resource for evaluation of latent TB status. This is required by day 30 after first day of employment. Employees who converted are seen by an ID physician through workers comp. If employees are terminated before they are seen and evaluated, a letter is sent by employee health to follow up with workers comp, private primary care physician or their new employee health department. Exposure follow up for employees who were terminated before the 10th week of follow up are notified by letter to follow up with their PCP or new employee health department.

### 4. TB Infection-Control Program

<table>
<thead>
<tr>
<th>Does the health-care setting have a written TB infection-control plan?</th>
<th>Yes – in the Infection Control Plan and a Broward Health policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is responsible for the infection-control program?</td>
<td>Chairman of Infection Control Committee.</td>
</tr>
<tr>
<td>When was the TB infection-control plan first written?</td>
<td>06/05</td>
</tr>
<tr>
<td>When the TB infection-control plan was last reviewed or updated?</td>
<td>2/2018</td>
</tr>
<tr>
<td>Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., &gt;1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of <em>M. tuberculosis</em>)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, which groups are represented on the infection-control committee? (Check all that apply.)</td>
<td>Laboratory personnel</td>
</tr>
<tr>
<td>✓ Physicians</td>
<td>✓ Health and safety staff</td>
</tr>
<tr>
<td>✓ Nurses</td>
<td>✓ Administrator</td>
</tr>
<tr>
<td>✓ Epidemiologists</td>
<td>✓ Risk assessment</td>
</tr>
<tr>
<td>✓ Engineers</td>
<td>✓ Quality control (QC)</td>
</tr>
<tr>
<td>✓ Pharmacists</td>
<td>✓ Environmental staff</td>
</tr>
<tr>
<td>✓ Nutritional staff</td>
<td>✓ Respiratory</td>
</tr>
<tr>
<td>✓ Laboratory personnel</td>
<td>✓ Facilities management</td>
</tr>
</tbody>
</table>

### 5. Implementation of TB Infection-Control Plan Based on Review by Infection-Control Committee

| Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name: | Yes. Dr. Melvin Kohan, Infection Control Committee Chairman |
Based on review of the medical records, what is the average number of days for the following:

- Presentation of patient until collection of specimen 1
- Specimen collection until receipt by laboratory 1
- Receipt of specimen by laboratory until smear results are provided to healthcare provider 1
- Diagnosis until initiation of standard antituberculosis treatment 1
- Receipt of specimen by laboratory until culture results are provided for healthcare provider 1
- Receipt of drug susceptibility results until adjustment of antituberculosis treatment, if indicated 1
- Admission of patient to hospital until placement in airborne infection isolation (AII) 1

Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized? Review of laboratory results, outbreak investigations and other means of surveillance.

What mechanisms are in place to correct lapses in infection control? Process improvements, outbreak investigation, literature search, multidisciplinary team work, reporting through committee process within the facility.

Based on measurement in routine QC (Quality Control) exercises, is the infection-control plan being properly implemented? Yes

Is ongoing training and education regarding TB infection-control practices provided for HCWs? Yes

6. Laboratory Processing of TB-Related Specimens, Tests, and Results Based on Laboratory Review

<table>
<thead>
<tr>
<th>Test</th>
<th>In-house</th>
<th>Sent out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid-fast bacilli (AFB) smears</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Culture using liquid media (e.g., Bactec and MB-BacT)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Culture using solid media</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Drug-susceptibility testing</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Nucleic acid amplification (NAA) testing</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Does the laboratory at your health-care setting or the reference laboratory used by your health-care setting report AFB smear results for all patients within 24 hours of receipt of specimen? What is the procedure for weekends? Yes. The same process is utilized on nights and weekends as regular business hours. Laboratory will page the on call Epidemiologist to communicate positive AFB results outside of normal business hours.

7. Environmental Controls

Which environmental controls are in place in your health-care setting? (Check all that apply and describe)

- All rooms
- Local exhaust ventilation (enclosing devices and exterior devices)
- General ventilation (e.g., single-pass system, recirculation system.)
- Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] filtration and ultraviolet germicidal irradiation [UVGI])

What are the actual air changes per hour (ACH) and design for various rooms in the setting?

Inpatient rooms: (Med Surg, tele, etc) 6 ACH
Emergency Department: 12 ACH
<table>
<thead>
<tr>
<th>Operating Rooms:</th>
<th>15 ACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-section in South Tower</td>
<td>20 ACH</td>
</tr>
<tr>
<td>All Rooms:</td>
<td>12 ACH</td>
</tr>
<tr>
<td>Bronchoscopy Room (in GI suite):</td>
<td>12 ACH</td>
</tr>
<tr>
<td>Endoscopy Rooms</td>
<td>– 12 ACH</td>
</tr>
<tr>
<td>Interventional Radiology Procedure Room -</td>
<td>15 ACH</td>
</tr>
</tbody>
</table>

Which of the following local exterior or enclosing devices such as exhaust ventilation devices are used in your health-care setting? (Check all that apply)
- Laboratory hoods
- Booths for sputum induction

What general ventilation systems are used in your health-care setting? (Check all that apply)
- Single-pass system
- Constant air volume (CAV)
- Recirculation system

What air-cleaning methods are used in your health-care setting? (Check all that apply)
- HEPA filtration
- Fixed room-air recirculation systems

<table>
<thead>
<tr>
<th>How many AII rooms are in the health-care setting?</th>
<th>33 rooms</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED rooms:</td>
<td>13, 14, 20, 34, 35</td>
</tr>
<tr>
<td>ICU rooms:</td>
<td>1, 8</td>
</tr>
<tr>
<td>CCU rooms:</td>
<td>1, 8</td>
</tr>
<tr>
<td>3 East:</td>
<td>352</td>
</tr>
<tr>
<td>3 South:</td>
<td>381, 395</td>
</tr>
<tr>
<td>4 East:</td>
<td>438, 452</td>
</tr>
<tr>
<td>4 West:</td>
<td>401, 409, 410, 411, 412, 415, 416, 417, 418, 423, 424, 425</td>
</tr>
<tr>
<td>M/B (2nd floor South):</td>
<td>212 &amp; 228</td>
</tr>
<tr>
<td>NICU (2nd floor South):</td>
<td>10</td>
</tr>
<tr>
<td>L&amp;D (1st floor South):</td>
<td>5</td>
</tr>
<tr>
<td>3 Peds:</td>
<td>301</td>
</tr>
<tr>
<td>PICU (in Peds unit):</td>
<td>5</td>
</tr>
<tr>
<td>Bronch room (in GI suite):</td>
<td>1</td>
</tr>
</tbody>
</table>

What ventilation methods are used for AII rooms? (Check all that apply)
**Primary (general ventilation):**
- Single-pass heating, ventilating, and air conditioning (HVAC)
- Recirculating HVAC systems

**Secondary (methods to increase equivalent ACH):**
- Fixed room recirculating units
- HEPA Filtration

Does your health-care setting employ, have access to, or collaborate with an environmental engineer (e.g., professional engineer) or other professional with appropriate expertise (e.g., certified industrial hygienist) for consultation on design specifications, installation, maintenance, and evaluation of environmental controls? Yes

Are environmental controls regularly checked and maintained with results recorded in maintenance logs? Yes

Are AII rooms checked daily for negative pressure when in use? Yes

Is the directional airflow in AII rooms checked daily when in use with smoke tubes or visual checks? Yes

Are these results readily available? Yes
What procedures are in place if the AII room pressure is not negative?  
Patient is transferred. Facilities is notified and the room is closed until pressure is confirmed negative.

Do AII rooms meet the recommended pressure differential of 0.01-inch water column negative to surrounding structures?  
Yes

### 8. Respiratory-Protection Program

<table>
<thead>
<tr>
<th>Does your health-care setting have a written respiratory-protection program?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which HCWs are included in the respiratory protection program? (Check all that apply)</td>
<td></td>
</tr>
</tbody>
</table>
- Physicians  
- Mid-level practitioners (NPs and PAs)  
- Nurses  
- Administrators  
- Laboratory personnel  
- Contract staff  
- Construction or renovation staff  
- Service personnel |
| Janitorial staff  
- Maintenance or engineering staff  
- Transportation staff  
- Dietary staff  
- Students |

Are respirators used in this setting for HCWs working with TB patients? If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients).

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Model</th>
<th>Specific application</th>
</tr>
</thead>
<tbody>
<tr>
<td>3M corporation</td>
<td>N-95 #1860 &amp; 1860S</td>
<td>Routine Contact with Infectious TB patients</td>
</tr>
</tbody>
</table>

Is annual respiratory-protection training for HCWs performed by a person with advanced training in respiratory protection?  
Yes

Does your health-care setting provide initial fit testing for HCWs?  
If yes, when is it conducted?  
On hire by employee health  
Yes

Does your health-care setting provide periodic fit testing for HCWs?  
If yes, when and how frequently is it conducted?  
Yearly  
Yes

What method of fit testing is used? Describe.  
Hood/Taste  
1. Fit check: Saccharin or Bitrex fit check. Individual is asked to do normal, deep breathing; bend over; side to side and up/down head movements.  

Is qualitative fit testing used?  
Yes

Is quantitative fit testing used? (Available)  
No

### 9. Reassessment of TB risk

How frequently is the TB risk assessment conducted or updated in the health-care setting?  
Yearly

When was the last TB risk assessment conducted?  
02/2018

What problems were identified during the previous TB risk assessment?  
No problems were identified.

What actions were taken to address the problems identified during the previous TB risk assessment?  
Not applicable.

Did the risk classification need to be revised as a result of the last TB risk assessment?  
No. Our risk remained the same.
Recommendations:

1. Continue annual PPD testing and/or symptom screening and x-ray review of all employees and volunteers.
2. Continue to closely monitor all patients admitted for suspected/known TB for appropriate isolation practices.
3. Continue referring new employees for latent TB infection evaluation as indicated.
4. Continue education on yearly basis and as needed.

* If the population served by the health-care facility is not representative of the community in which the facility is located, an alternate comparison population might be appropriate.
† Test conversion rate is calculated by dividing the number of conversions among HCWs by the number of HCWs who were tested and had prior negative results during a certain period (see Supplement, Surveillance and Detection of M. tuberculosis infections in Health-Care Settings).

ANNUAL APPRAISAL FOR CY2019

I. Overview of Program

The Infection Control Program at Broward Health Imperial Point (BHIP) is directed by the Coordinator of Epidemiology. The Coordinator of Epidemiology reports to the Regional Manager of Quality and Epidemiology and thereon to the Medical Executive Council and Board. The Infection Control Committee is a multidisciplinary committee with representation from, but not limited to, the Medical Staff, Executive Leadership, Nursing, Pharmacy, Laboratory, Surgical Services, Environmental Services, Facilities Management, Employee Health, Ancillary staff, Nutritional Services and other departments of the hospital. The Committee meets on a quarterly basis. In addition, the Coordinator of Epidemiology attends other hospital department meetings to present and review results of surveillance activities and provides infection control education to all employees in New Hire Orientation.

BHIP is a 204 bed multiservice hospital, with 47 Behavior Health Beds. Adult Medical/Surgical Services, Critical Care Services and Outpatient Services including Wound Care/ Clinical Hyperbaric-level II, and Rehabilitation are the predominant service lines offered. BHIP also has an Outpatient Surgery Center. BHIP is a Cardiac Services Level 1, Primary Stroke Center and Heart Failure Certified. The Coordinator of Epidemiology monitors and provides coverage for all services, both inpatient and outpatient, at BHIP.

This Program Evaluation is based in part on outcomes achieved during calendar year 2018. Outcomes are identified through review of performance measurement data, information resulting from Broward Health Imperial Point (BHIP) committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Broward Health Coral Imperial Point and in collaboration with other Broward Health facilities.

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

- Prospective surveillance is completed by Epidemiology for identification of infections.
- Rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
- Monthly reports are submitted to Patient Safety Quality Council Committee meeting where infections are discussed and opportunities for improvement are presented.
- Infections, results of ongoing surveillance, and Performance Monitoring Reports (PMR) are also presented at the quarterly Infection Control Committee meeting.
- Priority is given to device related infections based on risk assessment and analysis of collected data which is evaluated on an ongoing basis to provide immediate intervention when indicated to reduce or prevent infection.
Priority is also given to Surgical Site Infections based on the risk assessment and analysis of the collected data.
Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.

HOUSE WIDE INFECTIONS FOR CY2018

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>CY 17</th>
<th>CY18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Line Related BSI, laboratory confirmed</td>
<td>2.13</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>ALL NHSN Reportable units</td>
<td></td>
<td>4,420</td>
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<tr>
<td></td>
<td></td>
<td>0.68</td>
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<tr>
<td>Catheter Associated UTI ALL</td>
<td>1.15</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>NHSN Reportable units</td>
<td></td>
<td>4,272</td>
<td>3,130</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.64</td>
<td>1.28</td>
</tr>
<tr>
<td>Hospital Onset C-Difficile Infection</td>
<td>5.24</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>32,870</td>
<td>30,934</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.87</td>
<td>5.82</td>
</tr>
<tr>
<td>Hospital Onset MRSA Bacteremia</td>
<td>0.03</td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>32,870</td>
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<td></td>
<td></td>
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<td>0.03</td>
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<td></td>
<td>801</td>
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<td>2</td>
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<td></td>
<td>801</td>
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</tr>
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<td></td>
<td></td>
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<td>2.85</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>801</td>
<td>701</td>
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<tr>
<td></td>
<td></td>
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<td>0.00</td>
</tr>
<tr>
<td>Colon SSI CMS/VBP</td>
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<td>4</td>
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<td></td>
<td></td>
<td>143</td>
<td>132</td>
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<tr>
<td></td>
<td></td>
<td>5.59</td>
<td>3.03</td>
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<tr>
<td>Hyster SSI CMS/VBP</td>
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<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>245</td>
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<td></td>
<td></td>
<td>1.22</td>
<td>0.85</td>
</tr>
</tbody>
</table>

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

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

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

II. Device-Associated Infections

Central Line Associated Blood Stream Infections (CLABSI)

CLABSI CY2018

<table>
<thead>
<tr>
<th>ICU</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>3rd Qtr</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>4th Qtr</th>
<th>CY18</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rate</td>
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<td>21.3</td>
<td>0.0</td>
<td>0.0</td>
<td>6.8</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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</tr>
<tr>
<td>Patient Days</td>
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<td>239</td>
<td>276</td>
<td>192</td>
<td>191</td>
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<td>192</td>
<td>592</td>
<td>209</td>
<td>219</td>
<td>199</td>
<td>627</td>
<td>175</td>
</tr>
<tr>
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<td>0.43</td>
<td>0.38</td>
<td>0.46</td>
<td>0.49</td>
<td>0.44</td>
<td>0.26</td>
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<td>0.13</td>
<td>0.32</td>
<td>0.35</td>
<td>0.27</td>
<td>0.24</td>
<td>0.21</td>
<td>0.34</td>
</tr>
</tbody>
</table>

CLABSI CY2018

<table>
<thead>
<tr>
<th>ICU</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>3rd Qtr</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>4th Qtr</th>
<th>CY18</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
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</tr>
<tr>
<td>Patient Days</td>
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<td>631</td>
<td>817</td>
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<td>696</td>
<td>620</td>
<td>572</td>
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<td>692</td>
<td>582</td>
<td>666</td>
<td>1948</td>
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<tr>
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<td>0.20</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.10</td>
</tr>
</tbody>
</table>

CLABSI CY2018

<table>
<thead>
<tr>
<th>ICU</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>3rd Qtr</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>4th Qtr</th>
<th>CY18</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Rate</td>
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<td>0.07</td>
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<td>0.07</td>
<td>0.05</td>
<td>0.12</td>
<td>0.08</td>
</tr>
</tbody>
</table>

CLABSI CY2018

<table>
<thead>
<tr>
<th>ICU</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>3rd Qtr</th>
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<th>Dec</th>
<th>4th Qtr</th>
<th>CY18</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
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<td>0</td>
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<td>0</td>
<td>1</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Rate</td>
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<td>12.5</td>
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<td>0.0</td>
<td>3.3</td>
<td>2.0</td>
<td>2.0</td>
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<td>0.0</td>
<td>0.0</td>
<td>5.6</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>3.8</td>
</tr>
<tr>
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<td>2636</td>
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</tbody>
</table>

Analysis

Adults

The CLABSI rate in the adult population for CY2018 was 2.37 per 1000 central line days. This is an increase from a rate of 0.68 per 1000 central line days in CY2017. We also had a reduction in line days from 4,420 in CY2017 to 4,223 in CY2018.

The NHSN SIR for CY2018 was 3.4 which is an increase from 0.83 in CY2017. The SIR is still above 1, which is more than expected based on the NHSN definition. The SIR is a standardized infection ratio which is risk adjusted based on national data.
Action Plans

- We continue to monitor central lines for necessity, educate nursing staff and the medical staff on the use of midlines, when appropriate.
- BHIP participates in HIIN for best practices.
- Daily assessment of the central line included line necessity, discontinuation of the central line or change the central line to a midline when appropriate, improved awareness and communication which included bedside shift report.
- Rounding included ongoing interventions; line necessity, education and line dressing surveillance.
- 2 person dressing change and documented to reflect.
- Daily chlorhexidine bathing for inpatients on all units, except for the ICU/CCU for patients with central lines.
- Implementation of daily CHG bathing for all ICU/CCU patient, as part of nursing action plans.
- Bathing techniques were monitored and re-education was provided to all nursing staff. In addition, mandatory online education was provided through Healthstream.
- Continued use of disinfectant caps on all IV tubing access ports on all adult inpatient nursing units.
- Continued education of all existing RN’s along with new hire RNs with the use of the Guardian Angel Program with validation and competency.
- Central line bundle compliance monitoring completed by Epidemiology on a monthly basis to include review of EMR to reflect the following at every insertion: hands washed prior to procedure, use of CHG antiseptic at the procedure site, maximal barrier used, use of hat, mask, sterile gown, sterile gloves, number of additional line attempts, application of antimicrobial patch, if indicated, number of femoral central venous catheter insertions, number of femoral line insertions. This data is reported at the quarterly Infection Control Committee meeting.

Catheter Associated Urinary Tract Infections (CAUTI)

CAUTI CY2018
Analysis
Adults
The CAUTI rate in the adult population at BHIP for CY2018 was 1.2 per 1000 urinary catheter days. This is a decrease from the previous CY2017 rate of 1.6 per 1000 urinary catheter days. We also had a reduction in urinary catheter days from 4,272 in CY2017 to 3,220 in CY2018.

The NHSN SIR for CY2018 was 0.56 which is a reduction from 2.08 in CY2017. The SIR is now below 1, which is less than expected based on the NHSN definition. The SIR is a standardized infection ratio which is risk adjusted based on national data.

Action Plans
- Continue to monitor urinary catheter for necessity, educate nursing staff and the medical staff, when appropriate.
- Continue to utilize the HOUDINI protocol for indications for urinary catheter.
- BHIP participates in HIIN for best practices.
- Daily assessment of the urinary catheter included line necessity and discontinuation of the urinary catheter utilizing the HOUDINI protocol.
- Improved awareness and communication which included bedside shift report.
- 2 person indwelling catheter insertion and documented.
- Daily rounding included ongoing interventions, urinary catheter necessity, education and urinary catheter bundle compliance during surveillance.
- Education and reinforcement regarding appropriate use of antimicrobial product completed on a quarterly basis.

Ventilator Associated Pneumonia
Adults
The VAP rate in the adult population at BHIP for CY2018 was 0 which is a reduction from 1.25% in CY2017. We has also had a reduction in ventilator days from 801 days in CY2017 to 701 ventilator days in CY2018.

Action Plan
The VAP bundle continues to be utilized as well as rounding to ensure that the bundle measures are in place.
III. Surgical Infections Report

Colon Surgical Site Infections

Analysis

Colon Surgical Site Infections
For CY2018, the colon surgical site infection rate was 3.03%. This number represents 4 infections out of 132 colon surgical procedures. For CY2017, the colon surgical site infection rate was 5.59%. This number represents 8 infections out of 143 colon surgical procedures.

The NHSN SIR for CY2018 was 0.3 which is an increase from 0.27 in CY2017. The SIR is above 1, which indicated that there were more infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.
Hysterectomy Surgical Site Infections

For CY2018, the hysterectomy surgical site infection rate was 0.85%. This number represents 2 infections out of 235 hysterectomy surgical procedures. For CY2017, the hysterectomy surgical site infection rate was 1.22%. This number represents 3 infections out of 245 hysterectomy surgical procedures.

The NHSN SIR for CY2018 was 1.08 which is a increase from 0.50 in CY2017. The SIR is 1.08 which is above 1, which indicated that there were more infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

Analysis

C-Section Surgical Site Infections

For CY2018, the C-section surgical site infection rate was 0.4%. This number represents 5 infections out of 1,262 C-section surgical procedures. For CY2017, the C-section surgical site infection rate was 0.8%. This number represents 8 infections out of 991 C-section surgical procedures.
Action Plans for All Surgical Site Infections

- Continue to monitor colon, hysterectomy and include Class I and II surgical procedures for development of surgical site infection.
- Infections also be identified separately based on the following: Class I, Class II, total hip and total knee replacements. This is for standardization of internal reporting mandated by Broward Health.
- Continue to report surgical infections to Patient Safety and Quality Council Committee meeting, Department of Surgery Committee meeting and Infection Control Committee meeting.
- A Surgical Site Prevention Committee meeting continues on a monthly basis with the intent to focus the CDC Guidelines for Prevention of Surgical Site Infections.

- Multidisplinary rounding is also completed for all patients who are part of the Joint Commission Disease Specific Minimally Invasive program with Epidemiology in attendance.
- Communication regarding infections occurred with all nurse managers and administration during Patient Care Key Group and Infection Control Committee meetings.
- BHIP participates in HIIN for best practices.
- Preoperative education prior to surgery is provided to all patients regarding the importance of preoperative bathing with either soap or water or an antiseptic which is to be completed at home the night before surgery and the morning of surgery before coming to the hospital.
- CHG soap is provided to all patients that attend preoperative education classes. This information was communicated to the medical staff.
- Re-evaluation and implementation of CHG bathing preoperatively for all patients.

IV. MRSA Bacteremia and C. Difficile Infections

MRSA Bacteremia Infections
BHIP Tracks and trends MRSA Bacteremia cultured from patients to determine if they are community acquired versus hospital acquired. We do track and trend all MRSA bacteremia as per the NHSN guidelines.
Analysis
For CY2018, our infection rate for organisms that were culture positive for MRSA bacteremia was 0.03%. This number represents 1 infection out of 30,934 patient days. For CY2017, our infection rate for organisms that were culture positive for MRSA bacteremia was 0.09%. This number represents 3 infections out of 32,870 patient days.

The NHSN SIR for CY2018 was 0.58, which is a decrease from 1.66% in CY2017. The SIR is below 1, which indicated that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

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

Analysis
For CY2018, our infection rate for hospital onset C. difficile infection 5.82%. This number represents 18 infections out of 30,934 patient days. For CY2017, our infection rate for hospital onset C. difficile infections was 4.87%. This number represents 16 infections out of 32,870 patient days.

The NHSN SIR for CY2018 was 0.94. The NHSN SIR rate for CY2017 was 0.79, which is an increase in CY2017. The SIR is below 1, which indicated that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

There were 18 cases of hospital acquired C. difficile with no commonalities as to time and location.
Action Plans for All MRSA Bacteremia Infections & C. Difficile

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

V. Healthcare Worker Risks

- Provide education during new hire orientation, staff meetings/huddles and during rounding with focus on disease transmission and prevention.
- Implemented a recognition program to identify HCWs who perform hand hygiene by providing a business card with a life saver candy and a “thank you for being a life saver”.
- Provided education during Infection Prevention and Control Week.
- Isolation Precautions compliance is monitored on a monthly basis by Epidemiology and presented at the Infection Control Committee meeting.
- In-services and education provided to individual departments during their staff meetings to include Environmental Services and Nutritional Services.
• All hospital staff and LIPs are required to comply with mandatory in-service education about the prevention of health care associated infections, multi-drug resistant organisms, and prevention strategies, at hire and annually thereafter.

• All nursing staff are required to complete education about prevention of central line associated blood stream infections, catheter associated urinary tract infections, and ventilator associated pneumonia, surgical site infections, and transmission of multidrug-resistant organisms.

• Education is provided to all patients and families who are infected or colonized with a multidrug-resistant organism about health care associated infection prevention strategies.

• Surveillance plan based on prioritized risk of transmission of diseases identified in our community and from the characteristics of the population served was developed and approved by the Infection Prevention and Control Committee.

• Surveillance plan is carried out by the Epidemiology nurses on an ongoing basis resulting in prevention of disease transmission to patients, hospital staff, LIPs, students, volunteers and visitors.

• Epidemiology identifies risks for acquisition and transmission of infectious agents on an ongoing basis (MDROs, C. difficile, TB, Influenza) and annual risk assessments.

• There is a high incidence of TB in Broward County which requires constant surveillance to identify suspect cases. This is included in the risk analysis of reported data as high risk and requires close monitoring to prevent transmission.

• Continue to actively track and trend the traffic of patients for any increase influx of patients and/or need to implement the Pandemic Plan.

• Epidemiology nurses performed daily ongoing surveillance through the monitoring of ED logs, microbiology candidate reports and rounding helped identify influx of infectious patients.

• The ESSENCE reporting system that identifies syndromic trends through the ER is used to coordinate surveillance with the Broward County Department of Health.

• A database for TB reporting to the Health Dept. was utilized to maintain a record of communication.

• Early identification of patients colonized or infected with resistant organisms, TB, influenza or other infectious organisms and immediate transmission based isolation of these patients reduced and prevented further transmission.

• Individual patient positive MDRO results were entered into an ALERT data base system which is activated to display with subsequent patient visits. The ALERT screen enabled hospital staff to imitate transmission based precautions as indicated from the screen information.

• All exposures are reported to Employee Health. Employee Health tracked for any trends and all reports are presented to Environment of Care Committee meeting and the quarterly Infection Control Committee meeting.

VI. Communicable Diseases

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

Antibodies to Hepatitis C virus, and various gastrointestinal diseases such as Salmonella and Shigella were the top reported communicable diseases other than STD’s.
VII. Education

- Annual infection control education completed for all departments at BHIP via Healthstream. Attendance lists are on file in the Education office.
- Education provided at New Hire Orientation.
- Presentations at various hospital units staff meetings conducted throughout the year.
- Epidemiology is available for consultation 24 hours a day, seven days a week.
- Support and enhance public relations through community interactions and educational programs on BHIP campus and at various community centers throughout the county.

VIII. Trials / New Products

- All products that are introduced to Broward Health Imperial Point must first go through the Value Analysis Committee for approval which includes updates on trials of the product to ensure proper function and safety.
- When indicated, presentations are first given to the Regional Epidemiologists prior to being presented at Value Analysis Committee.
- Implementation of Purewick, which is an alternative for urinary catheters.
- Implementation of the new urinary catheter tray to aid in aseptic technique during insertion.
- Implementation of 7mm Biopatch availability for use in patients with hemodialysis catheters when appropriate.

IX. Evaluation

- The BHIP Infection Control Risk Assessment for CY2019 was presented to the Infection Control Committee for review, recommendations and approval.
- The annual appraisal CY2019 was presented for approval to the Infection Control Committee and will be presented to the Medical Executive Committee.
- The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified.
- The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- The Infection Control Committee meets quarterly. The Committee structure includes the Committee chair (Infectious Disease physician), staff physicians, administration, nursing, pharmacy, lab, nutritional services, environmental services, surgery, safety, facilities and other departments as needed.
- PMR and other reports are indicated are provided to the Patient Safety Quality Council Committee meeting on a monthly basis.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.
- All areas surveyed for construction were found to be fully ICRA compliant during CY 2018.
- All of the prioritized risks were reviewed and evaluated. Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- Epidemiology monitored sterilization and high level disinfection processes within the hospital. Ongoing review of the monitoring reports submitted by all departments are also
presented at the Environment of Care Committee meeting and Infection Control Committee meeting.

- The Coordinator of Epidemiology maintains membership of national and local chapters of their professional organizations, to include APIC and AORN, in order to receive education and competency related to Epidemiology/Infection Prevention and Control on an ongoing basis.

**CY2018 Epidemiology Accomplishments**

**Education and Celebration**
- Implemented Zero Hero program to recognize nursing units with Zero infections.
- Celebrated Infection Prevention and Control week with rounding on units and educating about Hand Hygiene with SOAP and Bubbles whom brought a fun game called Pick A Germ. This game was for staff to pick a germ from the bowl of germs and answer the questions. Discussion regarding the answer was conducted. In addition provided Germ Matching game and Infection Control Word Search game. Provided coloring page with crayons for staff to bring home to their children related to importance of hand hygiene. Also provided information from APIC on ways to protect patients, breaking the chain of infection and infection prevention.
- During the month of November provided C. diff education as it was C. diff awareness month. Poop Patrol went out to all units with specific questions geared to C. diff education. Created “What’s the Scoop on Poop” word search, created Wink on C. diff based on CDC guidelines. Provided one-on-one education including to, but not limited to each nursing unit, Nutritional Services, EVS services, and Rehab and physicians.

**Hand Hygiene 2018**
- Implemented a recognition program to identify HCWs who perform hand hygiene by providing a business card with a life saver candy and a “thank you for being a life saver”.
- Recognized during the Joint Commission Survey 2018 as a best practice with recommendation to submit to Joint Commission National Leading Practice Library.
- Implementation of PDI patient hand sanitizing wipes for improvement of hand hygiene for patient use.
- Implemented SOAP UP program based on the HIIN guidelines.

**CAUTI**
- Continued education on NHSN and surveillance definitions.
- Rounding on maintenance and care related to urinary catheters as well as reminders for removal.
- House wide collection of line days.
- Striving for zero infections.
- Pericare/foley care and CAUTI prevention provided to all staff.
- Introduction of new urinary catheter tray to aid in aseptic technique during insertion.
- Continue to ensure that all urinary catheters inserted with urimeters to prevent breaking closed system.
- CAUTI rate graphs provided monthly at Patient Safety Quality Council meetings.

**CLABSII**
- Education on NHSN and surveillance definitions
- CHG bathing techniques were monitored and re-education was provided to all nursing staff.
- Created mandatory online education was provided through Healthstream.
• Continued use of disinfectant caps on all IV tubing access ports on all adult inpatient nursing units.
• Continued education of all existing and new hire RNs with the use of the Guardian Angel Program with validation and competency.
• Rounding on the unit questioning the necessity of lines and observing dressings has contributed to the overall decline in CLABSI rates.
• CLABSI rate graphs provided monthly at Patient Safety Quality Council meetings.
• Discussion of CLABSI in at Patient Safety Quality Council meetings.
• Prevalence rounding by Epidemiology.
• Implementation of TEGO caps and availability of 7mm Biopatch.
• Biopatch in-services provided hospital wide, including the ED.

SSI
• Education on NHSN and surveillance definitions.
• Daily surveillance of cultures to identify any surgical site infections.
• A Surgical Site Prevention Committee meeting was established in November 2017 with the intent to focus the CDC Guidelines for Prevention of Surgical Site Infections, 2017 and institute those measures.
• Attendance at Multidisplinary Rounding for all patients who are part of the Joint Commission Disease Specific Minimally Invasive program.
• Communication regarding infections occurred with all nurse managers and administration during one-to-one meetings, at Nurse Leadership Committee on lessons learned to prevent infection.
• Presentation of all surgical site infections at the Surgical Site Infection Prevention Committee meeting with focus on risk factors and adherence to evidence based practice to reduce infections.
• SSI rate graphs provided at Patient Safety Quality Council meetings, Infection Control Meetings.
• Discussion of SSI at Patient Safety Quality Council meetings.
• Continued weight based dosing for pre op antibiotics as per evidence based practice.

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

MRSA Bacteremia and C. Difficile
• EVS in-services.
• Implementation of the use of Viresept, a bleach product, for EVS to use for daily cleaning and terminal cleaning for those patients on Enhanced Contact Isolation.
• Nutritional Services in-services
• Use of Medmined data mining system to capture any trends related to MDRO’s and CDI.
• Recognizing the importance of antimicrobial stewardship in decreasing the rates of MDROs, the Epidemiology Department continues to work with Pharmacy.
• Continued to implement Transmissions-Based Precautions and Standard Precautions
• Hand Hygiene education
• MDRO admission alerts, and frequent communication between clinical and nursing departments and Epidemiology.
• Continued use of Respiratory Viral Panel/Biofire technology to decrease antibiotic use when viruses are identified.
New policies, committees and initiatives

- System wide High Level Disinfection policy created.
- High Level Disinfection reinforced created to standardize practices across departments according to best practices from Joint Commission BoosterPak and in line with AORN guidelines and SGI guidelines.
- SOAP UP Campaign

Education

- CDC education on NHSN definitions by Epidemiology nurse.
- Certification in Infection Control obtained by Coordinator of Epidemiology
- Attendance at FHA Infection Control Boot Camp
- Continuous education through webinars, attendance at meetings and online education.

Coordinator of Epidemiology: _________________________________________

CNO, COO, or CFO: ____________________________________________________

Infection Control Committee Chairman: _________________________________

Date: 
### POLICY 

#### INFECTION CONTROL PLAN

**POLICIES AND PROCEDURE MANUAL-**

**BHIP ADDENDUM TO SYSTEM IC PLAN**

| POLICY #: | 
| --- | --- |
| **SUBJECT:** | Broward Health Imperial Point Infection Control Program (BHIP) Addendum |
| **PURPOSE:** | Broward Health Imperial Point (BHIP) has developed and implemented an effective Infection Control Program for the surveillance, prevention and control of infection. |
| **Sponsor:** | Epidemiology |
| **APPROVED BY:** | 
  - Chairman, Infection Control Committee  
  - Chief Executive Officer, BHIP  
  - Chief Nursing Officer, BHIP |

| **Addendum Effective:** | 4/2019 |
| **BHIP IC PLAN:** | 4/2018 |
| **DATE REVIEWED:** | 4/25/19 |
| **BHIP IC PLAN REVISED:** | 4/18 |
| **ADDENDUM APPROVED FOR USE AT BHIP** | 

**Purpose:** Broward Health has developed and implemented an effective system-wide Infection Prevention and Control Program for the surveillance, prevention and control of infection. This is the BHIP specific addendum to the plan.

### I. Description of Population

Broward Health Imperial Point is a 204 bed community hospital located in northeast Fort Lauderdale, in Broward County, Florida. The fastest growing age groups in this geographic area are ages 55-74 and age greater than 75. Additionally, the County is a popular tourist destination and major yachting center. There are a numerous hotels and restaurants and near to this facility is an executive airport. A large international airport and shipping port are approximately 11 miles south of this facility. In the entire Broward County population, the Health Department reports high numbers of sexually-transmitted diseases, chronic Hepatitis C, HIV/AIDS and tuberculosis cases for Broward County.

BHIP provides comprehensive care across the continuum of care for all age groups. Patient populations include: medical-surgical specialties, including but not limited to intensive care, general
surgery and medicine, gastroenterology, orthopedics, neurology, renal, pulmonary, endoscopy, wound care, hyperbaric oxygen treatment, stroke and oncology.

Per Fiscal Year 2018 statistics, our payer mix was Medicare 22.47%, Medicaid 4.02%, MC Commercial 23.79%, MC Medicare 22.65%, MC Medicaid 11.57%, and Charity & Selfpay 15.51%.

The Top 10 adult principle surgical procedures performed in CY2018 include: debridement subq, muscle, fascia, laparoscopic sleeve gastrectomy, vitrectomy, knee arthroscopy, laparoscopic cholecystectomy, open colectomy, lap appendectomy, lap hysterectomy, open hysterectomy, cystoscopy with ureteral stent.

The Top 10 adult inpatient principle diagnosis for CY2018 include: Sepsis, acute kidney failure, chronic obstructive pulmonary disease, pneumonia, cellulitis of left lower limb, acute respiratory failure with hypoxia, unilateral primary osteoarthritis, right knee, urinary track infection, hypertension heart disease with heart failure, cellulitis of right lower limb.

The Top 10 adult inpatient principle behavioral diagnosis CY 2018 include: major depressive disorder, recurrent severe without psych features, schizoaffective disorder, bipolar type, paranoid schizophrenia, brief psychotic disorder, bipolar disorder, crnt epsd depress, mild or mod severt, unsp, bipolar disorder, crnt epsd depress, severe with psych features, bipolar disorder, crnt episode manic severe with psych features, schizoaffective disorder, depressive type, major depressive disorder, single epsd, severe with out psych features.

The Top 10 adult emergency department diagnosis for CY2018 include: urinary tract infection, headache, low back pain, bronchitis, cough, alcohol abuse with intoxication, anxiety disorder, viral infection, unspecified abdominal pain, essential (primary) hypertension.

II. Scope of Program
   a. BHIP is licensed for 204 beds and has an average patient census of 130.
   b. Patient care units include:
      1. Emergency Department- 19 private patient rooms, plus 1 Code room with 2 bays There are 2 negative air pressure isolation rooms are available
      2. Medical Unit- 37 beds where healthcare workers care for patients with general medical conditions such as HIV, chronic kidney disease, diabetes, wound infections, endocarditis and tuberculosis.
      3. Surgical Unit- 33 beds where healthcare personnel care for patients primarily following surgical procedures. This unit may also care for patients undergoing chemotherapy. Remote telemetry is available on the surgical floor
      4. Critical Care Services-comprised of one ten (10) bed critical care unit and one progressive care unit. There are forty-nine (49) available monitored beds on the progressive care unit. These beds are utilized for the care of patients with cardiac, respiratory, neurological, or surgical conditions that require an intensive and/or intermediate level of care.
      5. There is a 47 bed Behavioral Health Unit located on the 6th floor.
6. There are a total of 16 negative air pressure rooms are strategically located throughout the facility.
7. The Surgical Services Units has seven (7) surgical suites with one cystoscopy room. The highest volume of surgical cases are in the following categories: general surgery, orthopedic, ophthalmology, and gynecology.
8. A ten (10) bed Post Anesthesia Care Unit (PACU) provides care for the post-operative patient.
9. Same Day Surgery has six (6) pre-operative beds, five (5) pre-op/post-op holding beds, five (5) post-op discharge beds, and five (5) reclining chairs for patients who are recovered and awaiting disposition.
10. A two (2) room Endoscopy Unit is located on the 2nd floor.
11. Bronchoscopy is performed in the Cardio-Pulmonary Department on the 2nd floor. Negative air pressure is utilized when indicated.
12. Wound Care Center- including a Hyperbaric chamber is located on the 3rd floor.
13. Interventional Radiology and Invasive Cardiology are located on the 2nd floor.
14. 4 bed Outpatient Surgery Center for ambulatory cases, primarily for Ophthalmology, Pain Management, minor orthopedic procedures, Urology, and Plastic Surgery services.
15. Rehabilitation Services is located on the 1st floor.
16. Nutritional Services is located on the 1st floor.
17. Outpatient services are provided on the 1st and 2nd floors.
18. Pharmacy, Laboratory, and Sterile Processing are housed on the 2nd floor.

c. Services provided at BHIP include but are not limited to:
   **Adult Care**
   a. Emergency Department
   b. Surgical Services Department
   c. Minimally Invasive Colorectal Services
   d. Inpatient Rehabilitation
   e. Outpatient Rehabilitation
   f. Endoscopy Unit
   g. Bronchoscopy Unit
   h. Interventional Radiology
   i. Orthopedic Service
   j. Joint Replacement
   k. Inpatient Dialysis
   l. Cardiopulmonary Services
   m. Wound Care Center
   n. Inpatient Dialysis
   o. Hospice
   p. Medical/surgical
   q. Behavioral Health
   r. Intensive Care
   s. Progressive Care

III. **At Risk Patient Populations**
The Infection Control Committee at Broward Health Imperial Point has identified the following patient populations as being at higher risk for healthcare associated or transmissible community acquired infections:
a. Patients undergoing mechanical ventilation

b. Patients undergoing surgical & invasive procedures

c. Patients with indwelling medical devices (urinary catheters and peripheral and central venous catheters)

d. Employees at risk for occupational exposure to tuberculosis, blood borne pathogens, and other communicable diseases

e. Patients with immunosuppression due to chronic illness (diabetes, ESRD, HIV disease, COPD, sickle cell disease and drug and alcohol abuse)

f. Patients with significant pathogens (i.e., multidrug resistant organisms, including C. difficile)

g. Patients with limited mobility, compromised nutritional status, and diminished sensory perception

h. Patients with chronic conditions with recurrent hospitalizations (i.e., CHF, COPD)

IV. Roles and Responsibilities of the Infection Control Committee (ICC)

a. The ICC is a multidisciplinary committee with representation from but not limited to Medical Staff, Executive Leadership, Nursing, Pharmacy, Laboratory, Surgical Services, Environmental Services, Facilities Management, Employee Health, Ancillary staff, and other departments of the hospital. The role of the ICC is to oversee the BHIP Infection Prevention and Control Program.

b. Responsibilities of the Infection Control Committee include but are not limited to the following:

i. Recommends the minimum amount of time allocated to the Infection Prevention and Control Program based on the needs of the population served.

ii. Requests changes to the allocation of time as needs change or program goals cannot be met.

iii. Facilitates the allocation of resources needed to access information, supplies, equipment and laboratory services.

iv. Approves the Infection Control Plan, Annual Appraisal, Risk Assessments, BHIP IC Program revisions, and Infection Control new policies/revised policies and the BHIP Hand Hygiene Plan.

v. Initiates recommendations based on mandatory reporting data, surveillance findings, epidemiological investigations and performance indicator trends.

c. The multidisciplinary Infection Control Committee meets quarterly. The Chairman of the ICC, has the authority of the Chief of Staff and Chief Executive Officer of Broward Health Imperial Point to oversee the Infection Prevention and Control Program. The Coordinator of Epidemiology serves as the facilitator. All hospital departments are encouraged to participate in the ICC and contribute to the infection prevention and control objectives of the program.

d. Employee Health functions relating to Infection Control are conducted by the Employee Health Practitioner. Employee Health trends are reviewed and analyzed by the Infection Control Committee, to include the following:

e. Employee blood and body fluid exposures and follow up with each occurrence reviewed to identify high-risk procedures and/or products. Based on the evaluations, corrective actions can be developed and implemented. Summary evaluations are presented to the Infection Control Committee and Environment of Care Committee.

f. Employees are screened for TB at least annually. Employees with skin test conversions are referred for evaluation and follow-up. TB screenings and
conversions are tracked monthly by department and for the facility as a whole. An annual summary is presented to the Infection Control Committee.

g. Infections of epidemiologic significance among employees are reported along with any control measures instituted, follow-up required, or cases of secondary spread.
   1. Pre-employment screening is completed by the Employee Health Practitioner to evaluate immunity to certain infectious diseases. Vaccines are offered when indicated.
   2. The Employee Health Practitioner or designee coordinates and performs initial fit test and annual fit-checks for N-95 Respirators.
   3. The Employee Health Practitioner will perform surveillance of employee illnesses and monitor and report any significant communicable disease. This will also be reported at the Infection Control Committee.

**Information generated by Infection Control activities is confidential and all individuals having knowledge of this information will maintain confidentiality of privileged health information. Results of infection control findings will be presented only to committees and/or personnel responsible for conducting or monitoring the quality of patient care, or to appropriate public health personnel.**

V. Objectives

Objectives for the Epidemiology department are as follows:

*Please see Appendix A: Goals and Objectives CY2019*

Organizations referenced:

1. Centers for Disease Control and Prevention (CDC)
2. The Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)
3. Association of peri-Operative Registered Nurses (AORN)
4. Association for the Advancement of Medical Instrumentation (AAMI)
5. The Society for Healthcare Epidemiology of America (SHEA).

REFERENCES:

1. CDC, Template for State Healthcare Associated Infections Plans 2010
6. The Joint Commission Infection Prevention and Control Standards
Related Policies: Broward Health Infection Control Plan (System), Broward Health Epidemiology and Department Specific Infection Control Policies.

Authors: Broward Health Imperial Point Epidemiology Department

Reviewed/Approved: BHIP Infection Control Committee, BHIP CNO
Date: 4/25/2019

A risk assessment guides prioritization of infection prevention and control goals and objectives and is completed by the Infection Control Committee. BHIP identifies the risks for acquiring and transmitting infections based on its geographical location, community findings, care, treatment and services provided, healthcare worker risks, and environmental risks.

The Risk Assessment is conducted annually and/or whenever risks change significantly. Scoring of the Risk Assessment is approved by the Infection Control Committee (ICC) to ensure a multidisciplinary approach to assess the needs of the population served at Broward Health Imperial Point.
Appendix A
Goals and Objectives CY 2019

*Based on Risk Assessment of Events
*Will review monthly
*Target goals based on 10% reduction in harm events from LCY and VBP achievement threshold using NHSN SIR data.

Hospital Acquired Infection (HAI)/Admission Related Risks
Goal # 1: Overall reduction of hospital acquired infections.
*Pareto Analysis reveals multi drug resistant organisms (MDRO) and surgical site infections (SSI) both constitute the highest risk percent at 56% each in the HAI/Admission risk portion of the risk assessment. The top 5 risks identified in the Pareto analysis were MDROs, surgical site infections, central line blood stream infection (CLABSI), catheter associated urinary tract infection (CAUTI), and C-Difficile infections. All HAI are of concern and we strive in chasing zero.

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<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
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<th>Team</th>
<th>Methodology</th>
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<tr>
<td>MDRO (including MRSA bacteremia) and C. diff</td>
<td>All patients</td>
<td>1. Determine risk factor for HAI 2. Decrease HAI 3. Decrease sepsis 4. Continue participating in FHA HIIN 5. Decrease readmissions</td>
<td>BHIP: Target Rates MRSA: 0.47 VRE: 0.09 CRE: 0.03 ESBL: 0.06 CDIFF: 5.24 SIR MRSA bac: 0.815 CDIFF: 0.852</td>
<td>IP Nurses Physicians Pharmacists</td>
<td>1. Daily review of surveillance including ED visit log, review of all microbiology results/monitor labs, identify and verify infections, analyze data. 2. Utilize MedMined data mining program to assist with identifying potential clusters. 3. Review Antibiogram and discuss at ICC and Antimicrobial Stewardship committee 4. Continue contact precautions for active infection and 3 month history of infection. 5. Utilize Respiratory Viral Panel (Biofire) to prevent antibiotics for viruses. 6. C. diff: Place patient on enhanced contact precautions per policy and monitor compliance with bleach based disinfection.</td>
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</tbody>
</table>
| SSI | Patients who had surgery | 1. Determine risk factors for HAI 2. Decrease HAI 3. Decrease sepsis 4. Continue participating in FHA HIIN 5. SSI Prevention Committee | BHIP target rate:  
SIR hyst: 0.722  
colo: 0.781 | IP Surgical Services Nurses  
Physicians  
Anesthesiologists  
Pharmacists  
Surgeons | 1. Monitor infection rates for all class I and II surgeries and report to appropriate stakeholders.  
2. Monitor all total hip and total knee surgeries and report to appropriate stakeholders.  
3. Monitor COLO and HYST infections and report to NHSN and stakeholders.  
4. Daily surveillance of ED log, micro reports, OR schedule.  
5. Review for weight based dosing for antibiotics, redosing as necessary.  
6. Review to ensure glycemic monitoring is performed in all surgical cases.  
7. Discuss each SSI during Patient Safety Quality Council meeting  
8. Discuss in depth SSI at monthly SSI Prevention meeting to determine lessons learned.  
9. Review patient temperatures to ensure normothermia during surgery and upon admission to PACU.  
10. Review to monitor for appropriate administration of antibiotic prophylaxis prior to surgery.  
|---------|-----------------------------|---------------------------------|----------------|-------------------|--------------------------------------|----------------------|------------------------|----------|-----------------------------------------------|-----------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| CLABSI  | Inpatients with Foley catheters | 1. Determine risk factor for HAI | 2. Decrease HAI | 3. Decrease sepsis | 4. Continue participating in FHA HIIN | 5. Decrease foley days | BHIP target rate: 1.15 | SIR: 0.828 | IP Nurses Physicians Pharmacists Clinical Education | 1. IP rounds facility wide. | 2. Daily surveillance to monitor labs, identify and verify infections, analyze data. | 3. Continue with 2 person when inserting or changing line. | 4. Identify risks, assess daily need/removal. | 5. Nurse driven catheter removal protocol. | 6. Monitor bundle compliance including foley below level of bladder, not on floor, foley bag not more
than ½ full, secured to thigh, etc.
7. Educate on best practices in nursing orientation and rounding.
8. Nurse driven action plans.
9. Education through Webinar and the HIIN.
10. Discuss each CAUTI with nurse manager to determine opportunities/lessons learned.
11. Perform RCA on all infections
12. Infections are reviewed by the RMO if indicated.

| VAE | Inpatients on a ventilator | 1. Determine risk factor for HAI | 2. Decrease HAI | 3. Decrease sepsis | 4. Continue participating in FHA HIIN | 5. Decrease vent days | BHIP target rate: VAP: 0.00 | IP Respiratory Nurses Physicians Pharmacists | 1. Daily surveillance to monitor labs, identify and verify infections, analyze data. | 2. Utilize NHSN definition and report to appropriate stakeholders. | 3. Educate staff on best practices. | 4. IP rounds facility wide to ensure VAP bundle compliance. | 5. Infections are reviewed by the RMO if indicated. |

**Other Identified Events:**

**Active TB, unknown at time of admission**

1. All patients with signs and symptoms or questionable TB disease may be placed on airborne isolation by nursing without a physician’s order per airborne isolation policy.
2. Reeducation of nursing and physicians mandatory ED assessment for potential TB.
3. Review of Transmission based precautions, included difference between droplet and airborne isolation during New Hire Orientation and as needed.
4. Meeting with Clinical Specialist of the ED, ED ANM, and Patient Access Manager to review process of registration and admission in order to quickly identify those high risk patients.
Notification of Community Acquired Infections

1. Continue to utilize admit alert system and communicate with nursing and outside facilities as needed when patient admitted with a community acquired infection.

Outbreak

1. Monitor daily surveillance for any unusual organisms or clusters of organisms.
2. Initiate infection control measures based on CDC guidelines or other evidence based recommendations.
3. Consult with Florida Department of Health as necessary.
4. Educate healthcare staff on organism identified in outbreak and measures to prevent spread of further infections.
5. Utilize Outbreak procedure policy during any outbreak identified.
6. Report clusters/outbreaks to necessary stakeholders and committees.

Notification of Internal HAIs

1. Continue to utilize admit alert system and communicate with internal departments and bed control as needed when patient is admitted or transferred in the hospital with an MDRO.
2. Review of isolation log and review patient diagnosis to ensure accurate transmission based precautions are in use and education staff as needed.
3. Utilize HAS report system to track and trend occurrences and follow up with managers and conduct education as needed.

Community Risks

Goal #2: Reduction of community risk.

*Pareto analysis reveals long term care patients constitute the highest risk percent at 44% community related risks and emerging infectious disease at 41%. The rest of the top 4 risks identified in the Pareto Analysis were seasonal flu, pandemic flu, and community acquired MDROs. All risks from the community are evaluated and Epidemiology works closely with the Health Department.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emerging infectious disease/other epidemics/influx of infectious</td>
<td>All patients</td>
<td>BHIP will be prepared for an emerging infectious disease or</td>
<td>EM Drills 100%</td>
<td>IP</td>
<td>1. Continue utilizing infectious disease screening tool for all patients during triage to screen for all potentially infectious patients.</td>
</tr>
<tr>
<td>Long term patients</td>
<td>All patients</td>
<td>BHIP has nearby high admitting SNFs.</td>
<td>Length of stay</td>
<td>IP Nursing Case management Physicians</td>
<td>1. Active surveillance for incoming patients include blood and urine cultures as indicated. 2. Communication with physicians and transferring/accepting facilities to identify infections.</td>
</tr>
<tr>
<td>Seasons flu and pandemic flu</td>
<td>All patients</td>
<td>BHIP will offer influenza vaccination to all qualified patients.</td>
<td>BHIP target: 90%</td>
<td>IP Nursing Quality</td>
<td>1. Inpatients vaccinated during flu season per Centers for Medicaid and Medicare Services (CMS) protocol unless contraindicated. 2. Patients with influenza placed on Droplet isolation precautions per policy. 3. If pandemic flu, work with Florida Department of Health and Emergency Preparedness.</td>
</tr>
<tr>
<td>Community acquired MDRO</td>
<td>All patients</td>
<td>Identify community onset infections for prompt isolation. Placing patients on transmission based precautions.</td>
<td>BHIP target: 90%</td>
<td>IP Nursing Physicians Case management</td>
<td>1. Identification of patients through daily surveillance admitted with MDROs and alert tab. 2. Assess staff need for education. 3. Communication with SNF and LTC admitters. 4. Education for staff and physicians about HO and CO C. diff and MRSA bacteremia to identify community onset MDRO as early as possible and within the first 3 days of admission based on the NHSN definition. 5. Education at New Hire Orientation. 6. Review of daily isolation log and review of patient diagnosis to ensure that patient is placed on correct transmission based precautions.</td>
</tr>
</tbody>
</table>
Other Identified Events

Displaced person
1. Work with case management and social services to assist in timely discharge of patients with hospital acquired infections or multi drug resistant organisms as needed.

Active TB admissions
1. Continue to follow IC TB Plan.

HIV/AIDS
1. Continue to work with Florida Department of Health as necessary.

Bioterrorism/Ebola and Hemorrhagic Fever Diseases
1. Work with Emergency Preparedness with drills and PPE training.
2. Communicate with Florida Department of Health as necessary
3. Continue with established drills and EM updates and education.

Flood
2. Yearly hurricane drills.

Waterborne Outbreak
1. Continue to monitor for waterborne organisms through Medmined and daily surveillance.
2. Work with facilities and consultant to identify risks in water management system.
4. Report to Florida Department of Health as necessary.

Food Associated Outbreaks
1. Adhere to established outbreak policy and procedure for outbreak management.
2. Continue to report positive cultures to Florida Department of Health.
Healthcare Worker Risks

Goal #3: Reduction of healthcare worker risk of infection secondary to injury and/or exposure.

*Pareto Analysis reveals: sharps injuries at 19% and failure to follow protocols and use safety devices or PPE at 13% are the two highest risk percent for healthcare worker related risks. The remaining 3 risks identified in the Pareto analysis were non-compliance with hand hygiene and non-compliance with seasonal flu immunization. All risks to healthcare workers are followed by both Employee Health and Epidemiology and presented at Environment of Care Committee.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharps Injuries</td>
<td>All employees, physicians, students, volunteers</td>
<td>Decrease amount of sharps injuries</td>
<td>BHIP target: 5% decrease</td>
<td>IP EH Administration</td>
<td>1. Education by Employee health at New Hire Orientation.</td>
</tr>
<tr>
<td>Failure to follow protocols and use safety devices or PPE</td>
<td>All employees, physicians, students, volunteers</td>
<td>Decrease needle sticks, splashes, other preventable exposures.</td>
<td>BHIP target: 90%</td>
<td>IP EH Administration</td>
<td>1. IP rounds to reinforce protocols, use of safety devices, proper PPE.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Revised isolation signs to standardize with rest of Broward Health. Signs to include new recommendations for transport of patients on isolation as well as PPE requirements in 3 different languages.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Reeducation of PPE requirements for visitors of patients on Airborne Isolation and provided sign to put on door specifically for visitors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Just in time education and remediation as needed.</td>
</tr>
<tr>
<td>Non-Compliance with hand hygiene</td>
<td>All employees, physicians, students, volunteers</td>
<td>Strive for 100% of hand hygiene compliance.</td>
<td>BHIP target: 95%</td>
<td>IP Administration</td>
<td>1. Monitor compliance in all areas of hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Just in time education and reinforcement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Hand Hygiene education at New Hire Orientation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Follow any further directive from corporate</td>
</tr>
</tbody>
</table>
Non-Compliance with seasonal flu immunization

- All employees, physicians, students, volunteers
- Increase compliance by 10% each year until 90% goal of 2020
- BHIP target: 90%
- IP EH Administration Medical Staff Clin Edu

1. Collaborate with corporate on plan on influenza vaccination implementing influenza policy.
2. Educate personnel on importance of immunization during rounds, general orientation and nursing orientation.
3. Provide onsite influenza vaccination to all staff at no cost
4. Flu vaccine consent or declination forms will be maintained by appropriate department.
5. Administration support
6. Follow any further directive from corporate

Other Identified Events:

Non-compliance with standard precautions
1. Continue to educate nursing at orientation and periodically on standard precautions according to policy.
2. IP rounding.
3. Just in time education and remediation as needed.

Employee Knowledge Deficit of Disease Transmission and Prevention
1. Coordinate with Clinical Education on utilization of the Wink forum.
2. Continue to present relevant education on disease transmission in nursing orientation.

Failure to recognize employee outbreak
1. Utilize HAS reports with risk management, Patient and Medication Safety meeting, and Nurse Practice Council to address any staff infection control issues.
2. IP rounds to engage and education staff.

**Delay in Proper Isolation Precautions**
1. Patients placed on isolation by nursing, but it has been observed that there are times where there is no order for isolation in the patients chart. Infection control and Clinical Education to educate all nursing on the need to place order for isolation in computer system.
2. Daily review of isolation log. Will educate nursing on a case by case basis on the requirements for isolation.

**Environmental Risks**  
**Goal #4: Reduction of environmental risk.**
*Pareto analysis reveals improper cleaning as the highest risk percent at 26%. The remaining top 3 risks identified in the Pareto Analysis were: improper sharps handling, improper disinfection of equipment, improper handling of biohazardous waste and failure of negative ventilation.*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper environmental cleaning</td>
<td>EVS staff</td>
<td>Compliance with proper cleaning protocols and products.</td>
<td>BHIP target: 90%</td>
<td>EVS</td>
<td>1. Partnership with epidemiology and EVS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. EVS maintains pivotal role in Infection Prevention and Control Committee.</td>
</tr>
<tr>
<td>Improper sharps handling</td>
<td>All staff</td>
<td>Reduce incidence of employee injury due to improper sharps handling.</td>
<td>BHIP target: 90%</td>
<td>All employees</td>
<td>1. Education at general orientation by EH and Epi.</td>
</tr>
<tr>
<td>Improper disinfection of equipment</td>
<td>All staff</td>
<td>Compliance with proper disinfection protocols and products.</td>
<td>BHIP target: 90%</td>
<td>All employees</td>
<td>1. IP rounds and educates on PDI wipe products.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Education on hospital approved disinfectants in New Hire Orientation, in-services, during rounding</td>
</tr>
<tr>
<td>Improper handling of biohazardous waste</td>
<td>All staff</td>
<td>Reduce misuse of red bag biohazard waste.</td>
<td>BHIP target: 90%</td>
<td>All employees</td>
<td>1. EOC rounds to check biohazard waste.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. DOH inspections.</td>
</tr>
</tbody>
</table>
Other Identified Events

Improper Sterilization or High Level Disinfection of Equipment
1. Central processing department to monitor biological pass/fail. Monthly report sent to IC. IC to be identified immediately of failed biological. Procedure for failed biological to be carried out per policy.
2. Immediate use steam sterilization report sent monthly to Infection Control by Central Processing Department
3. Infection Control to investigate any cases reported of improper sterilization.
4. Monitor for High Level Disinfection adherence with Trophon use for all vaginal probes, Reset for all TEE probes and MedEvator AER (automatic endoscope reprocessor) for all endoscopes and bronchoscopes.

Failure of Negative Pressure Ventilation
1. Adhere to existing process for failure of negative pressure ventilation. Refer to Infection Control Policy # 21 Isolation Room Checks.
2. Facilities to ensure compliance with monthly temp and humidity measures in surgical environment per standards.
Tuberculosis (TB) risk assessment worksheet

This model worksheet should be considered for use in performing TB risk assessments for health-care facilities and nontraditional facility-based settings. Facilities with more than one type of setting will need to apply this table to each setting.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>√ or Y = Yes</th>
<th>X or N = No</th>
<th>NA = Not Applicable</th>
</tr>
</thead>
</table>

1. Incidence of TB

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.

**Broward County**
- **Community rate:** ↓ 3.2 (2017) 3.5 (2016)
- **State rate:** ↓ 2.7 (2017) 3.2 (2016)
- **National rate:** ↓ 2.8 (2017) 2.9 (2016)

**Facility rate:** CY 2018
(# of confirmed diagnosed cases of TB/number of admissions)
- 0/11,451 = 0 per 100,000 patients

Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?

Yes

If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)? Review laboratory data, infection-control records, and databases containing discharge diagnoses.

<table>
<thead>
<tr>
<th>Year</th>
<th>Suspected</th>
<th>Confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>2017</td>
<td>54</td>
<td>7</td>
</tr>
<tr>
<td>2016</td>
<td>30</td>
<td>0</td>
</tr>
</tbody>
</table>

Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?

No

2. Risk Classification

**Inpatient settings**
- How many inpatient beds are in your inpatient setting? 175
- How many patients with MTB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.
- Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting (≥200 beds)? (See Appendix C.)
  - In CY 2018, there were no confirmed MTB patient cases; therefore BHIP is classified as a “low risk” facility.

*This information can be obtained from the state or local health department.*
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease? | Yes

3. **Screening of HCWs for *M. tuberculosis* Infection**

<table>
<thead>
<tr>
<th>Does the health-care setting have a TB screening program for HCWs?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, which HCWs are included in the TB screening program? (Check all that apply.)</td>
<td>✓ Janitorial staff</td>
</tr>
<tr>
<td>✓ Physicians</td>
<td>✓ Maintenance or engineering staff</td>
</tr>
<tr>
<td>✓ Mid-level practitioners (nurse practitioners [NP] and physician’s assistants [PA])</td>
<td>✓ Transportation staff</td>
</tr>
<tr>
<td>✓ Nurses</td>
<td>✓ Dietary staff</td>
</tr>
<tr>
<td>✓ Administrators</td>
<td>✓ Receptionists</td>
</tr>
<tr>
<td>✓ Laboratory workers</td>
<td>Trainees and students (Medical students-under GME; Nursing and Allied under Learning/Nursing department. Records and compliance are managed by the above departments)</td>
</tr>
<tr>
<td>✓ Respiratory therapists</td>
<td>✓ Volunteers</td>
</tr>
<tr>
<td>✓ Physical therapists</td>
<td></td>
</tr>
<tr>
<td>Contract staff (Required by the contracting department. Records kept in contracting department)</td>
<td></td>
</tr>
<tr>
<td>Construction or renovation workers (same as contract workers)</td>
<td></td>
</tr>
<tr>
<td>✓ Service workers</td>
<td>o Others_________________</td>
</tr>
</tbody>
</table>

Is baseline skin testing performed with two-step TST (Tuberculin Skin Test) for HCWs? | Yes: 2018 Total # PPD administered: 672 |

Is baseline testing performed with QFT (Quantiferon) or other BAMT (Blood Assay for Mycobacterium Tuberculosis) for HCWs? | No |

How frequently are HCWs tested for *M. tuberculosis* infection? | Annually during their anniversary hire period. |

Are the *M. tuberculosis* infection test records maintained for HCWs? | Yes |

Where are the *M. tuberculosis* infection test records for HCWs maintained? Who maintains the records? | Employee Health Department |

If the setting has a serial TB screening program for HCWs to test for *M. tuberculosis* infection, what are the conversion rates for the previous years?†

| Benchmark 1.0% |
| (2018)- 0% |
| (2017)- 0% |
| (2016) -0.02% 2/849 |

Number of employee exposures | 2018:0 |
| 2017: 5 |
| 2016: 0 |

Has the test conversion rate for *M. tuberculosis* infection been increasing or decreasing, or has it remained the same over the previous 5 years? (check one) | Decreasing – 2017-2018 decreased. |
Do any areas of the health-care setting (e.g., waiting rooms or clinics) or any group of HCWs (e.g., lab workers, emergency department staff, respiratory therapists, and HCWs who attend bronchoscopies) have a test conversion rate for *M. tuberculosis* infection that exceeds the health-care setting’s annual average? | No. While not above the annual average, there were 0 conversions this year that represents an decrease from previous years.

For HCWs who have positive test results for *M. tuberculosis* infection and who leave employment at the health setting, are efforts made to communicate test results and recommend follow-up of latent TB infection (LTBI) treatment with the local health department or their primary physician? | Yes - New hire positive skin test results are screened with a chest x-ray and are referred to their PCP or community resource for evaluation of latent TB status. This is required by day 60 after first day of employment. Employees who converted are seen by an ID physician through workers comp. If employees are terminated before they are seen and evaluated, a letter is sent by employee health to follow up with workers comp, private primary care physician or their new employee health department. Exposure follow up for employees who were terminated before the 10th week of follow up are notified by letter to follow up with their PCP or new employee health department.

### 4. TB Infection-Control Program

<table>
<thead>
<tr>
<th>Does the health-care setting have a written TB infection-control plan?</th>
<th>Yes – in the Infection Control Plan and a Broward Health policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is responsible for the infection-control program?</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>When was the TB infection-control plan first written?</td>
<td>06/05</td>
</tr>
<tr>
<td>When the TB infection-control plan was last reviewed or updated?</td>
<td>4/2019</td>
</tr>
<tr>
<td>Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., &gt;1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of <em>M. tuberculosis</em>)?</td>
<td>No</td>
</tr>
<tr>
<td>Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If yes, which groups are represented on the infection-control committee? (Check all that apply.)

- [x] Physicians
- [x] Nurses
- [x] Epidemiologists
- [x] Engineers
- [x] Pharmacists
- [x] Laboratory personnel
- [x] Health and safety staff
- [x] Administrator
- [x] Risk assessment
- [x] Quality control (QC)
- [x] Environmental staff
- [x] Respiratory
- [x] Clinical education
- [x] Facilities management

### 5. Implementation of TB Infection-Control Plan Based on Review by Infection-Control Committee

Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name: ___Chairman of Infection Control Committee/ Medical Director of Epidemiology ___ | Yes. Marah Lee, DO |
Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized?

Review of laboratory results, outbreak investigations and other means of surveillance.

What mechanisms are in place to correct lapses in infection control?

Process improvements, outbreak investigation, literature search, multidisciplinary team work, reporting through committee process within the facility.

Based on measurement in routine QC (Quality Control) exercises, is the infection-control plan being properly implemented?

Yes

Is ongoing training and education regarding TB infection-control practices provided for HCWs?

Yes

### 6. Laboratory Processing of TB-Related Specimens, Tests, and Results Based on Laboratory Review

<table>
<thead>
<tr>
<th>Test Type</th>
<th>In-house</th>
<th>Sent out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid-fast bacilli (AFB) smears</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Culture using liquid media (e.g., Bactec and MB-BacT)</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Culture using solid media</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Drug-susceptibility testing</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Nucleic acid amplification (NAA) testing</td>
<td>✔️</td>
<td></td>
</tr>
</tbody>
</table>

Does the laboratory at your health-care setting or the reference laboratory used by your health-care setting report AFB smear results for all patients within 24 hours of receipt of specimen? What is the procedure for weekends?

Yes. The same process is utilized on nights and weekends as regular business hours. Laboratory will page the on call Epidemiologist to communicate positive AFB results outside of normal business hours.

### 7. Environmental Controls

Which environmental controls are in place in your health-care setting? (Check all that apply and describe)

- **Environmental control**
  - ✔️ All rooms
  - ✔️ Local exhaust ventilation (enclosing devices and exterior devices)
  - ✔️ General ventilation (e.g., single-pass system, recirculation system.)
  - ✔️ Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] filtration and ultraviolet lighting)

What are the actual air changes per hour (ACH) and design for various rooms in the setting?

- Med Surge / Tele Rooms - 6 ACPH
- Emergency Department - 12 ACPH
- Operating Rooms / Surgical Services – 20 ACPH
- Negative Isolation Rooms – 12 ACPH
- Bronchoscopy Rooms - 12 ACPH
- Endoscopy Rooms – 12 ACPH
- Cath Labs - 15 ACPH
- Interventional Radiology Procedure Room - 15 ACPH

Which of the following local exterior or enclosing devices such as exhaust ventilation devices are used in your health-care setting? (Check all that apply)
What general ventilation systems are used in your health-care setting? (Check all that apply)
- Single-pass system
- Constant air volume (CAV)
- Recirculation system

What air-cleaning methods are used in your health-care setting? (Check all that apply)
- HEPA filtration
- Fixed room-air recirculation systems
- UVGI
- Portable room-air cleaners

### How many AII rooms are in the health-care setting?

<table>
<thead>
<tr>
<th>Room Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 300</td>
</tr>
<tr>
<td>2. 301</td>
</tr>
<tr>
<td>3. 302</td>
</tr>
<tr>
<td>4. 303</td>
</tr>
<tr>
<td>5. 400</td>
</tr>
<tr>
<td>6. 402</td>
</tr>
<tr>
<td>7. 404</td>
</tr>
<tr>
<td>8. 500</td>
</tr>
<tr>
<td>9. 502</td>
</tr>
<tr>
<td>10. 504</td>
</tr>
<tr>
<td>11. GI 3</td>
</tr>
<tr>
<td>12. ICU 1</td>
</tr>
<tr>
<td>13. ICU 6</td>
</tr>
<tr>
<td>14. Bronc</td>
</tr>
<tr>
<td>15. ED Rm 17</td>
</tr>
<tr>
<td>16. ED Rm 18</td>
</tr>
</tbody>
</table>

What ventilation methods are used for AII rooms? (Check all that apply)

**Primary (general ventilation):**
- Single-pass heating, ventilating, and air conditioning (HVAC)
- Recirculating HVAC systems

**Secondary (methods to increase equivalent ACH):**
- Fixed room recirculating units
- UVGI

Does your health-care setting employ, have access to, or collaborate with an environmental engineer (e.g., professional engineer) or other professional with appropriate expertise (e.g., certified industrial hygienist) for consultation on design specifications, installation, maintenance, and evaluation of environmental controls? **Yes**

Are environmental controls regularly checked and maintained with results recorded in maintenance logs? **Yes**

Are AII rooms checked daily for negative pressure when in use? **Yes**

Is the directional airflow in AII rooms checked daily when in use with smoke tubes or visual checks? **Yes**

Are these results readily available? **Yes**

What procedures are in place if the AII room pressure is not negative? Patient is transferred

Do AII rooms meet the recommended pressure differential of 0.01-inch water column negative to surrounding structures? **Yes**
8. **Respiratory-Protection Program**

<table>
<thead>
<tr>
<th>Does your health-care setting have a written respiratory-protection program?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which HCWs are included in the respiratory protection program? (Check all that apply)</td>
<td>✓ Physicians</td>
</tr>
<tr>
<td>✓ Mid-level practitioners (NPs and PAs)</td>
<td>✓ Nurses</td>
</tr>
<tr>
<td>✓ Administrators</td>
<td>✓ Laboratory personnel</td>
</tr>
<tr>
<td>Contract staff</td>
<td>Construction or renovation staff</td>
</tr>
<tr>
<td>✓ Service personnel</td>
<td>Janitorial staff</td>
</tr>
<tr>
<td>✓ Maintenance or engineering staff</td>
<td>Transportation staff</td>
</tr>
<tr>
<td>✓ Dietary staff</td>
<td>Respiratory Therapist</td>
</tr>
</tbody>
</table>

Are respirators used in this setting for HCWs working with TB patients? If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients).

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Model</th>
<th>Specific application</th>
</tr>
</thead>
<tbody>
<tr>
<td>3M corporation</td>
<td>N-95 #1860 &amp; 1860S</td>
<td>Routine Contact with Infectious TB patients</td>
</tr>
</tbody>
</table>

Is annual respiratory-protection training for HCWs performed by a person with advanced training in respiratory protection? Yes

Does your health-care setting provide initial fit testing for HCWs? If yes, when is it conducted? __On hire by employee health__ Yes

Does your health-care setting provide periodic fit testing for HCWs? If yes, when and how frequently is it conducted? Yearly Yes

What method of fit testing is used? Describe. **Hood/Taste 1.** Fit check: Saccharin or Bitrex fit check. Individual is asked to do normal, deep breathing; bend over; side to side and up/down head movements. |

Is qualitative fit testing used? Yes

Is quantitative fit testing used? (Available) No

9. **Reassessment of TB risk**

<table>
<thead>
<tr>
<th>How frequently is the TB risk assessment conducted or updated in the health-care setting?</th>
<th>Yearly</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was the last TB risk assessment conducted?</td>
<td>04/2018</td>
</tr>
</tbody>
</table>

What problems were identified during the previous TB risk assessment?

1) There are some employees who refuse to shave facial hair. Facial hair prevents an adequate seal with the N-95 respirator.

What actions were taken to address the problems identified during the previous TB risk assessment?

1) Male employees who cannot be fit tested with the N95 mask by Employee Health due to facial hair are non-compliant with OSHA requirements for respiratory personal protection as an N95 mask is required to enter airborne precaution room. Nor are they compliant with the EoC Respiratory Protection and PPE policies. Managers are notified and so is the Safety Officer. Alternate patient assignments are necessary. Employees are told they can go to HR and request an ADA accommodation which can only be granted for documented religious and medical reasons. If granted, the alternate assignments are permanent as long as the employees are in the current position. If the ADA accommodation is not granted and the employee refuses to remove his beard for personal reasons only, then the employee cannot be adequately fit tested with the N95 mask and meet the job position requirements that requires the PPE consistent with airborne precautions. The employee is terminated for noncompliance.
2) Work with Value Analysis to maintain alternate vendor options for adequate supply of N95 masks.

<table>
<thead>
<tr>
<th>Did the risk classification need to be revised as a result of the last TB risk assessment?</th>
<th>Yes, due to the decreased number of confirmed TB cases we became a low risk facility.</th>
</tr>
</thead>
</table>

Recommendations:
1. Continue annual PPD testing and/or symptom screening and x-ray review of all employees and volunteers.
2. Continue to closely monitor all patients admitted for suspected/known TB for appropriate isolation practices.
3. Continue referring new employees for latent TB infection evaluation as indicated.

* If the population served by the health-care facility is not representative of the community in which the facility is located, an alternate comparison population might be appropriate.
† Test conversion rate is calculated by dividing the number of conversions among HCWs by the number of HCWs who were tested and had prior negative results during a certain period (see Supplement, Surveillance and Detection of M. tuberculosis infections in Health-Care Settings).
EVALUATION OF THE SURVEILLANCE, PREVENTION AND CONTROL OF INFECTION PROGRAM PLAN CALENDAR YEAR 2018

This Program Evaluation is based in part on outcomes achieved during calendar year 2018 (1/2018 to 12/2018). Outcomes are identified through review of performance measurement data, information resulting from our committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Broward Health Medical Center and in collaboration with other Broward Health facilities.

The Infection Control Program is an organization wide program that provides for surveillance, prevention and control of infections in patients, employees, students, LIP’s, physicians and all visitors to the organization. The Plan addresses epidemiologically important issues of infections among patients, employees and non-employees and exposure to communicable disease, device related infections, surgical site infections, and healthcare associated infections in special care units, epidemiologically important and antibiotic resistant organisms, maternal and neonatal infections, and reporting of communicable disease to the public health authorities. The Plan addresses all aspects of Infection Control activities and education. This Plan is appropriate for the size and complexity of the medical center and includes assessment and prioritization of infection risks, recommendation for the implementation of strategies to reduce or eliminate the prioritized risks and is reviewed on a continuing basis.

Scope of Program

The BHMC provides tertiary care for all age groups and includes The Salah Foundation Children’s Hospital, Lillian Wells Women’s Center, the Medical Center, outpatient services and select office practices. Services are provided across the continuum of care and include inpatient, outpatient, ambulatory, and rehabilitation.

Patient populations served include: medical –surgical specialties and subspecialties including but not limited to: trauma, medical-surgical, intensive care, maternal child care, cancer and blood dyscrasias, cardiac and interventional services, orthopedics, neurology, transplant services, renal, pulmonary, diagnostics, endoscopy, international patients and rehabilitation.

Targets

The following top organizational risk priority targets identified from the CY2018 Broward Health Medical Center Infection Control Risk Assessment, 2018 Annual Plan and 2018 PMR data analysis (targets adopted from administration goal to reduce yearly harm by 10%, Value Based Purchasing performance achievement threshold, CDC, NHSN data, HIIN recommendations and historical trends) were:

<table>
<thead>
<tr>
<th>1. Overall reduction of hospital acquired infections. Provide a program for surveillance and reporting of a device related infection to include central line associated blood stream infection (CLABSI), catheter associated urinary tract infection (CAUTI), and ventilator associated events (VAE). Minimize the risk of healthcare acquired infections associated with invasive devices.</th>
<th>2018 BHMC target</th>
<th>2018 Final</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI Central Line Infections Central Line Days X 1000 = Rate per 1000 Central Line Days SIR = observed/predicted</td>
<td>0.61</td>
<td>1.14↑</td>
<td>1.02</td>
</tr>
<tr>
<td></td>
<td>0.784</td>
<td>0.818↑</td>
<td>0.784 threshold↑</td>
</tr>
</tbody>
</table>

261
**Analysis**

- Infections are identified from prospective surveillance by the Epidemiology.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
- Monthly reports are submitted to BHMC Infection Prevention and Control Committee, Medical Care Evaluation Committee and Patient Safety Key Group.
- Priority is given to device related infections based on risk assessment and analysis of collected data which is evaluated on an ongoing basis to provide immediate intervention when indicated to reduce or prevent infection.
- Rates increased and decreased depending on the unit.
- Communicated with nurse managers and administration during weekly management huddle on lessons learned to prevent infection.
- Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.
- No new units added for public reporting.

**Effectiveness**

**CLABSI**
- CLABSI rates increased overall in 2018 compared to 2017. CVICU, 4Atrium, 6ST, PHO decreased their CLABSI while Peds, 6NT, 5Atrium, 5NT, 4NT, RCU, TICU, CCU all increased their CLABSI in 2018.
- CY 2018 SIR above VBP threshold.
- There was a 19.2% decrease in central line days from 2017 to 2018.
- Compliance with evidence based best practices as well as continuing improvement solutions to reduce CLABSI such as daily assessment of a central line included line necessity, discontinuation or an alternative to the central line, improved awareness and communication (patient hand-off), Epidemiology Medical Director follow up with physicians regarding line necessity, appropriate central line dressing kits were made available in all nursing care areas, curos caps on all central lines, daily chlorhexidine bath for patients with CVC lines was implemented facility wide, “WHAT and WHY” communications were created for nursing staff, Epidemiology and nurse management daily rounding included ongoing interventions; line necessity, education and line dressing surveillance.
- Met as a multidisciplinary group for any event identified to determine any opportunities for improvement.
- Communicated with nurse managers and administration during weekly management huddle on lessons learned to prevent CLABSI.
- Strive for “zero”
- Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.

