NOTICE OF MEETING

NORTH BROWARD HOSPITAL DISTRICT

BOARD OF COMMISSIONERS

A Quality Assessment & Oversight Committee meeting will be held on Tuesday, September 8, 2020, at 8:00 a.m., via WebEx. The purpose of this committee meeting is to review and consider any matters within the committee’s jurisdiction.

NOTE: This public Committee meeting shall be conducted only through communications media technology in accordance with Fla. Exec. Order No. 20-193, extends Section 3 of Fla. Exec. Order 20-179, expires on October 1, 2020.

This meeting shall be open to the public who may attend by using the call-in toll number provided below:

Call-In Toll Number: (650) 479-3208  
Meeting Access Code: 160 093 9958  
Meeting Password: aaVJPRkQ266

For the most updated information, please check our website as schedules may change for reasons beyond our control https://www.browardhealth.org/pages/board-calendar

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.
QUALITY ASSESSMENT & OVERSIGHT COMMITTEE MEETING
10:00 A.M., JUNE 17, 2020

The Quality Assessment & Oversight Committee of the North Broward Hospital District was held at 10:00 a.m. on June 17, 2020 via WebEx video conference.

1. NOTICE

Official notice and agenda of this meeting is attached to the Minutes, as EXHIBIT I and EXHIBIT II, as presented for consideration of the Committee.

2. CALL TO ORDER

There being a quorum present, the meeting was called to order by Chair Nancy W. Gregoire at 10:01 a.m.

3. COMMITTEE MEMBERS

Present: Commissioner Nancy W. Gregoire, Chair
Commissioner Stacy L. Angier, Vice Chair
Commissioner Ray T. Berry

Senior Leadership

Additionally Present: Marie C. Waugh/Commissioner, Gino Santorio/President/Chief Executive Officer, Alan Goldsmith/Chief Administrative Officer, Alex Fernandez/Chief Financial Officer, Linda Epstein/Corporate General Counsel, Jerry Del Amo/Deputy General Counsel

4. GOVERNOR’S EXECUTIVE ORDER ANNOUNCEMENT

General Counsel delivered the Governor’s Executive Order for the record, as seen below.

“This public board meeting is being conducted through communications media technology in accordance with the Governor’s Executive Order No. 2020-69 as extended by the Governor’s Executive Order No. 2020-139 and § 120.54(5)(b)2., Florida Statutes. This meeting is open to the public who are able to attend this meeting via telephone conference call. The conference call information is currently posted on Broward Health’s website. All the requirements of Florida’s Sunshine Law are still in effect including the memorialization of minutes. While not a requirement under Florida law, we will attempt to record this meeting and post it on Broward Health’s website for the public and for those who may not be able to attend this live telephone conference.”
5. **PUBLIC COMMENTS**

None.

6. **APPROVAL OF MINUTES**

Staff Recommendation: That the Quality Assessment & Oversight Committee of the North Broward Hospital District approve the minutes from December 11, 2019.

**Staff recommendation carried without dissent.**

7. **CONSENT AGENDA**

Mr. Barry Gallison, Director of Risk and Quality Management, requested approval of the quarterly reports listed on the Consent Agenda, as seen below:

- 7.1. Community Health Services: Healthcare for Homeless
- 7.2. Ambulatory - Physician Practice Update
- 7.3. Gold Coast Home Health & Hospice
- 7.4. Population Health
- 7.5. Medicare Readmission
- 7.6. Medicare Mortalities
- 7.7. Antimicrobial Stewardship
- 7.8. Environment of Care
- 7.9. Sepsis Prevention
- 7.10. Infection Prevention
- 7.11. Hospital Acquired Pressure Injury
- 7.12. Grievances
- 7.13. Patient Satisfaction HCAHPS

Staff Recommendation: That the Quality Assessment & Oversight Committee of the North Broward Hospital District approve items 7.1-7.14 on the Consent Agenda.

**Staff recommendation carried unanimously.**

8. **QUALITY AND SAFETY AGENDA** – presented by – Barry Gallison, Director, Risk and Quality Management

8.1. Value Based Purchasing Update

Required by Affordable Care Act and Social Security Act:

MINUTES

North Broward Hospital District Board Of Commissioners
1700 Northwest 49th Street, Suite #150, Ft. Lauderdale, 33309

- 25% Person and Community Engagement – HCAHPS
- 25% Clinical Care-30-day mortality for AMI, HF, PN, COPD
- 25% Safety-NHSN measures (Clabsi, Cauti, SSI, MDRO)
- 25% Efficiency and Cost Reduction – MSPB

- 2020 Reimbursement for Prior Performance
  - Baseline for Engagement and Safety – CY 2017
  - Performance July 2018-June 2019
  - Baseline Clinical-July 2011-Jun 2014
  - Performance July 2015-June 2018

- Estimated Payment for 2020 – $186,520.

- Quality Indicators Engagement, Clinical, and Safety
  - New systems implemented to close gaps.

8.2. Joint Commission Disease Specific Certifications (DSC) – certified every three years

- Disease Specific Certifications for Broward Health Hospitals
  - Broward Health Imperial Point (BHIP)
    - Advanced Primary Stroke Center – 10/2019
    - Heart Failure – 3/2020
  - Broward Health Medical Center (BHMC)
    - Advanced Primary Stroke Center – 5/2019
    - Joint Replacement Hip/Knee – 6/2019
    - Pediatric Asthma – in progress
  - Broward Health North (BHN)
    - Advanced Primary Stroke – 10/2019
    - Advanced Thrombectomy Capable Stroke Center – application submitted 2/2020 (NEW)
    - Advanced Total Hip/Knee Replacement – 3/2020
    - Alzheimer’s Disease 10/2019
    - Spine Surgery 7/2019
    - Stroke Rehabilitation 10/2019
  - Broward Health Coral Springs (BHCS)
    - Advanced Primary Stroke Center 4/2019
    - Minimally Invasive Colorectal Surgery 11/2019
    - GERD Center (Gastro Esophageal Reflux Disease) – Finalizing certification

8.3. Infection Control System Update

- High Reliable Organization
  - Introduce team
    - Regional Quality Leaders & Epidemiologist
Transformational Change
- Leadership
- Safety Culture
- Robust Process Improvement
- ORO Assessments

Commitment to Zero Harm

Standardization
- District wide Infection Control Plan
  - Standardize approach to emerging threats – one program for all four hospitals.
- Standardize Products and Protocols to reduce changes in practice.
- Intense Analysis for every event
  - At local level, evaluate processes, track and trend
- Unified Goals – Balanced score card helps drive this change.

Future Steps
- Chasing Thresholds & Benchmarks (Zero!)
- Improve Public Reporting
- Accountability in Practice
- Goal Alignment: Balance Score Card

Outcomes: Calendar Year 2018 to Calendar Year 2019
- CLABSI
- CAUTI
- MRSA
- C Diff

Current Balance Score Card, Quality Domain Fiscal Year 2020
Proposed Balance Score Card, Quality Domain Fiscal Year 2021

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

That the Quality Assessment & Oversight Committee recommend that the Board of Commissioners of the North Broward Hospital District authorize the District to approve the Proposed Balance Score Card, Quality Domain Fiscal Year 2021.

Staff recommendation carried unanimously.

8.4. Influenza Program

- 2020 Healthcare Personnel Influenza Vaccination, October 1 and March 31
  - Summary Employees
    - Received – 87%
    - Medical Contraindications – 7%
    - Did not received due to turnover in staff – 6%
  - Summary Medical Staff
    - Received – 70%
8.5. Patient Engagement System Update

- Journey to High Reliable Organization
  - Transformational Change
  - Align Culture
  - Press Ganey Partnership
    - Standardized survey tools
    - Ambulatory Service – modified the tool to match the telemedicine process.
    - New kiosk in the Health Care for Homeless Clinic to allow for participation in the satisfaction program.
  - Survey Priority Indicators
  - Process & Frequency of Rounding – provided education to staff to ensure patient needs are met.
  - Orientation & Staff Education
  - Reward & Recognize
  - Balance Score Card
  - Physician Engagement
    - Identify MD champions
  - Balance Score Card Goal Comparison: BHMC & BHN

- Overall rating of hospital
  - 75th percentile
    - BHMC – 78.0
    - BHN – 78.0
  - Fiscal Year 2020 Goal
    - BHMC – 75.7
    - BHN – 80.1
  - Calendar Year 2019
    - BHMC – 69.9
    - BHN – 76.0
  - Calendar Year 2018
    - BHMC - 69.2
    - BHN – 77.4
  - Willing to recommend
    - 75th percentile
      - BHMC – 78.0
      - BHN 78.0
    - Fiscal Year 2020 Goal
      - BHMC – 77.2
      - BHN – 79.1
    - Calendar Year 2019
Quality Assessment & Oversight Committee 6

For additional meeting detail, please visit www.BrowardHealth.org/pages/board-calendar
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7.1 COMMUNITY HEALTH SERVICES: HEALTHCARE FOR THE HOMELESS
### Performance Measure for HCH Patients with Diabetes, CY 2019

<table>
<thead>
<tr>
<th>Goal 1: Decrease No-Show rate for AADE certified diabetes self-management classes by at least ten percent (10%) by July 2020. Goal 58%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement of monthly attendance in diabetes classes</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td># of patients who attended class</td>
</tr>
<tr>
<td># of patients who were scheduled for class</td>
</tr>
<tr>
<td>NO SHOW RATE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2: Reduce participating HCH patients with HbA1c of 10% or higher by 2% within 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete outreach to all patients with HbA1c 8% or greater and schedule at least 80% of identified patients for group DSM classes.</td>
</tr>
<tr>
<td># of patients with HbA1c 8% or greater and scheduled for DSM class</td>
</tr>
<tr>
<td># of patients identified as having HbA1c 8% or greater</td>
</tr>
<tr>
<td>Average HbA1c</td>
</tr>
<tr>
<td>Proportion of patients with HbA1c higher than 8% past 3 months.</td>
</tr>
<tr>
<td># of patients with HbA1c greater than 8% who were seen by PCP this month</td>
</tr>
<tr>
<td># of patients with HbA1c greater than 8% past 3 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3: Promote diabetes control and prevention through education to more patients by August 1, 2020 as evidenced by increase in the average number of participants in group DSM classes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase average # of participants in group DSM classes from 3 patients to at least 5 patients per class</td>
</tr>
<tr>
<td># of established patients with diagnosis of pre-DM and DM who attend group classes</td>
</tr>
<tr>
<td># of established patients with diagnosis of pre-DM and DM</td>
</tr>
</tbody>
</table>
7.2 AMBULATORY PHYSICIAN PRACTICE UPDATE
# AVMED MEDICARE VALUE BASED METRICS
CLAIMS THROUGH 12/14/19

## MEDICARE Scorecard

![AvMed Logo](image)

### Count for payout (10 Measures)

<table>
<thead>
<tr>
<th>Measure Domain</th>
<th>Source</th>
<th>Measure</th>
<th>1.5% of Premium (Max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HD1: Staying Healthy: Screenings, Tests and Vaccines</td>
<td>HEDIS Software</td>
<td>C01: Breast Cancer Screening</td>
<td>83 76</td>
</tr>
<tr>
<td></td>
<td>HEDIS Software</td>
<td>C02: Colorectal Cancer Screening</td>
<td>80 73</td>
</tr>
<tr>
<td></td>
<td>HEDIS Software</td>
<td>Controlling High Blood Pressure &lt;= 140/90 ^^</td>
<td>82 75</td>
</tr>
<tr>
<td>HD2: Managing Chronic (Long Term) Conditions</td>
<td>HEDIS Software</td>
<td>C15: Diabetes Care – Blood Sugar Controlled</td>
<td>85 72</td>
</tr>
<tr>
<td></td>
<td>HEDIS Software</td>
<td>C19: Medication Reconciliation Post-Discharge</td>
<td>84 71</td>
</tr>
<tr>
<td></td>
<td>HEDIS Software</td>
<td>C20: Plan All-Cause Readmissions ^</td>
<td></td>
</tr>
<tr>
<td>DD4: Drug Safety and Accuracy of Drug Pricing</td>
<td>Accumen</td>
<td>D10: Medication Adherence for Diabetes Medications</td>
<td>85 82</td>
</tr>
<tr>
<td></td>
<td>Accumen</td>
<td>D11: Medication Adherence for Hypertension (RAS antagonists)</td>
<td>88 86</td>
</tr>
<tr>
<td></td>
<td>Accumen</td>
<td>D12: Medication Adherence for Cholesterol (Statins)</td>
<td>87 84</td>
</tr>
<tr>
<td></td>
<td>Accumen</td>
<td>D14: Stain Use in Persons with Diabetes (SUPD)</td>
<td>83 81</td>
</tr>
</tbody>
</table>

### Overall Analysis

<table>
<thead>
<tr>
<th>Total Eligible Measures</th>
<th>Total Eligible Medicare Measures</th>
<th>Total Open Medicare Gaps</th>
<th>Overall Medicare Star Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>2965</td>
<td>2291</td>
<td>631</td>
<td>3.0</td>
</tr>
</tbody>
</table>

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*Note: Tier 5 Star = 100% Payout, Tier 4 Star = 30% Payout*
<table>
<thead>
<tr>
<th>Population</th>
<th>Measure</th>
<th>Eligible</th>
<th>Compliant</th>
<th>Provider Rate</th>
<th>Expected Rate</th>
<th>Members Needed To Reach Expected Rate</th>
<th>Current Star Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>BCS - Breast Cancer Screening</td>
<td>85</td>
<td>67</td>
<td>78.82%</td>
<td>83.00%</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Medicare</td>
<td>CDC2 - HbA1c &lt;8</td>
<td>47</td>
<td>35</td>
<td>74.47%</td>
<td>79.00%</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Medicare</td>
<td>COL - Colorectal Cancer Screening</td>
<td>169</td>
<td>128</td>
<td>75.74%</td>
<td>83.00%</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Medicare</td>
<td>D12-Medication Adherence for Diabetes</td>
<td>58</td>
<td>50</td>
<td>86.21%</td>
<td>86.00%</td>
<td>0</td>
<td>5</td>
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<tr>
<td>Medicare</td>
<td>D13-Medication Adherence for Hypertension</td>
<td>155</td>
<td>132</td>
<td>85.16%</td>
<td>89.00%</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Medicare</td>
<td>D14-Medication Adherence for Cholesterol</td>
<td>184</td>
<td>159</td>
<td>86.41%</td>
<td>83.00%</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Medicare</td>
<td>PCR1 - All Cause Readmissions</td>
<td>43</td>
<td>39</td>
<td>90.70%</td>
<td>92.00%</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Medicare</td>
<td>SPDA - Statin Therapy Diabetes 80% Adherence</td>
<td>25</td>
<td>12</td>
<td>48.00%</td>
<td>80.00%</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Analysis</th>
<th>Total Eligible Commercial Measures</th>
<th>Total Commercial Open Gaps</th>
<th>Overall Commercial Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>674</td>
<td>316</td>
<td>3.0</td>
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</table>
## AVMED COMMERCIAL VALUE BASED Q4 2019 METRICS

**DECEMBER PARTIAL, INCLUDES CLAIMS RECEIVED THROUGH 12/14/2019**

<table>
<thead>
<tr>
<th>Population</th>
<th>Measure</th>
<th>Eligible</th>
<th>Compliant</th>
<th>Provider Rate</th>
<th>Expected Rate</th>
<th>Members Needed To Reach Expected Rate</th>
<th>Current Star Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>BCS - Breast Cancer Screening</td>
<td>31</td>
<td>27</td>
<td>87.10%</td>
<td>80.00%</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Commercial</td>
<td>COL - Colorectal Cancer Screening</td>
<td>67</td>
<td>42</td>
<td>62.69%</td>
<td>72.00%</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Commercial</td>
<td>PCR1 - All Cause Readmissions</td>
<td>4</td>
<td>4</td>
<td>100.00%</td>
<td>92.50%</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Commercial</td>
<td>SPDA - Statin Therapy Diabetes 80% Adherence</td>
<td>6</td>
<td>3</td>
<td>50.00%</td>
<td>67.00%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Category</td>
<td>High Level Measure</td>
<td>Measure Title</td>
<td>Points</td>
<td>Goal</td>
<td>Results</td>
<td></td>
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<tr>
<td>-----------------</td>
<td>-------------------</td>
<td>--------------------</td>
<td>----------------------------------------</td>
<td>--------</td>
<td>-------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Achieve Wow</td>
<td>Member Wow</td>
<td>Ease of appointment</td>
<td>E-Scheduling, Timeliness, Concierge treatment</td>
<td>8.0</td>
<td>94%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Wow patient experience</td>
<td></td>
<td>Managing My Health</td>
<td>Care Plan clarity, wellness, Concierge treatment</td>
<td>8.0</td>
<td>91%</td>
<td>92.86%</td>
<td></td>
</tr>
<tr>
<td>Managing My Health</td>
<td></td>
<td>Provider Access</td>
<td>Office Hours, email access, Concierge Treatment</td>
<td>8.0</td>
<td>87%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Patient office Experience</td>
<td></td>
<td>Patient Doctor Experience</td>
<td>Wait time, Office Staff, Concierge Treatment</td>
<td>8.0</td>
<td>89%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Patient Doctor Experience</td>
<td></td>
<td>Time Spent, thoroughness, Concierge Treatment</td>
<td>8.0</td>
<td>95%</td>
<td>93.75%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# HUMANA MEDICARE HMO

### Measure Eligible Passes Gaps Rate HUM Weight Gaps % Score Rate HUM Rate HUM

<table>
<thead>
<tr>
<th>Measure</th>
<th>Eligible</th>
<th>Passes</th>
<th>Gaps</th>
<th>Rate</th>
<th>HUM</th>
<th>Weight</th>
<th>Gaps</th>
<th>% Score</th>
<th>Rate</th>
<th>HUM</th>
<th>Rate</th>
<th>HUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td>180</td>
<td>177</td>
<td>3</td>
<td>98.33%</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>99%</td>
<td>98%</td>
<td>98.34%</td>
<td>4</td>
<td>98.42%</td>
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<tr>
<td>Anti-rheumatic drug for RA</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>75%</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>86%</td>
<td>78%</td>
<td>75%</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>95</td>
<td>75</td>
<td>20</td>
<td>78.95%</td>
<td>4</td>
<td>1</td>
<td>7</td>
<td>86%</td>
<td>81%</td>
<td>80.85%</td>
<td>4</td>
<td>81.19%</td>
</tr>
<tr>
<td>COA- Functional Status Assessment</td>
<td>28</td>
<td>14</td>
<td>14</td>
<td>50%</td>
<td>2</td>
<td>1</td>
<td>14</td>
<td>98%</td>
<td>86%</td>
<td>48.28%</td>
<td>2</td>
<td>75.76%</td>
</tr>
<tr>
<td>COA- Medication Review</td>
<td>28</td>
<td>22</td>
<td>6</td>
<td>78.57%</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>98%</td>
<td>86%</td>
<td>75.86%</td>
<td>3</td>
<td>93.94%</td>
</tr>
<tr>
<td>COA- Pain Screening</td>
<td>28</td>
<td>16</td>
<td>12</td>
<td>57.14%</td>
<td>2</td>
<td>1</td>
<td>12</td>
<td>98%</td>
<td>86%</td>
<td>55.17%</td>
<td>2</td>
<td>90.91%</td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>184</td>
<td>117</td>
<td>67</td>
<td>63.59%</td>
<td>3</td>
<td>1</td>
<td>40</td>
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<td>71%</td>
<td>60.75%</td>
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<tr>
<td>Controlling High Blood Pressure</td>
<td>187</td>
<td>125</td>
<td>62</td>
<td>66.84%</td>
<td>3</td>
<td>1</td>
<td>34</td>
<td>85%</td>
<td>70%</td>
<td>52.08%</td>
<td>2</td>
<td>n/a</td>
</tr>
<tr>
<td>Diabetes Care - Blood Sugar Controlled</td>
<td>52</td>
<td>37</td>
<td>15</td>
<td>71.15%</td>
<td>3</td>
<td>3</td>
<td>10</td>
<td>89%</td>
<td>75%</td>
<td>72%</td>
<td>3</td>
<td>82.35%</td>
</tr>
<tr>
<td>Diabetes Care - Eye Exam</td>
<td>52</td>
<td>40</td>
<td>12</td>
<td>76.90%</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>86%</td>
<td>71%</td>
<td>74%</td>
<td>4</td>
<td>74.51%</td>
</tr>
<tr>
<td>Diabetes Care - Nephropathy Screen</td>
<td>52</td>
<td>50</td>
<td>2</td>
<td>96.15%</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>99%</td>
<td>97%</td>
<td>98%</td>
<td>4</td>
<td>96.08%</td>
</tr>
<tr>
<td>Medication Adh - Ace/ARB</td>
<td>198</td>
<td>176</td>
<td>22</td>
<td>88.89%</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>88%</td>
<td>92%</td>
<td>92.27%</td>
<td>5</td>
<td>82.83%</td>
</tr>
<tr>
<td>Medication Adh - Diabetes</td>
<td>61</td>
<td>57</td>
<td>4</td>
<td>93.44%</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>87%</td>
<td>91%</td>
<td>93.22%</td>
<td>5</td>
<td>74.67%</td>
</tr>
<tr>
<td>Medication Adh- STATins</td>
<td>198</td>
<td>177</td>
<td>21</td>
<td>89.39%</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>88%</td>
<td>90%</td>
<td>89.01%</td>
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<td>24</td>
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<td>53%</td>
<td>28.89%</td>
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<td>56.34%</td>
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<td>2</td>
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<td>1</td>
<td>50%</td>
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<td>1</td>
<td>1</td>
<td>78%</td>
<td>48%</td>
<td>50%</td>
<td>3</td>
<td>33.33%</td>
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<td>Plan all cause readmissions</td>
<td>46</td>
<td>36</td>
<td>10</td>
<td>78.26%</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>92%</td>
<td>87%</td>
<td>82.50%</td>
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<td>84.85%</td>
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<tr>
<td>Statin Therapy for Cardiovasc DZ</td>
<td>11</td>
<td>9</td>
<td>2</td>
<td>81.82%</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>87%</td>
<td>80%</td>
<td>83.33%</td>
<td>4</td>
<td>86.96%</td>
</tr>
<tr>
<td>Statin Therapy for Diabetes</td>
<td>49</td>
<td>43</td>
<td>6</td>
<td>87.76%</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>85%</td>
<td>84%</td>
<td>80.39%</td>
<td>4</td>
<td>83.61%</td>
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</table>

**Totals:** 2,547, 2,103, 444

Data Sept 2019

## Humana Weighted Average

<table>
<thead>
<tr>
<th>Membership</th>
<th>549</th>
<th>F 330</th>
<th>M 219</th>
<th>Mbr w/gaps</th>
<th>266</th>
<th>Percentile</th>
<th>17</th>
<th>Rate</th>
<th>76.16%</th>
<th>Hum</th>
<th>Prev. Year</th>
<th>Prev. Month</th>
<th>Curr. Month</th>
<th>Status</th>
</tr>
</thead>
</table>

16
MY BLUE - QUALITY OUTCOMES

myBlue Performance Report - Group Summary

North Broward Hospital District

Affordability

Affordability

Quality Gate

Average Members: 9,481
Average Risk Score: 1.964

Actual Loss Ratio: 70.2%

Enhanced Cap PMPM: $0.00
YTD Enhanced Cap: $0
Annualized Enhanced Cap: $0

Not Eligible for Bonus

*Assumes same PMPM on full year MDM

201901 to 201911 with 1 month of runout
Quality performance metrics for the quality gate are compared to the entire Commercial population

Quality

Quality Score: 47.3%

Below Peer

50% Peer: 57.7% 80% Peer: 66.8%

Small Sample: 5 Below Expectations: 14 Meets Expectations: 5 Exceeds Expectations: 3

*There are a total of 27 HEDIS measures included in this report. Detail can be found on Quality tabs in the Clinical Appendix.