**CAUTI**
- CAUTI rates increased overall in 2018 compared to 2017. AICU, CCU, 4NT, 6NT all increased their CAUTI in 2018. CVICU, TICU, RCU, 4AT, 5ST, 5NT, PICU all increased their CAUTI.
- CY 2018 SIR were above VBP threshold.
- There was a 21% decrease in foley days from 2017 to 2018.
- Compliance with evidence based best practices as well as continuing improvement solutions to reduce CAUTI such as: facility wide nurse driven Urinary Catheter Removal Protocol using HOUDINI indications which included discontinuation and alternatives to the indwelling catheter, improved awareness and communication (patient hand-off), Epidemiology Medical Director follow up with physicians regarding indwelling catheter necessity, ICUs and SCUs increased Foley and peri care to every 4 hours using an antimicrobial solution, “WHAT and WHY” communications created for nursing staff, Epidemiology and nurse management daily rounding included ongoing interventions; Foley necessity, education and Foley care surveillance.
- Drill down on all CAUTI infections weekly with an opportunity to discuss lessons learned with management and administration.
- Epidemiology will continue to monitor trends associated with CAUTI, and communicate findings with appropriate stakeholders.
- Strive for “zero”

**VAE**
- There were 13 PVAP in 2018 that was followed by a mini-root cause analysis, meeting with stakeholders, and review of best practices with unit staff.
- Increase in VAC and IVAC in CY 2018 was identified involving change from retrospective to prospective
surveillance of ventilators.
- Prospective surveillance started on all ventilated patients in house is done on Mondays, Wednesdays, and Fridays so a change in oxygenation can be identified in real time.
- Analysis of the data reviewed at the Infection Prevention and Control Committee and subsequently by the Respiratory Coordinator and ad hoc meetings as necessary revealed a need to re-educate respiratory therapists regarding VAE criteria.
- Early recognition of VAEs prevents a decline in patient’s respiratory status by initiating additional modalities to improve the patient respiratory condition, i.e. increased inspiratory time on the ventilator, using the bed percussion to mobilize secretions, increased frequency with repositioning patient, and concentration on evidence based bundle to prevent pneumonia.
- The VAP bundle continues to be utilized.
- Epidemiology monitors for VAC, IVAC, and Possible Ventilator Pneumonia.
- Collaboration with respiratory therapy, the trauma service as well as Pulmonary and other appropriate stakeholders continues on an ongoing basis.
- All VAEs are collected and reported to NHSN.
- Collaboration with respiratory therapy, the trauma service as well as Pulmonary and other appropriate stakeholders continues on an ongoing basis.
- All VAEs are collected and reported to NHSN.

2. Surgical Site Infections (SSI) Carry out systemic program surveillance and reporting of all Class I and II surgical site infections.

<table>
<thead>
<tr>
<th>Surgical Site Infections/ Surgical Procedures Completed X 100 = SSI Rate</th>
<th>Targeted Class</th>
<th>CY 2018 Target</th>
<th>CY 2018 Rate</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I: (All)</td>
<td>0.52</td>
<td>0.53↑</td>
<td>0.48</td>
<td></td>
</tr>
<tr>
<td>Open Heart</td>
<td>1.04</td>
<td>0.55↓</td>
<td>0.49</td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td>1.18</td>
<td>0.93↓</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td>0.68</td>
<td>0.82↑</td>
<td>0.73</td>
<td></td>
</tr>
<tr>
<td>Pacemaker</td>
<td>0.23</td>
<td>0.57↑</td>
<td>0.51</td>
<td></td>
</tr>
<tr>
<td>C-Section (class II)</td>
<td>0.58</td>
<td>0.42↓</td>
<td>0.38</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy (A)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Colon</td>
<td>4.40</td>
<td>4.96↑</td>
<td>7.83</td>
<td></td>
</tr>
<tr>
<td>Spinal</td>
<td>0.4</td>
<td>0.45↑</td>
<td>0.26</td>
<td></td>
</tr>
<tr>
<td>Colon</td>
<td>0.781</td>
<td>2.056↑</td>
<td>0.781</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>0.722</td>
<td>0</td>
<td>0.722</td>
<td></td>
</tr>
</tbody>
</table>

Analysis

- Class I surgeries in 2018 were over target.
- Colon SIR was above VBp threshold.
- CABG SSI decreased 47% below target.
- Analysis of all SSI data reviewed at the Infection Prevention and Control Committee.
- Intense analysis of colon and hysterectomy infections with Action Plan that includes all SSI prevention.
- Drill down on all SSI infections with an opportunity to discuss lessons learned with management and administration.
- Re-education was provided to clinical staff regarding pre-op chlorhexidine bathing; the antibiotic, time given and re-dosing time are written on the individual OR rooms white board. Patient education “How to Prevent SSI” continues to be included in admission packet.
- C-section rates will be tracked for all classes.

Effectiveness

- New Performance Improvement team for 2018 to work on SSI Reduction.
- Gap analysis and action plan regarding strategies supported by evidence-based medicine to reduce SSI which includes: preoperative bathing with chlorhexidine, surgical site scrub with chlorhexidine, silver coated antimicrobial dressing (ACTICOAT), and weight based antibiotic dosing and appropriate antibiotic selection for patients susceptible or likely to have MRSA.
- Surveillance of evidence based best practices as well as the improvement solutions remain on-going to maintain a downward trend with reducing colon surgery infections as well as class I and II SSI.
- Drill down on all SSI infections weekly with an opportunity to discuss lessons learned with management and administration.
3. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs) and Clostridium difficile (CDIFF)

<table>
<thead>
<tr>
<th></th>
<th>2018 BHMC target</th>
<th>2018 Final</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRE</td>
<td># of patients with MDRO</td>
<td>0.02</td>
<td>0.04↑</td>
</tr>
<tr>
<td></td>
<td># of patient days x 1000 =</td>
<td>0.08</td>
<td>0.11↑</td>
</tr>
<tr>
<td>VRE</td>
<td># of patients with MDRO</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td># of patient days x 1000 =</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RAS</td>
<td>MDRO rate</td>
<td>0.24</td>
<td>0.09↓</td>
</tr>
<tr>
<td>ESBL K. Pneumo</td>
<td></td>
<td>0.24</td>
<td>0.19↓</td>
</tr>
<tr>
<td>ESBL E.coli</td>
<td></td>
<td>0.41</td>
<td>0.35↓</td>
</tr>
<tr>
<td>MRSA rate</td>
<td></td>
<td>3.94</td>
<td>2.81↓</td>
</tr>
<tr>
<td>CDIFF rate</td>
<td></td>
<td>0.815</td>
<td>1.143↑</td>
</tr>
</tbody>
</table>

**Analysis**
- 25% decrease in CDIFF overall from CY 2017 to CY 2018.
- There was a decrease in overall MRSA and a decrease in MRSA bacteremia but it is still above VBP achievement threshold.
- Early identification of patients colonized or infected with resistant organisms or other infectious organisms and immediate transmission based isolation of these patients reduced and prevented further transmission.
- Epidemiology performed daily surveillance of cultures from patients admitted with or developing infection.
- Individual patient positive MDRO results were entered into an ALERT data base system which is activated to display with subsequent patient visits. The ALERT screen enabled hospital staff to imitate transmission based precautions as indicated from the screen information.
- Epidemiology also monitored the daily ED visit log, admission log, disease alert log and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the Epidemiology nurse to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission based precautions.
- The Epidemiology department provided large amounts of information on transmission based precautions to all staff via unit based in-services.
- The CDC isolation precautions are uploaded to the general Broward Health intranet website as a resource for all staff to have access to.
- We continued to implement Transmissions-Based Precautions and Standard Precautions, Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical and nursing departments and Epidemiology.
- Continued active surveillance for CRE for international patients who were admitted to an international hospital for >48 hours.

**Effectiveness**
- Surveillance rounds and lab monitoring are mechanisms in which information is gathered. Individual clusters were and will continue be analyzed and interventions will be determined at that time.
- The Epidemiology team continuously strives to increase staff and physician education.
- Add Resistant Pseudomonas and Resistant Acinetobacter surveillance to 2018.
- Continued emphasis on hand hygiene and antimicrobial stewardship.
- The Epidemiology department provided large amounts of information on transmission based precautions to all staff via the Need 2 Know format as well as unit based in-services.
- The CDC isolation precautions are uploaded to the general BHMC website as a resource for all staff to have access to.
- Frequently used Transmission based precautions guide disseminated to all nursing and ancillary units.
- We continued to implement Transmissions-Based Precautions and Standard Precautions, Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical and nursing departments and Epidemiology.
- Hand hygiene program in place that measures observed compliance as opposed to self-reported.
- Appropriate testing guidelines for C-diff disseminated to all medical staff.
<table>
<thead>
<tr>
<th>4. Reduction of healthcare worker risk of infection secondary to injury and/or exposure.</th>
<th>2018 target</th>
<th>2018 Rate</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assure all Health Care Workers receive proper education on Disease modes of transmission Department of Clinical Education will have 100% compliance on all assigned modules relating to Infection Control.</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Analysis/Effectiveness**

- Health Stream was used to educate staff on disease transmission and prevention.
- Broward Health and BHMC orientations were targeted with a robust presentation on infection prevention.
- Unit level in-services continued to be presented.
- Need2know was another forum Infection Control utilized to disseminate information to all employees of BHMC.
- Participation in Skills fair: Information disseminated related to Hand Hygiene and C-diff.
- Unit level in-services continued to be presented; organization wide skills fair was completed; in-service coordination with Environmental Services, Transport, Nutrition and the Environment of Care team helped reach many healthcare workers.
- All hospital staff and LIPs are required to comply with mandatory in-service education about the prevention of health care associated infections, multi-drug resistant organisms, and prevention strategies, at hire and annually thereafter.
- All nursing staff is required to complete education about prevention of central line associated blood stream infections, catheter associated urinary tract infections, and ventilator associated pneumonia, surgical site infections, and transmission of multidrug-resistant organisms.
- Education is provided to all patients and families who are infected or colonized with a multidrug-resistant organism about health care associated infection prevention strategies.
- Educational materials are approved by the Infection Prevention and Control Committee, provided on the intranet or printed and used to educate staff, patients and families.

<table>
<thead>
<tr>
<th>5. Prevent unprotected exposure to pathogens (i.e. seasonal flu, pandemic flu, influx of infectious patients, active TB patients and patients with history of MDRO, unusual clusters of organisms or HAI). Monitor the inpatient and outpatient traffic for any potential cases of active TB or increase in influx of infectious patients.</th>
<th>2018 BHMC target</th>
<th>2018 Rate</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Influx Trends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influx of Infectious Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Analysis**

- There were five TB exposures, one meningitis exposure, and one mumps exposure for CY 2018. Each exposure was followed by Employee Health. There were no transmissions.
- No unusual clusters of organisms or HAI. If necessary, cohorting of patients and staff can be utilized to decrease spread of infection.
- The surveillance plan based on prioritized risk of transmission of diseases identified in our community and from the characteristics of the population served was developed and approved by the Infection Prevention and Control Committee.
- The surveillance plan is carried out by the Epidemiology nurses on an ongoing basis resulting in prevention of disease transmission to patients, hospital staff, LIPs, students, volunteers and visitors.
- Epidemiology identifies risks for acquisition and transmission of infectious agents on an ongoing basis (MDROs, C. difficile, TB, Influenza) and annual risk assessments.
- There is a high incidence of TB in Broward County which requires constant surveillance to identify suspect cases. This is included in the risk analysis of reported data as high risk and requires close monitoring to prevent transmission.
- There are also a large number of indigent patients admitted from the community with other types of communicable conditions including head and body lice and scabies. These patients are monitored closely for appropriate transmission based precautions and treatment to prevent transmission.

**Performance:**
• BHMC will also to continue to obtain chest x-rays on all admitted patients except those who are pregnant or psychiatric patients who have had a chest x-ray within the last month.
• BHMC will continue to actively track and trend the traffic of patients for any increase influx of patients and/or need to implement the Pandemic Plan.
• Epidemiology nurses performed daily ongoing surveillance through the monitoring of admissions logs, Emergency Dept. logs, admit alert reports, microbiology candidate reports and walking rounds helped identify influx of infectious patients. We met the goal of identifying trends and clusters.
• The ESSENCE reporting system that identifies syndromic trends through the ER was used to coordinate surveillance with the Broward County Department of Health.
• A database for TB reporting to the Health Dept. was utilized to maintain a record of communication.
• Laboratory screening for Inpatient Rehab Unit: Urine cultures were done upon admission for external patient admissions.
• Early identification of patients colonized or infected with resistant organisms, TB, influenza or other infectious organisms and immediate transmission based isolation of these patients reduced and prevented further transmission.
• Individual patient positive MDRO results were entered into an ALERT data base system which is activated to display with subsequent patient visits. The ALERT screen enabled hospital staff to imitate transmission based precautions as indicated from the screen information. The Epidemiology nurses also monitored the daily ED visit log, admission log, disease alert log and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the Epidemiology nurse to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission based precautions.

**Effectiveness**

- All blood and body fluid exposures documented in CY 2018 were followed up by Employee Health and resulted in zero transmissions.
- No TB conversions from exposures.

### 6. Improve Hand Hygiene Performance

<table>
<thead>
<tr>
<th></th>
<th>2017 Rate</th>
<th>2018 Rate</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Hygiene (Observed)</td>
<td>74%</td>
<td>87%↑</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Analysis/Effectiveness**

- Robust hand hygiene program with HIIN SOAP UP campaign.
- Screen savers and marketing posters for hand hygiene.
- Program utilized voluntary “ninjas” from a variety of departments.
- Standardized training utilizing TJC education on observing compliance provided to ninjas
- Epidemiology conducted observations while rounding on units.
- Teachable moments used to encourage hand hygiene if non-compliance was observed.
- Hand Hygiene was further promoted through unit and departmental in-services.
- Graphical and tracking reports were shared with inpatient unit managers and directors monthly.
- Hand care program with hospital approved lotion available at each unit.
- Respiratory etiquette stands with hand hygiene, cover your cough education, and masks placed at entrances.

### 7. Promote and Improve Seasonal Flu immunization organization wide

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HCW Influenza immunization rate</td>
<td>44.8%, below target</td>
<td>In progress with 85% goal</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Analysis**

- There were 2,649 vaccinated at BHMC in 2018. This is an increase from 2,016 in 2017 which is a 31.4% increase.
- CY 2019 data will include a robust increase in physician numbers due to sharing of information at each Broward Health hospital.
- CY 2018 data will include a corporate initiative that started mandatory masking as well as an incentive to receive influenza vaccination through decreased health insurance payment.
- Influenza vaccine program is initiated in September and continues through March for all staff, volunteers, medical staff, and LIPs. Nursing offers vaccination to inpatient patients meeting recommended guidelines during influenza vaccine season.
- Vaccination is administered in Employee Health during the entire flu season as well as times when mobile vaccination
carts attend units and meetings.

- Mandatory influenza education is provided to all hospital staff via Health Stream, newsletters, and educational brochures are used to educate staff, physicians, and LIPs about the importance of influenza immunization.
- Individual counseling and encouragement for participation includes a video to watch for employees who decline vaccination.
- Declination forms are used to monitor the reasons given for declining the vaccine as well as the effect of educational interventions.

**Effectiveness**

- Flu vaccination information is available on health stream and is mandatory to complete for all Broward Health employees.
- Administration participated in providing the flu vaccine.
- Employees who decline the flu vaccine must wear a mask during flu season.
- Employees who decline the flu vaccine are not incentivized with health insurance premiums.
- Corporate human resources and employee health will continue to explore methods to increase the rate of flu vaccination among health care workers. Our goal is to obtain 90% vaccination rate compliance of employees by 2020 by improving vaccination rates by 10% annually.

<table>
<thead>
<tr>
<th>8. PMR</th>
<th>2017 Rate</th>
<th>2018 Rate</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis Water/Dialysate Cultures/Endotoxins</td>
<td>99%</td>
<td>100%↑</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>98%</td>
<td>100%↑</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Analysis/Effectiveness**

- No fall outs in 2018.
- Tracking of cultures for water, dialysate and endotoxin continues. Cultures collected monthly.
- Results communicated to Epidemiology, DaVita (company contracted to provide dialysis services) as well as to the dialysis manager.

**Reporting Communicable Diseases**

- Epidemiology continues to monitor surveillance and communicate mandatory reportable based off of Florida State Health Department list of reportable diseases.

<table>
<thead>
<tr>
<th>Sterilizer/Steris Monitoring</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Use Steam Sterilization Monitoring</td>
<td>3%</td>
<td>2.08%↓</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Sterile Processing Department continuously strives for zero “flash” and reports at Infection Prevention and Control Committee monthly.

**Analysis**

- Epidemiology has one-on-one discussion with nurse to remind them about the importance of placing transmission based precautions order in EMR to facilitate communication between departments.
- Tracking of cultures for water, dialysate and endotoxin continues. Cultures collected monthly. Results communicated to Epidemiology, DaVita (company contracted to provide dialysis services) as well as to the dialysis manager.
- There were no adverse outcomes to patients regarding sterilizers. There were no biological recalls.
- Epidemiology monitors endotoxin and water cultures for the reverse osmosis water system cultures and dialysis machines cultures monthly.
- Epidemiology evaluates cleaning procedures and solutions used by Environmental Services.
- EOC/Infection Prevention rounding team observed for EOC compliance throughout the hospital and forwarded non-compliance issues requiring corrective actions to the responsible area when indicated.
- All disinfectants are approved by the Infection Prevention and Control Committee. Education regarding the product use is provided to the EVS staff by the EVS management team as well as the product vendors.
- The ICRA (Infection Control Risk Assessment) for all construction and renovation projects is carried out on a continuing basis with numerous projects reported throughout the year through the Infection Prevention and Control Committee. The Epidemiology nurse rounds in the construction areas to ensure appropriate ICRA measures are maintained during the construction period to reduce infection transmission.
- Educational brochures, posters and information sheets are used to educate patients, visitors, families and licensed independent practitioners regarding responsibilities for preventing infections and infection transmission within the hospital.
- Infections identified after patient discharge or transfer is reported to the receiving organization immediately following review of the data per Infection Control Policy. Patients received from another organization with an infection requiring action are also reported to the transferring organization.
- The hospital has a system for reporting infection surveillance, prevention and control information to appropriate staff within the hospital, federal, state, and local public health authorities, accrediting bodies and referring or receiving organizations when a patient was transferred or referred and the presence of an infection was not known at the time of
Effectiveness

- In addition to the routine immediate fax reporting of reportable infections to the Health Department there were several telephone reports and faxing to other facilities required during CY 2018.
- Microbiology telephone notification for specific pathogens has been effective in early intervention by Epidemiology with appropriate transmission based precautions and notification to the inpatient care area as well as Broward County Health Department when indicated.
- The Epidemiology nurse rounded daily, utilizing the isolation log to monitor transmission based precautions compliance. Appropriate use of PPE, hand hygiene and Environment of Care (EOC) compliance are monitored during these rounds as well, with reports submitted to appropriate managers for review and corrective action when indicated.

Surveillance data is reported monthly to the Infection Control Committee.


<table>
<thead>
<tr>
<th>Program policies and procedures completed</th>
<th>2018 Target</th>
<th>2018 Final</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiologist Clinical Nurse Specialist, Certification in Infection Control</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Epidemiologists, APIC trained</td>
<td>100%</td>
<td>66.6%</td>
<td>100%</td>
</tr>
<tr>
<td>Medical Director, Board Certified Infectious Disease Physician</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Analysis

- The Comprehensive Infection Control Risk Assessment for CY2018 was presented to the Infection Prevention and Control Committee for review, recommendations and approval.
- The effectiveness of the Infection Control Plan as outlined in the Annual Evaluation of the Program was presented for approval to the Infection Prevention and Control Committee and Medical Council. The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified. The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- The Infection Prevention and Control Committee meets monthly. The Committee structure includes the Committee chair (Infectious Disease physician), staff physicians, administration, nursing, pharmacy, lab, nutritional services, environmental services, surgery, safety, facilities and other departments as needed. Indicator compliance and action plans are forwarded monthly to Patient Safety Key Group and Medical Care Evaluation.
- Computer technology is utilized for analysis, trending and tracking of infection surveillance data.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.
- All areas surveyed for construction were found to be fully ICRA compliant during CY 2018

Effectiveness

- All of the prioritized risks were reviewed and evaluated. Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- Epidemiology monitored sterilization and high level disinfection processes within the medical center. Ongoing review of the monitoring reports submitted by all departments utilizing a sterilization/high level disinfection process is effective in identifying deficiencies or problems immediately and initiation of recall procedures when necessary. Data are reported to the Infection Prevention and Control Committee on the monthly PMR.
- Epidemiology and Surgical Services Departments remained vigilant and compliant with FDA Safety Communications and Heater Cooler manufacturer cleaning and processing updates. Compliance with updates regarding the Heater Cooler disinfection is ongoing.
- The Epidemiologists are members of the national and local chapter of their professional organization and receive education related to Epidemiology/Infection Prevention and Control on an ongoing basis.
- Significant improvement in analysis of surveillance data has been accomplished with increased utilization of Excel spreadsheets and MedMined surveillance over the calendar year. This has provided more accurate analysis to better prioritize our risks and set new goals for the coming calendar year.
<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>ELEMENTS OF PERFORMANCE</th>
<th>EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IC.01.01.01</strong>&lt;br&gt;Does the organization identify the individual(s) responsible for the infection prevention and control program?</td>
<td>1. Does the organization identify an individual(s) with clinical authority over the infection prevention and control program?</td>
<td>1. Authority statement in the IC Annual Plan.</td>
</tr>
<tr>
<td></td>
<td>2. When the individual(s) with clinical authority over the infection prevention and control program does not have expertise in infection prevention and control, he or she consults with someone who has such expertise in order to make knowledgeable decisions.</td>
<td>2. Medical Director of Epidemiology, Infectious Disease physician</td>
</tr>
<tr>
<td></td>
<td>3. The organization assigns responsibility for the daily management of infection prevention and control activities (see also HR .01.02.01, EP 1, LD .02.01.01, EP 3) Note: Number and skill mix of the individual(s) assigned should be determined by the goals and objectives of the infection prevention and control program.</td>
<td>3. Staff position descriptions, experience, licenses and certifications</td>
</tr>
<tr>
<td></td>
<td>4. &quot;For hospitals that use Joint Commission accreditation for deemed status purposes: Is the individual with clinical authority over the infection prevention and control program responsible for the following:</td>
<td>1. Comprehensive surveillance and analysis of epidemiological data is completed by 2 full time epidemiologists on a daily basis.</td>
</tr>
<tr>
<td></td>
<td>- Developing policies governing control of infections and communicable diseases?</td>
<td>2. Epidemiologists identify and intervene to assist the facility and its various departments in preventing transmission of infection.</td>
</tr>
<tr>
<td></td>
<td>- Implementing policies governing control of infections and communicable diseases?</td>
<td>3. The annual risk assessment and evaluation help to create the annual plan for the Epidemiology Dept. The plan may change to meet unforeseen priorities.</td>
</tr>
<tr>
<td></td>
<td>- Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases?”</td>
<td>4. The Medical Director of Infectious Diseases, Epidemiology department Director, Clinical Nurse Specialist and Epidemiologists work together to develop and implement policies that prevent the spread of infection. The team investigates, responds and intervenes to prevent and contain communicable diseases. These events are reported to the Infection Prevention and Control Committee and the Quality Council as well as other unit based committees. Communicable diseases are reported to the Broward County Department of Health.</td>
</tr>
<tr>
<td><strong>IC.01.02.01</strong>&lt;br&gt;Do the organization leaders allocate needed resources for the infection prevention and control program.</td>
<td>1. Does the organization provide access to information needed to support the infection prevention and control program? (See IC.01.01.01, EP 2; IC.01.03.01, EP 3; IC.01.05.01, EPs 1 and 2; IC.01.06.01, EP 2; IC.02.01.01, EP 8; IC.03.01.01, EP 1; IM.02.02.03, EP 2)</td>
<td>1. The Epidemiology Department uses technology for data gathering, analysis, trending and tracking of infection surveillance data.</td>
</tr>
<tr>
<td></td>
<td>1. The Epidemiology Department uses technology for data gathering, analysis, trending and tracking of infection surveillance data. Medmined Cerner Powerchart Cerner Surginet Cerner Reports/Alerts Microsoft Office Discern Analytics</td>
<td></td>
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</tbody>
</table>
2. Does the organization provide laboratory resources when needed to support the infection control program? (See IC.01.05.01, EP 2)

3. Does the organization provide equipment and supplies to support the infection control program. (See IC.01.05.01, EP 2 and LD.03.03.01, EP 4)

1. The organization identifies risks for acquiring and transmitting infection based on the following:
   - Its geographic location, community and population served (see also NPSG.07.03.01, EP 1)
   - The care, treatment and services it provides. (see also NPSG.07.03.01, EP 1)
   - The analysis of surveillance activities and other infection control data. (see also NPSG0.07.03.01, EP 1; TS.03.03.01, EP2)
   - Does the organization reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing and leadership. (see also NPSG.07.03.01, EP 1)
   - Does the organization prioritize the identified risks for acquiring and transmitting infections? These prioritized risks are documented. (see also, NPSG.07.03.01, EP 1)

2. The Epidemiology team receives daily Candidate reports from the Laboratory and Microbiology for surveillance and analysis.
   - Surveillace Report
   - Quest Diagnostic reporting
   - Phone alerts

3. Lab serves as a resource when microbiological information is necessary (outbreak investigation, NHSN LabID event information).

4. Computers, offices with equipment, phones, faxes, printers, copier and supplies.

1& 2. The Infection Control Plan is based upon the population it serves and location. A description of the population can be found in the BHMC specific Infection Control Plan. Surveillance data, communicable disease data as well as the Risk Assessment drive the plan.

3&4. An infection control risk assessment is conducted annually and as needed (Cluster/outbreak) and presented to the Infection Prevention and Control Committee for approval.

5. Risks are prioritized according to probability and impact utilizing a Pareto Diagram and incorporated into the annual plan.

The Infection Control Plan and Risk Assessment guide the Epidemiology department.

1. Risks are prioritized by the Risk Assessment.
2. Standard/Transmission based precautions are followed. An electronic alert system identifies patients previously admitted with select MDROs.
3. Routine surveillance of surgical and other procedures is conducted through Microbiology lab results, reports and by assisting in multi-disciplinary rounds and committees. The PMR tracks surgical procedures and the infection rates associated with them.
4. Infections associated with medical devices are prevented by the maintenance of hand sanitizers, PPE and hospital improved disinfection wipes throughout clinical areas.
5. Hand Hygiene is encouraged and promoted by maintaining hand sanitizer products in clinical areas, hand hygiene observation tracking, orientation education and in-services and fairs.
<table>
<thead>
<tr>
<th><strong>IC.01.05.01</strong></th>
<th>Does the organization have an infection prevention and control plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When developing infection prevention and control activities, the organization uses evidence based, national guidelines or, in the absence of such guidelines, expert consensus.</td>
<td></td>
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<tr>
<td>2. The organization’s infection prevention and control plan includes a written description of the activities, including surveillance, to minimize reduce or eliminate the risk of infection.</td>
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<tr>
<td>3. The organization describes, in writing, the process for investigating outbreaks of infectious diseases. (see also IC.02.01.01, EP 5)</td>
<td></td>
</tr>
<tr>
<td>4. Are all organization components and functions integrated into infection prevention and control activities? (see HR.01.04.01, EPS 2 and 4)</td>
<td></td>
</tr>
<tr>
<td>5. The organization identifies methods for reporting infection surveillance and control information to external organizations. (see also IC.02.01.01, EP 9)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>IC.01.06.01</strong></th>
<th>The organization prepares to respond to an influx of potentially infectious patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the organization obtain current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients?</td>
<td></td>
</tr>
<tr>
<td>2. Does the organization have a method for communicating critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients?</td>
<td></td>
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<tr>
<td>3. The organization describes, in writing, how it will respond to an influx of potentially infectious patients. (See also EM.01.01.01. EP 2). Note: One acceptable response is to decide not to accept patients.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>IC.01.06.01 cont’d</strong></th>
<th>The organization prepares to respond to an influx of potentially infectious patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The organization follows CDC hand hygiene guidelines and CDC/NHSN definitions of organization acquired infections and</td>
<td></td>
</tr>
<tr>
<td>2. The Infection Control Plan includes a written description of the activities, including surveillance, to minimize reduce or eliminate the risk of infection.</td>
<td></td>
</tr>
<tr>
<td>3. The Infection Control Plan is updated annually and reviewed and approved by the Infection Control Committee.</td>
<td></td>
</tr>
<tr>
<td>4. The Organization has a policy for investigating outbreaks. (Outbreak Management Plan).</td>
<td></td>
</tr>
<tr>
<td>5. The Epidemiology team participates in Nursing Orientation for all Broward Health facilities level and presents Infection Prevention module to all BHMC new hires. It also conducts annual updates and participates in various competency projects.</td>
<td></td>
</tr>
</tbody>
</table>

The organization reports communicable diseases to the local, state and federal Departments of Health and to other organizations when necessary. Faxed copies are stored and a daily log of number of cases is reported out to on the Performance Measure Review (PMR).

<table>
<thead>
<tr>
<th><strong>IC.02.01.01</strong></th>
<th>Does the organization implements its infection and control plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.</td>
<td></td>
</tr>
<tr>
<td>2. Does the organization use standard precautions, including the use of personal protective equipment, to reduce the risk of infection? (See also EC.02.02.01, EP 4)</td>
<td></td>
</tr>
<tr>
<td>Note 1: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>IC.02.01.01</strong></th>
<th>Does the organization implements its infection and control plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Infection Control Program is directed by a full time Infectious Disease physician and managed by a Director of Epidemiology, Safety &amp; Quality, 3 Staff Epidemiologists, and a Clinical Nurse Specialist in Epidemiology. The Infection Control Committee has been given the authority for the Program and includes community and staff physicians, administration, pharmacy, dialysis, critical care adult and pediatric nursing, microbiology, environmental services, surgery, education, quality, safety, facilities and other departments as needed.</td>
<td></td>
</tr>
<tr>
<td>1. Computer technology will be utilized for analysis, trending and tracking of infection surveillance data (MEDMINED).</td>
<td></td>
</tr>
<tr>
<td><strong>IC.02.01.01 cont’d</strong></td>
<td><strong>IC.02.02.01</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Does the organization implements its infection and control plan?</td>
<td>Does the organization reduce the risk of infections associated with medical equipment, devices and supplies?</td>
</tr>
<tr>
<td>3. Does the organization implements transmission-based precautions in response to the pathogens that are suspected or identified within the organization’s service setting and community.</td>
<td>1. The organization implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment devices, and supplies. Note: low level disinfection is used for items such as stethoscopes, and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission based precautions.</td>
</tr>
<tr>
<td>5. Does the organization investigate outbreaks of infectious disease? (See IC.01.05.01, EP 5)</td>
<td>1. A policy for disinfection of high touch surfaces has been implemented. This policy is “Cleaning Protocol for Touch Surfaces in the Nursing Station/Clinical Areas and Frequently Used Non-Critical Medical Equipment”.</td>
</tr>
<tr>
<td>6. The organization minimizes the risk of infection when storing and disposing of infectious waste. (See also EC.02.02.01, EP 1&amp;12)</td>
<td>2. The Epidemiology Department tracks biological monitoring, treatment, and/or isolation. A log is maintained.</td>
</tr>
<tr>
<td>7. Does the hospital implement its methods to communicate responsibilities for preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families? Information for visitors, patients, and families includes hand and respiratory hygiene practices? (See also HR.01.04.01, EP 4)</td>
<td>3. Transmissions based precautions according to CDC guidelines is implemented across the facility. An electronic alert system and electronic medical records assist in identifying patients with MDRO’s</td>
</tr>
<tr>
<td>8. Does the organization reports infection surveillance, prevention and control information to the appropriate staff within the organization?</td>
<td>5. The organization investigates outbreaks whenever suspect clusters or reports are obtained through surveillance activities.</td>
</tr>
<tr>
<td>9. Does the organization report infection surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with law and regulation? (See also IC.03.01.01, EP 6)</td>
<td>6. The organization maintains a current list of inventory of hazardous materials and waste, sharps containers, red bags and other protective products are used to guard infectious waste.</td>
</tr>
<tr>
<td>10. When the organization becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or isolation, does it inform the receiving organization?</td>
<td>7. The Epidemiology team and EOC team educate the staff through Health stream, in-services and orientation on hand hygiene. PPE and blood and body fluids exposures. The public is educated through brochures and handouts on the importance of infection prevention and hand hygiene.</td>
</tr>
<tr>
<td>11. When the organization becomes aware that it received a patient from another organization who has an infection requiring action, and the infection was not communicated by the referring organization, does it inform the referring organization?</td>
<td>8. The Infection Control Committee, Patient Safety Care Key Group, EoC Committee and various Medical/Quality committees are informed</td>
</tr>
<tr>
<td>1. Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.</td>
<td>9. The organization reports infection surveillance, prevention and control information to local, state and federal public health authorities in accordance with law and regulation. ESSENCE and HIV directly and others via phone, HL7 and fax.</td>
</tr>
<tr>
<td>1. The Epidemiologists are on call and available on a 24/7 basis. The Director or designees are members of or attend all major organization committees.</td>
<td>10. The organization informs receiving organizations when we become aware that we transferred a patient who has an infection requiring monitoring, treatment, and/or isolation, or if we receive such a patient. A log is maintained.</td>
</tr>
<tr>
<td>2. The organization educates and uses standard precautions and personal protective equipment for employees.</td>
<td>11. The organization, if not communicated prior to transfer, informs the facility the patient was sent from of any infection identified on admission requiring monitoring, treatment and/or isolation. A communication log is maintained.</td>
</tr>
<tr>
<td>3. Transmissions based precautions according to CDC guidelines is implemented across the facility. An electronic alert system and electronic medical records assist in identifying patients with MDRO’s</td>
<td></td>
</tr>
<tr>
<td>IC.02.03.01</td>
<td>Does the organization work to prevent the transmission of infectious diseases among patients, licensed independent practitioners and staff?</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1.</td>
<td>Does the organization make screening for exposure and/or immunity to infectious disease available to licensed independent practitioners and staff who may come in contact with infections at the workplace?</td>
</tr>
<tr>
<td>2.</td>
<td>When licensed independent practitioners or staff have, or are suspected of having, and infectious disease that puts others at risk, the organization provides them with or refers them for assessment and potential testing, prophylaxis/ treatment or counseling?</td>
</tr>
<tr>
<td>3.</td>
<td>When licensed independent practitioners or staff have, have been occupationally exposed to, and infectious disease, the organization provides them with or refers them for assessment and potential testing, prophylaxis/ treatment or counseling?</td>
</tr>
<tr>
<td>4.</td>
<td>When patients have been exposed to an infectious disease, the organization provides them with or refers them for assessment and</td>
</tr>
<tr>
<td>5.</td>
<td>When reprocessing single-use devices, the organization implements infection prevention and control activities that are consistent with regulatory and professional standards.</td>
</tr>
</tbody>
</table>

**Note:** Surveillance may be targeted rather than hospital wide.

| 1.2 and 3. | Several polices outline the protocols that address screening for infectious diseases for LIP, staff and others; it also addresses responses to exposures. The policies are Broward Health Tuberculosis Infection Control Plan, Chicken Pox Exposure, and Blood borne Pathogen Plan. |

| 3 & 4. | Surveillance rounds conducted by Epidemiology and EoC that routinely monitor the disposal and storing of medical equipment. |

| 5. | FDA third party processor used to reprocess approved single use devices. |

<p>| 4. | The Outbreak management plan, as well as the Blood borne pathogen plan, outlines the organization’s response to patient exposures and potential follow-up. |</p>
<table>
<thead>
<tr>
<th>IC.02.04.01</th>
<th>Does the organization offer vaccination against influenza to licensed independent practitioners and staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Does the organization establish an annual influenza vaccination program that is offered to licensed independent practitioners and staff?</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Does the organization educate licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza. (See also HR.01.04.01, EP 4)</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>The organization provides influenza vaccination at sites accessible to licensed independent practitioners and staff.</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Does the organization include in its infection control plan the goal of improving influenza vaccination rates? (For more information, refer to Standard IC.01.04.01)</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Does the organization set incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020?</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>IC.02.04.01cont’d</th>
<th>Does the organization offer vaccination against influenza to licensed independent practitioners and staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6.</strong></td>
<td>Does the organization have a written description of the methodology used to determine influenza vaccination rates? (See IC.02.04.01, EP 1)</td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td>Does the organization provide influenza vaccination rate data to key stakeholders who may include leaders, licensed independent practitioners, nursing staff, and other staff at least annually?</td>
</tr>
<tr>
<td><strong>8.</strong></td>
<td>Does the organization improve its vaccination rates according to its established goals at least annually? (For more information, refer to Standards PI.02.01.01 and PI.03.01.01)</td>
</tr>
<tr>
<td><strong>9.</strong></td>
<td>Does the organization provide influenza vaccination rate data to key stakeholders who may include leaders, licensed independent practitioners, nursing staff, and other staff at least annually?</td>
</tr>
</tbody>
</table>

1. The Influenza Immunization Program is initiated October 1st and continues through March 31st for all staff, physicians, and LIPs as well as all patients meeting recommended guidelines.

2. LIPs and staff are educated via health stream annually. Employee Health advertises availability of vaccination in the Health Office covering all shifts and also provides a mobile vaccination program to all the nursing units and departments at various times during the season. Declination forms are used to monitor the effect of intervention.

3. Vaccination is offered on site, at an advertised schedule, and at other convenient times and locations.

4. & 5. The goal of increasing vaccination rates by year is located in the annual infection control plan.

5. The hospital uses Joint Commission recommendations to calculate influenza vaccination rates for LIP’s, staff and contracted staff.

6. Possible methods for increasing employee vaccination rates discussed at the Infection Control Committee. Employee Health compiles a list of reasons employees declined vaccine. This information is reported after the flu season has ended. Some methods discussed include mandatory vaccination or donning of mask during flu season if not vaccinated.

7. Yes. Annual rates have increased.

8. Yes. Rates are sent out weekly during flu season by Employee Health through administration.
<table>
<thead>
<tr>
<th>NATIONAL PATIENT SAFETY GOALS STANDARDS EVALUATION 2018</th>
</tr>
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<tbody>
<tr>
<td><strong>STANDARD</strong></td>
</tr>
<tr>
<td>NPSG.07.01.01</td>
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<td>NPSG.07.03.01</td>
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<td>NPSG.07.03.01 cont’d</td>
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<tr>
<td>4. Measure and monitor multi drug-resistant organism prevention processes and outcomes, including the following:</td>
</tr>
<tr>
<td>a. Multi drug-resistant organism infection rates using evidence-based metrics</td>
</tr>
<tr>
<td>b. Compliance with evidence-based guidelines or best practices</td>
</tr>
<tr>
<td>c. Evaluation of the education program provided to staff and licensed independent practitioners. Note: Surveillance may be targeted rather than organization-wide.</td>
</tr>
<tr>
<td>5. Provide multi drug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.</td>
</tr>
<tr>
<td>6. Implement policies and practices aimed at reducing the risk of transmitting multi drug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).</td>
</tr>
<tr>
<td>7. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multi drug resistant organisms. Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.</td>
</tr>
<tr>
<td>8. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multi-drug-resistant organisms. Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both. Note 2: Each organization may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation.</td>
</tr>
<tr>
<td>9. A Laboratory based alert system has been implemented that targets inpatients and readmitted patients. Critical results as outlined by the policy “Microbiology Critical &amp; Reportable Cultures &amp; Test Results” are communicated to the Epidemiologist, or on-call Epidemiologist 24 hours/7 days a week.</td>
</tr>
<tr>
<td>10. Patient’s positive for histories of MDRO are entered into the alert system by Epidemiology. On each subsequent visit to the organization, when the patients chart is opened, an admit alert pops up notifying the provider of the patients history of MDRO infection.</td>
</tr>
<tr>
<td>NPSG.07.04.01</td>
</tr>
<tr>
<td>Note: This requirement</td>
</tr>
<tr>
<td>1. Educate staff and licensed independent practitioners who are involved in managing central lines about central line associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when Involvement in these procedures is added to an</td>
</tr>
</tbody>
</table>
covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

2. Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention.

3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

4. Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices and evaluate the effectiveness of prevention efforts. Then risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital wide, not targeted.

5. Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

6. Use a catheter checklist and a standardized protocol for central venous catheter insertion.

7. Perform hand hygiene prior to catheter insertion or manipulation.

8. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.

9. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.

10. Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.

11. Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations. *

   Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency (ies). It is not acceptable to follow a patient chart.

3. CLABSI policies and practices meet applicable regulatory requirements and are aligned with evidence based standards, professional organization guidelines and best practices.

4. Epidemiology monitors CLABSI infection rates. The NHSN definition of CLABSI is used for surveillance purposes. Epidemiology monitors all central line infections and compliance with CLABSI prevention practices and the findings are reported in the annual assessment of the Infection Control program.

5. Epidemiology provides infection rates monthly to the Infection Prevention and Control Committee, Quality Council and other committees as needed. CLABSI rates and compliance issues that may be identified are communicated on a monthly basis to the Infection Prevention and Control Committee. Any breach in compliance with infection prevention is addressed immediately with the health care provider and nurse manager. All CLABSI infections are discussed with management and administration on a weekly basis to identify lessons learned to prevent in the future.

6-13. BHMC utilizes a CLABSI bundle for CVC insertion that addresses all of the evidence based elements of infection prevention including but not limited to: hand hygiene, avoidance of the femoral site, utilization of a central line insertion kit, maximal sterile barrier precautions for inserter as well as assistant, chlorhexidine based antiseptic, disinfection of catheter hubs and injection ports prior to accession, as well as removal of non-essential central venous catheters.
practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.

13. Evaluate all central venous catheters routinely and remove nonessential catheters.

NPSG.07.05.01
Implement evidence-based practices for preventing surgical site infections.

1. Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual’s job responsibilities.

2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.

3. Implement policies and practices aimed at reducing the risk of surgical site infections that meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

4. As part of the effort to reduce surgical site infections:
   - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
   - Select surgical site infection measures using best practices or evidence-based guidelines.
   - Monitor compliance with best practices or evidence-based guidelines.
   - Evaluate the effectiveness of prevention efforts.

Note: Surveillance may be targeted to certain procedures based on the hospital’s risk assessment.

5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The hospital’s measurement strategies follow evidence-based guidelines.

Note 1: Surveillance may be targeted to certain procedures based on the hospital’s risk assessment.

Note 2: The NHSN is the Centers for Disease Control and Prevention’s health care–associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care–associated infections. For more information on NHSN procedural codes, see

NPSG.07.05.01 cont’d
Implement evidence-based practices for preventing surgical site infections.

1. Education regarding SSIs, the importance of preventing SSIs and other infection prevention strategies are based on risk assessments and surveillance findings, and are provided on hire during the orientation process, annually through health stream and when involvement in surgical procedures is added to an individual’s job responsibilities.

2. Educational materials are provided to all surgical patients utilizing approved fact sheets.

3. Evidence based practices outlined in AORN, APIC, SHEA & CDC standards for prevention of SSI’s have been adopted and HAIs are monitored by the Epidemiology department.

4 & 5. The Epidemiology department closely monitors high volume and high risk procedures. These include but are not limited to colorectal surgeries, hip & knee replacements, Hysterectomies, and all other surgeries. The Epidemiology department follows NHSN guidelines for time frame for surveillance monitoring. Colorectal surgeries and Hysterectomies are reported to NHSN on a monthly basis. Tracking and trending of all surgical site infections is completed by the Epidemiology department.

6. Infection statistics are shared with stakeholders on a regular basis through the Infection Prevention and Control Committee, Patient Safety Key Group, OR Committee, Department of Surgery as well as directly to managers and staff by way of in-services, staff meetings and nursing and Medical staff committees. Epidemiology has worked closely with Surgery to target and reduce infections in those areas.

7. Evidence based practice is followed regarding the type and dose of antimicrobial selected.

8. The chosen method for hair removal if needed is clipping.
6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders
7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations. *
   Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.
8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations. *
   Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

<table>
<thead>
<tr>
<th>NPSG.07.06.01</th>
<th>Implement evidence based practices to prevent catheter associated urinary tract infections (CAUTI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Educate</strong> staff and licensed independent practitioners involved in the use of indwelling urinary catheters about CAUTI and the importance of infection prevention. Education occurs upon hire or granting of initial privileges and when involvement in indwelling catheter care is added to an individual’s job responsibilities. <strong>Ongoing</strong></td>
<td></td>
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<tr>
<td>2. <strong>Patient/Family</strong> education is provided using patient FAQ sheets and is documented in the patient chart.</td>
<td></td>
</tr>
<tr>
<td>3. HOUDINI protocol is utilized.</td>
<td></td>
</tr>
</tbody>
</table>
Implement evidence-based practices to prevent catheter-associated urinary tract infections (CAUTI) education and competence assessment occur at intervals established by the organization.

2. Educate patients who will have an indwelling catheter, and their families as needed, on CAUTI prevention and the symptoms of a urinary tract infection. Note: See FAQs about “Catheter-associated Urinary Tract Infection” at http://www.shea-online.org/images/patients/NNL_CA-UTI.pdf.

3. Develop written criteria, using established evidence-based guidelines, for placement of an indwelling urinary catheter. Written criteria are revised as scientific evidence changes. Note: Examples of criteria for placement of an indwelling urinary catheter include the following:
- Critically ill patients who need accurate urinary output measurements
- Patients with acute urinary retention or bladder outlet obstruction
- Patients who require prolonged immobilization (for example, a potentially unstable thoracic or lumbar spine or multiple traumatic injuries such as pelvic fractures)
- Incontinent patients with an open sacral wound or perineal wounds
- Perioperative use for selected surgical procedures, such as patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract; patients who will have a prolonged duration of surgery (catheters inserted for this reason should be removed in a post-anesthesia care unit); patients anticipated to receive large-volume infusions or diuretics during surgery; patients needing intraoperative monitoring of urinary output
- End-of-life care
- Neurogenic bladder

4. Follow written procedures based on established evidence-based guidelines for inserting and maintaining an indwelling urinary catheter. The procedures address the following:
- Limiting use and duration
- Performing hand hygiene prior to catheter insertion or maintenance care
- Using aseptic techniques for site preparation, equipment, and supplies
- Securing catheters for unobstructed urine flow and drainage
- Maintaining the sterility of the urine collection system
- Replacing the urine collection system when required
- Collecting urine samples
Note: There are medical conditions that require a prolonged use of an indwelling catheter.

4. Procedures are adopted using best practices as outlined by IHI, APIC, SHEA, CDC, etc.
urinary catheter in order to avoid adverse events and promote patient safety. Examples can include, but are not limited to, patients with a spinal cord injury, multiple sclerosis, Parkinson’s disease, and spina bifida. (See also PC.02.01.01, EP 1)

5. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
   - Selecting measures using evidence-based guidelines or best practices
   - Having a consistent method for medical record documentation of indwelling urinary catheter use, insertion, and maintenance (See also RC.01.01.01, EP 7)
   - Monitoring compliance with evidence-based guidelines or best practices
   - Evaluating the effectiveness of prevention efforts

Note: Surveillance may be targeted to areas with a high volume of patients using indwelling catheters. High-volume areas are identified through the hospital’s risk assessment as required in IC.01.03.01, EP 2.

5. Nurses document in the EMR on insertion, maintenance and need for urinary catheters. Epidemiology utilizes the NHSN definition for CAUTI. Epidemiology monitors for compliance to best practices and evidence based guidelines and evaluates the effectiveness of prevention efforts.

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**The Joint Commission Standards Evaluation**

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>ELEMENTS OF PERFORMANCE</th>
<th>EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IC.01.01.01</strong></td>
<td>The hospital identifies the individual(s) responsible for the infection prevention and control program?</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The hospital identifies the individual(s) with clinical authority over the infection prevention and control program?</td>
<td>4. Authority statement in the IC Annual Plan.</td>
</tr>
<tr>
<td>5.</td>
<td>When the individual(s) with clinical authority over the infection prevention and control program does not have expertise in infection prevention and control, he or she consults with someone who has such expertise in order to make knowledgeable decisions.</td>
<td>3. Infectious disease physician available 24/7, 365 days a year.</td>
</tr>
<tr>
<td>6.</td>
<td>The hospital assigns responsibility for the daily management of infection prevention and control activities (see also HR .01.02.01, EP 1, LD .02.01.01, EP 3) Note: Number and skill mix of the individual(s) assigned should be determined by the goals and objectives of the infection prevention and control program.</td>
<td>4. Comprehensive surveillance and analysis of epidemiological data is completed by 2 part time epidemiologists as well as two full time epidemiologists on a daily basis.</td>
</tr>
<tr>
<td>7.</td>
<td>&quot;For hospitals that use Joint Commission accreditation for deemed status purposes: Is the individual with clinical authority over the infection</td>
<td>5. Epidemiologists identify and intervene to assist the facility and its various departments in preventing transmission of infection.</td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td>6. The annual risk assessment and evaluation help to create the annual plan for the Epidemiology Dept. The plan may change to meet unforeseen priorities.</td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td>7. Dr. David Droller, Regional Medical Officer and Chair of Infection Control Committee.</td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td>Clinical Nurse Specialist and other Epidemiologists work together to develop and implement policies</td>
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<tr>
<td>Prevention and control program responsible for the following:</td>
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<tr>
<td>- Developing policies governing control of infections and communicable diseases?</td>
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<td></td>
</tr>
<tr>
<td>- Implementing policies governing control of infections and communicable diseases?</td>
<td></td>
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<tr>
<td>- Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases?</td>
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</tbody>
</table>

that prevent the spread of infection. The team investigates, responds and intervenes to prevent and contain communicable diseases. These events are reported to the Infection Control Committee and the Patient Safety Care Key Group as well as other unit based committees. Communicable diseases are reported to the Broward County Department of Health and recorded in a log.

<table>
<thead>
<tr>
<th>Hospital leaders allocate needed resources for the infection prevention and control program.</th>
</tr>
</thead>
</table>
| **IC.01.02.01**  
1. The hospital provides access to information needed to support the infection prevention and control program? (See IM 02.02.03) |
2. The hospital provides laboratory resources when needed to support the infection control program? |
3. The hospital provides equipment and supplies to support the infection control program. |

1. The Epidemiology Department uses technology for data gathering, analysis, trending and tracking of infection surveillance data.  
   - Medmined  
   - Cerner Powerchar  
   - Cerner Reports/Alerts  
   - Microsoft Office  
   - Discern Analytics  

<table>
<thead>
<tr>
<th>Do the organization leaders allocate needed resources for the infection prevention and control program.</th>
</tr>
</thead>
</table>
| **IC.01.02.01 cont’d**  
1. The Epidemiology team receives daily Candidate reports from the Laboratory and Microbiology for surveillance and analysis.  
   - d. Surveillance Report  
   - e. Quest Diagnostic reporting  
   - f. Phone alerts  
2. Lab serves as a resource when microbiological information is necessary (outbreak investigation, NHSN LabID event information).  
3. Laptop computers, offices with equipment, phones, faxes, printers, copier and supplies. |

<table>
<thead>
<tr>
<th>The hospital identifies risks for acquiring and transmitting infections?</th>
</tr>
</thead>
</table>
| **IC.01.03.01**  
2. The hospital identifies risks for acquiring and transmitting infection based on the following:  
   - Its geographic location, community and population served: The care, treatment and services it provides; The analysis of surveillance activities and other infection control data. (see also NPSG0.07.03.01, EP 1)  
3. The hospital reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing and leadership. (see also NPSG0.07.03.01, EP 1)  
3. The hospital prioritizes the identified risks for acquiring and transmitting infections? These prioritized risks are documented. |

1. The Infection Control Plan is based upon the population it serves and location. A description of the population can be found in the BHMC specific Infection Control Plan. Surveillance data, communicable disease data as well as the Risk Assessment drive the plan.  
2. An annual infection control risk assessment & PRN (Cluster/outbreak) is conducted and presented to the Infection Control Committee for approval.  
3. Risks are prioritized according to probability and impact utilizing a Pareto Diagram and incorporated into the annual plan.
Based on the identified risks, the organization sets goals to minimize the possibility of transmitting infections. Note: See NPSG.07.01.01 for hand hygiene guidelines.

6. Do the organization’s written infection prevention and control goals include the following:
   - Addressing its prioritized risks.
   - Limiting unprotected exposure to pathogens
   - Limiting the transmission of infections associated with procedures.
   - Limiting the transmission of infection associated with the use of medical equipment, devices, and supplies.
   - Improving compliance with hand hygiene guidelines. (See also NPSG.07.01.01)

1. The Infection Control Plan and Risk Assessment guide the Epidemiology department.
   - Risks are prioritized by the Risk Assessment.
   - Standard/Transmission based precautions are followed. An electronic alert system identifies patients previously admitted with select MDRO’s.
   - Routine surveillance of surgical and other procedures is conducted through Microbiology lab results, reports and by assisting in multidisciplinary rounds and committees. The PMR tracks surgical procedures and the infection rates associated with them.
   - Infections associated with medical devices are prevented by the maintenance of hand sanitizers, PPE and hospital improved disinfection wipes throughout clinical areas. Medical devices are disinfected following manufacturer’s instructions for use.
   - Hand Hygiene is encouraged and promoted by maintaining hand sanitizer products in clinical areas, hand hygiene observation tracking, orientation education and in-services and fairs. A comprehensive hand hygiene program initiated May 2017.

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<table>
<thead>
<tr>
<th>STANDARD</th>
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</tr>
</thead>
<tbody>
<tr>
<td>IC.01.05.01</td>
<td>The hospital has an infection prevention and control plan?</td>
<td>3. When developing infection prevention and control activities, the hospital uses evidence based, national guidelines or, in the absence of such guidelines, expert consensus.</td>
</tr>
<tr>
<td></td>
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<td>4. The organization follows CDC hand hygiene guidelines and CDC/NHSN definitions of organization acquired infections and</td>
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<tr>
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<td></td>
<td>5. The Infection Control Plan includes a written description of the activities, including surveillance, to minimize reduce or eliminate the risk of infection.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. All hospital components and functions integrated into infection prevention and control activities?</td>
</tr>
<tr>
<td>IC.01.06.01</td>
<td>The hospital prepares to respond to an influx of potentially infectious patients.</td>
<td>2. The hospital obtains current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. The hospital has a method for communicating critical information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. The organization utilizes frequent updates from the local health department and the Centers of Disease Control as resources. The ESSENCE, a statewide system alert system based on common syndromic presentations is monitored by the local and state Departments of Health for common symptoms among patients.</td>
</tr>
<tr>
<td>IC.02.01.01</td>
<td>The hospital implements its infection and control plan.</td>
<td></td>
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<tr>
<td><strong>IC.02.01.01 cont’d</strong></td>
<td>Does the organization implements its infection control plan?</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The hospital uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection? (See also IC.02.02.01, EP 4)</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The hospital implements transmission-based precautions in response to the pathogens that are suspected or identified within the organization’s service setting and community.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The hospital describes, in writing, how it will respond to an influx of potentially infectious patients. (See also EM.01.01.01. EP 2). Note: One acceptable response is to decide not to accept patients.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The hospital investigates outbreaks of infectious disease? (See IC.01.05.01, EP 5)</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The hospital minimizes the risk of infection when storing and disposing of infectious waste. (See also EC.02.02.01, EP 1&amp;12)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The hospital implements its methods to communicate responsibilities for preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families? Information for visitors, patients, and families includes hand and respiratory hygiene practices?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The hospital reports infection surveillance, prevention and control information to the appropriate staff within the organization?</td>
<td></td>
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<tr>
<td>9.</td>
<td>The hospital reports infection surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with law and regulation?</td>
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<tr>
<td>10.</td>
<td>When the hospital becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or isolation, does it</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>3. Communication of critical information is communicated through various methods that utilize email, fax, phone, website updates and other methods.</td>
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</tbody>
</table>

1. The Infection Control Program is directed by a full time Infectious Disease physician and managed by a Director of Epidemiology, Safety & Quality, 3 Staff Epidemiologists, and a Clinical Nurse Specialist in Epidemiology. The Infection Control Committee has been given the authority for the Program and includes community and staff physicians, administration, pharmacy, dialysis, critical care adult and pediatric nursing, microbiology, environmental services, surgery, education, quality, safety, facilities and other departments as needed. |

1. Computer technology will be utilized for analysis, trending and tracking of infection surveillance data (MEDMINED). |

1. Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis. |

1. The Epidemiologists are on call and available on a 24/7 basis. The Director or designee are members of or attend all major organization committees. |

2. The organization educates and uses standard precautions and personal protective equipment for employees. |

3. Transmissions based precautions according to CDC guidelines is implemented across the facility. An electronic alert system and electronic medical records assist in identifying patients with MDRO’s. |

5. The organization investigates outbreaks whenever suspect clusters or reports are obtained through surveillance activities. |

6. The organization maintains a current list of inventory of hazardous materials and waste, sharps containers, red bags and other protective products are used to guard infectious waste. |

7. The Epidemiology team and EOC team educate the staff through Health stream, in-services and orientation on hand hygiene, PPE and blood and body fluids exposures. The public is educated through brochures and handouts on the importance of infection prevention and hand hygiene. |

8. The Infection Control Committee, Patient Safety Care Key Group, EoC Committee and various Medical/Quality committees are informed. |

9. The organization reports infection surveillance, prevention and control information to local, state and federal public health authorities in accordance with law and regulation. ESSENCE and HIV directly and
<table>
<thead>
<tr>
<th>IC.02.02.01</th>
<th>The hospital reduces the risk of infections associated with medical equipment, devices and supplies?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment devices, and supplies. Note: low level disinfection is used for items such as stethoscopes, and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission based precautions.</td>
</tr>
<tr>
<td>2.</td>
<td>The hospital implements infection prevention &amp; control activities when doing the following: Sterilizing Performing intermediate, high-level disinfection and sterilization of medical equipment, devices, &amp; supplies? (See also EC.02.04.03, EP 4) Note 1: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.</td>
</tr>
<tr>
<td>3.</td>
<td>The hospital implements infection prevention &amp; control activities when doing the following: Disposing of medical equipment, devices, and supplies?</td>
</tr>
<tr>
<td>4.</td>
<td>The hospital implements infection prevention &amp; control activities when doing the following: Storing medical equipment, devices, and supplies?</td>
</tr>
<tr>
<td>5.</td>
<td>When reprocessing single-use devices, the hospital implements infection prevention and control activities that are consistent with regulatory and professional standards.</td>
</tr>
<tr>
<td>IC.02.02.01 cont’d</td>
<td>Does the organization reduce the risk of infections associated with medical equipment, devices and supplies?</td>
</tr>
<tr>
<td>3.</td>
<td>A policy for disinfection of high touch surfaces has been implemented. This policy is “Cleaning Protocol for Touch Surfaces in the Nursing Station/Clinical Areas and Frequently Used Non-Critical Medical Equipment”.</td>
</tr>
<tr>
<td>4.</td>
<td>The Epidemiology Department tracks biological indicator data on a routine basis. All areas that conduct critical disinfection activities report sterilization reports to the Epidemiology department.</td>
</tr>
<tr>
<td>5.</td>
<td>FDA third party processor used to reprocess approved single use devices.</td>
</tr>
<tr>
<td>IC.02.03.01</td>
<td>The hospital works to prevent the transmission of infectious diseases among patients, licensed independent practitioners</td>
</tr>
<tr>
<td>5.</td>
<td>The hospital make screening for exposure and/or immunity to infectious disease available to licensed independent practitioners and staff who may come in contact with infections at the workplace?</td>
</tr>
<tr>
<td>1&amp; 2.</td>
<td>Several polices outline the protocols that address screening for infectious diseases for LIP, staff and others; they also address responses to exposures. The policies are Broward Health Tuberculosis Infection Control Plan, Chicken Pox Exposure, and Blood borne Pathogen Plan.</td>
</tr>
<tr>
<td>and staff?</td>
<td>6. When licensed independent practitioners or staff have, or are suspected of having, an infectious disease that puts others at risk, the organization provides them with or refers them for assessment and potential testing, prophylaxis/treatment or counseling?</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. The hospital establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff?</td>
<td>5. The Influenza Immunization Program is initiated October 1st and continues through March 31st for all staff, physicians, and LIP’s as well as all patients meeting recommended guidelines. 6. LIP’s and staff are educated via health stream annually. Employee Health advertises availability of vaccination in the Health Office covering all shifts and also provides a mobile vaccination program to all the nursing units and departments at various times during the season. Declination forms are used to monitor the effect of intervention. 7. Vaccination is offered on site, at an advertised schedule, and at other convenient times and locations. 4. &amp; 5. The goal of increasing vaccination rates by year is located in the annual infection control plan. 6. The hospital uses Joint Commission recommendations to calculate influenza vaccination rates for LIP’s, staff and contracted staff. 7. Declination reasons are collected by employee health 8. Influenza vaccination rates have increased since CY2015. 9. Rates are sent out during flu season by Employee Health through administration.</td>
</tr>
<tr>
<td>IC.02.04.01</td>
<td>2. The hospital educates licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non–vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza. 3. The hospital provides influenza vaccination at sites and times accessible to licensed independent practitioners and staff. 4. The hospital includes in its infection control plan the goal of improving influenza vaccination rates? (For more information, refer to Standard IC.01.04.01) 5. The hospital sets incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020?</td>
</tr>
<tr>
<td>The hospital offers vaccination against influenza to licensed independent practitioners and staff?</td>
<td>Note: The U.S. Department of Health and Human Services' Action Plan to Prevent Healthcare-Associated Infections is located at: <a href="http://www.hhs.gov/ash/initiatives/ha/i/hcpflu.html">http://www.hhs.gov/ash/initiatives/ha/i/hcpflu.html</a>. 6. The hospital has a written description of the methodology used to determine influenza vaccination rates? 7. The hospital evaluates the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually. 8. The hospital improves its vaccination rates according to its established goals at least annually? (For more information, refer to Standards PL.02.01.01 and PL.03.01.01) 9. The hospital provides influenza</td>
</tr>
<tr>
<td>STANDARD</td>
<td>ELEMENTS OF PERFORMANCE</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| IC.03.01.01   | 9. The hospital evaluates the effectiveness of its infection prevention and control plan annually and whenever risks significantly change?  
|               |   - The evaluation includes a review of the following: The infection prevention and control plan’s prioritized risks.  
|               |   - The infection prevention and control’s plans goals.  
|               |   - Implementation of the infection prevention and control plan’s activities.  
|               | 6. Findings from the evaluation are communicated at least annually to the individuals or interdisciplinary group that manages the patient safety program.  
|               | 7. The hospital uses the findings of its evaluation of the infection prevention and control plan when revising the plan. (See also LD.01.02.01.EP 4) | 1. The Infection Control Plan is based upon the population it serves and location. Surveillance data, communicable disease data and the facility specific risk assessment drive this plan.  
|               |                                                                                       | 1. An annual Infection Control risk assessment is conducted and presented to the Infection Control Committee for approval. Risks are prioritized according to probability and impact.  
|               |                                                                                       | 1. The Plan is implemented as planned.  
|               |                                                                                       | 6. The Infection Control Committee; Patient Safety Care Key Group; MCE, MEC and the board evaluate infection rates and the annual evaluation of program goals.  
|               |                                                                                       | 7. The analysis of the annual activities and results are used to revise the new infection control program plan. |
| NPSG.07.01.01 | 1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.  
|               | 2. Set goals for improving compliance with hand hygiene guidelines. (2. See also IC.03.01.01 EP3) | 1. The organization follows CDC Hand Hygiene Guidelines.  
|               | 3. Use compliance with hand hygiene guidelines based on established goals.               | 2. Hand Hygiene is encouraged and promoted by maintaining hand sanitizer products in clinical areas, hand hygiene observation tracking, orientation education and in-services.  
|               |                                                                                       | 3. Hand hygiene tool is completed monthly by trained observers and turned into the Epidemiology department. Epidemiology also performs hand hygiene monitoring during surveillance rounds. New plan for hand hygiene surveillance will be initiated CY 2019.  
|               |                                                                                       | 4. Monthly graphs of hand hygiene compliance are supplied to each nursing unit.  
|               |                                                                                       | 5. Goal of 85% identified. Will accomplish through continuous education on the importance of hand hygiene.  
|               |                                                                                       | 6. Initiation of hand hygiene PI team interventions will begin CY 2018. |
| NPSG.07.03.01 | 1. Conduct periodic risk assessments (in time frames defined by the organization) for multi-drug-resistant organism acquisition and transmission. (See also IC.01.03.01 EP 1-3) | 1. An annual risk assessment of MDRO transmission is conducted and data tracked during the year.  
|               | 2. Educate staff and licensed independent practitioners about multidrug-resistant organisms and prevention strategies. Education occurs upon hire or granting of initial privileges and periodically thereafter as determined by the organization. Note: The education provided recognizes the | 2. On hire and annually staff is educated on the basics of infection prevention and MDRO’s.  
|               |                                                                                       | 3. Patient education is carried out by nursing staff, FAQ sheets are available for use, and documentation in the EMR is reflected of the education provided.  
|               |                                                                                       | 4. Surveillance, reports, alerts provide reports on MDRO transmission and influx.  
|               |                                                                                       | 5. A Performance Measurement Report (PMR) is |
such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multi-drug resistant gram negative bacteria.

<table>
<thead>
<tr>
<th>NPSG.07.03.01 cont’d</th>
</tr>
</thead>
<tbody>
<tr>
<td>diverse roles of staff and licensed independent practitioners and is consistent with their roles within the organization.</td>
</tr>
<tr>
<td>3. Educate patients and their families as needed, who are infected or colonized with a multi-drug-resistant organism about health care–associated infection prevention strategies.</td>
</tr>
<tr>
<td>4. Implement a surveillance program for multi-drug-resistant organisms based on the risk assessment.</td>
</tr>
<tr>
<td>5. Measure and monitor multi drug-resistant organism prevention processes and outcomes, including the following:</td>
</tr>
<tr>
<td>o Multi drug-resistant organism infection rates using evidence-based metrics</td>
</tr>
<tr>
<td>o Compliance with evidence-based guidelines or best practices</td>
</tr>
<tr>
<td>o Evaluation of the education program provided to staff and licensed independent practitioners. Note: Surveillance may be targeted rather than organization-wide.</td>
</tr>
<tr>
<td>6. Provide multi drug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.</td>
</tr>
<tr>
<td>7. Implement policies and practices aimed at reducing the risk of transmitting multi drug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).</td>
</tr>
<tr>
<td>8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multi drug resistant organisms. Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.</td>
</tr>
<tr>
<td>9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multi-drug-resistant organisms. Note: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both. Note 2: Each organization may define its own parameters in terms of time and clinical manifestation to determine which re- tracked, CDC isolation guidelines are followed. Compliance with contact precautions used for patients with an MDRO is also conducted during surveillance.</td>
</tr>
<tr>
<td>6. The Infection Control Committee as well as other meetings provide information to key stakeholders.</td>
</tr>
<tr>
<td>7. Policy: “Multi-Drug Resistant Organisms” provides guidance on reducing MDRO transmission. The International Hospital Transfer Patients CRE Screening Protocol also outlines a process for patients admitted for 48 hours or greater outside of the United States. Patients who meet these criteria have a rectal swab culture completed to rule out CRE. Patients are placed on contact isolation until CRE is ruled out.</td>
</tr>
<tr>
<td>8. A Laboratory based alert system has been implemented that targets inpatients and readmitted patients. Critical results as outlined by the policy “Microbiology Critical &amp; Reportable Cultures &amp; Test Results” are communicated to the Epidemiologist, or on-call Epidemiologist 24 hours/7 days a week.</td>
</tr>
<tr>
<td>9. Patient’s positive for histories of MDRO are entered into the alert system by Epidemiology. On each subsequent visit to the organization, when the patients chart is opened, an admit alert pops up notifying the provider of the patients history of MDRO infection.</td>
</tr>
</tbody>
</table>
| NPSG.07.04.01 cont’d | 1. Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire or granting of initial privileges and periodically thereafter as determined by the organization.
2. Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention.
3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).
4. Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices and evaluate the effectiveness of prevention efforts. Then risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital wide, not targeted.
5. Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.
6. Use a catheter checklist and a standardized protocol for central venous catheter insertion.
7. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters
8. Perform hand hygiene prior to catheter insertion or manipulation
9. Use maximum sterile barrier precautions during central venous catheter insertion.
10. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable
11. Use an alcoholic chlorhexidine antiseptic for skin preparation during central venous catheter insertion unless contraindicated.
12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.
13. Evaluate all central venous catheters routinely and remove nonessential catheters.

|  | 1. Staff education requirements regarding CLABSI’s, the importance of preventing CLABSI’s and infection prevention strategies are included in new hire orientation and the mandatory annual education in Healthstream.
2. Patient/Family education is provided using patient FAQ sheets and is documented in the patient chart.
3. CLABSI policies and practices meet applicable regulatory requirements and are aligned with evidence based standards, professional organization guidelines and best practices.
4. Epidemiology monitors CLABSI infection rates. The NHSN definition of CLABSI is used for surveillance purposes. Epidemiology monitors all central line infections and compliance with CLABSI prevention practices and the findings are reported in the annual assessment of the Infection Control program.
5. Epidemiology provides infection rates monthly to the Infection Control Committee, Patient Safety Care Key Group and Quality and other committees as needed. CLABSI rates and compliance issues that may be identified are communicated on a monthly basis to the Infection Control Committee. Any breach in compliance with infection prevention is addressed immediately with the health care provider and nurse manager. All CLABSI infections are discussed with management and administration on a weekly basis to identify lessons learned to prevent in the future.
6-13. BHMC utilizes a CLABSI bundle for CVC insertion that addresses all of the evidence based elements of infection prevention including but not limited to: hand hygiene, avoidance of the femoral site, utilization of a central line insertion kit, maximal sterile barrier precautions for inserter as well as assistant, chlorhexidine based antiseptic, disinfection of catheter hubs and injection ports prior to accession, as well as removal of non-essential central venous catheters.
NPSG.07.05.01
Implement evidence-based practices for preventing surgical site infections.

1. Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual’s job responsibilities.
2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.
3. Implement policies and practices aimed at reducing the risk of surgical site infections that meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).
4. As part of the effort to reduce surgical site infections:
   - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
   - Select surgical site infection measures using best practices or evidence-based guidelines.
   - Monitor compliance with best practices or evidence-based guidelines.
   - Evaluate the effectiveness of prevention efforts.
   Note: Surveillance may be targeted to certain procedures based on the hospital’s risk assessment.
5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The hospital’s measurement strategies follow evidence-based guidelines. Note 1: Surveillance may be targeted to certain procedures based on the hospital’s risk assessment.
6. Infection statistics are shared with stakeholders on a regular basis through the Infection Control Committee, Patient Safety Care Key Group and Medical/Quality Committees, as well as directly to managers and staff by way of in-services, staff meetings and nursing and Medical staff committees. Epidemiology has worked closely with Orthopedics and Surgery to target and reduce infections in those areas.
7. Evidence based practice is followed regarding the type and dose of antimicrobial selected.
8. The chosen method for hair removal if needed is clipping.

NPSG.07.05.01 cont’d

1. Education regarding SSI’s, the importance of preventing SSI’s and other infection prevention strategies are based on risk assessments and surveillance findings, and are provided on hire during the orientation process, annually through health stream and when involvement in surgical procedures is added to an individual’s job responsibilities.
2. Educational materials are provided to all surgical patients utilizing approved fact sheets.
3. Evidence based practices outlined in AORN, APIC, SHEA & CDC standards for prevention of SSI’s have been adopted and HAI’s are monitored by the Epidemiology department.
4 & 5. The Epidemiology department closely monitors high volume and high risk procedures. These include but are not limited to colorectal surgeries, hip & knee replacements, Coronary artery bypass, C-sections, Hysterectomies, and all other surgeries. The Epidemiology department follows NHSN guidelines for time frame for surveillance monitoring. Colorectal surgeries and Hysterectomies are reported to NHSN on a monthly basis. Tracking and trending of all surgical site infections is completed by the Epidemiology department.
6. Infection statistics are shared with stakeholders on a regular basis through the Infection Control Committee, Patient Safety Care Key Group and Medical/Quality Committees, as well as directly to managers and staff by way of in-services, staff meetings and nursing and Medical staff committees. Epidemiology has worked closely with Orthopedics and Surgery to target and reduce infections in those areas.
7. Evidence based practice is followed regarding the type and dose of antimicrobial selected.
8. The chosen method for hair removal if needed is clipping.
Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations. * Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

| NPSG.07.06.01 | 1. Educate staff and licensed independent practitioners involved in the use of indwelling urinary catheters about CAUTI and the importance of infection prevention. Education occurs upon hire or granting of initial privileges and when involvement in indwelling catheter care is added to an individual’s job responsibilities. Ongoing education and competence assessment occur at intervals established by the organization. |
| NPSG.07.06.01 cont’d | 2. Educate patients who will have an indwelling catheter, and their families as needed, on CAUTI prevention and the symptoms of a urinary tract infection. Note: See FAQs about “Catheter-associated Urinary Tract Infection” at [http://www.shea-online.org/images/patients/NNL_CAUTI.pdf](http://www.shea-online.org/images/patients/NNL_CAUTI.pdf). |
| 3. Staff is educated upon hire and annually or when job responsibilities are changed to include care of urinary catheters. | 4. Patient/Family education is provided using patient FAQ sheets and other resources and is documented in the patient chart. |
| | 3. HOUDINI protocol is utilized. |
3. Develop written criteria, using established evidence-based guidelines, for placement of an indwelling urinary catheter. Written criteria are revised as scientific evidence changes.

Note: Examples of criteria for placement of an indwelling urinary catheter include the following:
- Critically ill patients who need accurate urinary output measurements
- Patients with acute urinary retention or bladder outlet obstruction
- Patients who require prolonged immobilization (for example, a potentially unstable thoracic or lumbar spine or multiple traumatic injuries such as pelvic fractures)
- Incontinent patients with an open sacral wound or perineal wounds
- Perioperative use for selected surgical procedures, such as patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract; patients who will have a prolonged duration of surgery (catheters inserted for this reason should be removed in a post-anesthesia care unit); patients anticipated to receive large-volume infusions or diuretics during surgery; patients needing intraoperative monitoring of urinary output
- End-of-life care
- Neurogenic bladder

4. Follow written procedures based on established evidence-based guidelines for inserting and maintaining an indwelling urinary catheter. The procedures address the following:
- Limiting use and duration
- Performing hand hygiene prior to catheter insertion or maintenance care
- Using aseptic techniques for site preparation, equipment, and supplies
- Securing catheters for unobstructed urine flow and drainage
- Maintaining the sterility of the urine collection system
- Replacing the urine collection system when required
- Collecting urine samples

Note: There are medical conditions that require a prolonged use of an indwelling urinary catheter in order to avoid adverse events and promote patient safety. Examples can include, but are not limited to, patients with a spinal cord injury, multiple sclerosis, Parkinson’s disease, and spina bifida.

5. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
- Selecting measures using evidence-based procedures are adopted using best practices as outlined by IHI, APIC, SHEA, CDC ect

5. Nurses document in the EHR on insertion, maintenance and need for urinary catheters. Epidemiology utilizes the NHSN definition for CAUTI. Epidemiology monitors for
guidelines or best practices
- Having a consistent method for medical record documentation of indwelling urinary catheter use, insertion, and maintenance
- Monitoring compliance with evidence-based guidelines or best practices
- Evaluating the effectiveness of prevention efforts
Note: Surveillance may be targeted to areas with a high volume of patients using indwelling catheters. High-volume areas are identified through the hospital’s risk assessment as required in IC.01.03.01, EP 2.

compliance to best practices and evidence based guidelines and evaluates the effectiveness of prevention efforts.

Epidemiology Accomplishments CY 2018

Hand Hygiene / isolation precautions

1. Participation in multiple committee meetings discussing the importance of hand hygiene. These include but are not limited to: MCE, ICC, SFCH ICC, PKSG, Continuing Medical Education, Department of OB, Department of Pediatrics and Nursing Leadership.

2. Regular monthly dissemination of hand hygiene compliance graphs to individual units. Graphs also presented at multiple committee meetings.

3. Need 2 know related to hand hygiene distributed.

4. Increased number of hand sanitizer stations at elevators and entrances of facility.

5. Creation of screen savers for promotion of hand hygiene on all computers in facility.

CAUTI

1. 21.4% decrease in foley catheter days.

2. CAUTI/CLABSI PI team continued.

3. Epidemiology staff education focused on NHSN surveillance definitions.

4. Emphasis on daily rounding focused ion discussion related to indication and potential alternatives to indwelling urinary catheter.

5. PureWick alternative female urinary device use began.


7. House wide collection of line days. All floors have been provided the standardized tool from NHSN.

8. Striving for zero infections.

9. All urinary catheters inserted with urimeters to prevent breaking closed system.
10. Point prevalence completed. Communicated all findings to PI team and appropriate stakeholders.

11. Education provided to nursing staff related to insertion and maintenance of indwelling urinary catheters.


13. CAUTI prevention education provided to all staff via Health stream.

**CLABSI**

1. 19.1% decrease in central line days.