Uses claims and supplementary data submitted as of 12/30/2019
Quality performance metrics for scoring purposes are compared to the entire myBlue population
myBlue Performance Report - Quality Summary

North Broward Hospital District
Uses claims and supplementary data submitted as of 12/30/2019

Quality

47.3%

Below Peer

50% Peer: 57.7% 20% Peer: 66.8%

Quality Scoring - All Measures

<table>
<thead>
<tr>
<th>Quality Conclusion</th>
<th>Count</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Sample</td>
<td>N/A</td>
<td>5</td>
</tr>
<tr>
<td>Below Expectations</td>
<td>0-2 points</td>
<td>14</td>
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<tr>
<td>Meets Expectations</td>
<td>2-5 points</td>
<td>5</td>
</tr>
<tr>
<td>Exceeds Expectations</td>
<td>5 points</td>
<td>3</td>
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</table>

Points
Points Possible
Score

Opportunities - Not Met

<table>
<thead>
<tr>
<th>Measure</th>
<th>Opportunities</th>
<th>Not Met</th>
<th>Met</th>
<th>Rate</th>
<th>Not Met Seen in CY</th>
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</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>3,931</td>
<td>1,901</td>
<td>2,030</td>
<td>52%</td>
<td>66%</td>
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<tr>
<td>Controlling High Blood Pressure</td>
<td>2,373</td>
<td>1,582</td>
<td>791</td>
<td>23%</td>
<td>92%</td>
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<tr>
<td>Cervical Cancer Screening</td>
<td>4,097</td>
<td>1,479</td>
<td>2,618</td>
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<td>63%</td>
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<tr>
<td>Adult BMI Assessment</td>
<td>5,950</td>
<td>1,221</td>
<td>4,729</td>
<td>79%</td>
<td>50%</td>
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<tr>
<td>Comprehensive Diabetes Care: Eye Exam</td>
<td>983</td>
<td>605</td>
<td>378</td>
<td>35%</td>
<td>91%</td>
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<tr>
<td>Adherence to Statins</td>
<td>1,684</td>
<td>446</td>
<td>1,038</td>
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<td>94%</td>
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<tr>
<td>Adherence to Renin Angiotensin Antagonists</td>
<td>1,401</td>
<td>341</td>
<td>1,060</td>
<td>76%</td>
<td>89%</td>
</tr>
<tr>
<td>Proportion of Days Covered: Oral Diabetes Meds</td>
<td>540</td>
<td>152</td>
<td>388</td>
<td>72%</td>
<td>88%</td>
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<tr>
<td>Annual Monitoring for Patients on Persistent Meds: ACE/ARB</td>
<td>1,252</td>
<td>130</td>
<td>1,122</td>
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<td>72%</td>
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<td>Comprehensive Diabetes Care: HbA1c</td>
<td>933</td>
<td>91</td>
<td>842</td>
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<td>71%</td>
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<tr>
<td>Weight Counseling</td>
<td>68</td>
<td>62</td>
<td>6</td>
<td>9%</td>
<td>81%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>114</td>
<td>59</td>
<td>55</td>
<td>48%</td>
<td>49%</td>
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<tr>
<td>Annual Monitoring for Patients on Persistent Meds: Diuretics</td>
<td>656</td>
<td>57</td>
<td>599</td>
<td>91%</td>
<td>74%</td>
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<tr>
<td>Comprehensive Diabetes Care: Nephropathy Monitoring</td>
<td>933</td>
<td>96</td>
<td>877</td>
<td>94%</td>
<td>73%</td>
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<tr>
<td>Plan All-Cause Readmission</td>
<td>289</td>
<td>55</td>
<td>234</td>
<td>86%</td>
<td>90%</td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>94</td>
<td>26</td>
<td>68</td>
<td>63%</td>
<td>86%</td>
</tr>
<tr>
<td>Post Partum Care</td>
<td>35</td>
<td>26</td>
<td>9</td>
<td>26%</td>
<td>48%</td>
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</table>
## Quality Summary

Uses claims and supplementary data submitted as of 12/16/2019

### Region
SOUTH

### Group Name
North Broward Hospital District

### Group Number
00020

<table>
<thead>
<tr>
<th>Measures</th>
<th>Opportunities</th>
<th>Met</th>
<th>Not Met</th>
<th>Rate</th>
<th>50th Percentile</th>
<th>80th Percentile</th>
<th>Quality Conclusion</th>
<th>Score</th>
<th>Possible Points</th>
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</thead>
<tbody>
<tr>
<td>Adherence to Renin Angiotensin Antagonists</td>
<td>1,410</td>
<td>1,079</td>
<td>331</td>
<td>76.5%</td>
<td>75.6%</td>
<td>82.7%</td>
<td>Meets Expectations</td>
<td>2.4</td>
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<td>Adherence to Statins</td>
<td>1,615</td>
<td>1,101</td>
<td>514</td>
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<td>70.2%</td>
<td>76.4%</td>
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<td>Adult BMI Assessment</td>
<td>5,990</td>
<td>4,752</td>
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<td>87.1%</td>
<td>94.6%</td>
<td>Below Expectations</td>
<td>1.8</td>
<td>5.0</td>
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<tr>
<td>Adults with Bronchitis, 18-64 years</td>
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<td>92</td>
<td>37</td>
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<td>59.5%</td>
<td>70.6%</td>
<td>Exceeds Expectations</td>
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<td>Annual Monitoring for Patients on Persistent Meds: ACE/ARB</td>
<td>1,262</td>
<td>1,119</td>
<td>143</td>
<td>88.7%</td>
<td>91.9%</td>
<td>96.8%</td>
<td>Below Expectations</td>
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<td>5.0</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Meds: Diuretics</td>
<td>663</td>
<td>595</td>
<td>68</td>
<td>89.7%</td>
<td>92.1%</td>
<td>95.9%</td>
<td>Below Expectations</td>
<td>1.9</td>
<td>5.0</td>
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<td>Appropriate Testing for Children With Pharyngitis</td>
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<td>80.0%</td>
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<td>81.8%</td>
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<td>Children with Upper Respiratory Infection</td>
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<td>-</td>
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</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>114</td>
<td>54</td>
<td>60</td>
<td>47.4%</td>
<td>64.8%</td>
<td>74.6%</td>
<td>Below Expectations</td>
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<td>5.0</td>
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<td>Colorectal Cancer Screening</td>
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<td>48.0%</td>
<td>56.8%</td>
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<td>320</td>
<td>616</td>
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<td>29.8%</td>
<td>48.6%</td>
<td>Meets Expectations</td>
<td>2.7</td>
<td>5.0</td>
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<tr>
<td>Comprehensive Diabetes Care: HbA1c</td>
<td>936</td>
<td>856</td>
<td>80</td>
<td>91.5%</td>
<td>93.3%</td>
<td>97.0%</td>
<td>Below Expectations</td>
<td>2.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Nephropathy Monitoring</td>
<td>936</td>
<td>876</td>
<td>60</td>
<td>93.6%</td>
<td>93.3%</td>
<td>96.3%</td>
<td>Meets Expectations</td>
<td>2.3</td>
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<td>Controlling High Blood Pressure</td>
<td>2,382</td>
<td>783</td>
<td>1,599</td>
<td>32.9%</td>
<td>35.7%</td>
<td>63.8%</td>
<td>Below Expectations</td>
<td>1.8</td>
<td>5.0</td>
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<tr>
<td>Immunizations for Adolescents</td>
<td>3</td>
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<td>3</td>
<td>18.8%</td>
<td>23.5%</td>
<td>-</td>
<td>Small Sample</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Medication Management for People with Asthma, 75% PDC, Total</td>
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<td>51</td>
<td>25</td>
<td>67.1%</td>
<td>56.4%</td>
<td>64.0%</td>
<td>Exceeds Expectations</td>
<td>5.0</td>
<td>5.0</td>
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<tr>
<td>Plan All-Cause Readmission</td>
<td>387</td>
<td>336</td>
<td>51</td>
<td>86.8%</td>
<td>90.0%</td>
<td>93.3%</td>
<td>Below Expectations</td>
<td>1.9</td>
<td>5.0</td>
</tr>
<tr>
<td>Post Partum Care</td>
<td>37</td>
<td>9</td>
<td>28</td>
<td>73.8%</td>
<td>74.0%</td>
<td>80.5%</td>
<td>Below Expectations</td>
<td>1.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Proportion of Days Covered: Oral Diabetes Meds</td>
<td>543</td>
<td>401</td>
<td>142</td>
<td>73.8%</td>
<td>74.0%</td>
<td>80.5%</td>
<td>Below Expectations</td>
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<td>Timeliness of Prenatal Care</td>
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<td>68.8%</td>
<td>74.3%</td>
<td>Below Expectations</td>
<td>1.9</td>
<td>5.0</td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>95</td>
<td>58</td>
<td>37</td>
<td>61.1%</td>
<td>72.9%</td>
<td>81.5%</td>
<td>Below Expectations</td>
<td>1.7</td>
<td>5.0</td>
</tr>
<tr>
<td>Weight Counseling</td>
<td>58</td>
<td>5</td>
<td>53</td>
<td>8.6%</td>
<td>30.4%</td>
<td>66.7%</td>
<td>Below Expectations</td>
<td>0.6</td>
<td>5.0</td>
</tr>
<tr>
<td>Well Care Visits, 1st 15 months, 6+ visits</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>81.3%</td>
<td>86.2%</td>
<td>Small Sample</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Well-Child Visits in the 3rd - 6th Years of Life</td>
<td>19</td>
<td>9</td>
<td>10</td>
<td>47.4%</td>
<td>69.2%</td>
<td>76.0%</td>
<td>Below Expectations</td>
<td>1.4</td>
<td>5.0</td>
</tr>
</tbody>
</table>

**Note:**
Quality performance metrics for scoring purposes are compared to the entire myBlue population.
These "Quality Conclusions" are not directly related to Quality Gates included in incentive program contracts.
Inpatient Utilization

201901 to 201910 with 1 month of runout

Region: SOUTH
Group Name: North Broward Hospital District
Group Number: 00020

<table>
<thead>
<tr>
<th>Group</th>
<th>Peer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Risk Score</td>
<td>1.91</td>
</tr>
<tr>
<td>Admits per 1000</td>
<td>85</td>
</tr>
<tr>
<td>Risk Score for admits</td>
<td>13.74</td>
</tr>
<tr>
<td>Readmits per 1000</td>
<td>10.5</td>
</tr>
<tr>
<td>Risk Score for readmits</td>
<td>35.41</td>
</tr>
<tr>
<td>% of IP with no PCP visits</td>
<td>20.1%</td>
</tr>
<tr>
<td>% of readmits with no PCP visits</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

% of Admits

- 2% 4% 6% 8% 10% 12% 14% 16% 18%

Top 10 Facilities by Admits

- BROWARD HEALTH NORTH
- BROWARD HEALTH MEDICAL CENTER
- BROWARD HEALTH IMPERIAL POINT
- NORTHWEST MEDICAL CENTER
- CLEVELAND CLINIC FLORIDA HEALTH SYSTEM NONPROFIT
- BOCA RATON REGIONAL HOSPITAL INC
- HOLY CROSS HOSPITAL
- BROWARD HEALTH CORAL SPRINGS
- WEST BOCA MEDICAL CENTER
- NORTH SHORE MEDICAL CENTER FMC CAMPUS
UNITED MEDICARE QUALITY INCENTIVE OUTCOMES

2019 NORTH BROWARD HSPTL DIST (596012065) MA-PCPI Baseline & Interim Report

The following data shows metrics for HEDIS measures that indicate a potential care opportunity. Metrics include assigned and/or attributed Medicare Advantage members specific to the MA-PCPI Program, which are not included in the I&MR ACO Program.

| Total MA-PCPI Patients | 429 |

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Eligible Members</th>
<th>Compliant Members</th>
<th>Non-Compliant Members</th>
<th>Current Rate</th>
<th>4 STAR Threshold % Target</th>
<th># of Members to Achieve 4 STAR Threshold</th>
<th>5 STAR Threshold % Target</th>
<th># of Members to Achieve 5 STAR Threshold</th>
<th>Quality Rating</th>
<th>CMS Weight</th>
<th>CMS Weighted Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>C01 Breast Cancer Screening</td>
<td>91</td>
<td>70</td>
<td>21</td>
<td>77%</td>
<td>≥70.0%</td>
<td>0</td>
<td>≥50.0%</td>
<td>0</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>C02 Cervical Cancer Screening</td>
<td>190</td>
<td>145</td>
<td>45</td>
<td>75%</td>
<td>≥73.0%</td>
<td>4</td>
<td>≥50.0%</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td>1</td>
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<td>C07 Adult BMI Assessment</td>
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<td>172</td>
<td>29</td>
<td>66%</td>
<td>≥66.0%</td>
<td>21</td>
<td>≥50.0%</td>
<td>27</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>C13 Diabetes Care - Eye Exam</td>
<td>58</td>
<td>46</td>
<td>12</td>
<td>79%</td>
<td>≥73.0%</td>
<td>0</td>
<td>≥50.0%</td>
<td>0</td>
<td>5</td>
<td>1</td>
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<td>58</td>
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<td>3</td>
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<td>≥50.0%</td>
<td>10</td>
<td>3</td>
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<tr>
<td>D10 Medication Adherence for Diabetes Medications</td>
<td>50</td>
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<td>≥85.0%</td>
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<td>≥50.0%</td>
<td>0</td>
<td>5</td>
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<tr>
<td>D11 Medication Adherence for Hyperension (RAS antagonists)</td>
<td>165</td>
<td>138</td>
<td>28</td>
<td>83%</td>
<td>≥85.0%</td>
<td>5</td>
<td>≥50.0%</td>
<td>9</td>
<td>3</td>
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<td>D12 Medication Adherence for Hypercholesterol (Statins)</td>
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<td>≥50.0%</td>
<td>10</td>
<td>3</td>
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<td>D14 Statin Use in Persons with Diabetes</td>
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Quality Care Incentive Measures

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<tr>
<th>Quality Measure</th>
<th>Eligible Members</th>
<th>Compliant Members</th>
<th>Non-Compliant Members</th>
<th>Current Rate</th>
<th>4 STAR Threshold % Target</th>
<th># of Members to Achieve 4 STAR Threshold</th>
<th>5 STAR Threshold % Target</th>
<th># of Members to Achieve 5 STAR Threshold</th>
<th>Quality Rating</th>
<th>MA-PCPI Weight</th>
<th>MA-PCPI Weighted Quality Rating</th>
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<tbody>
<tr>
<td>C12 Osteoporosis Management in Women who had a Fracture</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>50%</td>
<td>≥50.0%</td>
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<tr>
<td>C17 Rheumatoid Arthritis Management</td>
<td>6</td>
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<td>2</td>
<td>67%</td>
<td>≥70.0%</td>
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<td>≥50.0%</td>
<td>2</td>
<td>2</td>
<td>0</td>
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<tr>
<td>C25 Medication Reconciliation Post Discharge</td>
<td>57</td>
<td>50</td>
<td>7</td>
<td>14%</td>
<td>≥71.0%</td>
<td>33</td>
<td>≥50.0%</td>
<td>40</td>
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</table>

MA-PCPI Measures and Thresholds

This information in this table is subject to change from time to time at CMS’ discretion. The table shows the information for 2019 Star Ratings, effective Jan. 1, 2019. For final evaluation of the Average Star Rating Bonus, UnitedHealthcare will use the most recently published CMS information at the time we calculate your Average Star Rating.

To determine your Quality Rating, we’ll use your HEDIS Compliance Percentage for each MA-PCPI Measure. We’ll then use your Quality Rating for each MA-PCPI Measure to calculate your Average Star Rating. MA-PCPI Measures identified by CMS as having a weight of three will also be assigned a weight of three for calculating your Average Star Rating. We’ll measure your Average Star Rating to the second decimal and not round up or down to the nearest half star. For example, an Average Star Rating of 3.74 will not be rounded up to 4.00.
<table>
<thead>
<tr>
<th>Type</th>
<th>Performance Measure</th>
<th>Performance Measure Description</th>
<th>Num</th>
<th>Den</th>
<th>Score</th>
<th>60TH%</th>
<th>60th needed</th>
<th>75TH%</th>
<th>75th needed</th>
<th>90TH%</th>
<th>90th needed</th>
<th>Base Points</th>
<th>60th Weight</th>
<th>75th Weight</th>
<th>90th Weight</th>
<th>Weighted Total</th>
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<tbody>
<tr>
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<td>ABA</td>
<td>Adult BMI Assessment</td>
<td>78</td>
<td>138</td>
<td>56.52%</td>
<td>88.36%</td>
<td>44</td>
<td>90.48%</td>
<td>47</td>
<td>93.66%</td>
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<td>0.75</td>
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<tr>
<td>Family Practice</td>
<td>BCS</td>
<td>Breast cancer screening</td>
<td>13</td>
<td>20</td>
<td>65.00%</td>
<td>62.26%</td>
<td>(1)</td>
<td>66.52%</td>
<td>0</td>
<td>70.29%</td>
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<td>1</td>
<td>0.23</td>
<td>0.50</td>
<td>0.75</td>
<td>0.25</td>
</tr>
<tr>
<td>Family Practice</td>
<td>CAP, 12-19 years</td>
<td>Children’s Access to Primary Care – Members 12 to 19 Years of Age</td>
<td>36</td>
<td>43</td>
<td>83.72%</td>
<td>90.96%</td>
<td>3</td>
<td>92.40%</td>
<td>4</td>
<td>94.72%</td>
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<td>1.50</td>
<td>3.00</td>
<td>4.50</td>
<td>0.75</td>
</tr>
<tr>
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<td>CAP, 12-24 months</td>
<td>Children’s Access to Primary Care – Members 12 to 24 Months of Age</td>
<td>10</td>
<td>10</td>
<td>100.00%</td>
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<td>97.09%</td>
<td>(0)</td>
<td>97.89%</td>
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<td>3</td>
<td>0.25</td>
<td>0.50</td>
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<td>0.75</td>
</tr>
<tr>
<td>Family Practice</td>
<td>CAP, 25 months-6 years</td>
<td>Children’s Access to Primary Care – Members 2 to 6 Years of Age</td>
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<td>31</td>
<td>88.87%</td>
<td>89.32%</td>
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<tr>
<td>Family Practice</td>
<td>CAP, 7-11 years</td>
<td>Children’s Access to Primary Care – Members 7 to 11 Years of Age</td>
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<td>92.14%</td>
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<td>1</td>
<td>96.09%</td>
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<tr>
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<td>Comprehensive diabetes care -Hba1c good control (&lt;8.0%)</td>
<td>12</td>
<td>36</td>
<td>33.33%</td>
<td>51.26%</td>
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<td>53.65%</td>
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<tr>
<td>Family Practice</td>
<td>CDC, Eye Exam</td>
<td>Comprehensive diabetes care -Eye exam</td>
<td>22</td>
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<td>59.22%</td>
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## Community Care Plan (CCP) - BHPG

### BROWARD HEALTH PHYSICIAN GROUP

**YTD HEDIS Report Card**

- **BHPG Specific**

**Report For January, 2019**

*Individual members may differ from the eligibility tab.*

<table>
<thead>
<tr>
<th>Type</th>
<th>Performance Measure</th>
<th>Performance Measure Description</th>
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<td>0.25</td>
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<tr>
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<td>BCS</td>
<td>Breast cancer screening</td>
<td>13</td>
<td>20</td>
<td>65.00%</td>
<td>62.26%</td>
<td>(1)</td>
<td>65.52%</td>
<td>0</td>
<td>70.29%</td>
<td>1</td>
<td>1</td>
<td>0.25</td>
<td>0.50</td>
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<td>96.40%</td>
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<td>97.09%</td>
<td>(0)</td>
<td>97.89%</td>
<td>(0)</td>
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<td>90.76%</td>
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<td>93.16%</td>
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<td>92.14%</td>
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<td>96.09%</td>
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<td>2.00</td>
<td>3.00</td>
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<td>CDC, A1c &lt;8% Good Control</td>
<td>Comprehensive diabetes care -HbA1c good control (&lt;8.0%)</td>
<td>12</td>
<td>36</td>
<td>33.33%</td>
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<td>6</td>
<td>53.65%</td>
<td>7</td>
<td>59.12%</td>
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<td>Comprehensive diabetes care -Eye exam</td>
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<td>36</td>
<td>61.11%</td>
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**Sub-Total**

- **GOLD** 61-90

- **SILVER** 31-60

- **BRONZE** 16-30
## OPTUM 2019 COMPREHENSIVE (RISK) GAP ASSESSMENT INCENTIVE PROGRAM (AETNA MEDICARE ADVANTAGE)

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<td>Administrative reimbursement</td>
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<td>Maximum potential reimbursement</td>
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<tr>
<td>Amount – Late (Assessments returned after 60 days of DOS)</td>
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<td>CGAP reimbursement</td>
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### Dates to remember

- Date of service: 2019 calendar year
- Submission Deadline: 1/31/2020
- Rejection submission deadline: 3/2020

### Broward Health Physician Group

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<th>Client</th>
<th>Net Deployed</th>
<th>Returned</th>
<th>In process</th>
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<tr>
<td>Aetna</td>
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<tr>
<td>Centene (AllWell)</td>
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<td>Coventry</td>
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# HUMANA MEDICARE HMO ENTERPRISE 2019 FINAL

## HEDIS PERFORMANCE YEAR 2019

**FLORIDA MEDICARE HMO PROVIDER PERFORMANCE REPORT**

Data includes claims/encounters processed through Part C: 1/31/2020, Part D: 12/31/2019, MTM: 12/31/2019 and membership through December/2019, who met specific measure denominator criteria, and thresholds for BY2022.

**Release Date:** March/2020  
**Membership Run Period:** 202003

### Market: South FL  Size: Medium  Grouper: NORTH BROWARD HOSPITAL

<table>
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<tr>
<th>Measure</th>
<th>Eligible</th>
<th>Passes</th>
<th>Gaps</th>
<th>Rate</th>
<th>HUM</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Adult Access to Primary Care</td>
<td>435</td>
<td>416</td>
<td>19</td>
<td>95.63%</td>
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<td>0</td>
</tr>
<tr>
<td>Adult DMI Assessment</td>
<td>103</td>
<td>101</td>
<td>2</td>
<td>92.11%</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Anti-rheumatic drug for RA</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>85.71%</td>
<td>4</td>
<td>1</td>
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<td>75</td>
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<td>Colorectal Cancer Screening</td>
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<td>85.11%</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes Care - Eye Exam</td>
<td>47</td>
<td>38</td>
<td>9</td>
<td>80.85%</td>
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### HUM Weighted Average

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<tr>
<td>Hum</td>
<td>3.60</td>
<td>3.62</td>
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### Status

- Hum | 3.60 | 3.62 | 3.59 | **

### Current Month

<table>
<thead>
<tr>
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<th>Eligible</th>
<th>Passes</th>
<th>Gaps</th>
<th>Rate</th>
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<td>1</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>89</td>
<td>75</td>
<td>14</td>
<td>82.02%</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>COA - Functional Status Assessment</td>
<td>25</td>
<td>20</td>
<td>5</td>
<td>80.00%</td>
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</tr>
<tr>
<td>COA - Medication Review</td>
<td>25</td>
<td>24</td>
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<td>96.00%</td>
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<td>1</td>
</tr>
<tr>
<td>COA - Pain Screening</td>
<td>25</td>
<td>23</td>
<td>2</td>
<td>92.00%</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>173</td>
<td>132</td>
<td>41</td>
<td>76.30%</td>
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<td>1</td>
</tr>
<tr>
<td>Completion Rate for Comprehensive Medication Review</td>
<td>28</td>
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<td>6</td>
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</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>173</td>
<td>137</td>
<td>41</td>
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<td>1</td>
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<td>Depression Screening</td>
<td>502</td>
<td>453</td>
<td>49</td>
<td>80.24%</td>
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<td>Diabetes Care - Blood Sugar Controlled</td>
<td>47</td>
<td>40</td>
<td>7</td>
<td>85.11%</td>
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<td>5</td>
</tr>
<tr>
<td>Diabetes Care - Eye Exam</td>
<td>47</td>
<td>38</td>
<td>9</td>
<td>80.85%</td>
<td>4</td>
<td>1</td>
</tr>
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<td>Diabetes Care - HbA1c Testing</td>
<td>47</td>
<td>43</td>
<td>2</td>
<td>95.74%</td>
<td>2</td>
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</table>

### HUM Max Store

<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Hum</td>
<td>94.97%</td>
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<td>95.99%</td>
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### Prev. Month

<table>
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<tr>
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<th>Rate</th>
<th>HUM</th>
<th>Rate</th>
<th>HUM</th>
</tr>
</thead>
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<td>Hum</td>
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<td>N/A</td>
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### Prev. Year Final

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<tr>
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<th>HUM</th>
<th>Rate</th>
<th>HUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hum</td>
<td>4</td>
<td>N/A</td>
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<td>N/A</td>
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</tbody>
</table>
2019 HUMANA MEDICARE ENTERPRISE HMO

HEDIS PERFORMANCE YEAR 2019
FLORIDA MEDICARE HMO PROVIDER PERFORMANCE REPORT


Membership: 548 Mbrs
Size: 324 Medium
Grouper: NORTH BROWARD HOSPITAL
Mbr W/Gaps: 222
Percentile: 11
Rate: 82.94%

HUM Weighted Average

<table>
<thead>
<tr>
<th>Measure</th>
<th>Eligible</th>
<th>Passes</th>
<th>Gaps</th>
<th>Rate</th>
<th>HUM Weight</th>
<th>Gaps</th>
<th>% Score</th>
<th>Measure Avg**</th>
<th>Prev. Mnth</th>
<th>Prev. Year Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Care - Monitoring Diabetic Nephropathy</td>
<td>47</td>
<td>45</td>
<td>2</td>
<td>95.74%</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>90%</td>
<td>95.74%</td>
<td>4</td>
</tr>
<tr>
<td>Medication Adherence - ACE/ARB</td>
<td>212</td>
<td>183</td>
<td>29</td>
<td>86.32%</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>86%</td>
<td>86.32%</td>
<td>4</td>
</tr>
<tr>
<td>Medication Adherence - Diabetes</td>
<td>63</td>
<td>56</td>
<td>7</td>
<td>88.10%</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>87%</td>
<td>88.10%</td>
<td>5</td>
</tr>
<tr>
<td>Medication Adherence - STATINS</td>
<td>227</td>
<td>185</td>
<td>41</td>
<td>81.64%</td>
<td>3</td>
<td>3</td>
<td>14</td>
<td>88%</td>
<td>81.94%</td>
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</tr>
<tr>
<td>Medication Reconciliation Post Discharge</td>
<td>57</td>
<td>27</td>
<td>30</td>
<td>47.37%</td>
<td>2</td>
<td>1</td>
<td>20</td>
<td>81%</td>
<td>47.37%</td>
<td>2</td>
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<tr>
<td>Osteoporosis Management 2020</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>33.33%</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>78%</td>
<td>33.33%</td>
<td>2</td>
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<tr>
<td>Plan All-Cause No Readmissions</td>
<td>55</td>
<td>42</td>
<td>13</td>
<td>70.30%</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td>92%</td>
<td>70.30%</td>
<td>1</td>
</tr>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease</td>
<td>11</td>
<td>9</td>
<td>2</td>
<td>81.82%</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>87%</td>
<td>81.82%</td>
<td>4</td>
</tr>
<tr>
<td>Statin Use in Persons with Diabetes</td>
<td>55</td>
<td>47</td>
<td>8</td>
<td>85.08%</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>85%</td>
<td>85.08%</td>
<td>3</td>
</tr>
</tbody>
</table>

TOTALS | 2,524 | 2,190 | 334

Groups with similar HMO Humana mbrs in South FL is ranked 51 out of 57
Groups with similar HMO Humana mbrs in Florida is ranked 59 out of 73
The following data shows metrics for HEDIS measures that indicate a potential care opportunity. Metrics include assigned and/or attributed Medicare Advantage members specific to the MA-PCP Program, which are not included in the MBR ACO Program.