2. Epidemiology staff education focused on NHSN surveillance definitions.

3. PICC team increased focus on midlines and extended dwell peripheral catheters.


5. Daily chlorhexidine bathing provided to all patients with central lines.

6. Central line dressing changes occur every 7 days and as needed.

7. Emphasis on daily rounding focused on discussion related to indication and potential alternatives to central line.

8. Education through Centurion Angel program assigned to all nursing.

9. Point prevalence rounds completed. Data shared with PI team and other appropriate stakeholders.

10. Alcohol impregnated disinfecting ports utilized on all central lines.

11. Pre filled flush syringes in place.

12. House wide collection of line days. All floors have been provided the standardized tool from NHSN.

**SSI**

1. Epidemiology staff education focused on NHSN surveillance definitions.

2. SSI PI team initiated

3. Daily surveillance of isolates.

4. Daily surveillance of Emergency Department visits.

5. Guide for weight based dosing disseminated to medical staff and Anesthesia

7. Chlorhexidine bathing for all inpatient procedures the night before and morning of surgery.

8. Focus on bathing and Acticoat dressings for all Emcare C-section patients.

9. All C-section infections discussed at monthly OB meetings.

10. Antibiotic prophylaxis guidelines presented to surgery departments: weight based, single dose and timed.

VAE

1. Education in NHSN and surveillance definitions.

2. Surveillance through rounding (Both Epi and managers) observing for compliance to VAP bundles.

3. Discussion of cases with managers and administration in weekly huddles

4. Multidisciplinary meetings when upward trend identified.

C-diff

1. Education provided to nursing related to appropriate specimen collection.

2. Appropriate testing guidelines for C-diff disseminated to all medical staff.

3. Education provided to EVS on appropriate cleaning of all isolation rooms.

4. Utilization of Virusept for daily high touch cleaning and terminal cleaning of all isolation rooms.

5. IT support

MDRO

1. Provided information related to transmission based precautions to all staff via Need 2 know.

2. CDC isolation precautions available to all staff via the BH intranet.

3. Antibiogram available to medical staff via the BH intranet.

4. Frequently used transmission guide disseminated to staff.

5. Utilize MDRO admit alerts.

6. Hand hygiene program.

Education

1. CDC education on NHSN definitions by Epi staff.

2. HIIN in person training on the topics of MDRO and C-diff.

3. CDC, HIIN -multiple webinars attended.
4. Participation in new hire orientation for all staff.

5. Participation in interdisciplinary rounds’

6. Education provided to nutritional services and transportation related to hand hygiene and isolation precautions.

**Project participation**

1. Heater Cooler focus group
   
   a. Intent was to ensure compliance with manufacturer’s instructions for use, evidence based literature as well as regulatory bodies. Standardize processes related to: pre cleaning, transportation, and storage.

**New Policies and committees**

1. PI teams:
   
   a. SSI
   
   b. CLABSI/CAUTI

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**Surgical Services Report**

**CY 2018**

<table>
<thead>
<tr>
<th>Location of Surgery</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>71</td>
</tr>
<tr>
<td>Outpatient</td>
<td>3,494</td>
</tr>
<tr>
<td>Inpatient</td>
<td>7,046</td>
</tr>
<tr>
<td>SSP</td>
<td>865</td>
</tr>
<tr>
<td>RES</td>
<td>3</td>
</tr>
<tr>
<td>PRE</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,483</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of Surgery</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean (Class I)</td>
<td>5,116</td>
</tr>
<tr>
<td>Clean-Contaminated (Class II)</td>
<td>4,457</td>
</tr>
<tr>
<td>Contaminated (Class III)</td>
<td>1,119</td>
</tr>
<tr>
<td>Infected (Class IV)</td>
<td>790</td>
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<tr>
<td><strong>Total Surgeries</strong></td>
<td><strong>11,483</strong></td>
</tr>
</tbody>
</table>

**Top 10 Class 1- Surgical Procedure 2016-2018**

<table>
<thead>
<tr>
<th></th>
<th>CY 2016</th>
<th>CY 2017</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Insertion IV Access Catheter</td>
<td>315</td>
<td>Coronary Artery Bypass Graft</td>
</tr>
<tr>
<td>2.</td>
<td>Replacement Total Hip Anterior</td>
<td>252</td>
<td>Insertion IV Access catheter</td>
</tr>
<tr>
<td></td>
<td>Procedure</td>
<td>CY 2016</td>
<td>CY 2017</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>1</td>
<td>Cesarean Section</td>
<td>1396</td>
<td>1193</td>
</tr>
<tr>
<td>2</td>
<td>Circumcision (Peds)</td>
<td>346</td>
<td>212</td>
</tr>
<tr>
<td>3</td>
<td>Exploratory Laparotomy</td>
<td>312</td>
<td>190</td>
</tr>
<tr>
<td>4</td>
<td>Rehab Oral</td>
<td>272</td>
<td>129</td>
</tr>
<tr>
<td>5</td>
<td>Laparoscopic Appendectomy</td>
<td>224</td>
<td>119</td>
</tr>
<tr>
<td>6</td>
<td>Tonsillectomy &amp; Adenoidectomy</td>
<td>206</td>
<td>112</td>
</tr>
<tr>
<td>7</td>
<td>Tracheostomy</td>
<td>184</td>
<td>107</td>
</tr>
<tr>
<td>8</td>
<td>Laparoscopic Cholecystectomy</td>
<td>124</td>
<td>91</td>
</tr>
<tr>
<td>9</td>
<td>Myringotomy Insertion PE Tubes (Peds)</td>
<td>120</td>
<td>74</td>
</tr>
<tr>
<td>10</td>
<td>Davinci Laparoscopic Cholecystectomy</td>
<td>115</td>
<td>66</td>
</tr>
</tbody>
</table>

Top 10 Class 2 Surgical Procedures 2016-2018
PURPOSE: Broward Health has developed and implemented an effective system-wide Infection Prevention and Control Program for the surveillance, prevention and control of infection. This is the BHMC specific addendum to the plan.

I. Description of Population

Broward Health Medical Center is a level 1 trauma center located in downtown Fort Lauderdale, in Broward county Florida. BHMC provides tertiary care across the continuum of care for all age groups. Its services include liver transplant, cancer services, Level 3 NICU, inpatient dialysis and other services which are delineated in the Scope of Program section.

Per Fiscal Year 2018 statistics, our payer mix was approximately 34.12% managed care, 15.96% Medicare, 12.52% Medicaid, 3.56% indigent, 10.25% self-pay, and 23.59% Commercial Payer. According to the Broward County Health Department, there are high numbers of infectious diseases reported. These include primarily of: HIV/AIDS, Hepatitis C, STDs, and Tuberculosis. BHMC encounters a high rate of patients diagnosed with Tuberculosis. The community (Broward County) rate of Tuberculosis as of 2017 was 3.2/100,000 people. For CY 2018, BHMC saw a rate of 30.22/100,000 patients which was increased from CY 17 of 14.85/100,000 patients. This may be attributed to the facilities’ close proximity to Port Everglades, Fort Lauderdale International airport, as well as its downtown location. A stringent TB program is in place at BHMC to aid in early diagnosis and to prevent the spread of TB in the facility.

The Top 10 Surgeries CY 2018 include: cesarean section, rehab oral, circumcision (peds), laparotomy exploratory, coronary artery bypass graft, insertion IV access catheter, irrigation and debridement lower extremity wound, tracheostomy, tonsillectomy and adenoidectomy, Davinci laparoscopic cholecystectomy.

The Top 10 Inpatient principle Diagnosis, exclusive of Behavioral Health CY 2018 include: Single liveborn infant, delivered vaginally; Single liveborn infant, delivered by cesarean; Maternal care for low transverse scar from previous cesarean delivery; Sepsis, unspecified organism; Hb-Sickle cell disease with crisis, unspecified; Pneumonia, unspecified organism; Non-ST elevation (NSTEMI) myocardial infarction; First degree perineal laceration during delivery; Acute kidney failure, unspecified; Encounter for full-term uncomplicated delivery.
The Top 10 Inpatient principle behavioral diagnosis CY 2018 include: Paranoid schizophrenia; Schizoaffective disorder, bipolar type; Major depressv disorder, recurrent severe w/o psych features; Brief psychotic disorder; Bipolar disorder, crnt episode mixed, severe, w psych features; Bipolar disorder, crnt epsd depress, mild or mod sevrt, unsp; Bipolar disorder, crnt episode manic severe w psych features; Major depressv disorder, recurrent, severe w psych symptoms; Bipolar disorder, crnt epsd depress, severe, w psych features; Bipolar disorder, current episode mixed, unspecified.

The Top 10 Emergency Department diagnosis for CY 2018 include: Paranoid schizophrenia; Sepsis, unspecified organism; Hb-Sickle cell disease with crisis, unspecified; Schizoaffective disorder, bipolar type; Pneumonia, unspecified organism; Acute kidney failure, unspecified; Non-ST elevation (NSTEMI) myocardial infarction; Hypertensive heart disease with heart failure; Chronic obstructive pulmonary disease w (acute) exacerbation; Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny

Conditions such as cancer, HIV/AIDS, indwelling medical devices, use of anti-rejection drugs, disorders that affect the immune system, alcoholism, drug abuse, diabetes and renal failure amongst others can increase an individual’s risk for acquiring infections. The behavioral health population at BHMC may also be at an increased risk due to lack of housing, risky lifestyle, non-compliance and drug/alcohol dependence.

The top 5 pediatric principle surgical procedures performed for CY2018 were: Phimosis; Dental caries, unspecified; Chronic serous otitis media, bilateral; Hypertrophy of tonsils with hypertrophy of adenoids; Unil inguinal hernia, w/o obst or gangr, not spcf as recur.

The top 5 pediatric inpatient principle diagnosis, CY2018 include: Single liveborn infant, delivered vaginally; Single liveborn infant, delivered by cesarean; Hb-SS disease with crisis, unspecified; Unspecified asthma with (acute) exacerbation; Pneumonia, unspecified organism.

The top 5 Pediatric Emergency Department diagnosis for CY2018 include: Acute upper respiratory infection, unspecified; Viral infection, unspecified; Noninfective gastroenteritis and colitis, unspecified; Constipation, unspecified; Otitis media, unspecified, bilateral.

II. Scope of Program
A. BHMC is a full service 716 bed facility that provides tertiary care across the continuum of care for all age groups and includes the Salah Foundation Childrens Hospital, a variety of inpatient, outpatient, and rehabilitative services and select community health services.

B. Patient populations include: medical –surgical specialties and subspecialties including but not limited to: trauma, medical-surgical, intensive care, maternal child care, cancer and blood dyscrasias, cardiac and interventional services, orthopedics, neurology, transplant services, renal, pulmonary, diagnostics, endoscopy, and rehabilitation.

C. Services provided at BHMC include but are not limited to:

1. Adult Care
   a. Breast Center
   b. Cancer Center
   c. Heart Center of Excellence
   d. Interventional Radiology
   e. Outpatient Radiology
   f. Cardiac Research
   g. Cardiac Rehabilitation
h. Diabetes Program
i. Emergency Department
j. Joint Replacement
k. Liver Transplant
l. Orthopedic Sports Medicine
m. Outpatient Neurology
n. Sleep Disorders
o. Stroke Center
p. Level 1 Trauma
q. Behavioral Health
r. Urology Center
s. Inpatient Dialysis
t. Respiratory Services
u. Endoscopy
v. Rehabilitation Center
w. Community Health Services
x. Outpatient Clinic

2. Salah Foundation Children’s Hospital
   a. Pediatric Emergency Department
   b. Level 1 Trauma Center
c. Neonatal Intensive Care Unit
d. Pediatric Intensive Care Unit
e. Pediatric Unit
f. Children’s Cancer Center
g. Sickle Cell Day Treatment Center
h. Pediatric Hematology and Oncology
i. Pediatric Sedation
j. Labor and Delivery
k. Maternity Unit
l. Lactation Center
m. Nursery

II. At Risk Patient Populations
   A. The Infection Control Committee at Broward Health Medical Center has identified the following patient populations as being at higher risk for health care associated or transmissible community acquired infections:
      1. Patients undergoing mechanical ventilation
      2. Patients undergoing surgical & invasive procedures
      3. Trauma patients
      4. Patients undergoing vascular access procedures
      5. Patients with urinary catheter treatment
      6. Employees at risk for occupational exposure to tuberculosis, blood borne pathogens, and other communicable diseases
      7. Patients with significant pathogens (i.e., multi-drug resistant organisms, \textit{C.difficile})
      8. Patients admitted through the International Program
      9. Immunocompromised patient (HIV/AIDS, sickle cell, cancer)
     10. NICU patient
III. Roles and Responsibilities of the Infection Control Committee (ICC)

A. The ICC is a multidisciplinary committee with representation from but not limited to Medical Staff, Executive Leadership, Nursing, Ancillary staff, Allied Health and Community Health Services. The role of the ICC is to oversee the BHMC Infection Prevention and Control Program.

B. Responsibilities of the Infection Control Committee include but are not limited to the following:
   1. Recommends the minimum amount of time allocated to the Infection Control Program based on the needs of the population served.
   2. Requests changes to the allocation of time as needs change or program goals cannot be met.
   3. Facilitates the allocation of resources needed to access information, supplies, equipment and laboratory services.
   4. Approves the IC Program’s Annual Appraisal, Risk Assessment, BHMC IC Program revisions, and Infection Control new policies/revised policies.
   5. Initiates recommendations based on mandatory reporting data, surveillance findings, epidemiological investigations and performance indicator trends.

C. The multidisciplinary Infection Control Committee meets at least every other month. The Chairperson of the ICC, who has the authority of the Chief of Staff and Chief Executive Officer of Broward Health Medical Center to oversee the hospital-wide Infection Control Program. The Epidemiology Clinical Nurse Specialist or designee serves as the facilitator. All hospital departments are encouraged to participate in the ICC and contribute to the infection control and prevention objectives of the program.

D. Pediatric Infection Control Committee
   1. In view of the unique infection prevention needs of a level 3 NICU & Pediatric population, a pediatric infection control committee was created and sanctioned by the Medical Executive Committee.
   2. The committee has been meeting quarterly and as needed.

IV. Objectives

Objectives for the Epidemiology department are as follows:

Please see appendix a- Goals and Objectives CY 2019

References:

Organizations referenced:
1. Centers for Disease Control and Prevention (CDC)
2. The Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)
3. Association of Peri-Operative Registered Nurses (AORN)
4. Association for the Advancement of Medical Instrumentation (AAMI)
5. The Society for Healthcare Epidemiology of America (SHEA)

Related Policies: Broward Health Infection Control Plan (System), Broward Health Epidemiology and Department Specific Infection Control Policies

Authors: Broward Health Medical Center Epidemiology Dept.

Reviewed/Approved by: BHMC Infection Control Committee, BHMC

Date: CNO 2/2019
Appendix A

Goals and Objectives CY 2019

*Based on yearly risk assessment of events
*Will review monthly

*Target goals based on 10% reduction in harm events from LCY and VBP achievement threshold using NHSN SIR data.

Hospital Acquired Infection (HAI) Related Risks

Goal # 1: Overall reduction of hospital acquired infections

*Pareto Analysis reveals that outbreaks constitute the highest risk with a risk priority number (RPM) of 288 and the highest risk percent of 35.8% in the HAI risk portion of the risk assessment. The top 5 risk identified in the Pareto analysis were outbreaks, Clostridoides difficile, surgical site infections (SSI), central line associated bloodstream infection (CLABSI) and catheter associated urinary tract infection (CAUTI) constituting 83.1% identified risks. All HAIs are of concern and we strive to achieve zero.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outbreaks</td>
<td>All patients</td>
<td>1. Reduce nosocomial outbreak 2. Follow Outbreak procedure and policy whenever applicable</td>
<td>0</td>
<td>Housewide</td>
<td>1. Monitor daily surveillance for any unusual organisms or clusters of organisms. 2. Initiate infection control measures based on CDC or other evidence based recommendations. 3. Consult with Florida Department of Health as necessary. 4. Educate healthcare staff on organism identified in outbreak, chain of infection and measures to prevent spread of further infections. 5. Report clusters/outbreaks to necessary stakeholders and committees. Early detection of infection trends through vigilant surveillance, communication with the Broward County Health Department, and monitoring of CDC alerts. 6. Monitor compliance related to transmission based precautions, hand hygiene and EOC inspections</td>
</tr>
</tbody>
</table>
| CDIFF (and MDROs including MRSA bacteremia) | All patients | 1. Determine risk factor for HAI  
2. Decrease HAI  
3. Continue participating in FHA HIIN  
4. Decrease readmissions  
5. | BHMC Target Rates  
MRSA: 0.31  
VRE: 0.1  
CRE: 0.01  
RAS: 0.04  
ESBL k. pneumo: 0.13  
ESBL e.coli: 0.09  
RPsued: 0.02  
CDIFF: 3.32  
MRSA bac: 0.08  
SIR  
MRSA bac: 0.815  
CDIFF: 0.852 | IP  
Nurses  
Physicians  
Pharmacists | 1. Daily review of surveillance including admission log, ER log, and microbiology results/monitor labs, identify and verify infections, analyze data.  
2. Utilize MedMined data mining program to assist with identifying potential clusters.  
3. Review antibiogram and discuss at IPCC and Antimicrobial Stewardship committee.  
4. Continue active surveillance for CRE in international patients who were hospitalized >48 hours prior to admission.  
5. Continue contact precautions for active infection and 3 month history of infection.  
6. Utilize Respiratory Viral Panel (Biofire) to prevent antibiotics for viruses.  
7. CDIFF: Place patient on enhanced contact precautions per policy and monitor compliance with bleach based disinfection.  
8. Cohort if necessary on case by case basis.  
9. Intense analysis of all CDIFF and MRSA bacteremia cases including antibiotic indications and all room changes.  
10. IP rounds facility wide.  
11. Prevalence rounds for isolation, PPE use, equipment disinfection compliance.  
12. Utilize Biofire as a component of the antimicrobial stewardship program to discontinue or prevent use of inappropriate antimicrobials.  
13. Initiate infection control measures based on CDC or other evidence based recommendations.  
14. Need 2 know related to Transmission Based precautions to be disseminated.  
15. Daily huddle related to CDIFF |
| SSI | Patients who had surgery | 1. Determine risk factor for HAI  
2. Decrease complications after surgery  
3. Decrease readmissions related to SSI  
4. Continue participating in FHA HIIN  
5. SSI PI team | BHMC target rate:  
I: 0.48  
II: 0.42  
SIR hyst: 0.722  
colo: 0.781 | IP Nurses  
Physicians  
Pharmacists |
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<tbody>
<tr>
<td>16.</td>
<td>Housewide education to be provided related to Bristol stool scale.</td>
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<tr>
<td>17.</td>
<td>Creation of soft alert to notify ordering providers of patients laxative/stool softener status.</td>
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<tr>
<td>18.</td>
<td>Hard stop creation to prevent test for cure related to CDIFF. Prevention of CDIFF antigen order if a positive lab within 30 days currently exists.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19.</td>
<td>Cancellation of order if stool not collected.</td>
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<tr>
<td>20.</td>
<td>ED triage mandatory question about diarrhea.</td>
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</tr>
<tr>
<td>21.</td>
<td>SOAP UP hand hygiene program.</td>
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</tbody>
</table>

| 1. | Monitor infection rates for all class I and II surgeries and report to appropriate stakeholders. |
| 2. | Monitor COLO and HYST infections and report to NHSN and stakeholders. |
| 3. | Daily surveillance of ER log, admission log, micro reports, OR schedule. |
| 4. | Weight based dosing for antibiotics, re-dosing as necessary. |
| 5. | MRSA screening tool for high risk patients to receive Vancomycin for prophylaxis. |
| 7. | Discuss each SSI weekly in huddle with management and administration to determine lessons learned. |
| 8. | CHG wash night before and morning of surgery. |
| 10. | SSI PI team led by general surgeon. |
| CLABSI | Inpatients with central lines | 1. Determine risk factor for HAI  
2. Decrease HAI  
3. Continue participating in FHA HIIN  
4. Decrease line days  
5. Point prevalence rounding quarterly | BHMC target rate: 1.02  
SIR: 0.784 | IP Nurses  
Physicians | 1. IP rounds facility wide.  
2. Daily surveillance to monitor labs, identify and verify infections, analyze data.  
3. Collect patient demographic data, line days  
4. Identify risks, assess daily need/removal  
5. Monitor bundle compliance during prevalence rounds: dressing, Biopatch, Curos cap  
6. Education, HIIN  
7. Nurse driven action plans  
8. Daily CHG bathing for all patients in house with a central line.  
9. Skills fair with Clinical Education  
10. Peripheral draws for blood specimens  
11. Discuss each CLABSI infection in weekly huddles with management and administration to determine lessons learned.  
12. Provide monthly reports to each individual units  
13. Discuss each CLABSI infection in weekly “huddles” with management and administration to determine lessons learned  
14. Continue to monitor use of femoral site for central lines  
15. Implement PI team recommendations as they relate to  
16. Fast facts related to CLABSI prevention  
17. Standardize daily line rounding form for BHMC and SFCH.  
18. Education utilizing Guardian Angel completed on an annual basis with check off validation |
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</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>Inpatients</td>
<td>1. Determine risk factor</td>
<td>BHMC</td>
<td>IP</td>
<td>1. IP rounds facility wide.</td>
</tr>
</tbody>
</table>

**Other Identified Events:**

**Ventilator Associated Event**
1. Continue to utilize VAP bundle to prevent Ventilator Associated Pneumonia. (Ongoing).
2. Continue to monitor for VAE according to the NHSN VAE definition and report to appropriate stakeholders. (Ongoing).
3. PedVAE definition from NHSN started January 2019 and workgroup to discuss cases that meet definition with NICU and PICU medical directors (January 2019).

**Active TB, unknown at time of admission**
1. All patients to have dictated chest x-ray in Emergency Department prior to being admitted per policy. (On-going).
2. All patients with signs and symptoms or questionable TB disease may be placed on airborne isolation by nursing without a physician’s order per airborne isolation policy. (On-going)
3. Reeducation of nursing and physicians on policy for placing patient on airborne isolation for suspected TB disease (On-going).

MDRO
1. Review of daily isolation patients with real time intervention for EMR orders (September 2018)
2. Review Antibiogram & discuss at Infection Control Committee (ICC) & Medical Care Evaluation (MCE) committee (February 2019)
3. Continue to participate on Antimicrobial Stewardship (ongoing).
4. Continue adherence to International Hospital Transfer Patients CRE Screening Protocol (ongoing).
5. Utilization of Medmined data mining program to monitor for MDRO’s and place patients in isolation in a timely manner (Ongoing).

Notification of Community Acquired Infections
1. Continue to utilize admit alert system and communicate with nursing and outside facilities as needed when patient admitted with a community acquired infection. (Ongoing).

No Internal Notification of HAIs
1. Continue to work with laboratory on notification of critical lab results related to potential communicable diseases (On-going)
Healthcare Worker Risks

Goal #2 Reduction of Healthcare Worker Risk of Infections Secondary to Injury and/or exposure.

*Pareto Analysis reveals non-compliance with standard precautions as the highest risk percent at 28.1%. The remaining of the top 4 risks identified in the Pareto analysis were non-compliance with hand hygiene, failure to follow protocols and use safety devices or PPE, and employee knowledge deficit of disease transmission which make up 79.7% of healthcare worker risks. All risks to healthcare workers are followed by Safety, Employee Health and Epidemiology.

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| Non-compliance with standard precautions and hand hygiene | All employees, physicians, students, volunteers | Strive for 100% of hand hygiene compliance.     | BHMC target: 90%  | IP Administration | 1. SOAP UP hand hygiene campaign.  
2. Collection of hand hygiene data from all areas of hospital and multiple disciplines.  
3. Monitor compliance in all areas of hospital.  
4. Poster campaign by corporate marketing.  
5. Compliance reported at monthly ICC.  
6. Continue to educate nursing at orientation and periodically on standard precautions according to policy. (On-going). |
| Failure to follow protocols and use safety devices or PPE | All employees, physicians, students, volunteers | Decrease needle sticks, splashes, other preventable exposures. | BHMC target: 90%  | IP Safety EH | 1. IP rounds to reinforce protocols, use of safety devices, proper PPE.  
2. Revised isolation signs to standardize with rest of Broward Health. Signs to include new recommendations for transport of patients on isolation as well as PPE requirements in 3 different languages.  
3. Safety to report trends related to sharps injuries to ICC on quarterly basis. |
| Employee knowledge deficit of disease transmission | All employees, physicians, students, volunteers | Employees understand root of HAI and infectious disease | Staff to attend drill downs | IP         | 1. Coordinate with Clinical Education on utilization of the Need-2-know forum  
2. Serve as a resource for staff for infection control processes |
Other Identified Events:

Sharps injuries
1. Coordinate with Safety and Employee Health on PPE education
2. Just in time coaching while rounding for PPE compliance.

Delay in Proper Isolation Precautions
1. Continue to monitor isolates and notify units when transmission based precautions are indicated.
2. Compare isolation log with isolation signs on patient rooms and order in EMR.
3. Monitor disease alert and evaluate timeliness of implementation of transmission based precautions.
4. Utilize new isolation signage.

Non-compliance with seasonal flu immunization
3. Collaborate with corporate on mandatory masking and influenza vaccination incentives.
4. Educate personnel on importance of immunization during rounds, general orientation, and nursing orientation.
5. Provide onsite influenza vaccination to all staff at no cost.
6. Flu vaccine declination forms must be signed.
7. Administration support
Community Risks

**Goal # 3: Reduction of community risk**

*Pareto analysis reveals bioterrorism constitutes the highest risk percent at 25.7% for community related risks. The rest of the top 4 risks identified in the Pareto Analysis were long term care patients and pandemic flu, hemorrhagic, fever diseases like Ebola and seasonal flu make up 84.3% of community risks. All risks from the community are evaluated and Epidemiology works closely with the Health Department.*

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<thead>
<tr>
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</tr>
</thead>
</table>
| Bioterrorism including emerging infectious disease/other epidemics/influx of infectious patients | All patients | BHMC will be prepared for an emerging infectious disease or influx of infectious patients. | EM Drills 100% | IP ED EP Nursing | 1. Continue utilizing infectious disease screening tool for all patients during triage to screen for all potentially infectious patients.  
3. Communicate with the Florida Department of Health as necessary.  
4. Continue with established drills and EM updates and education.  
| Long term care patients | All patients | BHMC has nearby high admitting SNFs. | Length of stay | IP Nursing Case management Physicians | 1. Any infections identified communicate with manager and discussed at weekly huddle.  
2. Active surveillance for incoming patients include cultures as indicated. |
| Seasonal flu and pandemic flu | All patients | BHMC will offer influenza vaccination to 90% by 2020 with a 10% increase each year | | IP Nursing Quality | 1. Inpatients vaccinated during flu season per Centers for Medicaid and Medicare Services (CMS) protocol unless contraindicated. |
2. Patients with influenza placed on Droplet isolation precautions per policy.
3. Unvaccinated staff required to wear mask for duration of flu season.
3. If pandemic flu, work with Florida Department of Health and Emergency Preparedness.

**Other Identified Events**

**Community Aquired MDRO**
1. Identification of patients through daily surveillance admitted with MDROs.
2. Assess staff need for education.
3. Continue adherence to International Hospital Transfer Patients CRE Screening Protocol developed 10/2013.
4. Refer to Page 1. See goal on antibiotic stewardship and reduction of MDROs.

**Waterborne Outbreak**
3. Report to Florida Department of Health as necessary.

**Active TB admissions**
1. Continue to follow IC TB Plan and TB Risk Assessment updated yearly.

**Food Associated Outbreaks**
1. Adhere to established outbreak management policy.
2. Continue to report positive cultures to Broward County Public Health Department.
Environmental Risks

Goal # 4 Reduction in environmental risks

*Pareto analysis reveals inadequate supplies of personal protective equipment (PPE), improper handling of biohazardous waste, and improper environmental cleaning as the highest RPN of 48 each with an overall 55% risk. The next identified risks were improper sharps handling, improper disinfection of equipment, inadequate preconstruction ICRA planning, and inadequate high level disinfection making up 85.5% of environmental risk priorities.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate supplies of PPE</td>
<td>All staff</td>
<td>Maintain adequate supplies of all PPE in all departments.</td>
<td>BHMC target: 90%</td>
<td>Materials</td>
<td>Materials management responsible for maintaining par levels of PPE on each nursing unit in the facility.</td>
</tr>
<tr>
<td>Improper handling of biohazardous waste</td>
<td>All staff</td>
<td>Reduce misuse of red bag biohazard waste.</td>
<td>BHMC target: 90%</td>
<td>All staff, Safety, Clinical Education</td>
<td>1. EoC rounds to check biohazard waste. 2. DoH inspections. 3. Education by safety officer</td>
</tr>
<tr>
<td>Improper environmental cleaning</td>
<td>EVS staff</td>
<td>Compliance with proper cleaning protocols and products.</td>
<td>BHMC target: 90%</td>
<td>EVS</td>
<td>1. Partnership with epidemiology and EVS. 2. EVS maintains pivotal role in Infection Prevention and Control Committee.</td>
</tr>
<tr>
<td>Improper sharps handling</td>
<td>All staff</td>
<td>Reduce incidence of employee injury due to improper sharps handling.</td>
<td>BHMC target: 90%</td>
<td>All staff, Safety, Clinical Education</td>
<td>1. Data reported by Safety 2. Participate in corporate Value Analysis for all product selection, trials, roll out.</td>
</tr>
<tr>
<td>Improper disinfection of equipment</td>
<td>Patients, staff</td>
<td>Compliance with proper disinfection protocols and products.</td>
<td>BHMC target: 90%</td>
<td>IP, Safety, Clinical Education, staff</td>
<td>1. IP rounds and educates on PDI wipe products. 2. Education on hospital approved disinfectants in general orientation, nursing orientation, in-services, during rounding 3. Just in time training during rounds 4. Need to know and newsletter education 5. Heater cooler work group</td>
</tr>
<tr>
<td>Inadequate pre-</td>
<td>Patients, staff</td>
<td>Multidisciplinary</td>
<td>BHMC</td>
<td>Facilities,</td>
<td>1. IP and safety at planning meetings for ICRA</td>
</tr>
</tbody>
</table>

16
### Other Identified Events

#### Improper Sterilization of Equipment
1. Central processing department to monitor biological on 1st sterilization load daily. Monthly report sent to IC. IC to be identified immediately of failed biological. Procedure for failed biological to be carried out per policy *Sterilizers, Attest Biological Monitoring*.
2. Flashing report sent monthly to Infection Control by Central Processing Department.
3. Infection Control to investigate any cases reported of improper sterilization.

#### Air Quality Monitoring
1. Air quality monitoring is conducted when concerns arise. Concerns are brought through employee notification or observations made during surveillance rounds.

#### Surgical Services- Environmental Controls
1. Continuation of Safety Subcommittee to evaluate process for compliance and consistency in attaining and maintaining air temp and humidity requirements in the surgical environment.
2. Facilities to measure; safety and infection control to ensure compliance with monthly temp and humidity measures in surgical environment per standards.
Tuberculosis (TB) risk assessment worksheet

This model worksheet should be considered for use in performing TB risk assessments for health-care facilities and nontraditional facility-based settings. Facilities with more than one type of setting will need to apply this table to each setting.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>√ or Y = Yes</th>
<th>X or N = No</th>
<th>NA = Not Applicable</th>
</tr>
</thead>
</table>

1. Incidence of TB

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.

<table>
<thead>
<tr>
<th>Facility rate: CY 2018</th>
<th>(# of confirmed diagnosed cases of TB/number of admissions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2018</td>
<td>8/26,469= 30.22 per 100,000 patients</td>
</tr>
<tr>
<td>CY2017</td>
<td>4/26,922 = 14.85 per 100,000 patients</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Community rate:</th>
<th></th>
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<tbody>
<tr>
<td>↑ 3.2 (2017)</td>
<td></td>
</tr>
<tr>
<td>3.1 (2016)</td>
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<tr>
<td>4.5 (2015)</td>
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<tr>
<td>2.9 (2014)</td>
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<th>State rate:</th>
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<td>↓ 2.7 (2017)</td>
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<tr>
<td>3.2 (2016)</td>
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<tr>
<td>3.0 (2015)</td>
<td></td>
</tr>
<tr>
<td>3.0 (2014)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National rate:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>↓ 2.8 (2017)</td>
<td></td>
</tr>
<tr>
<td>2.9 (2016)</td>
<td></td>
</tr>
<tr>
<td>3.0 (2015)</td>
<td></td>
</tr>
<tr>
<td>3.0 (2014)</td>
<td></td>
</tr>
</tbody>
</table>

Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?

<table>
<thead>
<tr>
<th>Yes</th>
</tr>
</thead>
</table>

If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)?

Review laboratory data, infection-control records, and databases containing discharge diagnoses.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. patients</th>
<th>Suspected</th>
<th>Confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>440</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>352</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>345</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>403</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>
Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?

| No |

## 2. Risk Classification

### Inpatient settings

<table>
<thead>
<tr>
<th>How many inpatient beds are in your inpatient setting?</th>
<th>719</th>
</tr>
</thead>
</table>
| How many patients with MTB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses. | 2018: 8  
2017: 4  
2016: 7  
2015: 16  
2014: 15 |
| Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting? (See Appendix C.) | Medium risk: settings in which the risk assessment has determined that HCWs will or will possibly be exposed to persons with TB disease or clinical specimens that might contain M. tuberculosis. |

Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?

Yes

## 3. Screening of HCWs for *M. tuberculosis* Infection

<table>
<thead>
<tr>
<th>Does the health-care setting have a TB screening program for HCWs?</th>
<th>Yes</th>
</tr>
</thead>
</table>
| If yes, which HCWs are included in the TB screening program? (Check all that apply.) | ✓ Physicians  
✓ Mid-level practitioners (nurse practitioners [NP] and physician’s assistants [PA])  
✓ Nurses  
✓ Administrators  
✓ Laboratory workers  
✓ Respiratory therapists  
✓ Physical therapists  
Contract staff (Required by the contracting department. Records kept in contracting department)  
Construction or renovation workers (same as contract workers)  
✓ Service workers |
| Janitorial staff  
✓ Maintenance or engineering staff  
✓ Transportation staff  
✓ Dietary staff  
✓ Receptionists  
Trainees and students (Medical students-under GME; Nursing and Allied under Learning/Nursing department. Records and compliance are managed by the above departments)  
✓ Volunteers |
| Is baseline skin testing performed with two-step TST(Tuberculin Skin Test) for HCWs? | Yes |
| Is baseline testing performed with QFT (Quantiferon) or other BAMT (Blood Assay for Mycobacterium Tuberculosis) for HCWs? | No |
| How frequently are HCWs tested for *M. tuberculosis* infection? | Annually during their anniversary hire period. |
| Are the *M. tuberculosis* infection test records maintained for HCWs? | Yes |
| Where are the *M. tuberculosis* infection test records for HCWs maintained? Who maintains the records? | Employee Health Department and Broward Health Workman’s Comp Department |
If the setting has a serial TB screening program for HCWs to test for *M. tuberculosis* infection, what are the conversion rates for the previous years? Benchmark 1.0%  
2018 0.6%  
2017 0.5%  
2016 0.6%  
2015 0.3%  
2014 0.5%  

Has the test conversion rate for *M. tuberculosis* infection been increasing or decreasing, or has it remained the same over the previous 5 years? (check one)  
- Increasing from 0.5% to 0.6% – Even though the percentages were up and down over the last five years, the numbers remain below the threshold.

Do any areas of the health-care setting (e.g., waiting rooms or clinics) or any group of HCWs (e.g., lab workers, emergency department staff, respiratory therapists, and HCWs who attend bronchoscopies) have a test conversion rate for *M. tuberculosis* infection that exceeds the health-care setting’s annual average?  
No

For HCWs who have positive test results for *M. tuberculosis* infection and who leave employment at the health setting, are efforts made to communicate test results and recommend follow-up of latent TB infection (LTBI) treatment with the local health department or their primary physician?  
Yes - New hire converters are evaluated by PCP/ID physician prior to hire. Employees who converted are seen by an ID physician through workers comp. If employees are terminated before they are seen and evaluated, a letter is sent by employee health to follow up with workers comp, private primary care physician or their new employee health department. Exposure follow up for employees who were terminated before the 10th week of follow up are notified by letter to follow up with their PCP or new employee health department.

### 4. TB Infection-Control Program

<table>
<thead>
<tr>
<th>Does the health-care setting have a written TB infection-control plan?</th>
<th>Yes and BH Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is responsible for the infection-control program?</td>
<td>Medical Director of Epidemiology/ chairman of infection control committee.</td>
</tr>
<tr>
<td>When was the TB infection-control plan first written?</td>
<td>06/05</td>
</tr>
<tr>
<td>When the TB infection-control plan was last reviewed or updated?</td>
<td>2/2019</td>
</tr>
<tr>
<td>Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., &gt;1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of <em>M. tuberculosis</em>)?</td>
<td>All infection control policies reviewed yearly.</td>
</tr>
<tr>
<td>Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If yes, which groups are represented on the infection-control committee? (Check all that apply.)  
- Physicians  
- Nurses  
- Epidemiologists  
- Engineers  
- Pharmacists  
- Laboratory personnel  
- Health and safety staff  
- Administrator  
- Risk assessment  
- Quality control (QC)  
- Environmental staff  
- Respiratory  
- Clinical education  
- Facilities management
### 5. Implementation of TB Infection-Control Plan Based on Review by Infection-Control Committee

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name: ____</td>
<td>Yes. Dr. David Droller Corporate Chief Infection Prevention/ Medical Director of Epidemiology</td>
</tr>
</tbody>
</table>

| Based on review of the medical records, what is the average number of days for the following: | 1. Presentation of patient until collection of specimen: 1  
2. Specimen collection until receipt by laboratory: 1  
3. Receipt of specimen by laboratory until smear results are provided to healthcare provider: 1  
4. Diagnosis until initiation of standard antituberculosis treatment: 1  
5. Receipt of specimen by laboratory until culture results are provided for healthcare provider: 1  
6. Receipt of drug susceptibility results until adjustment of antituberculosis treatment if indicated: 4  
7. Admission of patient to hospital until placement in airborne infection isolation (AII): 1 |

| Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized? | Review of laboratory results, outbreak investigations and other means of surveillance. |

| What mechanisms are in place to correct lapses in infection control? | Process improvements, outbreak investigation, literature search, multidisciplinary team work, reporting through committee process within the facility. |

| Based on measurement in routine QC (Quality Control) exercises, is the infection-control plan being properly implemented? | Yes |

| Is ongoing training and education regarding TB infection-control practices provided for HCWs? | Yes |

### 6. Laboratory Processing of TB-Related Specimens, Tests, and Results Based on Laboratory Review

<table>
<thead>
<tr>
<th>Test</th>
<th>In-house</th>
<th>Sent out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid-fast bacilli (AFB) smears</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Culture using liquid media (e.g., Bactec and MB-BacT)</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Culture using solid media</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Drug-susceptibility testing</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Nucleic acid amplification (NAA) testing</td>
<td>✔️</td>
<td></td>
</tr>
</tbody>
</table>

| Does the laboratory at your health-care setting or the reference laboratory used by your health-care setting report AFB smear results for all patients within 24 hours of receipt of specimen? What is the procedure for weekends? | Yes. The same process is utilized on nights and weekends as regular business hours. Laboratory will page the on call Epidemiologist to communicate positive AFB results outside of normal business hours. |

### 7. Environmental Controls

<table>
<thead>
<tr>
<th>Which environmental controls are in place in your health-care setting? (Check all that apply and describe)</th>
</tr>
</thead>
</table>
| Environmental control | ✔️ All rooms  
|                          | ✔️ Local exhaust ventilation (enclosing devices and exterior devices)  
|                          | ✔️ General ventilation (e.g., single-pass system, recirculation system.) |
Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] filtration and ultraviolet germicidal irradiation [UVGI])

What are the actual air changes per hour (ACH) and design for various rooms in the setting?

<table>
<thead>
<tr>
<th>Room Type</th>
<th>ACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Surge / Tele Rooms</td>
<td>6 ACPH</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>12 ACPH</td>
</tr>
<tr>
<td>Operating Rooms / Surgical Services</td>
<td>20 ACPH</td>
</tr>
<tr>
<td>Negative Isolation Rooms</td>
<td>12 ACPH</td>
</tr>
<tr>
<td>Bronchoscopy Rooms</td>
<td>12 ACPH</td>
</tr>
<tr>
<td>Endoscopy Rooms</td>
<td>12 ACPH</td>
</tr>
<tr>
<td>Cath Labs</td>
<td>15 ACPH</td>
</tr>
<tr>
<td>Interventional Radiology Procedure Room</td>
<td>15 ACPH</td>
</tr>
<tr>
<td>Delivery Room (Caesarean)</td>
<td>20 ACPH</td>
</tr>
</tbody>
</table>

Which of the following local exterior or enclosing devices such as exhaust ventilation devices are used in your health-care setting? (Check all that apply)

- Laboratory hoods
- Booths for sputum induction

What general ventilation systems are used in your health-care setting? (Check all that apply)

- Single-pass system
- Constant air volume (CAV)
- Recirculation system

What air-cleaning methods are used in your health-care setting? (Check all that apply)

- HEPA filtration
- Fixed room-air recirculation systems

HEPA filtration
- Portable room-air cleaners

How many AIIR rooms are in the health-care setting?

<table>
<thead>
<tr>
<th>Room Type</th>
<th>AIIR Rooms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Surge / Tele Rooms</td>
<td>6 AIIR Rooms</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>12 AIIR Rooms</td>
</tr>
<tr>
<td>Operating Rooms / Surgical Services</td>
<td>20 AIIR Rooms</td>
</tr>
<tr>
<td>Negative Isolation Rooms</td>
<td>12 AIIR Rooms</td>
</tr>
<tr>
<td>Bronchoscopy Rooms</td>
<td>12 AIIR Rooms</td>
</tr>
<tr>
<td>Endoscopy Rooms</td>
<td>12 AIIR Rooms</td>
</tr>
<tr>
<td>Cath Labs</td>
<td>15 AIIR Rooms</td>
</tr>
<tr>
<td>Interventional Radiology Procedure Room</td>
<td>15 AIIR Rooms</td>
</tr>
<tr>
<td>Delivery Room (Caesarean)</td>
<td>20 AIIR Rooms</td>
</tr>
</tbody>
</table>

What ventilation methods are used for AIIR rooms? (Check all that apply)

Primary (general ventilation):
- Single-pass heating, ventilating, and air conditioning (HVAC)
- Recirculating HVAC systems

Secondary (methods to increase equivalent ACH):
- Fixed room recirculating units
- UVGI

Does your health-care setting employ, have access to, or collaborate with an environmental engineer (e.g., professional engineer) or other professional with appropriate expertise (e.g., certified industrial hygienist) for consultation on design specifications, installation, maintenance, and evaluation of environmental controls?

Yes

Are environmental controls regularly checked and maintained with results recorded in maintenance logs?

Yes

Are AIIR rooms checked daily for negative pressure when in use?

Yes

Is the directional airflow in AIIR rooms checked daily when in use with smoke tubes or visual checks?

Yes

Are these results readily available?

Yes

What procedures are in place if the AIIR room pressure is not negative?

Patient is transferred

Do AIIR rooms meet the recommended pressure differential of 0.01-inch water column negative to surrounding structures?

Yes
8. Respiratory-Protection Program

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your health-care setting have a written respiratory-protection program?</td>
<td>Yes</td>
</tr>
<tr>
<td>Which HCWs are included in the respiratory protection program? (Check all that apply)</td>
<td>Janitorial staff, Maintenance or engineering staff, Transportation staff, Dietary staff</td>
</tr>
<tr>
<td>Physicians</td>
<td>✓</td>
</tr>
<tr>
<td>Mid-level practitioners (NPs and PAs)</td>
<td>✓</td>
</tr>
<tr>
<td>Nurses</td>
<td>✓</td>
</tr>
<tr>
<td>Administrators</td>
<td>✓</td>
</tr>
<tr>
<td>Laboratory personnel</td>
<td>✓</td>
</tr>
<tr>
<td>Service personnel</td>
<td>✓</td>
</tr>
<tr>
<td>Are respirators used in this setting for HCWs working with TB patients?</td>
<td>✓</td>
</tr>
<tr>
<td>If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients).</td>
<td>✓</td>
</tr>
<tr>
<td>Manufacturer</td>
<td>Halyard Health Inc. 3M corporation</td>
</tr>
<tr>
<td>Model</td>
<td>N-95 #62355, N-95 #1860 &amp; 1860S</td>
</tr>
<tr>
<td>Specific application</td>
<td>Routine contact with infectious TB patients, Routine Contact with Infectious TB patients</td>
</tr>
<tr>
<td>Is annual respiratory-protection training for HCWs performed by a person with advanced training in respiratory protection?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does your health-care setting provide initial fit testing for HCWs?</td>
<td>Yes; On hire by employee health</td>
</tr>
<tr>
<td>If yes, when is it conducted?</td>
<td></td>
</tr>
<tr>
<td>Does your health-care setting provide periodic fit testing for HCWs?</td>
<td>Yes; yearly</td>
</tr>
<tr>
<td>If yes, when and how frequently is it conducted?</td>
<td></td>
</tr>
<tr>
<td>What method of fit testing is used? Describe.</td>
<td>Hood/Taste</td>
</tr>
<tr>
<td>_x_1_Fit check: Saccharin or Bitrex fit check. Individual is asked to do normal, deep breathing; bend over; side to side and up/down head movements).</td>
<td></td>
</tr>
<tr>
<td>Is qualitative fit testing used?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is quantitative fit testing used? (Available)</td>
<td>No</td>
</tr>
</tbody>
</table>

9. Reassessment of TB risk

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>How frequently is the TB risk assessment conducted or updated in the health-care setting?</td>
<td>Yearly</td>
</tr>
<tr>
<td>When was the last TB risk assessment conducted?</td>
<td>02/2018</td>
</tr>
<tr>
<td>What problems were identified during the previous TB risk assessment?</td>
<td></td>
</tr>
<tr>
<td>1) Departments were identified by Safety department that had not been having yearly fit testing.</td>
<td></td>
</tr>
<tr>
<td>What actions were taken to address the problems identified during the previous TB risk assessment?</td>
<td></td>
</tr>
<tr>
<td>1) Employees were sent to Employee Health to be fit tested and it was added to yearly job requirement.</td>
<td></td>
</tr>
<tr>
<td>Did the risk classification need to be revised as a result of the last TB risk assessment?</td>
<td>No</td>
</tr>
</tbody>
</table>

* If the population served by the health-care facility is not representative of the community in which the facility is located, an alternate comparison population might be appropriate.
† Test conversion rate is calculated by dividing the number of conversions among HCWs by the number of HCWs who were tested and had prior negative results during a certain period (see Supplement, Surveillance and Detection of *M. tuberculosis* infections in Health-Care Settings).
This Program Evaluation is based in part on outcomes achieved during calendar year 2018. Outcomes are identified through review of performance measurement data, information resulting from Broward Health North (BHN) committees, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Broward Health North and in collaboration with other Broward Health facilities.

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

<table>
<thead>
<tr>
<th>UNIT</th>
<th>Total infections for each unit CY 17</th>
<th>Total infections for each unit CY 18</th>
<th>CY18 CLABSI</th>
<th>CY18 SSI</th>
<th>CY18 CAUTI</th>
<th>CY18 MRSA bac</th>
<th>CY18 CDiff</th>
<th>CY18 VAE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>MICU</td>
<td>13</td>
<td>21</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>SICU</td>
<td>8</td>
<td>9</td>
<td>1</td>
<td></td>
<td>2</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3SE</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3NE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REHAB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSCU -5</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEUROTELE-6</td>
<td>6</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSD</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCU – 7E</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI OF – 7W</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>SMCU -8</td>
<td>5</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>SURGTELE -9</td>
<td>7</td>
<td>9</td>
<td>2</td>
<td></td>
<td>2</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CICU</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>SSI Class I / II</td>
<td>30</td>
<td>15</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total CY 2018</strong></td>
<td><strong>92</strong></td>
<td><strong>11</strong></td>
<td><strong>15</strong></td>
<td><strong>5</strong></td>
<td><strong>10</strong></td>
<td><strong>28</strong></td>
<td><strong>17</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total YTD 2017</strong></td>
<td><strong>90</strong></td>
<td><strong>8</strong></td>
<td><strong>30</strong></td>
<td><strong>8</strong></td>
<td><strong>6</strong></td>
<td><strong>24</strong></td>
<td><strong>18</strong></td>
<td></td>
</tr>
</tbody>
</table>

** Ventilator Associated Event includes VAC, IVAC, PVAP.
**Scope of Program**
BHN is a 409 bed Adult Level II Trauma Center located in Deerfield Beach, Broward County, Florida providing tertiary care across a continuum of services from inpatient, outpatient, emergency, rehabilitation, and select community health services. Patient populations include: medical-surgical specialties and subspecialties including but not limited to trauma, intensive care, cancer, orthopedic, neurology, renal, pulmonary, diagnostics, endoscopy, and rehabilitation.

**Targets**
The following top organizational risk priority targets identified from the CY2018 Broward Health North Infection Control Risk Assessment, 2018 Annual Plan Evaluation and 2018 PMR data analysis (targets adopted from administration goal to reduce yearly harm by 3.5%, Value Based Purchasing performance achievement threshold, CDC, NHSN data and historical trends) were:

<table>
<thead>
<tr>
<th>1. Provide a program for surveillance and reporting of a device related infection to include central line associated blood stream infection (CLABSI), catheter associated urinary tract infection (CAUTI), and ventilator associated events (VAE).</th>
<th>2018 BHN target</th>
<th>2018 Final</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong> Central Line Infections</td>
<td>0.28</td>
<td>0.86</td>
<td></td>
</tr>
<tr>
<td>Central Line Days X 1000 = Rate per 1000 Central Line Days</td>
<td>0.784</td>
<td>0.689</td>
<td>0.784 threshold</td>
</tr>
<tr>
<td><strong>CAUTI</strong> Urinary Catheter Infections</td>
<td>0.46</td>
<td>0.40</td>
<td></td>
</tr>
<tr>
<td>Urinary Catheter Days X 1000 = Rate per 1000 Urinary Catheter Days</td>
<td>0.828</td>
<td>0.073</td>
<td>0.828 threshold</td>
</tr>
<tr>
<td><strong>VAE</strong> Ventilator Associated Events (VAC, IVAC, PVAP)</td>
<td>VAC - 3.40</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Ventilator Days X 1000 = Rate per 1000 Ventilator</td>
<td>IVAC - 0.00</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td><em>There was three PVAP infections in CY 2018.</em></td>
<td>PVAP – 0.28</td>
<td>0.94</td>
<td></td>
</tr>
</tbody>
</table>

**Analysis**
- Infections are identified from prospective surveillance by the Epidemiology nurses.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
- Monthly reports are submitted to BHN Infection Prevention and Control Committee and Quality Council.
- Priority is given to device related infections based on risk assessment and analysis of collected data which is evaluated on an ongoing basis to provide immediate intervention when indicated to reduce or prevent infection.
- Communicated with nurse managers and administration during weekly management huddle on lessons learned to prevent infection.
- Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.
- No new units added for public reporting.
- Increase of infections related to dialysis lines. Meet with contracted dialysis manger and instituted an action plan. Manager to identify trends in employees. Competency on dressing changes. Dialysis Coordinator to proactively discuss discontinuing dialysis lines when applicable. (Patients who have not received dialysis in several days and lab values are within normal limits)

**Effectiveness**

- **CLABSI**
  - CY 2018 SIR below VBP threshold.
  - Increase in number of CLABSI from CY 2017 to CY 2018.
  - There was a 2.5% increase in central line days from 2017 to 2018.
  - Compliance with evidence based best practices as well as continuing improvement solutions to reduce CLABSI such as daily assessment of a central line included line necessity, discontinuation or an alternative to the central line, improved awareness and communication (patient hand-off), Epidemiology Medical Director follow up with physicians regarding line necessity, appropriate central line dressing kits were made available in all nursing care areas, daily chlorhexidine bath for patients with CVC lines was implemented facility wide, “WHAT and WHY” communications were created for nursing staff, Epidemiology and nurse management daily rounding included ongoing interventions; line necessity, education and line dressing surveillance.

- **CAUTI**
  - CY 2018 SIR was below VBP threshold.
There was a 6.5 increase in foley days from 2017 to 2018.

Compliance with evidence based best practices as well as continuing improvement solutions to reduce CAUTI such as: facility wide nurse driven Urinary Catheter Removal Protocol using HOUDINI indications which included discontinuation and alternatives to the indwelling catheter, improved awareness and communication (patient hand-off), Epidemiology Medical Director follow up with physicians regarding indwelling catheter necessity, ICUs increased Foley and peri care to every 4 hours using an antimicrobial solution, “WHAT and WHY” communications created for nursing staff, Epidemiology and nurse management daily rounding included ongoing interventions; Foley necessity, education and Foley care surveillance.

- VAE
  - There was three PVAP in 2018 that was followed by a mini-root cause analysis, meeting with stakeholders, and review of best practices with unit staff.
  - Decrease in VAC and an increase IVAC in CY 2018 was identified involving acute intensive care.
  - Prospective surveillance continued on all ventilated patients in house is done on Mondays, Wednesdays, and Fridays so a change in oxygenation can be identified in real time.
  - Analysis of the data reviewed at the Infection Prevention and Control Committee and subsequently by the Respiratory Coordinator and ad hoc meetings as necessary revealed a need to re-educate respiratory therapists regarding VAE criteria.
  - Early recognition of VAEs prevents a decline in patient’s respiratory status by initiating additional modalities to improve the patient respiratory condition, i.e. increased inspiratory time on the ventilator, using the bed percussion to mobilize secretions, increased frequency with repositioning patient, and concentration on evidence based bundle to prevent pneumonia.
  - The VAP bundle continues to be utilized.
  - Epidemiology monitors for VAC, IVAC, and Possible Ventilator Pneumonia.
  - Collaboration with respiratory therapy, the trauma service as well as Pulmonary and other appropriate stakeholders continues on an ongoing basis.
  - All VAEs are collected and reported to NHSN.

2. Carry out systemic program surveillance and reporting of all Class I and II surgical site infections.

<table>
<thead>
<tr>
<th>Surgical Site Infections</th>
<th>2018 BHN target</th>
<th>2018 Final</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI Class I</td>
<td>0.762</td>
<td>0.000</td>
<td>0.762</td>
</tr>
<tr>
<td>SSI Class II</td>
<td>0.781</td>
<td>1.408</td>
<td>1.267</td>
</tr>
</tbody>
</table>

Analysis
- Class II surgeries in 2018 were under target.
- Colon surgery SIR was above VBP threshold.
- Although infection rates for Class I surgeries have remained below benchmark, analysis of the all SSI data reviewed at the Infection Prevention and Control Committee.
- Intense analysis of colon infections with Action Plan that includes all SSI prevention.
- Drill down on all SSI infections weekly with an opportunity to discuss lessons learned with management and administration.

Improve Solutions
- New Performance Improvement team for 2018 to work on SSI Reduction
- Gap analysis and action plan regarding strategies supported by evidence-based medicine to reduce SSI which includes: preoperative bathing with chlorhexidine, pre-surgical glucose monitoring, surgical site scrub with chlorhexidine, silver coated antimicrobial dressing (ACTICOAT), and weight based antibiotic dosing and appropriate antibiotic selection for patients susceptible or likely to have MRSA.
- Re-education was provided to clinical staff regarding pre-op chlorhexidine bathing; the antibiotic, time given and re-dosing time are written on the individual OR rooms white board. Patient education “How to Prevent SSI” continues to be included in admission packet.

Effectiveness
- Surveillance of evidence based best practices as well as the improvement solutions remain on-going to maintain a downward trend with reducing colon surgery infections as well as class I and II SSI.
- Interventions are ongoing.
3. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs) and Clostridium difficile (CDIFF)

<table>
<thead>
<tr>
<th></th>
<th>2018 BHN target</th>
<th>2018 Final</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRE</td>
<td>0.03</td>
<td>0.01</td>
<td>0.027</td>
</tr>
<tr>
<td>VRE</td>
<td># of patients with MDRO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.10</td>
<td>0.07</td>
<td>0.063</td>
</tr>
<tr>
<td>RAS</td>
<td># of patient days x 1000 = MDRO rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.07</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ESBL K. Pneumo</td>
<td>0.09</td>
<td>0.09</td>
<td>0.072</td>
</tr>
<tr>
<td>ESBL E. coli</td>
<td>0.18</td>
<td>0.05</td>
<td>0.045</td>
</tr>
<tr>
<td>MRSA rate</td>
<td>0.40</td>
<td>0.41</td>
<td>0.369</td>
</tr>
<tr>
<td>CDIFF rate</td>
<td>2.82</td>
<td>3.45</td>
<td>3.105</td>
</tr>
<tr>
<td>MRSA bacteremia SIR</td>
<td>SIR: observed predicted</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.07</td>
<td>1.977</td>
<td>1.779</td>
</tr>
<tr>
<td>CDIFF SIR</td>
<td>0.924</td>
<td>0.572</td>
<td>0.514</td>
</tr>
</tbody>
</table>

Analysis

- Increase in CDIFF overall from CY 2017 to CY 2018.
- There was an increase in overall MRSA and MRSA bacteremia that put us over the VBP achievement threshold.
- Early identification of patients colonized or infected with resistant organisms or other infectious organisms and immediate transmission based isolation of these patients reduced and prevented further transmission.
- Epidemiology nurses performed daily surveillance of cultures from patients admitted with or developing infection.
- Individual patient positive MDRO results were entered into an ALERT data base system which is activated to display with subsequent patient visits. The ALERT screen enabled hospital staff to imitate transmission based precautions as indicated from the screen information.
- The Epidemiology nurses also monitored the daily ED visit log, admission log, disease alert log and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the Epidemiology nurse to limit unprotected exposure to pathogens by taking immediate action with appropriate transmission based precautions.
- The HAI MDROs that BHN monitors and reports monthly on, all saw an increase in rates.
- The Epidemiology department provided large amounts of information on transmission based precautions to all staff via unit based in-services.
- The CDC isolation precautions are uploaded to the general Broward Health intranet website as a resource for all staff to have access to.
- An Action Plan for hospital onset MDRO transmission including CDIFF and MRSA bacteremia was created with a multidisciplinary focus and continued promotion of the Antimicrobial stewardship program; enforcing strict hand washing when exiting rooms with patients on Enhanced Contact Isolation; Adherence to high touch surface cleaning with hypochlorite based solution.
- We continued to implement Transmissions-Based Precautions and Standard Precautions, Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical and nursing departments and Epidemiology.
- Continued active surveillance for CRE for international patients who were admitted to an international hospital for >48 hours.

Effectiveness

- Surveillance rounds and lab monitoring are mechanisms in which information is gathered. Individual clusters were and will continue be analyzed and interventions will be determined at that time.
- The Epidemiology team continuously strives to increase staff and physician education.
- Added Resistant Pseudomonas surveillance in 2018.

4. Assure all Health Care Workers receive proper education on disease modes of transmission Department of Clinical Education will have 100% compliance on all assigned modules relating to Infection Control.

<table>
<thead>
<tr>
<th></th>
<th>2018 BHN target</th>
<th>2018 Final</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance of education</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Analysis/Effectiveness

- Health Stream was used to educate staff on disease transmission and prevention.
- Broward Health and BHN specific orientations were targeted with a robust presentation on infection prevention.
- Unit level in-services continued to be presented; organization wide skills fair was completed; in-service coordination with Environmental Services, Transport, Nutrition and the Environment of Care team helped reach many healthcare workers.
- All hospital staff and LIPs are required to comply with mandatory in-service education about the prevention of health care associated infections, multi-drug resistant organisms, and prevention strategies, at hire and annually thereafter.
5. Prevent unprotected exposure to pathogens (i.e. seasonal flu, pandemic flu, influx of infectious patients, active TB patients and patients with history of MDRO, unusual clusters of organisms or HAI). Monitor the inpatient and outpatient traffic for any potential cases of active TB or increase in influx of infectious patients.

<table>
<thead>
<tr>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- There were 3 TB exposures, no meningitis exposures, one varicella exposure, six disseminated shingles exposures, and no mumps exposure for CY 2018. Each exposure was followed by Employee Health. There were no detected transmissions.</td>
</tr>
<tr>
<td>- No unusual clusters of organisms or HAI. If necessary, cohorting of patients and staff can be utilized to decrease spread of infection.</td>
</tr>
<tr>
<td>- The surveillance plan based on prioritized risk of transmission of diseases identified in our community and from the characteristics of the population served was developed and approved by the Infection Prevention and Control Committee.</td>
</tr>
<tr>
<td>- The surveillance plan is carried out by the Epidemiology nurses on an ongoing basis resulting in prevention of disease transmission to patients, hospital staff, LIPs, students, volunteers and visitors.</td>
</tr>
<tr>
<td>- Epidemiology identifies risks for acquisition and transmission of infectious agents on an ongoing basis (MDROs, C. difficile, TB, Influenza) and annual risk assessments.</td>
</tr>
<tr>
<td>- There is a high incidence of TB in Broward County which requires constant surveillance to identify suspect cases. This is included in the risk analysis of reported data as intermediate risk and requires close monitoring to prevent transmission.</td>
</tr>
<tr>
<td>- There are also a large number of indigent patients admitted from the community with other types of communicable conditions including head and body lice and scabies. These patients are monitored closely for appropriate transmission based precautions and treatment to prevent transmission.</td>
</tr>
</tbody>
</table>

Performance:

- BHN will continue to actively track and trend the traffic of patients for any increase influx of patients and/or need to implement the Pandemic Plan.
- Epidemiology nurses performed daily ongoing surveillance through the monitoring of admissions logs, Emergency Dept. logs, admit alert reports, microbiology candidate reports and walking rounds helped identify influx of infectious patients. We met the goal of identifying trends and clusters.
- The ESSENCE reporting system that identifies syndromic trends through the ER was used to coordinate surveillance with the Broward County Department of Health.
- A database for TB reporting to the Health Dept. was utilized to maintain a record of communication.
- Laboratory screening for Inpatient Rehab Unit: Urine cultures were done upon admission for external patient admissions.
- Early identification of patients colonized or infected with resistant organisms, TB, influenza or other infectious organisms and immediate transmission based isolation of these patients reduced and prevented further transmission.
- Individual patient positive MDRO results are entered into an ALERT data base system which is activated to display with subsequent patient visits. The ALERT screen enables hospital staff to initiate transmission based precautions as indicated from the screen information. The Epidemiology nurses also monitored the daily ED visit log, admission log, disease alert log and isolation log. These measures assist with identifying previously colonized or infected patients with resistant organisms and allowed the Epidemiology nurse to limit unprotected exposure to pathogens by taking immediate
action with appropriate transmission based precautions.

**Effectiveness**
- All blood and body fluid exposures documented in CY 2018 were followed up by Employee Health and resulted in zero transmissions.

### 6. Improve hand hygiene and equipment disinfection

<table>
<thead>
<tr>
<th></th>
<th>2018 BHN Target</th>
<th>2018 Final</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene surveillance (Self Report and Observed)</td>
<td>90%</td>
<td>97%</td>
<td>90%</td>
</tr>
<tr>
<td>Equipment disinfection surveillance</td>
<td>90%</td>
<td>99%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Analysis/Effectiveness**
- Utilize staff on Infection Prevention and Control Committee and Patient and Medication Safety Committee to increase number of direct observers for extra hand hygiene surveillance data.
- Staff from various units completed hand hygiene and equipment disinfection surveillance forms each month.
- Epidemiology conducted observations while rounding on units.
- Teachable moments used to encourage hand hygiene if noncompliance was observed.
- Hand hygiene music video planned with the support of administration and physician champions.
- Hand hygiene was further promoted through unit and departmental in-services.
- Epidemiologists provide ongoing staff and student education and observation for compliance with Standard Precautions with emphasis on hand hygiene and equipment disinfection. Observers continue to use the revised hand hygiene and equipment disinfection observation form (2014). This monitoring tool allows for immediate feedback to the staff member for compliance or non-compliance with hand hygiene and equipment disinfection. Sustained improvement with hand hygiene and equipment disinfection continues.
- Infection prevention educational handout was provided to forensic staff assigned to inpatients.

### 7. Promote and improve seasonal flu immunization organization wide

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HCW Influenza immunization rate</td>
<td>67%, surpassed 60% goal</td>
<td>In progress with 88% goal</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Analysis**
- There were 1583 vaccinated at BHN in 2018. This is an increase from 1066 in 2017 which is a 23% increase.
- CY 2017 data will include a robust increase in physician numbers due to sharing of information at each Broward Health hospital.
- CY 2018 data will include a corporate initiative that started mandatory masking as well as an incentive to receive influenza vaccination through decreased health insurance payment.
- Influenza vaccine program is initiated in September and continues through March for all staff, volunteers, medical staff, and LIPs. Nursing offers vaccination to inpatient patients meeting recommended guidelines during influenza vaccine season.
- Vaccination is administered in Employee Health during the entire flu season as well as times when mobile vaccination carts attend units and meetings.
- Mandatory influenza education is provided to all hospital staff via Health Stream, newsletters, and educational brochures are used to educate staff, physicians, and LIPs about the importance of influenza immunization.
- Declination forms are used to monitor the reasons given for declining the vaccine as well as the effect of educational interventions.

**Effectiveness**
- Vaccination was promoted and the Epidemiology team collaborated closely with Employee Health to vaccinate staff.
- Discussion of mandatory vaccination has been presented at the Infection Prevention and Control Committee multiple times.
- Employees who decline the flu vaccine required religious or medical exemption
- Epidemiology in collaboration with employee health will continue to explore methods to increase the rate of flu vaccination among health care workers. Our goal is to obtain 90% vaccination rate compliance of employees by 2020 by improving vaccination rates by 10% annually.

### 8. PMR Review

<table>
<thead>
<tr>
<th></th>
<th>2018 Target</th>
<th>2018 Final</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis Water</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Dialysate Cultures</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Endotoxins

<table>
<thead>
<tr>
<th>Endotoxin</th>
<th>2018 Target</th>
<th>2018 Final</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission based precautions initiated</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Reporting to state, federal, local public health authorities</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Acetide-C Log Monitoring</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Analysis

- Epidemiology has one-on-one discussion with nurse to remind them about the importance of placing transmission based precautions order in EMR to facilitate communication between departments.
- Tracking of cultures for water, dialysate and endotoxin continues. Cultures collected monthly. Results communicated to Epidemiology, DaVita (company contracted to provide dialysis services) as well as to the dialysis manager.
- There were no adverse outcomes to patients regarding sterilizers. There were no biological recalls.
- Epidemiology monitors endotoxin and water cultures for the reverse osmosis water system cultures and dialysis machines cultures monthly.
- Epidemiology evaluates cleaning procedures and solutions used by Environmental Services.
- EOC/Infection Prevention rounding team observed for EOC compliance throughout the hospital and forwarded non-compliance issues requiring corrective actions to the responsible area when indicated.
- All disinfectants are approved by the Infection Prevention and Control Committee. Education regarding the product use is provided to the EVS staff by the EVS management team as well as the product vendors.
- The ICRA (Infection Control Risk Assessment) for all construction and renovation projects is carried out on a continuing basis with numerous projects reported throughout the year through the Infection Prevention and Control Committee. The Epidemiology nurse rounds in the construction areas to ensure appropriate ICRA measures are maintained during the construction period to reduce infection transmission.
- Educational brochures, posters and information sheets are used to educate patients, visitors, families and licensed independent practitioners regarding responsibilities for preventing infections and infection transmission within the hospital.
- Infections identified after patient discharge or transfer is reported to the receiving organization immediately following review of the data per Infection Control Policy. Patients received from another organization with an infection requiring action are also reported to the transferring organization.
- The hospital has a system for reporting infection surveillance, prevention and control information to appropriate staff within the hospital, federal, state, and local public health authorities, accrediting bodies and referring or receiving organizations when a patient was transferred or referred and the presence of an infection was not known at the time of transfer or referral.

Effectiveness

- In addition to the routine immediate fax reporting of reportable infections to the Health Department there were several telephone reports and faxing to other facilities required during CY 2018.
- Microbiology telephone notification for specific pathogens has been effective in early intervention by Epidemiology with appropriate transmission based precautions and notification to the inpatient care area as well as Broward County Health Department when indicated.
- The Epidemiology nurse rounds, utilizing the isolation log to monitor transmission based precautions compliance. Appropriate use of PPE, hand hygiene and Environment of Care (EOC) compliance are monitored during these rounds as well, with reports submitted to appropriate managers for review and corrective action when indicated.
- Surveillance data is reported monthly to the Infection Control Committee and Quality Council.


<table>
<thead>
<tr>
<th>2018 Target</th>
<th>2018 Final</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program policies and procedures completed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Epidemiologist Coordinator, Certification in Infection Control</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Nurse Epidemiologist, APIC trained</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Medical Director, Board Certified Infectious Disease Physician</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Analysis
- The Comprehensive Infection Control Risk Assessment for CY2017 was presented to the Infection Prevention and Control Committee for review, recommendations and approval.
- The effectiveness of the Infection Control Plan as outlined in the Annual Evaluation of the Program was presented for approval to the Infection Prevention and Control Committee and Medical Council. The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified. The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
- The Infection Prevention and Control Committee meets monthly. The Committee structure includes the Committee chair (Infectious Disease physician), staff physicians, administration, nursing, pharmacy, lab, nutritional services, environmental services, surgery, safety, facilities and other departments as needed. Indicator compliance and action plans are forwarded monthly to Quality Council. Items for approval are forwarded to Pharmacy and Therapeutics Committee and then to Medical Council.
- Computer technology is utilized for analysis, trending and tracking of infection surveillance data.
- Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.
- All areas surveyed for construction were found to be fully ICRA compliant during CY 2018.

Effectiveness
- All of the prioritized risks were reviewed and evaluated. Goals of the IPC program will be revised for the coming calendar year based on the effectiveness of the interventions identified in the previous plan.
- Epidemiology monitored sterilization and high level disinfection processes within the medical center. Ongoing review of the monitoring reports submitted by all departments utilizing a sterilization/high level disinfection process is effective in identifying deficiencies or problems immediately and initiation of recall procedures when necessary. Data are reported to the Infection Prevention and Control Committee on the monthly PMR.
- Epidemiology and Endoscopy Departments remained vigilant and compliant with FDA Safety. Compliance with updates regarding the endo scopes is ongoing.
- The Epidemiologists are members of the national and local chapter of their professional organization and receive education related to Epidemiology/Infection Prevention and Control on an ongoing basis.
- Significant improvement in analysis of surveillance data has been accomplished with increased utilization of Excel spreadsheets and MedMined surveillance over the calendar year. This has provided more accurate analysis to better prioritize our risks and set new goals for the coming calendar year.

The Joint Commission Standards Evaluation

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>ELEMENTS OF PERFORMANCE</th>
<th>EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC.01.01.01</td>
<td>Does the organization identify the individual(s) responsible for the infection prevention and control program?</td>
<td>1. Authority statement in the IC Annual Plan.</td>
</tr>
<tr>
<td></td>
<td>1. Does the organization identify an individual(s) with clinical authority over the infection prevention and control program?</td>
<td>2. Dr. Indulekha Gopal, Medical Director of Epidemiology, Infectious Disease physician</td>
</tr>
<tr>
<td></td>
<td>2. When the individual(s) with clinical authority over the infection prevention and control program does not have expertise in infection prevention and control, he or she consults with someone who has such expertise in order to make knowledgeable decisions.</td>
<td>3. Staff positions descriptions, experience, licenses and certifications</td>
</tr>
<tr>
<td></td>
<td>3. The organization assigns responsibility for the daily management of infection prevention and control activities (see also HR .01.02.01, EP 1, LD .02.01.01, EP 3) Note: Number and skill mix of the individual(s) assigned should be determined by the goals and objectives of the infection prevention and control program.</td>
<td>1. Comprehensive surveillance and analysis of epidemiological data is completed by 2 full time epidemiologists on a daily basis.</td>
</tr>
<tr>
<td></td>
<td>4. &quot;For hospitals that use Joint Commission accreditation for deemed ICRA compliant during CY 2018</td>
<td>2. Epidemiologists identify and intervene to assist the facility and its various departments in preventing transmission of infection.</td>
</tr>
<tr>
<td></td>
<td>3. The annual risk assessment and evaluation help to create the annual plan for the Epidemiology Dept. The plan may change to meet unforeseen priorities.</td>
<td>3. The annual risk assessment and evaluation help to create the annual plan for the Epidemiology Dept. The plan may change to meet unforeseen priorities.</td>
</tr>
<tr>
<td></td>
<td>4. &quot;For hospitals that use Joint Commission accreditation for deemed</td>
<td>1. The Medical Director of Infectious Diseases, Epidemiology department Director, Coordinator</td>
</tr>
</tbody>
</table>
status purposes: Is the individual with clinical authority over the infection prevention and control program responsible for the following:
- Developing policies governing control of infections and communicable diseases?
- Implementing policies governing control of infections and communicable diseases?
- Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases?"

and Epidemiologist work together to develop and implement policies that prevent the spread of infection. The team investigates, responds and intervenes to prevent and contain communicable diseases. These events are reported to the Infection Prevention and Control Committee and the Quality Council as well as other unit based committees. Communicable diseases are reported to the Broward County Department of Health.

### IC.01.02.01
Do the organization leaders allocate needed resources for the infection prevention and control program.

<table>
<thead>
<tr>
<th>1. Does the organization provide access to information needed to support the infection prevention and control program? (See IC.01.01.01, EP 2; IC.01.03.01, EP 3; IC.01.05.01, EPs 1 and 2; IC.01.06.01, EP 2; IC.02.01.01, EP 8; IC.03.01.01, EP 1; IM.02.02.03, EP 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Epidemiology Department uses technology for data gathering, analysis, trending and tracking of infection surveillance data. Medmined Cerner Powerchart Cerner Surginet Cerner Reports/Alerts Microsoft Office Discern Analytics</td>
</tr>
<tr>
<td>2. Does the organization provide laboratory resources when needed to support the infection control program? (See IC.01.05.01, EP 2)</td>
</tr>
<tr>
<td>2. The Epidemiology team receives daily Candidate reports from the Laboratory and Microbiology for surveillance and analysis. a. Surveillance Report b. Quest Diagnostic reporting c. Phone alerts</td>
</tr>
<tr>
<td>3. Does the organization provide equipment and supplies to support the infection control program. (See IC.01.05.01, EP 2 and LD.03.03.01, EP 4)</td>
</tr>
<tr>
<td>3. Lab serves as a resource when microbiological information is necessary (outbreak investigation, NHSN LabID event information).</td>
</tr>
<tr>
<td>3. Computers, offices with equipment, phones, faxes, printers, copier and supplies.</td>
</tr>
</tbody>
</table>

### IC.01.03.01
Does the organization identify risks for acquiring and transmitting infections?

<table>
<thead>
<tr>
<th>1. The organization identifies risks for acquiring and transmitting infection based on the following: Its geographic location, community and population served (see also NPSG.07.03.01, EP 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. The care, treatment and services it provides. (see also NPSG.07.03.01, EP 1)</td>
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<tr>
<td>3. The analysis of surveillance activities and other infection control data. (see also NPSG.07.03.01, EP 1; TS.03.03.01, EP 2)</td>
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<tr>
<td>4. Does the organization reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing and leadership. (see also NPSG.07.03.01, EP 1)</td>
</tr>
<tr>
<td>5. Does the organization prioritize risks according to probability and impact utilizing a Pareto Diagram and incorporated into the annual plan.</td>
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</table>

1& 2. The Infection Control Plan is based upon the population it serves and location. A description of the population can be found in the BHN specific Infection Control Plan. Surveillance data, communicable disease data as well as the Risk Assessment drive the plan.

3&4. An infection control risk assessment is conducted annually and as needed (Cluster/outbreak) and presented to the Infection Prevention and Control Committee for approval.

5. Risks are prioritized according to probability and impact utilizing a Pareto Diagram and incorporated into the annual plan.
| IC.01.04.01 | The identified risks for acquiring and transmitting infections? These prioritized risks are documented. (see also, NPSG.07.03.01, EP 1) | The Infection Control Plan and Risk Assessment guide the epidemiology department.  
1. Risks are prioritized by the Risk Assessment.  
2. Standard/Transmissions based precautions are followed. An electronic alert system identifies patients previously admitted with select MDROs.  
3. Routine surveillance of surgical and other procedures is conducted through microbiology lab results, reports and by assisting in multi-disciplinary rounds and committees. The PMR tracks surgical procedures and the infection rates associated with them.  
4. Infections associated with medical devices are prevented by the maintenance of hand sanitizers, PPE and hospital improved disinfection wipes throughout clinical areas.  
5. Hand hygiene is encouraged and promoted by maintaining hand sanitizer products in clinical areas, hand hygiene observation tracking, orientation education and in-services and fairs. |
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<tbody>
<tr>
<td>IC.01.05.01</td>
<td>Does the organization have an infection prevention and control plan?</td>
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</tbody>
</table>
1. The organization follows CDC hand hygiene guidelines and CDC/NHSN definitions of organization acquired infections and  
2. The Infection Control Plan includes a written description of the activities, including surveillance, to minimize reduce or eliminate the risk of infection.  
3. The Infection Control Plan is updated annually and reviewed and approved by the Infection Control Committee.  
4. The Organization has a policy for investigating outbreaks. (Outbreak Management Plan).  
5. The Epidemiology team participates in Nursing Orientation for all Broward Health facilities level and presents Infection Prevention module to all BHN new hires. It also conducts annual updates and participates in various competency projects.  
  
The organization reports communicable diseases to the local, state and federal Departments of Health and to other organizations when necessary. Faxed copies are stored and a daily log of number of cases is reported out to on the Performance Measure Review (PMR). |
| IC.01.06.01 | The organization prepares to respond to an influx of potentially infectious patients. |  
1. The organization utilizes frequent updates from the local health department and the Centers of Disease Control as resources. The ESSENCE, a statewide system alert system based on common syndromic presentations is monitored by the local and state Departments of Health for common symptoms among patients.  
2. Communication of critical information is communicated through various methods that utilize email, fax, phone, website updates and other methods. |
<table>
<thead>
<tr>
<th>Cluster</th>
<th>Question/Implementation Details</th>
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</table>
| IC.02.01.01 | 1. The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.  
2. Does the organization use standard precautions, including the use of personal protective equipment, to reduce the risk of infection? (See also EC.02.02.01, EP 4) Note 1: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients.  
3. Does the organization implement transmission-based precautions in response to the pathogens that are suspected or identified within the organization’s service setting and community.  
5. Does the organization investigate outbreaks of infectious disease? (See IC.01.05.01, EP 5)  
6. The organization minimizes the risk of infection when storing and disposing of infectious waste. (See also EC.02.02.01, EP 1&12)  
7. Does the hospital implement its methods to communicate responsibilities for preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families? Information for visitors, patients, and families includes hand and respiratory hygiene practices? (See also HR.01.04.01, EP 4)  
8. Does the organization reports infection surveillance, prevention and control information to the appropriate staff within the organization?  
9. Does the organization report infection surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with law and regulation? (See also IC.03.01.01, EP 6)  
10. When the organization becomes aware that it transferred a patient |


<table>
<thead>
<tr>
<th>Cluster</th>
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| IC.02.01.01 cont’d | 1. The Infection Control Program is directed by a full time Infectious Disease physician and managed by a Director of Epidemiology, Safety & Quality, 3 Staff Epidemiologists, and a Clinical Nurse Specialist in Epidemiology. The Infection Control Committee has been given the authority for the Program and includes community and staff physicians, administration, pharmacy, dialysis, critical care adult and pediatric nursing, microbiology, environmental services, surgery, education, quality, safety, facilities and other departments as needed.  
1. Computer technology will be utilized for analysis, trending and tracking of infection surveillance data (MEDMINED).  
1. Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.  
1. The Epidemiologists are on call and available on a 24/7 basis. The Director or designees are members of or attend all major organization committees.  
2. The organization educates and uses standard precautions and personal protective equipment for employees.  
3. Transmissions based precautions according to CDC guidelines is implemented across the facility. An electronic alert system and electronic medical records assist in identifying patients with MDRO’s  
5. The organization investigates outbreaks whenever suspect clusters or reports are obtained through surveillance activities.  
6. The organization maintains a current list of inventory of hazardous materials and waste, sharps containers, red bags and other protective products are used to guard infectious waste.  
7. The Epidemiology team and EOC team educate the staff through Health stream, in-services and orientation on hand hygiene, PPE and blood and body fluids exposures. The public is educated through brochures and handouts on the importance of infection prevention and hand hygiene.  
8. The Infection Control Committee, Patient Safety Care Key Group, EoC Committee and various Medical/Quality committees are informed  
9. The organization reports infection surveillance, prevention and control information to local, state and federal public health authorities in accordance with law and regulation. ESSENCE and HIV directly and
| IC.02.02.01 | Does the organization reduce the risk of infections associated with medical equipment, devices and supplies? | 1. The organization implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment devices, and supplies. Note: low level disinfection is used for items such as stethoscopes, and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission based precautions.  
2. Does the organization implement infection prevention & control activities when doing the following: Sterilizing Performing intermediate, high-level disinfection and sterilization of medical equipment, devices, & supplies? (See also EC.02.04.03, EP 4)  
Note 1: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.  
3. Does the organization implement infection prevention & control activities when doing the following: Disposing of medical equipment, devices, and supplies?  
4. Does the organization implement infection prevention & control activities when doing the following: Storing medical equipment, devices, and supplies?  
Note: Surveillance may be targeted rather than hospital wide.  
5. When reprocessing single-use devices, the organization implements infection prevention and control activities that are consistent with regulatory and professional standards. | 1. A policy for disinfection of high touch surfaces has is utilized. This policy is “Cleaning Protocol for Touch Surfaces in the Nursing Station/Clinical Areas and Frequently Used Non-Critical Medical Equipment”.  
2. The Epidemiology Department tracks biological indicator data on a routine basis. All areas that conduct critical disinfection activities report sterilization reports to the Epidemiology department.  
3. Opportunities identified and actions implemented. New Endoscopy log created to include negative reagent testing and pre-cleaning of OR instruments prior to transport to decontamination area. Education provided through huddles. Log audits; Education provided  
3 & 4. Surveillance rounds conducted by Epidemiology and EoC that routinely monitor the disposal and storing of medical equipment. |
| IC.02.03.01 | Does the organization make screening for exposure and/or | 1.2 and 3. Several polices outline the protocols that address screening for infectious diseases for LIP, |
work to prevent the transmission of infectious diseases among patients, licensed independent practitioners and staff?

<table>
<thead>
<tr>
<th>IC.02.04.01</th>
<th>Does the organization offer vaccination against influenza to licensed independent practitioners and staff?</th>
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<tbody>
<tr>
<td>1.</td>
<td>Does the organization establish an annual influenza vaccination program that is offered to licensed independent practitioners and staff?</td>
</tr>
<tr>
<td>2.</td>
<td>Does the organization educate licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza. (See also HR.01.04.01, EP 4)</td>
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<tr>
<td>3.</td>
<td>The organization provides influenza vaccination at sites accessible to licensed independent practitioners and staff.</td>
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<tr>
<td>4.</td>
<td>Does the organization include in its infection control plan the goal of improving influenza vaccination rates? (For more information, refer to Standard IC.01.04.01)</td>
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<tr>
<td>5.</td>
<td>Does the organization set incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020?</td>
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<thead>
<tr>
<th>Offer vaccination against influenza to licensed independent practitioners and staff?</th>
<th>6. Does the organization have a written description of the methodology used to determine influenza vaccination rates? (See IC.02.04.01, EP 1)</th>
</tr>
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<tbody>
<tr>
<td>7. Does the organization provide influenza vaccination rate data to key stakeholders who may include leaders, licensed independent practitioners, nursing staff, and other staff at least annually?</td>
<td>8. Does the organization improve its vaccination rates according to its established goals at least annually? (For more information, refer to Standards PI.02.01.01 and PI.03.01.01)</td>
</tr>
<tr>
<td>9. Does the organization provide influenza vaccination rate data to key stakeholders who may include leaders, licensed independent practitioners, nursing staff, and other staff at least annually?</td>
<td>1&amp;2. The Infection Control Plan is based upon the population it serves and location. Surveillance data, communicable disease data and the facility specific risk assessment drive this plan. 1&amp;2. An annual Infection Control risk assessment is conducted and presented to the Infection Control Committee for approval. Risks are prioritized according to probability and impact. 2. The Plan is implemented as planned. 3. The Infection Prevention and Control Committee and Quality Council evaluate infection rates and the annual evaluation of program goals. 4. The analysis of the annual activities and results are used to revise the new infection control program plan.</td>
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### National Patient Safety Goals Standards Evaluation

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>ELEMENTS OF PERFORMANCE</th>
<th>EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.07.01.01</td>
<td>1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.</td>
<td>1. The organization follows CDC Hand Hygiene guidelines.</td>
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<tr>
<td></td>
<td>2. Set goals for improving compliance with hand hygiene guidelines. (2. See also IC.03.01.01 EP3)</td>
<td>2. Hand Hygiene is encouraged and promoted by maintaining hand sanitizer products in clinical areas, hand hygiene observation tracking, orientation education and in-services, .</td>
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<td></td>
<td>3. Use compliance with hand hygiene</td>
<td>3. Hand hygiene tool is completed monthly by hand hygiene observers and turned into the Epidemiology department. Epidemiology also performs hand hygiene monitoring during</td>
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</table>
NPSG.07.03.01
Implement evidence based practices to prevent healthcare associated infections due to multi-drug resistant organisms in acute care hospitals. Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multi-drug resistant gram negative bacteria.

1. Conduct periodic risk assessments (in time frames defined by the organization) for multi-drug-resistant organism acquisition and transmission. (See also IC.01.03.01 EP 1-5)
2. Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care–associated infections, multi-drug-resistant organisms, and prevention strategies at hire and annually thereafter. Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the hospital.
3. Educate patients and their families as needed, who are infected or colonized with a multi-drug-resistant organism about health care–associated infection prevention strategies.
4. Implement a surveillance program for multi-drug-resistant organisms based on the risk assessment.
5. Implement guidelines based on established goals.
6. Measure and monitor multi drug-resistant organism infection rates and outcomes, including the following:
   a. Multi drug-resistant organism infection rates using evidence-based metrics
   b. Compliance with evidence-based guidelines or best practices
   c. Evaluation of the education program provided to staff and licensed independent practitioners. Note: Surveillance may be targeted rather than organization-wide.
7. Provide multi drug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.
8. Implement policies and practices aimed at reducing the risk of transmitting multi drug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).
9. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multi drug-resistant organism acquisition.

NPSG.07.03.01 cont’d

1. An annual risk assessment of MDRO transmission is conducted and data tracked during the year.
2. On hire and annually staff is educated on the basics of infection prevention and MDROs.
3. Patient education is carried out by nursing staff, FAQ sheets are available for use, and documented in the EMR is reflected of the education provided.
4. Surveillance, isolation reports, and alert tab provides reports on MDRO transmission and influx of patients with an MDRO.
5. A Performance Measurement Report (PMR) is tracked for MDROs of significance using NHSN LAB ID definition.
6. PMR compliance also tracked for CDC isolation guidelines are followed which is conducted during surveillance.
7. The Infection Prevention and Control Committee as well as other meetings provides information to key stakeholders.
8. Policies: “Multi-Drug Resistant Organisms” provides guidance on reducing MDRO transmission. The International Hospital Transfer Patients CRE Screening Protocol also outlines a process for patients admitted for 48 hours or greater outside of the United States. Patients who meet these criteria have a rectal swab culture completed to rule out CRE. Patients are placed on contact isolation until CRE is ruled out. Rule out cdiff patients are also placed on Enhanced Contact isolation until ruled out.
9. A Laboratory based alert system has been implemented that targets inpatients and readmitted patients. Critical results as outlined by the policy “Microbiology Critical & Reportable Cultures & Test Results” are communicated to the Epidemiologist, or on-call Epidemiologist 24 hours/7 days a week.
10. Patient’s positive for histories of MDRO are entered into the alert system by Epidemiology. On each subsequent visit to the organization, when the patients chart is opened, an admit alert pops up notifying the provider of the patients history of MDRO infection.
resistant organisms. Note: The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.

8. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multi-drug-resistant organisms. Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both. Note 2: Each organization may define its own parameters in terms of time and clinical manifestation to determine which readmitted patients require isolation.

### NPSG.07.04.01

Implement evidence-based practices to prevent central line–associated bloodstream infections. Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

| 1. | Educate staff and licensed independent practitioners who are involved in managing central lines about central line associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual’s job responsibilities. |
| 2. | Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention. |
| 3. | Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). |
| 4. | Conduct periodic risk assessments for central line associated blood stream infections, monitor compliance with evidence-based practices and evaluate the effectiveness of prevention efforts. These assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital wide, not targeted. |
| 5. | Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. |
| 6. | Use a catheter checklist and a standardized protocol for central venous catheter insertion. |
| 7. | Perform hand hygiene prior to catheter insertion or manipulation. |
| 8. | For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable. |

1. Staff education requirements regarding CLABSI, the importance of preventing CLABSI and infection prevention strategies are included in new hire orientation and the mandatory annual education in Health stream.

2. Patient/Family education is provided using patient FAQ sheets and is documented in the patient chart.

3. CLABSI policies and practices meet applicable regulatory requirements and are aligned with evidence-based standards, professional organization guidelines and best practices.

4. Epidemiology monitors CLABSI infection rates. The NHSN definition of CLABSI is used for surveillance purposes. Epidemiology monitors all central line infections and compliance with CLABSI prevention practices and the findings are reported in the annual assessment of the Infection Control program.

5. Epidemiology provides infection rates monthly to the Infection Prevention and Control Committee, Quality Council and other committees as needed. CLABSI rates and compliance issues that may be identified are communicated on a monthly basis to the Infection Prevention and Control Committee. Any breach in compliance with infection prevention is addressed immediately with the health care provider and nurse manager. All CLABSI infections are discussed with management and administration on a weekly basis to identify lessons learned to prevent in the future.

6-13. BHN utilizes a CLABSI bundle for CVC insertion that addresses all of the evidence based elements of infection prevention including but not limited to: hand hygiene, avoidance of the femoral site, utilization of a central line insertion kit, maximal sterile barrier precautions for inserter as well as assistant, chlorhexidine based antiseptic, disinfection of catheter hubs and injection...
9. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.

10. Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.

11. Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations. * 

   Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency (ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.

13. Evaluate all central venous catheters routinely and remove nonessential catheters.

**NPSG.07.05.01**

Implement evidence-based practices for preventing surgical site infections.

1. Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual’s job responsibilities.

2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.

3. Implement policies and practices aimed at reducing the risk of surgical site infections that meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

4. As part of the effort to reduce surgical site infections:
   - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
   - Select surgical site infection measures using best practices or evidence-based

1. Education regarding SSIs, the importance of preventing SSIs and other infection prevention strategies are based on risk assessments and surveillance findings, and are provided on hire during the orientation process, annually through health stream and when involvement in surgical procedures is added to an individual’s job responsibilities.

2. Educational materials are provided to all surgical patients utilizing approved fact sheets.

3. Evidence based practices outlined in AORN, APIC, SHEA & CDC standards for prevention of SSI’s have been adopted and HAI’s are monitored by the Epidemiology department.

4 & 5. The Epidemiology department closely monitors high volume and high risk procedures. These include but are not limited to colorectal surgeries, hip & knee replacements, Hysterectomies, and all other surgeries. The Epidemiology department follows NHSN guidelines for time frame for surveillance monitoring. Colorectal surgeries and Hysterectomies are reported to NHSN on a monthly basis. Tracking and trending of all surgical site infections is completed by the
**NPSG.07.05.01 cont’d**

Implement evidence-based practices for preventing surgical site infections.

- Monitor compliance with best practices or evidence-based guidelines.
- Evaluate the effectiveness of prevention efforts.

Note: Surveillance may be targeted to certain procedures based on the hospital’s risk assessment.

5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The hospital’s measurement strategies follow evidence-based guidelines.

Note 1: Surveillance may be targeted to certain procedures based on the hospital's risk assessment.

Note 2: The NHSN is the Centers for Disease Control and Prevention’s health care–associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care–associated infections. For more information on NHSN procedural codes, see [http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html](http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html).

6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.

7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.

Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations.

The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency (ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.

Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge.
for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or wide-spread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.

<table>
<thead>
<tr>
<th>NPSG.07.06.01</th>
<th>Implement evidence based practices to prevent catheter associated urinary tract infections (CAUTI)</th>
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<tbody>
<tr>
<td><strong>1.</strong> Educate staff and licensed independent practitioners involved in the use of indwelling urinary catheters about CAUTI and the importance of infection prevention. Education occurs upon hire or granting of initial privileges and when involvement in indwelling catheter care is added to an individual’s job responsibilities. Ongoing education and competence assessment occur at intervals established by the organization.</td>
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<tr>
<td><strong>2.</strong> Educate patients who will have an indwelling catheter, and their families as needed, on CAUTI prevention and the symptoms of a urinary tract infection. Note: See FAQs about “Catheter-associated Urinary Tract Infection” at <a href="http://www.shea-online.org/images/patients/NNL_CA-UTI.pdf">http://www.shea-online.org/images/patients/NNL_CA-UTI.pdf</a>.</td>
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<tr>
<td><strong>3.</strong> Develop written criteria, using established evidence-based guidelines, for placement of an indwelling urinary catheter. Written criteria are revised as scientific evidence changes. Note: Examples of criteria for placement of an indwelling urinary catheter include the following:</td>
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<td>- Critically ill patients who need accurate urinary output measurements</td>
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<td>- Patients with acute urinary retention or bladder outlet obstruction</td>
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<td>- Patients who require prolonged immobilization (for example, a potentially unstable thoracic or lumbar spine or multiple traumatic injuries such as pelvic fractures)</td>
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<td>- Incontinent patients with an open sacral wound or perineal wounds</td>
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<tr>
<td>- Perioperative use for selected surgical procedures, such as patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract; patients who will have a prolonged duration of surgery (catheters inserted for this</td>
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<tr>
<td><strong>1.</strong> Staff is educated upon hire and annually or when job responsibilities are changed to include care of urinary catheters.</td>
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<tr>
<td><strong>2.</strong> Patient/Family education is provided using patient FAQ sheets and is documented in the patient chart.</td>
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<tr>
<td><strong>3.</strong> HOUDINI protocol is utilized.</td>
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</table>
| NPSG.07.06.01 cont’d Implement evidence based practices to prevent catheter associated urinary tract infections (CAUTI) | reason should be removed in a post-anesthesia care unit; patients anticipated to receive large-volume infusions or diuretics during surgery; patients needing intraoperative monitoring of urinary output  
- End-of-life care  
- Neurogenic bladder  
4. Follow written procedures based on established evidence-based guidelines for inserting and maintaining an indwelling urinary catheter. The procedures address the following:  
- Limiting use and duration  
- Performing hand hygiene prior to catheter insertion or maintenance care  
- Using aseptic techniques for site preparation, equipment, and supplies  
- Securing catheters for unobstructed urine flow and drainage  
- Maintaining the sterility of the urine collection system  
- Replacing the urine collection system when required  
- Collecting urine samples  
Note: There are medical conditions that require a prolonged use of an indwelling urinary catheter in order to avoid adverse events and promote patient safety. Examples can include, but are not limited to, patients with a spinal cord injury, multiple sclerosis, Parkinson’s disease, and spina bifida. (See also PC.02.01.01, EP 1)  
5. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:  
- Selecting measures using evidence-based guidelines or best practices  
- Having a consistent method for medical record documentation of indwelling urinary catheter use, insertion, and maintenance (See also RC.01.01.01, EP 7)  
- Monitoring compliance with evidence-based guidelines or best practices  
- Evaluating the effectiveness of prevention efforts  
Note: Surveillance may be targeted to areas with a high volume of patients using indwelling catheters. High-volume areas are identified through the hospital’s risk assessment as required in IC.01.03.01, EP 2. | 4. Procedures are adopted using best practices as outlined by IHI, APIC, SHEA, CDC, etc.  
5. Nurses document in the EMR on insertion, maintenance and need for urinary catheters. Epidemiology utilizes the NHSN definition for CAUTI. Epidemiology monitors for compliance to best practices and evidence based guidelines and evaluates the effectiveness of prevention efforts.  
CY 2018 Epidemiology Accomplishments |
CAUTI-
1. Education on NHSN and surveillance definitions.
2. Epi rounding on maintenance and care related to Foley catheters as well as reminder for removal.
3. Daily rounding by managers. Discussing the need for the Foley catheter and alternatives as appropriate.
5. House wide collection of line days.
8. Peri-care/foley care and CAUTI prevention provided to all staff.

CLABSI-
1. Education on NHSN and surveillance definitions
2. Identified maintenance of central lines to be a contributing factor in CLABSI infection rate at BHN.
3. Communicated with nurse managers and administration during weekly management huddle on lessons learned to prevent CLABSI.
4. Chlorhexidine bathing to all patients with central lines.
5. Manager rounding on the unit questioning the necessity of lines Education through centurion Angel program offered to all nursing. This education provided a competency on central line maintenance including dressing changes.
7. Discussion of CLABSI in multidisciplinary meetings.
8. Curos caps utilized for all central lines. Influenced by the latest guidelines from SHEA regarding the prevention of central line infections.
9. House wide collection of line days.
10. Daily prevalence rounding by Epidemiology.

SSI-
1. Education on NHSN and surveillance definitions.
2. Daily surveillance of cultures to identify any surgical site infections.
3. Multidisciplinary RCA completed for each infection.
5. Participation in investigations.
6. Continued weight based dosing for pre op antibiotics as per evidence based practice.
7. Chlorhexidine bathing for all inpatient procedures the night before and morning of.
8. Tracking and trending of all surgical site infections.
9. Monitoring of glucose in all patients pre-operative, intra-operative and post-operative.

VAE-
1. Education in NHSN and surveillance definitions.
2. Unit based in-services completed.
3. Surveillance through rounding (both Epi and managers) observing for compliance to VAP bundles.
4. Multidisciplinary meetings when upward trend identified.

**Education**
1. CDC education on NHSN definitions by Epidemiology staff.
2. Nursing Grand Rounds conducted by Dr. Gopal July 2018 on MDRO and Antimicrobial Stewardship.
3. Ongoing education for CAUTI, CLABSI, MRSA bacteremia, C.diff, SSI prevention through HEN.

**Clostridium Difficile & MDROs**

1. EVS in-services.
2. Use of Medmined data mining system to capture any trends related to MDRO’s and CDI.
3. Recognizing the importance of antimicrobial stewardship in decreasing the rates of MDROs, the Epidemiology Department continues to work with Pharmacy.
4. Continued to implement Transmissions-Based Precautions and Standard Precautions, Hand Hygiene education, MDRO admission alerts, and frequent communication between clinical and nursing departments and Epidemiology.
5. Continued use of Respiratory Viral Panel/Biofire technology to decrease antibiotic use when viruses are identified.

**Policies and committees**


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**Surgical Services Report**

*(run from Discern Analytics)*

**CY 2018**

<table>
<thead>
<tr>
<th>Location of Patient</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>50</td>
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<tr>
<td>Outpatient</td>
<td>1685</td>
</tr>
<tr>
<td>Inpatient</td>
<td>4170</td>
</tr>
<tr>
<td>SSP</td>
<td>705</td>
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</table>

<table>
<thead>
<tr>
<th>Types of Surgery</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean (Class I)</td>
<td>4449</td>
</tr>
<tr>
<td>Clean-Contaminated (Class II)</td>
<td>1283</td>
</tr>
<tr>
<td>Contaminated (Class III)</td>
<td>417</td>
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<tr>
<td>Infected (Class IV)</td>
<td>465</td>
</tr>
<tr>
<td>Total Surgeries</td>
<td>6,614</td>
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</table>

**Top 12 Surgical Procedure 2018**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Count</th>
<th>Procedure</th>
<th>Count</th>
<th>Procedure</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replacement Total Hip Anterior</td>
<td>518</td>
<td>Creation AV Fistula</td>
<td>148</td>
<td>Insertion Catheter Hemodialysis</td>
<td>121</td>
</tr>
<tr>
<td>Vitrectomy</td>
<td>362</td>
<td>ORIF Hip Nail</td>
<td>148</td>
<td>Laporscopic Cholectectomy Cholangio</td>
<td>109</td>
</tr>
<tr>
<td>Incision &amp; Drainage</td>
<td>194</td>
<td>Exploratory Laparotomy</td>
<td>136</td>
<td>Fusion Anterior Cervical Discectomy</td>
<td>108</td>
</tr>
<tr>
<td>Replacement Total Knee</td>
<td>190</td>
<td>Cysto Ureteroscopy Stent Insertion</td>
<td>130</td>
<td>Ballon Angioplasty</td>
<td>101</td>
</tr>
</tbody>
</table>
PURPOSE: Broward Health has developed and implemented an effective system-wide Infection Prevention and Control Program for the surveillance, prevention and control of infection. This is the BHN specific addendum to the plan.

1. Description of Population

BHN is a 409 bed Adult Level II Trauma Center located in Deerfield Beach, in the northeast section of Broward County, Florida providing tertiary care across a continuum of services from inpatient, outpatient, emergency, rehabilitation, and select community health services. Patient populations include: medical-surgical specialties and subspecialties including but not limited to trauma, intensive care, cancer, orthopedic, neurology, renal, pulmonary, diagnostics, endoscopy, wound care, hyperbaric oxygen treatment, stroke and oncology. The facility’s close proximity to Interstate-95, commuter railroad service, adult retirement communities, skilled nursing and assisted living facilities, universities, detention centers, and homeless shelters have a direct influence with individuals needing or seeking medical attention.

Per fiscal year 2018 statistics, our overall payor mix was Medicare 14.3 %, Medicaid 3.2%, Managed Care HMO/PPO Medicare 15.3%, HMO Medicaid 15.9%, Managed Care HMO Other/PPO 22.4%, Commercial/WC/H 4.4%, Self Pay 18.3%, Charity 6.2%

In 2018 the median age of population served is forty years to forty nine years of age and the average household income was $66,243- $99,999. An increase of 5.3% in population is predicted between 2018-2023.

According to the Broward County Health Department, there are high numbers of infectious diseases reported. These primarily include: HIV/AIDS, Hepatitis C, STDs, and tuberculosis. BHN encounters a low rate of patients diagnosed with tuberculosis. The community rate of tuberculosis as of 2017 was 3.2
per 100,000 people which increased from 3.1100,000 in 2016. For CY 2017, BHN saw a rate of 14.43 per 100,000 patients; 2 confirmed cases of MTB/13,857 admissions per 100,000. In CY 2018, 3 confirmed cases of MTB 3/13507 admissions per 100,000 with a rate of 22.20. This may be attributed to the area’s large international community as well Broward County’s Port Everglades and Fort Lauderdale International airport. A stringent TB program is in place at BHN to aid in early diagnosis and to prevent the spread of TB in the facility (See TB Risk)

The top ten principle surgical procedures performed in CY 2018 were: replacement total hip anterior, vitrectomy, balloon angioplasty, replacement total knee, creation of AV fistula, fusion anterior cervical spine, microdiskectomy cervical, open reduction internal fixation hip nail, and insertion of IV access catheter, Exploratory Laparotomy.

The top ten principle diagnoses in CY 2018 were: pneumonia, urinary tract, acute kidney failure, sepsis, unilateral primary osteoarthritis, hypertensive heart disease, chronic obstructive pulmonary disease, cerebral infarction, non ST elevation.

The top ten Emergency Department principle diagnoses in CY 2018 were: unspecified abdominal pain, acute upper respiratory insufficiency, urinary tract infection, headache, bronchitis, essential (primary) hypertension, vomiting, acute pharyngitis, chest pain, dizziness, low back pain.

Conditions such as cancer, indwelling medical devices, disorders that affect the immune system, HIV/AIDS, alcoholism, drug abuse and renal disease can also increase the risk of an individual’s risk for acquiring infections.

II. SCOPE OF PROGRAM
A. Broward Health North (BHN) is a full service 409 bed facility that provides a continuum of care and includes a variety of inpatient, outpatient, rehabilitative, emergency services and select community health services.
B. Patient populations include: medical-surgical specialties including but not limited to: trauma, medical surgical, intensive care, cancer and blood dycrasias, cardiac and interventional services, orthopedics, neurology.
C. Services provided at BHN include but not limited to:
Adult Care:
Inpatient Rehabilitation
Outpatient Rehabilitation
Cancer Center
Neurological Institute
Interventional Radiology
Outpatient Radiology
Emergency Department
Joint Replacement
Spine Center
Memory Center
Sleep Center
Women’s Center
Stroke Center
Level 2 Trauma
Inpatient Dialysis
Respiratory Services
Community Health Services
Wound Care/Bariatric Center
III. At Risk Patient Populations:
A. The Infection Control Committee at Broward Health North has identified the following patient populations as being at a higher risk for health care associated or transmissible community acquired infections:
   1. Trauma patients
   2. Patients undergoing surgical and invasive procedures
   3. Patients undergoing vascular access procedures
   4. Patients undergoing mechanical ventilation
   5. Patients with significant pathogens (i.e., multi-drug resistant organisms, C.difficile)
   6. Patients with urinary catheters
   7. Patients admitted through our International Program
   8. Immunocompromised patient (Cancer, HIV/AIDS, Sickle Cell
   9. Patients with chronic conditions with recurrent hospitalizations (i.e., CHF, COPD)

IV. Roles and Responsibilities of the Infection Prevention and Control Committee:
The ICC is a multidisciplinary committee with representation from but not limited to Medical Staff, Executive Leadership, Employee Health, Nursing, Surgical Services, Ancillary staff, Allied Health, Pharmacy, Laboratory, Surgical Services, Facilities Management and Community Health Services. The role of the ICC is to oversee the BHN Infection Prevention and Control Program.
B. Responsibilities of the Infection Control Committee include but are not limited too the following:
   1. Reviews surveillance data finding (include trends in infections, clusters, infections due to unusual pathogens or any occurrence of hospital acquired infections) and facilitates the allocation of resources needed to access information, supplies, equipment, and laboratory services.
   2. Initiates recommendations based on mandatory reporting data, surveillance findings, epidemiological investigations, and performance indicator trends.
   4. Reports, reviews and makes any necessary recommendations for the Infection Control Risk Assessment (ICRA) as require for construction/renovation projects as needed.
   5. Approves the IPC program’s annual evaluation of the plan, infection control plan revisions, and reviews new/revised policies annually.
   6. The Committee, through the IP, keeps abreast of regulatory guidelines/standards related to infection control.
7. All hospital departments are encouraged to participate in the ICC and contribute to the infection control and prevention objectives of the program.
8. Infections of epidemiologic significance among employees are reported along with any control measures instituted, followed up required or cases of secondary spread.

V.: Objectives:
Objectives for the Epidemiology Department are as follows;
Please see appendix A- Goals and Objectives CY 2019

VI.: References:
1. CDC, Template for State Healthcare Associated Infections Plans 2010
   The Joint Commission Infection Prevention and Control Standards

   Organizations references:
   1. Centers for Disease Control and Prevention
   2. The Association for Professionals in Infection Control and Epidemiology, Inc (APIC)
   3. Association of Peri-Operative Registered Nurses (AORN)
   4. Association for the Advancement of Medical Instrumentation (AAMI)
   5. The Society for Healthcare Epidemiology of America (SHEA)

Related Policies:
Broward Health Infection Control Plan (System), Broward Health Epidemiology and Department Specific Infection Control Policies

Authors: Broward Health North
Reviewed/Approved by: BHN Infection Control Committee Date: ________
CNO Date: ________
CEO Date: ________
Appendix A

Goals and Objectives CY 2019

*Based on Risk Assessment of Events
*Will review monthly
*Target goals based on 10% reduction in harm events from LCY and VBP achievement threshold using NHSN SIR data.

Hospital Acquired Infection (HAI)/Admission Related Risks

Goal # 1: Overall reduction of hospital acquired infections.

*Pareto Analysis reveals Central Line Associated Blood Stream Infection (CLABSI), Surgical Site Infection (SSI), both constitute the highest risk percent at 61% each in the HAI/Admission risk portion of the risk assessment. The top 5 risks identified in the Pareto analysis were, central line blood stream infection (CLABSI), surgical site infections, Multi Drug Resistant Organism (MDRO), catheter associated urinary tract infection (CAUTI), Ventilator Associated Event. All HAI are of concern and we strive in chasing zero.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
</table>
| SSI | Patients who had surgery | 1. Determine risk factor for HAI  
2. Decrease HAI  
3. Decrease sepsis  
4. Continue participating in FHA HIIN  
5. SSI PI team | BHN target rates:  
I: 0.11  
II: 0.20  
SIR:  
hyst: 0.762  
colo: 0.783 | IP  
Nurses  
Physicians  
Pharmacists | 1. Monitor infection rates for all class I and II surgeries and report to appropriate stakeholders.  
2. Monitor COLO and HYST infections and report to NHSN and stakeholders.  
3. Daily surveillance of ER log, admission log, micro reports, OR schedule.  
4. Weight based dosing for antibiotics, re-dosing as necessary.  
5. MRSA screening tool for high risk patients to receive Vancomycin for prophylaxis.  
7. Discuss each SSI weekly in huddle with management and administration to determine lessons learned.  
8. CHG wash night before and morning of surgery.  
SSI PI team led by general surgeon.  
10. Review temperatures post operatively  
11. Review for adequate O2 saturation post op |
|----|-------------------------|---------------------------------|------------------|----------------|--------------------------------------------------|
| MDRO (including MRSA bacteremia) and CDIFF | All patients | 1. Determine risk factor for HAI  
2. Decrease HAI  
3. Decrease sepsis  
4. Continue participating in FHA HIIN  
5. Decrease readmissions | BHN Target Rates  
MRSA: 0.37  
VRE: 0.07  
CRE: 0.04  
RAS: 0.0  
ESBL k. pneumo: 0.09  
ESBL e.coli: 0.08  
RPsued: 0.00  
CDIFF: 2.71  
SIR  
MRSA bac: 0.854  
CDIFF: 0.924 | IP  
Nurses  
Physicians  
Pharmacists | 1. Daily review of surveillance including admission log, ER log, and microbiology results/monitor labs, identify and verify infections, analyze data.  
2. Utilize MedMined data mining program to assist with identifying potential clusters  
3. Review antibiogram and discuss at IPCC and Antimicrobial Stewardship committee  
4. Continue active surveillance for CRE in international patients who were hospitalized >48 hours prior to admission.  
5. Continue contact precautions for active infection and 3 month history of infection.  
6. Utilize Respiratory Viral Panel (Biofire) to prevent antibiotics for viruses. |
<table>
<thead>
<tr>
<th></th>
<th>Inpatients with Foley catheters</th>
<th>BHN target rate:</th>
<th>IP</th>
<th>Respiratory Nurses Physicians Pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Determine risk factor for HAI</td>
<td>0.36</td>
<td>IP</td>
<td>Nurses Physicians Pharmacists</td>
</tr>
<tr>
<td>1.</td>
<td>Decrease HAI</td>
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<td>2.</td>
<td>Decrease sepsis</td>
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<tr>
<td>3.</td>
<td>Continue participating in FHA HIIN</td>
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<td>4.</td>
<td>Decrease Foley catheters</td>
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<td>5.</td>
<td>Decrease Foley catheter removal</td>
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<td></td>
<td>CAUTI</td>
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<td></td>
<td>VAE</td>
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<tr>
<td>1.</td>
<td>Determiner risk factor for HAI</td>
<td></td>
<td>IP</td>
<td>Nurses Physicians Pharmacists</td>
</tr>
<tr>
<td>1.</td>
<td>Decrease HAI</td>
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<tr>
<td>2.</td>
<td>Decrease sepsis</td>
<td></td>
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<tr>
<td>3.</td>
<td>Continue participating in FHA HIIN</td>
<td></td>
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<tr>
<td>4.</td>
<td>Decrease vent days</td>
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<td>5.</td>
<td>Decrease vent days</td>
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<tr>
<td>6.</td>
<td>Prospective surveillance of vent settings</td>
<td></td>
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</tr>
<tr>
<td>1.</td>
<td>IP rounds facility wide</td>
<td></td>
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<tr>
<td>2.</td>
<td>Daily surveillance to monitor labs, identify and verify infections, analyze data.</td>
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<td>3.</td>
<td>Collect patient demographic data, line days</td>
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<td>4.</td>
<td>Identify risks, assess daily need/removal</td>
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<td>5.</td>
<td>Nurse driven catheter removal protocol with order</td>
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<td>7.</td>
<td>Nurse driven action plans.</td>
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<tr>
<td>8.</td>
<td>Education, HIIN.</td>
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<tr>
<td></td>
<td>Discuss each CAUTI in weekly huddles with management and administration to determine lessons learned.</td>
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<td></td>
</tr>
<tr>
<td>1.</td>
<td>Determine risk factor for HAI</td>
<td></td>
<td>IP</td>
<td>Respiratory Nurses Physicians Pharmacists</td>
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<tr>
<td>1.</td>
<td>Decrease HAI</td>
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<tr>
<td>2.</td>
<td>Decrease sepsis</td>
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<tr>
<td>3.</td>
<td>Continue participating in FHA HIIN</td>
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<tr>
<td>4.</td>
<td>Decrease vent days</td>
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<td></td>
<td>VAE</td>
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<td>Decrease sepsis</td>
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<tr>
<td>3.</td>
<td>Continue participating in FHA HIIN</td>
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<td>4.</td>
<td>Decrease vent days</td>
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<tr>
<td>5.</td>
<td>Decrease vent days</td>
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<td>VAE</td>
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<td>1.</td>
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<td>Decrease vent days</td>
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<td>6.</td>
<td>Prospective surveillance of vent settings</td>
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</tr>
<tr>
<td>1.</td>
<td>IP rounds facility wide</td>
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<tr>
<td>2.</td>
<td>Utilize NHSN definition and report to appropriate stakeholders.</td>
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<tr>
<td>3.</td>
<td>Educate staff on best practices.</td>
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<tr>
<td>4.</td>
<td>IP rounds facility wide to ensure VAP bundle compliance.</td>
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<tr>
<td></td>
<td>Multidisciplinary approach with physicians and respiratory and nursing.</td>
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</tbody>
</table>
Other Identified Events:

Active TB, unknown at time of admission
1. All patients with signs and symptoms or questionable TB disease may be placed on airborne isolation by nursing without a physician’s order per airborne isolation policy.
2. Reeducation of nursing and physicians mandatory ED assessment for potential TB.

Notification of Community Acquired Infections
1. Continue to utilize admit alert system and communicate with nursing and outside facilities as needed when patient admitted with a community acquired infection.

Outbreak
1. Monitor daily surveillance for any unusual organisms or clusters of organisms.
2. Initiate infection control measures based on CDC or other evidence based recommendations.
2. Consult with Florida Department of Health as necessary.
3. Educate healthcare staff on organism identified in outbreak and measures to prevent spread of further infections.
4. Utilize Outbreak procedure policy during any outbreak identified.
5. Report clusters/outbreaks to necessary stakeholders and committees.

Notification of Internal HAIs
1. Continue to utilize admit alert system and communicate with internal departments and bed control as needed when patient is admitted or transferred in the hospital with an MDRO.
2. Utilize HAS report system to track and trend occurrences and follow up with managers and conduct education as needed.

Healthcare Worker Risks
Goal #2: Reduction of healthcare worker risk of infection secondary to injury and/or exposure.
*Pareto Analysis reveals non-compliance with hand hygiene and noncompliance with Seasonal Flu Immunization
as the two top highest risk for healthcare worker related risks. The rest of the top 5 risks identified in the Pareto analysis were failure to follow protocols and use of Safety Devices, Noncompliance with Isolation Precautions and Sharps Injuries. All risks to healthcare workers are followed by both Employee Health and Epidemiology.

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-compliance with hand hygiene</td>
<td>All employees, physicians, students, volunteers</td>
<td>Strive for 100% of hand hygiene compliance.</td>
<td>BHN target: 90% or greater</td>
<td>IP Administration</td>
<td>1. Monitor compliance in all areas of hospital.</td>
</tr>
<tr>
<td></td>
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<td>2. Hand Hygiene Poster campaign Compliance reported at monthly IPCC.</td>
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<td>3. Just in time education and reinforcement</td>
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<td></td>
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<td></td>
<td>4. Hand Hygiene education at New Hire Orientation</td>
</tr>
<tr>
<td>Non-compliance with seasonal flu immunization</td>
<td>All employees, physicians, students, volunteers</td>
<td>Increase compliance by 10% each year until 90% goal of 2020.</td>
<td>The 2018/2019 rate is %.</td>
<td>IP EH Administration</td>
<td>1. Collaborate with corporate on plan on influenza vaccination including mandatory masking and health insurance incentive.</td>
</tr>
<tr>
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<td></td>
<td>2. Educate personnel on importance of immunization during rounds, general orientation, and nursing orientation.</td>
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<td>3. Provide onsite influenza vaccination to all staff at no cost.</td>
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<td>4. Flu vaccine declination forms must be signed. Physician documentation for contraindication.</td>
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<td></td>
<td></td>
<td>5. Administration support</td>
</tr>
<tr>
<td>Failure to follow protocols and use safety devices or PPE</td>
<td>All employees, physicians, students, volunteers</td>
<td>Decrease needle sticks, splashes, other preventable exposures.</td>
<td>BHN target: 90%</td>
<td>IP EH</td>
<td>1. IP rounds to reinforce protocols, use of safety devices, proper PPE.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Revised isolation signs to standardize with rest of Broward Health. Signs to include new recommendations for transport of patients on isolation as</td>
</tr>
</tbody>
</table>
Other Identified Events:

Sharps Injuries
1. Sharps injuries monitored by Employee Health. EH Continue to monitor and report to IPCC and EoC.

Non-compliance with standard precautions
1. Continue to educate nursing at orientation and periodically on standard precautions according to policy.

Employee Knowledge Deficit of Disease Transmission and Prevention
1. Coordinate with Clinical Education on utilization of the Need-2-know forum.
2. Continue to present relevant education on disease transmission in nursing orientation.
3. Provide real time education with rationale

Failure to recognize employee outbreak
1. Utilize HAS reports with risk management, Patient and Medication Safety meeting, and Nurse Practice Council to address any staff infection control issues.
2. IP rounds daily to talk with staff.

Delay in Proper Isolation Precautions
1. Patients placed on isolation by nursing, but it has been observed that there are times where there is no order for isolation in the patients chart. Infection control and Clinical Education to educate all nursing on the need to place order for isolation in computer system.
2. Daily review of isolation log. Will educate nursing on a case by case basis on the requirements for isolation.

Annual fit testing not completed
1. Coordinate with Employee Health

**Community**
Goal # 3: Reduction of community risk.

*Pareto analysis reveals long term care patients constitute the highest risk percent at 61% for community related risks. The rest of the top 4 risks identified in the Pareto Analysis were community acquired MDROs, emerging Infectious Disease and Seasonal Flu. All risks from the community are evaluated and Epidemiology works closely with the Health Department.*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
</table>
| Long term patients                             | All patients        | BHN has nearby high admitting SNFs.                                   | Length of stay      | IP Nursing Case management Physicians | 1. Any infections identified communicate with manager and discussed at weekly huddle.  
2. Active surveillance for incoming patients include blood and urine cultures as indicated. |
| Community acquired MDRO                        | All patients        | Identify community onset infections for prompt isolation. Placing patients on transmission based precautions. | BHN target: 90%     | IP Nursing Physicians Case management | 1. Identification of patients through daily surveillance admitted with MDROs and alert tab.  
2. Assess staff need for education.  
3. Active surveillance for CRE in international patients who were hospitalized >48 hours.  
4. Communication with SNF and LTC admitters. Education for staff and physicians about HO and CO cdiff and mrsa bacteremia to catch community onset MDRO. |
| Emerging infectious disease/other epidemics/influx of infectious patients | All patients        | BHN will be prepared for an emerging infectious disease or influx of | EM Drills 100%      | IP ED EP Nursing                      | 1. Continue utilizing infectious disease screening tool for all patients during triage to screen for all potentially infectious patients.  
<table>
<thead>
<tr>
<th>Event</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seasonal flu and pandemic flu</td>
<td>BHN will offer influenza vaccination to all qualified patients.</td>
</tr>
<tr>
<td></td>
<td>BHN target 90% 90% by 2020 with a 10% increase each year</td>
</tr>
<tr>
<td></td>
<td>IP Nursing Quality</td>
</tr>
<tr>
<td></td>
<td>1. Inpatients vaccinated during flu season per Centers for Medicaid and Medicare Services (CMS) protocol unless contraindicated.</td>
</tr>
<tr>
<td></td>
<td>3. Patients with influenza placed on Droplet isolation precautions per policy.</td>
</tr>
<tr>
<td></td>
<td>4. If pandemic flu, work with Florida Department of Health and Emergency Preparedness.</td>
</tr>
</tbody>
</table>

**Other Identified Events**

**Displaced person**
1. Work with case management and social services to assist in timely discharge of patients with hospital acquired infections or multi drug resistant organisms as needed.

**Active TB admissions**
1. Continue to follow IC TB Plan.

**HIV/AIDS**
1. Continue to work with Florida Department of Health as necessary.

**Bioterrorism/Ebola and Hemorrhagic Fever Diseases**
1. Work with Emergency Preparedness with drills and PPE training.
2. Communicate with Florida Department of Health as necessary
3. Continue with established drills and EM updates and education.

**Flood**
2. Yearly hurricane drills.

**Waterborne Outbreak**
1. Work with facilities and consultant to identify risks in water management system.
2. Utilize CDC Legionella risk assessment.

Report to Florida Department of Health as necessary.

**Food Associated Outbreaks**
1. Adhere to established outbreak policy and procedure for outbreak management.
2. Continue to report positive cultures to Florida Department of Health.

**Environmental Risks**
Goal #4: Reduction of environmental risk.

*Pareto analysis reveals improper cleaning as the highest risk percent at 26%. The remaining top 4 risks identified in the Pareto Analysis were:*, improper disinfection of equipment, Improper Sharps handling, Improper Disinfection of Equipment and Improper Handling of Biohazard Waste and improper handling of biohazardous waste, Inadequate compliance with IC Preconstruction

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper environmental cleaning</td>
<td>EVS staff</td>
<td>Compliance with proper cleaning protocols and products.</td>
<td>BHN target: 90%</td>
<td>EVS</td>
<td>1. Partnership with epidemiology and EVS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. EVS maintains pivotal role in Infection Prevention and Control Committee.</td>
</tr>
<tr>
<td>Improper sharps handling</td>
<td>All staff</td>
<td>Reduce incidence of employee injury due to improper sharps handling.</td>
<td>BHN target: 90%</td>
<td>All employees</td>
<td>Education at general orientation by EH and Epi.</td>
</tr>
<tr>
<td>Improper disinfection of equipment</td>
<td>All staff</td>
<td>Compliance with proper disinfection protocols and products.</td>
<td>BHN target: 90%</td>
<td>All employees</td>
<td>1. IP rounds and educates on PDI wipe products.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Education on hospital approved disinfectants in general orientation,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>nursing orientation, in-services, during rounding</td>
</tr>
<tr>
<td>Improper handling of biohazardous</td>
<td>All staff</td>
<td>Reduce misuse of red bag biohazard waste</td>
<td>BHN target: 90%</td>
<td>All employees</td>
<td>1. EoC rounds to check biohazard waste.</td>
</tr>
<tr>
<td>waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. DoH inspections.</td>
</tr>
</tbody>
</table>
Inadequate compliance with IC Preconstruction | All staff | Compliance | BHN target: 90% | Contracted staff | 1. Daily rounds on preparation of Construction area.  
2. Report findings to Facilities Manager/Project Director

Other Identified Events
Improper Sterilization or High Level Disinfection of Equipment
1. Central processing department to monitor biological pass/fail. Monthly report sent to IC. IC to be identified immediately of failed biological. Procedure for failed biological to be carried out per policy.
2. Immediate use steam sterilization report sent monthly to Infection Control by Central Processing Department
3. Infection Control to investigate any cases reported of improper sterilization.
4. Locations of HLD in house:
   a. Trophon EPR for high level disinfection (HLD) of vaginal probes.
   b. Steris Resert for HLD of TEE probes and specific types of video laryngoscope parts.
   c. Olympus automatic endoscope reprocessor (AER) for endoscopes and bronchoscopes.

Failure of Negative Pressure Ventilation
1. Adhere to existing process for failure of negative pressure ventilation. Refer to Infection Control Policy # 21 Isolation Room Checks.
2. Facilities to ensure compliance with monthly temp and humidity measures in surgical environment per standards.

Inadequate Supplies of PPE:
1. Materials management responsible for par levels of PPE for each nursing unit.

Organizations referenced:
- Centers for Disease Control and Prevention (CDC)
- The Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)
- Association of Peri-Operative Registered Nurses (AORN)
- Association for the Advancement of Medical Instrumentation (AAMI)
- The Society for Healthcare Epidemiology of America (SHEA).
**Tuberculosis (TB) risk assessment worksheet CY 2019**

This model worksheet should be considered for use in performing TB risk assessments for health-care facilities and nontraditional facility-based settings. Facilities with more than one type of setting will need to apply this table to each setting.

<table>
<thead>
<tr>
<th>Scoring</th>
<th>√ or Y = Yes</th>
<th>X or N = No</th>
<th>NA = Not Applicable</th>
</tr>
</thead>
</table>

### 1. Incidence of TB

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.

**Broward County**

|-----------------|------------|------------|------------|

|-------------|------------|------------|------------|

|----------------|------------|------------|------------|

| Facility rate: CY 2018 | # of confirmed diagnosed cases of TB/number of admissions | 3/13,509 = 22.20 per 100,000 patients | 3/13,857 = 14.43 per 100,000 patients 2017 |
|------------------------|------------------------------------------------|---------------------------------|

Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?

- Yes

If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)?

Review laboratory data, infection-control records, and databases containing discharge diagnoses.

<table>
<thead>
<tr>
<th>Suspected</th>
<th>Confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018: 38</td>
<td>3</td>
</tr>
<tr>
<td>2017: 30</td>
<td>2</td>
</tr>
<tr>
<td>2016: 16</td>
<td>6</td>
</tr>
</tbody>
</table>

Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?

- No

### 2. Risk Classification

**Inpatient settings**

<table>
<thead>
<tr>
<th>How many inpatient beds are in your setting?</th>
<th>409</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How many patients with MTB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.</th>
<th>CY 2018: 3</th>
<th>CY 2017: 2</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Depending on the number of beds and TB patients encountered in 1 year, what</th>
<th>In CY 2018, there were</th>
</tr>
</thead>
</table>
is the risk classification for your inpatient setting (≥200 beds)? (See Appendix C.)

According to the CDC guidelines 2005, a “low risk” facility has less than 6 TB patients a year. A “medium risk” facility has greater than or equal to 6 confirmed cases of tuberculosis annually.

<table>
<thead>
<tr>
<th>Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

### 3. Screening of HCWs for *M. tuberculosis* Infection

<table>
<thead>
<tr>
<th>Does the health-care setting have a TB screening program for HCWs?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, which HCWs are included in the TB screening program? (Check all that apply.)</td>
<td>✓ Janitorial staff ✓ Maintenance or engineering staff ✓ Transportation staff ✓ Dietary staff ✓ Receptionists Trainees and students (Medical students-under GME; Nursing and Allied under Learning/Nursing department. Records and compliance are managed by the above departments) ✓ Volunteers o Others</td>
</tr>
<tr>
<td>Is baseline skin testing performed with two-step TST (Tuberculin Skin Test) for HCWs?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is baseline testing performed with QFT (Quantiferon) or other BAMT (Blood Assay for Mycobacterium Tuberculosis) for HCWs?</td>
<td>No</td>
</tr>
<tr>
<td>How frequently are HCWs tested for <em>M. tuberculosis</em> infection?</td>
<td>Annually during their anniversary hire period.</td>
</tr>
<tr>
<td>Are the <em>M. tuberculosis</em> infection test records maintained for HCWs?</td>
<td>Yes</td>
</tr>
<tr>
<td>Where are the <em>M. tuberculosis</em> infection test records for HCWs maintained?</td>
<td>Employee Health Department</td>
</tr>
<tr>
<td>If the setting has a serial TB screening program for HCWs to test for <em>M. tuberculosis</em> infection, what are the conversion rates for the previous years?</td>
<td>Increased. Although the percentages were up and down over the last five years, the numbers are below the threshold.</td>
</tr>
</tbody>
</table>

† 2018: 0.2%  (2017): 0.7%  (2016): 0.3%  (2015): 0.3%  (2014): 0.1%
Do any areas of the health-care setting (e.g., waiting rooms or clinics) or any group of HCWs (e.g., lab workers, emergency department staff, respiratory therapists, and HCWs who attend bronchoscopies) have a test conversion rate for *M. tuberculosis* infection that exceeds the health-care setting’s annual average?

<table>
<thead>
<tr>
<th>Do any areas of the health-care setting (e.g., waiting rooms or clinics) or any group of HCWs (e.g., lab workers, emergency department staff, respiratory therapists, and HCWs who attend bronchoscopies) have a test conversion rate for <em>M. tuberculosis</em> infection that exceeds the health-care setting’s annual average?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. While not above the annual average, there were two conversions this year that represents a decrease from the previous year. None were involved in an exposure at the hospital. All worked in different departments including non-clinical.</td>
</tr>
</tbody>
</table>

For HCWs who have positive test results for *M. tuberculosis* infection and who leave employment at the health setting, are efforts made to communicate test results and recommend follow-up of latent TB infection (LTBI) treatment with the local health department or their primary physician?

<table>
<thead>
<tr>
<th>For HCWs who have positive test results for <em>M. tuberculosis</em> infection and who leave employment at the health setting, are efforts made to communicate test results and recommend follow-up of latent TB infection (LTBI) treatment with the local health department or their primary physician?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes. New hire positive skin test results are screened with a chest x-ray and are referred to their PCP or community resource for evaluation of latent TB status. This is required by day 30 after first day of employment. Employees who converted are seen by an ID physician through workers comp. If employees are terminated before they are seen and evaluated, a letter is sent by employee health to follow up with workers comp, private primary care physician or their new employee health department. Exposure follow up for employees who were terminated before the 10th week of follow up are notified by letter to follow up with their PCP or new employee health department.</td>
</tr>
</tbody>
</table>

### 4. TB Infection-Control Program

<table>
<thead>
<tr>
<th>Does the health-care setting have a written TB infection-control plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes – in the Infection Control Plan and a Broward Health policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who is responsible for the infection-control program?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman of Infection Control Committee.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When was the TB infection-control plan first written?</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/05</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When the TB infection-control plan was last reviewed or updated?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., &gt;1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of <em>M. tuberculosis</em>)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, which groups are represented on the infection-control committee? (Check all that apply.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Nurses</td>
</tr>
<tr>
<td>Epidemiologists</td>
</tr>
<tr>
<td>Engineers</td>
</tr>
<tr>
<td>Pharmacists</td>
</tr>
<tr>
<td>Nutritional staff</td>
</tr>
<tr>
<td>Laboratory personnel</td>
</tr>
<tr>
<td>Health and safety staff</td>
</tr>
<tr>
<td>Administrator</td>
</tr>
<tr>
<td>Risk assessment</td>
</tr>
<tr>
<td>Quality control (QC)</td>
</tr>
<tr>
<td>Environmental staff</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Facilities management</td>
</tr>
</tbody>
</table>

### 5. Implementation of TB Infection-Control Plan Based on Review by Infection-Control Committee

<table>
<thead>
<tr>
<th>Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes. Dr. Indulekha Gopal, Infection Control Committee Chairman</td>
</tr>
</tbody>
</table>

3 of 7
Based on review of the medical records, what is the average number of days for the following:

- Presentation of patient until collection of specimen: 1 day
- Specimen collection until receipt by laboratory: 1 day
- Receipt of specimen by laboratory until smear results are provided to healthcare provider: 1 day
- Diagnosis until initiation of standard antituberculosis treatment: 1 day
- Receipt of specimen by laboratory until culture results are provided for healthcare provider: 1 day
- Receipt of drug susceptibility results until adjustment of antituberculosis treatment, if indicated (can take up to a few weeks): 1 day
- Admission of patient to hospital until placement in airborne infection isolation (AII): 1 day

Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized? Review of laboratory results, outbreak investigations and other means of surveillance.

What mechanisms are in place to correct lapses in infection control? Process improvements, outbreak investigation, literature search, multidisciplinary team work, reporting through committee process within the facility.

Based on measurement in routine QC (Quality Control) exercises, is the infection-control plan being properly implemented? Yes

Is ongoing training and education regarding TB infection-control practices provided for HCWs? Yes

### 6. Laboratory Processing of TB-Related Specimens, Tests, and Results Based on Laboratory Review

<table>
<thead>
<tr>
<th>Test Type</th>
<th>In-house</th>
<th>Sent out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid-fast bacilli (AFB) smears</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Culture using liquid media (e.g., Bactec and MB-BacT)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Culture using solid media</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Drug-susceptibility testing</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nucleic acid amplification (NAA) testing</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Does the laboratory at your health-care setting or the reference laboratory used by your health-care setting report AFB smear results for all patients within 24 hours of receipt of specimen? What is the procedure for weekends? Yes. The same process is utilized on nights and weekends as regular business hours. Laboratory will page the on call Epidemiologist to communicate positive AFB results outside of normal business hours.

### 7. Environmental Controls

Which environmental controls are in place in your health-care setting? (Check all that apply and describe)

Environmental control
- ✓ All rooms
- ✓ Local exhaust ventilation (enclosing devices and exterior devices)
- ✓ General ventilation (e.g., single-pass system, recirculation system.)
- ✓ Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] filtration and ultraviolet germicidal irradiation [UVGI])

What are the actual air changes per hour (ACH) and design for various rooms in the setting?

- Med Surge/Telemetry: 6 ACH
- Emergency Department: 12 ACH
Operating Rooms: 20 ACH  
All Rooms: 12 ACH  
Cath Lab: 15 ACH  
Bronchoscopy Room (in GI suite): 12 ACH  
Endoscopy Rooms – 12 ACH  
Interventional Radiology Procedure Room - 15 ACH

<table>
<thead>
<tr>
<th>Rooms</th>
<th>ACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Rooms</td>
<td>20</td>
</tr>
<tr>
<td>All Rooms</td>
<td>12</td>
</tr>
<tr>
<td>Cath Lab</td>
<td>15</td>
</tr>
<tr>
<td>Bronchoscopy Room</td>
<td>12</td>
</tr>
<tr>
<td>Endoscopy Rooms</td>
<td>12</td>
</tr>
<tr>
<td>Interventional Radiology Procedure Room</td>
<td>15</td>
</tr>
</tbody>
</table>

Which of the following local exterior or enclosing devices such as exhaust ventilation devices are used in your health-care setting? (Check all that apply)
- ✓ Laboratory hoods
- ✓ Booths for sputum induction

What general ventilation systems are used in your health-care setting? (Check all that apply)
- ✓ Single-pass system
- ✓ Constant air volume (CAV)
- ✓ Recirculation system

What air-cleaning methods are used in your health-care setting? (Check all that apply)
- ✓ HEPA filtration
- ✓ Fixed room-air recirculation systems

<table>
<thead>
<tr>
<th>Rooms</th>
<th>ACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>MICU room #1</td>
<td></td>
</tr>
<tr>
<td>PACU Room # 16</td>
<td></td>
</tr>
<tr>
<td>Rm: 363</td>
<td></td>
</tr>
<tr>
<td>RM:618</td>
<td></td>
</tr>
<tr>
<td>Rm: 620</td>
<td></td>
</tr>
<tr>
<td>Rm: 622</td>
<td></td>
</tr>
<tr>
<td>Rm: 820</td>
<td></td>
</tr>
<tr>
<td>Rm: 822</td>
<td></td>
</tr>
<tr>
<td>Rm:824</td>
<td></td>
</tr>
<tr>
<td>Rm: 828</td>
<td></td>
</tr>
<tr>
<td>Rm: 916</td>
<td></td>
</tr>
<tr>
<td>Rm: 918</td>
<td></td>
</tr>
<tr>
<td>Rm:920</td>
<td></td>
</tr>
<tr>
<td>Rm:922</td>
<td></td>
</tr>
<tr>
<td>CCU Room #8</td>
<td></td>
</tr>
<tr>
<td>ENDO Room 3 (Bronch Suite)</td>
<td></td>
</tr>
<tr>
<td>ED; Green Pod</td>
<td></td>
</tr>
<tr>
<td>ED Orange Pod</td>
<td></td>
</tr>
<tr>
<td>ED Purple Pod</td>
<td></td>
</tr>
<tr>
<td>ED Yellow Pod</td>
<td></td>
</tr>
<tr>
<td>ED Decontamination Room</td>
<td></td>
</tr>
</tbody>
</table>

How many AII rooms are in the health-care setting? 21 rooms

What ventilation methods are used for AII rooms? (Check all that apply)

**Primary (general ventilation):**
- ✓ Single-pass heating, ventilating, and air conditioning (HVAC)
- ✓ Recirculating HVAC systems

**Secondary (methods to increase equivalent ACH):**
- ✓ Fixed room recirculating units
- ✓ HEPA Filtration

Does your health-care setting employ, have access to, or collaborate with an environmental engineer (e.g., professional engineer) or other professional with  

<p>| Yes |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are environmental controls regularly checked and maintained with results recorded in maintenance logs?</td>
<td>Yes</td>
</tr>
<tr>
<td>Are AII rooms checked daily for negative pressure when in use?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is the directional airflow in AII rooms checked daily when in use with smoke tubes or visual checks?</td>
<td>Yes</td>
</tr>
<tr>
<td>Are these results readily available?</td>
<td>Yes</td>
</tr>
<tr>
<td>What procedures are in place if the AII room pressure is not negative?</td>
<td>Patient is transferred. Facilities is notified and the room is closed until pressure is confirmed negative.</td>
</tr>
<tr>
<td>Do AII rooms meet the recommended pressure differential of 0.01-inch water column negative to surrounding structures?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**8. Respiratory-Protection Program**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your health-care setting have a written respiratory-protection program?</td>
<td>Yes</td>
</tr>
<tr>
<td>Which HCWs are included in the respiratory protection program? (Check all that apply)</td>
<td>Yes</td>
</tr>
<tr>
<td>- Physicians</td>
<td>Janitorial staff</td>
</tr>
<tr>
<td>- Mid-level practitioners (NPs and PAs)</td>
<td>Maintenance or engineering staff</td>
</tr>
<tr>
<td>- Nurses</td>
<td>Transportation staff</td>
</tr>
<tr>
<td>- Administrators</td>
<td>Dietary staff</td>
</tr>
<tr>
<td>- Laboratory personnel</td>
<td>Students</td>
</tr>
<tr>
<td>- Contract staff</td>
<td></td>
</tr>
<tr>
<td>- Construction or renovation staff</td>
<td></td>
</tr>
<tr>
<td>- Service personnel</td>
<td></td>
</tr>
<tr>
<td>Are respirators used in this setting for HCWs working with TB patients?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients).</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Manufacturer</strong></td>
<td><strong>Model</strong></td>
</tr>
<tr>
<td>3M corporation</td>
<td>N-95</td>
</tr>
<tr>
<td>Kimberly Clark KC200</td>
<td>N-95</td>
</tr>
<tr>
<td>Is annual respiratory-protection training for HCWs performed by a person with advanced training in respiratory protection?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does your health-care setting provide initial fit testing for HCWs?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, when is it conducted? ___On hire by employee health</td>
<td></td>
</tr>
<tr>
<td>Does your health-care setting provide periodic fit testing for HCWs?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, when and how frequently is it conducted? Yearly</td>
<td></td>
</tr>
<tr>
<td>What method of fit testing is used? Describe.</td>
<td>Hood/Taste</td>
</tr>
<tr>
<td>___1.Fit check: Saccharin or Bitrex fit check. Individual is asked to do normal, deep breathing; bend over; side to side and up/down head movements).</td>
<td></td>
</tr>
<tr>
<td>Is qualitative fit testing used?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is quantitative fit testing used? (Available)</td>
<td>No</td>
</tr>
</tbody>
</table>

**9. Reassessment of TB risk**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How frequently is the TB risk assessment conducted or updated in the health-care setting?</td>
<td>Yearly</td>
</tr>
<tr>
<td>When was the last TB risk assessment conducted?</td>
<td>02/2018</td>
</tr>
</tbody>
</table>
What problems were identified during the previous TB risk assessment?  
No problems were identified.

<table>
<thead>
<tr>
<th>What actions were taken to address the problems identified during the previous TB risk assessment?</th>
<th>No. Our risk remained the same.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the risk classification need to be revised as a result of the last TB risk assessment?</td>
<td>No. Our risk remained the same.</td>
</tr>
</tbody>
</table>

**Recommendations:**

1. Continue annual PPD testing and/or symptom screening and x-ray review of all employees and volunteers.
2. Continue to closely monitor all patients admitted for suspected/known TB for appropriate isolation practices.
3. Continue referring new employees for latent TB infection evaluation as indicated.
4. Continue education on early basis and as needed.

* If the population served by the health-care facility is not representative of the community in which the facility is located, an alternate comparison population might be appropriate.

† Test conversion rate is calculated by dividing the number of conversions among HCWs by the number of HCWs who were tested and had prior negative results during a certain period (see Supplement, Surveillance and Detection of *M. tuberculosis* infections in Health-Care Settings).
Broward Health Imperial Point Performance Improvement Appraisal CY 2018 and Goals and Objectives for CY 2019

Broward Health Imperial Point continuously strives to provide comprehensive, individualized, and competent care to the patients it serves, regardless of race, gender, sexual orientation, religion, national origin, physical handicap or financial status. We follow the Broward Health Mission and Vision Statements. Broward Health respects and follows the Broward Health Five Star Values, Strategic Priorities and Success Pillars: Service, People, Quality/Safety, Finance and Growth. The PI Plan is presented to the regional Quality Council for approval then to the Medical Staff and Board of Commissioners.

The Department Leaders at BHIP work with their Administrators to prioritize their decisions regarding indicators for review. While indicators are chosen for review each year, new indicators may be chosen during the year based on patient safety concerns, information from Root Cause Analysis, trends identified in adverse incidents, etc. Indicators were chosen either by requirements by external agencies such as The Joint Commission, Centers for Medicare and Medicaid Services, AHRQ and those that are problem prone, high risk, or high volume processes. This information is reported to Quality Council then to the Board of Commissioners through the Quality Assessment and Oversight Committee (QAOC) and the Board of Commissioners Finance Committee.

Initiatives for 2019 include continuous patient tracers for survey readiness and continuation / enhancement of weekly administrative huddles, unit shift huddles, and our total harm reduction program. BHIP participated in the Health Improvement Innovation Network (HIIN) project to decrease mortality and morbidity. There has been significant improvement in core measures and BHIP has been nationally recognized by The Joint Commission as a Top Performer on Key Quality Measures in 2015. BHIP received Joint Commission Disease Specific Certification in Primary Stroke in December 2017, their Heart Failure program in April 2018 and a successful triennial accreditation survey in July 2018.

Listed below is a summary of the PI activities that reflect the hospital endeavors to reduce the mortality and morbidity and to assure patient safety. BHIP will continue to work towards these goals during 2019.

<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals</th>
<th>Findings</th>
<th>Actions</th>
<th>Objectives for CY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Core Measures</td>
<td>Achieve Top Decile for indicators that are at or above national rate and achieve national or above rates for indicators that are below the national rate.</td>
<td>There has been continued compliance with the core measures for 2018: Stroke – all at top decile- Joint Commission certified SEPSIS –2019 current at 67% compliance with all measures IMM-2 Retired HBIPS- 2018 with multiple definitions and with modification to Cerner to match definitions and processes</td>
<td>Continue to collect the data and drill down on fallouts. Continue to educate new employees to core measure standards and expectations. Continue to coach and remediate all employees and physicians as necessary. Continue Sepsis PI Team with enhanced physician and staff education Stroke/ Heart Failure Coordinator to further assist with managing</td>
<td>Achieve top decile for 90% of all indicators.</td>
</tr>
</tbody>
</table>
# IMPROVE OUTCOMES

| Mortalities | Below Crimson National Average for Mid-Sized Non-Teaching Facilities | • The overall risk-adjusted mortality rate was 0.84% (15/1788) for 2018 which is below the Crimson Cohort of 1.37%.  
  • The risk-adjusted AMI mortality rate was 0% (0/13) for 2017 which is below the Crimson Cohort of 9.76%.  
  • The risk-adjusted heart failure mortality rate was 2.44% (1/41) for 2017 which is slightly above the Crimson Cohort Rate of 2.29%.  
  • The risk-adjusted pneumonia mortality rate was 9.38% (3/32) for 2017 which is above the Crimson Cohort rate of 3.12%.  
  • The risk-adjusted COPD mortality rate was 2.38% (1/42) for 2017 which is slightly above the Crimson Cohort rate of 1.33%. | • Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates.  
  • Rates above benchmarks due to low volumes. | Maintain risk-adjusted overall, AMI, heart failure, COPD and pneumonia mortality rates below the Crimson Cohort average. |
|---|---|---|---|---|
| Readmissions | Below Crimson National Average for All Hospitals | • The overall risk-adjusted all cause 30 day readmission rate was 13.40% (649/4844) which is above the Crimson Cohort rate of 12.48%.  
  • The risk-adjusted AMI readmission rate for 2018 was 10% (1/10) which is below the Crimson Cohort of 14.28%.  
  • The risk-adjusted heart failure readmission rate for 2018 was 12.77% (18/141) which is below the Crimson Cohort of 18.56%  
  • The risk-adjusted pneumonia readmission rate for 2018 was 15.51% (38/245) which is above the Crimson Cohort rate of 10.85%.  
  • The risk-adjusted COPD readmission rate for 2018 was 17.50% (35/200) which is above the Crimson Cohort rate of 16.72%. | • Proactive risk assessment for readmissions  
  • Rates above benchmarks due to low volumes.  
  • Referral of patients to Disease State Management  
  • Discharge folders with specific patient information have been rolled out to improve discharge communication around symptoms  
  • Advocating with physicians to have home care ordered whenever possible for home monitoring  
  • Continuation of multidisciplinary rounds to include CMO and physician groups  
  • Referral for follow-up appointments | Maintain risk-adjusted overall, AMI and heart failure readmission rates below the Crimson Cohort average. Improve pneumonia risk-adjusted readmission rates to at or below Crimson Cohort average. |
### IMPROVE PATIENT SAFETY

| Falls | <3.15 per 1000 patient days (NDNQI) | Total Falls 2018 all units 79/45185 with a rate of 1.75 which is over the target goal of 1.63; in comparison to 2017, there were 85 falls/47549 rate of 1.79  
There were 7 falls with injuries out of 45185 patient days. This was an increase from 2017 with 2 falls with injuries out of 47549 patient days. | Continue to perform post fall huddles and include patient/family whenever possible.  
Perform an intense analysis on all falls.  
Continue use of bed and chair alarms  
Educate staff and patients regarding fall prevention.  
Analyze data for trends.  
Include Clinical Practice Council for Nursing trends  
Include CMO on all fall analysis and to identify physician trends  
Maintain the hospital’s low fall rate and reduce falls and falls with injuries by 10% |
| Hospital-acquired Pressure Injuries (NDNQI) | Below National Average | There were 16 HAPI out of 45185 patient days for a rate of 0.04 for 2018  
Of those, there were 9 Stage II  
0 Stage III  
0 Stage IV  
6 were DTI  
1 was Unstageable | All nursing staff re-educated on skin incontinence and products to use.  
Weekly skin care rounds on all units  
Daily rounding by NM/ANM  
Education on hand-off  
communication to staff  
Perform IA on all hospital-acquired pressure ulcers  
Hospital wide bed analysis conducted for possible replacements  
Maintain hospital’s low HAPI rate and maintain 0 stage 3 and 0 stage 4 wounds |
| Mislabeled | < 0.3% | There were 3 mislabeled specimens out of 202,323 which was an improvement from 5 mislabeled specimens out of 203207 accessions in 2017. | Continue to coach and remediate employees as necessary.  
Perform intense analysis on all mislabeled specimens.  
Analyze data for trends.  
Continue the use of bedside specimen scanning.  
Decrease number of mislabeled/unlabeled specimens by 10%. Goal to be at zero. |

### DECREASE HOSPITAL-ACQUIRED INFECTIONS

| CLABSI (ICU) | <0.6 per 1000 device days | The number of CLABSI in 2018 was 10 out of 4223 device days for a rate of 2.4 which did not meet target of 0.6 target goal for 2018. | Increase surveillance to all nursing units and submit daily report to Corp Quality  
CMO support for physician trends identified  
Discussed at daily flow  
Aggressive rounding to get the  
Decrease the CLABSI rate housewide to below the VBP threshold as measured by SIR  
Decrease the number of line days. |
<table>
<thead>
<tr>
<th>Category</th>
<th>Target/Goal</th>
<th>Description</th>
<th>Actions</th>
<th>Additional Information</th>
</tr>
</thead>
</table>
| CAUTI (ICU)       | <1.4 per 1000 catheter days | The number of CAUTI in 2018 was 4 out of 3130 catheter days for a rate of 1.3 for 2018. Was below the target goal of 1.4. | - Increase surveillance to all nursing units and submit daily report to Corp Quality  
- CMO support for physician trends identified  
- Continue nurse catheter withdrawal protocol.  
- ED engagement in preventing insertion.  
- Continue Chlorhexidine bath.  
- Continue HOUDINI protocol for all patients with foley catheter.  
- Participate in HSAG HAI program.  
- Continue to follow catheter bundle. | Decrease ICU CAUTI rate to below the CMS national average. Decrease the number of line days. |
| VAP               | Zero               | There were 5 VAE’s in 2018. 3VAC, 2 IVAC.                                  | - Support Respiratory therapy in data collection  
- Continue with infection control rounds.  
- Educate staff regarding infection control practices.  
- Continue to follow bundle. | Maintain VAP rate for ICU at zero. |
| Surgical Site Infections | Below National Average | For 2018, there were 2 infections out of 235 hysterectomy procedures in comparison to 3 infection out of 245 hysterectomy procedures in 2017 for a rate of 0.9. There were 4 infections out of 132 colon surgeries for a rate of 3.0 which was below set target goal of 5. In comparison, there were 8 infections out of 142 colon surgeries for a rate of 5.6 in 2017. There were 5 THA infections out of 72 cases for 2018 with a rate of 6.3 which met target goal. 2 | - Intense analysis of all SSI with epidemiologist and OR Director  
- Continue to monitor recommended prophylactic antibiotic use.  
- Address SSI reduction strategies with medical staff surgeons  
- Monitor for trends.  
- Refer for peer review as | Decrease surgical site infections to below the VBP threshold as measured by SIR |
infections out of 198 cases for TKA with a rate of 1.01 was met below target goal of 1.7 necessary.

- Drill down on the infection related to colorectal surgery to identify trends.
- Review all surgical classifications to verify correct classification
- Work with surgeons to document infection pre-op.
- Verify weight based dosages of antibiotics being used

<table>
<thead>
<tr>
<th>IMPROVE EFFICIENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Throughput</td>
</tr>
<tr>
<td>At or Below National Average</td>
</tr>
<tr>
<td>Improve median ED throughput time to at or below national average.</td>
</tr>
</tbody>
</table>
Broward Health Coral Springs continuously strives to provide comprehensive, individualized, and competent care to the patients it serves, regardless of race, gender, sexual orientation, religion, national origin, physical handicap or financial status. We follow the Broward Health Mission and Vision Statements. Broward Health respects and follows the Broward Health Five Star Values, Strategic Priorities and Success Pillars: Service, People, Quality/Safety, Finance and Growth. The PI Plan is presented to the regional Quality Council for approval then to the Medical Staff and Board of Commissioners.

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Initiatives for 2019 include daily safety/flow leadership huddles, on-going monthly unit tracers, unit shift huddles, patient flow concentration, core measure improvements, critical values and our total harm reduction program. Broward Health Coral Springs participated in the Health Improvement Innovation Network (HIIN) project to decrease mortality and morbidity. Broward Health Coral Springs received Joint Commission Disease Specific re-Certification in Primary Stroke in 2018 and Minimally Invasive Colorectal Surgery in 2018 and completed their triennial accreditation survey in 2018.

Listed below is a summary of the PI activities that reflect the hospital endeavors to reduce the mortality and morbidity and to assure patient safety. Broward Health Coral Springs will continue to work towards these goals during 2019.

<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals</th>
<th>Findings</th>
<th>Actions</th>
<th>Objectives for CY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Core Measures</td>
<td>Achieve Top Decile for indicators that are at or above national rate and achieve national or above rates for indicators that are below the national rate.</td>
<td>There has been continued compliance with the core measures for 2018: • VTE – 90% compliance • Stroke – TJC certified • SEPSIS – 71% compliance – above Nat’l avg.</td>
<td>• Continue to collect the data and drill down on fallouts. • Continue to educate new employees to core measure standards and expectations. • Continue to coach and remediate all employees and physicians as necessary. • Continue Sepsis education with new metrics. Update Education slides. • VTE retired</td>
<td>Achieve top decile for 90% of all indicators. Ongoing work with corporate to adapt sepsis tools as measure is updated.</td>
</tr>
</tbody>
</table>
### IMPROVE OUTCOMES

<table>
<thead>
<tr>
<th>Mortalities</th>
<th>Below Crimson National Average for Mid-Sized Non-Teaching Facilities</th>
<th></th>
<th>Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates.</th>
<th>Maintain risk-adjusted overall, AMI, heart failure and pneumonia mortality rates below the Crimson Cohort average.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The overall risk-adjusted mortality rate was 0.58% (75/13043) for 2018 which is below the Crimson Cohort of 1.07%.</td>
<td></td>
<td>The risk-adjusted AMI mortality rate was 0% (0/4) for 2018 which is below the Crimson Cohort of 14.51%.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The risk-adjusted heart failure mortality rate was 0% (0/72) for 2018 which is below the Crimson Cohort Rate of 4.14%.</td>
<td></td>
<td>The risk-adjusted pneumonia mortality rate was 1.14% (1/88) for 2018 which is below the Crimson Cohort rate of 4.36%.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The risk-adjusted COPD mortality rate was 1.61% (1/62) for 2018 which is below the Crimson Cohort rate of 3.41%.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmissions</td>
<td>Below Crimson National Average for All Hospitals</td>
<td></td>
<td>Proactive risk assessment for readmissions</td>
<td>Maintain risk-adjusted overall, AMI, heart failure and pneumonia mortality rates below the Crimson Cohort average.</td>
</tr>
<tr>
<td></td>
<td>The overall risk-adjusted all cause 30 day readmission rate was 8.2% (1011/12329) which is below the Crimson Cohort rate of 8.54% for 2018</td>
<td></td>
<td>Assessment of readmitted patient to discover reasons for readmission to prevent recurrence.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The risk-adjusted AMI readmission rate for 2018 was 33.33% (1/3) which is above the Crimson Cohort of 14.33%. Very low volume.</td>
<td></td>
<td>Referral of patients to Population Health who are at high readmission risk.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The risk-adjusted heart failure readmission rate for 2018 was 19.18% (14/73) which is above the Crimson Cohort of 17.9%</td>
<td></td>
<td>Discharge folders with specific patient information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The risk-adjusted pneumonia readmission rate for 2018 was 13.1% (11/84) which is above the Crimson Cohort rate of 11.74%.</td>
<td></td>
<td>Advocating with physicians to have home care ordered for those who are moderate to high readmission risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The risk-adjusted COPD readmission rate for 2018 was 24.14% (14/58) which is above the Crimson Cohort rate of 15.22%.</td>
<td></td>
<td>Implementation of multidisciplinary rounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Arrange follow-up appointments on all HF and COPD patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Collaborate with post-acute care providers to prevent readmissions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Arrange clinic appointments on all uninsured/undocumented and tax fund patients and proved them with 2 weeks supply of medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### IMPROVE PATIENT SAFETY

<table>
<thead>
<tr>
<th>Category</th>
<th>Goal</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>&lt;2.00 per 1000 patient days</td>
<td>- There were 119 falls out of 51068 patient days for a rate of 2.33 for 2018.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- There were 3 falls with moderate to serious injuries out of 51068 patient days for a rate of 0.06 for 2018.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Monthly fall meetings lead by RM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Analysis of nursing discrepancies with Morse Fall Risk tool</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Continue to perform post fall huddles and include patient/family whenever possible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Perform an intense analysis on all falls.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Continue use of bed and chair alarms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Educate staff and patients regarding fall prevention.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Gate belts purchase, training and use when ambulating patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Analyze data for trends.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintain the hospital’s low fall rate and reduce falls with injuries by 5%</td>
</tr>
<tr>
<td>Hospital-acquired Pressure Inj</td>
<td>Below National Average</td>
<td>- There were 15 HAPIs out of 51068 patient days for a rate of 0.29 for 2018. (all types included)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- All nursing staff re-educated on skin incontinence and products to use.</td>
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<tr>
<td></td>
<td></td>
<td>- Weekly skin care rounds on all units</td>
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<tr>
<td></td>
<td></td>
<td>- Daily rounding by NM/ANM</td>
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<tr>
<td></td>
<td></td>
<td>- Education regarding proper documentation</td>
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<tr>
<td></td>
<td></td>
<td>- Staging to be completed by wound care nurse or physician only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Perform RCA/IA on all hospital-acquired pressure ulcers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Develop skills of the unit wound care champions through monthly meetings/workshops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintain hospital’s low HAPU rate and maintain 0 stage 3 and 0 stage 4 wounds</td>
</tr>
<tr>
<td>Mislabeled Specimens</td>
<td>Zero</td>
<td>- There were 6 mislabeled specimens in 2018.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Continue to coach and remediate employees as necessary.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Perform intense analysis on all mislabeled specimens.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Analyze data for trends.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Continue the use of bedside specimen scanning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease number of mislabeled specimens by 10%. Goal to be at zero.</td>
</tr>
<tr>
<td>CLABSI (ICU)</td>
<td>&lt;0.9 per 1000 device days</td>
<td>- The number of CLABSI in ICU was 2 out of 2141 device days for a rate of 0.93 for 2018. This is an increase from the rate of 0.53 for 2017.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increase surveillance to all nursing units.</td>
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<tr>
<td></td>
<td></td>
<td>- Aggressive rounding to get the central line out.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Continue Chlorhexidine baths.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Participate in HSAG HAI program.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Continue to follow central line bundle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease the CLABSI rate in ICU to below the VBP threshold as measured by SIR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease the number of line days.</td>
</tr>
<tr>
<td>CAUTI (ICU)</td>
<td>&lt;1.4 per 1000 catheter days</td>
<td>- The number of CAUTI in ICU was 3 out of 1939 catheter days for a rate of 1.03 for 2018. This is an increase from the rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increase surveillance to all nursing units.</td>
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<tr>
<td></td>
<td></td>
<td>- Continue nurse catheter withdrawal protocol.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease ICU CAUTI rate to below the CMS national average.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease the number of Foley.</td>
</tr>
<tr>
<td>VAC</td>
<td>Zero</td>
<td>There were 0 VACs in ICU for 2018 a decrease from 2 in 2017 with a rate of 2.28.</td>
</tr>
<tr>
<td>-----------</td>
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<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Surgical Site Infections</td>
<td>Below National Average</td>
<td>There were 0 infections out of 259 hysterectomy procedures in 2018 for a rate of 0.0. The rate of 2017 was 0.426 showing a reduction in 2018. There were 7 infections out of 139 colon surgeries for a rate of 5.04 in 2018. In 2017 the rate was 4.07 with fewer infections and fewer procedures completed in the year.</td>
</tr>
</tbody>
</table>

**IMPROVE EFFICIENCY**

| ED Throughput | At or Below National Average | ED-1b median time ED arrival to ED departure in 2017 was 347, in 2018 it was 296. ED-2b median admit decision time to ED | Tele-tracking implemented 2 bed huddles daily to address pending discharges and any other issues ED metrics collected daily for patient flow Monthly patient flow meetings led by ED | Improve median ED throughput time to at or below national average. |
| Departure was 167 minutes in 2017, in 2018 it was 118 minutes. This is an increase due to increased volumes. | Medical Director
- Hospitalist bed rounds to expedite discharges
- Interdisciplinary rounding for discharge planning |
Broward Health North continuously strives to provide comprehensive, individualized, and competent care to the patients it serves, regardless of race, gender, sexual orientation, religion, national origin, physical handicap or financial status. We follow the Broward Health Mission and Vision Statements. Broward Health North respects and follows the Broward Health Five Star Values, Strategic Priorities and Success Pillars: Service, People, Quality/Safety, Finance and Growth. The PI Plan is presented to the regional Quality Council for approval then to the Medical Staff and Board of Commissioners.