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Eligible Members</th>
<th>Compliant Members</th>
<th>Non-Compliant Members</th>
<th>Current Rate</th>
<th>4 STAR Threshold % Target</th>
<th># of Members to Achieve 4 STAR</th>
<th>5 STAR Threshold % Target</th>
<th># of Members to Achieve 5 STAR</th>
<th>Quality Rating</th>
<th>CMS Weight</th>
<th>CMS Weighted Quality Rating</th>
<th>4 STAR Predictive Threshold %</th>
<th>5 STAR Predictive Threshold %</th>
</tr>
</thead>
<tbody>
<tr>
<td>C01 Breast Cancer Screening</td>
<td>51</td>
<td>70</td>
<td>21</td>
<td>77%</td>
<td>≥76.0%</td>
<td>0</td>
<td>≥83.0%</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>≥77.0%</td>
<td>≥82.0%</td>
</tr>
<tr>
<td>C02 Colorectal Cancer Screening</td>
<td>139</td>
<td>147</td>
<td>42</td>
<td>78%</td>
<td>≥73.0%</td>
<td>0</td>
<td>≥80.0%</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>≥76.0%</td>
<td>≥83.0%</td>
</tr>
<tr>
<td>C07 Adult Epi Assessment</td>
<td>201</td>
<td>182</td>
<td>19</td>
<td>51%</td>
<td>≥86.0%</td>
<td>11</td>
<td>≥99.0%</td>
<td>17</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>≥95.0%</td>
<td>≥98.0%</td>
</tr>
<tr>
<td>C13 Diabetes Care - Eye Exam</td>
<td>58</td>
<td>46</td>
<td>12</td>
<td>79%</td>
<td>≥73.0%</td>
<td>0</td>
<td>≥80.0%</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>≥75.0%</td>
<td>≥83.0%</td>
</tr>
<tr>
<td>C14 Diabetes Care - Kidney Disease Monitoring</td>
<td>50</td>
<td>55</td>
<td>3</td>
<td>95%</td>
<td>≥95.0%</td>
<td>0</td>
<td>≥95.0%</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>≥90.0%</td>
<td>≥98.0%</td>
</tr>
<tr>
<td>C15 Diabetes Care - Blood Sugar Controlled</td>
<td>58</td>
<td>44</td>
<td>14</td>
<td>76%</td>
<td>≥72.0%</td>
<td>0</td>
<td>≥85.0%</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>≥75.0%</td>
<td>≥85.0%</td>
</tr>
<tr>
<td>D01 Medication Adherence for Diabetes Medications</td>
<td>52</td>
<td>46</td>
<td>6</td>
<td>82%</td>
<td>≥82.0%</td>
<td>0</td>
<td>≥85.0%</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>≥85.0%</td>
<td>≥88.0%</td>
</tr>
<tr>
<td>D11 Medication Adherence for Hypertension (RAAS) Antagonists</td>
<td>164</td>
<td>137</td>
<td>27</td>
<td>84%</td>
<td>≥86.0%</td>
<td>4</td>
<td>≥88.0%</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>≥88.0%</td>
<td>≥90.0%</td>
</tr>
<tr>
<td>D12 Medication Adherence for Cholesterol (Statins)</td>
<td>123</td>
<td>150</td>
<td>33</td>
<td>82%</td>
<td>≥84.0%</td>
<td>4</td>
<td>≥87.0%</td>
<td>13</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>≥85.0%</td>
<td>≥90.0%</td>
</tr>
<tr>
<td>D14 Statin Use in Persons w/ Diabetes</td>
<td>53</td>
<td>53</td>
<td>0</td>
<td>98%</td>
<td>≥91.0%</td>
<td>0</td>
<td>≥83.0%</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>≥82.0%</td>
<td>≥86.0%</td>
</tr>
<tr>
<td>C22 Sarcoid Therapy for Patients w/ Cardiovascular Disease</td>
<td>15</td>
<td>17</td>
<td>2</td>
<td>85%</td>
<td>≥83.0%</td>
<td>0</td>
<td>≥87.0%</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>≥85.0%</td>
<td>≥88.0%</td>
</tr>
</tbody>
</table>

Total 19  74

Current Year Average Star Rating: 3.89
Prior Year Final Average Star Rating: 3.6
Average Star Rating Year over Year: 0.29
# UNITED 2019 MEDICARE QUALITY OUTCOMES

## Quality Care Incentive Measures

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Eligible Members*</th>
<th>Compliant Members*</th>
<th>Non-Compliant Members*</th>
<th>Current Rate</th>
<th>4 STAR Threshold % Target</th>
<th>5 STAR Threshold % Target</th>
<th># of Members to Achieve 4 STAR</th>
<th># of Members to Achieve 5 STAR</th>
<th>Quality Rating</th>
<th>MA-PCPI Weight</th>
<th>MA-PCPI Weighted Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2: Osteoporosis Management in Women who had a Fracture</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>50%</td>
<td>≥50.0%</td>
<td>≥67.0%</td>
<td>1</td>
<td>4</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C7: Rheumatoid Arthritis Management</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>57%</td>
<td>≥73.0%</td>
<td>≥84.0%</td>
<td>2</td>
<td>1</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C20: Medication Reconciliation Post Discharge</td>
<td>57</td>
<td>8</td>
<td>43</td>
<td>14%</td>
<td>≥71.0%</td>
<td>≥86.0%</td>
<td>33</td>
<td>40</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**MA-PCPI Measures and Thresholds**
The information in this table is subject to change from time to time at CMS’ discretion. The table shows the information for 2018 Star Ratings, effective Jan. 1, 2018. For final evaluation of the Average Star Rating Bonus, UnitedHealthcare will use the most recently published CMS information at the time we calculate your Average Star Rating.

To determine your Quality Rating, we’ll use your HEDIS Compliance Percentage for each MA-PCPI Measure. We’ll then use your Quality Rating for each MA-PCPI Measure to calculate your Average Star Rating. MA-PCPI Measures identified by CMS as having a weight of three will also be assigned a weight of three for calculating your Average Star Rating. We’ll measure your Average Star Rating to the second decimal and not round up or down to the nearest half star. For example, an Average Star Rating of 3.74 will not be rounded up to 4.00.

**Please be aware:**
- These rates are based on criteria that’s meant to be actionable in a prospective outreach program.
- Figures are directional and will not match actual HEDIS measures.
- These screenings are recommendations based on previously reported risk factors and/or co-morbid conditions and may have already been performed.

**Medication Adherence Measures**
For Part D medication adherence measures MAD, MAH, and MAC, the Current Rates shown are the current adherence rates for relevant plan members. The 4- and 5-STAR Threshold % Target amounts are compliance targets for the current month. We use the current adherence rates and current month’s compliance targets to determine your Quality Ratings and Number of Members to Achieve Thresholds. These numbers will help you see how you’re tracking toward your year-end threshold.

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Doc #: PCA-433096-016000/18_024268/8

**Broward Health**
## HEDIS 2020 Reporting Year

### Administrative Results Only - Vendor Performance

**Part-C Data Processed From 1/1/2019 - 12/31/2019**

**Part-D Data Processed From 1/1/2019 - 2/16/2020**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Weight</th>
<th>Eligible</th>
<th>Pass</th>
<th>Gap</th>
<th>Rate%</th>
<th>Star</th>
<th>Minimum Passes to Next Star</th>
<th>Star Minimum Threshold %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 Star</td>
<td>3 Star</td>
</tr>
<tr>
<td>Adult Body Mass Index (BMI) Assessment</td>
<td>1</td>
<td>76.0</td>
<td>62.0</td>
<td>14.0</td>
<td>82.0%</td>
<td>2</td>
<td>4.0</td>
<td>11.0</td>
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<tr>
<td>DMARD for Rheumatoid Arthritis</td>
<td>1</td>
<td>2.0</td>
<td>2.0</td>
<td>0.0</td>
<td>100.0%</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>1</td>
<td>26.0</td>
<td>20.0</td>
<td>6.0</td>
<td>77.0%</td>
<td>3</td>
<td>1.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td>3</td>
<td>10.0</td>
<td>12.0</td>
<td>90.0</td>
<td>12.0%</td>
<td>1</td>
<td>43.0</td>
<td>54.0</td>
</tr>
<tr>
<td>Diabetes Management - Eye Exam</td>
<td>1</td>
<td>30.0</td>
<td>27.0</td>
<td>11.0</td>
<td>71.0%</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Management - HbA1c &gt; 9% (Poor Control)*</td>
<td>3</td>
<td>30.0</td>
<td>27.0</td>
<td>11.0</td>
<td>25.0%</td>
<td>1</td>
<td>-2.0</td>
<td>-4.0</td>
</tr>
<tr>
<td>Diabetes Management - HbA1c Test Completed**</td>
<td>1</td>
<td>30.0</td>
<td>33.0</td>
<td>5.0</td>
<td>87.0%</td>
<td>2</td>
<td>2.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Diabetes Management - Attention to Nephropathy</td>
<td>1</td>
<td>30.0</td>
<td>36.0</td>
<td>2.0</td>
<td>96.0%</td>
<td>3</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Care in Older Adults - Advance Care Planning**</td>
<td>0</td>
<td>52.0</td>
<td>8.0</td>
<td>44.0</td>
<td>15.0%</td>
<td>5</td>
<td>30.0</td>
<td>37.0</td>
</tr>
<tr>
<td>Care in Older Adults - Functional Status Assessment</td>
<td>1</td>
<td>52.0</td>
<td>27.0</td>
<td>25.0</td>
<td>52.0%</td>
<td>2</td>
<td>11.0</td>
<td>17.0</td>
</tr>
<tr>
<td>Care in Older Adults - Medication Review</td>
<td>1</td>
<td>52.0</td>
<td>17.0</td>
<td>35.0</td>
<td>33.0%</td>
<td>1</td>
<td>17.0</td>
<td>27.0</td>
</tr>
<tr>
<td>Care in Older Adults - Pain Screening</td>
<td>1</td>
<td>52.0</td>
<td>23.0</td>
<td>29.0</td>
<td>44.0%</td>
<td>1</td>
<td>5.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>1</td>
<td>70.0</td>
<td>54.0</td>
<td>16.0</td>
<td>77.0%</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Reconciliation Post Discharge</td>
<td>1</td>
<td>60.0</td>
<td>13.0</td>
<td>47.0</td>
<td>21.0%</td>
<td>1</td>
<td>11.0</td>
<td>21.0</td>
</tr>
<tr>
<td>Pain All-Cause Readmissions*</td>
<td>3</td>
<td>23.0</td>
<td>21.0</td>
<td>2.0</td>
<td>94.0%</td>
<td>4</td>
<td>-1.0</td>
<td></td>
</tr>
<tr>
<td>Statin Therapy for Cardiovascular disease - No Statin</td>
<td>1</td>
<td>3.0</td>
<td>3.0</td>
<td>0.0</td>
<td>100.0%</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-D - Medication Adherence - Cholesterol (Total)</td>
<td>3</td>
<td>116.0</td>
<td>95.5</td>
<td>21.4</td>
<td>62.0%</td>
<td>3</td>
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<td></td>
</tr>
<tr>
<td>Part-D - Medication Adherence - Diabetes</td>
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<td>39.0</td>
<td>27.3</td>
<td>11.6</td>
<td>70.0%</td>
<td>1</td>
<td>1.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Part-D - Medication Adherence - Hypertension (RAS)</td>
<td>3</td>
<td>126.1</td>
<td>96.3</td>
<td>29.8</td>
<td>76.0%</td>
<td>1</td>
<td>3.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Part-D - Statin Use in Persons with Diabetes</td>
<td>1</td>
<td>55.2</td>
<td>49.7</td>
<td>5.5</td>
<td>90.0%</td>
<td>5</td>
<td></td>
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</tr>
</tbody>
</table>

**Total Star Eligible Measures: 19**

**2.30 Weighted Average Star Rating**

---

*Inverse Measure - Lower Rate is Better - Rate represents % of Gaps
PartD Measures are based upon members years and not individual members
** Display Measure - Star Values Calculated Using NCQA® Percentiles as a base

NOTE: There are additional measures included above that are not STAR measures. These measures are NOT included in the weighted average. These can be identified by their blank values for the "Weight."
## 2019 MEDICA FINAL PART D

### STARS Scorecard

**NORTH BROWARD HSPTL DIST**  
MSO: NORTH BROWARD HSPTL DIST INC

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Eligible Population</th>
<th>Compliant Population</th>
<th>% Compliant</th>
<th>Stars</th>
<th>Population Needed</th>
<th>Goal</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part D (PQA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statin Use in Persons with Diabetes (SUPD)</td>
<td>3</td>
<td>2</td>
<td>66.67 %</td>
<td>*</td>
<td>1</td>
<td>83.00 %</td>
<td>1</td>
</tr>
<tr>
<td><strong>Medication Adherence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol (Statins) (MAC)</td>
<td>12</td>
<td>9</td>
<td>75.00 %</td>
<td>**</td>
<td>2</td>
<td>87.00 %</td>
<td>3</td>
</tr>
<tr>
<td>Diabetes Medication (MAD)</td>
<td>5</td>
<td>4</td>
<td>80.00 %</td>
<td>***</td>
<td>1</td>
<td>85.00 %</td>
<td>3</td>
</tr>
<tr>
<td>Hypertension (ACEI &amp; ARB) (MAH)</td>
<td>12</td>
<td>11</td>
<td>91.67 %</td>
<td>*****</td>
<td>-1</td>
<td>88.00 %</td>
<td>3</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>0.00 %</td>
<td>5</td>
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</tbody>
</table>

**Average Star Rating Part D** 3.73
## 2019 MEDICA FINAL PART C

### Part C (HEDIS, NCQA)

<table>
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<th>Service</th>
<th>Completed</th>
<th>Total</th>
<th>Percentage</th>
<th>STAR</th>
<th>Average STAR Rating</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment (ABA)</td>
<td>12</td>
<td>11</td>
<td>91.67 %</td>
<td>**</td>
<td>1</td>
<td>99.00 %</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>6</td>
<td>5</td>
<td>83.33 %</td>
<td>*****</td>
<td>-1</td>
<td>83.00 %</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>10</td>
<td>9</td>
<td>90.00 %</td>
<td>*****</td>
<td>-1</td>
<td>80.00 %</td>
</tr>
<tr>
<td>Medication Reconciliation Post Discharge (MRP)</td>
<td>5</td>
<td>0</td>
<td>0 %</td>
<td>*</td>
<td>5</td>
<td>84.00 %</td>
</tr>
<tr>
<td>Osteoporosis Management In Women - 2019 (OMW)</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Rheumatoid Arthritis Management (ART)</td>
<td>1</td>
<td>1</td>
<td>100 %</td>
<td>*****</td>
<td>0</td>
<td>84.00 %</td>
</tr>
<tr>
<td>Statin Therapy for Patients With Cardiovascular Disease (SPC)</td>
<td>1</td>
<td>0</td>
<td>0 %</td>
<td>*</td>
<td>1</td>
<td>87.00 %</td>
</tr>
</tbody>
</table>

#### Care For Older Adults (COA)

<table>
<thead>
<tr>
<th>Service</th>
<th>Completed</th>
<th>Total</th>
<th>Percentage</th>
<th>STAR</th>
<th>Average STAR Rating</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Status Assessment</td>
<td>12</td>
<td>8</td>
<td>66.67 %</td>
<td>**</td>
<td>4</td>
<td>93.00 %</td>
</tr>
<tr>
<td>Medication Review</td>
<td>12</td>
<td>9</td>
<td>75.00 %</td>
<td>**</td>
<td>3</td>
<td>95.00 %</td>
</tr>
<tr>
<td>Pain Screening</td>
<td>12</td>
<td>8</td>
<td>66.67 %</td>
<td>**</td>
<td>4</td>
<td>94.00 %</td>
</tr>
</tbody>
</table>

#### Comprehensive Diabetes Care (CDC)

<table>
<thead>
<tr>
<th>Service</th>
<th>Completed</th>
<th>Total</th>
<th>Percentage</th>
<th>STAR</th>
<th>Average STAR Rating</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Sugar Controlled</td>
<td>3</td>
<td>0</td>
<td>0 %</td>
<td>*</td>
<td>3</td>
<td>85.00 %</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>3</td>
<td>1</td>
<td>33.33 %</td>
<td>*</td>
<td>2</td>
<td>78.00 %</td>
</tr>
<tr>
<td>Kidney Disease Monitoring</td>
<td>3</td>
<td>2</td>
<td>66.67 %</td>
<td>*</td>
<td>1</td>
<td>97.00 %</td>
</tr>
</tbody>
</table>

**Quality Improvement**

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>---</th>
<th>---</th>
<th>---</th>
<th>---</th>
<th>---</th>
<th>---</th>
</tr>
</thead>
</table>

**Average Star Rating Part C 2.37**
# 2019 MEDICA FINAL PART C & D FINAL STAR SCORE

## TOTAL PART C & D

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Average Star Rating</td>
<td>2.97</td>
</tr>
<tr>
<td># of Eligible Measures:</td>
<td>16</td>
</tr>
<tr>
<td>Member Months:</td>
<td>349</td>
</tr>
<tr>
<td>Current Membership:</td>
<td>33</td>
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</tbody>
</table>

## Stars

<table>
<thead>
<tr>
<th>Bonus</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0.00</td>
<td>3.75</td>
</tr>
<tr>
<td>Partial</td>
<td>3.76</td>
<td>4.49</td>
</tr>
<tr>
<td>Full</td>
<td>4.50</td>
<td>5.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MCAIP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0%</td>
</tr>
<tr>
<td>Eligible</td>
<td>75%</td>
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</tbody>
</table>

**STARS Network Rep:** <No Filter>  
**STARS Outbound Rep:** <No Filter>

Collection Period Through 12/31/2019
## STARS Scorecard

### NORTH BROWARD HSPTL DIST

**MSO:** NORTH BROWARD HSPTL DIST INC

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Eligible Population</th>
<th>Compliant Population</th>
<th>% Compliant</th>
<th>Stars</th>
<th>Population Needed</th>
<th>Goal</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part D (PQA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statin Use in Persons with Diabetes (SUPD)</td>
<td>154</td>
<td>122</td>
<td>79.22 %</td>
<td>***</td>
<td>6</td>
<td>83.00 %</td>
<td>1</td>
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<tr>
<td><strong>Medication Adherence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol (Statins) (MAC)</td>
<td>321</td>
<td>254</td>
<td>79.13 %</td>
<td>**</td>
<td>26</td>
<td>87.00 %</td>
<td>3</td>
</tr>
<tr>
<td>Diabetes Medication (MAD)</td>
<td>137</td>
<td>115</td>
<td>83.94 %</td>
<td>****</td>
<td>2</td>
<td>85.00 %</td>
<td>3</td>
</tr>
<tr>
<td>Hypertension (ACEI &amp; ARB) (MAH)</td>
<td>332</td>
<td>281</td>
<td>84.64 %</td>
<td>***</td>
<td>12</td>
<td>88.00 %</td>
<td>3</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>6.00 %</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>944</td>
<td>772</td>
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**Average Star Rating Part D:** 3.00
## 2019 PREFERRED CARE PARTNERS  FINAL PART C

<table>
<thead>
<tr>
<th>Part C (HEDIS, NCQA)</th>
<th>Count</th>
<th>Count</th>
<th>%</th>
<th>Rating</th>
<th>Count</th>
<th>Rating</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment (ABA)</td>
<td>342</td>
<td>331</td>
<td>96.78 %</td>
<td>****</td>
<td>8</td>
<td>99.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>137</td>
<td>117</td>
<td>85.40 %</td>
<td>*****</td>
<td>-4</td>
<td>83.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>332</td>
<td>259</td>
<td>78.01 %</td>
<td>****</td>
<td>7</td>
<td>80.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Medication Reconciliation Post Discharge (MRP)</td>
<td>94</td>
<td>51</td>
<td>54.26 %</td>
<td>**</td>
<td>28</td>
<td>84.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Osteoporosis Management In Women - 2019 (OMW)</td>
<td>7</td>
<td>4</td>
<td>57.14 %</td>
<td>****</td>
<td>1</td>
<td>67.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Rheumatoid Arthritis Management (ART)</td>
<td>12</td>
<td>9</td>
<td>75.00 %</td>
<td>***</td>
<td>2</td>
<td>84.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Statin Therapy for Patients With Cardiovascular Disease (SPC)</td>
<td>30</td>
<td>25</td>
<td>83.33 %</td>
<td>****</td>
<td>2</td>
<td>87.00 %</td>
<td>1</td>
</tr>
<tr>
<td><strong>Care For Older Adults (COA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional Status Assessment</td>
<td>112</td>
<td>83</td>
<td>74.11 %</td>
<td>***</td>
<td>22</td>
<td>93.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Medication Review</td>
<td>112</td>
<td>84</td>
<td>75.00 %</td>
<td>**</td>
<td>23</td>
<td>95.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Pain Screening</td>
<td>112</td>
<td>78</td>
<td>69.64 %</td>
<td>**</td>
<td>28</td>
<td>94.00 %</td>
<td>1</td>
</tr>
<tr>
<td><strong>Comprehensive Diabetes Care (CDC)</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Sugar Controlled</td>
<td>148</td>
<td>116</td>
<td>78.38 %</td>
<td>****</td>
<td>10</td>
<td>85.00 %</td>
<td>3</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>148</td>
<td>126</td>
<td>85.14 %</td>
<td>*****</td>
<td>-11</td>
<td>78.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Kidney Disease Monitoring</td>
<td>148</td>
<td>145</td>
<td>97.97 %</td>
<td>****</td>
<td>-2</td>
<td>97.00 %</td>
<td>1</td>
</tr>
<tr>
<td>Quality Improvement</td>
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<td>4.00 %</td>
<td>5</td>
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<tr>
<td><strong>Total</strong></td>
<td>1,734</td>
<td>1,428</td>
<td>Average Star Rating Part C</td>
<td>4.00</td>
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</table>
# 2019 Preferred Care Partners Final Part C & D Total Star Score

<table>
<thead>
<tr>
<th>TOTAL PART C &amp; D</th>
<th>Stars</th>
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</thead>
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<td># of Eligible Measures:</td>
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</tr>
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<td>Member Months:</td>
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<tr>
<td>Current Membership:</td>
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<table>
<thead>
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<th>Bonus</th>
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<th>To</th>
</tr>
</thead>
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<tr>
<td>None</td>
<td>0.00</td>
<td>3.75</td>
</tr>
<tr>
<td>Partial</td>
<td>3.76</td>
<td>4.49</td>
</tr>
<tr>
<td>Full</td>
<td>4.50</td>
<td>5.00</td>
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<table>
<thead>
<tr>
<th>MCAIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>Eligible</td>
</tr>
</tbody>
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Collection Period Through 12/31/2019

Group

STARS Network Rep: <No Filter>

STARS Outbound Rep: <No Filter>
2019 ALLWELL – SUNSHINE MEDICARE **FINAL** PART C & D TOTAL STAR SCORE

### 2019 Allwell P4P Scorecard

**TIN # 590012005**  
NORTH BROWARD HOSPITAL DISTRICT

<table>
<thead>
<tr>
<th>Contract</th>
<th>Bonus Eamed (YTD)</th>
</tr>
</thead>
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<td>YTD Earned</td>
<td>$0.00</td>
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<tr>
<td>YTD Paid</td>
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<tr>
<td>Check Amount</td>
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### Performance Metrics

#### TOP 5 MEASURES BY HIGHEST NUMBER OF NON-COMPLIANT

<table>
<thead>
<tr>
<th>Measure</th>
<th>Non-Compliant</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Well Visit GT - Ann Well Visit GT</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Care Older Adults - Func Status</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Care Older Adults - Med Review</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Med Reg Post Dis - Total</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Cont Bp Mcm - Cont Bp Mcm</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Qualified</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Well Visit GT - Ann Well Visit GT</td>
<td>0</td>
<td>22.2%</td>
</tr>
<tr>
<td>Care Older Adults - Func Status</td>
<td>6</td>
<td>18.7%</td>
</tr>
<tr>
<td>Care Older Adults - Med Review</td>
<td>6</td>
<td>33.33%</td>
</tr>
<tr>
<td>Med Reg Post Dis - Total</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cont Bp Mcm - Cont Bp Mcm</td>
<td>4</td>
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### POTENTIAL BONUS

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<tr>
<td>$0.00</td>
<td>$1,230.00</td>
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NORTH BROWARD HOSPITAL DISTRICT

---

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# 2019 ALLWELL – SUNSHINE MEDICARE **F**INAL **P**ART **C** & **D**

**TOTAL STAR SCORE**

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Compliant Count</th>
<th>Qualified Count</th>
<th>Measure Score</th>
<th>3 STAR</th>
<th>4 STAR</th>
<th>5 STAR</th>
<th>Weight</th>
<th>Measure STAR Score</th>
<th>Weighted STAR Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE OLDER ADULTS - MED REVIEW</td>
<td>2</td>
<td>6</td>
<td>33.33%</td>
<td>84.00%</td>
<td>83.00%</td>
<td>62.00%</td>
<td>3.02%</td>
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<td>0</td>
</tr>
<tr>
<td>CARE OLDER ADULTS - PAIN ASSESS</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>73.00%</td>
<td>86.00%</td>
<td>67.00%</td>
<td>0.00%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MED REG POST DIS - TOTAL</td>
<td>0</td>
<td>2</td>
<td>0.00%</td>
<td>54.00%</td>
<td>86.00%</td>
<td>79.00%</td>
<td>7.84%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CARE OLDER ADULTS - PUNG STATUS</td>
<td>1</td>
<td>0</td>
<td>15.57%</td>
<td>69.00%</td>
<td>77.00%</td>
<td>90.00%</td>
<td>1.95%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BREAST CANCER - NON-MCR TOTAL</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>65.00%</td>
<td>70.00%</td>
<td>82.00%</td>
<td>0.00%</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>63.00%</td>
<td>72.00%</td>
<td>79.00%</td>
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<td>65.00%</td>
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<td>67.00%</td>
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<td>64.00%</td>
<td>72.00%</td>
<td>60.00%</td>
<td>7.84%</td>
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<td>60.00%</td>
<td>62.00%</td>
<td>75.00%</td>
<td>62.00%</td>
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<td>95.00%</td>
<td>67.00%</td>
<td>7.84%</td>
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<td>0</td>
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<td>76.00%</td>
<td>81.00%</td>
<td>85.00%</td>
<td>0.00%</td>
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<tr>
<td>STATIN THERA DIAB - MCR STATIN THERAPY</td>
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<td>76.00%</td>
<td>80.00%</td>
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7. 3 POPULATION HEALTH UPDATE
ACCOUNTABLE CARE ORGANIZATION
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<tr>
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<td>70.3%</td>
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<td>75.0%</td>
<td>71.4%</td>
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<td>72.1%</td>
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<td>78.7%</td>
<td>71.2%</td>
<td>72.9%</td>
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<tr>
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<td>88.7%</td>
<td>88.9%</td>
<td>88.0%</td>
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<td>78.9%</td>
<td>86.6%</td>
<td>79.2%</td>
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<td>73.4%</td>
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<tr>
<td>Pediatric - Well Child (15 mos)</td>
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<td>80.6%</td>
<td>83.8%</td>
<td>95.0%</td>
<td>88.0%</td>
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<td>40.0%</td>
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<td>25.7%</td>
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<td>36.1%</td>
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<td>69.4%</td>
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<td>Imaging for Low Back Pain</td>
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<td>77.2%</td>
<td>72.9%</td>
<td>67.7%</td>
<td>68.8%</td>
<td>73.5%</td>
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<tr>
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<td>78.8%</td>
<td>81.6%</td>
<td>82.2%</td>
<td>80.6%</td>
<td>82.5%</td>
<td>81.7%</td>
<td>83.6%</td>
<td>83.8%</td>
<td>84.0%</td>
<td>84.1%</td>
<td>84.9%</td>
<td>85.3%</td>
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<tr>
<td>Chlamydia Screening</td>
<td>48.3%</td>
<td>62.5%</td>
<td>60.9%</td>
<td>58.7%</td>
<td>60.1%</td>
<td>60.6%</td>
<td>55.7%</td>
<td>56.0%</td>
<td>56.2%</td>
<td>55.4%</td>
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<tr>
<td>Generic Dispensing Rate</td>
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<td>79.3%</td>
<td>84.9%</td>
<td>85.7%</td>
<td>85.9%</td>
<td>85.7%</td>
<td>86.3%</td>
<td>87.1%</td>
<td>87.7%</td>
<td>87.8%</td>
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<tr>
<td>ED Utilization - visits per 1000</td>
<td>217</td>
<td>231</td>
<td>197</td>
<td>202</td>
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# Florida Blue Quality Outcomes

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<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>
<th>Feb-20</th>
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<td>Breast Cancer Screening</td>
<td>77.1%</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>
<td>72.5%</td>
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<td>Cervical Cancer Screening</td>
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<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>
<td>75.7%</td>
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<td>91.7%</td>
<td>90.5%</td>
<td>91.9%</td>
<td>90.8%</td>
<td>85.0%</td>
<td>86.9%</td>
<td>88.9%</td>
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<tr>
<td>Diabetes - Nephropathy</td>
<td>89.4%</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>
<td>92.8%</td>
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<tr>
<td>Generic Dispensing Rate</td>
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<td>82.4%</td>
<td>82.0%</td>
<td>83.0%</td>
<td>83.0%</td>
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<td>83.0%</td>
<td>81.6%</td>
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<td>88.9%</td>
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</table>

** Important to note that the Benchmark noted is 2020 standards and has increased since 2018, causing metrics that previously met to appear as though they fall out.  

* As noted in previous QAOC, there was no contract for 2019, which is the reason for gap in data and ability to track progress.
Readmission Rates – All Payer (Crimson)
BHMC
HF
COPD
Pneumonia
AMI
Hip/Knee
CABG

National
21.9%
19.5%
16.6%
16.1%
4.0%
12.7%

LCY-19
21.7%
21.2%
10.9%
8.2%
2.5%
9.4%

Jul-19 Aug-19 Sep-19
30.5% 20.8% 17.4%
11.8% 14.3% 29.2%
14.6% 9.7%
8.6%
13.0% 3.5%
0.0%
0.0%
3.6%
0.0%
5.3%
0.0%
4.6%

Oct-19
22.6%
24.0%
11.8%
6.9%
11.8%
0.0%

Nov-19
17.7%
16.7%
10.0%
2.3%
0.0%
5.0%

Dec-19 2019 n
20.9% 147
14.3%
82
11.3%
56
8.8%
32
0.0%
6
15.0%
33

Jan-20 Feb-20 Mar-20
18.5% 18.8% 18.2%
16.7% 11.5% 6.7%
17.2% 11.0% 14.3%
12.5% 28.0% 7.1%
0.0% 10.5% 0.0%
5.6% 25.0% 8.3%

Apr-20
19.1%
11.1%
18.2%
0.0%
0.0%
0.0%

May-20
19.4%
10.5%
22.2%
6.7%
50.0%
23.1%

Jun-20
11.1%
30.8%
14.3%
13.3%
10.0%
21.1%

2020 2020n
18.5% 48
13.2% 16
15.0% 43
12.3% 14
6.9%
5
13.7% 14

BHN
HF
COPD
Pneumonia
AMI
Hip/Knee

National
21.9%
19.5%
16.6%
16.1%
4.0%

LCY-19
23.1%
20.5%
13.9%
11.8%
2.2%

Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
29.6% 33.3% 33.3% 13.8% 27.0%
24.0% 15.8% 20.8% 21.6% 25.0%
16.1% 15.6% 15.9% 2.9%
7.9%
10.0% 13.3% 5.6%
6.3% 20.0%
2.8%
0.0%
0.0%
3.1%
0.0%

Dec-19 2019 n
16.7%
91
32.3%
72
25.0%
63
8.3%
22
1.7%
17

Jan-20 Feb-20 Mar-20
7.5%
7.4% 14.3%
14.7% 31.0% 23.1%
11.6% 10.2% 6.9%
10.0% 0.0% 18.2%
4.9%
6.9%
1.9%

Apr-20
24.0%
15.8%
25.0%
0.0%
0.0%

May-20 Jun-20 2020 2020n
21.7% 3.6% 11.9% 21
10.0% 20.0% 20.3% 27
16.7% 14.3% 13.0% 40
25.0% 0.0% 10.4% 5
10.0% 6.9% 6.5% 18

BHIP
HF
COPD
Pneumonia
AMI
Hip/Knee

National
21.9%
19.5%
16.6%
16.1%
4.0%

LCY-19
27.7%
16.2%
14.0%
2.7%
2.2%

Jul-19 Aug-19 Sep-19
31.3% 25.0% 27.8%
25.0% 11.8% 7.1%
6.7% 17.4% 12.5%
0.0%
0.0%
0.0%
0.0%
0.0%
0.0%

Oct-19 Nov-19 Dec-19 2019 n
42.9% 27.3% 33.3%
39
36.4% 33.3% 23.5%
29
20.8% 4.6% 13.3%
38
0.0%
0.0% 25.0%
1
7.7%
0.0%
6.7%
18

Jan-20 Feb-20 Mar-20
0.0% 42.9% 16.7%
23.3% 22.2% 25.0%
14.3% 9.1%
7.0%
33.3% 0.0%
0.0%
0.0% 10.0% 0.0%

Apr-20 May-20 Jun-20 2020 2020n
30.0% 16.7% 7.1% 18.5% 12
57.1% 15.4% 33.3% 25.3% 25
10.0% 8.0% 10.5% 10.3% 20
0.0%
0.0%
0.0% 6.7%
1
0.0%
0.0%
0.0% 3.8%
2

BHCS
HF
COPD
Pneumonia
AMI
Hip/Knee

National
21.9%
19.5%
16.6%
16.1%
4.0%

LCY-19
17.1%
21.8%
9.9%
0.0%
4.3%

0.0% 35.3% 16.7% 13.6% 16.7% 25.0%
37
11.8% 47.2% 16.7% 14.3% 13.3% 21.9%
55
0.0% 19.4% 15.2% 5.9%
6.1%
8.8%
48
0.0%
0.0%
0.0%
0.0%
0.0%
0.0%
0
0.0%
0.0%
0.0%
0.0%
0.0%
0.0%
4

Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 2020 2020n
7.1% 20.0% 6.7% 36.4% 7.1%
7.1% 15.0% 17
29.4% 20.7% 5.0%
0.0% 38.5% 8.3% 18.6% 22
12.2% 0.0% 10.1% 12.5% 16.7% 25.0% 10.7% 26
0.0% 33.3% 0.0%
0.0%
0.0%
0.0% 7.7%
1
12.5% 8.3%
0.0%
0.0%
0.0% 25.0% 10.8% 4
41


Readmission Rates – Medicare (Crimson)
BHMC
National LCY-19 Jul-19 Aug-19
HF
21.9% 18.0% 28.6% 12.5%
COPD
19.5% 18.0% 16.7% 0.0%
Pneumonia 16.6% 11.6% 28.6% 12.5%
AMI
16.1% 5.5% 14.3% 0.0%
Hip/Knee
4.0% 0.0% 0.0% 0.0%
CABG
12.7% 8.0% 0.0% 0.0%

Sep-19 Oct-19 Nov-19
8.3% 20.0% 15.0%
25.0% 0.0% 0.0%
0.0% 10.0% 10.0%
0.0% 0.0% 0.0%
0.0% 0.0% 0.0%
0.0% 0.0% 0.0%

BHN
HF
21.9% 26.8% 71.4% 40.0% 45.5% 16.7% 30.0%
COPD
19.5% 19.0% 0.0% 0.0% 20.0% 0.0% 50.0%
Pneumonia 16.6% 14.6% 11.1% 30.0% 7.7% 11.1% 0.0%
AMI
16.1% 16.1% 0.0% 0.0% 25.0% 0.0% 33.3%
Hip/Knee
4.0% 2.6% 0.0% 0.0% 0.0% 4.6% 0.0%

Dec-19 2019n Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 2020 2020n
44.4%
28
22.2% 21.4% 8.3%
0.0%
0.0%
0.0% 17.0%
9
12.5%
16
14.3% 0.0%
8.3%
0.0% 33.3% 0.0% 13.3%
4
14.3%
11
15.4% 21.4% 25.0% 20.0% 0.0% 20.0% 20.4% 11
0.0%
5
12.5% 20.0% 0.0%
0.0%
0.0%
0.0% 0.0%
0
0.0%
0
0.0%
0.0%
0.0%
0.0% 100.0% 0.0% 7.7%
1
33.3%
9
25.0% 0.0%
0.0%
0.0%
0.0% 50.0% 13.3%
2
Dec-19 2019n Jan-20 Feb-20 Mar-20
25.0%
26
5.6% 12.5% 22.2%
50.0%
19
11.1% 40.0% 12.5%
35.7%
19
14.3% 33.3% 0.0%
0.0%
5
0.0%
0.0%
0.0%
0.0%
8
3.7%
0.0%
0.0%

Apr-20 May-20 Jun-20 2020 2020n
33.3% 0.0%
0.0% 12.0%
6
12.5% 0.0%
0.0% 20.9%
9
16.7% 25.0% 10.0% 13.3% 11
0.0%
0.0%
0.0% 0.0%
0
0.0% 14.3% 12.5% 9.6%
11

BHIP
HF
21.9% 30.6% 50.0% 66.7% 25.0% 40.0% 0.0% 50.0%
11
0.0% 50.0% 0.0% 100.0% 0.0%
0.0% 15.4%
2
COPD
19.5% 7.4% 25.0% 33.3% 0.0% 0.0% 0.0%
0.0%
5
28.6% 14.3% 0.0% 100.0% 0.0%
0.0% 21.7%
5
Pneumonia 16.6% 3.5% 0.0% 0.0% 0.0% 20.0% 0.0% 27.3%
2
5.3%
0.0%
6.3%
0.0%
0.0% 20.0% 5.4%
3
AMI
16.1% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0%
0.0%
0
0.0%
0.0%
0.0%
0.0%
0.0%
0.0% 0.0%
0
Hip/Knee
4.0% 5.7% 0.0% 0.0% 0.0% 0.0% 0.0%
0.0%
2
0.0%
0.0%
0.0%
0.0%
0.0%
0.0% 8.3%
1
BHCS
National LCY-19 Jul-19
HF
21.9% 18.8% 0.0%
COPD
19.5% 26.7% 0.0%
Pneumonia 16.6% 11.8% 0.0%
AMI
16.1% 0.0% 0.0%
Hip/Knee
4.0% 9.1% 0.0%

Aug-19
40.0%
42.9%
16.7%
0.0%
0.0%

Sep-19 Oct-19 Nov-19
33.3% 33.3% 20.0%
9.1% 0.0% 25.0%
25.0% 20.0% 12.5%
0.0% 0.0% 0.0%
0.0% 0.0% 0.0%

Dec-19 2019n Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 2020 2020n
44.4%
12
11.1% 12.5% 0.0% 25.0% 0.0%
0.0% 10.3%
3
25.0%
16
14.3% 28.6% 0.0%
0.0% 50.0% 0.0% 17.2%
5
10.0%
10
20.0% 0.0% 15.4% 20.0% 14.3% 20.0% 14.3%
6
0.0%
0
0.0%
0.0%
0.0%
0.0%
0.0%
0.0% 0.0%
0
0.0%
1
50.0% 0.0%
0.0%
0.0%
0.0%
0.0% 33.3%
1
42


7.5 MEDICARE MORTALITIES
AMI Medicare Mortalities 2nd Q 2020

Hospital Compare CMS benchmark 13.6%

Mortality Rate (with Exclusions) - System-All Physicians

BHMC

Mortality Rate (with Exclusions) - System-All Physicians

BHIP

Mortality Rate (with Exclusions) - System-All Physicians

BHN

Mortality Rate (with Exclusions) - System-All Physicians

BHCS

Result - Comparison
HF Medicare Mortalities 2nd Q 2020

Hospital Compare CMS benchmark 12.0%

Mortality Rate (with Exclusions) - System-All Physicians

BHMC

0.71σ

1/16

BHN

-0.39σ

0/14

BHIP

-0.52σ

0/4

BHCS

-0.31σ

0/8

Mortality Rate (with Exclusions) - System-All Physicians
COPD Medicare Mortalities 2nd Q 2020

Hospital Compare CMS benchmark 8.1%

BHMC

Mortality Rate (with Exclusions) - System-All Physician

BHCS

Mortality Rate (with Exclusions) - System-All Physician

BHN

Mortality Rate (with Exclusions) - System-All Physician

BHCS
PN Medicare Mortalities 2nd Q 2020

Hospital Compare CMS benchmark 16.0%

Mortality Rate (with Exclusions) - System-All Physicians

BHMC

Mortality Rate (with Exclusions) - System-All Physicians

BHN

Mortality Rate (with Exclusions) - System-All Physicians

BHCS

Mortality Rate (with Exclusions) - System-All Physicians

BHIP
CABG Medicare Mortalities 2nd Q 2020

Hospital Compare CMS benchmark 3.3%

BHMC

Mortality Rate (with Exclusions) - System-All Physicians

Jan '19  Jul '19  Jan '20  Jul '20

0.00%  2.50%  5.00%  7.50%

- Result  - Comparison

0/7

-1.0  0.0  1.0

-0.57σ

Broward Health
7.6 ENVIRONMENT OF CARE
Patient Handling Injuries
2018-2019

Reposition 29%
Transfers 16%
Lifts 18%
Ambulation 24%
Patient Contact 13%

Analysis
In 2018, at the recommendation of the Key Group, a quantitative and qualitative assessment of the patient handling injuries was conducted; subsequent of that, initiatives, which are still ongoing, were recommended. An analysis of the patient handling injury data during CY2019, when compared to the same period during CY2018, shows that the monitor negatively performed; as a result, the established target was not met. The number of and cost associated with patient handling injuries adversely affected the employees; whereas, 72 occurrences were reported, compared to 47 in CY2018, resulting in direct cost of $445,870 to the organization, up from $404,936 in CY2018.

Additional analysis of the data shows that 13% of the injuries when staff members were assisting patients to ambulate, 16% when a patient came into contact with staff, 18% from lifting patients, 24% while transferring patients and 29% from repositioning.

Action Plan:
To be developed by the Key Group Members
Analysis

In CY2017, the Key Group recommended and implemented initiatives, which resulted in a positive outcome. The “Spill Prevention” initiative that includes “cup lids,” “over the spill mats,” “posters,” and policy revisions resulted in a 24% reduction of reported injuries between CY17 (127) and CY 2018 (96). When compared to CY2018 (96), the organization experienced a 25% increase in 2019 (121), resulting in a 74% cost increase ($448,521.24 ↑ $780,834.00). Organization also experienced a 28% per injury cost increase ($6453.17 ↑ $4,672.10).

An analysis of the slip, trip, and fall data during CY2018 and 2019, 38.65% of the slip, trip, and fall injuries resulted from Slips, 11.35% from Trips, and 50% from Fall. Though there are different factors contributing to the falls injuries, falls from chairs comprised the largest percentage (21%).

Action Plan:
To be developed by the Key Group Members
Analysis
An analysis of the missing patient property data during CY2019, show a reduction in the number and rate of missing patient property reported.

During CY2018, the Key Group recommended and implemented, where not previously implemented, the “Sweep The Room” campaign.

With the exception of BHIP, each of the facilities implemented the program; based on the trend reflected in the data, the outcome has been positive for those facilities, while the quarterly report for BHIP reflect a negative trend.

Action Plan:
It is recommended that BHIP implement the “Sweep The Room” campaign initiatives.
Quality
KEY QUALITY DRIVER: Improve negatively performing trends

People
KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance
KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to OSHA Recordable Injury Rate negatively performed when compared to Threshold. The overall number of compensable injuries increased by 19 (37 ↑ 56) resulting in a rate increased by 5.77 (5.36 ↑ 11.13) with the exposures representing the most significant contributing factor.

Conversely; overexertion represented the most significant cost during the monitored period, with incurred cost of $137,870.00 for 10 compensable injuries or a rate of $13,787.00 per injury.

8 of the 10 (80%) overexertion injuries resulted from patient handling. With a focus on reducing the number of injuries to staff from handling patients, the Key Group’s recently to undergo a reengineering of their performance improvement initiative through designing and implementing new strategies, including a “safety coach” initiative.
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to Contaminated Needle Stick Rate negatively performed when compared to Threshold. The overall number of needlestick injuries increased by 5 (11 ↑ 16) resulting in a rate increased by 1.3 (1.99 ↑ 3.29). When compared to other Broward Health Regions, BHMC’s rate of contaminated needle stick is on par with two of the three sister hospitals.

Following 2 quarters where the monitor positively performed; the monitor has now shown two quarters where the performance continues to negatively trend, BHMC Managers provides re-education and reviewed correct procedures to prevent injuries and Safety Officer had Smiths-Medical team return June and July for re-education on their blood collection devices. Additional rounding in August when in-servicing the new safety lancet device.
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to Bodily Assault in the behavioral Health setting negatively performed.

During the period, BHMC experienced a total of thirteen (13) reports of bodily assaults. Of the 13 occurrences, nine (9) were compensable incurring worker’s comp cost. However; the number of injury occurrences positively performed when compared to previous quarters; BHMC experience a 50% (26 ↓ 13) decrease in the number of occurrence compared to Q1CY20 and 69% (32 ↓ 13) decrease when compared to Q4CY2019.

The data shows that during the monitored period; the number of patient to staff assault occurrences accounted for the highest number of cases.

The Behavioral Health Task Force at BHMC is undertaking strategic initiative to address the escalation of assaults, including requesting security presence to prevent foreseeable behavioral escalation, providing unit based education on how to manage behavioral patients.
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to the amount of biomedical waste generated setting negatively performed. During the period, BHMC generated 3,487 (82919 ↓ 79432) pounds less than the previous calendar quarter; however, the rate, which compares the weight generated to the number of adjusted patient days exceeded the threshold by .3.

The analysis also shows that the cost of managing BHMC exceeded the contracted cost by $25,379.67. The increase in cost is directly associated with the increased generation of pharmaceutical waste consistent with EPA regulations.
Quality

KEY QUALITY DRIVER: Improve negatively performing trends

People

KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance

KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost

REGIONAL ENVIRONMENT OF CARE OPPORTUNITIES & ACTION PLAN REPORT

BHN – SUSAN NEWTON
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to OSHA Recordable Injury Rate at BHN negatively performed. The overall performance was positive, BHN experienced a 27% (45 ↓ 33) and a 2.2 rate decrease in the number and rate of OSHA Recordable Injuries; however, BHN continued to experience performance rates that exceeds the established threshold. The performance rate of 12.03 exceed the establish threshold by 6.02. As a result, the BHN experienced a 47% Recordable Injury rate. Increase when compared to the previous calendar quarter.

Of the 33 total injuries reported, 20 (61%) were compensable, resulting in directly incurred costs of $98,152.00, a 10% cost increase compared to

Exposures, if those exposure are to communicable diseases are automatically classified as OSHA Recordable; during the monitored period, the largest amount of a single type of injury type was related to exposures.
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to Contaminated Needle Stick Rate negatively performed when compared to Threshold. The overall performance was positive, BHN experienced a 50% (10 ↓ 5) and a 1.27 rate decrease in the number and rate of OSHA Recordable Injuries; however, BHN continued to experience performance rates that exceed the established threshold. The overall number of needlestick injuries decreased by 5 (10 ↓ 5) resulting in a rate decreased by 1.27 (3.27 ↓ 2.00). When compared to other Broward Health Regions, BHN’s rate of contaminated needle stick is on par with other sister hospitals.

Regional and organization-wide’ Managers provides re-education and reviews correct procedures to prevent injuries and Safety Officer continues to work with the companies who provide needles to conduct additional educational in-services.
ANALYSES & ACTION PLAN:

During the reporting period (Q1 CY20), the performance monitor related to OSHA Recordable Injury Rate negatively performed when compared to Threshold; however, the performance showed a positive trend in the overall amount of injuries reported. BHMC experienced a 27% (15 ↓ 11) decrease in the number of contaminated needle stick, when compared to the previous measurable period.

When compared to other Broward Health Regions, BHMC’s rate of contaminated needle stick is on par with two of the three sister hospitals.

The overall performance shows a positive performance in reducing the total number of contaminated needle stick injuries. BHMC will continue its reduction efforts through initiative designed to reduce contaminated needle stick.
Quality
KEY QUALITY DRIVER: Improve negatively performing trends

People
KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance
KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost

REGIONAL ENVIRONMENT OF CARE OPPORTUNITIES & ACTION PLAN REPORT

BHCS – MICHAEL LEOPOLD
ANALYSES & ACTION PLAN:

During the reporting period (Q1CY20), the performance monitor related to OSHA Recordable Injury Rate negatively performed when compared to the threshold. The overall performance was positive, BHCS experienced a 33% (24 ↓ 16) and a 1.21 rate decrease in the number and rate of OSHA Recordable Injuries; however, BHN continued to experience performance rates that exceeds the established threshold. When compared to the established threshold, the OSHA Recordable Injury Rate exceeded by 2.27.

Approximately 28 injuries were reported at BHCS during Q2’CY20, of which 16 were classified and OSHA Recordable requiring medical attention.

The overall performance shows a positive performance in reducing the total number of injuries. BHCS will continue it’s reduction efforts through the exposure prevention, contaminated needle stick reduction and assault reduction initiatives.
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to Contaminated Needle Sticks negatively performed when compared to Threshold. BHCS experienced a 50% (4 ↑ 6) increase in the number of contaminated needle stick, when compared to the previous measurable period.

When compared to other Broward Health Regions, BHCS’ rate of contaminated needle stick is on par with two of the three sister hospitals.

The overall performance continues a show a negative performance trend in reducing the total number of contaminated needle stick injuries. BHCS will coordinate with the other hospitals to develop and implement strategic initiative to reduce the number and rate of contaminated needle sticks.
ANALYSES & ACTION PLAN:

During the reporting period (Q2CY20), the performance monitor related to the amount of biomedical waste generated setting negatively performed.

During the period, BHCS generated 1,189 (33,156 ↑ 34,345) pounds more than the previous calendar quarter; resulting in a rate increase of 0.57 (1.74 ↑ 2.31)

The analysis also shows that the cost of managing BHMC exceeded the contracted cost by $14,985.68. The increase in cost is directly associated with the increased generation of pharmaceutical waste consistent with EPA regulations.
Quality

KEY QUALITY DRIVER: Improve negatively performing trends

People

KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance

KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost

REGIONAL ENVIRONMENT OF CARE OPPORTUNITIES & ACTION PLAN REPORT

BHIP– NETONUA “TONI” REYES
ANALYSES & ACTION PLAN:

During the reporting period (Q1CY20), the performance monitor related to OSHA Recordable Injury Rate negatively performed when compared to the threshold. The overall performance was negative, BHIP experienced a 144% (9 ↑ 22) and a 7.10 rate increase in the number and rate of OSHA Recordable Injuries; however, BHIP continues to experience inconsistent performance rates that over the most recent 4 calendar quarters. The specific increase in rate and total numbers is directly attributable to occupational exposure to COVID-19.

The overall performance shows a positive performance in reducing the total number of injuries. BHIP will continue its reduction efforts through the exposure prevention, contaminated needle stick reduction and assault reduction initiatives.
Each Performance Monitor performed with threshold – No Opportunities Reported during Q1CY20 for the Ambulatory Sites for BHIP.

Full Performance Report available on the EM/EOC Key Group SharePoint Page.
Quality

KEY QUALITY DRIVER: Improve negatively performing trends

People

KEY PEOPLE DRIVER: Keep our employees and patients safe

Finance

KEY FINANCE DRIVER: Reduce the direct, indirect and total occupational injury cost

REGIONAL ENVIRONMENT OF CARE OPPORTUNITIES & ACTION PLAN REPORT

BHCO (AMBULATORY) – HEATHER WOOLF
Each Performance Monitor performed with threshold – No Opportunities Reported during Q1CY20 for the Ambulatory Sites.