The Department Leaders at Broward Health North work with their Administrators to prioritize their decisions regarding indicators for review. While indicators are chosen for review each year, new indicators may be chosen during the year based on patient safety concerns, information from Root Cause Analysis, trends identified in adverse incidents, etc. Indicators were chosen either by requirements by external agencies such as The Joint Commission, Centers for Medicare and Medicaid Services, AHCA, AHRQ and those that are problem prone, high risk, or high volume processes. This information is reported to Quality Council then to the Board of Commissioners through the Quality Assessment and Oversight Committee (QAOC) and the Board of Commissioners.

Initiatives for 2019 include continuous patient tracers, unit shift huddles, and our total harm reduction program as a part of our journey to becoming a High Reliability Organization (HRO). Broward Health North participated in the Health Innovation and Improvement Network (HIIN) project to decrease mortality and morbidity, in the AHRQ Pressure Ulcer Prevention Collaborative, and the STRIVE project with the FHA.

Listed below is a summary of the PI activities of Broward Health North that reflect the hospital endeavors to reduce the mortality and morbidity and to assure patient safety. Broward Health North will continue to work towards these goals during 2019.

<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals</th>
<th>Findings</th>
<th>Actions</th>
<th>Objectives for CY 2019</th>
</tr>
</thead>
</table>
| CMS / TJC Core Measures | Achieve Top Decile for indicators that are at or above national average rate. Achieve national average or above rates for indicators that are below the national average rate. | Data was collected on 24 Core measures  
- ED 1 (375), ED2 (240): Worse than National Average for very high volume hospitals – compared to 2017 ED 1 (384), ED2 (195)  
- IMM: 100%, at top decile, consistent with 2017  
- VTE 6 - 0%, top decile – consistent with 2017  
- STK – 1 (STK 8) of 8 indications at 100% and top decile, all above National average.  
  1 Fallout in STK- 1- 99.7%  
  2 fallouts in STK-2 -99.3%, |  
- Concurrent screening of all new admissions with real time intervention to assure compliance  
- Continue to collect the data and drill down on fallouts to identify improvement opportunities  
- Continue to educate new employees to core measure standards and expectations.  
- Continue to coach and remediate all employees and physicians as necessary.  
- Interdisciplinary Patient Flow Team at BHN to improve patient flow and | Achieve top decile for 90% of all indicators.  
Improve sepsis compliance to 55% or greater |
1 fallout in STK 3 - 97.9%
1 fallout in STK 4 - 97.8%
1 fallout in STK 5 - 99.6%
4 Fallouts in STK 6 - 98.5%
1 Fallout in STK 10 - 99.7%

- SEP – 2017 was 41.9% and improved in 2018 with 51%; volume increased from 246 cases (2017) to 341 (2018).
- OP 1, 2, 3: no population – consistent with 2017. OP 1 is retired from CMS for 2018
- OP 4, 2 cases (100% compliance) in Jan and Feb 2018 at 100%, top decile, consistent with 2017. OP 4 is retired by CMS for 2018
- OP 18: 2018 YTD was 178.71 slightly higher than 2017 which was 174.50
- OP 20, 21: Measures are retired from CMS for 2018
- OP 23: 100%, top decile same as in 2017 (100%)
- OP 29: 100%, top decile same as in 2017 (100%)
- OP 30: 100% top decile as in 2017 (100%)

Other than ED flow metrics (ED 1, 2, OP 18)
all indicators with National Benchmarks
achieved National average and improvement
noted with Sepsis.

### IMPROVE OUTCOMES

<table>
<thead>
<tr>
<th>Mortalities</th>
<th>Below Crimson National Average for all hospitals</th>
</tr>
</thead>
</table>
| • The overall risk-adjusted mortality rate was 1.58% (213/13478) compared to 2017 - 1.43% (200/13979), which is below the Crimson Cohort of 1.78%.
• The risk-adjusted AMI mortality rate was 5.78% (13/225) compared to 2017 - 2.11% (5/237) which is higher than the Crimson cohort of 3.62%.
• The risk-adjusted heart failure mortality rate was 2.46% (11/448) compared to 2017 of 1.93% (9/1467) which is above the Crimson Cohort rate of 1.53%. | • Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates.
• Clinical Care Teams initiated for COPD and HF to work on standardizing care for these populations |

- Maintain risk-adjusted overall, AMI, heart failure and pneumonia mortality rates below the Crimson Cohort average.
- Active participation in system wide Six Sigma team for Sepsis bundle improvement
- Reduce ED boarding times.
### Below Crimson National Average for All Hospitals for Medicare Patients Age 65 and older

- The risk-adjusted pneumonia mortality rate was 1.40 (8/571) compared to 2017 = 3.03% (13/429) which is lower compared to the Crimson cohort of 2.19%.
- The Medicare risk-adjusted AMI mortality rate was 6.12% (3/49) compared to 2017 = 7.14% (3/42) which is above the Crimson Cohort rate of 5.66%.
- The Medicare risk-adjusted heart failure mortality rate was 0.93% (1/107) compared to 2017 2.6% (2/97) which is lower than the Crimson Cohort rate of 1.96%.
- The Medicare risk-adjusted pneumonia mortality rate was 2.72% (4/147) compared to 2017 = 3% (3/100) which is lower the Crimson Cohort rate of 3.21%.

### Maintain Medicare risk-adjusted AMI, heart failure and pneumonia mortality rates below the Crimson Cohort average.

### Readmissions

<table>
<thead>
<tr>
<th>Below Crimson National Average for All Hospitals</th>
<th>Proactive risk assessment for readmissions using an EHR based tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall risk-adjusted all cause 30 day readmission rate was 12.9% (1507/11714) compared to 2017 = 12.27% (1536/12517) which is above the Crimson Cohort rate of 9.93%.</td>
<td></td>
</tr>
<tr>
<td>The risk-adjusted AMI readmission rate was 13.22 % (23/174) compared to 2017 = 8.9% (17/191) which is higher the Crimson Cohort rate of 9.07%.</td>
<td></td>
</tr>
<tr>
<td>The risk-adjusted heart failure readmission rate was 25.3% (102/403) compared to 2017= 23.56% (104/433) which is above the Crimson Cohort rate of 17.13%.</td>
<td></td>
</tr>
<tr>
<td>The risk-adjusted pneumonia readmission rate was 13.2% (67/508) compared to 2017= 11.99% (47/392) which is above the Crimson Cohort rate of 10.20%.</td>
<td></td>
</tr>
<tr>
<td>The risk-adjusted COPD readmission rate was 23.1% (68/294) compared to 2017= 23.21% (68/293) which is above the Crimson Cohort rate of 14.73%.</td>
<td></td>
</tr>
<tr>
<td>The Medicare risk-adjusted AMI readmission rate was 20.6% (7/ 34) compared to 2017= 5.15% (5/33) which</td>
<td></td>
</tr>
</tbody>
</table>

### Maintain risk-adjusted overall, AMI and heart failure readmission rates below the Crimson Cohort average. Improve pneumonia risk-adjusted readmission rates to at or below Crimson Cohort average.

- Referral of patients to Population Health
- Discharge folders with specific patient information have been rolled out to improve discharge communication around symptoms
- Advocating with physicians to have home care ordered whenever possible for home monitoring
- Have an agreement with the Margate Health Clinic to reserve 2 appointments daily for patient follow-up
- Case management to schedule follow-up appointments
- System wide Multidisciplinary PI team working to reduce readmissions
- Follow up calls from nursing
- COPD care team to look at in house care for standardization
- HF care team to look at in house care for standardization.

Maintain Medicare risk-adjusted readmission rates for AMI and HF below the Crimson Cohort average. Improve pneumonia Medicare.
is above the Crimson Cohort rate of 10.80%.
- The Medicare risk-adjusted heart failure readmission rate was 23.1% (24/104) compared to 18.09% (17/94) which is above the Crimson Cohort of 17.44%.
- The Medicare risk-adjusted pneumonia readmission rate was 13.7% (18/131) compared to 2017 = 7.61% which is below the Crimson Cohort rate of 11.55%.
- The Medicare risk-adjusted COPD readmission rate was 17.9% (14/78) compared to 2017 = 22.95% (14/61) which is above the Crimson Cohort Rate of 14.56%.

### IMPROVE PATIENT SAFETY

<table>
<thead>
<tr>
<th>Category</th>
<th>Rate/Measure</th>
<th>Details</th>
<th>Actions</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Falls                         | <2.15 per 1000 patient days         | There were 114 falls out of 81509 patient days for a rate of 1.4 falls per 1000 patient days compared to 2017 = 104 Falls out of 84773 patient days for a rate of 1.23 falls per 1,000 patient days. This represents an increase in falls and in rate. There were 3 falls with serious injuries out of 81509 patient days for a rate 0.04 compared to 2017= 6 falls with serious injuries out of 84,773 patient days for a rate of 0.07. This represents a decrease in event and rate. | - Continue to perform post fall huddles and include patient/family whenever possible.  
- Perform an intense analysis on all falls.  
- Continue use of bed and chair alarms  
- Proactive hourly rounds  
- Educate staff and patients regarding fall prevention.  
- Analyze data for trends. | Decrease the hospital’s fall rate and reduce falls with injuries by 3.5% |
| Hospital-acquired Pressure Injury | Below National Average | There were 17 HAPIs out of 82958 patient days for a rate of 0.20 per 1000 patient days compared to 2017= 31 HAPIs out of 84,773 patient days for a rate of 0.36 per 1,000 patient days. Of those, 4 Stage III for a rate of 0.05, 0 Stage IV for a rate 0.00 and 7 unstageable for a rate of 0.08. Compared to 2017 there were 7 Stage III for a rate of .083 , 2 Stage IV for a rate of .024 and 7 unstageable for a rate of 0.083  
This represents a decrease in overall HAPIs Stage III and unstageable wounds and a decrease in Stage IV wounds. | - All nursing staff required to attend SWAT Boot Camp  
- SWAT nurse to documents in IVIEW for consistency  
- PCA Bootcamp was completed for all floor PCAs to help educate at the bedside for all levels  
- Perform drill down on all hospital-acquired pressure ulcers  
- Annual patient safety fair for 100% of staff | Decrease the hospital’s HAPI rate by 3.5% |
| Mislabeled Specimens | Less than 7 | There were 6 mislabeled specimens out of 226,797 compared to 2017 = 13 mislabeled specimens out of 288,373. This represents a decrease. | • Continue to coach and remediate employees as necessary.  
• Perform intense analysis on all mislabeled specimens.  
• Analyze data for trends.  
• Continue the use of bedside specimen scanning. | Decrease number of mislabeled specimens by 3.5%. Overall goal to be at zero |
|----------------------|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|

### DECREASE HOSPITAL-ACQUIRED INFECTIONS

| CLABSI | <0.80 per 1000 device days | The number of CLABSI were 11 out of 13,547 device days for a rate of 0.81 compared to 2017 = 8 out of 13,212 device days for a rate of 0.61. This is an increase in both rate and device utilization.  
The Standardized Infection Ratio (SIR) as reported to NHSN increased to 0.689 in 2018 compared to 2017 = 0.254 | • Increase surveillance to all nursing units.  
• Aggressive rounding to get the central line out.  
• Continue the Centurion Guardian Program.  
• Continue Chlorhexidine bath.  
• Continue to follow central line bundle. | Decrease infection rates to below VBP achievement thresholds with an ultimate goal of zero. |
| CAUTI | <0.89 per 1000 catheter days | The number of CAUTI were 5 out of 12,600 catheter days for a rate of 0.40 compared to 2017 = 8 out of 11,862 catheter days for a rate of 0.67. This represents a decrease in rate and device utilization.  
The SIR as reported to NHSN dropped to 0.073 in 2018 compared to 2017 = 0.280. | • Increase surveillance to all nursing units.  
• Continue nurse catheter withdrawal protocol.  
• ED engagement in preventing insertion.  
• Continue Chlorhexidine bath.  
• Coordinate with surgeons to prevent unnecessary perioperative insertion  
• Continue HOUDINI protocol for all patients with foley catheter.  
• Participate in HSAG HAI program.  
• Continue to follow catheter bundle. | Decrease infection rates to below VBP achievement thresholds with an ultimate goal of zero. |
| PVAP | 0 per 1000 ventilator days | There were 3 out of 4,287 ventilator days compared to 2017 = 1 VAP out of 4,449 ventilator days. This is an increase. | • Epidemiology staff prospective surveillance of VAE signs and symptoms in order to alert Respiratory, Nursing, and Physicians before VAP develops.  
• Continue with infection control rounds.  
• Educate staff regarding infection control practices.  
• Continue to follow bundle. | Decrease PVAP rate to zero. |
| Surgical Site Infections | Below National Average | There were 0 total abdominal hysterectomy SSI out of 7 hysterectomy procedures for a rate of 0.00 compared to 2017 = 2 total | • SSI Six Sigma PI team to concentrate on class II colon and hysterectomy infections. | Decrease surgical site infections to below the VBP threshold as measured by |
| MRSA Lab ID | Below CMS VBP Achievement Threshold | abdominal hysterectomy SSI out of 39 hysterectomy procedures in 2017 for a rate of 5.13. Major decrease in total number procedures performed. The SIR as reported to NHSN was 0.00 decrease from 2017= 5.848 | • Continue tracking all colon infections even the ones that do not meet reportable definition. • Continue to monitor recommended prophylactic antibiotic use. • Address SSI reduction strategies with medical staff • Monitor for trends. • Refer for peer review as necessary. • Drill down on the infection related to colorectal surgery to identify trends. • Continue Chlorhexidine bath. • Epidemiology Medical Director to meet with Surgeons with SSI cases • Multidisciplinary team drill down on all SSIs |
| CDI Lab ID | Below CMS VBP Achievement Threshold | 4 colon SSI out of 105 colon procedures performed for a rate of 3.81 compared to 2017 = 4 colon SSI out of 126 colon procedures in 2017 for a rate of 3.17. This represents equal number of total colon SSI and a lower total number of colon surgeries performed. The SIR as reported to NHSN increased to 1.408 compared to 2017= 1.091 | • Staff education regarding what Lab ID event means and how to prevent accidentally causing false positives through delayed collection. • Hand hygiene • Blood culture performance competency • Ensure optimally appropriate antimicrobials by balancing clinical necessity and optimal patient care with negative consequences of inappropriate use. • Antibiotic duration, indication and PPI indication documentation. • IV to PO policy • Physician documented indication, duration a required field in the orders. • Debrief with staff involved after HAI identified. • Utilize HEN change packets, webinars, and best practice resources in action plan making. |
| MRSA Lab ID | Below CMS VBP Achievement Threshold | The Lab ID MRSA bacteremia rate was 10 out of 74,382 patient days for a rate of 0.13 infections per 1000 patient days compared to 2017= 6 out of 78,161 patient days for a rate of 0.08 infections per 1,000 patient days This is an increase. The SIR as reported in NHSN was 1.977 compared to 2017= 1.383 | Decrease infections to below the VBP threshold as measured by SIR |
The Lab ID C. Dif. Infection rate was 27 out of 74,382 patient days for a rate of 3.76 infections per 1000 patient days compared to 2017= 24 out of 78,161 patient days for a rate of 3.05 infections per 1,000 patient days.

The SIR as reported in NHSN was 0.572 compared to 2017= 0.41

- accidentally causing false positives through delayed collection.
- Hand hygiene program
- Analysis of causative risk factors in all positive cases such as age, SNF resident, recent antibiotics, proton pump inhibitor use
- Isolation precaution rounds for proper use of PPE to prevent collateral transfer

<table>
<thead>
<tr>
<th>IMPROVE EFFICIENCY</th>
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<tbody>
<tr>
<td>ED Throughput</td>
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Initiatives for 2018 include daily safety huddle, monthly patient tracers, infection control surveillance rounds and selected quarterly point prevalence studies, weekly management/safety huddles, unit shift huddles, monthly leadership meetings and weekend Administrator on Call (AOC) rounds. BHMC participates in the Health Improvement Innovation Network (HIIN) project to reduce patient harm events. Core measures performance above national benchmarks. The hospital triennial accreditation survey was conducted in July 2018.

Listed below is a summary of the PI activities that reflect the hospital endeavors to reduce the mortality and morbidity and to assure patient safety. BHMC will continue to work towards these goals during 2018.

<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals 2017</th>
<th>Outcomes</th>
<th>Actions 2018</th>
<th>Goals 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Core Measures</td>
<td>Achieve Top Decile for indicators that are at or above national rate and achieve national or above rates for indicators that are below the national rate.</td>
<td>There has been continued compliance with the core measures:</td>
<td>• Concurrent abstractions for Sepsis, VTE, IMM and HBIPS, drill down of case variances to identify process opportunities</td>
<td>Achieve Top Decile for indicators that are at or above national rate and achieve national or above rates for indicators that are below the national rate.</td>
</tr>
<tr>
<td></td>
<td>VTE - all at top decile</td>
<td>• VTE - all at top decile</td>
<td>• Continue Multidisciplinary education</td>
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<tr>
<td></td>
<td>Stroke – at 96% (National Benchmark 87%)</td>
<td>• Stroke – at 96% (National Benchmark 87%)</td>
<td>• Continue to collect the data and drill down on fallouts.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SEP – at 51% (Benchmark 40% for 2016)</td>
<td>• SEP – at 51% (Benchmark 40% for 2016)</td>
<td>• Continue to educate new employees to core measure standards and expectations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HBIPS - all at top decile</td>
<td>• HBIPS - all at top decile</td>
<td>• Continue to coach and remediate all employees and physicians as necessary.</td>
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</tr>
<tr>
<td></td>
<td>IMM – at 100%</td>
<td>• IMM – at 100%</td>
<td>• Continue Sepsis PI Team with enhanced physician and staff education</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Sepsis Current Initiatives</td>
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<td></td>
<td></td>
<td></td>
<td>• Pre Hospital fluid intake in I &amp; O</td>
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<td></td>
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<td></td>
<td>• Inpatient Sepsis Champion</td>
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<td></td>
<td>• Diagnosis one click time stamp</td>
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<td></td>
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<td></td>
<td>• Blood culture order to trigger an alert to order lactic acid</td>
<td></td>
</tr>
<tr>
<td>PI Indicators</td>
<td>Goals 2017</td>
<td>Outcomes</td>
<td>Actions 2018</td>
<td>Goals 2019</td>
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<tr>
<td>---------------</td>
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</tbody>
</table>
| Mortalities   | Below Crimson National Average for Mid-Sized Non-Teaching Facilities | - The overall risk-adjusted mortality rate was 1.23% (339/27783) for 2018 which is below the Crimson Cohort of 1.35%.  
- The risk-adjusted AMI mortality rate was 1.96% (2/102) for 2018 which is below the Crimson Cohort of 4.32%.  
- The risk-adjusted heart failure mortality rate was 1.52% (2/132) for 2018 which is slightly below the Crimson Cohort Rate of 2.41%.  
- The risk-adjusted pneumonia mortality rate was 3.73% (5/134) for 2018 which is above the Crimson Cohort rate of 6.27%.  
- The risk-adjusted COPD mortality rate was 2.56% (2/78) for 2018 which is slightly below the Crimson Cohort rate of 2.51%. | - Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates.  
- Rates above benchmarks due to low volumes.  
- Clinical Care Teams initiated for COPD to work on standardizing care for these populations | Maintain risk-adjusted overall, AMI, heart failure, COPD and pneumonia mortality rates below the Crimson Cohort average. |
<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals 2017</th>
<th>Outcomes</th>
<th>Actions 2018</th>
<th>Goals 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td>Below Crimson National Average for All Hospitals for Medicare Patients Age 65 and older</td>
<td>- The overall risk-adjusted all cause 30 day readmission rate was 9.84% (2536/257852) which is slightly above the Crimson Cohort rate of 9.58%.&lt;br&gt;- The Medicare risk-adjusted AMI readmission rate for 2018 was 8.60% (8/93) which is below the Crimson Cohort of 11.71%.&lt;br&gt;- The Medicare risk-adjusted heart failure readmission rate for 2018 was 18.9% (24/127) which is close to the Crimson Cohort of 18.2%.&lt;br&gt;- The Medicare risk-adjusted pneumonia readmission for 2018 was 11.02 (14/127) which is below the Crimson Cohort rate of 12.33%.&lt;br&gt;- The Medicare risk-adjusted COPD readmission rate for 2018 was 15.07% (11/73) which is below the Crimson Cohort rate of 15.76%.&lt;br&gt;- Implementation of multidisciplinary rounds&lt;br&gt;- Proactive risk assessment for readmissions&lt;br&gt;- CM partner with Population Health Referral of patients to Disease State Management&lt;br&gt;- CM partner with HSAG&lt;br&gt;- CM partner with identified SNFs and Rehabs&lt;br&gt;- CM re-education on readmissions reduction strategies&lt;br&gt;- Wellness Center consults implemented, see patient prior to discharge&lt;br&gt;- Checklist of discharge expectations developed for high risk HF and COPD discharges&lt;br&gt;- Discharge folders with specific patient information rollout&lt;br&gt;- Advocating with physicians to have home care ordered whenever possible for home monitoring&lt;br&gt;- Case reviews conducted at Weekly management huddle&lt;br&gt;- Referral for follow-up appointments</td>
<td>Maintain risk-adjusted overall, AMI and heart failure readmission rates below the Crimson Cohort average.&lt;br&gt;Improve pneumonia risk-adjusted readmission rates to at or below Crimson Cohort average.</td>
<td></td>
</tr>
</tbody>
</table>

**DECREASE HOSPITAL-ACQUIRED INFECTIONS**

<p>| CLABSI | Reach NHSN Benchmarks CMS benchmark = 0 CMS Achievement Threshold = 0.860 | There was a reduction from 2017 to 2018.&lt;br&gt;The number of CLABSI were 22 out of 22906 device days for a rate of 0.90 for 2018 | - PI Team in place, new team members added&lt;br&gt;- Increase in femoral line placements noted – 1:1 follow-up by RMO. Trends referred to peer review, medical staff&lt;br&gt;- Hard-wiring standardization of insertion process, daily line assessment/care&lt;br&gt;- Selection of impregnated CHG dressing at VAC for approval&lt;br&gt;- Staff competency&lt;br&gt;- Quarterly point prevalence | Reach CMS Achievement target&lt;br&gt;Decrease infection rates to below VBP achievement thresholds with an ultimate goal of zero.&lt;br&gt;Decrease the CLABSI rate in ICU to below the VBP threshold as measured by SIR&lt;br&gt;Decrease the number of line days. |</p>
<table>
<thead>
<tr>
<th>PI Indicators</th>
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<th>Outcomes</th>
<th>Actions 2018</th>
<th>Goals 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>Reach NHSN Benchmarks</td>
<td>The number of CAUTIs were 29 out of 12140 device days for a rate of 1.81 for 2018</td>
<td>- Daily manager rounding with focus on Foley catheters. Mandatory between 8:30-10:30 daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CMS benchmark = 0</td>
<td>This is well above the CMS VBP achievement threshold of 0.86</td>
<td>- Epidemiology rounding in Critical Care Units.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CMS Achievement Threshold = 0.822</td>
<td></td>
<td>- Intense Analysis/Drill down of CAUTIs conducted with Epidemiology, nurse manager and staff involved to determine any lessons learned and opportunities for improvement</td>
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<td></td>
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<td></td>
<td>- Re-chartered CAUTI PI Team</td>
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<td>- Revising CAUTI Prevention Policy created</td>
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<td>- Refer CAUTI cases to applicable Peer Review Committees</td>
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<td></td>
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<td></td>
<td>- Continue nurse catheter withdrawal protocol.</td>
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<td>- ED engagement in preventing insertion.</td>
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<td>- Coordinate with surgeons to prevent unnecessary perioperative insertion</td>
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<td>- Continue HOUDINI protocol for all patients with foley catheter.</td>
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<td>- Participate in HSAG HAI program.</td>
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<td></td>
<td>- Continue to follow catheter bundle</td>
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<td></td>
<td>Reach CMS Achievement target</td>
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<td></td>
<td>Decrease infection rates to below VBP achievement thresholds with an ultimate goal of zero.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgical Site Infections</th>
<th>Reach NHSN Benchmarks</th>
<th>2018 Colon Surgery SIR at 2.06 – above threshold and benchmark, 10 infections out of 145 procedures.</th>
<th>- Terminal Cleaning Task Group established focused on all procedural areas – standardized processes, EVS training, monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CMS benchmark = 0</td>
<td>2018 Hysterectomy SIR at 0 – CMS</td>
<td>- PI team re-chartered – gap analysis completed:</td>
</tr>
<tr>
<td></td>
<td>CMS Achievement</td>
<td></td>
<td>o Surgical Safety Checklist</td>
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<td>o Antibiotic Dosing and MRSA Screening</td>
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<td></td>
<td>o Pre-op Skin Cleaning</td>
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<td>o Post-op care</td>
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<td></td>
<td>Colon reach CMS threshold target &lt;0.781</td>
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<td></td>
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<td></td>
<td>Hysterectomy maintain CMS benchmark target of 0</td>
</tr>
</tbody>
</table>
## PI Indicators | Goals 2017 | Outcomes | Actions 2018 | Goals 2019
--- | --- | --- | --- | ---
Threshold = 0.783 CMS benchmark = 0 CMS Achievement Threshold = 0.854 | benchmark achieved | • Intense Analysis/Drill down of SSI’s conducted with Epidemiology, nurse manager and staff involved to determine any lessons learned and opportunities for improvement  
• Cases referred to applicable Peer Review Committee |  |  

### Antimicrobial Stewardship

Maintain processes to meet TJC MM.09.01.01 Standards

- Corporate Antibiotic Stewardship Committee
- Physician Champion
- Region – ASP reports at Infection Control Committee, P&T Committee and Medical Care Evaluation Committee

- Automatic IV to PO policy
- Automatic renal dose adjustment policy
- Pharmacy-driven kinetics program
- Restricted antibiotics, interchanges
- Perspective antibiotic review utilizing Medmined
- Antimicrobial reviews
- Inclusion of “duration” and “indication” added to antibiotic orders placed
- Biofire tool in place: review conducted to identify opportunities – de-escalation opportunity identified, results discussed by RMO at medical staff committees
- Antimicrobial research projects in place

Maintain current processes. Add new initiatives based on ABX reviews, studies.

## IMPROVE PATIENT SAFETY

### Falls

<3.15 per 1000 patient days (NDNQI)

Total Falls 2018 all units 285/336686 0.8%.  
This represents a decrease in falls over 2017.

- Continue to perform post fall huddles and include patient/family whenever possible.  
- Perform an intense analysis on all falls.  
- Continue use of bed and chair alarms  
- Educate staff and patients regarding fall prevention.  
- Analyze data for trends.

Maintain the hospital’s low fall rate and reduce falls and falls with injuries by 10%

### Hospital-acquired Pressure Injuries

Below National Average (NDNQI)

There were 52 HAPI out of 336609 patient days for a rate of 0.2 for 2018.  
Of those, there were  
Stage III-7  
Stage IV-2  
Unstageable- 13

- All nursing staff re-educated on skin incontinence and products to use.  
- Weekly skin care rounds on all units  
- Daily rounding by NM/ANM  
- Education on hand-off communication to staff  
- Perform IA on all hospital-acquired pressure ulcers

Maintain hospital’s low HAPU rate and maintain 0 stage 3 and 0 stage 4 wounds
<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals 2017</th>
<th>Outcomes</th>
<th>Actions 2018</th>
<th>Goals 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mislabeled</td>
<td>&lt; 0.3%</td>
<td>There were 25 mislabeled specimens out of 1334218 accessions in 2018. Rate of 0.001% 11 of the events were in ED and 3 were in the OR.</td>
<td>• Continue to coach and remediate employees as necessary. • Perform intense analysis on all mislabeled specimens. • Analyze data for trends. • Continue the use of bedside specimen scanning.</td>
<td>Decrease number of mislabeled/unlabeled specimens by 10%. Goal to be at zero.</td>
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</tbody>
</table>

### IMPROVE EFFICIENCY

<p>| ED Throughput | At or Below National Average | ED-1b median time ED arrival to ED departure in 2018 was 348. In 2017 it was . ED-2b median admit decision time to ED departure was 133 minutes in 2018. In 2017 it was . | • Daily bed huddles with all charge nurses and supervisor for discharge pending patients • Monthly patient flow meetings led by ED Medical Director • ED metrics collected daily for patient flow • Hospitalist bed rounds to expedite discharges • Six Sigma team was established to decrease throughput times | Improve median ED throughput time to at or below national average. |</p>
<table>
<thead>
<tr>
<th>Patient Safety Dashboard</th>
<th>CY18 Goal</th>
<th>Stretch Goal</th>
<th>Q1</th>
<th>Q2</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Q3</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Q4</th>
<th>CY 18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Goal 1: Identify patients correctly</td>
<td>98% 99% 98% 99% 98% 99% 98% 99% 98% 99% 97% 99% 98% 97%</td>
<td>100% 100% 100% 100.0% 100% 100% 100.0% 100% 100% 100% 100% 100% 100% 100% 100%</td>
<td>a. Use 2 patient identifiers when providing care, treatment &amp; services. 01.01.01</td>
<td>b. Eliminate transfusion errors related to patient misidentification 01.03.01</td>
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<tr>
<td>2. Goal 2: Improve staff communication</td>
<td>74% 78% 80% 82% 81% 83% 85% 83% 84% 79%</td>
<td>100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%</td>
<td>a. Report critical results on a timely basis. 02.03.01</td>
<td>b. Laboratory: Critical readback notification</td>
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<tr>
<td>3. Goal 3: Use medicines safely</td>
<td>98% 99% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%</td>
<td>100% 100% 27% 100% - - - - 100% 100% 100% 100% 76%</td>
<td>a. Label all medications, medication containers &amp; other solutions on &amp; off the sterile field in perioperative &amp; other procedural settings. 03.04.01</td>
<td>b. Reduce the likelihood of harm associated with anticoagulant therapy-excessive anticoagulation with warfarin or INR &gt; 5. 03.05.01</td>
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<td>4. Goal 4: Use alarms safely</td>
<td>99% - - - - - - - - - -</td>
<td>100% 100% 27% 100% - - - - 100% 100% 100% 100% 76%</td>
<td>a. Improve the safety of clinical alarm systems. 06.01.01</td>
<td>b. Use hand cleaning guidelines from CDC or WHO. Set goals for and improve hand cleaning. 07.01.01</td>
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<tr>
<td>5. Goal 5: Prevent infection</td>
<td>90% 95% 87% 87% 86% 90% 89% 88% 92% 94% 92% 93% 89%</td>
<td>100% 100% 27% 100% - - - - 100% 100% 100% 100% 76%</td>
<td>a. Conduct preprocedure verification process. UP.01.01.01</td>
<td>b. Mark procedure site. UP.01.02.01</td>
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<tr>
<td>6. Goal 6: Identify patient safety risks</td>
<td>74% 78% 80% 82% 81% 83% 85% 83% 84% 79%</td>
<td>100% 100% 98% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99%</td>
<td>a. Find out which patients are most likely to try to commit suicide. 15.01.01</td>
<td>b. Reduce Pressure Ulcer Prevalence Stage II</td>
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<td>7. Goal 7: Prevent mistakes in surgery</td>
<td>07.03.01</td>
<td>2.7 0.0 3.7 0.0 0.6 0.8 2.8 1.4 3.0 4.0 1.0 2.7 1.9</td>
<td>100% 100% 27% 100% - - - - 100% 100% 100% 100% 76%</td>
<td>a. Conduct preprocedure verification process. UP.01.01.01</td>
<td>b. Mark procedure site. UP.01.02.01</td>
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<tr>
<td>8. Improve Outcomes: NDNQI Nurse Sensitive</td>
<td>74% 78% 80% 82% 81% 83% 85% 83% 84% 79%</td>
<td>100% 100% 98% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99%</td>
<td>a. Find out which patients are most likely to try to commit suicide. 15.01.01</td>
<td>b. Reduce Pressure Ulcer Prevalence Stage II</td>
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<tr>
<td>9. Readmissions</td>
<td>8.99% TBD 7.0% 8.2% 8.0% 7.3% 8.2% 7.8% 7.2% 2.9% TBD 5.0% 7.2%</td>
<td>100% 100% 98% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99%</td>
<td>a. All cause all payer</td>
<td>c. COPD all payer</td>
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<td>10. Improve Efficiency</td>
<td>0% TBD</td>
<td>0.0% TBD 10.6% 0.0% 0.0% 17.5% 0.0% 5.8% 0.0% 19.2% TBD 9.6% 6.2%</td>
<td>100% 100% 98% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99%</td>
<td>a. Improve ED to IP TAT (adult)</td>
<td>b. Improve Operating Room First Case Start Time</td>
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</tbody>
</table>
| 11. Improve Surgical & Procedural Safety | 51% TBD 57% 73% 76% 74% 87% 79% 77% 82% 63% 74% 71% | 100% 100% 98% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% 99% | a. Incidence of Potentially Preventable Venous Thromboembolism (VTE6) | b. PSI 13 - Post op sepsis | c. Sepsis core measure | #DIV/0!
<table>
<thead>
<tr>
<th>Goal</th>
<th>National Patient Safety Goals</th>
<th>Methods</th>
<th>Target</th>
<th>Actual</th>
<th>Result</th>
<th>Result</th>
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<tr>
<td>1</td>
<td>Improve the accuracy of patient identification</td>
<td>% of patients correctly identified</td>
<td>100%</td>
<td>99%</td>
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<td>2</td>
<td>Reduce medication errors</td>
<td>% medication errors</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>3</td>
<td>Improve the effectiveness of monitoring and managing catheter-related bloodstream infections</td>
<td>% of patients with catheter-related bloodstream infections monitored and managed</td>
<td>100%</td>
<td>95%</td>
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<td>4</td>
<td>Improve the effectiveness of monitoring and managing pressure ulcers</td>
<td>% of patients with pressure ulcers monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>5</td>
<td>Improve the effectiveness of monitoring and managing falls</td>
<td>% of patients with falls monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<td>6</td>
<td>Reduce medical errors</td>
<td>% of medical errors prevented</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>7</td>
<td>Improve the effectiveness of monitoring and managing ventilator-associated pneumonia</td>
<td>% of patients with ventilator-associated pneumonia monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<td>8</td>
<td>Improve the effectiveness of monitoring and managing hospital-acquired infections</td>
<td>% of patients with hospital-acquired infections monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>9</td>
<td>Improve the effectiveness of monitoring and managing surgical site infections</td>
<td>% of patients with surgical site infections monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>10</td>
<td>Improve the effectiveness of monitoring and managing venous thromboembolism</td>
<td>% of patients with venous thromboembolism monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>11</td>
<td>Improve the effectiveness of monitoring and managing cardiac arrest</td>
<td>% of patients with cardiac arrest monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>12</td>
<td>Improve the effectiveness of monitoring and managing patient blood transfusion reactions</td>
<td>% of patients with blood transfusion reactions monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<td>13</td>
<td>Improve the effectiveness of monitoring and managing patient medication errors</td>
<td>% of patients with medication errors monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<td>14</td>
<td>Improve the effectiveness of monitoring and managing patient falls</td>
<td>% of patients with falls monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>15</td>
<td>Improve the effectiveness of monitoring and managing patient infections</td>
<td>% of patients with infections monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>16</td>
<td>Improve the effectiveness of monitoring and managing patient deaths</td>
<td>% of patients with deaths monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>17</td>
<td>Improve the effectiveness of monitoring and managing patient adverse drug reactions</td>
<td>% of patients with adverse drug reactions monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>18</td>
<td>Improve the effectiveness of monitoring and managing patient adverse effects</td>
<td>% of patients with adverse effects monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<tr>
<td>19</td>
<td>Improve the effectiveness of monitoring and managing patient pain</td>
<td>% of patients with pain monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<td>20</td>
<td>Improve the effectiveness of monitoring and managing patient satisfaction</td>
<td>% of patients with satisfaction monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<td>21</td>
<td>Improve the effectiveness of monitoring and managing patient care</td>
<td>% of patients with care monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<td>22</td>
<td>Improve the effectiveness of monitoring and managing patient communication</td>
<td>% of patients with communication monitored and managed</td>
<td>100%</td>
<td>90%</td>
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<td>23</td>
<td>Improve the effectiveness of monitoring and managing patient education</td>
<td>% of patients with education monitored and managed</td>
<td>100%</td>
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<td>National Patient Safety Goals</td>
<td>LCY</td>
<td>Target</td>
<td>Jan</td>
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<td><strong>Goal 1: Improve the Accuracy of Patient ID</strong></td>
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<td>% of Lab Mislabeled Specimens</td>
<td>numerator</td>
<td>0.005%</td>
<td>0.03%</td>
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<td>Staff checked ID</td>
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<td>288,371</td>
<td>24,180</td>
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<td><strong>Goal 2: Critical Test Results Timeliness - Overall Goal 90 minutes</strong></td>
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<td>Critical Results &amp; Values - Nursing</td>
<td>numerator</td>
<td>205</td>
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<td>Critical Test - Respiratory (AIG)</td>
<td>numerator</td>
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<td>Critical Test - Radiology (CT Brain Attack)</td>
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<td>18</td>
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<td><strong>Goal 3: Improve Safety of Using Medications</strong></td>
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<td>Anticoagulant Occurrences</td>
<td>numerator</td>
<td>9</td>
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<td>Near Miss Anticoagulant Occurrences</td>
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<td><strong>Goal 4: Reduce Harm Associated with Clinical Alarms</strong></td>
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<td>Ventilator Alarms Customized to the Patient</td>
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<td>Physiologic Monitors Customized to the Patient</td>
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<td>Physiologic Alarms Audible</td>
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**Risk for Suicide**

Goal 15: Reduce Harm Associated with Clinical Alarms

**Goal 16: Reduce HCA Infections**

**Goal 17: Reduce Risk of HCA Infections**

**Goal 18: Universal Protocol**

**Note:** The table above provides a snapshot of various patient safety goals and their corresponding metrics for the years CY18 and beyond. The data includes numerators and denominators for various metrics, indicating improvements or the need for further action. For a comprehensive understanding, please refer to the full document for detailed insights and context.
Patient Safety Dashboard
CY 2018

CY17

CY18
Goal

Stretch
Goal

Jan

Feb

Mar

Q1

Apr

May

Jun

Medication Scan (all departments)

97%

98%

99%

97%

98%

98%

98%

98%

98%

Specimen Scan (all departments)

96%

97%

99%

97%

97%

94%

96%

97%

97%

100%

100%

100%

100%

100%

100%

100%

100%

89%

87%

87%

88%

Q2

Jul

Aug

Sept

Q3

Oct

Nov

98%

98%

99%

98%

98%

97.3%

97%

97%

99%

99%

99%

99%

96%

96.7%

96%

97%

100%

100%

100.0%

100%

100%

100%

100.0%

100%

100%

88%

83%

88%

89%

100%

100%

93%

98%

95%

Dec

Q4

CY 18 YTD

99%

99%

98%

96.0%

96.3%

97%

100%

100.0%

100%

95%

96%

95%

92%

a. Use 2 patient identifiers when providing
care, treatment & services. 01.01.01
1

Goal 1
Identify patients correctly

b. Eliminate transfusion errors related to
patient misidentification 01.03.01
a. Report critical results on a timely basis.
02.03.01

2

3

4

5

6

7

Goal 2
Improve staff
communication

Goal 3
Use medicines safely

Goal 4
Use alarms safely

Goal 5
Prevent infection

Goal 6
Identify patient safety
risks

Laboratory: Critical readback notification

100%

98%

99%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

100%

Laboratory: Nursing to LIP

77%

80%

85%

77%

74%

74%

75%

77%

83%

77%

79%

100%

100%

86%

95%

90%

89%

92%

90%

85%

Radiology: Critical results called < 45 min

97%

98%

99%

100%

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100%

100%

100%

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100%

a. Label all medications, medication
containers & other solutions on & off the
sterile field in perioperative & other
procedural settings. 03.04.01

98%

100%

100%

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100%

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100%

b. Reduce the likelihood of harm
associated with anticoagulant therapyexcessive anticoagulation with warfarin
for IP- INR > 6.
03.05.01

0.4%

0.8%

0.5%

0.0%

0.0%

0.0%

0.0%

0.0%

3.7%

0.0%

1.2%

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0.4%

a. Improve the safety of clinical alarm
systems.
06.01.01

new

90%

95%

100%

100%

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100%

a. Use hand cleaning guidelines from CDC
or WHO. Set goals for and improve hand
cleaning 07.01.01

91%

90%

95%

82%

84%

96%

87%

90

95

93%

93%

100%

93%

91%

95%

86%

90%

89%

88%

91%

b. C-diff (use guidelines to prevent
infections that are difficult to treat)
07.03.01

0.79 SIR

0.7

0.5

3.3

6.7

3.3

4.4

3.9

8.4

8.2

6.8

11.7

4.0

4.1

6.6

8.9

4.6

3.9

5.8

5.9

c. MRSA (use guidelines to prevent
infections that are difficult to treat)
07.03.02

1.66SIR

1.5

1.0

0.0

0.0

0.0

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0.4

0.0

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a. Find out which patietns are most likely
to try to commit suicide - BHU only
15.01.01

100%

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a. Conduct preprocedure verification
process. UP.01.01.01

100%

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3.5

3.0

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2.4

1.6

1.7

1.9

0.6

1.5

1.4

1.2

1.7

9

8

6

1

0

2

3

2

2

0

4

1

1

0

2

0

0

1

1

10

c. Restraint Incidence

179

221

199

14

14

23

51

9

13

13

35

17

11

11

39

12

6

9

27

152

d. Restraint Hours

5279

3877

3490

295

462

354

1111

201

327

454

982

433

417

5

855

0

0

0

a. All cause all payer with psych

12%

12.50% 11.83% 14.04% 14.26% 12.93% 13.71%

13.71%

b. Psych only all payer

10%

11.99% 11.03% 10.81% 12.58% 12.21% 11.87%

11.87%

Goal 7
Prevent
b. Mark procedure site. UP.01.02.01
mistakes in surgery
c. A time-out is performed before the
procedure. UP.01.03.01
a. Falls with injury

8

9

Improve Outcomes:
NDNQI Nurse Sensitive

b. Reduce Pressure Ulcer Prevalence >
Stage II

11

2948

Readmissions
c. COPD all payer

10

Average

Improve
Efficiency

Improve Surgical &
Procedural Safety

22.00%

21.20%

tbd

38.90% 23.80% 9.09% 19.63%

0.00%

6.70% 14.30%

7.00%

30.80% 29.40% 5.00% 21.73% 7.70% 14.30% 33.30%

13.25% 12.15% 15.12% 14.86% 13.16% 14.38%

13.38%

10.10% 10.90%

11.46%

12.10% 14.00% 10.50% 12.20% 10.10% 13.90% 14.50%

29.63%

d. All cause all payer w/o psych

13%

12.83%

12.72%

a. Improve ED to IP TAT

237

240

216

271

297

274

281

232

242

222

232

218

210

209

212

204

211

222

212

234

66%

66%

64%

68%

65%

66%

62%

b. Improve Operating Room First Case
Start Time

52%

56%

61%

63%

53%

59%

58%

53%

64%

60%

59%

67%

66%

c. Surgery Case Turnover time < 25 min

27 min

< 25
min

< 23
min

27

26

28

27

28

25

26

26

29

29

a. Incidence of Potentially- Preventable
Venous Thromboembolism (VTE6) PSI 12

4%

0%

0%

0%

1%

0%

0%

1%

0%

0%

0%

0%

0%

1%

0%

0%

0%

0%

0%

0%

b. PSI 13 - Post op sepsis

3.0%

2.0%

1.0%

2.5%

0.0%

0.0%

0.8%

0%

0%

0%

0.0%

0.0%

0%

0%

0.0%

0.0%

0.0%

0.0%

0.0%

0.2%

c. Sepsis core measure

58%

TBD

TBD

82%

50%

65%

66%

79%

73%

81%

78%

86%

86%

78%

83%

59%

81%

63%

68%

74%

29

27

390


ANNUAL EVALUATION OF THE ENVIRONMENT OF CARE FOR BROWARD HEALTH CORAL SPRINGS, HOSPITAL CY 2018

Respectfully Submitted By: John O’Connell CHFM, CHSP, CHC, CHE.
MISSION AND VISION

**Mission:** The mission of Broward Health is to provide quality health care to the people we serve and support the needs of all physicians and employees.

**Vision:** The vision of Broward Health is to provide world class health care to all we serve.

**Five Star Values:**
- Exceptional service to our community
- Accountability for positive outcomes
- Valuing our employee family
- Fostering an innovative environment
- Collaborative organizational team
REGION'S COMPOSITION (List the facilities that are included in the evaluation).

<table>
<thead>
<tr>
<th>Region:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broward Health Coral Springs Hospital</td>
</tr>
<tr>
<td>Coral Springs MOB</td>
</tr>
<tr>
<td>Coral Springs Women’s Center</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

This report will include a summarization of the following;

- Overall performance evaluation of the environmental safety program and safety management plan.
- Overall performance evaluation of the security program and security management plan.
- Overall performance evaluation of the hazardous materials and waste program and hazardous materials and waste management plan.
- Overall performance evaluation of the fire safety program and fire Safety management plan.
- Overall performance evaluation of the utilities program and utilities management plan.
- Report of progress on calendar year 2018 performance goals and plan objectives
- Priorities and goals for calendar year 2019

Information Collection and Evaluation System (ICES) (Key performance indicators for each area of the environment of care are tracked by quarter, each performance indicator is assigned a performance target, the quarterly performance rate is compared to the target to see if the indicator falls within range or below target. All data is reviewed by the EOC Committee).

EVALUATION PROCESS AND COMPONENTS (The EOC committee meets quarterly to evaluate the tracked performance indicators and action plan any that fall below target.

Committee Members

<table>
<thead>
<tr>
<th>Title</th>
<th>Department</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cecile Kaplan  Director</td>
<td>Epidemiology</td>
<td>Infection Control</td>
</tr>
<tr>
<td>John O’Connell  Director</td>
<td>Facilities</td>
<td>Safety Officer EOC Chairman</td>
</tr>
<tr>
<td>Michael Leopold COO</td>
<td>Administration</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Roberto Martinez Director</td>
<td>Radiology</td>
<td>Committee Member</td>
</tr>
<tr>
<td>David Gidley Admin Assistant</td>
<td>Administration</td>
<td>Committee Member</td>
</tr>
<tr>
<td>David Peterson Director</td>
<td>Surgery / OR</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Sandra Porter</td>
<td>Surgery / OR</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Kimberly Cerri  Manager</td>
<td>Quality</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Cheryl Wild  CNO</td>
<td>Nursing</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Claudine Robinson  Manager</td>
<td>Risk</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Felipe Manrique  Manager</td>
<td>Laboratory</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Mike DeKorte  Director</td>
<td>EVS</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Joan Davis</td>
<td>Administration</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Garnett Coke</td>
<td>Corporate Safety / Security</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Kelly Keys</td>
<td>Emergency Management</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Christina Ominku</td>
<td>Employee Health</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Marcos Mantel</td>
<td>Biomed</td>
<td>Committee Member</td>
</tr>
</tbody>
</table>

The following table includes the name of those individual who manages the environment of care programs.

<table>
<thead>
<tr>
<th>Environment of Care Program</th>
<th>Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>John O’Connell</td>
</tr>
<tr>
<td>Category</td>
<td>Responsible Party</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Security</td>
<td>John O’Connell</td>
</tr>
<tr>
<td>Hazardous Materials</td>
<td>John O’Connell</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>John O’Connell</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>John O’Connell</td>
</tr>
<tr>
<td>Utility Systems</td>
<td>John O’Connell</td>
</tr>
</tbody>
</table>
SAFETY MANAGEMENT PROGRAM

Reviewer: John O'Connell
Title: Regional Director of Facilities / Safety Officer / EOC Chairman
Region: Broward Health Coral Springs
Review Date: May 21st, 2019

Purpose: (The Safety Management Plan (the "Plan") establishes the parameters within which a safe Environment of Care is established, maintained, and improved for Broward Health facilities)

Scope: (Broward Health (BH) is made up of many diverse medical facilities. This Plan applies to patients, staff, Licensed Independent Practitioners (LIPs) and everyone else who enters a BH facility. The plan comprises those processes that define and measure an effective Safety program. These processes provide for a physical environment free of hazards and manage activities that reduce the risk of injury. The processes used for this plan are founded on organizational experience, applicable laws and regulations, and generally accepted safety practices.
The facilities that the safety management plan applies to are: Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, Broward Health Weston, Broward Health Community Health Services, Broward Health Physician Group, and business occupancies. Any differences in activities at each site are noted or defined within the site specific policies, as appropriate.)

Evaluation of the Scope: (Evaluate the scope to determine whether it there is any changes required to the applicability to covered people, places, things and procedures)

- Review of Program Objectives: (1. Comply with all applicable safety regulations and accepted safety practices. 2. Develop and implement an effective employee safety training program. 3. Maintain a system of inspection activities as well as incident reports and investigations aimed at reducing risk.4. Identify opportunities to improve performance. 5. Ensure facilities are constructed, arranged and maintained to provide for physical safety and personal privacy of the patient.6. Ensure all employee accidents, and injuries, are reported.)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational injury’s &lt; 6.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contaminated Needle Sticks &lt;1.65</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of Performance: In 2018 our OSHA recordable injuries were considerably better than in 2017 (2017 - 121), (2018 – 71), however, our performance target for the year is still unfavorable. The contaminated needle stick performance indicator had a favorable performance rate for the year but an unfavorable performance rate for the fourth quarter.
Performance Monitors #1

Monitor: Occupational injury’s

Target: 6.01  (Total Hours Worked / OSHA recordable injury’s)

Performance: 7.18

Performance Monitor Analysis  Q1 – 6.50, Q2 - 7.26, Q3 – 9.43, Q4 – 5.52

Overall Effectiveness of the Program’s Effectiveness: For the first three quarters of 2018 the quarterly performance indicators were unfavorable, however, the fourth quarter had a very favorable 5.52 score. The monitoring and injury investigations are beginning to have a positive effect on our scores. We will continue to monitor this performance indicator in 2019.

Performance Monitors for 2019: This performance indicator will continue to be monitored in 2019 as it is still an area that we can improve.

Performance Monitors #2

Monitor: Contaminated needle Stick

Target: 1.65  (Medical encounters / Number of needle sticks)

Performance: 7.18

Performance Monitor Analysis  Q1 – 0.45, Q2 – 1.42, Q3 – 1.39, Q4 – 1.91

Overall Effectiveness of the Program’s Effectiveness: For the first three quarters of 2018 the quarterly performance indicators were favorable, however, the fourth quarter had an unfavorable 1.91 score. We had an increase in 2018 (11) in comparison to 2017 (10)

Performance Monitors for 2019: This performance indicator will continue to be monitored in 2019 as we had an increase from 2017
SECURITY MANAGEMENT PROGRAM

Reviewer: John O’Connell  
Title: Regional Director of Facilities / Safety Officer / EOC Chairman  
Region: Broward Health Coral Springs  
Review Date: May 21st, 2019

Purpose: (The purpose of the Security Management Plan is to provide safety and security for all patients, everyone who enters the facilities, and property of the regional medical centers and ancillary sites.)

Scope: (Broward Health (BH) is made up of many diverse medical facilities. The Security Management Plan applies to all visitors, patients Licensed Independent Practitioners (LIPs) and staff members of every facility in Broward Health. BH operates under regional Environment of Care (EoC) Committees and one EoC Key Group, which has the final approval for all policies affecting the EoC program. The facilities to which this Management Plan applies to are: Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, and the Broward Health Community Health Services. Significant differences in activities at each site may be noted in site-specific policies, as appropriate.)

Evaluation of the Scope: No Changes to the scope at this time.

Review of Program Objectives: (The Objectives for the Security Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year’s program activities, performance measures, incident and injury reports, and environmental tours. The Objectives for this Plan are:

- Implement accepted practices for the prevention, proper documentation, and timely investigation of security incidents.
- Provide timely response to emergencies and requests for assistance. Educate staff as to their roles in the Security Management Plan.
- Identify opportunities to improve performance.
- Monitor areas of the facility to ensure patient privacy regarding Protected Healthcare Information (PHI) and HIPAA standards.)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodily Assault</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security Procedures</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Review of Performance:** In 2018 our Bodily assault were higher than in 2017 (2017 - 5), (2018 – 7), however, our performance target for the year is still favorable. The Security Procedures performance indicator had a favorable performance rate for 2018 and a better rate over 2017

**Performance Monitors #1**

**Monitor:** Bodily Assault

**Target:** 2.5  (Number of assaults / number of medical encounters)

**Performance:** The bodily assault performance indicator was below target (Favorable) for the entire year.

**Performance Monitor Analysis**  Quarter one we had 2 assaults with 22150 medical encounters for a 0.09 Performance rate. In Quarter two we had 1 assault with 21126 medical encounters for a 0.05 Performance rate. In Quarter three we had 3 assaults with 21606 medical encounters for a 0.14 Performance rate. In Quarter four we had 1 assault with 20988 medical encounters for a 0.05 Performance rate. In comparison to 2017 we had 2 additional assaults in 2018.

**Overall Effectiveness of the Program's Effectiveness:** The performance indicator was below target for the entire year; we met our goal.

**Performance Monitors for 2019.** We will continue to monitor the bodily Assault performance indicator as we did have a 2- incident increase over 2017.

**Performance Monitors #2**

**Monitor:** Security Procedures

**Target:** 95%

**Performance:** 99% The Security Procedures performance indicator was below target (Favorable) for the entire year.

**Performance Monitor Analysis**  Quarter one we had 180 areas surveyed with 178 areas compliant for a 99% Performance rate. Quarter two we had 9 areas surveyed with 9 areas compliant for a 100% Performance rate. Quarter three we had 7 areas surveyed with 7 areas compliant for a 100% Performance rate. In Quarter four we had 7 areas surveyed with 7 areas compliant for a 100% Performance rate. In comparison to 2017 we had a better performance percentage.

**Overall Effectiveness of the Program’s Effectiveness:** The performance indicator was below target for the entire year; we met our goal.

**Performance Monitors for 2019.** We will continue to monitor the security procedure performance indicator for 2019.
HAZARDOUS MATERIALS & WASTE MANAGEMENT PROGRAM

Reviewer: John O'Connell
Title: Regional Director of Facilities / Safety Officer / EOC Chairman
Region: Broward Health Coral Springs
Review Date: May 21st, 2019

Purpose: (The purpose of the Hazardous Materials and Waste Management Plan is to describe methods for handling hazardous materials and waste through risk assessment and management. The plan addresses the risks associated with these materials, wastes or energy sources that can pose a threat to the environment, staff and patients, and to minimize the risk of harm. The plan is also designed to assure compliance with applicable codes and regulations as applied to Broward Health buildings and services. The processes include education, procedures for safe use, storage and disposal, and management of spills or exposures.)

Scope: (Broward Health has many diverse medical facilities. This Management Plan applies to patients, staff, and any other persons who enter a Broward Health site. The facilities that the Hazardous Materials and Waste Management Plan apply to are: Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, Broward Health Weston, Broward Health Community Health Services, Broward Health Physician Group, and Other business occupancies. Any differences in activities at each site are noted or defined within the specific site policies, as appropriate. The scope of the Hazardous Materials and Waste Management program is determined by the materials in use and the waste generated by each Broward Health facility. Safe use of hazardous materials and waste requires participation by leadership at an organizational and departmental level, and other appropriate staff to implement all parts of the plan. Protection from hazards requires all staff that use or are exposed to hazardous materials and waste be educated as to the nature of the hazards and to use equipment provided for safe use and handling. Rapid, effective response is required in the event of a spill, release or exposure to hazardous materials or waste. The plan includes management of staff's practices so the risk of injuries and exposures is reduced and staff can respond appropriately in emergencies. Special monitoring processes or systems may also be required to manage certain hazardous gases, vapors, or radiation undetectable by humans.)

Evaluation of the Scope: No Changes to the scope at this annual evaluation.

Review of Program Objectives: The objectives for the Hazardous Materials and Waste program are developed from information gathered during routine surveillance tours, risk assessments, performance measures and the annual evaluation of the previous year's program activities. The objectives for this Plan are to:

- Comply with all applicable local, state, and federal hazardous materials and waste regulations and guidelines, such as EPA, FDEP, OSHA, CMS, TJC, ANSI, and FL Department of Health.
- Provide a safe and healthy environment for patients, staff, and visitors by controlling risks by way of proper handling and storage of hazardous materials and wastes, and minimizing the threat of exposures.
- Ensure all areas where hazardous materials are stored comply with regulatory requirements.
- Educate employees in the proper procedures to protect themselves from the risks posed by hazardous materials and wastes such as the use of emergency eyewash stations.
- Ensure staff is educated on the processes to access Safety Data Sheets
- Staff is appropriately educated to respond safely to hazardous material spills
- Identify opportunities to improve performance.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pounds of regulated Waste</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bio Waste secured correctly</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Review of Performance:** The Pounds of regulated medical waste per medical encounter performance indicator was below target for the entire year, we met our goal. Our average performance rate for 2018 was identical to 2017 at 1.20.

The Number of areas observed where biohazard waste was secured correctly performance indicator was below target (unfavorable) for Q2 and Q3 and above target for Q1 and Q4. Our average score was 93.2 for 2018 this was slightly better than 2017.

**Performance Monitors #1**

**Monitor:** Pounds of regulated medical waste per medical encounter.

**Target:** 1.60

**Performance** The bodily assault performance indicator was below target (Favorable) for the entire year.

**Performance Monitor Analysis** Quarter one we had 28958 pounds of regulated waste with 22158 medical encounters for a 1.31 Performance rate Quarter two we had 21472 pounds of regulated waste with 21126 medical encounters for a 1.02 Performance rate. Quarter Three we had 27499 pounds of regulated waste with 21606 medical encounters for a 1.27 Performance rate. Quarter Four we had 25458 pounds of regulated waste with 20988 medical encounters for a 1.21 Performance rate.

**Overall Effectiveness of the Program’s Effectiveness:** The performance indicator was below target for the entire year, we met our goal. Our average performance rate for 2018 was identical to 2017 at 1.20.

**Performance Monitors for 2019:** We will continue to monitor Pounds of regulated medical waste per medical encounter. In 2019 as it is a very valuable tool to measure our costly regulated waste usage.

**Performance Monitors #2**
Monitor: Number of areas observed where biohazard waste was secured correctly?

Target: 95% Compliant areas / Areas surveyed

Performance: 93.2 The Number of areas observed where biohazard waste was secured correctly performance indicator was below target (unfavorable) for Q2 and Q3 and above target for Q1 and Q4. Our average score was 93.2 for 2018 this was slightly better than 2017.

Performance Monitor Analysis: Quarter one we had 180 areas surveyed with 178 areas compliant for a 98.3% Performance rate. Quarter two we had 12 areas surveyed with 10 areas compliant for an 88.9% Performance rate. Quarter three we had 7 areas surveyed with 6 areas compliant for an 85.7% Performance rate. Quarter four we had 8 areas surveyed with 8 areas compliant for a 100% Performance rate.

Overall Effectiveness of the Program’s Effectiveness: The average performance indicator rate was below target for the 2019, we did not met our goal. Our average score was 93.2 for 2018 this was slightly better than 2017.

Performance Monitors for 2019: We will continue to monitor Number of areas observed where biohazard waste was secured correctly In 2019 as we did not meet our goal.
FIRE SAFETY MANAGEMENT PROGRAM

Reviewer: John O'Connell

Title: Regional Director of Facilities / Safety Officer / EOC Chairman

Region: Broward Health Coral Springs

Review Date: May 21st, 2019

Purpose: (The Purpose of the Fire Safety Management Plan (hereafter referred to as the "Plan") is to minimize the possibility and risks of a fire and protect all occupants and property from fire, heat and products of combustion. To ensure that staff and Licensed Independent Practitioners (LIPs) are trained and tested in fire prevention and fire safety so that they are able to respond appropriately to any fire emergency.)

Scope: (The Fire Safety Management Program is designed to assure appropriate, effective response to fire emergency situations that could affect the safety of patients, staff, LIPs and visitors, or the environment of Broward Health. The program is also designed to assure compliance with applicable codes and regulations. The Fire Safety Management Plan applies to every patient and anyone who enters any Broward Health location. The Fire Safety Management Plan applies to Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, Broward Health-Weston, Broward Health Community Health Services, and Broward Health Physician Group, and other business occupancies. Any differences in activities at each site are noted or defined within the specific site policies, as appropriate.)

Evaluation of the Scope: (Evaluate the scope to determine whether it there is any changes required to the applicability to covered people, places, things and procedures)

Review of Program Objectives: The Objectives for the Fire Safety Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, reports and environmental tours.

Provide an environment that minimizes the risks of fire and related hazards.

Protect individuals served, patients, personnel, visitors, and all who enter the facility, and property from fire, smoke, and other products of combustion.

Report and investigate fire protection deficiencies, failures, and user errors.

Provide education to personnel on the elements of the Plan, including "defend in place," transfer of occupants to areas of refuge, smoke compartment use, and evacuation.

Ensure fire alarm, detection, and suppression systems are designed, installed, and maintained to ensure reliable performance.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>False Alarms</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impeded egress corridor</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Review of Performance In 2018 our number of false alarms per square foot were higher than in 2017 (2017 - 5), (2018 – 17), however, our performance target for the year is still favorable. The Impeded Egress Corridor performance indicator had a favorable performance rate for 2018 and a slightly lower percentage rate over 2017

Performance Monitors #1 False Alarms

Monitor: The number of false alarms per square foot.

Target: 0.05

Performance: The false alarm performance indicator was below target (Favorable) for the Q1 and Q2 and above target (unfavorable) for Q3 and Q4.

Performance Monitor Quarter one we had 2 false alarms for a 1.01 Performance rate Quarter two we had 4 false alarms for a 1.01 Performance rate. Quarter Three 7 false alarm for a 0.15 Performance rate. Quarter Four 4 false alarm for a 0.09 Performance rate.

Overall Effectiveness of the Program’s Effectiveness: The performance indicator was substantially over our target performance rate of 0.05 for 2018. This was driven by the construction project to build the south tower. Our average performance rate for 2018 was 0.19 as compared to 2017 at 0.015

Performance Monitors for 2019: We will continue to monitor Fire alarm false alarms in 2019 as we had a considerable increase in false alarms in 2018 (17) over 2017 (5)

Performance Monitors #2 Impeded Egress Corridor

Monitor: Impeded Egress Corridor.

Target: 100%

Performance: The Impeded Egress Corridor performance indicator was slightly below target (unfavorable) for the Q1 and at target (favorable) for Q2, Q3 and Q4.

Performance Monitor Quarter one we had 180 areas surveyed with 178 areas compliant for a 98% Performance rate. Quarter two we had 9 areas surveyed with 9 areas compliant for an 100% Performance rate. Quarter three we had 7 areas surveyed with 7 areas compliant for an 100% Performance rate. Quarter four we had 8 areas surveyed with 8 areas compliant for a 100% Performance rate.

Overall Effectiveness of the Program’s Effectiveness: The performance indicator was slightly under our target performance rate of 100% for 2018.

Performance Monitors for 2019: We will continue to monitor Impeded Egress Corridor In 2019 as we did not meet goal.
MEDICAL EQUIPMENT MANAGEMENT PROGRAM

Reviewer: John O’Connell

Title: Regional Director of Facilities / Safety Officer / EOC Chairman

Region: Broward Health Coral Springs

Review Date: May 21th, 2019

Purpose: (The purpose of the Medical Equipment Management Plan is to ensure that Broward Health will maintain a medical equipment technology management program that manages risk, promotes safe and effective use of medical equipment for the care, monitoring, diagnosis, and treatment of patients)

Scope: (Broward Health has many diverse medical facilities. This Management Plan applies to every visitor, patient and staff member who enters a Broward Health (BH) site. BH operates under Regional Environment of Care Committees and an Environment of Care Key Group.

The facilities that the Medical Equipment Management Plan applies to are: Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, Broward Health-Weston, and Broward Health Community Health Services in which patients receive care, treatment, and services. If there are any significant differences in activities at a site it is noted in site-specific policies as appropriate.

The BH Medical Equipment Management Plan is designed to assess and control the physical and clinical risks of all medical equipment. Starting with instrument selection and application to planned maintenance programs, safety testing, calibration, repairs, educational services and disposition. The Broward Health system ensures that safety, operational, and functional checks are performed on medical equipment, including all life-support equipment, and that these activities are documented.)

Evaluation of the Scope: (Evaluate the scope to determine whether it there is any changes required to the applicability to covered people, places, things and procedures)

- Review of Program Objectives: To establish criteria for identifying, evaluating and inventorying equipment included in the program.

- To minimize the clinical and physical risks of equipment through inspection, testing and regular maintenance.

- To provide education to personnel on the capabilities, limitations and special applications of equipment; operating, safety and emergency procedures of equipment; the procedures to follow when reporting equipment management problems, failures and user errors; and the skills and/or information to perform maintenance activities.

- Assure operational reliability and functionality of clinical equipment through programmed maintenance.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed Equipment Inspection</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improper Care</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Review of Performance: The number of failed equipment inspections per total inspections performance indicator was below target for the entire year; we met our goal. Our average performance rate for 2018 was just slightly over 2017.

Performance Monitors #1

Monitor: The number of failed equipment inspections per total inspections

Target: 6%

Performance: The Failed equipment inspection performance indicator was below target (Favorable) for the entire year of 2018

Performance Monitor Analysis: Quarter one we had 99 failed equipment inspections with 2464 total inspections for a 4% Performance rate. Quarter two we had 0 failed equipment inspections with 141 total inspections for a 0% Performance rate. Quarter three we had 4 failed equipment inspections with 610 total inspections for a 1% Performance rate. Quarter four we had 3 failed equipment inspections with 154 total inspections for a 4% Performance rate. In comparison to 2017 (0.0125%) we had a slight increase to 0.0175% in 2018

Overall Effectiveness of the Program’s Effectiveness: The performance indicator was below target for the entire year, we met our goal. Our average performance rate for 2018 was just slightly over 2017.

Performance Monitors for 2019: We will continue to monitor the number of failed equipment inspections per total inspections. In 2019 as it is a very valuable tool to measure how well or equipment is being maintained.

Performance Monitors #2

Monitor: The number of improperly cared for medical equipment

Target: 2%

Performance: The number of improperly cared for medical equipment performance indicator was at or below target (Favorable) for the entire year of 2018

Performance Monitor Analysis: Quarter one we had 23 improperly cared for medical equipment with 2464 total inspections for a 1% Performance rate. Quarter two we had 4 improperly cared for medical equipment with 141 total inspections for a 1% Performance rate. Quarter three we had 1 failed equipment inspections with 610 total inspections for a 0% Performance rate. Quarter four we had 11 failed equipment inspections with 666 total inspections for a 2% Performance rate. In comparison to 2017 we had a slight percentage increase in 2018

Overall Effectiveness of the Program’s Effectiveness: The performance indicator was below target for the entire year, we met our goal. Our average performance percentage rate for 2018 was just slightly over 2017.

Performance Monitors for 2019: We will continue to monitor The number of improperly cared for medical equipment In 2019 as it is a very valuable tool to measure how well or equipment is being maintained.
UTILITIES MANAGEMENT PROGRAM

Reviewer: John O’Connell

Title: Regional Director of Facilities / Safety Officer / EOC Chairman

Region: Broward Health Coral Springs

Review Date: May 21st, 2019

Purpose: (The Utility Systems Management Plan (hereafter referred to as the “Plan”) provides a process for the proper design, installation, and maintenance of appropriate utility systems and equipment to support a safe patient care and treatment environment at Broward Health.)

Scope: (The Plan will assure effective preparation of staff responsible for the use, maintenance, and repair of the utility systems, and manage risks associated with the operation and maintenance of utility systems. Finally, the Plan is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education, and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at Broward Health. The Purpose of the Utility Systems Management Plan is developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year’s program activities, performance monitoring and environmental tours. The Objectives for this Plan can vary from site to site. The facilities to which this Management Plan applies to are: Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, and the Broward Health Community Health Services. Significant differences in activities at each site may be noted in site-specific policies, as appropriate)

Evaluation of the Scope: (Evaluate the scope to determine whether it there is any changes required to the applicability to covered people, places, things and procedures)

1. Review of Program Objectives: The Objectives for the Plan are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year’s program activities, performance monitoring and environmental tours. The Objectives for this Plan can vary from site to site.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy Efficiency</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generator Test</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of Performance: The Energy Efficiency performance indicator was below target (Favorable) for the entire year of 2018
Performance Monitors #1

Monitor: Energy Efficiency

Target: KWH / Square footage  Average 9.77

Performance: The Energy Efficiency performance indicator was below target (Favorable) for the entire year of 2018

Performance Monitor Analysis  Q1, 2,870,672 KWH / 340,000 SF for a Performance Rate of 8.44. Q2, 3,631,759 KWH / 460,000 SF for a Performance Rate of 7.90. Q3, 4,361,042 KWH / 460,000 SF for a Performance Rate of 9.48. Q4, 4,120,800 KWH / 460,000 SF for a Performance Rate of 8.96.

Overall Effectiveness of the Program’s Effectiveness The performance indicator was below target for the entire year, we met our goal. Our average performance rate for 2018 was just substantially over 2017. The increase in usage was driven by the increase in square footage due to the opening of the new south tower.

Performance Monitors for 2019: We will continue to monitor Energy Efficiency performance indicator. In 2019 as it is a very valuable tool to measure how well our equipment is being maintained.

Performance Monitors #2

Monitor: Number of generator tests completed

Target: 100%  Number of tests completed / Number of tests scheduled

Performance: The Energy Efficiency performance indicator was below target (Favorable) for the entire year of 2018

Performance Monitor Analysis  Q1, 3 tests scheduled 3 tests completed 100%. Q2, 3 tests scheduled 3 tests completed 100%. Q3, 3 tests scheduled 3 tests completed 100%. Q4, 5 tests scheduled 5 tests completed 100%.

Overall Effectiveness of the Program’s Effectiveness The performance indicator was at target for the entire year, we met our goal. Our average performance rate for 2018 was identical to 2017

Performance Monitors for 2019: We will continue to monitor Energy Efficiency performance indicator. In 2019 as it is a very valuable tool to measure how well our equipment is being tested.

ENVIRONMENT OF CARE PERFORMANCE IMPROVEMENT PROJECT

Reviewer: John O’Connell

Title: Regional Director of Facilities / Safety Officer / EOC Chairman

Region: Broward Health Coral Springs

Review Date: February 4th, 2019

Purpose: Continual self-improvement by monitoring and reporting to the quarterly EOC Committee

Scope: Broward Health Coral Springs EOC Improvement
**Cause:** (What trend(s) were identified that required implementation of this performance improvement initiative?)

**Duration:** (2018)

**Actions:** (Our EOC Meeting will now be held monthly)

**Reporting:** (Reported quarterly to the EOC committee)

**Persons:** All BHCS Disciplines

**Analysis:** In 2018 we had many positive outcomes as well as a few challenges. Our staff has met the challenges head on and through the EOC committee meeting were able to address these challenges together for positive outcomes.

**Outcome:** I feel that 2018 will go into the record books as a great year for patient and staff safety at BHCS.
OVERALL PERFORMANCE SUMMARY FOR THE ENVIRONMENT OF CARE PROGRAM AND PLANNING OBJECTIVES

Overall Performance Summary: The EOC Committee will meet monthly instead of quarterly in 2109 to improve our performance indicator scores and reporting to the EOC committee.

Planning Objectives for CY2019:

- **Safety Management**  *We Will Monitor Bodily Assault, Security Procedures*
- **Security Management**  *We Will Monitor Occupational injuries, Contaminated Needle Sticks*
- **Hazardous Materials & Waste Management**  *We will monitor Pounds of regulated Waste, Bio Waste secured correctly*
- **Medical Equipment Management**;  *We will Monitor Failed Equipment Inspection, Improper Care*
- **Fire Safety Management**  *We will Monitor False Alarms, Impeded egress corridor*
- **Utilities Management**;  *We will Monitor Energy Efficiency, Generator Test*
ANNUAL EVALUATION OF THE ENVIRONMENT OF CARE FOR BROWARD HEALTH IMPERIAL POINT CY 2018

Respectfully Submitted By:

Peter Coughlin, Facility Services Safety officer,

Marcos Mantel, Biomedical Engineering Executive Director,

Widlaire Isma, Security lieutenant,

Steve Thornton, Emergency Preparedness coordinator

Steve Fredrickson, Regional Manager Facility Services and The Environment of care Committee
MISSION AND VISION

**Mission:** The mission of Broward Health is to provide quality health care to the people we serve and support the needs of all physicians and employees.

**Vision:** The vision of Broward Health is to provide world class health care to all we serve.

REGION’S COMPOSITION.

<table>
<thead>
<tr>
<th>Region:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broward Health Imperial Point</td>
</tr>
<tr>
<td>Broward Health Outpatient Surgical Center</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The Environment of Care Committee Annual Report is designed to evaluate the objectives, scope, performance and effectiveness of each of the six Environment of Care Programs and associated Plans.

The Annual Report is also an analysis of the methods and processes used to plan for a safe, accessible, effective, efficient, and comfortable environment, which supports the Medical Center mission.

The report highlights safety activities, Environment of Care Committee accomplishments, opportunities for improvement, and goals for the next year.

The Annual Report is approved by the Environment of Care Committee and is presented to the Broward Health Environment of Care Key Group and then reviewed by the QAOC (Quality Assurance and Oversight Committee).

This report will include a summarization of the following;

- Overall performance evaluation of the environmental safety program and safety management plan.
- Overall performance evaluation of the security program and security management plan.
- Overall performance evaluation of the hazardous materials and waste program and hazardous materials and waste management plan.
- Overall performance evaluation of the fire safety program and fire Safety management plan.
- Overall performance evaluation of the utilities program and utilities management plan.
- Report of progress on calendar year 2017 performance goals and plan objectives
- Priorities and goals for calendar year 2018

Information Collection and Evaluation System (ICES), Performance Monitoring Metrics (PMR) are established for each Element of the Environment of care. Targets are developed based on past performance and regulatory requirements.