Full Performance Report available on the EM/EOC Key Group SharePoint Page.
7.7 SEPSIS PREVENTION
port: Quality Performer-Wide for Proportion Measures

sis: Quarter
: 01/01/2017 to 06/30/2020

otion: Sepsis

Facility #11365  SEP-1: Sepsis

Time Period

BHN

Facility #11367  SEP-1: Sepsis

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

Time Period:
- Q1 2017
- Q2 2017
- Q3 2017
- Q4 2017
- Q1 2018
- Q2 2018
- Q3 2018
- Q4 2018
- Q1 2019
- Q2 2019
- Q3 2019
- Q4 2019
- Q1 2020
- Q2 2020
Comparative Report: Quality Performer-Wide for Proportion Measures
Facility: 11366
Interval of Analysis: Quarter
Discharge Dates: 01/01/2017 to 06/30/2020
Measure: SEP-1
Measure Description: Sepsis
7.8 INFECTION PREVENTION
CAUTI ~ PEDIATRIC

BHMC NHSN - CAUTI
SIR ~ ALL Pediatric
CY 2020

Threshold 0.774
Benchmark 0

BHCS NHSN - CAUTI
SIR ~ Pediatric (incl. PICU, Peds)
CY 2020

Threshold 0.774
Benchmark 0
HOSPITAL-ONSET C. DIFFICILE

BHMC Hospital-Onset C. Difficile
SIR ~ CY 2020

*Qtrly SIR

Threshold 0.852
Benchmark 0.091

BHNS Hospital-Onset C. Difficile
SIR ~ CY 2020

*Qtrly SIR

Threshold 0.852
Benchmark 0.091

BHIP Hospital-Onset C. Difficile
SIR ~ CY 2020

*Qtrly SIR

Threshold 0.852
Benchmark 0.091

BHCS Hospital-Onset C. Difficile
SIR ~ CY 2020

*Qtrly SIR

Threshold 0.852
Benchmark 0.091

Infections SIR Threshold

Infections SIR Threshold

Infections SIR Threshold

Infections SIR Threshold
HOSPITAL-ONSET MRSA BACTEREMIA

BHMC Hospital-Onset MRSA Bacteremia
SIR ~ CY 2020
Threshold 0.815
Benchmark 0

BHN Hospital-Onset MRSA Bacteremia
SIR ~ CY 2020
Threshold 0.815
Benchmark 0

BHIP Hospital-Onset MRSA Bacteremia
SIR ~ CY 2020
Threshold 0.815
Benchmark 0

BHCS Hospital-Onset MRSA Bacteremia
SIR ~ CY 2020
Threshold 0.815
Benchmark 0
COLORECTAL SSI

BHMC NHSN - Colorectal SSI
SIR ~ CY 2020
Threshold 0.781
Benchmark 0

BHN NHSN - Colorectal SSI
SIR ~ CY 2020
Threshold 0.781
Benchmark 0

BHCS NHSN - Colorectal SSI
SIR ~ CY 2020
Threshold 0.781
Benchmark 0

BHIP NHSN - Colorectal SSI
SIR ~ CY 2020
Threshold 0.781
Benchmark 0
HYSTERECTOMY SSI

BHMC NHSN - Hysterecomy SSI
SIR ~ CY 2020
Threshold 0.722
Benchmark 0

Infections  SIR  Threshold

BHN NHSN - Hysterecomy SSI
SIR ~ CY 2020
Threshold 0.722
Benchmark 0

Infections  SIR  Threshold

BHCS NHSN - Hysterecomy SSI
SIR ~ CY 2020
Threshold 0.722
Benchmark 0

Infections  SIR  Threshold

BHIP NHSN - Hysterecomy SSI
SIR ~ CY 2020
Threshold 0.722
Benchmark 0

Infections  SIR  Threshold
7.9 HOSPITAL ACQUIRED PRESSURE INJURY
HOSPITAL ACQUIRED PRESSURE INJURY

BHMC HAPU: Stage III, Stage IV, Unstageable
CY 2020

BHN HAPU: Stage III, Stage IV, Unstageable
CY 2020

BHIP HAPU: Stage III, Stage IV, Unstageable
CY 2020

BHCS HAPU: Stage III, Stage IV, Unstageable
CY 2020

Broward Health

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7.10 GRIEVANCES
COMPLAINTS & GRIEVANCES

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

• Monthly Grievance Committee meetings represented by Customer Service Manager, Risk Management, Administration & Quality
Q2 2020 BHCS CAPTURED COMPLAINTS & GRIEVANCES

- Attitude/Respect, 14, 22%
- Delay/process/financial issues, 9, 14%
- Appropriateness of Care/Instructions, 16, 26%
- Communication, 16, 26%
- Environment/Nutritional, 1, 2%
- Skill of Staff, 6, 10%
Q2 2020 BHN CAPTURED COMPLAINTS & GRIEVANCES

- Appropriateness of Care/Instructions: 9, 41%
- Communication: 3, 14%
- Safety Issues/Concerns: 3, 14%
- Environment/Nutritional: 2, 9%
- Responsiveness: 2, 9%
- Skill of Staff: 1, 5%
- Delay/process/financial issues: 1, 4%
- Attitude/Respect: 1, 4%
Q2 2020 BHIP CAPTURED COMPLAINTS & GRIEVANCES

- Appropriateness of Care/Instructions, 5, 36%
- Communication, 3, 22%
- Attitude/Respect, 2, 14%
- Safety Issues/Concerns, 2, 14%
- Environment/Nutritional, 1, 7%
- Delay/process/financial issues, 1, 7%
Q2 2020 BHMC CAPTURED COMPLAINTS & GRIEVANCES

- Appropriateness of Care/Instructions, 8
- Attitude/Respect, 8
- Safety Issues/Concerns, 8
- Communication, 2
- Responsiveness, 1
- Environment/Nutrition, 1
- Delay/process/financial issues, 1
- Skill of Staff, 1
7.11 PATIENT SATISFACTION HCAHPS
<table>
<thead>
<tr>
<th>Category</th>
<th>CMS 75%tile</th>
<th>BHCS CY 2019</th>
<th>CY 2020 to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to Recommend This Hospital</td>
<td></td>
<td>73.20</td>
<td>79.00</td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
<td></td>
<td>72.10</td>
<td>79.00</td>
</tr>
<tr>
<td>Communication with Nurses</td>
<td></td>
<td>71.90</td>
<td>78.80</td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td></td>
<td>73.90</td>
<td>85.00</td>
</tr>
<tr>
<td>Communication About Medicines</td>
<td></td>
<td>70.00</td>
<td></td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td></td>
<td>61.10</td>
<td>76.00</td>
</tr>
<tr>
<td>Discharge Information</td>
<td></td>
<td>61.00</td>
<td>81.70</td>
</tr>
<tr>
<td>Care Transition</td>
<td></td>
<td>57.00</td>
<td>79.30</td>
</tr>
<tr>
<td>Clean and Quiet Combined</td>
<td></td>
<td>67.00</td>
<td>81.00</td>
</tr>
<tr>
<td>Cleanliness of Hospital Environment</td>
<td></td>
<td>68.00</td>
<td></td>
</tr>
<tr>
<td>Quietness of Hospital Environment</td>
<td></td>
<td>68.00</td>
<td></td>
</tr>
</tbody>
</table>

Responses: 584
CY 2020 to Date
Ran data on 8/17/2020
BHMC CMS HCAHPS CY 2020

WILLINGNESS TO RECOMMEND THIS HOSPITAL
OVERALL RATING OF HOSPITAL
COMMUNICATION WITH NURSES
COMMUNICATION WITH DOCTORS
COMMUNICATION ABOUT MEDICINES
RESPONSIVENESS OF HOSPITAL STAFF
DISCHARGE INFORMATION
CARE TRANSITION
CLEAN AND QUIET COMBINED
CLEANLINESS OF HOSPITAL ENVIRONMENT
QUIETNESS OF HOSPITAL ENVIRONMENT

Responses: 782
CY 2020 to Date
Ran data on 8/17/2020
Salah Children's BHCS HCAHPS CY 2020

Responses: 10
CY 2020 to Date
Ran data on 8/17/2020

- WILLINGNESS TO RECOMMEND THIS HOSPITAL: CY 2020 to Date 86.50
- OVERALL RATING OF HOSPITAL: CY 2020 to Date 80.00
- COMMUNICATION WITH NURSES - CHILD: CY 2020 to Date 57.70
- COMMUNICATION WITH NURSES - PARENT: CY 2020 to Date 80.40
- COMMUNICATION WITH DOCTORS - CHILD: CY 2020 to Date 65.40
- COMMUNICATION WITH DOCTORS - PARENT: CY 2020 to Date 87.20
- COMMUNICATION ABOUT MEDICINES: CY 2020 to Date 70.00
- RESPONSIVENESS: CY 2020 to Date 82.10
- HOSPITAL ENVIRONMENT: CY 2020 to Date 88.90
- TEENS CARE: CY 2020 to Date 87.00
- DISCHARGE: CY 2020 to Date 88.00

PG 75%tile
SCF BHCS CY 2019
CY 2020 to Date

Responses: 10
CY 2020 to Date
Ran data on 8/17/2020
Responses: 29
CY 2020 to Date
Ran data on 8/17/2020
HCAHPS Summary Report

Broward Health Medical Center

Surveys Returned: May 2020 - July 2020

Global Comparison

- Rate hospital 0-10
- Recommend the hospital
- Comm w/ Nurses
- Response of Hosp Staff
- Comm w/ Doctors
- Hospital Environment
- Comm About Pain
- Comm About Medicines
- Discharge Information
- Care Transitions

Domain Comparison

% Top Box

- You
- All DB
- All PG DB
- AHA Region 4 Grp
Broward Health Coral Springs

HCAHPS Summary Report
Surveys Returned: May 2020 - July 2020
7.12 RISK MANAGEMENT REGIONAL REPORTS

A1. BHMC  Q2 2020
B1. BHN    Q2 2020
C1. BHIP   Q2 2020
D1. BHCS   Q2 2020
E1. BH AMB Q2 2020
7.13 2019 PATIENT SAFETY APPRAISAL BY REGION

A1. BHMC
B1. BHN
C1. BHIP
D1. BHCS
7.14 2019 PERFORMANCE IMPROVEMENT APPRAISAL BY REGION

A1. BHMC
B1. BHN
C1. BHIP
D1. BHCS
7.15 2019 INFECTION PREVENTION APPRAISAL BY REGION

A1. BHMC
B1. BHN
C1. BHIP
D1. BHCS
7.16 2019 ENVIRONMENT OF CARE APPRAISAL BY REGION

A1. BHMC
B1. BHN
C1. BHIP
D1. BHCS
During the 2nd Quarter CY 2020 there were a total of 1145 occurrence variance reports compared to 1440 during the 1st Quarter CY 2020 reflecting a 20.48% decrease in reporting. This can be directly attributed to the decrease in patient census related to lockdown measures and emergency orders because of the current and ongoing pandemic. There were a total of 28 reported near miss occurrences making up 2.44% of all occurrences.

There were 54 falls reported during the 2nd Quarter of 2020, a 30% decrease from Q1 CY20 - 78. The incidents occurred on the following departments: 3NT (8), 4NT (2), 4NWW (4), 4ST (1), 4SWW (4), 4Atrium (5), 5NT (4), 5ST (6), 5Atrium (9), 6ST (6), CVICU (1), PICU (1), ICU (1) and RCU (2).

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.

There were 12 falls with injuries reported during the 2nd Quarter CY20 – (2) Fall with fracture; (3) falls with laceration; (4) fall with abrasion; (3) fall with skin tear.

OB DELIVERY CY20:

All shoulder dystocia cases are sent to Quality for further review.

HAPIS CY20:
Trauma patient who was admitted for multiple GSW. Wound care was following the case 5 days into the admission and providing treatment recommendation. Risk, wound care, trauma and ICU team met to discussed opportunities. Action Plans put into place to monitor high risk patients more closely.
### MEDICATION VARIANCES CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Drug Discrepancy-count</td>
<td>1</td>
</tr>
<tr>
<td>Control Drug Diversion/Suspicion</td>
<td>2</td>
</tr>
<tr>
<td>Delayed dose</td>
<td>6</td>
</tr>
<tr>
<td>Extra Dose</td>
<td>3</td>
</tr>
<tr>
<td>Improper Monitoring</td>
<td>6</td>
</tr>
<tr>
<td>Omitted dose</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Prescriber Error</td>
<td>3</td>
</tr>
<tr>
<td>Unsecured Medication</td>
<td>1</td>
</tr>
<tr>
<td>Wrong Concentration</td>
<td>1</td>
</tr>
<tr>
<td>Wrong dosage form</td>
<td>1</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>6</td>
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<tr>
<td>Wrong Drug or IV Fluid</td>
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<tr>
<td>Wrong frequency or rate</td>
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<td>Wrong patient</td>
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<tr>
<td>Wrong time</td>
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<tr>
<td>MEDICATION Total</td>
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</table>

### ADR CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>1</td>
</tr>
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</table>

### SURGERY RELATED ISSUES CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia Complication</td>
<td>1</td>
</tr>
<tr>
<td>Consent Issues</td>
<td>5</td>
</tr>
<tr>
<td>Sponge/Needle/Instrument Issues</td>
<td>3</td>
</tr>
<tr>
<td>Sterile field contaminated</td>
<td>2</td>
</tr>
<tr>
<td>Surgical Count</td>
<td>13</td>
</tr>
<tr>
<td>Surgery Delay</td>
<td>2</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>3</td>
</tr>
<tr>
<td>SURGERY Total</td>
<td>33</td>
</tr>
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</table>

### SECURITY CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access control</td>
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</tr>
<tr>
<td>Aggressive behavior</td>
<td>26</td>
</tr>
<tr>
<td>Arrest</td>
<td>1</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>19</td>
</tr>
<tr>
<td>Code Assist</td>
<td>101</td>
</tr>
<tr>
<td>Code Elopement</td>
<td>7</td>
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<tr>
<td>Code Strong</td>
<td>2</td>
</tr>
<tr>
<td>Contraband</td>
<td>24</td>
</tr>
<tr>
<td>Criminal Event</td>
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<tr>
<td>Property Damaged/missing</td>
<td>16</td>
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<td>Security Presence Requested</td>
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<tr>
<td>Security Transport</td>
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<td>Smoking Issues</td>
<td>1</td>
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<td>Threat of violence</td>
<td>6</td>
</tr>
<tr>
<td>Vehicle Accident</td>
<td>1</td>
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<tr>
<td>Verbal Abuse</td>
<td>2</td>
</tr>
<tr>
<td>SECURITY Total</td>
<td>417</td>
</tr>
</tbody>
</table>

### MEDICATION VARIANCES CY20:

16.66% decrease in medication variances from 51 Q1 CY20 to 45 Q2 CY20 of which 8 were near misses. No Adverse Outcomes. 31 occurrences were on the Adult units and 11 on the Women and Children’s units and 3 in Retail Pharmacy.

### ADR CY20:

No trends identified.

### SURGERY RELATED ISSUES CY20:

All surgical count related issues came back with negative x-ray results. All consent issues were addressed real time - of those 2 received consent for the patients family and 1 was a trauma patient.

### SECURITY CY20:

12.39% decrease in security reporting from 476– Q1 CY20 to 417– Q2 CY20. 52% of all security incidents are related to our Behavior Health Population.

On going efforts to address property related issues. New policies and procedures will be established and education will go out in the next few weeks.
SAFETY CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biohazard Exposure</td>
<td>1</td>
</tr>
<tr>
<td>Code Red</td>
<td>26</td>
</tr>
<tr>
<td>Electrical Hazard</td>
<td>1</td>
</tr>
<tr>
<td>Safety Hazard</td>
<td>14</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>8</td>
</tr>
<tr>
<td>SAFETY Total</td>
<td>50</td>
</tr>
</tbody>
</table>

SAFETY CY20:
27.37% decrease in Safety reporting from 476 – Q1 CY20 to 417 – Q2 CY20. Only 3 Code red events were actual events, 2 were drills, all other incidents were either moisture or construction related.

REGIONAL RISK MANAGEMENT SECTION : (MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES , SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCAs COMPLETED, ETC.)

BAKER ACT ELOPMENT
A patient that was Baker Acted by PD for acute psychotic episode was admitted medically, and when brought to 4NT had all of his clothes and belongings with him. He got dressed later, and eloped from the floor. He was caught by staff in the neighborhood south of the hospital.

Actions Taken:
Education on Policy NUR-014-020 to all employees is to be completed by all Nurse Managers and Security Leadership Safety Officer and Nursing supervisor to revise current BA checklist to include removal of all patient belongings from room.

L&D/HIM
Two patients with similar names, one having never been to Broward Health before, had their records merged when a patient access clerk changed the demographic information of the one patient to match the other. This imported a complete medical history to the new patient that did not belong to her. Much of this history included elicit drug use.

Actions Taken:
- The medical records were purged/corrected within the limits of Cerner. A letter was provided for the new patient to give to all future providers detailing the error that occurred and to disregard any reference to elicit drug use
- Patients corrected medical records were mailed to the patient via Fedex to ensure delivery
- Patient Access Manager to inquire about receiving email notifications when key demographics are changed.

BHU FOREIGN BODY
A Behavioral Health patient was admitted to the medical floor secondary to swallowing razor blades. After they were removed, and the patient transferred to BHU, he was able to secure a small piece of plastic (disposable razor head cover?) from his belongings when he requested to get phone numbers, but snuck the piece of plastic when staff wasn’t looking.

Actions Taken:
- Door with a window was installed in patient belonging rooms to allow staff safely go through the patients belonging.
- Education was provided to all BHU staff regarding our policy and procedure for Care of Patient belongings.
- All patients who are identified as a high risk for swallowing will be placed on a 1:1, medical gown and private room. Educati n regarding new process completed with staff.
- Special gloves have been purchased to allow staff to safety go through patients belongings.

DEATH IN RESTRAINTS
A COVID patient in the ICU died within 24 hrs of being in soft wrist restraints and mittens. Later review of the CMS waivers related to the state of emergency showed this death in restraints did not need to be reported to CMS.

Actions Taken:
- During rounds, Intensivist and nursing team are now assessing patient restraints needs daily.

ER YELLOW – SUICIDE ATTEMPT
A Behavioral Health patient with a history of malingering, who had presented and was pending psychiatric evaluation was moved out of the Bubble/Blue locked unit area because he was considered voluntary. Fearing he would be discharged on evaluation, he utilized a sheet to tie around on of the overhead exam light arms in the Yellow section for hanging himself. Staff observed him, and he had no injury to himself.

Actions Taken:
- Education was provided to all ER staff that any patients who arrive to the ER and express suicidal ideation will be placed on a 1:1.
- Education was provided to all ER staff regarding not mixing general population and BH population when ER Blue is being utilized as Psych overflow.

CODE SILVER
An elderly gentleman seen in the ER was discharged after being treated and seen. Due to COVID and the no visitor policy, he was not reunited with his family who was waiting in the parking lot. He wandered south down 3rd Avenue and was missing for three days.

Actions Taken:
- Chart audit completed for the month June and July to verify that proper discharge plan is in place for elderly patients who are discharged from the ER. June showed 80% compliance and increased to 93% compliance for the month of July. Will continue to perform chart audits to ensure compliance.
During the 2nd Quarter CY 2020, there were a total of 699 occurrence variance reports compared to 768 during the 1st Quarter CY 2020, reflecting a 9% decrease in occurrence reports from 1st Quarter. The overall Near Miss Occurrences during the 2nd Quarter CY 2020 were 11, or 2% of overall occurrences. During part of the 2nd Quarter, the Covid-19 pandemic continued and elective surgeries were canceled, resulting in a decreased census. The goal continues to be increased reporting to discern trends in order to implement risk reduction measures.

INPATIENT FALLS BY CATEGORY CY20:
(Does not include Fall near misses). 28 falls in CY20Q2 compared to 32 in CY20Q1, with a rate of 1.5 with a benchmark of 2.61 (YTD 1.5). Robust Fall Prevention Action Plan in place by Nursing. One patient injury - displaced femur fracture (Not a HAC).

HAPIs CY20:
5 HAPIs, 2 of which are HACs. No trends. Rate of 0.16. Decrease in HAPIs from 6 in Q1 to 5 in Q2.

MEDICATION VARIANCES CY20:
Near miss 2 vs Actual 17. Rate of 0.01%. No Adverse Outcomes/Trends. Decrease in medication variances by 37% from 27 to 17.
Risk, nursing, and administration collaborate monthly to discuss medication variances, trends, and lessons learned from medication variances. Lessons learned are sent to managers to review with nursing staff.

SURGERY RELATED ISSUES CY20:
Decrease in surgical incidents from 22 in Q1 to 12 in Q2, reflecting a 45% decrease. During part of Q2, elective surgeries were suspended, decreasing from our normal volume. One surgical complication which resulted in no adverse outcome. Unplanned return to surgery (ROS) due to re-exploratorion of new AV graft (embolectomy).
RISK MANAGEMENT QUARTERLY REPORT QUARTER 2

SECURITY CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive behavior</td>
<td>3</td>
</tr>
<tr>
<td>Arrest</td>
<td>1</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>10</td>
</tr>
<tr>
<td>Code Assist</td>
<td>87</td>
</tr>
<tr>
<td>Code Eloponement</td>
<td>9</td>
</tr>
<tr>
<td>Code Strong</td>
<td>1</td>
</tr>
<tr>
<td>Contraband</td>
<td>23</td>
</tr>
<tr>
<td>Property Damaged/missing</td>
<td>29</td>
</tr>
<tr>
<td>Security Presence Requested</td>
<td>42</td>
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<tr>
<td>Threat of violence</td>
<td>1</td>
</tr>
<tr>
<td>Trespass</td>
<td>1</td>
</tr>
<tr>
<td>Vehicle Accident</td>
<td>2</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>210</td>
</tr>
</tbody>
</table>

SECURITY CY20: 210 Security occurrences in Q2 vs 175 in Q1, reflecting a 20% increase. Code Assists increased from 59 to 87 (47% increase). Security presence requested increased from 32 to 42, a 31% increase. During the 2nd quarter, majority of Code Assists were patients being aggressive/disruptive and multiple codes called on the same patients. Decrease in Code Elopements from 15 to 9 (40% decrease). No other trends identified.

FMEA Actions are pending for staff to evaluate, assess, and treat violent patients with the goal of de-escalating patients/visitors and reducing harm to patients and staff. In addition, BHN FMEA participants are working on evaluating patients with underlying medical conditions which exhibit aggressive behavior.

SAFETY CY20

<table>
<thead>
<tr>
<th>Category</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Red</td>
<td>1</td>
</tr>
<tr>
<td>Safety Hazard</td>
<td>1</td>
</tr>
<tr>
<td>Sharps Exposure</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
</tr>
</tbody>
</table>

SAFETY CY20: Decrease in Safety incidents from 10 in Q1 to 5 in Q2 (50% decrease). Decrease in sharps exposures from 5 in Q1 to 3 in Q2. No other trends identified.

REGIONAL RISK MANAGEMENT SECTION: (MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES, SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCAs COMPLETED, ETC.)

Possible over-narcotization in PACU patients

**Opportunities:** Anesthesia to update order sets to reduce individual ordered dosages of narcotics in narcotic-naive or sensitive patient (elderly, obese, OSA, etc.) Nursing to use clinical judgement on narcotic administration in relation to patient status (opiate-naive, obese, OSA, elderly, etc.)

**Actions:** Anesthesia instructed on benefits of ordering reduced narcotic dosages or incremental dosages to prevent possible over-narcotization. Nursing to consult anesthesia regarding tailoring dosages/increments to individualized patient assessments. Consideration for incorporating pain medication management with use of narcotics to annual competency for PACU staff.

Lost Specimen in Transit from BHN to BHMC

**Opportunities:** Develop tighter chain of custody for specimens packaged by BHN lab, picked up by Quality courier service and deliver to BHMC Central Processing Department. Initiate barcode scanning of locked coolers for each point of contact. New standardized transportation process for BH Labs: Implement Locked coolers for specimen transport. Train staff, implement new process.

**Actions:** Barcode locked coolers for chain of custody. Purchased locked coolers which will be used for transportation of specimens between the regions. Go live expected week of 8/10 or 8/17/2020 per Quality Transportation.

Patient slid off OR table during procedure

**Opportunities:** Clear communication between surgeon and nursing regarding surgical positioning (per BH policy). Consideration for use of supportive/positioning devices on a case-by-case basis (i.e. additional straps and supports). Team to stop procedure when they feel uncomfortable, including tech, RN, surgeon, anesthesia.

**Actions:** Surgery Director to review Positioning policy with other BH surgical directors to ensure it aligns with current guidelines. Chief of Anesthesia to review Positioning policy to ensure it aligns with current guidelines. Staff to speak up if concerned, uncomfortable, or see a safety issue (C.U.S.). Reinforce CUS with anesthesia providers. Review with nursing (OR) staff to add documentation in nursing intraoperative record for any incidents occurring in OR.
**Occurrence Category CY20**

<table>
<thead>
<tr>
<th>Category</th>
<th>Q2</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Issues</td>
<td>267</td>
<td>44%</td>
</tr>
<tr>
<td>Security</td>
<td>202</td>
<td>33%</td>
</tr>
<tr>
<td>Falls</td>
<td>26</td>
<td>4%</td>
</tr>
<tr>
<td>Surgery Issues</td>
<td>22</td>
<td>4%</td>
</tr>
<tr>
<td>Delay</td>
<td>18</td>
<td>3%</td>
</tr>
<tr>
<td>Medication Variance</td>
<td>13</td>
<td>2%</td>
</tr>
<tr>
<td>Lab</td>
<td>12</td>
<td>2%</td>
</tr>
<tr>
<td>Skin &amp; Wound</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>Adverse Drug Reaction</td>
<td>4</td>
<td>1%</td>
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<tr>
<td>Patient ID</td>
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<td>0.33%</td>
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<tr>
<td>HIPAA PHI</td>
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<tr>
<td>Infection Control</td>
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<td>0.33%</td>
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<tr>
<td><strong>Grand Total</strong></td>
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<td><strong>100%</strong></td>
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</table>

**Inpatient Falls by Category CY20**

<table>
<thead>
<tr>
<th>Category</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Found on floor</td>
<td>7</td>
</tr>
<tr>
<td>Slip</td>
<td>2</td>
</tr>
<tr>
<td>While ambulating</td>
<td>2</td>
</tr>
<tr>
<td>From chair</td>
<td>2</td>
</tr>
<tr>
<td>From Bed</td>
<td>1</td>
</tr>
<tr>
<td>Patient States</td>
<td>1</td>
</tr>
<tr>
<td>From Bedside Commode</td>
<td>1</td>
</tr>
<tr>
<td>From Toilet</td>
<td>1</td>
</tr>
<tr>
<td>From equipment, i.e stretcher, table, etc.</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

**HAPIs CY20**

<table>
<thead>
<tr>
<th>Category</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decubitus - Stage II</td>
<td>1</td>
</tr>
<tr>
<td>Deep Tissue Injury</td>
<td>2</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

**OCCURRENCE CATEGORY CY20:**
The total number of reported incidents decreased by 1.1% compared to last quarter. Categorized by risk severity we had a total of 551 Level 1, 36 Level 2, and 17 Level 3 incidents reported and reviewed.

**INPATIENT FALLS BY CATEGORY CY20:**
We had a decrease of 35% in inpatient falls. Out of the 18 falls, 7 patient falls with minor injuries.

**HAPIS CY20:**
There were no changes in the number of HAPI events compared to Q1.
### MEDICATION VARIANCES CY20

<table>
<thead>
<tr>
<th>Issue</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pyxis Count Discrepancy</td>
<td>4</td>
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<tr>
<td>Prescriber Error</td>
<td>1</td>
</tr>
<tr>
<td>Wrong Drug or IV Fluid</td>
<td>1</td>
</tr>
<tr>
<td>Hoarding Medications For Later Use</td>
<td>1</td>
</tr>
<tr>
<td>Unsecured Medication</td>
<td>1</td>
</tr>
<tr>
<td>Omitted dose</td>
<td>1</td>
</tr>
<tr>
<td>Extra Dose</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>13</td>
</tr>
</tbody>
</table>

**MEDICATION VARIANCES CY20:**

Out of the 13 medication variances, one was a Level 3 which required further monitoring of the patient.

### ADR CY20

<table>
<thead>
<tr>
<th>Issue</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>2</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>4</td>
</tr>
</tbody>
</table>

**ADR CY20:**

No significant trends identified.

### SURGERY RELATED ISSUES CY20

<table>
<thead>
<tr>
<th>Issue</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned Return to OR</td>
<td>8</td>
</tr>
<tr>
<td>Surgical Complication</td>
<td>5</td>
</tr>
<tr>
<td>Surgery/Procedure Cancelled</td>
<td>3</td>
</tr>
<tr>
<td>Consent Issues</td>
<td>2</td>
</tr>
<tr>
<td>Sterile field contaminated</td>
<td>1</td>
</tr>
<tr>
<td>Puncture or Laceration</td>
<td>1</td>
</tr>
<tr>
<td>Anesthesia Complication</td>
<td>1</td>
</tr>
<tr>
<td>Sponge/Needle/Instrument Issues</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>13</td>
</tr>
</tbody>
</table>

**SURGERY RELATED ISSUES CY20:**

Cancelled Surgeries and Unplanned Return to ORs are tracked and trend by Quality. Surgical incidents are referred to CMO as deemed appropriate.

### SECURITY CY20

<table>
<thead>
<tr>
<th>Issue</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Presence Requested</td>
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<tr>
<td>Code Assist</td>
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</tr>
<tr>
<td>Aggressive behavior</td>
<td>24</td>
</tr>
<tr>
<td>Contraband</td>
<td>13</td>
</tr>
<tr>
<td>Property Damaged/Missing</td>
<td>9</td>
</tr>
<tr>
<td>Code Elopement</td>
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</tr>
<tr>
<td>Verbal Abuse</td>
<td>3</td>
</tr>
<tr>
<td>Trespass</td>
<td>2</td>
</tr>
<tr>
<td>Assault/Battery</td>
<td>2</td>
</tr>
<tr>
<td>Threat of violence</td>
<td>1</td>
</tr>
<tr>
<td>Security Transport</td>
<td>1</td>
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<tr>
<td>Access control</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>202</td>
</tr>
</tbody>
</table>

**SECURITY CY20:**

For Q2, Risk Management introduced a new HAS category called security presence required. Security Presence required events precede calling code assist event. Security presence required is used when staff know a patient's behavior can change or is easily agitated. Security accompanies a nurse on standby in this event. Code assist is called when a patient's behavior escalates requiring security to intervene.
<table>
<thead>
<tr>
<th>Safety Hazard</th>
<th>Q2</th>
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<tbody>
<tr>
<td>Sharps Exposure</td>
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<tr>
<td>Electrical Hazard</td>
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<td>Biohazard Exposure</td>
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<tr>
<td>False Alarm</td>
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<tr>
<td>Grand Total</td>
<td>26</td>
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</tbody>
</table>

SAFETY CY20:

There has been a 62% increase in safety events compared to last quarter.