EVALUATION PROCESS AND COMPONENTS, Information is gathered for each quarter. The Data is summarized on a EOC Dash Board. Results on the Dash Board are reviewed and analyzed for any trends or Performance Indicators that are not meeting the goal.
# ENVIRONMENT OF CARE

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
<th>CY17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Productive Manhours</td>
<td>396,725</td>
<td>395,696</td>
<td>392,217</td>
<td>385,156</td>
<td>1,569,794</td>
<td>1,599,143</td>
</tr>
<tr>
<td><strong>Total Injuries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(#*200,000)/manhours</td>
<td>10</td>
<td>14</td>
<td>15</td>
<td>13</td>
<td>52</td>
<td>50</td>
</tr>
<tr>
<td>per 25 employees. Target &lt;or =6.01</td>
<td>5.04</td>
<td>7.08</td>
<td>7.65</td>
<td>6.75</td>
<td>6.63</td>
<td>6.25</td>
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<tr>
<td><strong>APD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Contaminated Needle Sticks</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>per 10,000 APD. Target &lt;or =1.4 *Formula APD's -23,392</td>
<td>1.71</td>
<td>2.25</td>
<td>0.92</td>
<td>1.94</td>
<td>1.98</td>
<td>2.30</td>
</tr>
<tr>
<td>Staff knowledge. Target &gt;90%</td>
<td>99%</td>
<td>99%</td>
<td>95%</td>
<td>97%</td>
<td>98%</td>
<td>93%</td>
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<tr>
<td><strong>Hazard Materials and Waste Mngt</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lbs of Red Bag Waste</td>
<td>13,254</td>
<td>14,251</td>
<td>14,300</td>
<td>9,100</td>
<td>27,505</td>
<td>58,296</td>
</tr>
<tr>
<td>Per APD target &lt; or = 1.80 APD-22246</td>
<td>0.57</td>
<td>0.64</td>
<td>0.66</td>
<td>0.44</td>
<td>0.61</td>
<td>0.59</td>
</tr>
<tr>
<td>Staff knowledge. Target &gt;90%</td>
<td>94%</td>
<td>91%</td>
<td>92%</td>
<td>91%</td>
<td>92%</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Fire Safety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>False Alarms # per quarter target &lt;or= 11 per year</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>0</td>
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<tr>
<td>Staff knowledge. Target &gt; or = to 95%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Security Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Bodily Assaults. Target &lt; or = 24</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Staff knowledge. Target &gt;90%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>97%</td>
<td>98%</td>
<td>96%</td>
</tr>
<tr>
<td><strong>Utilities Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy Efficiency Rate is kilowatt hours per sq ft of occupied space. Target &lt; or= 11.11 (kwh/304,000)</td>
<td>9.43</td>
<td>9.69</td>
<td>11.3</td>
<td>10.5</td>
<td>9.56</td>
<td>10.10</td>
</tr>
<tr>
<td>Unscheduled outages &gt;4 hrs. Target &lt; or= 2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Staff knowledge. Target &gt;90%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>93%</td>
</tr>
<tr>
<td><strong>Medical Equipment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failed Performance. Target &lt; or = 10%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Improper Care % of equip. Target &lt; or= 2%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Staff knowledge. Target &gt;90%</td>
<td>99%</td>
<td>96%</td>
<td>96%</td>
<td>95%</td>
<td>97%</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Emergency Preparedness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hazard Vunerability - due April</td>
<td>Pending</td>
<td>Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed Drills (requirement is ( 2 )</td>
<td>Pending</td>
<td>Pending</td>
<td>Complete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chapter Review - Annually</td>
<td>Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Negative Var >5%  Neg Var <5%  Meeting Target
### Committee Members

<table>
<thead>
<tr>
<th>Title</th>
<th>Department</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>Administration</td>
<td>Member</td>
</tr>
<tr>
<td>CFO</td>
<td>Administration</td>
<td>Member</td>
</tr>
<tr>
<td>Director Bio Medical Engineering</td>
<td>Bio Medical Engineering</td>
<td>Chapter Leader</td>
</tr>
<tr>
<td>Epidemiologist</td>
<td>Epidemiology</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Manager</td>
<td>Lab Manager</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Director</td>
<td>Operating room</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Director</td>
<td>Quality</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Manager</td>
<td>Emergency room</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Manager</td>
<td>Risk Management</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Manager 3rd floor/Wound care</td>
<td>Facility Services</td>
<td>Fire Safety officer/Chapter leader</td>
</tr>
<tr>
<td>Master Service Mechanic</td>
<td>Employee Health</td>
<td>Member</td>
</tr>
<tr>
<td>Health Nurse</td>
<td>Processing</td>
<td>Member</td>
</tr>
<tr>
<td>Supervisor</td>
<td>Nuclear Medicine</td>
<td>Member</td>
</tr>
<tr>
<td>Lead Nuclear Technician</td>
<td>Human Resource</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Manager</td>
<td>Facility Services</td>
<td>Life Safety, Hazardous materials, Utility management, Safety management/Chapter leader</td>
</tr>
<tr>
<td>Lieutenant/Site Captain</td>
<td>Security</td>
<td>Chapter Leader</td>
</tr>
<tr>
<td>Emergency preparedness coordinator</td>
<td>Emergency Preparedness</td>
<td>Emergency Management Chapter leader</td>
</tr>
</tbody>
</table>

The following table includes the name of those individual who manages the Environment of care programs.

<table>
<thead>
<tr>
<th>Environment of Care Program</th>
<th>Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Management</td>
<td>Steve Fredrickson</td>
</tr>
<tr>
<td>Security</td>
<td>Widlaire Isma</td>
</tr>
<tr>
<td>Hazardous Materials</td>
<td>Steve Fredrickson</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>Peter Coughlin</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Marcos Mantel</td>
</tr>
<tr>
<td>Utility Systems</td>
<td>Steve Fredrickson</td>
</tr>
<tr>
<td>Emergency Preparedness</td>
<td>Steve Thornton</td>
</tr>
</tbody>
</table>
Purpose: Providing an environment free from Hazards.
- Assessing risk associated with buildings, ground, equipment, occupants, and physical systems.
- Using risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff and other people coming to the Medical Center’s facilities.
- Evaluating environmental conditions, work practices and staff knowledge of the Environment of Care through a hazard surveillance process (environmental tours), conducted semi-annually in areas where patients are served and annually in non-patient areas.
- Reporting, investigating and taking actions as necessary to address incidents involving patients, staff, and other people coming to the Medical Center’s facilities as well as incidents involving equipment and buildings.
- Reviewing, distributing, practicing, and enforcing Safety/Environment of Care policy and procedures.
- Responding to product alerts and recalls in a timely manner.
- Providing Safety/Environment of Care orientation and on-going education through health stream.
- Managing staff activities to reduce the risks of injury.
- Conducting proactive risk assessments when planning demolition, construction, or renovation to address potential impact on air quality, infection control, utility requirements, noise, vibration and emergency procedures.
- Providing a smoke free environment in all the Medical Center’s facilities.
- Examining and addressing as necessary, Safety/Environment of Care issues at quarterly meetings of a multidisciplinary Environment of Care Committee.
- Having a qualified individual to oversee and monitor Safety Management, and intervene whenever conditions pose an immediate threat to life, health, equipment or disruption of service.
- Carrying out an effective worker safety program.
• Maintaining an environment that is sensitive to patient needs and conductive to comfort, social interaction, privacy and safety as well as minimizing environmental stress for patients, staff and other people coming to the Medical Center’s facilities. Based on a review of the current Safety Management Plan and performance indicators, these objectives are appropriate for the management of safety within Broward Health Imperial Point facilities. Therefore, no changes to the plan objectives will be recommended at this time.

Scope: The scope of the Safety Management Program was evaluated and encompasses the following:

• Broward Health Imperial Point buildings, grounds, equipment, and facilities on and off campus.

• Broward Health Imperial Point departments, services, and associated personnel on and off campus

• All Broward Health Imperial Point disciplines, with particular support and contribution from:
  • All applicable regulations promulgated by Federal, State and local authorities.
  • All applicable standards of accrediting organizations.
  • All applicable Medical Center and Broward Health policies and procedures

• Evaluation of the Scope: Performance associated with the Safety Management Program is determined by examining performance standards and indicators (measures), assessing compliance with regulatory/accreditation, and evaluating performance improvement projects, as well as opportunities for improvement identified. Reviewed and revised the Safety Management Plan to reflect changes made during the year, which was submitted for approval.

Occupational injuries/incidents:

• The number of lost time cases this year is 52 for the 12 month period, compared to 63 for CY17. Cost of injuries was $25,667 versus $29,141 in CA 17 12% a reduction of $3474. 12%

• The number of contaminated needle sticks in CY '18 is 15, compared to 14 total for CY17. When measuring contaminated needle stick injuries per 10,000 APD the incident rate this year is 2.30 compared to CY17 which was 1.35

• There were 2 Sharp Object injuries for the year.
• Slip Trips and fall was 12 compared to 17 in CY 17. In reviewing the incidents there was a number of falls related to broken chairs. Throughout CY 18 departments have been replacing chairs.
• Back injuries were 2 for CY 18 and 9 for CY 17.
• The OSHA recordable rate for CY1 is 6.63 for 52 cases, compared to 50 cases in CY2017 with a rate of 6.25
• The total number days of worker injuries for CY18 was 110 compared to 230 in CY 17.
• The number of body assaults was 12 compared to 13 in CY17.

**Environmental Tours/Staff knowledge of EOC:**

• A multidisciplinary team conducted environmental tours of all patient care areas semi-annually with 28 tours and 6 tours annually in non-Patient care areas.
• Results of the rounds were sent to the department managers and they completed corrective actions on the findings.
• The total findings were 1122. There were 475 General findings, these were for Facilities services, 647 Infection control findings, these were for Environmental Services, and 293 Life Safety findings.
• Staff knowledge and awareness of Safety Management assessed during environmental tours was above the 90% performance standard with a score of 98%.

**Construction Safety:**

• Weekly construction site hazard surveillances were performed for each of the 18 sites. Projects passed inspection (18) Infection Control Risk Assessments (ICRA) were performed to proactively address infection control and the safety impact associated with construction projects and facility renovations.
• There were no (0) projects that required Interim Life Safety Measures.

**Industrial Hygiene:**

• Hazardous gases and vapors were monitored and managed during the year. All results were within the OSHA/NIOSH permissible exposure limits (PELs).
• All Preventive Maintenance (PMs) for air relationships in all clean and soiled areas maintained. Increased surveillance in all the soiled and clean areas in the Operating rooms and support areas by doing daily pressure checks.
• Air exchange rates, temperature, and humidity were checked in all the 13 operating rooms. Any readings that were not within the FGI guidelines were adjusted or brought to the department’s attention. Readings are recorded daily first thing in the morning.
Increased temperature and Humidity sensors to Med rooms and other support areas.
(Temp Trak) on all Clinical refrigerators to improve proper temperature is ongoing.
Temp Trak training conducted bi weekly for all areas using the system.
Promoted Patient Safety through awareness programs, ongoing nursing unit and
departmental assessments, and addressing sentinel event alerts and National Patient
Safety Goals.

Other

The multidisciplinary Environment of Care Committee met four times during the 12 month
period.
Product recalls were checked and of those that required action which was addressed
100% of the time in CY 2018.

Effectiveness.
The Safety Management Program was determined effective during the year, as evidenced by
performance standards, goals, and objectives that were routinely met and
regulatory/accreditation compliance regularly maintained. However, opportunities for
improvement were identified and are included in CY2019 goals. Additional accomplishments
complementing the Safety Management Program and enhancing effectiveness included:

- Conducted Life Safety Environmental rounds weekly by a multidisciplinary group.
- Added follow up on these rounds
- Improved attendance during rounds.
- Daily Monitoring of the Temp trak system very beneficial.
- Provided staff education in Blood and Body fluid protection safe sharps handling to all
  clinical areas.
- Continue to remove surplus equipment from the facility.
- Successful TJC inspection. 4 findings.
- Successful AHCA inspection.
- Successful Fire Department inspection

Goals CY 18-

- Reduce contaminated needle sticks.

Goals CY 19-

- Decrease turnaround time on EOC rounds follow up to safety issues to 3 days.
- Continue education to staff on reducing needle sticks.
The Security Management Plan is designed to establish and maintain a security program that protects patients, visitors, and employees from harm and that guards the physical and intellectual property of the organization.

The Environment of Care Committee reviewed the Security Management Plan for effectiveness. The Objectives for the Security Management Plan were found to be appropriate in CY 2018. The Scope of the Security Management Plan was reviewed and it was determined to be adequate for supporting a safe and effective Environment of Care. Performance is discussed and analyzed below. The Security Management Plan is considered to be effective. Goals have been established to direct the Security Management Plan in CY 2019.

**Objectives**

The objectives of the Security Management Program are:

- Implement accepted practices for the prevention, proper documentation, and timely investigation of security incidents.
- Provide timely response to emergencies and requests for assistance.
- Educate Broward Health staff as to their roles in the Security Management Plan.
- Identify opportunities to improve performance.

Based on a review of our current plan and the performance indicators, the Security Management Plan objectives are appropriate. Therefore, no changes to the Plan objectives will be recommended at this time.

**Scope**

The Security Management Program applies to all employees, visitors, students, patients, and all those who enter Broward Health Imperial Point. Services include emergency room coverage, patient valuables control, consultative site reviews, access control assistance, investigative assistance, lost and found, patrol services of the facility and grounds, escort services, parking enforcement, assistance to Threat of Violence (TOV) victims, and other services. Local, county, state, and federal law enforcement agencies support the Protective Services Department through close working relationships with site security personnel.
Performance

- The number of Assault/Battery incidents decreased from 25 in CY 2017, to 14 in CY 2018.
- The number of Code Assist incidents decreased from 897 in CY 2017, to 58 in CY 2018.
- Missing/Lost Property incidents: new tracking metrics for CY 2018.
- The number of Thefts: decreased from 1 in CY 2018 to 0 in CY 2018.
- Staff knowledge and awareness of Security Management assessed during environmental tours was above the 90% performance standard with a score of 96% for 396 questions Answered in staff questionnaires.

Effectiveness

Broward Health transitioned to a new security provider in the second quarter of 2018. This transition had a direct impact on the security programs ability to meet the established goals set by Broward Health Imperial Point during 1Q18. While incident reporting and tracking remains a challenge, increases in the number of security incidents during CY2018 can be attributed to the transition between security providers and new reporting/documenting standards.

The goals that were not met will be a focus for the department in CY2018 by creating action plans and monitoring throughout the year. Other areas for improvement will be addressed through a series of increased awareness training sessions.

In addition to the annual survey, the department also participates in a series of EOC rounds to improve the quality of service and ensure that the overall goals of EOC are met. The department also has ongoing projects and surveys designed to improve the effectiveness of the Plan by working with several departments including Safety and Facilities to improve physical security aspects of the Plan. Security also conducts an annual Security Vulnerability Assessment designed to prioritize security concerns within the facility that can be addressed by Management.
Results of Goals for CY 2018

- Implement TrackTik, a cloud-based security workforce management platform that is used for establishing guard tours and incident/activity reporting. DONE
- Introduce a new template that will enhance reporting and tracking incident trends. This new template will be used as the monthly security report to the EOC. DONE
- Continue to monitor the amount of violent acts (assaults, aggressive behavior, and threats of violence) and in coordination with the safety officer and clinical leaders, establish a program that emphasizes “early intervention” to escalating behaviors.
- Continue to monitor the amount of missing property reports in a quarter. If the number of incidents increases more than 5% over the 2017 average, and action plan will be developed to address the issue.
- Enhance protection efforts through continued training and education of security staff.
  a) Conduct in-house security training meetings
  b) Ensure that security staff has knowledge of and demonstrate how to respond to BH emergency codes.

Goals for 2019

- Continue to decrease assaults thru education of staff in NVCI technics, and de-escalation principles
- Focus on educating staff on situational awareness and being more conscious about securing personal items as well as doors and or depts. that are not occupied.
- Emphasis on the reduction of lost and found items through education and implementation of the sweep the room campaign.
Purpose: The Hazardous Materials and Waste Management Program and associated plans are based upon the following objectives:

- Providing a process for the selecting, handling, storing, transporting, using and disposing of hazardous materials from receipt through final disposal (cradle to the grave).
- Insuring minimal risk to employees, patients, other people coming to the Medical Center’s facilities, the community and the environment by complying with all Federal, State and local regulations governing hazardous materials and wastes.
- Maintaining a current chemical inventory of hazardous materials both regulated and non-regulated and associated Safety Data Sheets (SDS) accessible to all staff through a contract with 3E for “SDS on Demand.”
- Managing chemical waste, chemotherapeutic and radioactive waste, universal waste, and regulated medical/ infectious waste, including sharps and waste gases in a manner to protect staff, patients, visitors, and the environment.
- Ensure appropriate space is maintained for safe handling and storage of hazardous materials and waste.
- Ensure appropriate labeling of containers of hazardous materials and waste and posting warning notices in areas where hazardous materials or wastes are used/ stored.
- Providing an orientation and on-going education/training program for staff, volunteers and contractors, through Health Stream.
- Conduct on-going monitoring of air quality in areas where hazardous materials are stored or used, including but not limited to formaldehyde, nitrous oxide, halogenated anesthetics and xylene.
- Providing a trained spill team for the remediation of hazardous chemical spills.
- Maintaining appropriate equipment for the Spill Team to safely mitigate spills.
- Reviewing, distributing, practicing, and enforcing the Hazardous Materials and Waste Management Plan policies and procedures.
- Maintaining current permits, licenses and other documentation to validate adherence to regulatory requirements.
• Maintaining manifests for handling hazardous materials and wastes.
• Managing disposal/recycling activities for hazardous waste.
• Carrying out an effective radiation safety program that protects patients, personnel, visitors and the environment.
• Ensure processes are designed, in place, and practiced to minimize the risk of harm from regulated medical waste. This includes but is not limited to education, procedures for safe handling, collection, storage, disposal and management of spill or exposures to regulated medical waste.

**Scope:** The scope of the Hazardous Materials and Waste Management Program encompasses the following:

• Compliance with regulations promulgated by the Occupational Safety and Health Administration, the US Environmental Protection Agency, NRC, Florida Department of Health, Agency for Health Care Administration (AHCA), the Florida Department of Environmental Protection and the City of Fort Lauderdale Public Works Department. Broward County.
• All applicable standards of accrediting organizations.
• Scope is effective for Hazardous materials.

**Evaluation of the Scope:** This past year we have seen increased surveillance and adherence to existing standards. Also new requirements From Broward County Environmental protection agency on diesel storage tanks.

**Review of Performance:** Performance associated with the Hazardous Materials and Waste Management Program is determined by examining performance standards and indicators, reviewing regulatory/accreditation compliance, and evaluating improvement projects or opportunities for improvement.

• There were 891 lbs. of Universal waste removed from the Medical Center for recycling by a licensed facility. This waste included fluorescent lamps, lead, and NiCad batteries.
• There were 15,250 lbs. of Pharmaceutical waste generated, manifested and removed per all USEPA requirements for Florida Universal Waste Pharmaceuticals.
• There were 6279 lbs. of P-listed waste generated, manifested, and removed.
• All hazardous waste was removed by licensed waste haulers, and manifested for disposal at licensed disposal facilities.
• Generated and disposed of 888,840 lbs solid waste in CY 18. Last CY was 75% of total waste this CY its 76% industry average is 77%.
• Generated and disposed of 50,935 lbs Regulated Medical waste in CY 18. Last CY was 3% of total waste this CY its 4% industry average is 8%.
• Generated and recycled 254,986 lbs of Card Board, paper plastic and other recyclable materials. Last CY was 20% of total waste this CY its 20%. Industry average is 15%.
- Staff knowledge and awareness of Hazardous Materials and Waste Management assessed during environmental tours did meet the 90% performance standard. There were 561 questions asked.
- Radioactive waste inventory was maintained on a daily basis.
- All radioactive waste was managed appropriately either by decaying on campus to background levels or by returning to the manufacturer in their leaded container.
- Hazardous gases and vapors were monitored and managed during the year. All results were within the OSHA/NIOSH permissible exposure limits (PELs).
- Reviewed and revised the Hazardous Materials and Waste Management Program to reflect changes made during the year, which was submitted for approval.
- Stericycle provided training sessions and trained staff on Regulated Medical waste, Pharmaceutical waste and recycling.
- Grease trap cleaning every three months.
- Biomedical waste was below target of 1.80 LBS per Adjusted patient at .59 LBS.
- Radioactive waste flow was monitored around the clock, 24/7.
- Annual heavy metals testing with the city of Fort Lauderdale, results negative.
- There were (1) spill cart training conducted this year

**Effectiveness:** Based on a review of the current Hazardous Materials and Waste Management Plan and performance indicators, these objectives and scope were appropriate and Effective for the management of hazardous materials and waste within the Broward Health Imperial Point facilities for CY2018.

**Performance Monitors for 2018 (Goals): Status**

- Conduct four Pharmaceutical waste handling in-services with clinical staff. **Completed**
- Conduct two Spill cart training classes. **Completed one**
- Conduct further training on the Labeling requirements for the SDS program. **Pending**
- Conduct training on signing/understanding Manifests. **Pending**
- Staff training on SDS and GHS labeling. **Ongoing through Health Stream**

**Performance Monitors for 2019 (Goals):**

- Conduct further training on the Labeling requirements for the SDS program.
- Conduct training on signing/understanding Manifests.
Purpose:

The Fire Safety Program and associated plans are designed to maintain a fire-safe environment for the protection of patients, staff and others coming into the hospital as well as property by meeting the following objectives:

- Inspecting, testing and maintaining fire protection systems, equipment and components in accordance with applicable standards.
- Ensuring the fire-resistive and smoke-tight integrity of building elements and features.
- Reporting, investigating and taking actions as necessary to address fire safety incidents.
- Providing an effective fire safety orientation and on-going education/training program for staff through Health stream.
- Conducting quarterly fire drills on each shift and increasing frequency when interim life safety measures are in place, there were none required this year.
- Monitoring, maintaining, and updating the Life safety conditions.
- Reviewing proposed acquisitions of furnishings, curtains, drapes, interior finishes, equipment, etc. for fire safety features/fire spread ratings.
- Implement interim life safety measures (ILSM) that compensate whenever the features of fire or life safety are compromised.
- Reviewing, distributing, practicing, and enforcing fire prevention and fire response policies and procedures.
- Maintaining a cooperative working relationship with the FLFD.
- Complying with all applicable Federal, State, and local Fire Safety regulations.
- Carrying out an effective Life Safety Building Maintenance Program.

Based on a review of the current Fire Safety Plan and performance indicators, these objectives are appropriate for the management of fire safety within Broward Health Imperial Point facilities. Therefore, no changes to the plan objectives will be recommended at this time.
Scope:

The scope of the Fire Safety Management Program encompasses the following:

- All Broward Health Imperial Point buildings, grounds, equipment and facilities on and off campus.
- All Broward Health Imperial Point departments, services and associated personnel on and off campus.
- The following Life Safety processes:
  1. Fire alarm testing, maintenance and certification
  2. Fire sprinkler system testing, maintenance and certification
  3. Contractor knowledge, training and certification
  4. Fire extinguisher and other fire suppression system testing, maintenance and certification.
  5. Annual Fire door inspections and corrections.
  6. Interim Life Safety management
  7. Completed Fire/damper inspections.
  8. Building rounds to assess life safety conditions.
  9. Mechanical systems assessment
  10. Fire drill planning, conducting drills, assessment and follow-up.
- All applicable regulations promulgated by Federal, State and local authorities.
- All applicable standards of accrediting organizations.

Performance

Performance associated with the Fire Safety Program is determined by examining performance standards and indicators (measures), assessing regulatory, and accreditation compliance, and evaluating performance improvement projects as well as opportunities for improvement. Additionally, performance is evaluated on timeliness and completion of preventive maintenance and/or repairs of fire/life safety systems, equipment and components.

The following information highlights CY2018 performance:

- Fire drills were held on all shifts at a rate of at least 1 drill per shift per quarter, with additional quarterly drills in the Lab and the ASC, for a total of 20 fire drills conducted with 68 monitored areas.
- All drills were evaluated and exceeded the 80% performance standard with an average score of 99%.
- Staff knowledge of fire safety, assessed during fire drills, the performance standard of 95% was met with a score of 98%. There were 1,399 correct answers.
- All inspection, testing, and maintenance of fire alarm detection systems, and all automatic fire extinguishing systems were completed within prescribed time frames, with identified deficiencies corrected in timely manner.
- All fire extinguishers were inspected monthly and received their annual maintenance and certification. The distribution and location of fire extinguishers was evaluated and additional fire extinguishers were installed where it was felt to be necessary.
- There was 5 unscheduled activation of the fire alarm system for the CY 18, the benchmark was 11 or less for the year. The ongoing implementation of the hot work permit program and increased awareness and vigilance etc. has resulted in fewer false alarms.
- Annual Fire department inspection.
- TJC inspection.
- Fire dampers inspections completed

![Chart showing BHIP False Fire Alarms Since FY 2009](image)

- There was 0 fires in CY 18
- The building maintenance program was 100% compliant with respect to the functional status of fire safety features, exceeding the target of 95%.

**Effectiveness**

- The Fire Safety Program was considered effective during CY2018 as evidenced by performance standards, goals and objectives that were met and
the level of regulatory compliance maintained. Over all very good inspection by the TJC.

- An ICES report is submitted on a quarterly basis to the EOC Committee. See the metrics for CY 2018 below:

**Results on Goals for CY 2018 Fire Safety**

- Replace standard fire sprinkler heads in ICU with quick response heads. **Completed**
- Deploy and arm Inergen fire extinguishing system in computer room. **Completed**
- Replace recalled fire sprinkler heads in Outpatient Dept. **Completed**
- Replace Duct Detectors on 7th floor. **Completed**
- Continue to train staff on RACE and PASS. Ongoing through Health Stream.
Replace buried 10 inch fire line and main feeds to fire department connections.  
Completed

Goals for CY 2019 Fire Safety

- Get approval to reset the Fire alarm after a false activation of the Fire alarm system.
- Get all Fire alarm systems and devices covered with Contracts.
- Update all Nodes with new Firmware and hardware
Purpose: Unlike other EoC functions, the management of the Medical Equipment program for all the facilities of Broward Health is done by the Clinical/Biomedical Engineering Executive Director and his staff from one central location. In keeping in line with the centralized nature of the Biomedical Engineering organization, this section of the annual appraisal covers all the Broward Health facilities/regions. Performance is tracked by region with corresponding corrective action plans as deemed necessary.

Objectives

The Medical Equipment Management Plan is designed to meet the following objectives:

- To establish criteria for identifying, evaluating and inventorying equipment included in the program.
- To minimize the clinical and physical risks of equipment through inspections, testing and regular maintenance. An Alternate Equipment Management (AEM) Program (CMS) is implemented for all equipment with some exceptions.
- To provide education to personnel on the capabilities, limitations and special applications of equipment; operating, safety and emergency procedures of equipment; the procedures to follow when reporting management problems, failures and user errors; and the skills and/or information to perform maintenance activities.

Based on a review of our current Plan and the Environment of Care performance indicators, these objectives are appropriate for the management of medical equipment within the Broward Health facilities. Therefore, no changes to the Plan objectives will be recommended at this time.

Scope

The Plan provides an overview of the processes that are implemented to ensure the effective and safe management of medical equipment in the environment of care. The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnosis, therapy, monitoring, and treatment of patients at Broward Health facilities. Radiological, Dialysis, Sterilizer, Lasers and some Laboratory Analyzer service is contracted to outside vendors. This service is overseen by user department and/or Clinical/Biomedical Engineering or the EOC Committees.
Performance

The Medical Equipment Management Plan is designed to support the delivery of quality patient care in the safest possible manner through the active management of medical equipment. During the CY 2018, performance standards for the Medical Equipment Management Plan were tracked in the following areas:

- Active Inventory
- Work Orders Opened
- Work Orders Closed
- Inspection Completed
- Labor Hours
- Parts Cost
- QA Rounds
- Parameter
- Work orders Not Closed for the Quarter*
- Failed Performance*
- Failed Electrical safety*
- New to Inventory (unreported)*
- Calls Where no Problem was Found*
- Improper Care*
- Missing Accessories*
- Staff Instruction*

Effectiveness

A review of performance indicators* in eight separate areas, as well as a review of the stated goals is used as the basis for determining effectiveness of the Plan on an annual basis. Evaluation and review of these criteria indicates an effective medical equipment management program. All performance indicators and goals were met in all facilities CY 2018.

Accomplishments-Special Projects

BHIP

- Medtronic CAP 20 ETCO2 Project Specifications – July 2018
- NK Network Survey – September 2018

Assure all staff receives proper medical equipment training in order to perform their
respective duties in a safe and proficient manner - Ongoing

- Ensure that all alerts, Recalls and hazards that pertain to medical equipment are investigated - Ongoing
- Review and revise the Medical Equipment Management Program as necessary - Ongoing

Strength

Our Scheduled Maintenance (SM) program is unique because we do “environmental” SM’s. This helps us achieve close to 100% annual completion of all SM’s in all facilities.

The ability to move Biomed staff as needed to the different facilities helps maintain optimum efficiencies and decrease down time of equipment.

Strong participation in the EOC Committees in all facilities provides a venue for implementing best practices throughout Broward Health.

Evaluation of CY 2018 Performance Indicators

Quarterly reports to the Environment of Care Committees.

<table>
<thead>
<tr>
<th>Table I</th>
<th>Goal</th>
<th>BHMC</th>
<th>BHN</th>
<th>BHIP</th>
<th>BHC S</th>
<th>BHW</th>
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<td>- New To Inventory (Unreported)</td>
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Recommended Goals for CY 2019

Medical Equipment Management Goals were submitted to the Environment of Care Committees at all facilities for approval. The Committees approved the following goals for CY 2018:

**BHIP**

- Replace all NK 2000, 4000, 5000 series Bedside Monitors and Centrals – June 2019 - July 2020
- Replace the NK Monitoring Network – June 2019 - July 2020
- Connect All NK Monitors to Cerner CareAware EMR – June 2019 -July 2020
- Medtronic CAP 20 ETCO2 Project Install – May 2019
- Infusion Pumps Replacement with EMR Connectivity – June 2019

**ALL**

- Assure all staff receives proper medical equipment training in order to perform their respective duties in a safe and proficient manner - Ongoing
- Ensure that all alerts, recalls and hazards that pertain to medical equipment are investigated - Ongoing
- Review and revise the Medical Equipment Management Program as necessary – Ongoing

**Summary**

The Medical Equipment Management Plan and its continuation was considered effective this year. We will continue to trend the current performance indicators for another year, reassess. The targets and make appropriate changes based on the consensus of the EoC.
BROWARD HEALTH
Clinical/Biomedical Engineering Performance Assessment
Calendar Year (January-December) 2018

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<tr>
<th>All Regions</th>
<th>BHMC</th>
<th>BHN</th>
<th>BHIP</th>
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<tr>
<td>[INSPECTIONS COMPLETED]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Comments:
**UTILITIES MANAGEMENT PROGRAM**

Reviewer: Steve Fredrickson  
Title: Regional Manager Facility services  
Region: BHIP  
Review Date: April 2019

**Purpose:** The Purpose of the Utilities Management Plan is to describe how BHIP establishes and maintains utility systems to control risks and promote a safe, controlled, and comfortable environment of care; reduce the potential for organizational-acquired illness; assess and minimize risks of utility failures; and ensure operational reliability of utility systems. Criteria for identifying, evaluating, and taking inventory of critical operating components of systems are included.

The Plan addresses eight designated Essential Utility Systems:

- Electrical Distribution Systems
- Heating, Ventilation, and Air Conditioning Systems (HVAC)
- Domestic Water Systems and Sewage Removal Systems
- Medical Gas Systems, and vacuum Systems
- Vertical Transport Systems
- Communications Systems
- Steam Distribution Systems
- Fire Alarm Systems

**Scope:** The BHIP Utilities Management Plan applies to the direct responsibility of Facilities management personnel, clinical staff members regarding critical utilities use and contingency responses, the hospital, hospital property, utilities building, Medical Office Building, Medical Arts Pavilion, as appropriate.

**Review of Program Objectives:** All critical elements of the utility systems used for life support, infection control, environmental support, equipment support, and communications are included in the program. The BHIP Utilities Management Program addresses the safe operation, maintenance, and emergency response procedures for these critical operating systems, as well as evaluation, assessment, and improvement in operational costs without compromise to service or quality.

The objectives of the BHIP Utilities Management Plan include:
• Assure the operational reliability of the utility systems.
• Reduce the potential for hospital-acquired illness.
• Assess of the special risks of the utility systems.
• Respond to utility systems failures.
• Provide a safe, controlled and comfortable environment for patients, staff members, and other individuals in the facilities.
• Establish and maintain program policies and procedures consistent with the organization’s mission, vision, and values.
• Enhance the maintenance of the utility systems to reduce and minimize system failures and/or interruption.

**Review of Performance:** Indicators have been developed to measure the Effectiveness of the Utility Systems Management Program. They are demonstrated in an ICES/ PMR, Information Collection and Evaluation System and presented quarterly:
Overall Effectiveness of the Program

The Utilities management plan was considered Effective during CY2018 as evidenced by performance standards, goals and objectives that were met and the level of regulatory compliance maintained.

- All Life safety, Infection control, and building maintenance Preventive Maintenance activities were completed.
- 1400 equipment items had preventive maintenance conducted
- BS4 PM’S 100%, BS4-IC PM’S 100%, BS4-LS 100% for the 12 month period.
- Two-hour emergency generator runs due to FPL load shed.
- Air exchange rates, temperature, and humidity were checked in all the operating rooms. All were at or above the FGI guidelines at the time of reading.
- There was 0 utility failures for CY 18

### Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Sample Size</th>
<th>TARGET</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Utility Failures</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Occurrences per Quarter</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>B. Utility System Scheduled Shut Downs</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Occurrences per Quarter</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>C. Equipment Preventive Maintenance Work Order Completion Rate (BS4)</td>
<td>80/80</td>
<td>90/90</td>
<td>86/86</td>
<td>148/148</td>
<td>Number per Quarter</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>D. Infection Control Preventive Maintenance Work Order Completion Rate (BS4-IC)</td>
<td>112/112</td>
<td>121/121</td>
<td>132/132</td>
<td>138/138</td>
<td>Number per Quarter</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>E. Life Safety Preventive Maintenance Work Order Completion Rate (BS4-LS)</td>
<td>200/199</td>
<td>189/189</td>
<td>194/194</td>
<td>122/122</td>
<td>Number per Quarter</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>F. Generator Test Results (Hospital Main) (see attached graph)</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>G. Generator Test Results (New Emergency) (see attached graph)</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>H. Generator Test Results (Surgery Center) (see attached graph)</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>3 of 3</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

**1st Quarter:** Work on Fire line throughout the 1st quarter. ICRA completed one adverse event, Fire line ruptured Steam line creating a 3 hour steam system outage. Five fire watches completed for fire line tie in and for repairs after installation of phases. Completed the 4 hour run for the OSC generator. Completed annual PM on the Generators, Fire pump, Ice machines. Replaced LIMs to Self testing calibrating ones. Completed annual Chiller PM at the OSC. Cleaned all four cooling towers. Installed new water filters on all Ice Machines, and water fountains. OSC Vacuum pump fell out and is being done in April.

**2nd Quarter:** Completed test and balance of all the critical and non critical care areas/rooms. Completed industrial hygiene testing in the Lab, OR, ENDO, GI, Bronk, . Replaced door operator at the south entrance. Boiler inspection completed. Toured insurance company and completed inspection. Replaced ceiling in the kitchen. Completed Energen tie in. Completed several FEMA follow up inspection following IRMA repairs. Installed new 10"line on cooling tower. completed UPS battery PM. Chem Aqua serviced the Boilers, chillier cooling towers, treatment.

**3rd Quarter:** FPL load shed conducted this quarter. Vacuum pump replaced at the MAP. Changed out the coils at the MOB. Changed out Motor on the MAP chiller. Annual Back flow preventors completed. Quarterly PM on all the vacuum pumps, completed PMs on the ATS. Quarterly fire alarm testing. Had the TJC inspection, painted doors frames throughout the facility. Installed new water filters on all ice machines, water fountains and ice machines. Removed all bathroom doors on the 6th floor and repaired door frames. Installed break away curtains in all bathroom door ways. Installed more tamper proof screws on the 6th floor and ED BHU. Corrected all deficiencies at time of survey. Replaced fauset in the ED BHU bathroom. Anti ligature risks identifed and corrected in select rooms on the floors for At risk patients. Fire sprinkler heads installed under the canopy at the ED west exit and the Mouge exit.

**4th Quarter:** Had AHCA inspection. Received 4 citations, 1. WAG outlets in surgery, 2. Mixed sprinkler heads, 3. Fire Chalking, 4. Battery electrolyte testing.

**Facilities Services Signature:** Steve Fredrickson

January 8th 2019.
• Annual Insurance inspection completed.
• Annual Boiler and Chillers inspections.
• Fuel tank systems inspection by Broward County Environmental Protection agency.
• Ongoing Testing and treatment of water systems for the boiler and the chillers.
• Water treatment and testing on the cooling towers were both negative.
• City Fort Lauderdale treated the domestic water system twice this year.
• On going Water Management program with a multi-disciplinary team approach.

Performance Monitors for 2018 (Goals): Status

• Complete Fire line. Completed
• Complete Clean room project. Pending
• Complete Cooling tower repiping. Completed
• Complete MOB Chiller refurbishing. Completed
• Complete electrical study to increase AHU on Emergency power. On going

Performance Monitors for 2019 (Goals):

• Electrical study to increase AHU on Emergency power.
• 600 Ton Chiller installation.
• ASCO main power switch replacement.
• Electrical consumption reduction with LED lighting.
EMERGENCY MANAGEMENT PROGRAM

Reviewer: Steve Thornton
Title: Emergency Preparedness Coordinator
Region: BHIP
Review Date: April 2019

➢ Objectives
Broward Health Imperial Point (BHIP) is committed to providing a safe, accessible and effective environment, consistent with its mission, services, and applicable governmental mandate. This commitment includes fostering the protection, safety, well-being of patients, employees, staff, and visitors during natural or man-made disasters, and ensuring, to the fullest extent possible, adherence to our social purpose and commitment to the community.

To that end, it is the intent of the Emergency Operations and Management plan to describe the local emergency preparedness program and ensure an effective response to a variety of natural or man-made disasters that could cause harm and/or disrupt the environment of care. The plan provides distinct policy direction, describes the roles and responsibilities or personnel and contains information and references to corresponding department mitigation, preparedness, response, and recovery procedures.

The objectives the Broward Health Imperial Point’s Emergency Management and Operations Plan, both before and during a crisis, are set forth for the following:

- Maintaining an assessment of Broward Health Imperial Point’s vulnerability to potential unusual events
- Orientation, training, and exercising personnel for their roles during an emergency
- Use of the Hospital Incident Command System (HICS) for clear and direct command, control, and management of the hospital during a crisis
- Mobilization and response of Broward Health Imperial Point and its departments to any type of situation or event that adversely impacts its ability to provide services or provides an overload of patients
- Integration of Broward Health Imperial Point, the regional health care community, local government, and emergency response agencies
- Supporting maintenance of a suitable environment of care, reporting EM Committee activities to BHIP EOC Committee
- Providing and maintain necessary emergent logistical support for the physical plant, facility systems, and material, nutritional supplies, and waste management
- Enabling crisis planning that tracks current situations, anticipates future developments, and develops timely strategies/action planning to mitigate their impact
• Maintaining the business continuity of the health care organization to the extent possible
• Management of critical incident stress for our staff and patients during extended incidents
• Integration of Quality Management oversight into the emergency management process
• Compliance with applicable regulatory requirements

❖ Plan and Approach
Meeting these objectives will enable the hospital to fulfill its primary functions in a crisis which are to:

• Provide proper medical care to our patients and victims of a disaster and restores normal services as quickly as possible following an emergency
• Maintain patient care in the event of partial or total evacuation of the hospital
• Planning alternate care sites that have the capabilities to meet the clinical needs of patients in the event of an evacuation
• Conducting a hazard vulnerability analysis in a collaboration with community emergency responders, to evaluate risks to the Medical Center, including probability of occurrence and preparedness
• Cooperatively planning for emergencies/disasters with other healthcare organizations via participation in the Broward County Healthcare Coalition, Emergency Coordination Council, ESF 8 at the Broward County Emergency Operations Center, and the S.E. Regional Domestic Security Task Force.
• Maintaining backup internal and external communication systems when normal communication systems are interrupted
• Identifying alternative means of meeting essential building utility needs
• Providing a means for radioactive, biological, and chemical isolation and decontamination
• Addressing as necessary, vulnerabilities to business continuity during emergency operations

Based on a review of the current Emergency Management Plan and performance indicators these objectives are appropriate for the management of emergencies by Broward Health Imperial Point facilities for 2018.

❖ Program Implementation

➢ Scope

The Emergency Operations and Management Plan applies to a natural, technological or manmade events that significantly disrupts the environment of care and treatment (i.e., earthquake, loss of utilities, civil disturbance, act of terrorism, etc.); or that results in sudden, significantly changed, or increased demands for the organization’s services (i.e., bioterrorist attack, building collapse, plane crash, etc.). The plan identifies the alert, notification, and activation of key personnel, the internal management structure and reporting relationships, as well as coordination with external agencies.
and the community. The plan and corresponding procedures address **four phases** of emergency management: mitigation, preparedness, response, and recovery and the **six critical areas**: Communication, Resources and Assets, Safety and Security, Staff Responsibility, Utilities Management, and Patient Clinical and Support Activities.

➢ **Performance**

Emergency Management Program Performance is determined by examining performance standards and indicators (measures), assessing regulatory and accreditation compliance, and evaluating performance improvement projects or opportunities for improvement. The following information data reflects CY2018 performance status:

- A CDC ChemPack was set up at BHIP in case of a large scale emergency such as a chemical or biological attack.
  - With an assessment of the environment and security of the storage area. There were no non-compliant findings.
  - A BHIP-specific Emergency Management and Operations plan has been completed and approved.

- The CEMP-Emergency Preparedness plan (AHCA Requirement) was submitted and approved by the Broward County Office of Emergency Management.
- Continued community integration during emergencies/disasters by participating in a county-wide exercise coordinated by the Broward County.
- BHIP participated (Monthly) in the Broward County Health Care Coalition which coordinates hospitals with the Broward County Office of Emergency Management, Broward County Department of Health, and Broward Health system, in addition to the local police and fire department (EMS).
- Enhanced the incident command system by identifying additional resources to assume each incident command system position using staff on all shifts. Updated as needed.
- Updated emergency contact information for key personnel.
- Updated Collabria emergency contact roster which was used successfully as a call out and status reporting system during a planned drill.
- Updated Emergency Call and contact information for Communications Plan
- All Decon and Hazmat supplies were maintained at levels appropriate for the facility, outdated equipment replaced and Upgrade Kits installed to PAPRS. Par Levels re-established.
- All Hurricane supplies were inventoried, checked for outdates. Par levels re-confirmed.
- Continued to work with the National Disaster Medical System as part of the National Disaster Plan.
- An annual Hazard Vulnerability Analysis was completed using a multi-disciplinary approach team.

➢ **Overall Evaluation**
To sum up, the Emergency Management Program was effective during CY2018 as evidenced by performance objectives which were met. Opportunities for improvement were identified in the Incident Command System which was addressed by the implementation of Collabria, a command organization program and a mass communication system. Additional accomplishments complementing the Emergency Management Program and enhancing effectiveness included:

- There was a planned Mass Casualty exercise held in conjunction with community partners.
- 2018 Hurricane Season Preparedness
  - Team A and B rosters were compiled for each response department. Alert notification process and contact phone numbers finalized.
  - Critical inventories for nutritional services, fuel, medications and medical/surgical supplies were reviewed and updated as needed on the recently developed BHIP 96 hour inventory tracking sheet.
- HVA was completed in conjunction with Community Partners June 30, 2018.
- The CEMP-Emergency Preparedness plan (AHCA Requirement) was submitted and approved by the Broward County Office of Emergency Management.
- Identified a County Emergency Operations Center (EOC) Hospital Coordinator back up position to assist with an activated Emergency Support Function 8 (Health & Medical) group for patient placement coordination. Successfully trained with prerequisites and credentialed to report to the EOC.

Goals met:

- **Exercises/Drills** Conduct a Code Active Shooter Drill
- Provide Paraslyde Training (Evacuation)
- Continue to build Hospital Hazmat Decontamination teams
- Increasing Physician preparedness and enhancing relations

**Recommended Goals for 2019**

- Conduct two drills for the year
- Using a multidisciplinary team conduct an HVA
ANNUAL EVALUATION OF THE ENVIRONMENT OF CARE FOR BROWARD HEALTH MEDICAL CENTER

Respectfully Submitted By:
Shirley Ochipa, Safety Officer
Jaime Alfayate, Director, Facilities and Support Services
Clifford Bain, Corporate Director of Security
Marcos Mantel, Executive Director, Biomedical Engineering
MISSION AND VISION

Mission: The mission of Broward Health is to provide quality health care to the people we serve and support the needs of all physicians and employees.

Vision: The vision of Broward Health is to provide world class health care to all we serve.

Five Star Values:

- Exceptional service to our community
- Accountability for positive outcomes
- Valuing our employee family
- Fostering an innovative environment
- Collaborative organizational team
**REGION’S COMPOSITION** *(List the facilities that are included in the evaluation).*

<table>
<thead>
<tr>
<th>Region:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broward Health Medical Center</td>
</tr>
<tr>
<td>Cora E. Braynon Family Health Center</td>
</tr>
<tr>
<td>Clinica de las Americas</td>
</tr>
<tr>
<td>Comprehensive Care Center</td>
</tr>
<tr>
<td>Bernard P. Alicki</td>
</tr>
<tr>
<td>Specialty Care Center</td>
</tr>
<tr>
<td>Lauderdale Lakes Community Health Center</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

(Provide a summary of the areas that comprise the environment of care and what the reader should expect to review when reading the evaluation report).

This report will include a summarization of the following:

- Overall performance evaluation of the environmental safety program and safety management plan.
- Overall performance evaluation of the security program and security management plan.
- Overall performance evaluation of the hazardous materials and waste program and hazardous materials and waste management plan.
- Overall performance evaluation of the fire safety program and fire safety management plan.
- Overall performance evaluation of the utilities program and utilities management plan.
- Report of progress on calendar year 2018 performance goals and plan objectives
- Priorities and goals for calendar year 2019

Information Collection and Evaluation System (ICES) - Performance Improvement indicators are selected based on regulatory requirements, opportunities identified from proactive risk assessments, results of external accrediting agency surveys, trends from internal Environment of Care (EoC) surveillance inspections, lessons learned from actual or near miss incidents.

EVALUATION PROCESS AND COMPONENTS – LEADERS RESPONSIBLE FOR COMPLIANCE OF AN EOC MANAGEMENT PLAN COLLABORATE WITH MEMBERS OF INTERNAL TEAMS, TASK FORCES OR SUBCOMMITTEES AND APPROPRIATE END USERS TO ASSESS THE EFFECTIVENESS OF EACH EOC PLAN COMPARING PERFORMANCE TO THE PREVIOUS YEAR AND GOALS THAT WERE ESTABLISHED. GOALS ESTABLISHED THE PREVIOUS YEAR AND PERFORMANCE INDICATORS NOT MET IN ADDITION TO ORGANIZATION STRATEGIC GOALS WHICH HAVE A SIGNIFICANT IMPACT ON THE ENVIRONMENT OF CARE ARE USED TO DEVELOP GOALS FOR THE NEXT CALENDAR YEAR.

Committee Members

<table>
<thead>
<tr>
<th>Title</th>
<th>Department</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Officer</td>
<td>Safety</td>
<td>Chairperson, EoC Committee</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Administration</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Chief Human Resources Officer</td>
<td>Human Resources</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Director</td>
<td>Facilities and Support Services</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Director &amp; Manager</td>
<td>Biomedical Engineering</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Corporate Director</td>
<td>Security</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Director</td>
<td>Quality</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Director &amp; Manager</td>
<td>Surgery, SDS, PACU &amp; GI</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Director</td>
<td>Cardiac and Cancer Center Product Lines</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Director &amp; Manager</td>
<td>Behavioral Health Services</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Manager</td>
<td>Employee Health</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Coordinator</td>
<td>Epidemiology</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Risk Manager</td>
<td>Risk Management</td>
<td>EoC Committee Member</td>
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</table>
The following table includes the name of those individuals who manage the Environment of Care programs.

<table>
<thead>
<tr>
<th>Environment of Care Program</th>
<th>Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Shirley Ochipa</td>
</tr>
<tr>
<td>Security</td>
<td>Jaime Alfayate, Clifford Bain</td>
</tr>
<tr>
<td>Hazardous Materials &amp; Waste</td>
<td>Shirley Ochipa</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>Jaime Alfayate, Shirley Ochipa</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Marcos Mantel, Fred McMurtrie</td>
</tr>
<tr>
<td>Utility Systems</td>
<td>Jaime Alfayate</td>
</tr>
</tbody>
</table>
SAFETY MANAGEMENT PROGRAM

Reviewer: Shirley Ochipa

Title: Safety Officer

Region: Broward Health Medical Center

Review Date: April 24, 2019

Purpose: The purpose of the Safety Management Plan (“The Safety Plan”) is to provide a physical environment free of hazards and to manage staff activities to reduce the risk of injuries. Three components are fundamental to the program: the ability to identify risk prior to any incident (e.g. environmental surveillance tours, risk assessments), the ability to report and investigate incidents that occur and the ability to correct unsafe conditions or actions that are identified through this process. The Safety Plan ensures compliance with safety requirements promulgated by OSHA and other consensus standards such as those by NIOSH, ANSI, and CDC.

Scope: The scope of the Safety Management Plan encompasses all personnel within Broward Health Medical Center (BHMC) and the community health services sites under its oversight. All individuals (employees, leadership, licensed independent practitioners, and medical residents/students are required to act in a safe and responsible manner that does not place themselves, patients or others at risk. All individuals have a duty to report unsafe conditions or actions so that they may be addressed. The commitment to a safe hospital setting is supported by the Board of Commissioners through the Chief Executive Officer and the authority granted to the Environment of Care Committee and to the Safety Officer.

Evaluation of the Scope: During 2018, the scope of the Safety Management Plan was reviewed. The objectives of the Safety Management Plan and the scope of the Plan were determined to be acceptable to ensure a safe environment. The Safety Management Plan and program were found to be effective. Goals have been established to direct the Safety Management Plan in 2019.

Review of Program Objectives:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comply with all applicable safety regulations and accepted safety practices</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain a system of inspection activities and incident reporting</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure facilities are constructed, arranged and maintained to provide physical safety and personal privacy of the patient</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure all employee accidents and injuries are analyzed aimed at reducing risk for recurrence</td>
<td>Met</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Review of Performance: Performance monitors for 2018 are as follows

Performance Monitor #1: OSHA Recordable Cases

Target: \( \leq 6.01/\text{quarter} \)

Performance: Average quarterly performance in 2018 was 7.36/qtr. ranging from 5.72-8.47, reduced by 37% compared to 2017

Performance Monitor Analysis

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - (# injuries X 200,000) / productive manhours- OSHA Recordable Cases</td>
<td>( \leq 6.01/\text{qtr} )</td>
<td>5.72</td>
<td>7.61</td>
<td>7.65</td>
<td>8.47</td>
<td>7.36</td>
<td>11.70</td>
</tr>
</tbody>
</table>

Two main root causes were determined for the #’s of OSHA recordable cases exceeding target. Firstly, a lack of awareness of surroundings resulted in preventable struck by, fall and abrasion incidents. Education on use of cell phones and the importance of not rushing, being distracted and asking for assistance with tasks such as picking up heavier loads that contribute to back strains were assigned to all BHMC employees. Secondly, several clusters of employees exposed to contagious diseases resulted in over 100 employees receiving prophylaxis or treatment.

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was not found to be effective and will continue to be monitored in 2019 to assess progress in meeting and sustaining the established benchmark and identify interventions needed if a positive trend is not observed.

A reduction in OSHA Recordable cases was primarily due to earlier detection of suspected patients with communicable infectious diseases and their proper placement in appropriate transmission based precaution environments.

Performance Monitor #2: Contaminated Needlestick Exposure Rate

Target: \( \leq 1.65/\text{quarter} \)

Performance: Average quarterly performance in 2018 was 2.09 ranging from 1.08-3.28, reduced by 2% compared to 2017
Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - Contaminated Needlestick Injuries</td>
<td>≤ 40/yr</td>
<td>10</td>
<td>18</td>
<td>13</td>
<td>6</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>Workers Comp - Contaminated Needlestick Injuries/APDx10,000</td>
<td>≤ 1.65/qtr</td>
<td>1.66</td>
<td>3.28</td>
<td>2.35</td>
<td>1.08</td>
<td>2.09</td>
<td>2.12</td>
</tr>
</tbody>
</table>

Various stakeholders collaborate with the Safety Officer to focus on negative trend observed with employee exposures involving contaminated needlesticks. Performance met target in the 4th quarter 2018 after almost 2 years of focused actions to reduce occurrences since 2017. See details under 2018 EoC Program Initiative.

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was not found to be effective and will continue to be monitored in 2019 to assess progress in meetings and sustaining the established benchmark and identify interventions needed if a positive trend is not observed.

This occupational injury category was selected as the 2018 EoC program initiative.

Performance Monitor #3: Back/Shoulder/Neck Injuries relating to Patient Handling Rate

Target: ≤ 0.44/quarter

Performance: Average quarterly performance in 2018 was 0.61/qtr. ranging from 0-1.08

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - Back/Shoulder Injuries (Patient Handling)</td>
<td>≤ 14/yr</td>
<td>5</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Back/Shoulder Injuries Rate (Patient Handling/APD x 10,000)</td>
<td>0.44/qtr</td>
<td>0.83</td>
<td>n/a</td>
<td>1.08</td>
<td>0.64</td>
<td>0.61</td>
<td>0.25</td>
</tr>
</tbody>
</table>

A negative trend was noted in employees experiencing neck/back/shoulder strains due to manual activities related to patient lifting, handling and repositioning specifically with the Adult Care and Transportation teams. Reinvigorating the Safe Patient Handing (SPH) program in the clinical areas where leaders and super-users are no longer employed. Education on existing SPH equipment is not robust in these areas and therefore sustaining competent staff to use safely with has been a challenge.
Overall Effectiveness of the Program’s Effectiveness: This performance monitor was not found to be effective and will continue to be monitored in 2019 for further compliance to assess progress in meeting and sustaining the established benchmark and identify additional interventions needed if a positive trend is not observed.

This occupational injury category was selected as the 2019 EoC program initiative.

Performance Monitor #4: Employee Slip, Trip and Fall Incident Rate

Target: \( \leq 2.34/\text{quarter} \)

Performance: Average quarterly performance in 2018 was 1.34 ranging from 1.08-1.83

Performance Monitor Analysis

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - Employee Slip/Trip/Fall Incidents</td>
<td>( \leq 60/\text{yr} )</td>
<td>7</td>
<td>10</td>
<td>7</td>
<td>6</td>
<td>30</td>
<td>47</td>
</tr>
<tr>
<td>Employee Slip/Trip/Fall Rate/APD x 10,000</td>
<td>2.34/qtr</td>
<td>1.16</td>
<td>1.83</td>
<td>1.27</td>
<td>1.08</td>
<td>1.34</td>
<td>1.96</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: Action plans developed with a core team have resulted in decreased slip, trip and fall employee incidents throughout 2018 with a 32% decrease in quarterly average performance compared to 2017. This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #5: # Employees exposed to *M. tb*/total # of Employees/quarter

Target: \( \leq 1\%/\text{quarter} \)

Performance: Performance monitor in 2018 was 0.23% ranging from 0.06%-0.40%

Performance Monitor Analysis

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Health - # Employees exposed to <em>M.tb</em>/total # of employees per qtr.</td>
<td>( \leq 1%/\text{qtr} )</td>
<td>48/9509</td>
<td>0.5%</td>
<td>6/9479</td>
<td>0.06%</td>
<td>38/9515</td>
<td>0.40%</td>
</tr>
</tbody>
</table>

Monitor met target each quarter in 2018.
Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #6: # of Employees exposed to contagious diseases/# of Employees per quarter

Target: ≤ 1%/quarter

Performance: Performance monitor in 2018 was 0.18% ranging from 0.03%-0.32%

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Health - # Contagious disease exposures/total # of employees per qtr.</td>
<td>≤ 1%/qtr</td>
<td>22/9509 0.23%</td>
<td>30/9479 0.32%</td>
<td>14/9515 0.15%</td>
<td>3/9635 0.03%</td>
<td>0.18%</td>
<td>0.80%</td>
</tr>
</tbody>
</table>

Monitor met target each quarter in 2018 and reduced by 78% compared to 2017 average performance.

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #7: # Hemodialysis water/ Dialysate cultures (done/passed)

Target: 100%/quarter

Performance: Average quarterly performance was 100% in 2018

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiology - # Hemodialysis Water/Dialysate Cultures (done/#passed)</td>
<td>100%/yr</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99.25%</td>
</tr>
</tbody>
</table>

Performance was met in every quarter of 2018 and reduced by 1% compared to 2017

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.
Performance Monitor #8: # Hemodialysis water Endotoxin-LAL (done/passed)

Target: 100%/quarter

Performance: Average quarterly performance was 100% in 2018

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiology - # Hemodialysis Endotoxin - LAL (done/#passed)</td>
<td>100%/yr</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Performance was met in every quarter of 2018 and reduced by 2% compared to 2017

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #9: Scan Safety-# of Burns from MRI Scanner (new)

Target: 0/quarter

Performance: Average quarterly performance met target each quarter in 2018 with no occurrences.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI Scan Safety-# of Burns from MRI Scanner (NEW)</td>
<td>&lt;1/qtr</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #10: MRI Scan Safety-# of Unplanned Metallic Objects in MRI Scanner

Target: 0/quarter

Performance: Average quarterly performance was 1 occurrence in each of the 1st and 2nd quarters followed by 0 occurrences each in the 3rd and 4th quarters
Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI Scan Safety-# of Unplanned Metallic Objects in MRI Scanner (NEW)</td>
<td>&lt;1/qtr</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>N/A</td>
</tr>
</tbody>
</table>

1. A non-MRI compatible cardiac monitor was used on a patient in the MRI scan room. There was no adverse event for the patient and the employee was disciplined for this safety breach. Re-education was conducted with the entire MRI team.

2. A patient brought into the MRI was donned in a patient gown and verbally screened for metal objects. A butter knife had been sequestered in the patient’s socks that was pulled into the MRI equipment and successfully removed. There were no injuries to the patient. Process was changed whereby MRI techs will routinely check inside patients’ socks before proceeding with the MRI exam.

Overall Effectiveness of the Program’s Effectiveness:

This performance monitor was not found to be effective with 2 occurrences of unplanned metallic objects being discovered in Zone IV. No adverse patient outcomes occurred and personnel actions were initiated as appropriate. This performance monitor will continue to be monitored in 2019 for compliance.

Performance Monitor #11: Staff Knowledge Score in Safety Management from EoC Surveillance Tours

Target: 90%/quarter

Performance: Average quarterly performance was 98% in 2018

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Safety Management from EoC Surveillance Tours</td>
<td>≥ 90%/qtr</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
<td>99%</td>
</tr>
</tbody>
</table>

Performance was met in every quarter of 2018.

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.
Performance Monitors for 2019:

Two key performance monitors will be a focus in 2019

- Reduce rate of employee back, neck and shoulder strains due to patient lifting, repositioning and transfer activities by 5%; benchmark rate = 0.44/qtr. A 43% increase was observed in 2018 compared to 2017 specifically in the Adult Care units where the turnover of leaders, staff and super users of safe patient handling equipment were no longer employed at BHMC. A multidisciplinary team will be formed to reinvigorate the program with the expected success as noted in the critical are units.

- Reduce rate of employee contaminated needle stick exposures by 5%; benchmark rate = 1.65/qtr. Despite several hospital-wide action plans resulting from drill downs of root causes, only a 2% decrease in the contaminated needlestick rate was noted in 2018. Participation in the FHA HIIN collaborative on Worker Safety-We Have Your Back is expected to be another opportunity to adopt any other best practices at reducing needlesticks and mucus membrane exposures.

The contaminated sharps injury (other than needlestick exposures) performance monitor will be removed for 2019 based on compliance with quarterly targets being met 11 out of 12 quarters with no trends in devices, locations or healthcare worker types noted.

<table>
<thead>
<tr>
<th>Performance Monitor</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - (# injuries X 200,000) / productive manhours-OSHA Recordable Cases</td>
<td>≤ 6.01/qtr</td>
</tr>
<tr>
<td>Workers Comp - Contaminated Needlestick Injuries</td>
<td>≤ 40/yr</td>
</tr>
<tr>
<td>Workers Comp - Contaminated Needlestick Injuries/APD x 10,000</td>
<td>≤ 1.65/qtr</td>
</tr>
<tr>
<td>Workers Comp - Back/Shoulder Injuries (Patient Handling)</td>
<td>≤ 14/yr</td>
</tr>
<tr>
<td>Back/Shoulder Injuries Rate (Patient Handling/APD x 10,000)</td>
<td>0.44/qtr</td>
</tr>
<tr>
<td>Workers Comp - Employee Slip/Trip/Fall Incidents</td>
<td>≤ 60/yr</td>
</tr>
<tr>
<td>Employee Slip/Trip/Fall Rate/APD x 10,000</td>
<td>2.34/qtr</td>
</tr>
<tr>
<td>Employee Health - # Employees exposed to M.tb/total # of employees per qtr.</td>
<td>≤ 1%/qtr</td>
</tr>
<tr>
<td>Employee Health - # Contagious disease exposures/total # of employees per qtr.</td>
<td>≤ 1%/qtr</td>
</tr>
<tr>
<td>Epidemiology - # Hemodialysis Water/Dialysate Cultures (done/#passed)</td>
<td>100%/yr</td>
</tr>
<tr>
<td>Epidemiology - # Hemodialysis Endotoxin - LAL (done/#passed)</td>
<td>100%/yr</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>MRI Scan Safety - # of Burns from MRI Scanner</td>
<td>&lt;1/qtr</td>
</tr>
<tr>
<td>MRI Scan Safety - # of Unplanned Metallic Objects in MRI Scanner</td>
<td>&lt;1/qtr</td>
</tr>
<tr>
<td>Staff Knowledge Score in Safety Management from Surveillance Tours</td>
<td>≥ 90%/qtr</td>
</tr>
</tbody>
</table>
**SECURITY MANAGEMENT PROGRAM**

**Reviewer:** Clifford Bain  
**Title:** HSS Corporate Project Director  
**Region:** Broward Health Medical Center  
**Review Date:** April 24, 2019

**Purpose:** The purpose of the Security Management Plan is to establish and maintain a security program that protects, patients, employees, licensed independent practitioners, and visitors from harm and that guards the physical and intellectual property of the organization.

**Scope:** The scope of the Security Management Plan ("The Security Plan") applies to all patients, employees, licensed independent practitioners, and visitors at BHMC. The Security Plan is administered by HSS in conjunction with Broward Health Corporate and regional administrative oversight. Services include central station monitoring, consultative site reviews, access control, investigative assistance, lost and found, patrol services of hospital and grounds, escort services for employees who are threat of violence victims. Local, county, state and federal law enforcement agencies support the Security department through close working relationships with site security personnel.

**Evaluation of the Scope:** The scope of the Security Management Plan was reviewed and determined to be acceptable to ensure a secure environment. Additionally, the annual Security Risk assessment was valuable in identifying facility threats and opportunities to further harden its Security features throughout the facility.

**Review of Program Objectives:**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement accepted practices for the prevention, proper documentation</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and timely investigation of security incidents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide timely response to emergencies and requests for assistance</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Track and trend performance indicators to improve performance</td>
<td></td>
<td></td>
<td>Met with Conditions</td>
<td>Changes in the department staff and more detailed post orders improved the overall</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>department performance</td>
</tr>
</tbody>
</table>


Review of Performance: Performance monitors for 2018 are as follows

Performance Monitors #1: Rate of Bodily Assaults-non-Behavioral Health Services

Target: \( \leq 1.00/\text{qtr} \)

Performance: This performance monitor met benchmark every quarter of 2018.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY 2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Bodily Assaults (non BHS-Adult)</td>
<td>Informational /qtr</td>
<td>7</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Assault Rate/Census x 1,000 (non-BHS-Adult)</td>
<td>( \leq 1.00/\text{qtr} )</td>
<td>0.12</td>
<td>0.03</td>
<td>1</td>
<td>0.11</td>
<td>0.32</td>
<td>0.30</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor goal was met in 2018 and will continue to be monitored in 2019 for further compliance.

Performance Monitors #2: Rate of Bodily Assaults-Behavioral Health Services

Target: \( \leq 2.50/\text{qtr} \)

Performance: This performance monitor was met in 3 of the 4 quarters in 2018.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY 2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Bodily Assaults (BHS)</td>
<td>Informational /qtr</td>
<td>13</td>
<td>5</td>
<td>2</td>
<td>15</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Assault Rate/Census x1,000 (BHS)</td>
<td>( \leq 2.50/\text{qtr} )</td>
<td>2.3</td>
<td>0.88</td>
<td>0.03</td>
<td>2.77</td>
<td>1.50</td>
<td>1.77</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: The average rate for this performance monitor in 2018 was 15% below the average for 2017. Ten incidents in the more acute BHS unit involved extremely aggressive patients with extended stays. Security personnel were assigned to conduct more frequent patrols. Drill downs of each incident identified one trend. Additional meetings were held with the court judges regarding the challenges hospital employees able to manage very aggressive forensic patients referred from jails to the medical center in a safe manner. This performance monitor will continue to be monitored in 2019 for consistent compliance.
Performance Monitors #3: Rate of Code Assists-non Behavioral Health Services

Target: ≤ 0.75/qtr

Performance: This performance monitor was met in 3 of the 4 quarters in 2018

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY 2018</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Assists (non-BHS)</td>
<td>Informational/qtr</td>
<td>22</td>
<td>26</td>
<td>45</td>
<td>56</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>Code Assist Rate/Census x1,000 (non-BHS)</td>
<td>≤ 0.75/qtr</td>
<td>0.3</td>
<td>0.41</td>
<td>0.74</td>
<td>0.88</td>
<td>0.58</td>
<td>0.54</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: The average rate in 2018 for this performance monitor met benchmark in 2018, 7% above the annual rate in 2017. A total of 56 Code Assists occurred with the highest number of occurrences in 6 Adult Care units. Security personnel were assigned to conduct more frequent patrols. An increase in Workplace Violence Prevention classes were offered with the expectation that at least 75% of the staff in these non-BHS units complete the training in the first half of 2019. This performance monitor will continue to be monitored in 2019 for consistent compliance.

Performance Monitors #4: Rate of Code Assists –Behavioral Health Services

Target: ≤ 1.00/qtr

Performance: This performance monitor was not met in 2018

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY 2018</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Assists (BHS)</td>
<td>Informational/qtr</td>
<td>0</td>
<td>10</td>
<td>20</td>
<td>9</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Code Assist Rate/Census x1,000 (BHS)</td>
<td>≤ 1.00/qtr</td>
<td>n/a</td>
<td>1.76</td>
<td>3.32</td>
<td>1.66</td>
<td>1.69</td>
<td>0.69</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor did not meet criteria and will continued to be monitored for improvement in 2019. BHS staff called Code Assists for earlier intervention by Security and mental health employees prior to the escalation of aggressive patient behaviors in both the Psych ED and inpatient BHS units. Post-incident debriefing focused on more frequent psychiatrist interventions and assessments of medication protocols, 1:1 sitters for continuous monitoring, separating patients whose aggressive behaviors had the potential to affect the safety of other patients and staff, and restricting visitors. The medical center will form a Workplace Violence Prevention multi-disciplinary team starting in January 2019 who will follow the TJC Sentinel
Event Alert #59 suggested actions to assess current strategies and look for further solutions to reduce the risk of verbal or physical violence from patients or visitors reinforcing the hospital’s commitment to our employees and LIP’s that workplace violence will not be tolerated.

**Performance Monitors #5 Critical Units Security System Equipment Status**

**Target:** Incremental by Qtr

**Performance:** This performance monitor did not meet bench mark however, incremental improvements where seen throughout the course of year as reflected in the PI dash board below.

**Performance Monitor Analysis:** This performance monitor was not met. As a result of older infrastructure, Security equipment was identified for replacement in the annual Security Risk Assessment conducted by the Security program vendor. Corrective actions have been taken to start correcting the camera systems in the North and South Parking garages.

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Units Security System Equipment Status</td>
<td>Incremental by Qtr.</td>
<td>76%</td>
<td>83%</td>
<td>88%</td>
<td>86%</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>85%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness:** This performance monitor did not meet criteria and will continue to be monitored in 2019 to ensure further compliance and improvement to the performance monitor.

**Performance Monitors #6: Staff Knowledge Score in Security Management from EoC Surveillance Tours**

**Target:** ≥ 90%/qtr

**Performance:** Average quarterly performance was 98% in 2018

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY 2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Security Management from EoC Surveillance Tours</td>
<td>≥ 90%/qtr</td>
<td>97%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Performance was met in every quarter of 2018.

**Overall Effectiveness of the Program’s Effectiveness:** This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.
### Performance Monitors for 2019:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Category</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Bodily Assaults (non BHS-Adult)</td>
<td>Informational /qtr</td>
<td>≤ 1.00/qtr</td>
</tr>
<tr>
<td>Assault Rate/Census x 1,000 (non-BHS-Adult)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported Bodily Assaults (BHS)</td>
<td>Informational/qtr</td>
<td></td>
</tr>
<tr>
<td>Assault Rate/Census x 1,000 (BHS)</td>
<td></td>
<td>≤ 2.50/qtr</td>
</tr>
<tr>
<td>Code Assists (non-BHS)</td>
<td>Informational/qtr</td>
<td></td>
</tr>
<tr>
<td>Code Assist Rate/Census x 1,000 (non-BHS)</td>
<td></td>
<td>≤ 0.75/qtr</td>
</tr>
<tr>
<td>Code Assists (BHS)</td>
<td>Informational/qtr</td>
<td></td>
</tr>
<tr>
<td>Code Assist Rate/Census x 1,000 (BHS)</td>
<td></td>
<td>≤ 1.00/qtr</td>
</tr>
<tr>
<td>Critical Units Security System Equipment Status</td>
<td>Incremental by Qtr.</td>
<td></td>
</tr>
<tr>
<td>Missing Patient Property-NEW</td>
<td>Informational/qtr</td>
<td></td>
</tr>
<tr>
<td>Missing Patient Property/APD-NEW</td>
<td></td>
<td>≤ 1.00/qtr</td>
</tr>
<tr>
<td>Missing BH Property-NEW</td>
<td>Informational/qtr</td>
<td></td>
</tr>
<tr>
<td>Missing BH Owned Property/APD-NEW</td>
<td></td>
<td>≤ 0.50/qtr</td>
</tr>
<tr>
<td>Contraband Search by Security-NEW</td>
<td>Informational/qtr</td>
<td></td>
</tr>
<tr>
<td>Contraband Search by Security/APD-NEW</td>
<td></td>
<td>≤ 10.00/qtr</td>
</tr>
</tbody>
</table>

The 2019 performance monitors were selected through the Security Risk Annual Assessment and Security Vendor KPI contractual metrics provided to evaluate the overall effectiveness of the Security Management Plan. These monitors will be reviewed on an annual basis to determine if they need to be enhanced or replaced by new monitors.
HAZARDOUS MATERIALS & WASTE MANAGEMENT PROGRAM

Reviewer: Shirley Ochipa
Title: Safety Officer
Region: Broward Health Medical Center
Review Date: April 24, 2019

Purpose: The purpose of the Hazardous Material and Waste Management Plan ("The HM/HW Plan") is to control the process for the selection, labeling, handling, usage, storage, transportation and disposal of hazardous materials and waste including but not limited to regulated medical waste, Chemotherapy waste, hazardous waste, pharmaceutical waste, anesthetic gases, hazardous chemicals and ionizing and non-ionizing radiation sources. Identifying and managing the materials and waste are critical to avoid the risk of harm to hospital personnel and the environment. Equally important is the on-going effort to reduce waste and replace hazardous substances with less hazardous or non-hazardous substitutes wherever possible. Safety Data sheets provide the core of staff education on how to protect themselves and the environment.

Scope: The scope of the HM/HW Plan establishes parameters for the selection, labeling, handling, usage, storage, transportation and disposal of hazardous materials and waste from receipt or generation through its use and final disposition. Comprehensive hazardous chemical and material inventories in addition to an approval process before any new hazardous materials are allowed to be purchased provides a monitoring system for compliance with local, state and federal regulations and ensures the safety of the personnel handling hazardous materials and waste and the environment in which they are stored and disposed of.

Evaluation of the Scope: During 2018, the scope of the Hazardous Material and Waste Management Plan was reviewed. The objectives of the HM/HW Plan and the scope of the HM/HW Plan were determined to be appropriate for hazardous materials and wastes generated at BHMC. The Hazardous Material and Waste Management Plan and program were found to be effective. Goals have been established to direct the Hazardous Material and Waste Management Plan in 2019.

Review of Program Objectives:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comply with all applicable local, state, and federal HM/HW regulations</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess opportunities to reduce, replace or standardize based on the facility's hazardous chemical and materials inventories</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Educate end users on the safe handling, storage, transporting, disposing, personal protective equipment and spill clean-up responses in departments whose inventories list the highest risk categories of chemicals. End-user education also includes how to access Safety Data Sheets and their relevant content.

<table>
<thead>
<tr>
<th>Review of Performance: Performance monitors for 2018 are as follows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Monitors #1: Non-Laboratory Biohazardous Waste Rate</td>
</tr>
<tr>
<td><strong>Target:</strong> ( \leq 1.65 \text{ lbs/APD/quarter} )</td>
</tr>
<tr>
<td><strong>Performance:</strong> Average quarterly performance was 1.22 ranging from 1.18-1.26</td>
</tr>
<tr>
<td><strong>Performance Monitor Analysis:</strong> Each quarter the rate of non-laboratory biohazardous waste was below target and reduced by 14% in 2018 to a rate of 1.22 compared to a rate of 1.41 in 2017.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous Materials and Hazardous Waste</td>
<td>Benchmark</td>
<td>Q1 CY18</td>
<td>Q2 CY18</td>
<td>Q3 C18</td>
<td>Q4 CY18</td>
<td>CY2018</td>
</tr>
<tr>
<td>NonLab Biohazardous Waste (lb)/APD</td>
<td>( \leq 1.60 \text{ lbs./APD qtr} )</td>
<td>1.26</td>
<td>1.20</td>
<td>1.18</td>
<td>1.26</td>
<td>1.22</td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness:** This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

<table>
<thead>
<tr>
<th>Performance Monitor #2: Laboratory Biohazardous Waste (without Pathology Waste) Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target:</strong> ( \leq 0.36 \text{ lbs/APD/quarter} )</td>
</tr>
<tr>
<td><strong>Performance:</strong> Average quarterly performance was 0.34 ranging from 0.33 to 0.35</td>
</tr>
</tbody>
</table>
Performance Monitor Analysis: Each quarter the rate of laboratory biohazardous waste was below target and reduced by 8% in 2018 to 0.34 compared to a rate of 0.37 that exceeded target in 2017.

<table>
<thead>
<tr>
<th>Hazardous Materials and Hazardous Waste</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous Materials and Hazardous Waste</td>
<td>Benchmark</td>
<td>Q1 CY18</td>
<td>Q2 CY18</td>
<td>Q3 CY18</td>
<td>Q4 CY18</td>
<td>CY2018</td>
<td>CY2017</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program's Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #3: Proper Segregation of Biomedical Waste and Solid Waste

Target: >/= 90%/quarter

Performance: Average quarterly performance was 88% ranging from 83%-94%

Performance Monitor Analysis: This indicator was a new performance monitor added in 2018 due to an increase in noncompliant observations during EoC surveillance inspections. Quarterly performance in 2018 was 2% above the target. Additional Education was prepared, assigned to all BHMC employees and distributed to LIP’s and medical residents throughout the year.

<table>
<thead>
<tr>
<th>Hazardous Materials and Hazardous Waste</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proper Segregation of Biomedical Waste and Solid Waste-NEW</td>
<td>&gt;/=90% compliance/qtr.</td>
<td>83%</td>
<td>94%</td>
<td>90%</td>
<td>86%</td>
<td>88%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program's Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #4: Staff Knowledge Score in Hazardous Material and Waste Management assessed during EoC Surveillance Tours

Target: >/= 90%

Performance: Average quarterly performance in 2018 was 96% ranging from 92%-100% /qtr.

Performance Monitor Analysis: Performance benchmark was exceeded each quarter in 2018.
### Hazardous Materials and Hazardous Waste

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in HM/HW Management from Surveillance Tours</td>
<td>≥ 90%/qtr</td>
<td>92%</td>
<td>100%</td>
<td>97%</td>
<td>93%</td>
<td>96%</td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness**: This performance monitor was found to be effective will continue to be monitored in 2019 for further compliance as part of the EoC surveillance rounds.

**Overall Effectiveness of the Program’s Effectiveness:**

The Hazardous Material and Waste program was effective with sustainable performance and improvement noted throughout 2018 with the new indicator following the roll out of 3 educational modules and formation of 10 new teams consisting of EoC Committee members working collaboratively conducting more frequent EoC surveillance inspections. This process change allowed for more real time coaching with staff if noncompliant observations were noted.

**Performance Monitors for 2019:**

| Non-Laboratory Biohazardous Waste (lb)/APD | ≤ 1.65 lbs. /APD qtr |
| Laboratory Biohazardous Waste (lb)/APD without Pathology Waste | ≤ 0.36 lbs. /APD qtr |
| Proper Segregation of Biomedical Waste and Solid Waste | ≥ 90%/qtr |
| Staff Knowledge of Hazardous Material & Waste Management | ≥ 90%/qtr |
| Sharps Containers Secured and at or below 3/4 Fill Line-NEW | >95%/qtr |

Based on a finding from the Department of Health Biomedical Waste compliance inspection, a new performance monitor was added in 2019 tracking compliance with maintaining sharps containers in manner to not pose any risk of exposure to end users.
**FIRE SAFETY MANAGEMENT PROGRAM**

**Reviewer:** Jaime Alfayate, Shirley Ochipa  
**Title:** Director, Facilities and Support Services; Safety Officer  
**Region:** Broward Health Medical Center  
**Review Date:** April 24, 2019

**Purpose:** The purpose of the Fire Safety Management Plan ("The Fire Safety Plan") is to minimize the risk of fire, injury and property damage as the risk of fire carries with it the most significant threat to the Environment of Care as our patients are routinely incapable of self-preservation and must rely on others for assistance and on building fire protection features for protection.