REGIONAL RISK MANAGEMENT SECTION: (MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES, SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCAs COMPLETED, ETC.)

One AHCA Annual Reportable event. 57 year old male presented to the Emergency Room with complaints of abdominal pain. CT Scan revealed perforation at the rectosigmoid. General Surgery consulted and taken to the OR. Patient sustained a iatrogenic bladder injury during a exploratory laporotomy for rectal perforation. During procedure urologist was called in to perform a cystotomy repair.

No Code 15 Reportable events for Q2 2020.
OCCURRENCE CATEGORY CY20:

Falls were 19 Inpatients, 1 Inpatient that occurred in MRI, 4 in the Emergency Room, 5 Visitors and 1 Employee

<table>
<thead>
<tr>
<th>Occurrence Category CY20</th>
<th>Q2</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADR</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>DELAY</td>
<td>16</td>
<td>6%</td>
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<tr>
<td>FALL</td>
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<tr>
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<tr>
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<td>PATCARE</td>
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<td>SAFETY</td>
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<td>SECURITY</td>
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<td>SKINWOUND</td>
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<tr>
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<td>GRAND TOTAL</td>
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<td>100%</td>
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INPATIENT FALLS BY CATEGORY CY20:

During this Quarter, a patient sustained fractures of the Tibia and Fibula while ambulating to the bathroom. Opportunities identified during RCA process were:

1) Random chart audits to verify accuracy of MFRS on patients identified as fall risks (at least 10 charts/month for the next 3 mths). Compliance rate should be 100%, requires an Action plan.

2) The MFRS needs to be reviewed for each falls to verify accuracy, report). If inaccurately scored, review with involved team members.

3) The staff should be incorporating fall preventative checks on patient's identified as fall risks during their hourly rounds. (i.e. bed alarm is on & functioning, so etc.).

HAPIS CY20:

This consisted of 1 Stage II and 1 Stage III pressure injury. Regarding the pt with very high risk for breakdown due to immobility, incontinence, therefore, all prevention measures were implemented upon admission but was never received. EVS department implemented change which improved outcomes.

<table>
<thead>
<tr>
<th>HAPls CY20</th>
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**MEDICATION VARIANCES CY20**

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<thead>
<tr>
<th>Category</th>
<th>Count</th>
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<tbody>
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<td>Control Drug Discrepancy - Count</td>
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<tr>
<td>Control Drug Diversion/Suspicion</td>
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<tr>
<td>Delayed Dose</td>
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<tr>
<td>Improper Monitoring</td>
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<tr>
<td>Omitted Dose</td>
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<tr>
<td>Other</td>
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<tr>
<td>Pyxis Count Discrepancy</td>
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<td>Pyxis Miss Fill</td>
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<td>Return Bin Process Error</td>
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**ADR CY20**

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**SURGERY RELATED ISSUES CY20**

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<td>Sponge/Needle/Instrument Issues</td>
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<td>Surgery Delay</td>
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**SECURITY CY20**

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<td>Verbal Abuse</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>57</strong></td>
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</tbody>
</table>

**MEDICATION VARIANCES CY20:**

All Medication Variances are reviewed at the Medication Safety Committee and the P & T Committee.

The Committees review for quality improvement opportunities, and recommendations are addressed collectively by all Regions.

**ADR CY20:**

ADR events are reviewed for Hospital Related vs Present on Admission. ADRs are reported to the P & T Committee for tracking and trending. If an allergic reaction is confirmed, the patient’s record is updated in Cerner.

**SURGERY RELATED ISSUES CY20:**

**SECURITY CY20:**

Staff provides patient education on securing personal property, with an emphasis on sending their belongings home.

The Education Department distributes flyers for all units titled "Facts about Patients’ Belongings.”

Staff is encouraged to speak up on any form of abuse, be it lateral or horizontal.
REGIONAL RISK MANAGEMENT SECTION: (MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES, SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCAs COMPLETED, ETC.)

BHCS FALLS SAFETY MEASURES:
Continue to encourage and reinforce the need for purposeful rounding.
Continue to educate on the Morse Fall Risk Scale Score.
Continue to reinforce the need for thorough and proper patient assessment.
Medications review by decentralized pharmacists post-fall, to provide real time review.
All patient’s receiving sedatives prior to a procedure, should be transported via stretcher, not wheelchair.
During 2nd Quarter, all older beds were replaced by new beds with user friendly fall/safety features.

INTENSE ANALYSIS On Inpatient Fall with Major Injury
Scenario:
33 YO male with known history of Sickle Cell Disease was admitted 2 days prior with chief complaints of chest and upper back pain. Labs on day of admission were WBC= 13.0, HGB= 7.7, HCT=22.3 and PLT=200. AM labs on the day of incident were WBC=10.76, HGB=6.7, HCT=18.7 and PLT=180. Patient was informed on the need for blood transfusion and also on the symptoms of anemia. Apparently patient ambulated to the bathroom without asking for assistance, fell and sustained tibia/fibular fractures.

OPPORTUNITIES:
1) Confirming that all fall preventative measures are in place during the handoff process
2) Newly revised Morse Fall Risk Score (MFRS) Scale has components open to interpretation (IT notified of findings and will revise accordingly).
3) MFRS module will be reassigned to staff in Healthstream with a 30-day due date. Case studies will be done with the staff to validate them on correctly assessing the patient and completing the MFRS form.

Action:
1) BHCS have since replaced all the older beds, with ones that have more user friendly fall/safety features.
2) Clinical educator will work on providing laminate copies of MFRS, as a source of reference.
3) MFRS module will be reassigned to staff in Healthstream with a 30-day due date. Case studies will be done with the staff to validate them on correctly assessing the patient and completing the MFRS form.

ACHA ANNUAL REPORTABLE EVENTS:
There were (5) AHCA Annual Reportable Events, which comprised Surgery Complication, OB Delivery Complication, Skin/Wound Acquired and Fall.

CODE 15 REPORTS:
There was (0) Code 15 reported, for the 2nd Quarter CY 2020.
Ten of the 11 falls were from Gold Coast, 9 home health and one home hospice. One patient had syncope episode s/p bypass surgery, suffered facial bone fracture that did not require intervention. Four falls resulted in minor injury. All patients receiving PT services and fall prevention education.

Five HIPAA/PHI reports, one duplicate, all different facilities. Compliance enforcing their policy GA-004-160 Sanctions for Non-Compliance with Information Privacy and Security Policies. In accordance with this policy whenever there are HIPAA violations, the employee’s manager is to reach out to HR for a corrective action. HR determines corrective action.

Six medication variances. One wrong patient (PPID policy reinforced), 3 wrong dose (provider instructed on best drop down option for ordering to reduce profiling error), 2 duplicate therapy (pharmacists reminded of importance of med reconciliation). No harm to patients.

One patient care event was related to patient with multiple medical records. Registration of patients as per DL reinforced. Two patients required BA.

Safety occurrences included vaccine freezer temperature outside required limits (proper steps taken), one related to COVID-19 positive patient, one employee needle stick due to patient move (reported to employee health).

Delay occurrences related to Gold Coast. No harm to patients.

Infection, report reported patient who presented to clinic when should be at home isolation post TB. Other patient with possible COVID symptoms presented to clinic, patient transferred to hospital.
Infection events reported: patient who presented to clinic when should be at home isolation post TB. Other patient with possible COVID symptoms presented to clinic and was transferred to hospital.

<table>
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<th>WESTON &amp; IMAGING</th>
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<th>Mar</th>
<th>1st Qtr</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>2nd Qtr</th>
<th>Total CY20</th>
</tr>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>

Three occurrences reported.

Patient care due to abnormal CT brain result at imaging center and patient transfer to ED.

One Lab occurrence related to specimen for trichomoniasis collected in a way BHMC could not process, patient contacted but already on medication, nurse manager informed all UCC’s staff that it should be a urine specimen to be sent to BHMC. Other related to UCC not realizing that patient needed swab test instead of antibody test ordered by surgeon for surgery pre-op. Patient returned without additional charge.
### PHYSICIAN OFFICES

<table>
<thead>
<tr>
<th>Category</th>
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<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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<th>2nd Qtr</th>
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</tbody>
</table>

Total of 10 occurrences reported.

Two falls. One patient slid out of the chair and was able to stand unassisted. One visitor fall. No injuries.

Three patient care events. One x-ray misread referred to medical peer review at BHMC. Pediatric patient self injury reported to physician. Allegations of inappropriate care provided by physician received from patient’s spouse, reviewed by CMO and care deemed appropriate.

Safety event due to physician needle stick while recapping needle. Employee health notified. BHPG nurse managers to ensure that the offices have safety needles/devices and if possible dispose needles/syringes without proper safety devices.

Lab related to wrong patient label. MA had already called Quest for pick up when patient was drawn. MA was rushing and left purple tube in the centrifuge. According to Quest tube could still be sent when MA realized error. This time MA printed the wrong patient label to send to Quest with purple tube. When physician reviewed results in the afternoon, noted she got 2 CBCs for the same patient, she realized error based on patient’s history and addressed correctly. Nurse manager addressed errors with MA.

Infection control occurrence should have been entered as complaint about x-ray tech not wearing mask during procedure with patient. Nurse manager contacted patient. Employee counseled.
<table>
<thead>
<tr>
<th>CDTC</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>1st Qtr</th>
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</tbody>
</table>

Total of 6 occurrences.

Two of the 4 HIPAA/PHI events reported Early Steps form mailed to wrong provider. Compliance held educational session with staff.

Patient care occurrence related to patient allegations against provider that were not substantiated. Also one patient reported abuse at home during visit with provider and DCF was contacted.
Seven occurrences reported.

One visitor fall outside ISC building, no environmental issues identified or injuries reported.

Three patient care events related to COVID-19 testing sites. One patient presented with SOB and was transferred to ED. Part of swab stayed logged in patient’s nare requiring transfer to ED, DOH who provides swabs was notified, claims department notified as patient would like BH to pay for ED visit. RN misread COVID result and called patient with negative when patient was positive, this was discovered during end day positive results review, RN realized short cut should not been used as previously discussed.

Three lab occurrences related to COVID-19 testing sites. Quest reported receiving specimens for one patient with requisitions for another patient, patients were retested, requisition printing process evaluated. No similar events since May.
<table>
<thead>
<tr>
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<th>Prior YTD</th>
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<th>Q2</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Improve the Accuracy of Patient ID</strong></td>
<td>% of Lab Mislabeled Specimens (Lab-NR)</td>
<td># of Mislabeled</td>
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</tbody>
</table>
## Patient Safety Dashboard

### CY 2019

<table>
<thead>
<tr>
<th></th>
<th>CY19 Goal</th>
<th>Stretch Goal</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>CY 20 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1</strong></td>
<td><strong>Identify patients correctly</strong></td>
<td>a. Use 2 patient identifiers when providing care, treatment &amp; services. 01.01.01</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication Scan (all departments)</td>
<td>97%</td>
<td>99%</td>
<td>97%</td>
<td>97.3%</td>
<td>97.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specimen Scan (all departments)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>b. Eliminate transfusion errors related to patient misidentification 01.03.01</td>
<td>97%</td>
<td>99%</td>
<td>97%</td>
<td>97.3%</td>
<td>97.0%</td>
<td>95.3%</td>
</tr>
<tr>
<td><strong>Goal 2</strong></td>
<td><strong>Improve staff communication</strong></td>
<td>a. Report critical results on a timely basis. 02.03.01</td>
<td>98.00%</td>
<td>99.00%</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Laboratory: Critical readback notification</td>
<td>98%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radiology: Critical results called ≤ 45 min</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Goal 3</strong></td>
<td><strong>Use medicines safely</strong></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>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td></td>
<td>b. Reduce the likelihood of harm associated with anticoagulant therapy-excessive anticoagulation with warfarin for IP- INR &gt; 5. 03.05.01</td>
<td>1%</td>
<td>0%</td>
<td>0.0%</td>
<td>0.0%</td>
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<td>0.0%</td>
</tr>
<tr>
<td><strong>Goal 4</strong></td>
<td><strong>Use alarms safely</strong></td>
<td>a. Improve the safety of clinical alarm systems. 06.01.01 (RR by monitor tech)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Goal 5</strong></td>
<td><strong>Prevent infection</strong></td>
<td>a. Use hand cleaning guidelines from CDC or WHO. Set goals for and improve hand cleaning 07.01.01</td>
<td>90%</td>
<td>95%</td>
<td>93%</td>
<td>92%</td>
<td>93.3%</td>
</tr>
<tr>
<td></td>
<td>b. C-diff (use guidelines to prevent infections that are difficult to treat) 07.03.01</td>
<td>2.8</td>
<td>0.0</td>
<td>0.9</td>
<td>0.0</td>
<td>0.9</td>
<td>2.8</td>
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<tr>
<td></td>
<td>c. Prevent CLABSI 07.04.01</td>
<td>0.27</td>
<td>0.0</td>
<td>1.5</td>
<td>1.1</td>
<td>0.0</td>
<td>1.0</td>
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<tr>
<td></td>
<td>d. Prevent SSI’s 07.05.01</td>
<td>1.0</td>
<td>0.0</td>
<td>0.00</td>
<td>0.61</td>
<td>0.25</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>e. Prevent CAUTI 07.06.01</td>
<td>1.00</td>
<td>0.00</td>
<td>4.1</td>
<td>1.1</td>
<td>1.1</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Goal 6</strong></td>
<td><strong>Identify patient safety risks</strong></td>
<td>a. Find out which patients are most likely to try to commit suicide 15.01.01</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Goal 7</strong></td>
<td><strong>Prevent mistakes in surgery</strong></td>
<td>a. Conduct preprocedure verification process. UP.01.01.01</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td></td>
<td>b. Mark procedure site. UP.01.02.01</td>
<td>100%</td>
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<td>c. A time-out is performed before the procedure. UP.01.03.01</td>
<td>100%</td>
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<tr>
<td></td>
<td>a. Reduce Pressure Ulcer Prevalence ≥ Stage II</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>8</td>
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<tr>
<td></td>
<td>b. PSI 13 - Post op sepsis</td>
<td>0.0%</td>
<td>0%</td>
<td>0.0</td>
<td>0.7</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td></td>
<td>c. Sepsis core measure</td>
<td>75%</td>
<td>80%</td>
<td>77%</td>
<td>93%</td>
<td>90.8%</td>
<td>85%</td>
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<td>99% 99% 99% 99.2% 99.2% 99% 99%</td>
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<td>98% 99% 100% 99.7% 99.7% 100% 99.8%</td>
</tr>
<tr>
<td><strong>Laboratory: Nursing to LIP</strong></td>
<td>80% 90% 78% 73.8% 67.7% 72.2% 71% 74%</td>
</tr>
<tr>
<td><strong>Radiology: Critical results called ≤ 45 min</strong></td>
<td>99% 100% 100%</td>
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<td><strong>b.</strong> Reduce the likelihood of harm associated with anticoagulant therapy-excessive anticoagulation with warfarin for IP- INR &gt; 5. 03.05.01</td>
<td>0.5 0.0 0.0 ~ ~ ~ 0.0</td>
</tr>
<tr>
<td><strong>c.</strong> Record and pass along correct information about a patient’s medicines 03.06.01</td>
<td>99% 100% 99.3% 99.1% 99.3% 99.6% 99.3% 99.3%</td>
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<td>90% 95% 89% 91% 95% 89.7% 92% 90%</td>
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<tr>
<td><strong>b.</strong> C-diff (use guidelines to prevent infections that are difficult to treat) 07.03.01</td>
<td>2.8 0.0 0.3 0.00 3.22 3.69 2.3 1.3</td>
</tr>
<tr>
<td><strong>c.</strong> Prevent CLABSI 07.04.01</td>
<td>0.27 0.0 0.0 1.27 0.00 0.0 0.4 0.2</td>
</tr>
<tr>
<td><strong>d.</strong> Prevent SSI's 07.05.01</td>
<td>1.0 0.0 0.0 0.93 0.90 0.00 0.6 0.3</td>
</tr>
<tr>
<td><strong>e.</strong> Prevent CAUTI 07.06.01</td>
<td>1.00 0.00 0.0 0.0 2.05 0.00 0.7 0.3</td>
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<td>100% 100% 100%</td>
</tr>
<tr>
<td><strong>a.</strong> Reduce Pressure Ulcer Prevalence - Stage II</td>
<td>4 2 6 1 1 0 2 8</td>
</tr>
<tr>
<td><strong>b.</strong> PSI 13 - Post op sepsis</td>
<td>0.0% 0% 6.1 71.4 0.0 0.0 23.8 14.9</td>
</tr>
<tr>
<td><strong>c.</strong> Sepsis core measure</td>
<td>75% 80% 79%</td>
</tr>
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</table>
BHMC Performance Improvement Appraisal/Evaluation CY 2019

Broward Health Medical Center 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 BHMC 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 included 8:30am daily safety huddle, monthly patient tracers, infection control surveillance rounds and selected quarterly point prevalence studies, weekly HAI huddles, unit shift huddles, monthly leadership meetings, 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. Completed the Joint Commission Triennial Survey May 2018 maintained accreditation status. Received The Joint Commission Re-accreditation certification Disease Specific Re-certifications in Re-certification in Total Hip and Knee in July 2018 and Primary Stroke in August 2018. Regulatory goals for 2020 include successful completion on disease specific TJC surveys: Stroke and Total joint.

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.

<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals 2019</th>
<th>Outcomes</th>
<th>Actions 2019</th>
<th>Goals 2020</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 2019 YTD…</td>
<td>• Patient through put committee initiated in ED, additionally metrics reviewed at daily safety huddle.</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>Metric</td>
<td>Benchmark</td>
<td>Result</td>
<td>Concurrent abstractions for HBIPS and Stroke. Drill down of case variances to identify process opportunities</td>
<td>Achieve Letter B grade in Leapfrog</td>
</tr>
<tr>
<td>ED-1B</td>
<td>334</td>
<td>247</td>
<td>Continued multidisciplinary Program specific committee meetings</td>
<td>Achieve CMS 3 Star Rating</td>
</tr>
<tr>
<td>ED-2B</td>
<td>136</td>
<td>102</td>
<td>Continued multidisciplinary education (Updates, Standard &amp;</td>
<td></td>
</tr>
<tr>
<td>PI Indicators</td>
<td>Goals 2019</td>
<td>Outcomes</td>
<td>Actions 2019</td>
<td>Goals 2020</td>
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<tr>
<td></td>
<td></td>
<td>Metric</td>
<td>Benchmark</td>
<td>Result</td>
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<tr>
<td></td>
<td></td>
<td>STK – 5</td>
<td>100%</td>
<td>97%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>STK -6</td>
<td>100%</td>
<td>99.6%</td>
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<tr>
<td></td>
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<td>STK – 8</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
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<td>STK – 10</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td></td>
<td></td>
<td>HBIPS - 1a</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HBIPS - 2a</td>
<td>0.68</td>
<td>0.17</td>
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<td>HBIPS - 3a</td>
<td>0.49</td>
<td>0.18</td>
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<td></td>
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<td>HBIPS - 5a</td>
<td>57%</td>
<td>99%</td>
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<td></td>
<td></td>
<td>PC-01</td>
<td>0%</td>
<td>0.7%</td>
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<tr>
<td></td>
<td></td>
<td>Seps-1</td>
<td>44%</td>
<td>70%</td>
</tr>
</tbody>
</table>

**STK**

- **Metric**: STK – 5, STK -6, STK – 8, STK – 10
- **Benchmark**: 100%
- **Result**: 97%, 99.6%, 99%, 100%

**HBIPS**

- **Metric**: HBIPS - 1a, HBIPS - 2a, HBIPS - 3a, HBIPS - 5a
- **Benchmark**: 0.68, 0.49, 57%
- **Result**: 0.17, 0.18, 99%

**PC**

- **Metric**: PC-01
- **Benchmark**: 0%
- **Result**: 0.7%

**Seps**

- **Metric**: Seps-1
- **Benchmark**: 44%
- **Result**: 70%

**HCAHPS**

- **Metric**: Rating, Recommend, Comm Nurses, Response
- **Benchmark**: 75th%
- **Score**: 69.8, 70.2, 76.9, 61.2
- **%Rank**: 36, 41, 22, 21

**Goals 2020**

- **Expectations**
  - **Hired Sepsis coordinator** – to have concurrent review of practice

**Actions 2019**

- **Continuation of FY18 initiatives**:
  - Mandatory skills lab training all RNs and clinical staff
  - Partnered with PG for Boot camps on NL and hourly rounding
  - Structured validation by NM
  - Standardized Shift Huddle
  - Discharge phone calls
  - Patient Family Advisory Committee created
  - Patient Experience Committee
  - Operations Leader Rounding on Nursing Units
- **New Customer Service Manager hired**; evaluating current initiatives
- **Implementation of 4 non-negotiable processes**
  - Purposeful Rounding (3 tier
<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals 2019</th>
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<th>Actions 2019</th>
<th>Goals 2020</th>
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<tbody>
<tr>
<td></td>
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<td>strategy</td>
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<td>o Bedside report</td>
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<td>o Commit to sit</td>
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<td>o Final Touch</td>
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<tr>
<td></td>
<td>10% reduction in 2018 rate 1.026</td>
<td>20/26,955 line days 0.74</td>
<td>We reached the facility goal but not the CMS goal of zero.</td>
<td>10% reduction in 2019 rate 0.66</td>
</tr>
<tr>
<td></td>
<td>CMS benchmark = 0</td>
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<td>CMS benchmark = 0</td>
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<tr>
<td>CLABSI</td>
<td></td>
<td></td>
<td>• Daily multidisciplinary rounding and indication review</td>
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<td>• Dialysis rounds</td>
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<td></td>
<td>• Vascular access team exchanging lines for midlines and extended dwell peripheral IVs</td>
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<td></td>
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<td></td>
<td>• Resident and medical student education and Epi shadowing</td>
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<td>• Nursing and PCA competencies</td>
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<td>• Removal of catheters for elective joints</td>
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<td></td>
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<td>• New hire orientation with CLABSI and CAUTI prevention interactive boards</td>
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<td>• Standardized products for foley care</td>
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<td></td>
<td>• HOUDINI physician re-education including Trauma quality</td>
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<td>• UA to UC reflex update</td>
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<td>• Removal of catheters for</td>
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</tr>
<tr>
<td>CAUTI</td>
<td>10% reduction in 2018 rate 1.863</td>
<td>19/13,440 line days 1.41</td>
<td>We reached the facility goal but not the CMS goal of zero.</td>
<td>10% reduction in 2019 rate 1.27</td>
</tr>
<tr>
<td></td>
<td>CMS benchmark = 0</td>
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<td></td>
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<td></td>
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<td></td>
<td>• Six Sigma Project completed by Janis Smith Love</td>
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<td>• HOUDINI physician uncheck disabled in IT</td>
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<td></td>
<td>• Daily multidisciplinary rounding and indication review</td>
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<td>• IT documentation of Foley bundle to EBCC</td>
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<td>• CUSP AHRQ education</td>
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<td>• Resident and medical student education and Epi shadowing</td>
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<td></td>
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<td></td>
<td>• Nursing and PCA competencies</td>
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<td>• Standardized products for foley care</td>
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<td>• HOUDINI physician re-education including Trauma quality</td>
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<td>• UA to UC reflex update</td>
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<td></td>
<td>• Removal of catheters for</td>
<td></td>
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<tr>
<td>PI Indicators</td>
<td>Goals 2019</td>
<td>Outcomes</td>
<td>Actions 2019</td>
<td>Goals 2020</td>
</tr>
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<td>---------------</td>
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</tr>
</tbody>
</table>
| Surgical Site Infections | 10% reduction in 2018 rate 7.83 | **Colon Surgery 8/138 5.8** We reached the facility goal but not the CMS goal of zero. | • 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  
  • PI team re-chartered – focus on HRET Change Packet  
  • Multi-disciplinary Weekly HAI Safety Huddle  
  • Pre-procedure education about bathing  
  • Keep track of bathing issues in pre-op for inpatient side for immediate follow up  
  • Physician office manager outreach  
  • PCR nasal swabs (Gene-Xpert)  
  • Glucose control process  
  • Normothermia  
  • Attire  
  • Post op dressing changes  
  • EVS  
  • Patient hand hygiene wipes  
  • Out of bed post-op | 10% reduction in 2019 rate 5.22  
  CMS benchmark = 0 |
| | CMS benchmark = 0 | 10% reduction in 2018 rate 0 | 10% reduction in 2019 rate 2.07 | CMS benchmark = 0 |
| | CMS benchmark = 0 | | | |
| C-diff | 10% reduction in 2018 rate 3.32 | **28/119,840 2.34 SIR 0.30** We reached the facility goal and the CMS achievement Goal but not the CMS goal of zero. | • EHR hard stop for reordering C-diff antigen within 7-days  
  • ED Triage screen in place  
  • Continue Antibiotic monitoring - pharmacist interventions and RMO  
  • C-diff decision tree tool created  
  • EVS staff room cleaning re-education validation of rooms | 10% reduction in 2019 rate 2.115  
  CMS benchmark = 0 |
<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals 2019</th>
<th>Outcomes</th>
<th>Actions 2019</th>
<th>Goals 2020</th>
</tr>
</thead>
</table>
| Readmissions  | Below Crimson National Average for All Hospitals for Medicare Patients Age 65 and older | • The Medicare AMI readmission rate for 2019 was 12.83% which is below the National (13.5%) and increase from last year.  
• The Medicare risk heart failure readmission rate for 2019 was 23.59% which is above National (21.92%) and increased from last year.  
• The Medicare pneumonia readmission for 2019 was 14.18% which is below the National (14.7%) but above last year’s rate.  
• The Medicare risk-adjusted COPD readmission rate for 2019 was 23.75% which is above National (19.91%) and increased from last year.  
• All payers 30 day readmission rate 11.72 national comparison was 12.10 | • CM/SW workflow process revised  
  o SW assigned to specific units; CM focus on Interqual and authorizations  
  o Pilot – CM placed in ED  
  o Revised discharge rounding, additional disciplines added  
• Corporate Re-admissions PI Team  
  o Checklist for d/c process and handoff created  
  o Education to CM d/c process  
  o F/U appt for by CM on COPD and CHF readmitted patients  
  o Electronic process for Population Health, Coordination of Care  
  o Developed new assessment for TOC follow-up call on high risk patients | Below Crimson National Average for All Hospitals for Medicare Patients Age 65 and older |
|               |           |          | Continued actions outlined below:  
• CM partner with Population Health  
• CM partner with HSAG  
• CM partner with identified SNFs |           |
<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals 2019</th>
<th>Outcomes</th>
<th>Actions 2019</th>
<th>Goals 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimicrobial Stewardship</td>
<td>Continue processes to maintain TJC Standards</td>
<td>• Maintained focus on ASP standards&lt;br&gt;• Corporate Chief Infection Prevention Officer in place</td>
<td>• Regional and Corporate Multidisciplinary committee&lt;br&gt;• Decentralized pharmacists to units&lt;br&gt;• Antimicrobial prospective audit and feedback (MedMined, Mpage, PK)&lt;br&gt;• ASP policies automatic IV to PO renal dosing, PK&lt;br&gt;• ASP initiatives (required antibiotic duration, indication, PPI indication)&lt;br&gt;• Ongoing Medication Utilization Evaluations (MUEs)&lt;br&gt;• Antimicrobial research projects in place</td>
<td>Continue processes to maintain TJC Standards&lt;br&gt;10% reduction in MDROs</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>Hospital-wide Achieve &gt;85%</td>
<td>• FY19 achieved 94% 7905/8441 hospital-wide compliance.</td>
<td>• Hand Hygiene Ninja’s secret shoppers&lt;br&gt;• Ongoing unit level observations and mock team observations.&lt;br&gt;• HH data shared at various hospital and medical staff committees&lt;br&gt;• Unit level HH data pushed out monthly by Quality&lt;br&gt;• IC rounds&lt;br&gt;• TJC tracers</td>
<td>5% improvement in hand hygiene rates.</td>
</tr>
</tbody>
</table>
Performance Improvement Appraisal CY 2019 and Goals and Objectives for CY 2020

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 2020 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). In 2019, 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 2020.