**Scope:** The scope of Fire Safety Management Plan establishes the parameter within which a safe and secure environment is maintained and improved at Broward Health Medical Center. The BHMC specific Fire Plan is implemented to ensure staff, leaders and licensed independent practitioners, and students are educated in the fire prevention features in the physical environment and are able to demonstrate how to react appropriately to a variety of fire/smoke emergencies that may affect the safety of its occupants including students and visitors or the delivery of patient care.

**Evaluation of the Scope:** During 2018, the scope of the Broward Health (BH) Fire Safety Management Plan and BHMC Fire Safety Plan were reviewed. The objectives of the BH Fire Management Plan and the scope of the BH Fire Safety Management Plan were determined to be acceptable to ensure an environment that minimizes fire risks and related hazards. The Fire Safety Management Plan and program were found to be effective. Goals have been established to direct the Fire Safety Management Plan in 2019.

**Review of Program Objectives:**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect individuals served including patients, visitors, physicians and LIP’s and BHMC property from fire, smoke and other products of combustion</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report and investigate fire protection deficiencies, failures and user errors</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide education to personnel on the elements of the Fire Safety Plan including defend in place, transfer of occupants to areas of refuge, smoke compartmentation and means of evacuation</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement fire alarm, detection and suppression systems that are</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
designed, installed and maintained to ensure reliable performance

Conduct unannounced fire drills to assess effectiveness of trained personnel response and assess function of fire response systems

<table>
<thead>
<tr>
<th></th>
<th>Met</th>
</tr>
</thead>
</table>

Review of Performance: 2018 performance monitors are as follows

Performance Monitors #1 # False Fire Alarms-User Errors, System Problem/Failure

**Target:** ≤ 14/qtr

**Performance:** Average quarterly performance in 2018 was 9/qtr. In 2017, the average quarterly performance was 33/qtr.

**Performance Monitor Analysis:** This performance indicator was met in 2018 and overall reduced from prior year (2017) by 24 reported incidents.

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td># False Fire Alarms-User Errors, System Problem/Failure</td>
<td>≤ 14/qtr</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>14</td>
<td>10</td>
<td>33</td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness:** This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitors #2: False Fire Alarms Rate per 10,000 sq. ft.

**Target:** ≤ 0.09/qtr

**Performance:** Average quarterly performance in 2018 was 0.08/qtr. In 2017, the average quarterly performance was 0.19/qtr.

**Performance Monitor Analysis:** This performance indicator was met every quarter in 2018 except the 4th qtr. However, the average yearly rate was reduced 42% from prior year (2017).

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td># False Fire Alarms Rate per 10,000 sq. ft.</td>
<td>≤ 0.09/qtr</td>
<td>0.06</td>
<td>0.07</td>
<td>0.08</td>
<td>0.11</td>
<td>0.08</td>
<td>0.19</td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness:** This performance monitor goal was met in 2018 and will continue to be monitored in 2019 for consistent compliance.
Performance Monitors #3

**Monitor:** % of Successful Code Red Drills

**Target:** ≥ 95%/qtr

**Performance:** Average quarterly performance in 2018 was 93% compared to 95% in 2017

**Performance Monitor Analysis:** Performance benchmark was not met in 2018

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Successful Code Red Drills</td>
<td>≥ 95%/qtr</td>
<td>94%</td>
<td>84%</td>
<td>97%</td>
<td>97%</td>
<td>93%</td>
<td>95%</td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness:** Twenty-four fire drills were conducted in 2018. In 3 drills, department staff were challenged to implement all the steps in RACE. Just in time training was conducted at the drill debriefing and action plans assigned to each Manager with the expectation all actions were to be completed with 100% staff. Repeat fire drills in each of these departments yielded improved performances and scores above 95%. This performance monitor will continue to be monitored closely in the 2019.

Performance Monitors #4

**Monitor:** Staff Knowledge Score in Medical Equipment Management assessed during EoC Surveillance Tours

**Target:** >/= 90%

**Performance:** Average quarterly performance in 2018 was 98%/qtr. exceeding the target in each quarter.

**Performance Monitor Analysis:** Performance benchmark continued to be exceeded in 2018 as it was in 2017

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Life/Fire Safety Management Surveillance Tours</td>
<td>≥ 90% qtr</td>
<td>96%</td>
<td>100%</td>
<td>99%</td>
<td>95%</td>
<td>98%</td>
<td>98%</td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness:** This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance
## Performance Monitors for 2019:

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td># False Fire Alarms-User Errors, System Problem/Failure</td>
<td>≤ 14/qtr</td>
</tr>
<tr>
<td># False Fire Alarms Rate per 10,000 sq. ft.</td>
<td>≤ 0.09/qtr</td>
</tr>
<tr>
<td>% of Successful Code Red Drills</td>
<td>≥ 95%/qtr</td>
</tr>
<tr>
<td>% Compliance with Critical Room Pressurization Testing- NEW</td>
<td>100%</td>
</tr>
<tr>
<td>Staff Knowledge Score in Life/Fire Safety Management Surveillance Tours</td>
<td>≥ 90% qtr</td>
</tr>
</tbody>
</table>

In 2019 a new indicator was selected to be monitored as part of the Fire/Life Safety program to test the compliance with Critical Room Pressurization. This performance monitor was selected as an area of focus for the Facilities team to ensure compliance with the critical room pressurization requirements.
MEDICAL EQUIPMENT MANAGEMENT PROGRAM

Reviewer: Marcos Mantel
Title: Executive Director, Corporate Biomedical Engineering
Region: Broward Health Medical Center
Review Date: April 1, 2019

Purpose: The purpose of the Medical Equipment Management Plan (“The ME Plan”) is to establish criteria to minimize clinical and physical risks of medical equipment and ensure patient safety by maintaining a facility-specific equipment inventory and perform scheduled maintenance in the required frequencies. An Alternate Equipment Management (AEM) Program (CMS) is implemented for all equipment with some exceptions. The Biomedical Engineering department also provides oversight of equipment serviced by contracted vendors to ensure compliance. The ME Plan includes the capabilities, limitations of equipment, operations, safety and emergency procedures, and process to remove from service and report any equipment with problems as soon as detected.

Scope: The scope of the Medical Equipment Management Plan provides an overview of the processes that are implemented to ensure the effective and safe management of medical equipment. The scope encompasses all medical equipment used in the diagnosis, therapy, monitoring, and treatment of patients at Broward Health Medical Center. Medical equipment used in Radiology, Dialysis, for Sterilization, Lasers in Surgery and some Laboratory analyzer services are contracted to outside vendors.

Evaluation of the Scope: During 2018, the Medical Equipment Management Plan was reviewed. The objectives for the ME Plan and the scope of the plan were reviewed and determined to be acceptable to ensure the medical equipment used at BHMC is safe for patients and personnel using the equipment. The Medical Equipment Management Plan and program were found to be effective. Goals have been established to direct the Medical Equipment Management Plan in 2019.

Review of Program Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintains current medical equipment inventory</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs inspections, testing and maintenance of medical equipment</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educate end users on the operation, safety features and emergency procedures to reduce risk of equipment issues due to user errors</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Review of Performance: 2018 performance monitors are as follows

Performance Monitor #1: Failed Equipment Performance

**Target:** <6/= %/quarter

**Performance:** Target met each quarter in 2018 ranging from 1%-4%

**Performance Monitor Analysis:** Performance was met in every quarter of 2018

<table>
<thead>
<tr>
<th>Medical Equipment Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>BioMed - Failed Equipment Performance</td>
<td>≤ 6%/qtr</td>
<td>1%</td>
<td>1%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness:** This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #2: Improper Care of Equipment:

**Target:** <= 2%/quarter

**Performance:** Target met each quarter in 2018 ranging from 1%-2%

**Performance Monitor Analysis:** Performance was met in every quarter of 2018.

<table>
<thead>
<tr>
<th>Medical Equipment Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 C18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>BioMed - Improper Care of Equipment</td>
<td>≤ 2%/qtr</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Overall Effectiveness of the Program’s Effectiveness:** This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

**Performance Monitor #3:** Improper Equipment Operation

**Target:** <= 2%/quarter

**Performance:** Target met each quarter in 2018 ranging from 0%-1%

**Performance Monitor Analysis:** Performance was met in every quarter of 2018.
Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #4: Laser Safety-Quality Assurance

Target: \( \leq 3\% \)/quarter

Performance: Quality performance indicator was 0% each quarter of 2018

Performance Monitor Analysis: Performance was met in every quarter of 2018 and improved from a 1% quarterly average in 2017

<table>
<thead>
<tr>
<th>Medical Equipment Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laser Safety - Quality Assurance</td>
<td>( \leq 3%/qtr )</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #5: Staff Knowledge Score in Medical Equipment Management assessed during EoC Surveillance Tours

Target: \( \geq 90\% \)

Performance: Average quarterly performance in 2018 was 99%/qtr. exceeding the target in each quarter.

Performance Monitor Analysis: Performance bench mark was exceeded from 2017 by 2% in 2018

<table>
<thead>
<tr>
<th>Medical Equipment Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Med Equipment Management EoC Surveillance Tours</td>
<td>( \geq 90% qtr )</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>99%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective will continue to be monitored in 2019 for further compliance as part of the EoC surveillance rounds.
### Performance Monitors for 2019:

<table>
<thead>
<tr>
<th>Monitor</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>BioMed - Failed Equipment Performance</td>
<td>&lt;= 6%/qtr</td>
</tr>
<tr>
<td>BioMed - Improper Care of Equipment</td>
<td>&lt;= 2%/qtr</td>
</tr>
<tr>
<td>BioMed – Improper Equipment Operation</td>
<td>&lt;= 2%/qtr</td>
</tr>
<tr>
<td>Laser Safety – Failed Equipment Performance</td>
<td>&lt;= 3%/qtr</td>
</tr>
<tr>
<td>Staff Knowledge of Medical Equipment Management</td>
<td>&lt;= 90%/qtr</td>
</tr>
</tbody>
</table>
UTILITIES MANAGEMENT PROGRAM

Reviewer: Jaime Alfayate
Title: Director, Facilities and Support Services
Region: Broward Health Medical Center
Review Date: April 24, 2019

Purpose: The Utilities Management Program is designed to effectively and efficiently provide a safe, controlled and comfortable environment for patients, visitors, and staff. The plan covers those utilities delivered under the direction of the Facilities Services Department at Broward Health Medical Center and the Information Systems Department for Broward Health.

Scope: The Utilities Management Program addresses the safe operation, maintenance and emergency response procedures for critical operating systems. Additionally, it provides for the evaluation, assessment, and improvement in operational costs without compromising service or quality.

Evaluation of the Scope: During 2018, the Utilities System Management Plan was reviewed. The objectives established for the management plan and the scope of the plan were reviewed and found to be appropriate for Broward Health Medical Center. The plan and program were found to be effective. Goals have been established to direct the Utilities Systems Management Plan in 2019.

Review of Program Objectives:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assure the operational reliability of the utility systems</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess the special risks of the utility systems</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respond to utility systems failures.</td>
<td>Met</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Monitor: Performance monitors for 2018 are as follows:

- Any Unscheduled Outages >4hrs Target = 0/qtr
- Utility Systems Failures Target = 0/qtr
- Utility Systems Problems Target = 0/qtr
- (Total WO Count) Work Order Class BS4-LS Target = 100%/qtr
- (Total WO Count) Work Order Class BS4-IC Target = 100%/qtr
- Generator Test Results Target = 100%/qtr
- Energy Efficiency (Benchmark changes per seasonal quarter), kW Hrs per sq. ft. Occupied Space, (Old Hospital, Atrium Bldg, and CEP) Target = Seasonal By qtr
- Staff Knowledge Score in Utilities Management Surveillance Tours Bench Mark = ≥ 90%/qtr
Performance Monitor #1: Any Unscheduled Outages >4hrs

Target: 0/qtr

Performance: Average quarterly performance in 2018 was 0/qtr. reduced by 1/qtr. compared to 2017

Performance Monitor Analysis: In 2018 there were no Unscheduled Outages >4hrs encountered

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Unscheduled Outages &gt;4hrs.</td>
<td>0/qtr</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored for trends in 2019.

Performance Monitor #2: Utility Systems Failures

Target: 0/qtr

Performance: Average quarterly performance in 2018 was 0/qtr. 2017 Average quarterly performance was 0/qtr.

Performance Monitor Analysis: In 2018 there were no Utility Systems Failures encountered

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utility Systems Failures</td>
<td>0/qtr</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.

Performance Monitor #3: Utility Systems Problems Bench Mark= 0/qtr.

Target: 0/qtr

Performance: Average quarterly performance in 2018 was 0/qtr. 2017 Average quarterly performance was 0/qtr.

Performance Monitor Analysis: In 2018, there were no Utility Systems Problems encountered.
Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will be continue to be monitored in 2019 for further compliance.

Performance Monitor #4: (Total WO Count) Work Order Class BS4-LS

Target: 100%/qtr

Performance: Average quarterly performance with work order compliance on BS4-LS in 2018 was 98.65%/qtr. 2017 Average quarterly performance was 99.40%.

Performance Monitor Analysis: In 2018 there were some issues encountered with back order of parts for some of the BS4-LS work orders causing the decrease of compliance.

Performance Monitor #5: (Total WO Count) Work Order BS4-IC

Target: 100%/qtr

Performance: Average quarterly performance with work order compliance on BS4-IC in 2018 was 100%/qtr. 2017 Average quarterly performance was 98.60%.

Performance Monitor Analysis: Performance was met in every quarter of 2018 and reduced by 1% compared to 2017.

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2019 for further compliance.
Performance Monitor #6: Generator Test Results

Target: 100%/qtr

Performance: In 2018 we attained 100% compliance with this indicator in all qtrs.

Performance Monitor Analysis: Performance was met in every quarter of 2018.

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generator Test Results</td>
<td>100%/qtr</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective will be continue'd to be monitored in 2019 for further compliance.

Performance Monitor #7: Energy Efficiency (Benchmark changes per seasonal quarter), kW Hrs per sq. ft. Occupied Space, (Old Hospital, Atrium Bldg. and CEP)

Target: Seasonal by qtr

Performance: In 2018 & 2017 the facility maintain the overall building energy efficiencies below the Kw hrs. per sq. ft as intended.

Performance Monitor Analysis: Performance was met in every quarter of 2018 and 2017

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generator Test Results</td>
<td>100%/qtr</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective will be continue to be monitored in 2019 for further compliance.

Performance Monitor #8: Staff Knowledge Score in Utilities Management Surveillance Tours

Target: ≥ 90%/qtr

Performance: Average quarterly performance in 2018 was 97%/qtr. 2017 Average quarterly performance was 96%/qtr.

Performance Monitor Analysis: Performance bench mark was exceeded from 2017 by 2% in 2018

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY18</th>
<th>Q2 CY18</th>
<th>Q3 CY18</th>
<th>Q4 CY18</th>
<th>CY2018</th>
<th>CY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Utilities Management Surveillance Tours</td>
<td>≥ 90%/qtr</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
<td>96%</td>
</tr>
</tbody>
</table>
Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective will continue to be monitored in 2019 for further compliance as part of the EoC surveillance rounds.

Performance Monitors for 2019:

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Unscheduled Outages &gt;4hrs.</td>
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<tr>
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<tr>
<td>(Total WO Count) Work Order Class BS4-LS</td>
<td>100%/qtr</td>
</tr>
<tr>
<td>(Total WO Count) Work Order Class BS4-IC</td>
<td>100%/qtr</td>
</tr>
<tr>
<td>Generator Test Results</td>
<td>100%/qtr</td>
</tr>
<tr>
<td>Energy Efficiency (Benchmark changes per seasonal quarter)</td>
<td>Seasonal By Qtr</td>
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<tr>
<td>kW Hrs per sq. ft. Occupied Space (Old Hospital, Atrium Bldg. and CEP)</td>
<td></td>
</tr>
<tr>
<td>Staff Knowledge Score in Utilities Management EoC Surveillance Tours</td>
<td>≥ 90%/qtr</td>
</tr>
</tbody>
</table>
ENVIRONMENT OF CARE PERFORMANCE IMPROVEMENT PROJECT

Reviewer: Shirley Ochipa
Title: Safety Officer
Region: Broward Health Medical Center
Review Date: April 26, 2019

Purpose: Reduce Contaminated Needlesticks by 5%
(What was the expected outcome of the performance improvement initiative?)

Scope: Scope of this hospital-wide initiative included staff and managers from all BHMC departments where patient care was provided both inpatient and outpatient services, Surgical and Invasive Procedural suites, Outpatient Laboratory, Clinical Education, Medical Staff, Graduate Medical Education

Cause: Unfavorable trend in the quarterly contaminated needlestick performance monitor was noted as 2017 progressed. Action plans provided to the Safety Officer from the department Managers where exposures occurred failed to make a significant decrease in exposures. Safety Officer suggested to the EoC Committee that we continue our 2017 initiative into 2018 which was unanimously approved.

Duration: The monitoring period for this indicator occurred throughout 2018.

Actions: Based on the drill down of exposures in 2017 and in early 2018, the 2 highest root causes were failure/error in activation of the device’s safety feature and incorrect contaminated needle disposal. Action plans were required of Managers for preventable needlesticks. A module on proper disposal of contaminated sharps that included direct and indirect impact statements to those healthcare workers required to complete the post-exposure protocol were assigned to all BHMC employees including Medical Residents. Administration was informed of preventable needlesticks (CNO and COO) and the CMO informed when physicians’ practices contributed to the risk of employee exposures. All nursing personnel were assigned on Healthstream a video on the correct use of the BD insulin safety syringe. Diabetes specialists from Becton-Dickinson were at the hospital to assess clinical practice with this device and coach clinical staff if incorrect techniques were observed. They also provided training with all the Clinical Nurse Specialists so they could conduct competencies with return demonstration with every nurse over a 3 month period. The safe injection practice using the BD 6mm insulin syringes was added to the new hire nursing orientation checklist and also added to the annual competency checklist.

Reporting: Progress was reported to the EoC Committee every 1-2 months. Performance monitors were reported to this committee quarterly as well as MCE a physician meeting, Nursing Leadership, Infection Control Committee, PSCKG/RQC, and GME Resident orientation plus 3 additional presentations with the medical residents.

The multi-disciplinary team who designed, implemented, monitored and reviewed the performance improvement initiative were Safety Officer (coordinator of all action plans), Employee Health Manager,
Directors and Managers of Critical Care Nursing, Adult Care Nursing, Behavioral Health Services and Emergency Department with their respective Clinical nurse specialists, Clinical Education, Administration (CMO, COO, CNO), Medical Director of GME, and select Chiefs of Medical Staff divisions.

Analysis:

**REDUCE YOUR RISK OF CONTAMINATED NEEDLE STICKS**

*Always Follow Safe Injection and Disposal Practices*
*A Single Mistake Can Change Your Life*

**BD SafetyGlide Insulin Syringe with 6mm needle**
- Product meets diabetes/needle length recommendations
- ½ unit dosing scale improves confidence in small dose delivery
- Do not pinch the skin with your secondhand when administering insulin
- Only use one-handed technique to activate safety feature and reduce risk of accidental needle sticks. Keep second hand away from the contaminated needle.
- Dispose used needle/syringe directly into a sharps container

Need-to-Know education was assigned to all nursing staff as a reference on correctly using the BD 6mm Safety-Glide insulin needle and syringe for insulin administration. Instructions on the correct procedure to follow to reduce the risk of needlestick injuries was also a key focus.
In May, 5 exposures involved GME Residents due to risks while suturing and incorrect disposal e.g. recapping used needles. The OMFS Medical Director was informed and provided additional education on safe techniques especially with OMFS residents to reduce the risk of needlestick injuries.

In September as actions for this initiative proceeded, another source of contaminated needlesticks was discovered by the Safety Officer. A respiratory therapist received a needlestick injury using a substitute product in the ABG kit from a previous back-order which did not have a needle safety feature. Further investigation revealed the primary ABG kit with the safety needle/syringe was not being used in any of the Broward Health hospitals. The sub product was removed by each facility’s Materiels Distribution department and the correct safety ABG kits ordered.
Outcome: A 17% decrease in needlesticks due to the top root causes was noted in the 3rd quarter compared to the 2nd quarter of 2018. By the end of the calendar year, an 8% decrease in the # of contaminated needlestick exposures with a 2% decrease in the rate was noted compared to 2017. The Safety Officer continues to conduct drill downs on all contaminated sharp injuries holding leaders and employees responsible for safe work practice and following all best practices to reduce the risks for bloodborne pathogen exposures and maintain a healthcare workforce who focuses not only on patient safety, but also and their own personal safety.
2018 ANNUAL EVALUATION OF THE ENVIRONMENT OF CARE FOR BROWARD HEALTH NORTH

Respectfully Submitted By:
David L. Porter
Regional Safety Officer,
Broward Health North
MISSION AND VISION

**Mission:** The mission of Broward Health is to provide quality health care to the people we serve and support the needs of all physicians and employees.

**Vision:** The vision of Broward Health is to provide world class health care to all we serve.

**Five Star Values:**

- Exceptional service to our community
- Accountability for positive outcomes
- Valuing our employee family
- Fostering an innovative environment
- Collaborative organizational team

REGION’S COMPOSITION

<table>
<thead>
<tr>
<th>Region:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BROWARD HEALTH NORTH</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The Scope, Objectives, Performance and Effectiveness of the Environment of Care Management (EOC) Programs were evaluated by the functional leaders with input from other interrelated functions such as Emergency Preparedness, Employee Health, Clinical Education, Risk Management, etc. The annual evaluation has determined the EOC plans to be effective in reference to their main scope and objectives.

Some opportunities for improvement were identified as well, which will be addressed during CY 2019.

The following is an Executive summary of the Environment of Care performance highlights for CY 2018 followed by recommended Goals for CY 2019 for Broward Health North.

This report will include a summarization of the following:
- Overall performance evaluation of the environmental safety program and safety management plan.
- Overall performance evaluation of the security program and security management plan.
- Overall performance evaluation of the hazardous materials and waste program and hazardous materials and waste management plan.
- Overall performance evaluation of the fire safety program and fire Safety management plan.
- Overall performance evaluation of the utilities program and utilities management plan.
- Report of progress on calendar year 2018 performance goals and program objectives
- Priorities and goals for calendar year 2019

Information Collection and Evaluation System (ICES): An Information Collection Evaluation System (ICES) or Elements of Performance (EP) is used for data collection. The ICES or EP is used to analyze metrics in each of the Safety Management Plan. The ICES or EP is also used to identify and communicate issues and general information about periodic or structured activities to the EOC Committee. All reports are submitted to the EOC Committee on a quarterly basis.

Evaluation Process and Components: The Scope, Objectives, Performance and Effectiveness of the Environment of Care Management (EOC) Plans were evaluated by the functional leaders with input from other interrelated functions such as Emergency Preparedness, Employee Health, Clinical Education, Risk Management, etc. The annual evaluation has determined the EOC plans to be effective in reference to their main scope and objectives.

Committee Members

<table>
<thead>
<tr>
<th>Title</th>
<th>Department</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Officer</td>
<td>Environmental Safety</td>
<td>Chair</td>
</tr>
<tr>
<td>Corporate Manager</td>
<td>Emergency Preparedness</td>
<td>Member</td>
</tr>
<tr>
<td>Corporate Manager</td>
<td>Worker’s Compensation</td>
<td>Member</td>
</tr>
<tr>
<td>Corporate Safety Officer</td>
<td>Corporate Safety</td>
<td>Member</td>
</tr>
<tr>
<td>Regional COO</td>
<td>Administration</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Manager</td>
<td>Epidemiology</td>
<td>Member</td>
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<tr>
<td>Regional Manager</td>
<td>Facilities Services</td>
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<tr>
<td>Regional Manager</td>
<td>Emergency Services</td>
<td>Member</td>
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<td>Regional Manager</td>
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<td>Regional Manager</td>
<td>Radiology Services</td>
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<td>Rehabilitation Services</td>
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<td>Surgical Services</td>
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<td>Regional Manager</td>
<td>Risk Management</td>
<td>Member</td>
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<td>Regional Manager</td>
<td>Trauma Services</td>
<td>Member</td>
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<tr>
<td>Regional Manager</td>
<td>Financial Services</td>
<td>Member</td>
</tr>
<tr>
<td>Regional Manager</td>
<td>Regional Medical Officer</td>
<td>Member</td>
</tr>
</tbody>
</table>

The following table includes the name of those individual who manages the Environment of Care programs.

<table>
<thead>
<tr>
<th>Environment of Care Program</th>
<th>Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Garnett Coke, David Porter</td>
</tr>
<tr>
<td>Security</td>
<td>Scott Payne, Elvis Creese</td>
</tr>
<tr>
<td>Hazardous Materials</td>
<td>Justin Santasier, Howard Scott</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>Scott Payne, David Porter</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Marcos Mantel, Ronald Ellis</td>
</tr>
<tr>
<td>Utility Systems</td>
<td>Scott Payne, David Porter</td>
</tr>
</tbody>
</table>
SAFETY MANAGEMENT PROGRAM
Reviewer: Garnett Coke, David Porter
Title: Safety Management Program
Region: Broward Health North
Review Date: February 20, 2019

Purpose: The Safety Management Program establishes the parameters within which a safe Environment of Care is established, maintained, and improved for Broward Health facilities.

Scope: Broward Health (BH) is made up of many diverse medical facilities. This Program applies to patients, staff, Licensed Independent Practitioners (LIPs) and everyone else who enters a BH facility. The plan comprises those processes that define and measure an effective Safety program. These processes provide for a physical environment free of hazards and manage activities that reduce the risk of injury. The processes used for this plan are founded on organizational experience, applicable laws and regulations, and generally accepted safety practices.

Any differences in activities at each site are noted or defined within the site specific policies, as appropriate.

Evaluation of the Scope: The scope of the Safety Management Program was evaluated and encompasses the following:
- Broward Health North buildings, grounds, equipment, and facilities
- Broward Health North departments, services, and associated personnel
- All Broward Health North disciplines, with particular support and contribution from:
  - Safety
  - Risk Management
  - Facility Services
  - Quality Management
  - Materiel Distribution
  - Biomedical Engineering
  - Environmental Services
  - Workers’ Compensation
  - Surgical Services
  - All applicable regulations promulgated by Federal, State and local authorities.
  - All applicable standards of accrediting organizations.
  - All applicable Broward Health policies and procedures.

Review of Program Objectives: The Safety Management Program was not effective towards three of the five objectives listed below. Each of these have adjusted objectives listed individually in their Performance Monitors.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met w/ Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>REDUCE STAFF NEEDLE STICKS BY 5</td>
<td>✓</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>REDUCE STAFF SLIPS/TRIPS/FALLS (STF’s) TO 12</td>
<td></td>
<td>✓</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>REDUCE VISITOR FALLS TO 17</td>
<td>✓</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>REDUCE EMERGENCY DEPARTMENT PATIENT FALLS TO 11</td>
<td></td>
<td>✓</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>REDUCE OUTPATIENT DEPARTMENT PATIENT FALLS TO 5</td>
<td></td>
<td>✓</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Review of Performance:

Performance Monitors #1

Monitor: REDUCE STAFF NEEDLE STICKS
Target: REDUCE STAFF NEEDLE STICKS BY 5 (25)
Performance: Met

Performance Monitor Analysis:
Program's Effectiveness: The Program was effective in reducing needle sticks from 30 to 25. In 2018, Broward Health North implemented a Process Improvement to assist with the reduction by coordinating with the vendor of our syringes for in-services to the staff on proper handling and all employees who have had an incident were assigned a learning module in Health Stream. The facility will continue to utilize this Process Improvement and the results will be monitored and reported back at the EOC Meetings.

Performance Monitors for 2019: Broward Health North has set a goal of reducing Needle Sticks to 20.

Performance Monitors #2

Monitor: REDUCE STAFF SLIPS/TRIPS/FALLS (STF)
Target: Reduce Staff Slip, Trip and Falls to 12.
Performance: Not Met
Performance Monitor Analysis:

Program's Effectiveness: The program was not effective in reducing Slip Trip and Falls to 12. One item that was identified was spill stations that were removed. Broward Health North will be reinstalling spill stations to aide in lowering instances in the facility.

Performance Monitors for 2019: Broward Health North has kept the goal of reducing Staff Slip, Trip and Falls to 12 in 2019.

Performance Monitors #3

Monitor: VISITOR FALLS
Target: Reduce visitor falls to 17.
Performance: Met
Performance Monitor Analysis:
Program’s Effectiveness: The Safety Management Program was effective in reducing the amount of Visitor Falls in 2018.

Performance Monitors for 2019: Broward Health North has adjusted the goal of reducing Visitor Falls to no more than 13 in 2019.

Performance Monitors #4

Monitor: EMERGENCY DEPARTMENT PATIENT FALLS
Target: Reduce ED Falls to 11.
Performance: Not Met
Performance Monitor Analysis:

Program’s Effectiveness: Although on a downward trend, the Safety Management Program was ineffective to reduce Emergency Department Patient Falls by 5.

Performance Monitors for 2019: Broward Health North has kept the goal of reducing E.D. Falls to 11 for 2019.

Performance Monitors #5

Monitor: OUTPATIENT DEPARTMENT PATIENT FALLS
Target: Reduce Outpatient Falls to 5.
Performance: Met
Performance Monitor Analysis:
Program’s Effectiveness: The Safety Management Program was effective in reducing our Outpatient Department Patient Falls to 5.

Performance Monitors for 2019: Broward Health North has adjusted the goal of reducing Outpatient Department Patient Falls to no more than 4.

Performance Monitors for 2019:
- Reduce Needle Sticks to no more than 20
- Reduce Staff Slip, Trip and Fall’s to no more than 12
- Reduce Visitor Falls to no more than 13
- Reduce E.D. Falls to no more than 11
- Reduce Outpatient Department Patient Falls to no more than 4
SECURITY MANAGEMENT PROGRAM
Reviewer: Elvis Creese, Cliff Bain
Title: Security Management Program
Region: Broward Health North
Review Date: March 1, 2019

Purpose: The purpose of the Security Management Plan is to provide safety and security for all patients, everyone who enters the facilities, and property of the regional medical centers and ancillary sites.

Scope: Broward Health (BH) is made up of many diverse medical facilities. The Security Management Plan applies to all visitors, patients Licensed Independent Practitioners (LIPs) and staff members of every facility in Broward Health. BH operates under regional Environment of Care (EOC) Committees and one EOC Key Group, which has the final approval for all policies affecting the EOC program.

An annual risk assessment is conducted to help determine the essential elements of the security management plan for all facilities of BH.

The facilities to which this Management Plan applies to are: Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, and the Broward Health Community Health Services. Significant differences in activities at each site may be noted in site-specific policies, as appropriate.

Evaluation of the Scope: Based on a review of the current Security Management Program and performance indicators, these objectives are appropriate for the management of safety within Broward Health North. Therefore, no changes to the plan objectives will be recommended at this time.

Review of Program Objectives: The goals that were not met will be a focus for the department in CY2019 by creating action plans and monitoring throughout the year. Other areas for improvement will be addressed through a series of increased awareness training sessions.

In addition to the annual survey, the department also participates in a series of EOC rounds to improve the quality of service and ensure that the overall goals of EOC are met. The department also has ongoing projects and surveys designed to improve the effectiveness of the Plan by working with several departments including Safety and Facilities to improve physical security aspects of the Plan.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
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<tbody>
<tr>
<td>ASSAULT/BATTERY</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THREAT OF VIOLENCE</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGGRESSIVE BEHAVIOR</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODE ASSIST</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MISSING/LOST PROPERTY</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THEFTS: PATIENT BELONGINGS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THEFTS: AUTO/VANDALISM</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECURITY MANAGEMENT
- The number of Assault/Battery incidents increased to 25 in CY 2018, compared to 17 in CY 2017.
- The number of Threat of Violence incidents decreased from 9 in CY 2017 to 8 in CY 2018.
- The number of Aggressive Behavior incidents decreased from 102 in CY 2017 to 61 in CY 2018.
- The number of Code Assist incidents increased from 283 in CY 2017 to 492 in CY 2018.
- The number of Missing/Lost Property incidents decreased from 117 in CY 2017 to 84 in CY 2018.
- The number of Vehicle Burglary incidents decreased from 8 in CY 2017 to 7 in CY 2018.
- The number of Contraband searches increased from 140 in CY 2017 to 144 in CY 2018.
Review of Performance:

1. Implement TrackTik, a cloud-based security workforce management platform that is used for establishing guard tours and incident/activity reporting. **Goal Met.**
2. Continue to monitor the amount of violent acts (assaults, aggressive behavior, and threats of violence) and in coordination with the safety officer and clinical leaders, establish a program that emphasizes “early intervention” to escalating behaviors. **Goal Met.**
3. Monitor the average number of “crime related” events in a quarter. If the number of incidents increases more than 5% over the 2017 average, an action plan will be developed to address the issue. **Goal was not met.**
4. Enhance protection efforts through continued training and education of security staff.
   a. Conduct in-house security training meetings. **Goal Met.** The security department conducted quarterly department meetings with emphasis being placed on de-escalation training, emergency code responses, report writing, and slip/trip/fall investigations. In addition to the quarterly meetings, the following monthly training bulletins were presented to the security team:
      i. January 2018 – Use of Force Training
      ii. February 2018 – Use of Force Incident Report Writing
      iii. March 2018 – Sexual Harassment Training
      iv. April 2018 – Gang Awareness Training
      v. May 2018 – Heat Illness Training
      vi. June 2018 – Suicide Awareness Training
      vii. July 2018 – Free to Leave/Patient Watch Training
      viii. August 2018 – Respect and Civility in the Workplace
      ix. September 2018 – Cell Phone Use and Privacy
      x. October 2018 – Driver Safety Training
      xi. November 2018 – Terrorism Awareness Training
      xii. December 2018 – EMTALA Training
   b. Ensure that security staff has knowledge of and demonstrates how to respond to BHN emergency codes. **Goal Met.**

Performance Monitors for 2019:

- Continue to monitor the amount of violent acts (assaults, aggressive behavior, and threats of violence) and in coordination with the safety officer and clinical leaders, establish a program that emphasizes “early intervention” to escalating behaviors. The goal of the program is to decrease violent acts as well as the number of Code Assists. **Goal:** Reduce the amount of Code Assists to 50.
- Increase the amount of “Security Presence” calls.
- Continue to monitor the average number of “crime related” events in a quarter. If the number of incidents increases more than 5% over the 2018 average, an action plan will be developed to address the issue.
- Continue to monitor the amount of reported missing/damaged property and in coordination with Risk, Patient Registration, Environmental Services, and Administration, reintroduce the “sweep the room” campaign, in an attempt to reduce the amount of patient belongings that are being discarded with dirty linens and trash. **Goal:** 10% reduction in the amount of missing patient belongings.
- Install security fencing, badge readers and restrict access to the parking garage to only employees and physicians.
- Enhance protection efforts through continued training and education of security staff.
HAZARDOUS MATERIALS & WASTE MANAGEMENT PROGRAM

Reviewer: Aaron Pascale, EVS

Title: Hazardous Materials & Waste Management Program

Region: Broward Health North

Review Date: February 20, 2019

Purpose: The purpose of the Hazardous Materials and Waste Management Plan is to describe methods for handling hazardous materials and waste through risk assessment and management. The plan addresses the risks associated with these materials, wastes or energy sources that can pose a threat to the environment, staff and patients, and to minimize the risk of harm. The plan is also designed to assure compliance with applicable codes and regulations as applied to Broward Health buildings and services. The processes include education, procedures for safe use, storage and disposal, and management of spills or exposures.

Scope: Broward Health has many diverse medical facilities. This Management Plan applies to patients, staff, and any other persons who enter a Broward Health site.

The facilities that the Hazardous Materials and Waste Management Plan apply to are: Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, Broward Health Weston, Broward Health Community Health Services, Broward Health Physician Group, and Other business occupancies.

Any differences in activities at each site are noted or defined within the specific site policies, as appropriate.

The scope of the Hazardous Materials and Waste Management program is determined by the materials in use and the waste generated by each Broward Health facility. Safe use of hazardous materials and waste requires participation by leadership at an organizational and departmental level, and other appropriate staff to implement all parts of the plan. Protection from hazards requires all staff that use or are exposed to hazardous materials and waste be educated as to the nature of the hazards and to use equipment provided for safe use and handling. Rapid, effective response is required in the event of a spill, release or exposure to hazardous materials or waste. The plan includes management of staff’s practices so the risk of injuries and exposures is reduced and staff can respond appropriately in emergencies. Special monitoring processes or systems may also be required to manage certain hazardous gases, vapors, or radiation undetectable by humans.

Evaluation of the Scope: Based on a review of the current Hazardous Materials & Waste Management Program and performance indicators, these objectives are appropriate for the management of safety within Broward Health North. Therefore, no changes to the plan objectives will be recommended at this time.

Review of Program Objectives: The Hazardous Materials and Waste Management Objectives were considered effective this year. We will continue to trend the current Objectives for another year and make appropriate changes as needed.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain Biohazardous Waste below target of 1.60 lbs./APD</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase Recycled Waste by 3%</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain zero Code Spills in the facility</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct one (1) spill cart training class</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Review of Performance:

Performance Monitors #1

Monitor: Maintain Biohazardous Waste below target of 1.60 lbs./APD
Target: Below 1.60 lbs./APD
Performance: This goal was met

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>CY 2018 BIOHAZARD ROLL-OFF WASTE ONLY (RMW)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADJUSTED PATIENT DAYS</strong></td>
</tr>
<tr>
<td><strong>1ST QUARTER</strong></td>
</tr>
<tr>
<td>JANUARY</td>
</tr>
<tr>
<td>FEBRUARY</td>
</tr>
<tr>
<td>MARCH</td>
</tr>
<tr>
<td><strong>AVERAGE .LBS/APD PER QUARTER TOTAL=</strong> .86 LBS/QTR</td>
</tr>
<tr>
<td><strong>2ND QUARTER</strong></td>
</tr>
<tr>
<td>APRIL</td>
</tr>
<tr>
<td>MAY</td>
</tr>
<tr>
<td>JUNE</td>
</tr>
<tr>
<td><strong>AVERAGE .LBS/APD PER QUARTER TOTAL=</strong> .78 LBS/QTR</td>
</tr>
<tr>
<td><strong>3RD QUARTER</strong></td>
</tr>
<tr>
<td>JULY</td>
</tr>
<tr>
<td>AUGUST</td>
</tr>
<tr>
<td>SEPTEMBER</td>
</tr>
<tr>
<td><strong>AVERAGE .LBS/APD PER QUARTER TOTAL=</strong> .62 LBS/QTR</td>
</tr>
<tr>
<td><strong>4TH QUARTER</strong></td>
</tr>
<tr>
<td>OCTOBER</td>
</tr>
<tr>
<td>NOVEMBER</td>
</tr>
<tr>
<td>DECEMBER</td>
</tr>
<tr>
<td><strong>AVERAGE .LBS/APD PER QUARTER TOTAL=</strong> .59 LBS/QTR</td>
</tr>
</tbody>
</table>

**YEARLY AVERAGE =** .71 LBS/APD

Program’s Effectiveness: The Hazardous Material and Waste Management Program was effective in maintaining our Biohazardous Waste below 1.60 lbs./APD.

Performance Monitors for 2019: Broward Health North has set a goal to maintain Biohazardous Waste to below .85 lbs./APD.
Performance Monitors #2

Monitor: Increase Recycled Waste
Target: Increase by 3% to 5.57 LBS/APD.
Performance: This goal was not met.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>CY 2018 RECYCLED WASTE ONLY (RCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADJUSTED PATIENT DAYS</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td><strong>1ST QUARTER</strong></td>
</tr>
<tr>
<td>JANUARY</td>
</tr>
<tr>
<td>FEBRUARY</td>
</tr>
<tr>
<td>MARCH</td>
</tr>
<tr>
<td><strong>AVERAGE LBS/APD PER QUARTER TOTAL= 5.57 LBS/QTR</strong></td>
</tr>
<tr>
<td><strong>2ND QUARTER</strong></td>
</tr>
<tr>
<td>APRIL</td>
</tr>
<tr>
<td>MAY</td>
</tr>
<tr>
<td>JUNE</td>
</tr>
<tr>
<td><strong>AVERAGE LBS/APD PER QUARTER TOTAL= 5.04 LBS/QTR</strong></td>
</tr>
<tr>
<td><strong>3RD QUARTER</strong></td>
</tr>
<tr>
<td>JULY</td>
</tr>
<tr>
<td>AUGUST</td>
</tr>
<tr>
<td>SEPTEMBER</td>
</tr>
<tr>
<td><strong>AVERAGE LBS/APD PER QUARTER TOTAL= 5.17 LBS/QTR</strong></td>
</tr>
<tr>
<td><strong>4TH QUARTER</strong></td>
</tr>
<tr>
<td>OCTOBER</td>
</tr>
<tr>
<td>NOVEMBER</td>
</tr>
<tr>
<td>DECEMBER</td>
</tr>
<tr>
<td><strong>AVERAGE LBS/APD PER QUARTER TOTAL= 5.40 LBS/QTR</strong></td>
</tr>
<tr>
<td><strong>YEARLY AVERAGE = 5.30 LBS/APD</strong></td>
</tr>
</tbody>
</table>

Program's Effectiveness: The Hazardous Material and Waste Management Program was not effective with increasing our Recycled Waste by 3% to 5.57 LBS/APD.

Performance Monitors for 2019: Broward Health North has set a goal of increasing our Recycled Waste by 3% TO 5.46 LBS/APD.

Performance Monitors #3

Monitor: Maintain zero Code Spills
Target: 0
Performance: This goal was met

Program’s Effectiveness: The Hazardous Material and Waste Management Program was effective in obtaining the goal of no Code Spills.

Performance Monitors for 2019: Broward Health North will continue to set a goal of zero for Code Spills through ongoing training and education.

Performance Monitors #4

Monitor: Conduct (1) spill cart training class
Target: 1
Performance: This goal was not met

Overall Effectiveness of the Program’s Effectiveness: The Hazardous Material and Waste Management Program was not effective towards completing spill cart training.

Performance Monitors for 2019: Conduct (1) spill training class
Performance Monitors for 2019:

- Maintain Biohazardous Waste to below .85 lbs./APD
- Increase Recycled Waste by 3% TO 5.46 LBS/APD
- Continue zero Code Spills through ongoing training and education
- Conduct one spill training class
FIRE SAFETY MANAGEMENT PROGRAM
Reviewer: R. Scott Payne, David Porter
Title: Fire Safety Management Program
Region: Broward Health North
Review Date: January 20, 2019

Purpose: The Purpose of the Fire Safety Management Program is to minimize the possibility and risks of a fire and protect all occupants and property from fire, heat and products of combustion. To ensure that staff and Licensed Independent Practitioners (LIPs) are trained and tested in fire prevention and fire safety so that they are able to respond appropriately to any fire emergency.

Scope: The Fire Safety Management Program is designed to assure appropriate, effective response to fire emergency situations that could affect the safety of patients, staff, LIPs and visitors, or the environment of Broward Health. The program is also designed to assure compliance with applicable codes and regulations.

The Fire Safety Management Program applies to every patient and anyone who enters any Broward Health location. The Fire Safety Management Plan applies to Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, Broward Health-Weston, Broward Health Community Health Services, and Broward Health Physician Group, and other business occupancies. Any differences in activities at each site are noted or defined within the specific site policies, as appropriate.

Evaluation of the Scope: Based on a review of the current Fire Safety Management Program and performance indicators, the scope is appropriate for the management of safety within Broward Health North.

Review of Program Objectives: Based on a review of the current Fire Safety Management Program and performance indicators, these objectives are appropriate for the management of safety within Broward Health North. Therefore, no changes to the plan objectives will be recommended at this time.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform fire drills, 1 per quarter, per shift. If Interim Life Safety Measures (ILSM's) are being used, perform 2 per quarter, per shift.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decrease the number of unscheduled alarms to less than 24.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain no actual fires.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review Life Safety plans and update</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of Performance:

Performance Monitors #1
Monitor: Perform fire drills, 1 per quarter, per shift. If ILSM’s are being used, perform 2 per quarter, per shift.
Target: One fire drill per shift, per quarter.
Performance: All fire drills were completed at the appropriate times meeting all testing criteria of NFPA. There were 16 fire drills completed exceeding the requirements of one per shift, per quarter.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CY 16</th>
<th>CY 17</th>
<th>CY 18</th>
<th>DIFFERENCE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRE DRILLS COMPLETED</td>
<td>24</td>
<td>25</td>
<td>16</td>
<td>-9</td>
</tr>
</tbody>
</table>

Program’s Effectiveness: The Fire Safety Management Program was effective in achieving our goal for fire drills. Although there were extra fire drills performed for CAP and CARF requirements, there was a decrease in drills caused by the completion of all projects and returning to testing the system without ILSM’s in place.
Performance Monitors for 2019: Broward Health North will continue to use the NFPA guidelines of one fire drill, per quarter, per shift (12); unless (ILSM’s) are used in the facility, in which case two fire drills, per quarter, per shift will be performed (24).

Performance Monitors #2
Monitor: Number of actual fires
Target: Zero
Performance: Broward Health North continued to have no actual fires.
Performance Monitor Analysis:

| INDICATOR                  | CY 16 | CY 17 | CY 18 | DIFFERENCE:
|----------------------------|-------|-------|-------|-------------
| NUMBER OF ACTUAL FIRES     | 0     | 0     | 0     | EQUAL       

Program’s Effectiveness: The Fire Safety Management Program was effective in achieving our goal of zero actual fires.

Performance Monitors for 2019: Broward Health North will continue to use zero as a goal for actual fires.

Performance Monitors #3
Monitor: Number of false fire alarms
Target: Less than 21 for calendar year 2019
Performance Monitor Analysis:

| INDICATOR                  | CY 16 | CY 17 | CY 18 | DIFFERENCE:
|----------------------------|-------|-------|-------|-------------
| NUMBER OF FALSE ALARMS     | 21    | 23    | 13    | -10         

Program’s Effectiveness: Broward Health North was able to reduce the number of False Fire Alarms to 13. The facility continues to train staff to prevent incidences.

Performance Monitors for 2019: Broward Health North has set a goal of 10 false fire alarms for 2019.

Performance Monitors #4
Monitor: Review Life Safety plans and update
Target: Complete
Performance: All reviews and updates to the Life Safety drawings for the facility have been completed.

Overall Effectiveness of the Program’s Effectiveness: The Fire Safety Management Plan for CY 2018 was proven to be effective by the outcomes of the goals that were met. The overall success of the program was aided by the department’s commitment to improving outcomes and also by participating in joint efforts with other departments. Through these collective efforts and information sharing, the Program continues to have positive outcomes and meet and exceed the goals set. In addition to the annual survey, the department also participates in a series of EOC rounds to improve the quality of service and ensure that the overall goals of EOC are met. The department also has ongoing projects and surveys designed to improve the effectiveness of the Program by working with several departments including Safety and Facilities to improve physical aspects of the Program.

Performance Monitors for 2019:
- Perform fire drills, 1 per quarter, per shift. If ILSM’s are being used, perform 2 per quarter, per shift.
- Decrease the number of unscheduled fire alarms to 10.
- Maintain no actual fires in the facility.
Unlike other EoC functions, the management of the Medical Equipment program for all the facilities of Broward Health is done by the Clinical/Biomedical Engineering Executive Director and his staff from one central location. In keeping in line with the centralized nature of the Biomedical Engineering organization, this section of the annual appraisal covers all the Broward Health facilities/regions. Performance is tracked by region with corresponding corrective action plans as deemed necessary.

Objectives
The Medical Equipment Management Plan is designed to meet the following objectives:

- To establish criteria for identifying, evaluating and inventorying equipment included in the program.
- To minimize the clinical and physical risks of equipment through inspections, testing and regular maintenance. An Alternate Equipment Management (AEM) Program (CMS) is implemented for all equipment with some exceptions.
- To provide education to personnel on the capabilities, limitations and special applications of equipment; operating, safety and emergency procedures of equipment; the procedures to follow when reporting management problems, failures and user errors; and the skills and/or information to perform maintenance activities.

Based on a review of our current Plan and the Environment of Care performance indicators, these objectives are appropriate for the management of medical equipment within the Broward Health facilities. Therefore, no changes to the Plan objectives will be recommended at this time.

Scope
The Plan provides an overview of the processes that are implemented to ensure the effective and safe management of medical equipment in the environment of care. The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnosis, therapy, monitoring, and treatment of patients at Broward Health facilities. Radiological, Dialysis, Sterilizer, Lasers and some Laboratory Analyzer service is contracted to outside vendors. This service is overseen by user department and/or Clinical/Biomedical Engineering or the EOC Committees.

Performance
The Medical Equipment Management Plan is designed to support the delivery of quality patient care in the safest possible manner through the active management of medical equipment. During the CY 2018, performance standards for the Medical Equipment Management Plan were tracked in the following areas:

- Active Inventory
- Work Orders Opened
- Work Orders Closed
- Inspection Completed
- Labor Hours
- Parts Cost
- QA Rounds
- Parameter
- Work orders Not Closed for the Quarter*
- Failed Performance*
- Failed Electrical safety*
- New to Inventory (unreported)*
- Calls Where no Problem was Found*
- Improper Care*
- Missing Accessories*
- Staff Instruction*

Effectiveness
A review of performance indicators* in eight separate areas, as well as a review of the stated goals is used as the basis for determining effectiveness of the Plan on an annual basis. Evaluation and review of these criteria indicates an effective medical equipment management program. All performance indicators and goals were met in all facilities CY 2018.
Accomplishments-Special Projects

- Nikon Kohen (NK) Network Survey – September 2018
- Assure all staff receives proper medical equipment training in order to perform their respective duties in a safe and proficient manner – Ongoing
- Ensure that all alerts, recalls and hazards that pertain to medical equipment are investigated – Ongoing
- Review and revise the Medical Equipment Management Program as necessary - Ongoing

Strength

Our Scheduled Maintenance (SM) program is unique because we do “environmental” SM’s. This helps us achieve close to 100% annual completion of all SM’s in all facilities.

The ability to move Biomed staff as needed to the different facilities helps maintain optimum efficiencies and decrease down time of equipment.

Strong participation in the EOC Committees in all facilities provides a venue for implementing best practices throughout Broward Health.

Evaluation of CY 2018 Performance Indicators

Quarterly reports to the Environment of Care Committees.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Goal</th>
<th>BHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Work Orders Not Closed</td>
<td>≤ 10%</td>
<td>MET</td>
</tr>
<tr>
<td>- Failed Performance*</td>
<td>≤ 6%</td>
<td>MET</td>
</tr>
<tr>
<td>- Failed Electrical Safety</td>
<td>≤ 1%</td>
<td>MET</td>
</tr>
<tr>
<td>- New To Inventory (Unreported)</td>
<td>≤ 5%</td>
<td>MET</td>
</tr>
<tr>
<td>- No Problem Was Found</td>
<td>≤ 15%</td>
<td>MET</td>
</tr>
<tr>
<td>- Improper Care</td>
<td>≤ 2%</td>
<td>MET</td>
</tr>
<tr>
<td>- Missing Accessories * new FY 18</td>
<td>≤ 2%</td>
<td>MET</td>
</tr>
<tr>
<td>- Staff Instruction</td>
<td>≤ 2%</td>
<td>MET</td>
</tr>
</tbody>
</table>

Recommended Goals for CY 2019

Medical Equipment Management Goals were submitted to the Environment of Care Committees at all facilities for approval. The Committees approved the following goals for CY 2018:

- Replace all NK 2000, 4000, 5000 series Bedside Monitors and Centrals – June 2019 - July 2020
- Replace the NK Monitoring Network – June 2019 - July 2020
- Connect All NK Monitors to Cerner CareAware EMR – June 2019 - July 2020
- Infusion Pumps Replacement with EMR Connectivity – June 2019
- Assure all staff receives proper medical equipment training in order to perform their respective duties in a safe and proficient manner - Ongoing
- Ensure that all alerts, recalls and hazards that pertain to medical equipment are investigated - Ongoing
- Review and revise the Medical Equipment Management Program as necessary – Ongoing

Summary

The Medical Equipment Management Plan and its continuation was considered effective this year. We will continue to trend the current performance indicators for another year, reassess the targets and make appropriate changes based on the consensus of the EoC Committees.
## Clinical/Biomedical Engineering Performance Assessment
### Calendar Year (January-December) 2018

<table>
<thead>
<tr>
<th>SAMPLE SIZE:</th>
<th>BHMC</th>
<th>BHN</th>
<th>BHIP</th>
<th>BHCS</th>
<th>BHW</th>
<th>CHS/PHY</th>
<th>SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNITS IN INVENTORY</td>
<td>10,081</td>
<td>4,301</td>
<td>2,318</td>
<td>3,592</td>
<td>53</td>
<td>2,236</td>
<td>22,581</td>
</tr>
<tr>
<td>W. O. OPENED</td>
<td>5,796</td>
<td>2,401</td>
<td>1,443</td>
<td>1,814</td>
<td>19</td>
<td>426</td>
<td>11,899</td>
</tr>
<tr>
<td>TOTAL W. O. COMPLETED</td>
<td>5,816</td>
<td>2,422</td>
<td>1,437</td>
<td>1,787</td>
<td>19</td>
<td>409</td>
<td>11,890</td>
</tr>
<tr>
<td>INSPECTIONS COMPLETED</td>
<td>9,604</td>
<td>4,747</td>
<td>2,606</td>
<td>3,369</td>
<td>36</td>
<td>1,916</td>
<td>22,278</td>
</tr>
<tr>
<td>W. O./INSPECTIONS COMPLETED</td>
<td>15,420</td>
<td>7,169</td>
<td>4,043</td>
<td>5,156</td>
<td>55</td>
<td>2,325</td>
<td>34,168</td>
</tr>
<tr>
<td>LABOR HOURS</td>
<td>7,879</td>
<td>3,830</td>
<td>2,204</td>
<td>2,407</td>
<td>29</td>
<td>1,112</td>
<td>17,461</td>
</tr>
<tr>
<td>PARTS/ MATERIALS</td>
<td>$225,836</td>
<td>$85,366</td>
<td>$27,699</td>
<td>$55,615</td>
<td>$615</td>
<td>$7,281</td>
<td>$402,412</td>
</tr>
<tr>
<td>QA ROUNDS</td>
<td>3,921</td>
<td>3,003</td>
<td>2,562</td>
<td>2,609</td>
<td>NA</td>
<td>NA</td>
<td>12,095</td>
</tr>
<tr>
<td>PARAMETERS</td>
<td>17,112</td>
<td>7,296</td>
<td>4,029</td>
<td>6,524</td>
<td>74</td>
<td>2,906</td>
<td>37,941</td>
</tr>
</tbody>
</table>

### INDICATORS:

#### W.O. NOT CLOSED

- **<= 10%**
  - BHMC: 206, BHN: 77, BHIP: 53, BHCS: 60, BHW: 1, CHS/PHY: 8, SYSTEM: 405

#### FAILED PERFORMANCE

- **<= 6%**

#### FAILED ELECTRICAL SAFETY

- **<= 1%**
  - BHMC: 33, BHN: 23, BHIP: 8, BHCS: 17, BHW: 0, CHS/PHY: 5, SYSTEM: 86

#### NEW TO INVENTORY

- **<= 5%**
  - BHMC: 120, BHN: 17, BHIP: 31, BHCS: 31, BHW: 0, CHS/PHY: 22, SYSTEM: 221

#### CALLS WHERE NO PROBLEM WAS FOUND

- **<= 15%**
  - BHMC: 297, BHN: 133, BHIP: 36, BHCS: 61, BHW: 0, CHS/PHY: 10, SYSTEM: 537

#### IMPROPER CARE

- **<= 2%**

#### MISSING ACCESSORIES

- **<= 2%**
  - BHMC: 57, BHN: 31, BHIP: 9, BHCS: 11, BHW: 0, CHS/PHY: 2, SYSTEM: 110

#### STAFF INSTRUCTION

- **<= 2%**
  - BHMC: 45, BHN: 14, BHIP: 8, BHCS: 3, BHW: 0, CHS/PHY: 7, SYSTEM: 77

**Comments:**
UTILITIES MANAGEMENT PROGRAM
Reviewer: R. Scott Payne, David Porter
Title: Utilities Management Program
Region: Broward Health North
Review Date: January 16, 2019

Purpose: The Broward Health north Utilities Management Program applies to the direct responsibility of Facilities Services personnel, clinical staff members regarding critical utilities use and contingency responses, the hospital, hospital property, as appropriate.

Scope: The Utilities Systems Management Program provides a process for the proper design, installation, and maintenance of appropriate utility systems and equipment to support a safe patient care and treatment environment at Broward Health. The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the utility systems, and manage risks associated with the operation and maintenance of utility systems. Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education, and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at Broward Health.

The facilities to which this Management Plan applies to are: Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North, and the Broward Health Community Health Services. Significant differences in activities at each site may be noted in site-specific policies, as appropriate.

Evaluation of the Scope: Based on a review of the current Utilities Management Plan and performance indicators, these objectives are appropriate for the management of safety within Broward Health North. Therefore, no changes to the plan objectives will be recommended at this time.

Evaluation of the Scope: Based on a review of the current Utilities Systems Management Program and performance indicators, the scope is appropriate for the management of safety within Broward Health North.

Review of Program Objectives: Based on a review of the current Utilities Systems Management Program and performance indicators, these objectives are appropriate for the management of safety within Broward Health North. Therefore, no changes to the plan objectives will be recommended at this time

<table>
<thead>
<tr>
<th>Objective</th>
<th>Met</th>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
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<tbody>
<tr>
<td>Reduce electric consumption by 3%</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete all Regulatory, Infection Control and Life Safety Preventative Maintenance 100%</td>
<td>✓</td>
<td></td>
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</table>

Review of Performance:

Performance Monitors #1
Monitor: Reduce electric consumption by 3%
Target: 18,881,632 kWh/calendar year
Performance: In 2017, Broward Health North used 19,465,600 kWh’s of power. A 3% reduction is equal to 18,881,632 kWh’s. The actual consumption for calendar year 2018 was 19,567,600 kWh’s, an increase of .52% or 102,000 kWh’s. This was a result of the new Central Energy plant, the new Operating Rooms and the new Emergency department being open for a full year since completion of construction.

Performance Monitors #2
Monitor: Complete all Regulatory, Infection Control and Life Safety Preventative Maintenance
Target: 100% completion of PM’s.
Performance: All Regulatory, Infection Control and Life Safety Preventative Maintenance have been completed at the target rate of 100%.
Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CY 16</th>
<th>CY 17</th>
<th>CY 18</th>
</tr>
</thead>
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<tr>
<td>EQUIPMENT PREVENTATIVE MAINTENANCE COMPLETION RATIO</td>
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<td>100%</td>
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<td>INFECTION CONTROL PREVENTATIVE MAINTENANCE COMPLETION RATIO</td>
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<tr>
<td>LIFE SAFETY PREVENTATIVE MAINTENANCE COMPLETION RATION</td>
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</table>

Overall Effectiveness of the Program’s Effectiveness: The performance of the Utilities Management Program was acceptable, effective, stable, and sustainable with no additional action needed to achieve the expected outcome.

Performance Monitors for 2019:

- Complete all Regulatory, Infection Control and Life Safety Preventative Maintenance at the target rate of 100%.
- Reduce electric consumption by 1% by continuing to replace existing fluorescent indoor lighting with energy efficient LED lighting in 3SE, Human Resources, Cafeteria, MRI, and the 2nd floor main hallway and optimizing the new chiller plant.
OVERALL PERFORMANCE SUMMARY FOR THE ENVIRONMENT OF CARE PROGRAM AND PLANNING OBJECTIVES

Overall Performance Summary: Based on a review of the current overall performance indicators, some goals were not able to be met in 2018. With the actions planned in the individual Objectives above, the following goals have been chosen for 2019:

Planning Objectives for CY2019:

Safety Management
- Reduce Needle Sticks to no more than 20
- Reduce Staff Slip, Trip and Fall’s to no more than 12
- Reduce Visitor Falls to no more than 13
- Reduce E.D. Falls to no more than 11
- Reduce Outpatient Department Patient Falls to no more than

Security Management
- Continue to monitor the amount of violent acts (assaults, aggressive behavior, and threats of violence) and in coordination with the safety officer and clinical leaders, establish a program that emphasizes “early intervention” to escalating behaviors. The goal of the program is to decrease violent acts as well as the number of Code Assists. Goal: Reduce the amount of Code Assists to 50.
- Increase the amount of “Security Presence” calls.
- Continue to monitor the average number of “crime related” events in a quarter. If the number of incidents increases more than 5% over the 2018 average, an action plan will be developed to address the issue.
- Continue to monitor the amount of reported missing/damaged property and in coordination with Risk, Patient Registration, Environmental Services, and Administration, reintroduce the “sweep the room” campaign, in an attempt to reduce the amount of patient belongings that are being discarded with dirty linens and trash. Goal: 10% reduction in the amount of missing patient belongings.
- Install security fencing, badge readers and restrict access to the parking garage to only employees and physicians.
- Enhance protection efforts through continued training and education of security staff.

Hazardous Materials & Waste Management
- Maintain Biohazardous Waste to below .85 lbs./APD
- Increase Recycled Waste by 3% TO 5.46 LBS/APD
- Continue zero Code Spills through ongoing training and education
- Conduct one spill training class

Medical Equipment Management
- Replace all NK 2000, 4000, 5000 series Bedside Monitors and Centrals – June 2019 - July 2020
- Replace the NK Monitoring Network – June 2019 - July 2020
- Connect All NK Monitors to Cerner CareAware EMR – June 2019 - July 2020
- Infusion Pumps Replacement with EMR Connectivity – June 2019
- Assure all staff receives proper medical equipment training in order to perform their respective duties in a safe and proficient manner - Ongoing
- Ensure that all alerts, recalls and hazards that pertain to medical equipment are investigated - Ongoing
- Review and revise the Medical Equipment Management Program as necessary – Ongoing

Fire Safety Management
- Perform fire drills, 1 per quarter, per shift. If ILSM’s are being used, perform 2 per quarter, per shift.
- Decrease the number of unscheduled fire alarms to 10.
- Maintain no actual fires in the facility.

Utilities Management
- Complete all Regulatory, Infection Control and Life Safety Preventative Maintenance at the target rate of 100%.
- Reduce electric consumption by 1% by continuing to replace existing fluorescent indoor lighting with energy efficient LED lighting in 3SE, Human Resources, Cafeteria, MRI, and the 2nd floor main hallway and optimizing the new chiller plant.
24. Infection Prevention and Control Program
Surveillance Plan

1. SCOPE

Broward Health (BH) has developed and implemented a system-wide Infection Prevention and Control Program (IPC) for the surveillance, prevention and control of infection. The aim of our program is to deliver safe, cost-effective quality care to our patients, staff, visitors, and others in the healthcare environment. The program is designed to prevent and reduce hospital acquired infections (HAI) and provide information and support to all healthcare providers, employees, and the community regarding the principles and practices of Infection Prevention and Control in order to support the development of a safe environment for all who enter the facility.

Authority Statement

The Chief of Infection Prevention, Epidemiology and Antimicrobial Stewardship or Medical Director of Epidemiology or Chairman of Infection Control Committee maintains clinical authority over the IPC Program. The Infection Prevention and Control Committee (IPCC) is a multidisciplinary committee which includes physician members appointed by the Chief of Staff of each hospital, has responsibility for overseeing the IPC and shall meet at least quarterly. The chairperson of the IPCC shall be either a physician specializing in Infectious Diseases or a physician whose credentials document knowledge of and a special interest or experience in, infection control. This physician is appointed by the Chief of Staff.

The Director of Quality, Patient Safety & Epidemiology or Regional Manager of Quality and Epidemiology has operational oversight of the Epidemiology department. The Coordinators, Clinical Nurse Specialist, and staff Epidemiologists are responsible for the daily management of the infection prevention and control activities including any surveillance, prevention, and/or control measures when any condition exists that could result in the spread of infection within the hospital or its facilities or creates a hazard for any person at the hospital or its facilities. To facilitate early identification, completed reporting and rapid disease containment, the Epidemiology department, under the direction of the IPCC, has the authority to investigate outbreaks. Examples of appropriate prevention and/or control measures include but are not limited to: institution of appropriate isolation precautions in accordance with hospital policy and/or CDC guidelines, initiation of culture and sensitivity testing in the face of obvious indication, restricting visitors, temporarily closing a unit or ward to further admissions in the case of a suspected or actual outbreak, restricting movement of patients from one area to another, and education to staff, patients, and other persons at the hospital or its facilities. Other control measures may be initiated based on surveillance findings, reports of infections, and potential infections.
Discontinuation of services is decided by the Chief of Infection Prevention, Epidemiology and Antimicrobial Stewardship or Medical Director of Epidemiology or Chairman of Infection Control Committee or designee of Infectious Disease and local administrator.

Description of Population

BH is one of the ten largest health systems in the United States and located in Broward County, Florida. BH is a public, non-profit hospital system governed by the North Broward Hospital District Board of Commissioners, a seven member district board appointed by the Governor. In FY 2019, Broward Health has 1,579 licensed beds, 279,523 Emergency Department visits, 203,573 Outpatient Medical Center visits. There are 1,688 active medical staff and 8,447 employees. The medical centers provide tertiary care across a continuum of services from inpatient, outpatient, emergency, rehabilitation, behavioral health and select community health services. Patient populations include: medical-surgical specialties and subspecialties including but not limited to trauma, intensive care, orthopedic, neurology, renal, cardiology, pulmonary, infectious disease, dialysis, diagnostics, endoscopy, wound care, hyperbaric oxygen treatment, stroke, hematology, oncology, hospice, geriatrics, women's and children's services. The system services all segments of the community. The system's close proximity to highways, international airports, shipping ports, commuter railroad service, adult retirement communities, skilled nursing and assisted living facilities, universities, detention centers, and homeless shelters have a direct influence with individuals needing or seeking medical attention.

According to the Broward County Department of Health (BCDOH) there are high numbers of infectious diseases reported. These primarily include: HIV/AIDS, Hepatitis C, STDs, and tuberculosis. Conditions such as cancer, HIV/AIDS, indwelling medical devices, disorders that affect the immune system, alcoholism, drug abuse, diabetes and renal failure can also increase an individual's risk for acquiring infections.

2. STRATEGY

A. The Infection Prevention and Control Program uses evidence based national guidelines, or in the absence of such guidelines, expert consensus. These experts may include the Centers for Disease Control and Prevention (CDC), Center for Medicare and Medicaid Services (CMS), Infectious Disease Society of America (IDSA), Society for Healthcare Epidemiology of America (SHEA), Association for Professionals in Infection Control and Epidemiology (APIC), Occupational Safety and Health Administration (OSHA), The Joint Commission (TJC), Association of periOperative Nurses (AORN), and Association for the Advancement of Medical Instrumentation (AAMI).

B. Epidemiologic data will be used to plan, implement, evaluate and improve infection control strategies. Surveillance is a critical component of the program.

C. The hospital identifies risks for acquiring and transmitting infections based on:
   1. Its geographic location, community, and populations served.
   2. The care, treatment, and services it provides.
   3. The analysis of surveillance activities and other infection control data.
   4. Guidance from national and international sources.

D. There is ongoing concurrent review and analysis of epidemiologically significant aspects of based on historical data, high volume, high risk, and high cost. The aspects of care include, but are not limited to:
   1. Device related infections.
   2. Surgical site infections.
   3. Health care acquired infections in specialty care units.
   4. Epidemiologically important and antibiotic resistant organisms.
5. Tuberculosis and other communicable diseases, especially vaccine preventable infections.

6. High risk populations.

E. The Infection Prevention and Control Program is evaluated at least annually to assess its effectiveness and determine if any revisions are needed.

F. Performance Improvement indicators and benchmarks are adopted on an annual basis and approved by the Infection Control Committee based on the annual risk assessments and the annual Infection Control Plan.

G. Infection Prevention and Control education programs are determined by the educational needs of the employees, results of surveillance activities, and observation of infection prevention and control practices of employees by the Epidemiologist.

3. ASSIGNMENT OF RESPONSIBILITY / PROGRAM MANAGEMENT

A. Members of the Infection Prevention and Control Committee (IPCC)

1. The Committee chairperson, appointed by Chief of Staff, is a physician specializing in Infectious Diseases or a physician whose credentials document knowledge of and a special interest or experience in, infection control.

2. The IPCC is a multidisciplinary committee with representation from but not limited to Medical Staff, Executive Leadership, Employee Health, Nursing, Surgical Services, Ancillary staff including Environmental Services, Nutritional Services, Allied Health, and Community Health Services as needed.

3. The role of the IPCC is to oversee the Infection Prevention and Control Program. All hospital departments are encouraged to participate in the IPCC and contribute to the infection prevention and control objectives of the program.

4. In collaboration with Executive Leadership, Infection Prevention and Control Program is managed by the Director or Regional Manager of Quality and Epidemiology, the Coordinator or Clinical Nurse Specialist of Epidemiology, the Chairman of the Infection Control Committee (ICC) and the IPCC members.

B. Duties and Responsibilities of the Infection Prevention and Control Committee

The Committee defines the epidemiological issues, sets specific annual objectives, and modifies the Infection Prevention and Control Plan to meet those objectives as necessary. Information generated by the Infection Prevention and Control activities is confidential and all individuals having knowledge of this information will maintain confidentiality of privileged health information. The Infection Prevention and Control Committee, which meets at least quarterly:

1. Reviews surveillance data finding (include trends in infections, clusters, infections due to unusual pathogens or any occurrence of hospital acquired infections) and facilitates the allocation of resources needed to access information, supplies, equipment, and laboratory services.

2. Recommends corrective action(s) and approves all proposals and protocols for special infection control studies and findings, when deemed necessary.

3. Initiates recommendations based on mandatory reporting data, surveillance findings, epidemiological investigations, and performance indicator trends.

4. Targeted health care acquired infections will be reported for the hospital and by departments in order to identify specific patient locations to assist in timely identification of trends or clusters of
5. Reviews antibiotic susceptibility/resistance trends.

6. Reports, reviews and makes any necessary recommendations for the Infection Control Risk Assessment (ICRA) as required for construction/renovation projects as needed.

7. Approves the IPC program's annual evaluation of the plan, infection control plan revisions, and reviews new/revised policies annually.

8. The Committee, through the Chairperson, Medical Director or designee, is authorized to institute appropriate control measures or studies when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, and/or the community.

9. The Committee, through the Epidemiology department, keeps abreast of regulatory guidelines/standards related to infection control.

10. Performance Improvement indicators include, but are not limited to, resistant organism monitoring, dialysis water culture reports, biological monitoring of sterilizers, and any unusual or epidemiologically significant infections among patients or staff, exposures to infectious disease, PPD conversions among employees, and blood and body fluid exposures.

11. The Epidemiology department provides consultation regarding the purchase of equipment and supplies for decontamination, cleaning and disinfection, high level disinfection, and sterilization including schedules used throughout the hospital. Any changes in products or techniques are reviewed by the Epidemiology department and presented to IPCC.

C. Oversight and Coordination of Infection Prevention and Control Program

1. The Coordinator, Clinical Nurse Specialist of Epidemiology, or designee has been given the authority to implement and enforce the surveillance, epidemiology policies, coordinate all infection prevention and control activities within the hospital and facilitate ongoing monitoring of the effectiveness of infection prevention and control interventions:
   a. Facilitates appropriate reporting for state and regulatory requirements.
   b. Notifies the Broward County Department of Health (BCDOH) reportable diseases and conditions.
   c. Promotes compliance with regulatory agencies, (i.e. OSHA) and evaluates and institutes recommendations from other recognized experts in Infection Control and Prevention (i.e. CDC, IHI, HICPAC).
   d. Maintains a log of incidents related to infections and communicable diseases.

2. The Coordinator or Clinical Nurse Specialist of Epidemiology consults with the Chairman or Medical Director of the IPCC as appropriate for infection prevention and control activities and decisions. Responsibilities are outlined in the job description and include but are not limited to:
   a. Provides oversight and coordination of infection prevention and control activities
   b. Facilitates prioritization of risk reduction goals, objectives, and activities
   c. Describes demographics and patient populations.
   d. Identifies infection clusters.
   e. Performs healthcare associated infection surveillance and prevalence rounds.
   f. Calculates health care associated infection rates.
g. Reviews microbiological cultures and antibiotic susceptibilities.

h. Conducts outbreak investigation and follow-up.

i. Reviews construction plans.

j. Monitors hospital isolation practices.

k. Monitors and reviews reports of dialysis water, dialysate cultures and endotoxin testing.

l. Conducts special studies based on epidemiological need.

3. Develops strategies to minimize risk of infection:

a. Formulates and implements policies and procedures to reduce risk of infections and communicable diseases.

b. Develops and implements systems for identifying, reporting, investigating and control of infections and communicable diseases.

c. Monitors for adherence to standard precautions and transmission based precautions.

d. Reviews and approves all procedures for cleaning, disinfection, high level disinfection, sterilizing and reprocessing based on manufacturer’s guidelines.

e. Implements processes for safe patient transfers internally or to another facility.

4. Committee participation: The Epidemiology department shall be included at, but not limited to, the following Committees: Nursing Leadership, Value Analysis Steering Committee, Pharmacy & Therapeutics Committee, Patient Safety/Quality Council, Critical Care Committee, Surgical Services Committee, Perinatal Committee, Emergency Management Committee, Environment of Care Committee, Regional Epidemiology Committee, Antibiotic Stewardship Committee, Construction Committee, and Performance Improvement related committees.

5. Serves as a resource for infection prevention and control related issues.

a. Provides patient and family education addressing the disease process, transmission, and prevention which can also be performed by any member of the healthcare team.

b. Serves as a consultant on infectious disease and infection prevention/control issues to the medical staff, clinical staff, ancillary departments, administration, and the community.

c. Communicates to the medical staff and hospital employees regarding current public health issues and other infection prevention and control issues (i.e. blast fax, emails, and flyers).

d. Participates with Facilities Services and Safety in conducting infection control risk assessments for construction and renovation plans.

e. Participates in Value Analysis Committees to provide input on product review and selection.

f. Participates in Environment of Care and Tracer rounds.

g. Serves as the Facility Administrator for NHSN surveillance system and is responsible for the timeliness and accuracy of data entry for required measures.

h. Serves as community resource.

6. Policies

a. All Broward Health infection control policies are reviewed annually and revised as needed.

b. All infection control policies are revised in compliance with applicable regulatory requirements.
c. All infection control policies are approved by the Infection Prevention and Control Committee.

d. Department managers are responsible for submitting department infection control policies to the Epidemiology department for review.

7. Facilitates the appropriate allocation of needed resources.

a. Hospital leaders will review on an ongoing basis the effectiveness of the hospital's infection prevention and control activities.

b. The Epidemiology department has access to information via the intranet, internet, written publications, and journals.

c. Systems to access information will be provided to support infection prevention and control activities. The following computer programs are available for patient specific information: Cerner including Power Chart and MedMined.

d. The Epidemiology department has access to both open and closed medical record health documentation including all information at the time of discharge, including concurrent and retrospective patient review.

e. Networking with other Epidemiologists.

f. The Epidemiology department has its own cost center and budget that is reviewed annually to provide necessary equipment and supplies to support the program.

g. The hospital provides laboratory resources both internally and through reference laboratories as needed to support the Infection Prevention and Control Program.

h. A Clinical pharmacist monitors the appropriateness of antibiotics relative to the results of cultures and sensitivities. A clinical Pharmacist monitors and impacts appropriate anti-infective utilization through the annual antibiogram, limited dosing for post-op antibiotic therapy, education as needed, interventions during Kinetic monitoring and is the lead for the Antimicrobial Stewardship Program.

i. An information systems specialist is assigned to support Epidemiology.

j. Supplement communicable disease reporting completed by the Emergency Department, Laboratory, and Community Health Services staff as needed.

k. The Infection Prevention and Control Program is affected and supported by all applicable federal, state, and local laws and regulations.

8. Ensures licensed professionals from the Epidemiology department are available for consultation. The designated persons will ensure continuous services (24 hours a day / 7 days a week / 365 days a year) for infection prevention and control programs.

9. Educates employees, volunteers, and students. Infection Prevention and Control education is provided to all new Broward Health employees in general orientation. All employees complete mandatory annual education in conjunction with their annual evaluation.

a. The Epidemiology department participates and/or serves as the subject matter experts in the development of these educational offerings.

b. In-services of employees in specific departments may also be conducted as needed based on:

i. Observations during infection control surveillance rounds or environment of care surveillance rounds.

ii. Alerts from Broward County Department of Health, CDC, FDA or other regulatory agencies.
iii. Introduction of new or updated products, procedures, or processes.
iv. Patients, family, or employee educational needs.
v. Informal education and serves as a consultant to the staff during routine patient/facility rounding.

c. Educates using formal and informal models of education which includes learning objectives, audio-visual material, online newsletters and 'Need to Know' publications, handouts, and program evaluation forms.
d. Clinical Education maintains records of attendance and completion of online learning for all employees.