<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals</th>
<th>Findings</th>
<th>Actions</th>
<th>Objectives for CY 2020</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 17 Core measures
- ED 1 (359), ED2 (150): Worse than National Average for very high volume hospitals – compared to 2018 ED 1 (375), ED2 (240)
- IMM: retired
- VTE 6: retired
- STK core measures- within or above the National average.
2019 Data:
  - 2019: 3 Fallout in STK-1 (VTE prophylaxis by end of day 2) 99.2% (Nat’l average: 92% )
  - 2019: 2 fallouts in STK-2 (DC on antithrombotic) 99.3% (Nat’l average: 99%)
| 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 reduce ED boarding times. | Achieve top decile for 90% of all indicators.
Improve sepsis compliance to 70% or greater |
2019: 2 fallout in STK 3
(Anticoagulant therapy for atrial fibr/flutter prescribed at DC) 95.1% (Nat' l average: 95%)
  2019: 1 fallout in STK-4
(thrombolytic therapy) 97.7% (Nat’ l average:63%)
  2019 5 fallout in STK 5 (anti-thrombotic started by end of Day 2) 98.0%
  (Nat’ l average:98%)
  2019: 2 Fallouts in STK 6 (statin prescribed at DC) 99.3%
  (Nat’ l average:94%)
  2019: 1 Fallout in STK 8 (stroke education) 99.7%
  (Nat’ l average:87%)
  2019: 1 Fallout in STK 10 (assessed for rehab services) 99.7%
  (Nat’ l average:97%)

Compared to 2018
  2018: 1 Fallout in STK- 1- 99.7%
  2018: 2 fallouts in STK-2-99.3%,
  2018: 1 fallout in STK 3- 97.9%
  2018: 1 fallout in STK-4 – 97.8%,
  2018: 1 fallout in STK 5- 99.6%
  2018: 4 Fallouts in STK 6 - 98.5%
  2018: 0 Fallout in STK 8 100%
  2018: 1 Fallout in STK 10- 99.7%

SEP 1 – 2019 compliance was 64%
(247/384) improved compared to 2018 of 51% (174/341).

• OP 1 retired
• OP 2, 3: no population – consistent with 2018: no population.
• OP 4 retired
• OP 5: time is 17 higher compared from 6.2 (2018),
  2019 only had 2 months data (Jan/Feb)= 17 mins
• OP 18: 2019 YTD was 184.33 slightly higher than 2018 which was 178.71
• OP 20 retired
• OP 21: retired
• OP 23: 85.7%, lower compliance

• Multidisciplinary team involvement in the sepsis committee
• Compared to 2018 (100%)
  - OP 29: 100%, top decile same as in 2018 (100%)
  - OP 30 retired
• 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

| Mortalities | Below Crimson National Average for all hospitals | The overall risk-adjusted mortality rate was 1.61% (216/13434) compared to 2018-1.58% (213/13478), which is below the Crimson Cohort of 2.25% (2018:1.78%).
| Below Crimson National Average for All Hospitals for Medicare Patients Age 65 and older | The risk-adjusted AMI mortality rate was 3.0% (7/231) compared to 2018 – 5.78% (13/225) which is higher than the Crimson cohort of 2.70% (2018:3.62%).
| | The risk-adjusted heart failure mortality rate was 2.08% (9/432) compared to 2018 of 2.46% (11/448) which is above the Crimson Cohort rate of 1.49% (2018:1.53%).
| | The risk-adjusted pneumonia mortality rate was 2.6% (13/503) compared to 2018= 1.40% (8/571) which is lower compared to the Crimson cohort of 3.05% (2018:2.19%).
| | The risk-adjusted COPD mortality rate was 0.53% (2/375) compared to 2018= 0.88% (3/342) which is lower compared to the Crimson cohort of 1.29% (2018: 1.67%).
| | The Medicare risk-adjusted AMI mortality rate was 9.5% (4/42) compared to 2018= 6.12% (3/49) which is above the Crimson Cohort rate of 3.38% (2018:5.66%).
| | The Medicare risk-adjusted heart failure mortality rate was 4.55% (5/110) compared to 2018 0.93% (1/107) which is higher than the Crimson Cohort rate of 2.07% (2018:1.96%).
| | The Medicare risk-adjusted pneumonia mortality rate was 2.9% (4/138)

| 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 to work on standardizing care for these populations

Maintain risk-adjusted overall, AMI, heart failure and pneumonia mortality rates below the Crimson Cohort average.

Maintain Medicare risk-adjusted AMI, heart failure and pneumonia mortality rates below the Crimson Cohort average.
compared to 2018= 2.72% (4/147) which is lower the Crimson Cohort rate of 3.91% (2018:3.21%).
- The Medicare risk-adjusted COPD mortality rate was 0.00% (0/103) compared to 2018= 0.00% (0/85) which is lower compared to the Crimson Cohort rate of 1.13% (2018:1.86%).

<table>
<thead>
<tr>
<th>Readmissions</th>
<th>Below Crimson National Average for All Hospitals</th>
</tr>
</thead>
</table>
| • The overall risk-adjusted all cause 30 day readmission rate was 12.71% (1474/11596) compared to 2018 = 12.9% (1507/11714) which is above the Crimson Cohort rate of 11.51%(2018:9.93%).
• The risk-adjusted AMI readmission rate was 11.83% (22/186) compared to 2018 =13.22% (23/174) which is higher the Crimson Cohort rate of 8.89% (2018:9.07%).
• The risk-adjusted heart failure readmission rate was 23% (91/394) compared to 2018= 25.3% (102/403) which is above the Crimson Cohort rate of 17.1% (2018:17.13%).
• The risk-adjusted pneumonia readmission rate was 13.88% (63/455) compared to 2018= 13.2% (67/508) which is above the Crimson Cohort rate of 10.85% (2018:10.20%).
• The risk-adjusted COPD readmission rate was 20.45% (72/352) compared to 2018= 23.1% (68/294) which is above the Crimson Cohort rate of 15.01% (2018:14.73%).
• The Medicare risk-adjusted AMI readmission rate was 16.1% (5/31) compared to 2018= 20.6% (7/34) which is above the Crimson Cohort rate of 11.01% (2018:10.80%).
• The Medicare risk-adjusted heart failure readmission rate was 26.8% (26/97) compared to 2018= 23.1% (24/104 which is above the Crimson Cohort of 18.03% (2018:17.44%).
• The Medicare risk-adjusted pneumonia readmission rate was 20.45% (72/352) compared to 2018= 23.1% (68/294) which is above the Crimson Cohort rate of 15.01% (2018:14.73%).
• Proactive risk assessment for readmissions using an EHR based tool
• 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
• Case management to schedule follow-up appointments
• System wide Multidisciplinary PI team working to reduce readmissions

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.

Maintain Medicare risk-adjusted readmission rates for AMI and HF below the Crimson Cohort average. Improve pneumonia Medicare risk-adjusted readmission rates to at or below Crimson Cohort average.
**Readmission Rate**

- The readmission rate was 14.62% (19/130) compared to 2018 = 13.7% (18/131) which is higher than the Crimson Cohort rate of 11.34% (2018:11.55%).
- The Medicare risk-adjusted COPD readmission rate was 19.0% (19/100) compared to 2018 = 17.9% (14/78) which is above the Crimson Cohort Rate of 15.22% (2018:14.56%).

**Improve Patient Safety**

<table>
<thead>
<tr>
<th>Category</th>
<th>Target</th>
<th>Description</th>
<th>Actions</th>
<th>Result</th>
</tr>
</thead>
</table>
| Falls                             | <2.15 per 1000 patient days | There were 123 falls out of 80975 patient days for a rate of 1.5 falls per 1000 patient days compared to 2018= 114 Falls out of 81509 patient days for a rate of 1.4 falls per 1,000 patient days. This represents an increase in falls and in rate. There were 1 falls with serious injuries out of 80975 patient days for a rate of 0.012 compared to 2018= 3 falls with serious injuries out of 81,509 patient days for a rate of 0.04. 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 31 HAPIs out of 82,595 patient days for a rate of 0.38 per 1000 patient days compared to 2018= 17 HAPIs out of 82,958 patient days for a rate of 0.20 per 1,000 patient days. Of those, (1) Stage III for a rate of 0.01; (1) Stage IV for a rate 0.01 and (4) unstageable for a rate of 0.05. Compared to 2018 there were (4) Stage III for a rate of 0.05, (0) Stage IV for a rate of 0.00 and (7) unstageable for a rate of 0.08  
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 4 mislabeled specimens out of 229,052 compared to 2018 = 6 mislabeled specimens out of 226,797. 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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Incidence Rate</th>
<th>Incidence Description</th>
<th>Prevention Strategies</th>
<th>Target</th>
<th>Comments</th>
</tr>
</thead>
</table>
| **CLABSI**     | <0.80 per 1000 device days | The number of CLABSI were 13 out of 12953 device days for a rate of 1.00 compared to 2018= 11 out of 13,547 device days for a rate of 0.81. This is an increase in both rate and device utilization. The Standardized Infection Ratio (SIR) as reported to NHSN increased to 0.739 in 2019 compared to 2018= 0.689 | - 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  
- Multidisciplinary team drill down on all CLABSI | 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 18 out of 11685 catheter days for a rate 1.54 compared to 2018= 5 out of 12,600 catheter days for a rate of 0.40. This represents an increase in rate and device utilization. The SIR as reported to NHSN increased to 0.806 in 2019 compared to 2018= 0.073. | - 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.  
- Continue to follow catheter bundle  
- Multidisciplinary team drill down on all CAUTI | 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 5007 ventilator days compared to 2018= 3 VAP out of 4,287 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.  
- Multidisciplinary team drill down on all PVAP | Decrease PVAP rate to zero. |
<p>| <strong>Surgical Site Infections</strong> | Below National Average | There were 0 total abdominal hysterectomy SSI out of 11 hysterectomy procedures for a | - Continue tracking all colon infections even the ones that do not | Decrease surgical site infections to below the VBP |</p>
<table>
<thead>
<tr>
<th>Lab ID</th>
<th>Below CMS VBP Achievement Threshold</th>
<th>SIR as reported to NHSN</th>
<th>SIR as reported to NHSN</th>
<th>Decrease infections to below the VBP threshold as measured by SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MRSA Lab ID</strong></td>
<td>10 out of 85264 patient days for a rate 0.12 infections per 1000 patient days compared to 2017= 10 out of 74,382 patient days for a rate of 0.13 infections per 1,000 patient days</td>
<td>1.68 compared to 2017= 1.977</td>
<td>1.68 compared to 2017= 1.977</td>
<td><strong>Decrease infections to below</strong> <strong>the VBP threshold as measured by SIR</strong></td>
</tr>
<tr>
<td><strong>CDI Lab ID</strong></td>
<td>27 out</td>
<td>1.28 compared to 2018= 1.37</td>
<td>1.37 compared to 2018= 1.37</td>
<td><strong>Decrease infections to below</strong> <strong>the VBP threshold as measured by SIR</strong></td>
</tr>
</tbody>
</table>

- **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.**
- **Multidisciplinary team drill down on all MRSA**
<table>
<thead>
<tr>
<th>Threshold</th>
<th>of 85264 patient days for a rate of 3.17 infections per 1000 patient days compared to 2018= 27 out of 74,382 patient days for a rate of 3.76 infections per 1,000 patient days This is a decrease. The SIR as reported in NHSN was 0.529 compared to 2018= 0.572</th>
<th>ID event means and how to prevent 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 • Multidisciplinary team drill down on all CDIFF • Antibiotic stewardship • C-diff task force in place</th>
<th>the VBP threshold as measured by SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPROVE EFFICIENCY</td>
<td><strong>ED Throughput</strong></td>
<td><strong>At or Below National Average</strong></td>
<td><strong>IMPROVE EFFICIENCY</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ED-1 turn-around time was 359 minutes, compared to 2018=375 This is a decrease • ED-2 turn-around time was 150 compared to 2018=240 This is a decrease</td>
<td>• Patient Flow team • ED stakeholders team • Bed ahead • Code Purple policy</td>
</tr>
</tbody>
</table>
Broward Health Imperial Point Performance Improvement Appraisal CY 2019 and Goals and Objectives for CY 2020

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 2020 include continuous patient tracers 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. BHIP received Joint Commission Disease Specific re-certification in Primary Stroke in December 2019 and is scheduled for review of Heart Failure Disease Specific program in Q2 2020. The triennial accreditation hospital-wide survey is due in 2021 window opens in November 2020.

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 2020.

<table>
<thead>
<tr>
<th>PI Indicators</th>
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<th>Findings</th>
<th>Actions</th>
<th>Objectives for CY 2020</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 are 3 core measures retired in 2019: VTE-6, IMM-2, ED1, and ED 2 There has been continued compliance with the core measures for 2020: Stroke – all at top decile- Joint Commission certified SEPSIS –2019 current at 89% compliance with all measures which surpassed national benchmark of 87.1% HBIPS- 2019 strong improvement with modification to Cerner and reeducation to BHU physicians,</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 Continue collaboration with BHU to improve HBIPS outcomes</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 0.79% (60/7572) Crimson Cohort of 1.24%.
- The risk-adjusted AMI mortality rate was 0% (0/11) for 2019 which is below the Crimson Cohort of 7.42%.
- The risk-adjusted heart failure mortality rate was 1.75% (1/57) for 2019 which is slightly above the Crimson Cohort Rate of 1.66%.
- The risk-adjusted pneumonia mortality rate was 2.13% (1/9) for 2019 which is below the Crimson Cohort rate of 3.00%.
- The risk-adjusted COPD mortality rate was 1.72% (1/58) for 2019 which is slightly above the Crimson Cohort rate of 1.71%.

- 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.

### Readmissions

**Below Crimson National Average for All Hospitals**

- The overall risk-adjusted all cause 30 day readmission rate was 11.58% (849/7330) which is below the Crimson Cohort rate of 12.48%.
- The risk-adjusted AMI readmission rate for 2019 was 0% (0/11) which is below the Crimson Cohort of 13.36%. Very low volume.
- The risk-adjusted heart failure readmission rate for 2019 was 35.71% (20/56) which is above the Crimson Cohort of 19.02%
- The risk-adjusted pneumonia readmission rate for 2019 was 15.22% (14/92) which is slightly above the Crimson Cohort rate of 14.35%.
- The risk-adjusted COPD readmission rate for 2019 was

- Proactive risk assessment for readmissions
- Rates above benchmarks due to low volumes.
- Referral of patients to Disease State Management
- Heart Failure Coordinator ensuring and improving discharge communication related to symptoms
- Interdisciplinary rounds to be inclusive of Hospitalist groups
- Case Management ensuring follow-up appointments made prior to discharge

- Maintain risk-adjusted overall, AMI, heart failure, COPD and pneumonia mortality rates below the Crimson Cohort average.

- Maintain risk-adjusted overall, AMI, pneumonia, heart failure and readmission rates below the Crimson Cohort average. Improve pneumonia risk-adjusted readmission rates to at or below Crimson Cohort average.
10.53% (6/57) which is below the Crimson Cohort rate of 17.22%.

<table>
<thead>
<tr>
<th>IMPROVE PATIENT SAFETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
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<tr>
<td>Hospital-acquired Pressure Injuries</td>
</tr>
<tr>
<td>There were 17 HAPI out of 43644.75 patient days for a rate of 0.04 for 2019. Of those, there were 6 Stage II 1 Stage III 1 Stage IV 5 were DTI 3 Unstagable 0 were MDRPI</td>
</tr>
<tr>
<td>• All nursing staff re-educated on the September 2019 change in wound reporting to include DTI’s and unstagable wounds.</td>
</tr>
<tr>
<td>• Review and implementation of new skin products to preserve skin integrity.</td>
</tr>
<tr>
<td>• Weekly skin care rounds on all units</td>
</tr>
<tr>
<td>• Daily rounding by NM/ANM</td>
</tr>
<tr>
<td>• Education on hand-off communication to staff</td>
</tr>
<tr>
<td>• Perform intense analysis on all hospital-acquired pressure ulcers to affirm adherence to current practices and/ or opportunities for improvement.</td>
</tr>
<tr>
<td>Maintain hospital’s low HAPU rate and maintain 0 stage 3 and 0 stage 4 wounds</td>
</tr>
<tr>
<td>Mislabeled</td>
</tr>
<tr>
<td>There were 2 mislabeled specimens out of 205593 accessions in 2019.</td>
</tr>
<tr>
<td>• Continue to coach and remediate employees as necessary.</td>
</tr>
<tr>
<td>• Perform intense analysis on all mislabeled specimens for trends identified.</td>
</tr>
<tr>
<td>• Continue the use of bedside specimen scanning.</td>
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<tr>
<td>Decrease number of mislabeled/unlabeled specimens by 10%. Goal to be at zero.</td>
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<tr>
<td>Infection Type</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
| **CLABSI**     | 2.13 (Rate) | 2019– CLABSI with 4199 device days rate of 0.95 representing a significant decrease from 2018 | - Continue surveillance to all nursing units.  
- Daily interdisciplinary rounds to be inclusive of Case Management, Nursing, and Hospitalists  
- Continue to discuss at daily leadership AM flow meetings  
- Continue the Centurion Guardian Program.  
- Continue Chlorhexidine bath.  
- Participate in HSAG HAI program.  
- Continue to follow central line bundle | Prevalence unit rounding by Epidemiologist for staff resource, dressing change observations, just-in-time learning, and further supporting staff |
| **CAUTI**      | 1.15 (Rate) | The number of CAUTI for 2019 was 5 with 3310 device days for a rate of 1.51 This is an increase from 2018 which was 4 CAUTIs, 3130 catheter days for a rate of 1.28 | - Continue surveillance to all nursing units.  
- ED engagement in preventing insertion.  
- Continue HOUINDI protocol for all patients with foley catheter.  
- Continue to discuss at daily leadership AM flow meetings  
- Participate in HSAG HAI program.  
- Continue to follow catheter bundle | Prevalence unit rounding by Epidemiologist for staff resource, dressing change observations, just-in-time learning, and further supporting staff |
| **PVAP**       | Zero | There were 6 VAC’s and 1 PVAP in comparison to 3 VAC’s, 2 IVAC and 0 PVAP in 2018 in ICU. | - Continue VAE surveillance  
- Continue daily ICU Intensivist lead interdisciplinary rounds for concurrent review and management of ventilators  
- Continue to follow bundle. | Continue to monitor |
### Surgical Site Infections:
- Colon
- Hysterectomy

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon</td>
<td>2.73</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>0.77</td>
</tr>
</tbody>
</table>

In 2019, there was 1 colon surgery infection out of 112 surgeries performed for a rate of 0.89 which is below target. There was 1 hysterectomy infection out of 260 surgeries for a rate of 0.38 which is below the target.

- 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 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.
- Drill down on the infection related to colorectal surgery to identify trends.

### IMPROVE EFFICIENCY

<table>
<thead>
<tr>
<th>Category</th>
<th>Target</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Throughput</td>
<td>At or Below National Average</td>
<td>ED-1b median time ED arrival to ED departure in 2019 was 229 minutes which is below CY 2018 ~234 and goal of 240. ED-2b median admit decision time to ED departure was 120 minutes in 2016. In 2017 it approved to 111 minutes.</td>
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<tr>
<td></td>
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<td>- Daily flow meeting to discuss ED, Lab, Rad volume and TAT’s concurrently</td>
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<td>- Teletracking monitoring TAT’s concurrently</td>
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<td></td>
<td></td>
<td>- Monthly patient flow meetings led by ED Medical Director</td>
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<td>- Display ED and patient flow metrics daily at Leadership AM flow meetings. Action plans and/or process change are implemented when opportunities for improvement are identified.</td>
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<td></td>
<td></td>
<td>- Patient admitting orders time placed on Hospitalist scorecard. Reviewed and discussed monthly with Hospitalists to further enhance process and expedite ED admissions</td>
</tr>
</tbody>
</table>

Continue to improve median ED throughput time to at or below national average.
Broward Health Coral Springs Performance Improvement Appraisal CY 2019 and Goals and Objectives for CY 2020

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.

The Department Leaders at Broward Health Coral Springs 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 2020 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 2020.

<table>
<thead>
<tr>
<th>PI Indicators</th>
<th>Goals</th>
<th>Findings</th>
<th>Actions</th>
<th>Objectives for CY 2020</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 2019: • ED-2b – 109 minutes better than Nat'l avg for high volume ED • PC-01 – 0.00• PC-02 – 0.323 • PC-03 – 1.00 • PC-05 – 0.255 PC 01, 02, 03 are better than the benchmarks. PC 05 is below the benchmark • SEPSIS ~76% 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 regarding new or revised metrics. • Report details in monthly quality meeting</td>
<td>Maintain compliance with measures Improve measure scores for PC05 Ongoing work with corporate to adapt sepsis tools as measure is updated.</td>
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<tr>
<td>IMPROVE OUTCOMES</td>
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<tr>
<td><strong>Mortalities</strong></td>
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<tr>
<td>Below Crimson National Average for Mid-Sized Facilities</td>
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<td>(focus: year, BHCS, conditions tab-clinical conditions)</td>
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<tr>
<td>• The overall risk-adjusted mortality rate was 0.52% (65/12545) for 2019 which is below the Crimson Cohort of 1.04%.</td>
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<tr>
<td>• The risk-adjusted AMI mortality rate was 0% (0/55) for 2019 which is well below the Crimson Cohort of 3.57%.</td>
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<tr>
<td>• The risk-adjusted heart failure mortality rate was 1.30% (3/231) for 2019 which is below the Crimson Cohort Rate of 1.82%.</td>
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<tr>
<td>• The risk-adjusted pneumonia mortality rate was 1.08% (4/372) for 2019 which is below the Crimson Cohort of 1.55%.</td>
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<tr>
<td>• The risk-adjusted COPD mortality rate was 0% (0/207) for 2019 which is below the Crimson Cohort rate of 3.41%.</td>
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<tr>
<td>• Continue to review all mortalities, identify trends, perform peer review when necessary, and look for opportunities to continue to decrease mortality rates.</td>
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<tr>
<td>• All percentages are below the cohort rates</td>
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<tr>
<td>Maintain risk-adjusted overall, AMI, heart failure, pneumonia &amp; COPD mortality rates below the Crimson Cohort average.</td>
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<tr>
<td><strong>Readmissions</strong></td>
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<tr>
<td>Below Crimson National Average for All Hospitals</td>
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<tr>
<td>(any apr-drg)</td>
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<tr>
<td>(focus: year, BHCS, conditions tab-clinical conditions)</td>
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<tr>
<td>• The overall risk-adjusted all cause 30 day readmission rate was 9.94% (1241/12480) which is below the Crimson Cohort rate of 10.28% for 2019.</td>
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<tr>
<td>• The risk-adjusted AMI readmission rate for 2019 was 12.73% (7/55) which is above the Crimson Cohort of 9.89%.</td>
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<tr>
<td>• The risk-adjusted heart failure readmission rate for 2019 was 15.35% (35/228) which is below the Crimson Cohort of 24.2%.</td>
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<tr>
<td>• The risk-adjusted pneumonia readmission rate for 2019 was 10.33% (38/368) which is below the Crimson Cohort rate of 11.74%.</td>
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<tr>
<td>• The risk-adjusted COPD readmission rate for 2019 was 22.22% (46/207) which is above the Crimson Cohort rate of 20.03%.</td>
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<tr>
<td>• Identify High risk patient with daily email list.</td>
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<tr>
<td>• Complete High Risk Assessment with 24-48 hours.</td>
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<tr>
<td>• Readmission assessment to identify reasons and prevent future readmissions.</td>
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<tr>
<td>• Refer all high risk, COPD/HF/PN to Population Health.</td>
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<tr>
<td>• Nursing provides education on disease process.</td>
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<tr>
<td>• Respiratory therapist provides inhaler teaching for COPD.</td>
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<tr>
<td>• Obtain HHC for COPD/HF management when appropriate.</td>
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<tr>
<td>• Multi-Disciplinary Rounds to identify high risk patient who need education and f/u care.</td>
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<tr>
<td>• Obtain follow up appointment on all HF/COPD patients.</td>
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<tr>
<td>• Arrange clinic appointment on all uninsured.</td>
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<tr>
<td>• Arrange PCP appointment on patients</td>
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<tr>
<td>Maintain risk-adjusted overall, heart failure and pneumonia readmission rates below the Crimson Cohort average.</td>
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<tr>
<td>Improve AMI and COPD risk-adjusted readmission rates to at or below Crimson Cohort average.</td>
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</table>
with no primary care physician.

- Collaboration with AHCA, Medicaid Plans, and the South Florida hospital district on a discharge planning Pilot to decrease readmission.