10. Surveillance Data and Reporting

a. The hospital shall have systems for reporting and gathering surveillance data to include but not limited to the following:
   i. The appropriate staff within the hospital.
   ii. Internally to appropriate committees as required including findings, recommendations to Medical Staff through Medical Executive Committee and up to the Board.
   iii. Federal, state, and local public health authorities in accordance with law and regulation. The epidemiology department reports all communicable diseases as required by the Florida Department of Health to all need to know parties (i.e. BCDOH). The Epidemiology department is the liaison to the BCDOH during unusual circumstances (i.e. pandemic influenza, outbreaks/clusters, increase of influx of patients).
   iv. Accrediting bodies as indicated (Sentinel Event Reporting) including mandatory surveillance reporting of specific healthcare associated infections (HAIs) as required by the Centers of Medicare and Medicaid Services (CMS) through the standardized surveillance methods and definitions provided by National Healthcare Safety Network (NHSN) which is managed by the Division of Healthcare Quality Promotion at the Centers for Disease Control (CDC) and Prevention.

b. The referring or receiving organization when a patient was transferred or referred and the presence of an HAI was not known at the time of referral.

c. The minutes of the IPCC are provided to all members of the IPCC for approval and include recommendations in response to clusters or PMR outliers, action plans, responsible parties, and timelines.

d. The Epidemiology department forwards recommendations for department specific actions to the appropriate department manager and monitors progress.

e. The occurrence and follow up of infections/communicable diseases among patients and any staff exposures will be documented by the Epidemiology department and reported to the Infection Prevention and Control Committee.

f. Infection Database Management
   i. All infections will be classified and a list of healthcare associated infections maintained.
   ii. In cooperation with the Quality and Risk Departments, the Epidemiology department will participate in a root cause analysis/intense analysis of any infections that results in unanticipated death or permanent loss of function.
   iii. An intense assessment may be done for infections as determined by the facility as being
iv. Data shall be aggregated, analyzed, and prepared for presentation as needed.

11. Problem Resolution:
   a. Once a problem has been defined, sufficient criteria to evaluate the problem are established and a retrospective review or concurrent monitoring is performed.
   b. The findings are analyzed, specific problems are detailed, and possible solutions are recommended.
   c. If changes are within the scope and responsibility of the Committee Chairman or Department Manager, immediate corrective action shall be made through the appropriate Administrator or Medical Executive Committee.
   d. An identified problem brought to the attention of the IPCC will be addressed with conclusions, recommendations, and actions including periodic follow-up and monitoring until resolution.

D. Maintenance of Qualifications for Infection Prevention and Control Program Leadership

1. The Epidemiology Coordinator or Clinical Nurse Specialist shall maintain competency in all essential elements of the job through professional organizations and attending formal, in-person, and webinar infection control education as needed and at minimum yearly including NHSN annual training.

2. Support and encourage the Epidemiology Coordinator or Clinical Nurse Specialist to become certified in infection control and then maintain certification.

3. The Epidemiology Coordinator or Clinical Nurse Specialist shall supervise the staff Epidemiologist.

E. Shared Responsibilities for the Infection Prevention and Control Program

1. Medical Staff Responsibilities: The Medical Staff provides expertise from their respective areas and disciplines in conjunction with the members of the IPCC to manage the hospital infection surveillance, prevention, and control program.
   a. The Medical Staff will review and comply with the hospital-specific infection prevention and control policies and procedures.

2. Department-Specific Responsibilities: The Department Managers or department designee is responsible for monitoring employees, and assuring compliance with IPC policies and procedures. Responsibilities include, but are not limited to:
   a. Ensuring current infection prevention and control policies and procedures are available in all patient care areas/departments.
   b. Ensuring proper patient care practices and product safety are maintained within the department.
   c. For primary nursing care areas, each Department Manager will ensure proper device day collection for invasive devices (urinary catheters, central lines, and ventilators).
   d. Coordinating with the Epidemiology department to present educational programs on prevention and control of infections.
   e. Department managers identifying infection control issues which may require additional education or training, will contact the Epidemiology department for educational or in-service activities as needed.

3. Healthcare Worker Responsibilities: All healthcare workers of the organization will:
   a. Adhere to hand hygiene guidelines.
   b. Adhere to standard precautions and transmission based precautions, including the use of personal
protective equipment.

c. Adhere to the Infection Control Plan for the control of infections.
d. Complete the annual Rapid Regulatory Compliance Clinical I and II on line education.
e. Participate fully in the Employee Health/Occupational Health program.
f. Notify the Epidemiology department of infection control related issues.
g. Adhere to all infection control policies which are accessible via the BH intranet. In the event the computer systems are down, hard copies of the Infection Control Manual are available in the Epidemiology Department and in Administration.

4. Employee Health (EH)

a. Responsible for overseeing employee surveillance and follow-up as it relates to infections, exposures, and/or accidents.
b. The infectious disease exposure and incidents are monitored and evaluated including review at Infection Prevention and Control Committee.
c. The Employee Health Nurse and Epidemiologist will collaborate as necessary to establish written guidelines for infections or communicable diseases in employees.
d. Any clusters will be promptly reported to Epidemiology department.

4. RISK ASSESSMENTS AND INFECTION PREVENTION AND CONTROL PLAN

A. Risk Assessment:

   1. A careful assessment of the risk for infections is conducted for all areas of the hospital.
   2. The risk assessment is conducted by the Epidemiology department and the IPCC to ensure a multi-disciplinary group has assessed the needs of the population served at each individual medical center.
   3. At minimum, a reassessment of risk will be conducted annually. A reassessment will be conducted whenever risks are significantly changed. (see hospital specific Annual Infection Control Risk Assessment).
   4. Unscheduled reassessments can occur based on the following:
      a. Changes in the scope of the program.
      b. Changes in the results of the risk analysis.
      c. Changes in the emerging and re-emerging problems in the health care community that potentially affect the hospital (ex: highly infectious agents).
      d. Changes in the success or failure of interventions for preventing and controlling infection.
      e. In response to concerns raised by leadership and others within the hospital.
      f. Changes of relevant infection prevention and control guidelines that are based on evidence or, in the absence of evidence, expert consensus.
   5. The overall findings on the Risk Assessment drive the areas targeted for surveillance during the following calendar year. Those findings with the highest scores (Risk priority numbers) are assigned priority and determine the Infection Prevention and Control Program goals.
   6. These findings are presented to the Infection Prevention and Control Committee, Medical Executive
Committee, and to the Quality Assessment and Oversight Committee that includes Board of Commissioner representation.

7. In addition to the Risk Assessment, the Infection Prevention and Control Program also tracks and trends healthcare associated infection rates based on analysis of surveillance data.

8. The findings from the Performance Measurement Report (PMR) target the specific interventions needed to promote evidence-based practice and ensure that the needs of at risk populations have been addressed.

B. Infection Prevention and Control Surveillance Plan

1. The purpose of the surveillance plan is to identify and document infections, both health care associated and community acquired, with the potential for significant effects on patient and employee outcomes. Trends or clusters identified through surveillance may become the basis for focused monitoring. Department Managers, Directors, Risk Management, Quality and Leadership may be asked to assist in investigations and/or the development of action plans.

2. Broward Health uses definitions of healthcare associated infections from CDC and NHSN which are approved by the Infection Prevention and Control Committee.

3. Targeted surveillance is used for identified at risk patient populations at each medical center.

4. Surveillance includes a review of the antibiotic susceptibility patterns and reports prepared in conjunction with Pharmacy and Microbiology at least annually.

5. Employee Health Program: The Employee Health program involves interventions for reducing the risk of infection transmission, including recommendations for immunizations and testing for immunity. The Epidemiology department will collaborate with EH in promoting employee and patient safety.

   a. The program will include screening for health issues, tuberculosis screening, immunization, evaluation of post-exposure assessment to blood/body fluid exposures and/or other communicable diseases.

   b. When indicated, the program will also include monitoring of employee illnesses in order to identify potential relationships among employee illness, infections and/or environmental health factors.

   c. The Epidemiology department will be available to the Employee Health Department for consultation regarding infectious disease concerns.

   d. The Employee Health department will develop policies and procedures for the evaluation of ill employees, including assessment of disease communicability, indications for work restrictions, and management of employees who have been exposed to infectious diseases, including post exposure prophylaxis and work restrictions.

   e. At the time of employment, all facility personnel will be evaluated by the Employee Health nurse practitioner for conditions relating to communicable diseases including but not limited to: Hepatitis B, Varicella immunity, mumps, rubella, rubeola immunity, TB.

   f. Employees will be offered immunizations for communicable diseases.

6. The employees of the hospital play an integral role in surveillance activities. Personnel providing patient care or facilitating/supporting the provision of care are encouraged to report actual/potential infections or risk factors as soon as possible to the Epidemiology department.

7. Screening for exposure and/or immunity to infectious disease is available to licensed independent practitioners and any staff students who may come in contact with infections at the workplace. The
8. When patients have been exposed to an infectious disease, the hospital provides them with or refers them for assessment and potential testing, prophylaxis/treatment, and/or counseling.

9. Signs and symptoms of infections or circumstances where increased risk of infections are determined shall be reported to the healthcare worker providing the patient's care in a timely manner.

10. Using baseline surveillance data to determine if an outbreak is occurring.

11. Investigating infections for trends, clusters, and unusual infections.

C. Annual Appraisal/Evaluation of the Infection Prevention and Control Plan

1. An annual evaluation of the Infection Prevention and Control Plan will be written each year including but not limited to:
   a. Effectiveness of the Infection Prevention and Control Plan
   b. Results of Performance Measurement Report
   c. Ability to meet goals
   d. New or modified processes to prevent/control infection
   e. Healthcare worker educational needs
   f. Community educational needs
   g. New products to prevent/control infection
   h. Review of the Infection Prevention and Control Plan's prioritized risks, goals and activities.
   i. Outcomes achieved by the strategies implemented the previous calendar year.
   j. Recommendations for the next calendar year.

2. Findings from this evaluation will be communicated to the Infection Prevention and Control Committee Regional Medical Executive Committees and to the Broward Health Board of Commissioners through the Quarterly Assessment and Oversight Committee.

3. Performance Improvement indicators and benchmarks are adopted on an annual basis and approved by the Infection Prevention and Control Committee based on the annual risk assessment, annual program evaluation and Infection Prevention and Control Plan.

D. Surveillance Methodology

1. Sources for infection identification include:
   a. Daily microbiologic reports including MedMined surveillance system.
   b. Daily reports including patient census/diagnosis, emergency department visit logs, disease alert report, surgical services and central sterile and processing reports, ventilator reports, radiology reports, post-discharge surveillance reports, health information management reports, employee health reports, and departmental reports including but not limited to materials management, quality management, environmental services, nutritional services, facilities, case management, and financial management.
c. Routine chart reviews.

d. Staff reports of suspect/known infections or infection control issues

e. Device days (i.e. indwelling urinary catheters, central line catheters and ventilator days facility-wide).

f. Employee Health reports reflecting epidemiological significant employee infections.

g. Public Health reporting for State mandated reportable infections.

h. Ongoing review of surveillance data.

i. Prevalence rounds.

j. Referrals from risk management, hospital staff, and physicians.

2. Data collection may be conducted by other departments as necessary to include but not limited to surgical services, health information management, laboratory, nursing, pulmonary services, and cardiac services.

E. Environmental Assessment/Surveillance: Environmental Assessment/Surveillance is performed in conjunction with the Environment of Care (EOC) group and includes the following:

1. Verifying compliance with the IPC program, the Epidemiology department will conduct periodic infection control rounds with follow-up required by the surveyed department.

2. Ensuring clean equipment and supplies are stored separately from soiled ones.

3. Ensuring linens are kept covered during transport and storage.

4. Ensuring sterile supplies are stored in a manner as to prevent contamination or damage to the packaging.

5. Reviewing the sterilization and high level disinfection parameters for all patient care items processed within the facility to assure standards are met.

6. Review the temperature, humidity, and air pressure relationships in all processing areas.

7. Review the documentation of sterile processing and high level disinfection in all areas including Central Sterile Processing, Surgery, Endoscopy, Radiology and Cardio Pulmonary to ensure all sterilization/disinfection performed in the facility meets the same standards.

8. Evaluate the surgical services department immediate use steam sterilization report to determine if adequate supplies are being maintained.

9. Assist in the evaluation of sterilization failures, reporting findings to the Infection Prevention and Control Committee, Medical Staff, Risk Management, Patient Safety Officer, attending physician, and patient care manager of area involved.

10. Monitoring microbiology of treated water and dialysate according to State and Federal standards.

11. Evaluating patients or employees with infections or diseases from environmental organisms, e.g., legionellosis, aspergillosis.

12. Culturing of personnel or the environment is only performed under the direction of the Epidemiology Department, approved by the Infectious Disease physician or Medical Director or designee, or as required by regulatory agencies in order to address a specific finding requiring further investigation. Routine sampling of the environment, air, surfaces, water, food, etc., is discouraged unless a related infection control issue is identified.

13. Performing Infection Control Risk Assessments (ICRA) prior to renovation, new construction, or planned interruption of the utility system within the patient care environment.

14. The ICRAs are to be approved by the appropriate committees, which may include, but are not limited to:
15. Rounds of the construction/renovation site are conducted to evaluate compliance with ICRA requirements. The Epidemiology department will have the authority to stop any project that is in substantial non-compliance with the requirements.

16. Any time there is construction or renovation, the Epidemiology department will be consulted during design process.

17. Evaluate the use of negative pressure environments in the care of patients with airborne diseases.


G. Emergency Management/Influx of Potentially Infectious Patients

1. Refer to BHMC Code Green (Mass Casualty Incident), BHCS Code Green (Mass Casualty Incident), BHIP Code Green (Mass Casualty Incident), and BHN Code Green (Mass Casualty Incident) policies.

2. As part of emergency management activities, Broward Health will be prepared to respond to an influx or the risk of an influx of infectious patients including individuals affected by acts of bioterrorism.

3. Broward Health uses the BCDOH syndromic surveillance program called ESSENCE. This surveillance program is managed by the BCDOH’s Communicable Diseases Epidemiology Program Manager and gathers data based on ICD-10 codes. In the event that the BCDOH syndromic surveillance report detects any changes in the current trends in each regional emergency department (i.e. increase in patients being triaged for influenza-like illness, increase in the same chief complaint, etc.), a member of the BCDOH Communicable Disease Division notifies the regional Epidemiology department or designee. Once notification has taken place, the Epidemiology department will continue further investigation and continue on-going communication with the BCDOH of their initial findings. Communication to Administration, Risk Management and the Chief of Infection Prevention, Epidemiology and Antimicrobial Stewardship or Medical Director of Epidemiology or Chairman of Infection Control Committee or designee will be expedited as information is validated.

4. The Epidemiology department, in addition to the ESSENCE program, receives a daily Emergency Department registration report which identifies every patient triaged and their chief complaint. Individuals with suspicious symptoms (i.e. influenza-like illness, gastroenteritis, etc.) will be further assessed using the following programs for patient specific information: Cerner Powerchart, and Medmined.

5. The Epidemiology department has several methods to communicate any pertinent information regarding any public health issue or information regarding emerging infections that can potentially cause an influx of infectious patients at our facility. All methods of communication include but are not limited to: Broward Health (BH) intranet, internet, email, overhead announcements, Collabria, newsletter, blast fax, flyers and in-services.

6. In the event that a medical center receives an influx of potentially infectious patients, each hospital follows the Broward Health Comprehensive Emergency Management Plan in addition to the facility specific Emergency Management Operations Plan and Code Green (Mass Casualty Incident) policies. Broward Health operates under the principles outlined in the National Incident Management System (NIMS) and the National Response Plan utilized by the Federal Emergency Management Agency and
other governmental and non-governmental agencies. Each medical center CEO in conjunction with the Broward Health Corporate CEO and Infectious Disease Medical-Technical Specialist will determine the need to establish the Incident Command Center depending on the expected impact an influx of infectious patients will have on normal operations. Communication with the BCDOH will be conducted by the Liaison Officer in conjunction with Epidemiology department.

7. The organization determines how it will keep abreast of current information about the emergence of epidemics or new infections that may result in the organization activating its response, determines how it will disseminate critical information to staff and other key practitioners, and identifies resources in the community (through local, state, and/or federal public health systems) for obtaining additional information.

H. Extraordinary Events and Unforeseen Circumstances

1. In the event of a novel virus or an event that occurs that requires a change in infection control practices due to the nature of the virus/event, current policies will remain in effect.

2. Any additions/changes for specific events will be in the form of protocols to address the rapidly changing guidance from local, state or federal agencies.

3. In the event that, due to unforeseen circumstances recommended PPE is not available following normal ordering procedures, every effort will be made to obtain appropriate PPE from other sources. Should other sources be unable to meet the facility needs, alternatives will be utilized to maximum capacity and to every degree possible under extraordinary circumstances to ensure the safety of staff, physicians, patients, visitors, volunteers and vendors.

5. PRIORITIES AND GOALS

A. Evaluate, monitor, and improve the quality of the infection prevention and control program and provide a safe environment for all patients, staff, and visitors.

B. Prevent and/or reduce the risk of infections:
   1. Identifying and preventing the occurrences of healthcare-associated infections by pursuing sound infection prevention and control practices such as aseptic technique, environmental sanitation, standard precautions, and transmission based precautions of patients as needed and monitoring the appropriate use of antibiotics and other antimicrobials.

2. Broward Health implements infection prevention and control activities when
   i. Cleaning and performing low-level disinfection of medical equipment, devices, and supplies.
   ii. Performing immediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.
   iii. Disposing of medical equipment, devices, and supplies.
   iv. Storing medical equipment, devices, and supplies.

3. Assisting in the evaluation of products and equipment.

4. Communicating identified problems and recommendations to the appropriate individuals, committees and/or departments.

5. To verify compliance with the program, the Epidemiologist shall conduct routine infection prevention and control rounds with follow-up/action plan required by the department manager.

6. The Department Managers or designee will conduct direct observation of appearances and practices in their specific clinical areas.
C. Limit the spread and/or occurrence of Infections:
   1. Hand-hygiene program (See Hand Hygiene policy/program.)
   2. Storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment
   3. Use of standard precautions, transmission based precautions and personal protective equipment
      i. This hospital has adopted the CDC Guidelines for Isolation Precautions – 2007
      ii. See Contact, Enhanced Contact, Droplet, Airborne Isolation Policies
   4. Program to reduce the incidence of antimicrobial resistant infections
      i. See Broward Health Epidemiology Department MDRO policy
      ii. See Antimicrobial Stewardship Program

D. Support and enhance public relations through community interactions and educational programs.

E. Improve the quality of health care based on the mission, vision, and values of the organization.

6. ANNUAL INFLUENZA VACCINATION PLAN

A. The hospital establishes an annual vaccination program that is offered to all staff, licensed independent practitioners, contract staff, and volunteers.

B. Employee Health, in collaboration with Epidemiology and Human Resources:
   1. Provides free influenza vaccination at sites and times accessible to all licensed independent practitioners and staff. Employee health deploys a nurse during day and night shifts to round each unit offering the flu vaccine.
   2. Evaluates annually the vaccination rate compliance and the reasons given for declining the influenza vaccination to target opportunities to educate and plan future campaigns. All employees are required to fill out a signed declination form delineating the reasons given for declining the influenza vaccination.
   3. Educates licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza. Specifically, Influenza vaccination and non-vaccine influenza control measure education is provided to all staff through written flyers, newsletters, in-services, Health stream, and huddle discussions. This education is focused on dispelling myths related to vaccination, hand hygiene, respiratory and cough etiquette, and the diagnosis, transmission, and potential impact of influenza.
   4. Sets incremental influenza vaccination goals, consistent with achieving the 90% vaccination rate established in the national influenza initiatives for 2020. This initiative remains a priority for the organization.
   5. It is the policy of Broward Health to comply with all requirements of the Joint Commission addressing influenza vaccination for licensed independent practitioners and staff.
   6. Shall determine the influenza vaccination rate by calculating the numerator which will then be divided by a denominator and multiplied by 100%. The numerator and denominator shall be defined using CDC and NHSN definition.

REFERENCES


7. The Joint Commission Infection Prevention and Control Standards


RELATED POLICIES

1. Outbreak Management Plan
2. Emergency Management Operations Plan
   a. BHMC Emergency Operations Plan
   b. BHCS Emergency Operations Plan
   c. BHIP Emergency Operations Plan
   d. BHN Emergency Management Plan
4. Code Green (Mass Casualty Incident)
   a. BHMC Code Green (Mass Casualty Incident)
   b. BHCS Code Green (Mass Casualty Incident)
   c. BHIP Code Green (Mass Casualty Incident)
   d. BHN Code Green (Mass Casualty Incident)

Attachments: No Attachments

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PL-006-500 Performance Improvement Plan

I. Purpose
The Performance Improvement (PI) Plan for the North Broward Hospital District (NBHD) (d/b/a Broward Health) defines a system-wide quality management program. Including, the scope, structure, goals, processes, roles, responsibilities, and guiding principles used by the organization for activities supporting patient safety, patient/family engagement, improving patient outcomes and improving overall quality of care. The foundation of the PI Plan is the Mission, Vision, and the Five Star Values, as well as the safety and quality goals of the organization. This plan outlines the collaborative efforts among the Board of Commissioners, Leadership, and Medical and Hospital and Community staff to ensure patient care and services meet or exceed customer expectations.

II. Definitions
MISSION STATEMENT: The mission of Broward Health is to provide quality health care to the people we serve and support the needs of all physicians and employees.

VISION STATEMENT: The vision of Broward Health is to provide world class health care to all we serve.

FIVE STAR VALUES
- Accountability for Positive Outcomes
- Valuing Our Employee Family
- Fostering an Innovative Environment
- Collaborative Organizational Team
- Exceptional Service to Our Community

III. Policy
A. This Performance Improvement Plan involves all of the NBHD facilities and encompasses every process of care and service within the NBHD. Broward Health Medical Center, Broward Health Coral Springs, Broward Health Imperial Point, and Broward Health North and across Broward Health Ambulatory. Together providing comprehensive acute care and rehabilitation services. Additional services are provided by the Primary Care Facilities, Urgent Care Centers, Hospice and Home Health. The NBHD serves a culturally diverse population and a variety of special needs and services are provided to enhance the quality and safety of the services provided.

B. The Board of Commissioners of the NBHD has ultimate responsibility for oversight, direction, and support of the Performance Improvement Program. The Performance Improvement Program is a system-wide
planned, comprehensive and ongoing effort to achieve safety and excellence in our structures, processes, and outcomes. The Board of Commissioners, through the District-wide Board Quality Assessment and Oversight Committee (QAOC) will exercise its ultimate overseeing responsibility by receiving and reviewing summaries of organizational performance improvement, risk management, environment of care, nursing services, patient engagement activities, and where applicable, recommending additional PI and Safety initiatives.

IV. Procedure

The Board of Commissioners delegates the authority to manage the details of the performance improvement activities to the President and Chief Executive Officer of the North Broward Hospital District. The President/CEO of the NBHD therefore extends this authority to the CEO and the Medical Staff Executive Committee of the respective NBHD facilities, who in turn, delegate the hospital performance functions to the Regional Medical Councils and Regional Quality Councils. This is accomplished by systematically collecting aggregating and analyzing the data, comparing the data to established internal and external benchmarks, identification of trends that suggests opportunities for improvement, and implementation of action plans for improvement.

Medical staff and hospitals departments involved in patient care functions measure, aggregate, and assess high volume, high risk and/or problem prone indicators within their areas and identify when a system or process requires an intensive assessment to determine if an opportunity for improvement exists.

Sample sizes are consistent with Joint Commission or data vendors’ recommendations when evaluating compliance.

The hospitals and other Broward Health departments then report aggregated outcomes and performance improvement results to the Quality Assessment and Oversight Committee:

Quality Assessment and Oversight Committee (“QAOC”)

1. Composition. The QAOC shall consist of the following voting members: Three (3) members of the Board who shall be appointed by the Chair; the President/CEO; two (2) senior corporate members assigned by President/CEO; two (2) members of Corporate Quality and Risk Management; the Chief Medical Officer or a physician designated by the Chief Medical Officer; and one (1) Regional Chief Nursing Officer. The QAOC shall also consist of the following non-voting ex officio members: the Corporate Safety Officer; the SVP, Ambulatory Services; the Administrator of Gold Coast Home Health & Hospice; AVP, Clinical Services Ambulatory Division; the General Counsel, or his or her designee; the Chief Internal Auditor; and the four (4) Regional CEOs, CMOs, and Quality Services Managers.

The Board shall also consist of the General Counsel and the Internal Auditor as non-voting ex-officio members.

Duties. The duties of the QAOC shall include, but not be limited to evaluating the needs and expectations of the individuals served by the District to determine how the District might improve its overall efforts, identify new programs and processes to better assist those individuals served by the District, identify high volume, high risk, problem prone or high cost processes and recommend methods of improvement, make recommendations regarding patient safety, and to evaluate the impact of patient outcomes. The QAOC should engage and receive input and data from outside regulatory and accrediting agencies, as appropriate, to assist in the performance of its duties. The QAOC shall also perform any other duties as may be requested by the Board from
The organization's appropriate individuals, departments and disciplines, work collaboratively in the effort to reduce and prevent errors and enhance quality, safety, and performance. Broward Health uses several improvement processes and methodologies, including, but not limited to:

- Six Sigma (DMAIC)
  - Define the problem
  - Measure the problem
  - Analyze the problem
  - Improve the process
  - Control the process
- PDSA/PDCA
  - Plan
  - Do
  - Study/Check
  - Act
- Rapid Cycle Improvement
- Performance Improvement Teams
- Failure Mode and Effects Analysis
- Root Cause Analysis

The Quality Improvement Program includes but is not limited to the goals/metrics/activities:

1. **Goals:**

Performance Improvement will drive a culture of safety and high quality outcomes as evidenced by:

- Improved CMS Value Based Purchasing, Hospital Acquired Conditions and Readmission Penalty outcomes.
- Improved CMS STAR ratings.
- Improved continuous readiness for regulatory surveys.
- Increased Leapfrog Hospital Survey scores and robust process.
- Improved clinical integration across the continuum of care.
- Demonstrated compliance with required data collection and subsequent action planning.

**Metrics (as required by regulatory bodies and/or as determined by Broward Health) related to and may include:**

Value Based Purchasing, Readmissions, Hospital Acquired Conditions as defined by the Center for Medicare and Medicaid Services

Operative or other procedures placing patients at risk of disability or death. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses. Adverse events related to using moderate or deep sedation or anesthesia.

The use of blood and blood components and all reported and confirmed transfusion reactions.

The results of cardiac resuscitations.

Significant medication errors.

Quality improvement activities including at least clinical laboratory services, diagnostic imaging services,
dietetic services, nuclear medicine services, and radiation oncology services.

Patient Engagement scores and plans.

Patient thermal injuries that occur during magnetic resonance imaging exams. Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanner room- Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room.

Infection Control including antimicrobial stewardship, and sepsis management.

Use of restraint and seclusion.

Medication management system including Antibiotic Stewardship.

**Activities of Enterprise wide Quality Programs:**

Community Health Services.

Ambulatory Physician Practices.

Gold Coast Home Care and Hospice.

Population Health

**Actions:**

Review Environment of Care Quarterly and Annual reports.

Review of the Annual Strategic Plan for Quality.

Review of a High Reliability Organization Assessment and Action plan.


Review of the AHRQ Culture of Safety Survey results.

Review of publicly reported CMS STAR ratings.

Review evaluations of contracted services.

Review of patient flow processes when goals are not achieved.

Approval of Utilization Review Plans.

Approval of Infection Control Annual Reports including Hand Hygiene.

Approval of Patient Safety Annual Report.

Approval of Annual Environment of Care Reports.

**V. Related Policies**

**VI. Regulation/Standards**

The Joint Commission Hospital Accreditation Performance Improvement standards, 2018/2019

CMS Conditions of Participation 482.21 (e) Quality Assessment and Performance improvement Program

AHCA ASPEN page 123/250, 9-27-16 version; Title QUALITY IMPROVEMENT - System

Statute or Rule 59A-3.271(1), FAC
## Approval Signatures

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I. Purpose
To improve patient safety and reduce risk through an environment that encourages:

A. Recognition and acknowledgment of risks to patient safety and medical/health errors
B. The initiation of actions to reduce these risks
C. The internal reporting of what has been found and the actions taken
D. A focus on process and systems rather than individual actions
E. A non-punitive culture through minimization of individual blame or retribution for involvement in a medical/health care error
F. Organizational learning about cause and prevention of medical/health care errors
G. Support of the sharing of that knowledge to effect behavioral changes in all Broward Health facilities

II. Definitions
A. Adverse Event: an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred.
B. Near Miss: any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome.
C. Error: an unintended act, either of omission or commission or an act that does not achieve its intended outcome.
D. Hazardous Condition: any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of a serious adverse outcome.
E. Occurrence/Variance: any event which is not, or may not be, consistent with normal routine and/or established policies, guidelines, procedures as referenced in Policy RA-008-040, Occurrence/Variance Reporting.
F. Sentinel Event: an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "of risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. These events include any occurrence that meets any of the following criteria:
   1. The event has resulted in an unanticipated death, permanent harm or severe temporary harm or
major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or

2. The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
   a. Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
   b. Unanticipated death of a full-term infant
   c. Discharge of an infant to the wrong family
   d. Abduction of any patient receiving care, treatment and services
   e. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
   f. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
   g. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the hospital
   h. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital.
      i. Sexual abuse/assault (including rape) — defined as nonconsensual sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration of fondling of the patient's sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present:
         i. Any staff-witnessed sexual contact as described above
         ii. Sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact
         iii. Admission by the perpetrator that sexual contact, as described above, occurred on the premises
     i. Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
        i. Invasive procedures, including surgery, on the wrong patient, or at the wrong site, or that is the wrong procedure are reviewable under the policy, regardless of the type of the procedure or the magnitude of the outcome.
        ii. If a foreign object (for example, a needle tip or screw) is left in the patient because of a clinical determination that the relative risk to the patient of searching for and removing the object exceeds the benefit of removal, this would not be considered a sentinel event to be reviewed. However, in such cases, the organization shall (1) disclose to the patient the unintended retention, and (2) keep a record of the retentions to identify
trends and patterns (for example, by type of procedure, by type of retained item, by manufacturer, by practitioner) that may identify opportunities for improvement.

j. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
k. Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose
l. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
m. Any intrapartum (related to the birth process) maternal death
n. Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm

G. Code 15: When an adverse incident, whether occurring in a Broward Health facility or arising from health care prior to admission, results in any of the following, it will be reported by the facility to AHCA within 15 calendar days after it is reported to Risk Management:
1. The death of a patient
2. Brain or spinal damage to a patient
3. The performance of a surgical procedure on the wrong patient
4. The performance of a wrong-site surgical procedure
5. The performance of wrong surgical procedure
6. The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
7. The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not recognized specific risk, as disclosed to the patient and documented through the informed consent process; or
8. The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure

H. High-Risk Patient Care Process: Any activity that:
1. Has a history of adverse patient outcome
2. Is identified in the literature as high-risk
3. Has several characteristics of a high-risk process:
   a. Constant modification to accommodate input variation
   b. Complex process with many interdependent steps
   c. Inconsistency from lack of standardization
   d. Tightly coupled steps, which follow one another so closely that a variation in the output of one step cannot be recognized and responded to before the next step is underway.
   e. Heavy reliance on human intellectual and/or physical actions
   f. Tight time constraints between process steps
4. Is a new or redesigned process
   a. Common high-risk patient care processes include but are not limited to:
      i. Use of medication
      ii. Pain management
      iii. Operative and other invasive procedures
      iv. Use of blood and blood components
      v. Opportunities identified when appropriate to reduce restraint or seclusion use
      vi. Cardiopulmonary resuscitation
      vii. Interpretation of diagnostic results
      viii. Security of infants and other patients at high risk for abduction
      ix. Use of medical equipment that has been shown to be at risk for human error

5. All medication and Adverse Drug Reactions.

   **Severity of Events**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>An event occurred but the patient was not harmed</td>
</tr>
<tr>
<td>2</td>
<td>An event occurred that resulted in the need for increased patient assessments but no change in vital signs and no patient harm</td>
</tr>
<tr>
<td>3</td>
<td>An event occurred that resulted in the need for treatment and/or intervention and caused temporary patient harm</td>
</tr>
<tr>
<td>4</td>
<td>An event occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm</td>
</tr>
<tr>
<td>5</td>
<td>An event occurred that resulted in permanent patient harm or near death event, such as anaphylaxis</td>
</tr>
<tr>
<td>6</td>
<td>An event occurred that resulted in patient death</td>
</tr>
</tbody>
</table>

III. **Policy**

   A. Broward Health is active in promoting initiatives to improve patient safety in health care. The Patient Safety Plan is designated to promote such a function among the services of all Broward Health facilities. A further intent of the Patient Safety Plan is to assure compliance with patient safety related regulatory directives.

   B. An effective Patient Safety Plan cannot exist without optimal reporting of medical errors and occurrences. Therefore, it is the intent of Broward Health to adopt a just approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical errors and should do so without the fear of reprisal. Broward Health supports the concept that errors occur due to breakdown in systems and processes and will focus on improving those, rather than disciplining those, responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members. (See policy, Non-Punitive Reporting of Medical/Clinical Errors.)
C. The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions, and services.

D. Leaders implement a system-wide patient safety program and provide direction and resources to conduct proactive activities to reduce risk to patients.
   1. At least every 18 months, one high-risk process is selected for proactive risk assessment (Failure Mode Effects Analysis)
   2. Accountability is promoted for all employees, including assuming proactive and reactive responsibility for personal actions and for patients
   3. New goals for the organization are identified on a regular basis
   4. The Patient Safety Plan is reviewed and revised as appropriate

E. The maintenance and improvement of patient safety is a coordinated and collaborative effort. The approach to optimal patient safety involves multiple departments and disciplines in establishing plans, processes and mechanisms that comprise the patient safety activities of Broward Health. The Patient Safety Plan is developed by an interdisciplinary committee and approved by the Medical Staff, Board of Commissioners and Administration.

F. The Patient Safety Plan encompasses the patient population, visitors, volunteers and staff, including medical staff. The program addresses maintenance and improvement in patient safety issues in every department throughout all Broward Health facilities. Important patient care functions are emphasized, such as:
   1. Environment of Care
   2. Emergency Management
   3. Human Resources
   4. Infection Prevention and Control
   5. Information Management
   6. Leadership
   7. Life Safety
   8. Medication Management
   9. Medical Staff
   10. Nursing
   11. Provision of Care, Treatment and Services
   12. Rights and Responsibilities of the Individual
   13. Transplant Safety
   14. Waived Testing
   15. Performance Improvement
   16. Record of Care, Treatment and Services
   17. Risk Management
18. National Patient Safety Goals

G. The scope of the Patient Safety Plan includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregate data reports will be reviewed by the Regional Patient Safety Committee(s) to prioritize organizational patient safety efforts.

IV. Procedure

A. The Regional Patient Safety Officers in conjunction with the Regional Patient Safety Committees are responsible for the oversight of the Patient Safety Program. These Regional Committees operate as subcommittees of the Risk Management Practice Council. The Regional Patient Safety Committees are co-chaired by key leadership. The Patient Safety co-chairpersons have administrative responsibility for the program and report to the oversight committee. Membership of the committee is multidisciplinary and establishes the linkages to the other committees such as Patient Care Key Group (PCKG), Pharmacy and Therapeutics, Regional Quality Council, Medical Staff, Nursing Leadership, and Environment of Care Committee. The Safety Officer or his/her designee may be included in membership.

B. The Patient Safety Officer at each Region will be determined by the Chief Executive Officer (CEO). All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to Risk Management, where the information will be aggregated and presented in a report to the Regional Patient Safety Committee, Risk Management Practice Council, Quality Assessment and Oversight Committee, Regional Quality Council, and Medical Staff Leadership committee(s).

C. The Patient Safety Committee and/or Regional Quality Council will select at least one high-risk safety process for proactive risk assessment every 18 months. The proactive risk assessment – Failure Mode Effects Analysis (FMEA) – will include:

1. Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identification of the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be;

2. An intense analysis or root cause analysis of the most critical effects to determine why the undesirable variation leading to that effect may occur;

3. Redesign of the process and/or underlying systems to determine why the undesirable variation leading to that effect may occur;

4. Testing and implementation of the redesigned process;

5. Identification and implementation measures of the effectiveness of the redesigned process;

6. Implementation of a strategy for maintaining the effectiveness of the redesigned process over time.

D. When a medical error is identified, the patient care provider will immediately:

1. Perform necessary health care interventions to protect and support the patient's clinical condition;

2. Contact the patient's attending physician and other physicians as appropriate, to report the error and carry out any physician orders as necessary;

3. Preserve any information related to the error (including physical evidence). This includes
documenting the facts on an occurrence variance report via HAS program, and in the medical record, in accordance with current policy;

4. Report the medical error to the staff member's immediate supervisor;

5. Notify the Quality Management Department of the facility when quality of care is compromised;

6. Submit the occurrence/variance report to the Risk Manager in accordance with the current Occurrence/Variance Policy of the Broward Health.

E. If the staff members involved in an event suspect that the event may be either a Code 15 or a Sentinel Event, then the occurrence/variance will be managed by the pre-established Broward Health Policy, RA-008-015, Reporting, Disclosure and Management of Adverse Events, Code 15's, Sentinel Events, Near Misses and Hazardous Conditions.

1. Immediate action/intervention may be required to prevent a re-occurrence and risk of injury to other patients. However, if warranted, further and more in-depth analysis is to be initiated promptly.

2. The Regional Risk Manager will notify the respective Chief Executive Officer, Corporate Director of Risk and Insurance Services, and Chief of Staff of each potential Code 15/Sentinel Event. The Regional Risk Manager will initiate an investigation of the facts and determine if the occurrence/variance meets the criteria for a Code 15 or a Sentinel Event and report as appropriate.

3. The Regional Risk Managers of Risk and/or Quality will determine promptly whether a Root Cause Analysis (RCA) or Intense Analysis is needed and will provide oversight of the RCA on the identified Code 15/Sentinel Event.

4. The scope of the RCA will minimally include the evaluation of the systems and components of care identified on the RCA matrix. Attachment A

5. Action plans related to the analysis will be implemented as appropriate and monitored for effectiveness by the identified department directors/managers and reported to the Regional Patient Safety Committee, Regional Quality Council and Risk Management Practice Council.

F. Although certain occurrences/variances not specifically referenced in this policy may necessitate a further evaluation, a RCA will be conducted on the following Code 15/Sentinel Events that actually occur and/or those near misses that, if not corrected, could result in:

1. Surgical or other invasive procedures on the wrong patient
2. Wrong site (side or organ) surgery
3. Any error or deviation in policy or procedure, such as a medication error, delay in treatment, or failure to follow an order, that resulted in:
   a. Death of a patient
   b. Brain/spinal injury
   c. Loss of limb, permanent disfigurement, neurological, physical, or sensory limitations
   d. A condition requiring a more acute level of care or the need for specialized medical or surgical intervention
4. Attempted or successful suicide of a patient
5. Assault, homicide, rape and/or other crime resulting in a patient's death or major permanent loss...
of function
6. Abduction of any patient receiving care, treatment or services
7. Infant discharged to the wrong family
8. Death or serious injury while the patient was restrained
9. Elopements where the patient subsequently died, committed suicide, or suffered a major loss in function
10. Falls that directly caused death or permanent loss of function

G. Support Services will be provided for staff members involved in sentinel events, and Code 15’s through the Employee Assistance Program

H. COMMUNICATING WITH PATIENTS ABOUT SAFETY
1. Staff will educate patients and their families regarding their role in helping to facilitate the safe delivery of care. This could include, but not be limited to, information regarding safe and effective use of medications or equipment, food/drug interactions, adverse drug reactions, diet and/or exercise.
   a. An educational brochure describing Patient Safety Tips will be made available to patients.

2. Patients and, when appropriate, their families will be informed about outcomes of care including unanticipated outcomes (unusual occurrences), or when outcomes differ significantly from the anticipated outcomes.

I. STAFF EDUCATION
1. Staff will receive education and training during the orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical errors.
   a. The patient safety orientation and education program focuses on reducing the risk of illness and injury to patients.
   b. The orientation and education program addresses:
      i. assessment of each staff member's ability to fulfill specific responsibilities
      ii. familiarizes staff members with their jobs and work environment before the staff begin to administer patient care or other activities specific job-related aspects of patient safety
      iii. provision of safety-related information through new employee orientation and continuing education including basic information on RCA and FMEA
      iv. a review of reporting forms and protocols

2. Staff will also be educated and trained on the provision of an interdisciplinary approach to patient care.

3. Medical errors and occurrences, including Sentinel Events and Code 15’s, will be reported internally and externally, per policy, and through the channels established by this and/or other plans. Any external reporting will be performed in accordance with all state, federal, and regulatory body rules, laws and requirements.

J. PERFORMANCE IMPROVEMENT
1. Consistent with the Broward Health Performance Improvement Plan, each region will aggregate and analyze clinical and administrative data to support reduction in risks to patients.
   a. Data from patient safety initiatives and quality control will be collected on an ongoing basis.
   b. High-risk patient care processes will be measured and analyzed.
   c. At least one high-risk process will be selected every 18 months for proactive risk assessment (FMEA).
   d. Quarterly reports will be provided to the Regional Quality Council.
   e. At least once a year, the leaders responsible for the hospital wide patient safety program review a written report on the results of any analysis related to the adequacy of staffing and any actions taken to resolve any identified problems.
   f. Other measures related to patient safety will be monitored:
      i. Performance improvement priorities identified by leaders
      ii. Operative or other procedures that place patients at risk of disability or death
      iii. Significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
      iv. Adverse events related to using moderate or deep sedation or anesthesia
      v. Use of blood and blood components
      vi. Confirmed transfusion reactions
      vii. Results of resuscitation
      viii. Behavior management and treatment
      ix. Significant medication errors
      x. Significant adverse drug reactions
      xi. Patient perception of the safety and quality of care, treatment and services
      xii. Risk Management Activities

K. CONFIDENTIALITY

1. All reports, committee minutes, audits, studies and documentation of patient safety activities will be held confidential in accordance with Florida law.
   a. Review of minutes by third parties will be restricted to reviews conducted by state and federal auditors, or other parties authorized by law and accreditation survey teams.
   b. Distribution of reports, assessment results, and other patient safety specific documentation is restricted to the following:
      i. Board of Commissioners
      ii. Members of the Regional Patient Safety Committees
      iii. Legal Counsel or designee (as appropriate)
      iv. Risk Management (as appropriate)
      v. Quality Assessment and Oversight Committee

V. Related Policies
A. Broward Health Performance Improvement Plan
B. Reporting, Disclosure and Management of Adverse Events, Code 15's, Sentinel Events, Near Misses and Hazardous Conditions.
C. Occurrence / Variance Reporting
D. Non-Punitive Reporting of Medical / Clinical Errors

VI. Regulation/Standards
N/A

VII. References
The Joint Commission Hospital Accreditation Standards
Interpretation and Administration
Administration and Interpretation of this policy is the responsibility of the Senior Vice President / Chief Financial Officer

Attachments: No Attachments

Approval Signatures

<table>
<thead>
<tr>
<th>Step Description</th>
<th>Approver</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lee Ghezzi: SVP, QUALITY &amp; CASE MGMT</td>
<td>11/2018</td>
<td></td>
</tr>
<tr>
<td>Andrew Ta: EVP, CHIEF MEDICAL OFFICER</td>
<td>11/2018</td>
<td></td>
</tr>
<tr>
<td>Barry Gallison: CORP DIR, QUALITY</td>
<td>11/2018</td>
<td></td>
</tr>
<tr>
<td>Deborah Williams: REG DIR, QUAL/EPI/PAT SAFE-BG</td>
<td>08/2018</td>
<td></td>
</tr>
<tr>
<td>Donna Williamson: REG MGR, QUL/EPI/PS/PE-BHIP</td>
<td>08/2018</td>
<td></td>
</tr>
<tr>
<td>Kimberly Cerri: REG MGR, QUAL,ADMIN,PAT SAF-CS</td>
<td>08/2018</td>
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</table>
BROWARD HEALTH COMMUNITY HEALTH SERVICES

HEALTHCARE FOR THE HOMELESS
SCOPE OF SERVICES

Approved Service Delivery Sites – 7
Program FTEs – 21.4
Demographics mirror those of PIT Count

<table>
<thead>
<tr>
<th>UDS Data Trend (2017-2018)</th>
<th>CY 2017</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unduplicated Users</td>
<td>3,069</td>
<td>3,216</td>
</tr>
<tr>
<td>Medical Encounters</td>
<td>7,991</td>
<td>8,412</td>
</tr>
<tr>
<td>Psych Encounters</td>
<td>2,008</td>
<td>2,192</td>
</tr>
<tr>
<td>Oral Health Encounters</td>
<td>2,603</td>
<td>2,448</td>
</tr>
</tbody>
</table>
## 2018 Broward County Point-in-Time Homeless Count
### Final Summary of Results

<table>
<thead>
<tr>
<th>Total Households and Persons</th>
<th>Sheltered</th>
<th>Unsheltered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergency</td>
<td>Transitional</td>
<td>Safe Haven</td>
</tr>
<tr>
<td>Total Number of Households</td>
<td>698</td>
<td>401</td>
<td>31</td>
</tr>
<tr>
<td>Total Number of Persons</td>
<td>886</td>
<td>532</td>
<td>31</td>
</tr>
<tr>
<td>Number of Children (under 18)</td>
<td>171</td>
<td>117</td>
<td>0</td>
</tr>
<tr>
<td>Number of Persons (18-24)</td>
<td>86</td>
<td>43</td>
<td>1</td>
</tr>
<tr>
<td>Number of Persons (over age 24)</td>
<td>629</td>
<td>372</td>
<td>30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Shielded</th>
<th>Unsheltered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergency</td>
<td>Transitional</td>
<td>Safe Haven</td>
</tr>
<tr>
<td>Female</td>
<td>362</td>
<td>146</td>
<td>14</td>
</tr>
<tr>
<td>Male</td>
<td>522</td>
<td>378</td>
<td>17</td>
</tr>
<tr>
<td>Transgender/Gender Non-Conforming</td>
<td>2</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Sheltered</th>
<th>Unsheltered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergency</td>
<td>Transitional</td>
<td>Safe Haven</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>801</td>
<td>462</td>
<td>30</td>
</tr>
<tr>
<td>Hispanic</td>
<td>85</td>
<td>70</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Sheltered</th>
<th>Unsheltered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergency</td>
<td>Transitional</td>
<td>Safe Haven</td>
</tr>
<tr>
<td>White</td>
<td>265</td>
<td>212</td>
<td>17</td>
</tr>
<tr>
<td>Black</td>
<td>595</td>
<td>309</td>
<td>14</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>American Indian</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Multiple Races</td>
<td>16</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

### Homeless Subpopulations

<table>
<thead>
<tr>
<th>Subpopulation</th>
<th>Sheltered</th>
<th>Unsheltered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families (Households)</td>
<td>123</td>
<td>8</td>
<td>131</td>
</tr>
<tr>
<td>Unaccompanied Youth (Under 24)</td>
<td>101</td>
<td>40</td>
<td>141</td>
</tr>
<tr>
<td>Parenting Youth Households</td>
<td>22</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Total Persons in Parenting Youth Households</td>
<td>59</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>Chronically Homeless Individuals</td>
<td>207</td>
<td>232</td>
<td>439</td>
</tr>
<tr>
<td>Adults with Serious Mental Illness</td>
<td>182</td>
<td>235</td>
<td>417</td>
</tr>
<tr>
<td>Adults with Substance Use Disorder</td>
<td>235</td>
<td>206</td>
<td>441</td>
</tr>
<tr>
<td>Adults with HIV/AIDS</td>
<td>25</td>
<td>18</td>
<td>43</td>
</tr>
<tr>
<td>Victims of Domestic Violence</td>
<td>148</td>
<td>23</td>
<td>171</td>
</tr>
<tr>
<td>Total Number of Veterans</td>
<td>116</td>
<td>73</td>
<td>189</td>
</tr>
<tr>
<td>Foster Care</td>
<td>0</td>
<td>109</td>
<td>109</td>
</tr>
</tbody>
</table>

If you have any questions, please contact Shira Fowlkes at sfowlkes@brhpc.org or go to www.browardpointintime.org
Homelessness in Broward County 2011-2018

Broward County employs a technique entitled a single-contact census. The census is taken by a team of individuals in a clearly defined area where preliminary research suggests that homeless persons can be found. The advantages of using a single-contact census are twofold: It provides direct contact with the homeless population and additional information such as demographics can be collected.¹

<table>
<thead>
<tr>
<th>Year</th>
<th>Sheltered</th>
<th>Unsheltered</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>1,615</td>
<td>869</td>
</tr>
<tr>
<td>2017</td>
<td>1,493</td>
<td>957</td>
</tr>
<tr>
<td>2016</td>
<td>1,520</td>
<td>782</td>
</tr>
<tr>
<td>2015</td>
<td>1,796</td>
<td>819</td>
</tr>
<tr>
<td>2014</td>
<td>1,887</td>
<td>879</td>
</tr>
<tr>
<td>2013</td>
<td>1,981</td>
<td>829</td>
</tr>
<tr>
<td>2012</td>
<td>1,915</td>
<td>1,268</td>
</tr>
<tr>
<td>2011</td>
<td>2,533</td>
<td>1,268</td>
</tr>
</tbody>
</table>
IN VolvEmEnT IN tHe COMMU NinY

- HCH Consumer Advisory Board
- Board of Directors – Coalition to End Homelessness
- Broward County Continuum of Care Committee
- Broward County Health Advisory Board
- Homeless Providers/Stakeholders Committee
- BPHI Program Services Committee
- Behavioral Health/Primary Care Initiative
- Ongoing County initiatives to reduce homelessness
- Homeless Point-in-Time Count
- Annual Thanksgiving Feast
Program Challenges

- Recruitment of PCPs
- Clients’ episodic access and use of E.D. as PCP
- Lack of compliance with treatment/high no-show rate
- Patient compliance with preventive health screenings, routine lab studies and diagnostic tests
- Management of patient flow
- Conversion from paper patient satisfaction surveys; low number of responses
- CAB recruitment and membership
- Space at BPAHC
- Limited community resources
**PROGRAM SUCCESSES**

- Comprehensive system of integrated services available to clients
- Availability of specialty care services w/in program
- Collaborative efforts with partner agencies
- Patients are highly engaged with BH staff
- Staff expertise/longevity within the program
- Access and availability of services at multiple locations throughout CHS
- Availability of 340B medications and Patient Assistance Programs
HEALTHCARE FOR HOMELESS
DIABETES GOALS

• Decrease No Shows in diabetes care coordination program by 5% by December 31, 2019
  – Offer flexible (morning and afternoon) group classes twice per month
  – Utilize telephonic and/or mailings methods of communication to provide patient reminders
• For participating patients with Hgb A1C greater than or equal to 10, decrease Hgb A1C by two points within six months.
  – RN care coordinator will monitor the care of patients utilizing the seven AADE behaviors
  – Educate patients on risk factors of non-compliance thorough group and individual counseling
  – Refer patients to medication adherence counseling with clinical pharmacist
• Promote diabetes control and prevention by September 1, 2020.
  – Partner with local food/farmers’ market to provide diabetic friendly food items lunch box monthly by September 1, 2019.
  – Provide diabetes screening per United States Preventive Services Task Force (USPSTF) using fasting glucose or Hgb A1C for adults aged 40 to 70 years who do not have obvious symptoms of diabetes July 1, 2020
2019 Community Health Needs Assessment

Prepared By:

BRHPC
Community Health Needs Assessment

- A dynamic process involving multiple sectors of the community
- Draw upon qualitative and quantitative population health status data
- Identify unmet community needs to improve the health of vulnerable populations: the poor, homeless and disenfranchised
- Enable community-wide establishment of health priorities
### Why do a Needs Assessment?

<table>
<thead>
<tr>
<th><strong>Affordable Care Act</strong></th>
<th><strong>JCAHO Standards</strong></th>
<th><strong>IRS Form 990 Requirement</strong></th>
<th><strong>Opportunity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 501(r)(3) requires a community health needs assessment (CHNA) at every three years</td>
<td>The needs of the community must guide service delivery</td>
<td>Manner in which community information and health care needs are assessed</td>
<td>Identify unmet community needs to improve the health of vulnerable populations</td>
</tr>
<tr>
<td>An implementation strategy to meet the community health needs identified through the CHNA</td>
<td></td>
<td></td>
<td>Improve coordination of hospital with other efforts to improve community health</td>
</tr>
</tbody>
</table>
IRS Requirement for CHNA

Community served by the hospital.

Process and methods used to conduct the assessment, including list of all of the collaborating organizations.

A description of how the hospital took into account input from persons who represent the broad interests of the community.

A prioritized description of all of the community health needs identified through the CHNA.

A description of the existing resources available to meet the community health needs identified.
Process

Define the community:
- Collect data: quantitative and qualitative

Advisory Council reviews data and identifies unmet needs and service gaps

Advisory Council prioritizes needs

BRHPC summarizes in a Community Health Needs Assessment Report

BH develops a Community Health Plan
Defining the Community: Primary Service Areas (PSAs)

<table>
<thead>
<tr>
<th>Primary Service Areas</th>
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<tbody>
<tr>
<td>33311</td>
</tr>
<tr>
<td>33064</td>
</tr>
<tr>
<td>33065</td>
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<td>33060</td>
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<td>33316</td>
</tr>
<tr>
<td>33315</td>
</tr>
<tr>
<td>33304</td>
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### Data Collection and Presentation

#### Quantitative Data
- U.S. Bureau of the Census
- American Community Survey
- Florida Charts
- Broward Regional Health Planning Council Health Data Warehouse
  - Broward Health Hospital data
  - Hospital Utilization
  - Chronic Diseases
  - Prevention Quality Indicators
  - Diagnosis Related Groupings

#### Qualitative Data
- Youth Risk Behavior Survey
- Behavioral Risk Factor Surveillance System
- PRC Community Health Needs Assessment in Broward County
- Focus Groups
- Community Conversations (Town Hall Meetings)
- Key Informant Interviews
Prioritizing the Need: Role of Advisory Council

ACA: Input from “persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.”

Guide the assessment process

Act as a sounding board and assist in obtaining community input

Once the assessment is completed, may participate with the Planning Team in evaluating health issues and priorities with BH

Engage in collaborative action planning on an ongoing basis
# Community Health Needs Assessment Advisory Council

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan Goldsmith</td>
<td>EVP/CAO</td>
<td>Broward Health Corporate</td>
</tr>
<tr>
<td>Aldo Calvo, MD</td>
<td>Medical Director, Community Health Services</td>
<td>Broward Health Community Health Services</td>
</tr>
<tr>
<td>Alex Fernandez</td>
<td>Chief Financial Officer</td>
<td>Broward Health Corporate</td>
</tr>
<tr>
<td>Alice Taylor</td>
<td>CEO</td>
<td>Broward Health North</td>
</tr>
<tr>
<td>Allen Jackson</td>
<td>Pastor</td>
<td>Ark Restoration Church International</td>
</tr>
<tr>
<td>Ana Calderon Randazzo</td>
<td>Executive Director, CDTC</td>
<td>Children’s Special Needs</td>
</tr>
<tr>
<td>Barry Gallison</td>
<td>Corporate Director, Quality and Risk</td>
<td>Broward Health Corporate</td>
</tr>
<tr>
<td>Bernice Shorter-Meares</td>
<td>Regional Manager, Pharmacy</td>
<td>Broward Health Community Health Services</td>
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<tr>
<td>Beth Cherry</td>
<td>SVP, Physician Practices</td>
<td>Broward Health Corporate</td>
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<tr>
<td>Cara Boyarin</td>
<td>Wellness Coordinator</td>
<td>Broward Health Medical Center</td>
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<tr>
<td>Carolyn Carter</td>
<td>CNO</td>
<td>Broward Health Medical Center</td>
</tr>
<tr>
<td>Carolyn Michaels</td>
<td>Executive Vice President</td>
<td>Greater Fort Lauderdale Chamber</td>
</tr>
<tr>
<td>Dan Lindblade</td>
<td>President/CEO</td>
<td>Greater Fort Lauderdale Chamber</td>
</tr>
<tr>
<td>Daniel Oatmeyer</td>
<td>Battalion Chief/EMS Bureau &amp; Special Events</td>
<td>City of Fort Lauderdale Fire/EMS</td>
</tr>
<tr>
<td>Darrell Cunningham</td>
<td>Community Partnerships Division Director</td>
<td>Broward County Human Services</td>
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<tr>
<td>David Clark</td>
<td>AVP, Corporate Services</td>
<td>Broward Health Corporate</td>
</tr>
<tr>
<td>Denise Moore</td>
<td>VP, Corporate Marketing and Communications</td>
<td>Broward Health Corporate</td>
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<tr>
<td>Diana Arteaga</td>
<td>VP, Government Relations &amp; Community Affairs</td>
<td>Broward Health Corporate</td>
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<tr>
<td>Donna DeFornzo</td>
<td>Director, Department of Active Aging</td>
<td>City of Deerfield Beach</td>
</tr>
<tr>
<td>Eduardo Pineda</td>
<td>Program Manager, Community Care &amp; Disaster Recovery</td>
<td>Hispanic Unity</td>
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<tr>
<td>Gavin Malcolm</td>
<td>Director of Population Health</td>
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<tr>
<td>Gustavo Gonzalez</td>
<td>Care Coordinator</td>
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<tr>
<td>Janet Gerner</td>
<td>Behavioral Health Supervisor</td>
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<tr>
<td>Jared Smith</td>
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<td>Broward Health Coral Springs</td>
</tr>
<tr>
<td>Jonathan Turton</td>
<td>CEO</td>
<td>Broward Health Medical Center</td>
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## Community Health Needs Assessment Advisory Council (cont.)

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<thead>
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<th>Name</th>
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<tr>
<td>Jonathan Watkins</td>
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<tr>
<td>Laura Ganci</td>
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<td>Children's Services Council</td>
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<tr>
<td>Linda Cooke</td>
<td>Chair, BHMC Community Relations Council</td>
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<tr>
<td>Lou Cimaglia</td>
<td>BHCS Community Relations Council</td>
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<tr>
<td>Mark Ketcham</td>
<td>Executive Director, SunServe</td>
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<tr>
<td>Mark Reyes</td>
<td>Senior Director</td>
<td>Urban League of Broward County</td>
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<tr>
<td>Michael De Lucca</td>
<td>President and CEO</td>
<td>Broward Regional Health Planning Council, Inc.</td>
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<tr>
<td>Nicole Cohen</td>
<td>Public Information Officer</td>
<td>Broward Regional Health Planning Council, Inc.</td>
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<td>Phyllis Harris</td>
<td>Program Manager, Kinship Cares Initiative</td>
<td>Broward Health Community Health Services</td>
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<tr>
<td>Regine Kanzki</td>
<td>Division Director</td>
<td>Broward Regional Health Planning Council, Inc.</td>
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<tr>
<td>Renee Podolsky</td>
<td>Community Health Director</td>
<td>Florida Department of Health</td>
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<td>Robin Marzullo</td>
<td>Health Support Manager, Center for Active Aging</td>
<td>City of Deerfield Beach</td>
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<td>Sandra Coutain</td>
<td>Interim Executive Director</td>
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<td>Sarah Sabin</td>
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<td>Shawn Preston</td>
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<tr>
<td>Shira Fowlkes</td>
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<td>Shirley Snipes</td>
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<td>Sophia Mantovanelli</td>
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<td>Steve Schauder</td>
<td>Director of Development</td>
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<tr>
<td>Steven Marcus, Ed.D.</td>
<td>President/CEO</td>
<td>Health Foundation of South Florida</td>
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<td>Sue Gallagher</td>
<td>Chief Innovation Officer</td>
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<td>Director of Strategic Operations</td>
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<td>Vincenzo Averaimo</td>
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<td>Meeting Dates</td>
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<td>January 10, 2019</td>
<td>1. Broward County Quantitative Data Presentation (Part II)&lt;br&gt;2. Stakeholder Discussion&lt;br&gt;3. Identify Needs &amp; Gaps</td>
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<td>February 28, 2019</td>
<td>1. BH Quantitative Data Presentation (Part I)&lt;br&gt;2. Stakeholder Discussion&lt;br&gt;3. Identify Needs &amp; Gaps</td>
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<td>March 14, 2019</td>
<td>1. BH Quantitative Data Presentation (Part II)&lt;br&gt;2. BH Community Services Presentation&lt;br&gt;3. Stakeholder Discussion&lt;br&gt;4. Identify Needs &amp; Gaps</td>
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Data Overview
## Total Population, Broward & Florida, 2017

| Total Population | 2017 |  |  |  |  |  |  |  |  |  |  |  |
|------------------|------| | | | | | | | | | | |
|                  | Number | Percent | Number | Percent |
| **Broward**       | 1,935,878 | 100% | 20,984,400 | 100% |
| **Florida**       | 10,254,267 | 48.9% | 10,730,133 | 51.1% |
| Male              | 944,164 | 48.8% | 10,254,267 | 48.9% |
| Female            | 991,714 | 51.2% | 10,730,133 | 51.1% |
| 0-17              | 411,799 | 21.3% | 4,200,780 | 20.0% |
| 18-64             | 1,209,760 | 62.5% | 12,568,388 | 59.9% |
| 65+               | 314,319 | 16.2% | 4,215,232 | 20.1% |
| White             | 1,177,288 | 60.8% | 15,768,315 | 75.1% |
| Black             | 558,202 | 28.8% | 3,394,508 | 16.2% |
| Hispanic          | 574,026 | 29.7% | 5,370,860 | 25.6% |
| Asian             | 68,978 | 3.6% | 588,087 | 2.8% |
| Other             | 65,795 | 6.8% | 679,604 | 5.9% |

1,935,878 Residents in Broward County

22,363 Births
12,427 Migrants

15,976 Deaths

18,756 net population increase

55-64 age group had largest growth from 2016-2017

6,768

30%
of residents are Hispanic/Latino
Median Income $56,842

13.1% of all Broward residents have an income below the poverty line

17.7% families with female head of household live below the poverty line

3.9% Unemployment Rate

3.0% Job Growth

21.1% Employed in education, health or social services

270,550 students in Broward County Public Schools

89.4% of adult population has a high school diploma or higher

32.7% of adult population has a bachelor's degree or higher
Entry into Prenatal Care

1st Trimester Prenatal Care rates have gone down (74 to 72.9).

3rd Trimester or No Care rates have gone up (8.2 to 9.1).

The number of uninsured in Broward has increased by 0.1% in the past 3 years.

Black babies are at a higher risk of **negative** birth outcomes when compared to their White counterparts.

<table>
<thead>
<tr>
<th></th>
<th>Low Birth Weight</th>
<th>Preterm Births</th>
<th>Infant Mortality</th>
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<tbody>
<tr>
<td>Black Babies</td>
<td>13.6%</td>
<td>14.2%</td>
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<tr>
<td>White Babies</td>
<td>7.1%</td>
<td>8.6%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>
Heart Diseases account for the highest number of deaths in Broward County. Representing 23.3% of all deaths with a rate of 142.0.

Unintentional Injuries are responsible for the most Years of Potential Life Loss with a rate of 1,598.1

Major Causes of Death that Did Not Meet HP2020 Goals:
- Heart Disease: 103.4, 142.0
- Cerebrovascular Disease: 34.8, 58.7
- Unintended Injury: 36.4, 52.4

Major Causes of Death That Met HP2020 Goals:
- Diabetes Mellitus: 66.6, 18.8
- Cancer: 161.4, 146.1
The Total Sexually Transmitted Infection Rate for Broward County has been **increasing** since 2013. Going from **639.4** to **884.1**.

**Chlamydia 599.0 per 100,000**

**Gonorrhea 209.1 per 100,000**

**2,227.9** Chlamydia Rate per 100,000

**566.7** Gonorrhea Rate per 100,000

The AIDS rate in Broward has been **decreasing** since 2013. Going from **22.8** to **13.9**.

The HIV rate in Broward has had an overall **increase** since 2013. Going from **36.6** to **37.9**.
Chronic Conditions

$1.8 BILLION

Amount charged for chronic conditions in all BH hospitals combined.

Hypertension had the highest number of chronic condition cases in BH hospitals which accounted for over $808 million charges in 2017.

Congestive Heart Failure had the largest case-charge gap with $339 million being charged for less than 5 thousand cases.

Medicare was the payer source with the highest chronic condition charges in 2017.
Chronic Conditions

Service Area Statistics

Charges increased from 2015-2017 for chronic conditions in the BH PSAs by 4.6% while cases decreased by 9.1%.

Emergency Department Statistics

Emergency Department visits have decreased while admissions have increased over the past 3 years.

In 2017, PSA 33311 had the most cases and highest charges for each chronic conditions.
Avoidable Hospital Visits

Visit Classification

[81] Minor – problems are self-limited or of minor severity

[82] Low/Moderate – problems are low to moderate severity

Payer Source

[81] cases - self pay

[82] - Medicaid

Age Group

18-39
0-17

Race

White
Black

[81] [81]

[82] [82]
Prevention Quality Indicators

The most PQI cases and highest charges were for Congestive Heart Failure.

Medicare paid the greatest proportion of charges for most of the PQIs except for low birth weight (Medicaid) and perforated appendicitis (Private).

33311 had the highest cases for the majority of the observed PQIs with the exception of:
* Perforated appendicitis (33065)
* Bacterial pneumonia and urinary infections (33064)

33311 also had the highest charges for the majority of the observed PQIs with the exception of:
* Perforated appendicitis (33313)
* Bacterial pneumonia and urinary infections (33064).
Diagnosis Related Groups

Orthopedics had the highest number of discharges while general surgery had the highest charges in 2017.

Thoracic surgery had the highest average length of stay with an average of 24.0 days for 560 patients.
Consistent Themes Across Qualitative Study

- Affordability as significant barrier to access
- Lack of insurance coverage
- Continuity of care/Discharge planning
- Cultural Competency
- Immigration status
- Education about resources
- Integration of resources (one-stop shop)
- Racial equity training
- Customer service (people skills)
- Language barriers
- Use of technology (Telemedicine, EHR)
BH: Prioritizing the Needs in 2019

**Access to Care**
- Affordability for co-pays and medication
- Immigration status
- Continuity of Care
- Enrollment into ACA and Medicaid
- Coordination of care / Linkage to services
- Children with special needs

**Social Determinants of Health**
- Housing Quality and Affordability
- Poverty and homelessness
- Hunger/Food Insecurities
- Language and literacy (reading level)
- Elevation of the Economic well-being of the community through participation in the Anchor Hospital Initiative

**Preventive Care**
- Prenatal Care
- Prevention of Low Birthweight and Infant Mortality (emphasis on black mothers and infants)
- Screenings for chronic disease

**Community Education**
- Chronic Disease Self-Management
- Navigation of the system
- Health education and promotion

**Quality of Care**
- Consideration for diversity issues including languages spoken, patients with disabilities, gender, LGBTQ, and race
- Diversification and training of clinical and non-clinical staff

**Substance Abuse / Mental Health**
- Prevention of opioid death rate
- Adolescent mental health / suicide prevention

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<table>
<thead>
<tr>
<th>Rank</th>
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<tr>
<td>1</td>
<td>Qualitative: Focus Groups, Key Informants</td>
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</table>
For More Information

For more information, contact:

Regine Kanzki, MPH
Division Director
rkanzki@brhpc.org
www.brhpc.org

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Cary Zinkin, DPM

Michael De Lucca, MHM
President and CEO

Broward Regional Health Planning Council, Inc.
200 Oakwood Lane, Suite 100
Hollywood, FL 33020
(954) 561 - 9681
POPULATION HEALTH UPDATE
AMBULATORY SERVICES
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<th>Condition</th>
<th>Benchmark</th>
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<th>Sep-16</th>
<th>Dec-16</th>
<th>Mar-17</th>
<th>Jun-17</th>
<th>Sep-17</th>
<th>Dec-17</th>
<th>Mar-18</th>
<th>Jun-18</th>
<th>Sep-18</th>
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<td>80.6%</td>
<td>82.5%</td>
<td>81.7%</td>
<td>83.6%</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>56.7%</td>
<td>55.0%</td>
<td>59.3%</td>
<td>57.9%</td>
<td>63.6%</td>
<td>63.4%</td>
<td>65.0%</td>
<td>60.9%</td>
<td>58.7%</td>
<td>60.1%</td>
<td>60.6%</td>
<td>55.7%</td>
</tr>
<tr>
<td>Generic Dispensing Rate</td>
<td>84.1%</td>
<td>80.7%</td>
<td>81.0%</td>
<td>81.1%</td>
<td>82.3%</td>
<td>83.1%</td>
<td>83.9%</td>
<td>84.9%</td>
<td>85.7%</td>
<td>85.9%</td>
<td>85.7%</td>
<td>86.3%</td>
</tr>
<tr>
<td>ED Utilization - visits per 1000</td>
<td>212</td>
<td>222</td>
<td>228</td>
<td>211</td>
<td>204</td>
<td>206</td>
<td>201</td>
<td>197</td>
<td>202</td>
<td>203</td>
<td>208</td>
<td>210</td>
</tr>
</tbody>
</table>
## Florida Blue Quality Outcomes

<table>
<thead>
<tr>
<th>FL BLUE</th>
<th>Benchmark</th>
<th>Feb-17</th>
<th>May-17</th>
<th>Aug-17</th>
<th>Nov-17</th>
<th>Feb-18</th>
<th>May-18</th>
<th>Aug-18</th>
<th>Dec-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging for Low Back Pain</td>
<td>73.8%</td>
<td>62.1%</td>
<td>66.4%</td>
<td>63.6%</td>
<td>66.4%</td>
<td>66.6%</td>
<td>68.9%</td>
<td>76.9%</td>
<td>71.0%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>63.9%</td>
<td>75.6%</td>
<td>74.2%</td>
<td>76.0%</td>
<td>76.0%</td>
<td>75.8%</td>
<td>75.9%</td>
<td>64.2%</td>
<td>65.4%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>60.9%</td>
<td>79.1%</td>
<td>78.2%</td>
<td>76.8%</td>
<td>76.6%</td>
<td>73.3%</td>
<td>74.5%</td>
<td>65.4%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Diabetes - HgA1c Completed</td>
<td>85.6%</td>
<td>91.6%</td>
<td>90.2%</td>
<td>91.7%</td>
<td>90.5%</td>
<td>91.9%</td>
<td>90.8%</td>
<td>85.0%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Diabetes - Nephropathy</td>
<td>84.7%</td>
<td>91.2%</td>
<td>90.8%</td>
<td>95.1%</td>
<td>95.7%</td>
<td>95.9%</td>
<td>87.9%</td>
<td>89.3%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Generic Dispensing Rate</td>
<td>83.0%</td>
<td>82.0%</td>
<td>82.4%</td>
<td>82.0%</td>
<td>83.0%</td>
<td>83.0%</td>
<td>82.5%</td>
<td>83.0%</td>
<td>82.1%</td>
</tr>
<tr>
<td>ED Utilization - per 1000</td>
<td>248.88</td>
<td>256.00</td>
<td>236.96</td>
<td>230.73</td>
<td>227.00</td>
<td>245.50</td>
<td>235.40</td>
<td>237.77</td>
<td>233.20</td>
</tr>
</tbody>
</table>

- Overall Outpatient Quality Summary for YTD 2018 is **BETTER** than Market
- Received Shared Savings for CY 2017 of $3.9 Million
- On Track to receive $4.2 Million for CY 2018
LEAPFROG UPDATE
Opportunities/Next Steps

- **BHN**
  - Process/Structural
    - CPOE Clinical Alerts Team: Quality, Pharmacy & IT
    - Bar Coding

- **BHCS**
  - ICU Intensivist - active at BHCS, BHMC - June
  - Safety Survey - All regions 100 compliant
  - HCAHPS - steady improvements

- **BHIP**
  - Outcome Measures
    - Hospital Acquired Infections
      - Reduce SIR < 1
    - Patient Safety Indicators
      - Quality & Coding review all potential HACs
      - Focus on Reduction in Hospital Acquired Pressure Injuries

Next Public Reporting Period Fall 2019
AHRQ CULTURE OF SAFETY RESULTS
CULTURE OF SAFETY SURVEY

2019 participation rate performance (5065/8378 - 60%) increased from 2017 (58%).

• 24 questions fall into 4 categories: Engagement; Safety- Overall; Organization; Employee

• 2 identified concerns:
  – My work unit is adequately staffed.
  – The amount of job stress I feel is reasonable

• 9 identified strengths, each region had common & unique strengths.
## CULTURE OF SAFETY SURVEY

<table>
<thead>
<tr>
<th>(Scale 0-5)</th>
<th>ALL</th>
<th>BHIP</th>
<th>BHCS</th>
<th>BHN</th>
<th>BHMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>3.96</td>
<td>4.05</td>
<td>4.1</td>
<td>4.12</td>
<td>3.82</td>
</tr>
<tr>
<td>Safety- Overall</td>
<td>3.89</td>
<td>3.99</td>
<td>3.93</td>
<td>4.08</td>
<td>3.76</td>
</tr>
<tr>
<td>Organization</td>
<td>3.83</td>
<td>3.94</td>
<td>3.88</td>
<td>4.03</td>
<td>3.7</td>
</tr>
<tr>
<td>Employee</td>
<td>3.98</td>
<td>4.06</td>
<td>4.03</td>
<td>4.16</td>
<td>3.87</td>
</tr>
</tbody>
</table>
STRENGTHS

- In my work unit, we discuss ways to prevent errors from happening again.
- I can report patient safety mistakes without fear of punishment.
- Employees will freely speak up if they see something that may negatively affect patient care.
- We are actively doing things to improve patient safety.
- I feel free to raise workplace safety concerns.
- My work unit works well together.
- Broward Health provides high-quality care and service.
- Broward Health makes every effort to deliver safe, error-free care to patients.
- Mistakes have led to positive changes here.
ACTION PLAN

• Culture of Safety HAS Module

• Collaborate with Human Resources: Employee Assistance Program- stress reduction programs

• Staffing review –
2018-2019 INFLUENZA PROGRAM UPDATE
## 2019 HEALTHCARE PERSONNEL INFLUENZA VACCINATION SUMMARY - EMPLOYEES
### OCTOBER 1 & MARCH 31

<table>
<thead>
<tr>
<th>BROWARD HEALTH TOTAL STAFF</th>
<th>SYSTEM</th>
<th>BHMC</th>
<th>BHIP</th>
<th>BHCS</th>
<th>BHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of HCP at BH</td>
<td>7236</td>
<td>3381</td>
<td>921</td>
<td>1168</td>
<td>1766</td>
</tr>
<tr>
<td>Number of HCP received vaccine at BH</td>
<td>5164</td>
<td>2278</td>
<td>669</td>
<td>863</td>
<td>1354</td>
</tr>
<tr>
<td>Number of HCP provided documentation of vaccination outside BH</td>
<td>1215</td>
<td>611</td>
<td>164</td>
<td>222</td>
<td>218</td>
</tr>
<tr>
<td>Total received</td>
<td><strong>6379</strong></td>
<td><strong>2889</strong></td>
<td><strong>833</strong></td>
<td><strong>1085</strong></td>
<td><strong>1572</strong></td>
</tr>
<tr>
<td></td>
<td>88%</td>
<td>90%</td>
<td>93%</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Number of HCP with contraindication to</td>
<td>168</td>
<td>95</td>
<td>8</td>
<td>28</td>
<td>37</td>
</tr>
<tr>
<td>Number of HCP declined vaccine</td>
<td>352</td>
<td>162</td>
<td>60</td>
<td>49</td>
<td>81</td>
</tr>
<tr>
<td>Total not received</td>
<td>520</td>
<td>257</td>
<td>68</td>
<td>77</td>
<td>118</td>
</tr>
<tr>
<td></td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>6. Number of HCP with unknown status</td>
<td>337</td>
<td>235</td>
<td>20</td>
<td>6</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>7%</td>
<td>3%</td>
<td>0.01%</td>
<td>4%</td>
</tr>
</tbody>
</table>
**2019 HEALTHCARE PERSONNEL INFLUENZA VACCINATION SUMMARY - MEDICAL STAFF**  
**OCTOBER 1 & MARCH 31**

<table>
<thead>
<tr>
<th></th>
<th>BHMC</th>
<th>BHIP</th>
<th>BHCS</th>
<th>BHN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of HCP at BH</strong></td>
<td>1930</td>
<td>1117</td>
<td>677</td>
<td>872</td>
</tr>
<tr>
<td><strong>Number of HCP received vaccine at BH</strong></td>
<td>210</td>
<td>150</td>
<td>64</td>
<td>100</td>
</tr>
<tr>
<td><strong>Number of HCP provided documentation of vaccination outside BH</strong></td>
<td>930</td>
<td>497</td>
<td>323</td>
<td>422</td>
</tr>
<tr>
<td><strong>Total received</strong></td>
<td><strong>1140</strong></td>
<td>647 (58%)</td>
<td>387 (57%)</td>
<td>522 (60%)</td>
</tr>
<tr>
<td><strong>Number of HCP with contraindication to</strong></td>
<td>65</td>
<td>37</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td><strong>Number of HCP declined vaccine</strong></td>
<td>140</td>
<td>69</td>
<td>51</td>
<td>54</td>
</tr>
<tr>
<td><strong>Total not received</strong></td>
<td>205 (10%)</td>
<td>106 (10%)</td>
<td>74 (11%)</td>
<td>77 (9%)</td>
</tr>
<tr>
<td><strong>6. Number of HCP with unknown status</strong></td>
<td>594 (31%)</td>
<td>364 (32%)</td>
<td>216 (32%)</td>
<td>273 (31%)</td>
</tr>
</tbody>
</table>
## 2019 Healthcare Personnel Influenza Vaccination Summary - Volunteers

**October 1 & March 31**

<table>
<thead>
<tr>
<th>BROWARD HEALTH TOTAL Students &amp; Volunteers</th>
<th>BHMC</th>
<th>BHIP</th>
<th>BHCS</th>
<th>BHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of HCP at BH</td>
<td>980</td>
<td>334</td>
<td>664</td>
<td>925</td>
</tr>
<tr>
<td>Number of HCP received vaccine at BH</td>
<td>33</td>
<td>10</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Number of HCP provided documentation of vaccination outside BH</td>
<td>894</td>
<td>305</td>
<td>625</td>
<td>889</td>
</tr>
<tr>
<td>Total received</td>
<td><strong>927</strong></td>
<td><strong>315</strong></td>
<td><strong>638</strong></td>
<td><strong>903</strong></td>
</tr>
<tr>
<td></td>
<td><strong>94%</strong></td>
<td><strong>96%</strong></td>
<td><strong>98%</strong></td>
<td></td>
</tr>
<tr>
<td>Number of HCP with contraindication to</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Number of HCP declined vaccine</td>
<td>53</td>
<td>8</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>Total not received</td>
<td>53</td>
<td>11</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>6%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>6. Number of HCP with unknown status</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>16</td>
</tr>
</tbody>
</table>