## IMPROVE PATIENT SAFETY

<table>
<thead>
<tr>
<th>Category</th>
<th>Target/Status</th>
<th>Action Plan</th>
<th>Result</th>
</tr>
</thead>
</table>
| Falls                                         | <2.00 per 1000 patient days | - Monthly fall meetings lead by RM  
- Analysis of nursing discrepancies with Morse Fall Risk tool  
- Continue to perform post fall huddles and include patient/family whenever possible.  
- Perform an intense analysis on falls with injuries.  
- Continue use of bed and chair alarms  
- Educate staff and patients regarding fall prevention.  
- Gate belts purchase, training and use when ambulating patients  
- Analyze data for trends. | Reduce the facilities overall fall rate to below 2.0 with a 5% reduction being a rate of 1.957. |
| Hospital-acquired Pressure Injury             | Below National Average | - All nursing staff educated on pressure ulcer prevention, interventions and documentation  
- Weekly wound care rounds on all units by wound care nurse  
- Quarterly prevalence survey  
- Daily rounding by NM/ANM  
- Education regarding proper documentation  
- Staging to be completed by wound care nurse or physician only  
- Perform RCA/IA on all hospital-acquired pressure ulcers  
- Develop skills of the unit wound care champions through monthly meetings/workshops | Maintain hospital’s low HAPU rate. |
| Mislabeled Specimens                          | Zero          | - 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 | Decrease number of mislabeled specimens to zero. |
## DECREASE HOSPITAL-ACQUIRED INFECTIONS

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Rate</th>
<th>Description</th>
<th>Actions</th>
</tr>
</thead>
</table>
| **CLABSI (ICU)** | <0.9 per 1000 device days | The number of CLABSI in ICU was 2 out of 1747 device days for a rate of 1.14 for 2019. This is an increase from the rate of 0.93 for 2018. Number of line days decreased by 394 days compared to 2018. | - Increase surveillance to all nursing units.  
- Aggressive rounding to remove the central line.  
- Continue Chlorhexidine baths.  
- Participate in HSAG HAI program.  
- Continue to follow central line bundle  
- Work with intensivist group to decrease line days  
- Daily monitoring by quality team  
- Stand down when downgrading care from ICU/CCU to remove lines prior to transfer  
- Proper utilization of PICCs/Midlines |
| **CAUTI (ICU)** | <1.4 per 1000 catheter days | The number of CAUTI in ICU was 3 out of 1563 catheter days for a rate of 1.92 for 2019. This is an increase from the rate of 1.03 in 2018. Number of Foley days decreased by 376 days compared to 2018. | - Increase surveillance to all nursing units.  
- ED engagement in preventing insertion.  
- Continue Chlorhexidine bath.  
- HOUDINI protocol for all patients with Foley catheter.  
- IT changes made to not allow deselecting of Houdini protocol  
- Participate in HSAG HAI program.  
- Continue to follow catheter bundle  
- Work with intensivist group to decrease Foley days  
- Daily monitoring by quality team  
- Stand down when downgrading care from ICU/CCU to remove lines prior to transfer |
| **VAC** | Zero | There were 0 VACs in ICU for 2019 which is the same as 2018. | Continue with infection control rounds.  
- Educate staff regarding infection control practices.  
- Continue to follow bundle.  
- Continue with oral care per ventilator management protocol (NUR-006-205) |
| **Surgical Site Infections (VBP rates)** | Below National Average | There were 2 infections out of 313 hysterectomy procedures in 2019 for a rate of 0.64. The rate of 2018 was 0.0 showing an increase in 2019. There were 7 infections out of 148 colon surgeries for a rate of 4.73 in 2019. In 2018 | - Continue to monitor recommended prophylactic antibiotic use.  
- Address SSI reduction strategies with medical staff surgeons  
- Monitor for trends.  
- Refer for peer review as necessary.  
- Continue Chlorhexidine baths for all |
the rate was 5.04 with the same number of infections and fewer procedures completed in the year.

- Review all surgical classifications to verify correct classification – ongoing education and posting of signs in ORs regarding wound classification
- Work with surgeons to document infection pre-op.
- Work with surgeons regarding documentation of infection in operative notes
- Verify weight based dosages of antibiotics being used
- Intense analysis of all SSI with epidemiologist and OR Director and monitor for trends
- Implement Top Ten Checklist for SSI prevention from HRET-HIIN
- Report in monthly quality meetings

<table>
<thead>
<tr>
<th>Hospital Acquired All MDROs</th>
<th>Target ≤0.07</th>
<th>There were 8 MDROs for the 2019 calendar year out of 47,988 patient days for a rate of 0.17. This is an increase from 2018 rate of 0.08.</th>
</tr>
</thead>
</table>

**IMPROVE EFFICIENCY**

<table>
<thead>
<tr>
<th>ED Throughput</th>
<th>At or Below National Average</th>
<th>ED-1b median time ED arrival to ED departure in 2019 was 270 minutes; in 2018 it was 296 minutes. (Nat’l rate for very high volume ED = 312 min) ED-2b median admit decision time to ED departure was 108 minutes in 2019, in 2018 it was 118 minutes. (Nat’l rate for very high volume ED = 138 min)</th>
<th>Continue to decrease ED throughput times. 5% goals ED1b=257 min. ED 2b=103 min. 10% goals ED 1b=243 min. ED 2b=97 min.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>• Tele-tracking to monitor times • Daily bed huddles to address pending discharges and any other issues • ED metrics collected daily for patient flow • Monthly patient flow meetings led by ED Medical Director • Hospitalist bed rounds to expedite discharges • Interdisciplinary rounding for discharge planning</td>
<td></td>
</tr>
</tbody>
</table>
EPIDEMIOLOGY
INFECTION CONTROL PLAN – BHMC ADDENDUM

POLICY #: Broward Health Medical Center (BHMC) Infection Control Plan Addendum
SUBJECT: Broward Health Medical Center (BHMC) Infection Control Plan Addendum
SPONSOR: Epidemiology
APPROVED: BHMC
Heather Havericak CEO
Donna Small CNO
EFFECTIVE DATE: Date: 04/2001
REVISED: Dates: 10/09, 10/10, 12/11, 10/12, 4/15, 3/16, 3/17, 1/18, 2/19, 1/20
APPROVED FOR USE: BHMC

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 and kidney transplant, cancer services, Level 3 NICU, inpatient dialysis and other services which are delineated in the Scope of Program section.

Per Fiscal Year 2019 statistics, our payer mix was approximately 33.52 % managed care, 15.17 % Medicare, 12.37 % Medicaid, 3.59 % indigent, 12.46 % self-pay, and 22.89% commercial payer. According to the Broward County Health Department, there are high numbers of infectious diseases reported. These include new and emerging multidrug resistant organisms like Candida auris as well as epidemiologically important communicable disease like 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 2018 was increased to 3.5 per 100,000 people from 3.2 in 2017. For CY 2019, BHMC saw a rate of 22.66 per 100,000 patients which was decreased from CY 18 of 30.22 per 100,000 patients. This placed BHMC at medium risk per CDC TB Risk Assessment that is completed yearly and 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 2019 include: cesarean section, rehab oral, insertion IV access catheter, irrigation and debridement lower extremity wound, coronary artery bypass graft, laparotomy exploratory, circumcision (peds), tonsillectomy and adenoidectomy, tracheostomy, and replacement total knee.

The Top 10 Inpatient principle diagnoses, exclusive of Behavioral Health CY 2019 include:
Single liveborn infant, delivered vaginally
Single liveborn infant, delivered by cesarean
Hb-SS disease with crisis, unspecified
Sepsis, unspecified organism
Matern care for low transverse scar from prev cesarean del
Non-ST elevation (NSTEMI) myocardial infarction
Acute kidney failure, unspecified
First degree perineal laceration during delivery
Hypertensive heart disease with heart failure
Encounter for full-term uncomplicated delivery

The **Top 10 Inpatient principle Behavioral Health diagnoses CY 2019** include:
Paranoid schizophrenia
Schizoaffective disorder, bipolar type
Major depression disorder, recurrent severe w/o psych features
Bipolar disorder, crnt epsd depress, severe, w psych features
Brief psychotic disorder
Bipolar disorder, crnt episode manic severe w psych features
Major depressv disorder, recurrent, severe w psych symptoms
Bipolar disorder, crnt episode mixed, severe, w psych features
Bipolar disorder, crnt epsd depress, mild or mod severt, unsp
Bipolar disorder, current episode mixed, unspecified

The **Top 10 Emergency Department diagnoses for CY 2019** include:
Paranoid schizophrenia
Hb-SS disease with crisis, unspecified
Sepsis, unspecified organism
Schizoaffective disorder, bipolar type
Acute kidney failure, unspecified
Hypertensive heart disease with heart failure
Chronic obstructive pulmonary disease w (acute) exacerbation
Pneumonia, unspecified organism
Non-ST elevation (NSTEMI) myocardial infarction
Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny

The **top 5 pediatric principle surgical procedures performed for CY2019 were:**
Introduction of Serum/Tox/Vaccine into Muscle, Perc Approach
ANESTHESIA INTRAORAL WITH BIOPSY NOS
Phototherapy of Skin, Multiple
SIMPLE REPAIR F/E/E/N/L/M 2.5CM/<
INSJ NON-NDWELLG BLADDER CATHETER
The top 5 pediatric inpatient principle diagnosis, CY2019 include:
Single liveborn infant, delivered vaginally
Single liveborn infant, delivered by cesarean
Hb-SS disease with crisis, unspecified
Unspecified asthma with (acute) exacerbation
Twin liveborn infant, delivered by cesarean

The top 5 Pediatric Emergency Department diagnosis for CY2019 include:
Acute upper respiratory infection, unspecified
Viral infection, unspecified
Noninfective gastroenteritis and colitis, unspecified
Constipation, unspecified
Otitis media, unspecified, bilateral

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.

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
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, *C. difficile*)
      8. Patients admitted through the International Program
      9. Immunocompromised patient (HIV/AIDS, sickle cell, cancer)
     10. NICU patients

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 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. Reports to monthly RQC and MCE/MEC.

E. 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 2020*

---

**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 & CEO
Appendix A
Goals and Objectives CY 2020
*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 37.1% in the HAI risk portion of the risk assessment. The top 5 risk identified in the Pareto analysis were outbreaks, Clostridoides difficile, multidrug resistant organisms (MRDO) and then tied were surgical site infections (SSI), central line associated bloodstream infection (CLABSI) and ventilator associated events (VAE) constituting 89.7% 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>
</table>
| Outbreaks | All patients | 1. Reduce nosocomial outbreak  
2. Follow Outbreak procedure and policy whenever applicable | CY 2019: 2 | Housewide | 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. Use rounding, huddles, need to know, grand rounds.  
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. |
| 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 | BHMC Target Rates is 10% decrease from LCY  
MRSA: 0.38  
VRE: 0.07  
CRE: 0.05  
RAS: 0.14  
ESBL k. pneumo: 0.15  
ESBL e.coli: 0.18  
RPseud: 0.02  
CDIFF: 3.15  
MRSA bac: 0.13  
SIR target is FY 21 VBP goal  
MRSA bac: 0.763  
CDIFF: 0.748 | IP Nursing  
Physicians  
Pharmacy  
EVS | 1. Daily review of surveillance including admission log, ER log, and microbiology results/monitor labs, identify and verify infections, analyze data.  
2. Review of daily isolation patients with real time intervention for EMR orders.  
3. Utilize MedMined data mining program to assist with identifying potential clusters, monitor for MDROs and place patients in isolation in a timely manner.  
4. Review antibiogram and discuss at IPCC and Antimicrobial Stewardship committee  
5. Continue active surveillance for CRE and add C.auris screen in international patients who were hospitalized >48 hours prior to admission.  
6. Continue contact precautions for active MDRO infection and select history of MDRO (CRE, Candida auris, CRPA = forever isolation).  
8. CDIFF: Place patient on enhanced contact precautions per policy and monitor compliance with bleach based disinfection.  
9. Cohort if necessary on case by case basis.  
10. Intense analysis of all CDIFF and MRSA bacteremia cases including antibiotic indications and all room changes. |
| SSI | Patients who had surgery | 1. Determine risk factor for HAI
2. Decrease complications after surgery | BHMC target rate: I: II: SIR | IP Nurses Physicians Pharmacy Anesthesia | 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.

1. IP rounds facility wide.
2. Prevalence rounds for isolation, PPE use, equipment disinfection compliance.
3. Utilize Biofire as a component of the antimicrobial stewardship program to discontinue or prevent use of inapporopriate antimicrobials
4. Initiate infection control measures based on CDC or other evidence based recommendations.
5. Need 2 know related to Transmission Based precautions to be disseminated.
6. Housewide education provided related to Bristol stool scale.
7. Creation of soft alert to notify ordering providers of patients laxative/stool softener status.
8. 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.
9. Cancellation of order if stool not collected.
10. ED triage mandatory question about diarrhea.
11. SOAP UP hand hygiene program.
12. Review Antibiogram & discuss at Infection Control Committee (ICC) & Medical Care Evaluation (MCE) committee.
13. Continue to participate on Antimicrobial Stewardship.
14. BHMC target rate:
   - I: 
   - II: SIR

<table>
<thead>
<tr>
<th>CLABSI</th>
<th>Inpatients with central lines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3. Decrease readmissions related to SSI</td>
</tr>
<tr>
<td></td>
<td>4. Continue participating in FHA HIIN</td>
</tr>
<tr>
<td></td>
<td>5. SSI PI team</td>
</tr>
<tr>
<td></td>
<td>hyst: 0.726 colo: 0.754</td>
</tr>
<tr>
<td></td>
<td>4. Weight based dosing for antibiotics, re-dosing as necessary.</td>
</tr>
<tr>
<td></td>
<td>5. Plan for ERAS, glucose monitoring.</td>
</tr>
<tr>
<td></td>
<td>6. Discuss each SSI with management and administration to determine lessons learned.</td>
</tr>
<tr>
<td></td>
<td>7. CHG wash night before and morning of surgery.</td>
</tr>
<tr>
<td></td>
<td>8. Nurse driven action plans.</td>
</tr>
<tr>
<td></td>
<td>1. Determine risk factor for HAI</td>
</tr>
<tr>
<td></td>
<td>2. Decrease HAI</td>
</tr>
<tr>
<td></td>
<td>3. Continue participating in FHA HIIN</td>
</tr>
<tr>
<td></td>
<td>4. Decrease line days</td>
</tr>
<tr>
<td></td>
<td>5. Point prevalence rounding quarterly</td>
</tr>
<tr>
<td></td>
<td>BHMC target rate: 0.67 SIR: 0.687</td>
</tr>
<tr>
<td></td>
<td>IP Nurses Physicians PICC team</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>
</tr>
<tr>
<td></td>
<td>5. Monitor bundle compliance during prevalence rounds: dressing, Biopatch, Curos cap</td>
</tr>
<tr>
<td></td>
<td>6. Education, HIIN, AHRQ CUSP program</td>
</tr>
<tr>
<td></td>
<td>7. Nurse driven action plans</td>
</tr>
<tr>
<td></td>
<td>8. Daily CHG bathing for all patients in house with a central line.</td>
</tr>
<tr>
<td></td>
<td>9. Skills fair with Clinical Education</td>
</tr>
<tr>
<td></td>
<td>10. Peripheral draws for blood specimens</td>
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<tr>
<td></td>
<td>11. Discuss each CLABSI infection in weekly huddles with management and administration to determine lessons learned.</td>
</tr>
<tr>
<td></td>
<td>12. Provide monthly reports to each individual units</td>
</tr>
<tr>
<td></td>
<td>13. Continue to monitor use of femoral site for central lines</td>
</tr>
<tr>
<td></td>
<td>14. Fast facts related to CLABSI prevention</td>
</tr>
<tr>
<td></td>
<td>15. Standardize daily line rounding form for BHMC and SFCH.</td>
</tr>
<tr>
<td></td>
<td>16. Education utilizing Guardian Angel completed on an annual basis with check off validation.</td>
</tr>
</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 on policy for placing patient on airborne isolation for suspected TB disease.
3. Physician order in place that includes pre-ordered 3 sputums 8 hours apart per evidence base.

**CAUTI**
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. Six Sigma PI team with Nurse Manager champion.
7. Updates to EMR with maintenance and documentation.
8. Educate on best practices in nursing orientation and rounding.
9. Nurse driven action plans and standardized intense analysis drill down form.
10. Education, HIIN, AHRQ CUSP program
11. Provide monthly reports to each individual units
12. Discuss each CAUTI in weekly HAC meeting with management and administration to determine lessons learned.
13. Participate in new product acquisition and rollout related to foley and incontinence care
14. CAUTI prevention Policy
15. Fast facts related to CAUTI prevention updated
16. Standardize daily line rounding form for BHMC and SFCH.
17. Implement PI team recommendations.

**Ventilator Associated Event**
1. Continue to utilize VAP bundle to prevent Ventilator Associated Pneumonia.
2. Continue to monitor for VAE according to the NHSN VAE definition and report to appropriate stakeholders.
3. PedVAE definition from NHSN started January 2019 and workgroup to discuss cases that meet definition with NICU and PICU medical directors.
4. Identified need for CHG order to comply with bundle.

**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.
2. Alert tab notification will populate for inpatients when epidemiology documents MDRO.

**No Internal Notification of HAIs**
1. Continue to work with laboratory on notification of critical lab results related to potential communicable diseases.
**Healthcare Worker Risks**

**Goal #2** Reduction of healthcare worker risk of infections secondary to injury and/or exposure.

*Pareto Analysis reveals non-compliance with hand hygiene as the highest risk percent at 29.5%. The remaining of the top 4 risks identified in the Pareto analysis were non-compliance with standard precautions, failure to follow protocols and use safety devices or PPE, sharps injuries, and employee knowledge deficit of disease transmission which make up 91.8% of healthcare worker risks. All risks to healthcare workers are followed by Safety, Employee Health and Epidemiology.

<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</td>
<td>All employees, physicians, students, volunteers</td>
<td>Strive for 100% of hand hygiene compliance.</td>
<td>BHMC</td>
<td>IP Administration</td>
<td>1. Compliance reported at monthly ICC and graphs sent to all managers for posting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>target: 90%</td>
<td></td>
<td>2. Targeted education for specific departments.</td>
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<tr>
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<td></td>
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<td>3. SOAP UP hand hygiene campaign.</td>
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<td>4. Collection of hand hygiene data from all areas of hospital and multiple disciplines.</td>
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<td>5. Monitor compliance in all areas of hospital.</td>
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<td>6. Poster campaign by corporate marketing.</td>
</tr>
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<td></td>
<td>7. Nursing at orientation and periodically on standard precautions according to policy.</td>
</tr>
</tbody>
</table>
| Failure to follow standard precautions and PPE | All employees, physicians, students, volunteers | Decrease communicable symptom exposures. | BHMC target: 90% | IP Safety EH | 1. IP rounds to reinforce protocols, use of safety devices, proper PPE.  
2. Competency for PPE donning and doffing.  
3. Face shields with surgical mask available and stocked.  
4. 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.  
5. Coordinate with Safety and Employee Health on PPE education  
6. Just in time coaching while rounding for PPE compliance |
| Sharps injuries, failure to follow safety devices | Nursing, Physicians, Students | Decrease needle sticks, splashes, other preventable exposures. | BHMC target: 90% | Safety EH | Safety to report trends related to sharps injuries to EOC 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  
3. Just in time coaching while rounding for PPE compliance |

**Other Identified Events:**

**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
1. Collaborate with corporate on mandatory masking and influenza vaccination incentives.
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 declination forms must be signed.
5. Administration support
6. Physician survey on intranet to capture the most updated information.

Community Risks
Goal # 3: Reduction of community risk

*Pareto analysis reveals bioterrorism constitutes the highest risk percent at 27.3% for community related risks. The rest of the top 4 risks identified in the Pareto Analysis were long term care patients, hemorrhagic fever diseases like Ebola, seasonal flu and pandemic flu make up 80.3% of community risks. All risks from the community are evaluated using Emergency Department admission logs, culture reports, as well as working closely with the Health Department in Broward and Miami-Dade, the state of Florida, and CDC.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
</table>
| Bioterrorism including emerging infectious disease/other epidemics/influx of infectious | 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 on ED triage for all patients during triage to screen for all potentially infectious patients by questioning travel.  
2. All updated emergency HAN CDC notifications shared with physicians and ED.  
<table>
<thead>
<tr>
<th>Event</th>
<th>Patients</th>
<th>Length of Stay</th>
<th>IP Nursing Case management Physicians</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Patients including Hemorrhagic fever disease (i.e. Ebola) | All patients                                 |                | BHMC has nearby high admitting SNFs.  | 4. Communicate with the Florida Department of Health as necessary.  
5. Continue with established drills and EM updates and education.  
| Long term care patients     | All patients                                  |                | BHMC has nearby high admitting SNFs.  | 1. Active surveillance for incoming patients include cultures as indicated.  
2. Communication between facilities promoted including use of C.auris transfer packet. |
| Seasonal flu and pandemic flu | All patients                                  | 90% by 2020 with a 10% increase each year | BHMC will offer influenza vaccination to all qualified patients.  | 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.  
4. If pandemic flu, work with Florida Department of Health and Emergency Preparedness.  

Other Identified Events
Waterborne Outbreak
3. Report to Florida Department of Health as necessary.

Food Associated Outbreaks
1. Adhere to established outbreak management policy.
2. Continue to report positive cultures to Broward County Public Health Department.

Community Acquired MDRO
1. Identification of patients through daily surveillance admitted with MDROs.
2. Screening high risk individuals.
3. Assess staff need for education.
4. Continue adherence to International Hospital Transfer Patients CRE Screening Protocol and add C. auris to policy.

Active TB admissions
1. Continue to follow IC TB Plan and TB Risk Assessment updated yearly.
2. Work closely with Florida Department of Health.
3. Include BH International in planning for high risk groups like cruise ship employees.
Environmental Risks

Goal # 4 Reduction in environmental risks

*Pareto analysis reveals improper environmental cleaning as highest risk with a risk priority number of 243. Next were improper sterilization of equipment, improper handling of biohazardous waste, inadequate high level disinfection, and inadequate supplies of personal protective equipment making up over 88% total environmental risks.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Plan</th>
<th>Benchmark</th>
<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
</table>
| Improper environmental cleaning | All patients All staff | Compliance with proper cleaning protocols and products. | BHMC target: 90% | EVS IP Administration | 1. Black light inspection of clean rooms.  
2. EVS maintains pivotal role in Infection Prevention and Control Committee. |
| Improper sterilization of equipment | All patients All Staff | | BHMC target: 90% | OR SPD Administration | 1. Administration and Quality walk through of SPD on regular basis.  
2. Monitoring biologicals, implants released, IUSS, One Tray usage at monthly Infection Control Committee. |
### Improper handling of biohazardous waste
- **All patients**
- **All staff**

Reduction of red bag biohazard waste.

| BHMC target: 90% | All staff, Safety, Clinical Education |

1. EoC rounds to check biohazard waste.
2. DoH inspections.
3. Education by safety officer

### Inadequate high level disinfection
- **All patients**
- **All staff**

Compliance with proper HLD protocols and policies.

| BHMC target: 90% | IP, GI/Endo, SPD, Cardiac, Ultrasound, Adminsitration |

1. Continued use of TD-100 and Trophon EPR.
2. Continued use of Olympus OER.
3. Monthly surveillance of all areas completing high level disinfection

### Inadequate supplies of PPE
- **All staff**

Maintain adequate supplies of all PPE in all departments.

| BHMC target: 90% | Materials |

Materials management responsible for maintaining par levels of PPE on each nursing unit in the facility.

### Other Identified Events

**Improper low level disinfection of equipment**
1. IP rounds and educates on PDI wipe products.
2. Trial of new Oxivir wipe.
3. Education on hospital approved disinfectants in general orientation, nursing orientation, in-services, during rounding.
4. Just in time training during rounds.
5. Need to know and newsletter education.

**Inadequate pre-construction ICRA planning**
1. Multidisciplinary IP and safety at planning meetings for ICRA.
2. Include walk through.

**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.

**Air Quality Monitoring**

1. Air quality monitoring is conducted when concerns arise. Concerns are brought through employee notification or observations made during surveillance rounds.
EVALUATION OF THE SURVEILLANCE, PREVENTION AND CONTROL OF INFECTION PROGRAM PLAN CALENDAR YEAR 2019

This Program Evaluation is based in part on outcomes achieved during calendar year 2019 (1/2019 to 12/2019). Outcomes are identified through review of performance measurement data (PMR), information resulting from our committees, evidence based best practice, team meetings and multidisciplinary rounds as well as interviews and discussions conducted with staff and leaders throughout Broward Health Medical Center other Broward Health facilities including ambulatory and off-site clinics and in close collaboration with the Florida Department of Health.

The infection prevention and control program is an organization wide program that provides for surveillance, prevention and control of infections in patients, employees, students, licensed independent practitioners, physicians and all visitors to Broward Health Medical Center. The infection control 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, 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.

Targets

The following top organizational risk priority targets identified from the CY2019 Broward Health Medical Center Infection Control Risk Assessment, 2019 Annual Plan and 2019 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).

CDC Tap Reports show a CY 2019 decrease in all CDI, CLABSI, CAUTI.
1. Contain outbreaks and clusters

<table>
<thead>
<tr>
<th>Outbreaks/clusters</th>
<th>2019 BHMC target</th>
<th>2019</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed two clusters: (1) waterborne organisms including <em>Serratia marcescens</em> and Carbapenem resistant <em>Pseudomonas aeruginosa</em> waterborne organisms, (2) <em>Candida auris</em> nosocomial transmission</td>
<td></td>
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</table>

Analysis/Effectiveness

- Infection Control Assessment and Response (ICAR) site visit conducted with CDC and Florida Department of Health.
- 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.
- Respiratory etiquette stands with hand hygiene, cover your cough education, and masks placed at entrances.

2. 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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>2019 BHMC target</th>
<th>2019 Final</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI Central Line Infections</td>
<td>1.02</td>
<td>0.74 ↓</td>
<td>0.67</td>
</tr>
<tr>
<td>Central Line Days X 1000 = Rate per 1000 Central Line Days</td>
<td>0.784</td>
<td>0.64 ↓</td>
<td>0.687 threshold</td>
</tr>
<tr>
<td>CAUTI Urinary Catheter Infections</td>
<td>1.86</td>
<td>1.41 ↓</td>
<td>0.828</td>
</tr>
<tr>
<td>Urinary Catheter Days X 1000 = Rate per 1000 Urinary Catheter Days</td>
<td>0.828</td>
<td>0.79 ↓</td>
<td>0.774 threshold</td>
</tr>
<tr>
<td>VAE Ventilator Associated Events (VAC, IVAC, PVAP)</td>
<td>VAC –</td>
<td>IVAC –</td>
<td>PVAP –</td>
</tr>
<tr>
<td>Ventilator Days X 1000 = Rate per 1000 Ventilator Days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Regional Quality Council.
- Priority is given to device related infections based on risk assessment and analysis of collected data which is evaluated on an ongoing basis to provide immediate intervention when indicated to reduce or prevent infection.
- Rates increased and decreased depending on the unit.
- 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.
- Highest risk units for CLABSI and CAUTI listed below using CDC NHSN TAP reports.

![TAP Dashboard Detail](image-url)
Effectiveness

• **CLABSI**
  - CLABSI rates decreased 42.8% overall in 2019 compared to 2018.
  - CY 2019 SIR below VBP threshold.
  - There was a 12.5% decrease in central line days from 2018 to 2019.
  - 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 decreased 42.4% overall in 2019 compared to 2018.
  - CY 2019 SIR were above VBP threshold.
  - There was a 15.7% decrease in catheter days from 2018 to 2019.
  - Six Sigma Team with Nurse Manager Leader accomplished updating HOUDINI so it is always ordered and adding maintenance bundle to EMR.
  - Education and competency completed in 2019.
  - 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 SCU 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; line 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 ___ PVAP in 2019 that was followed by a mini-root cause analysis, meeting with stakeholders, and review of best practices with unit staff.
  - ____ in VAC and IVAC in CY 2019 was identified with continued prospective surveillance of patients on 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
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.

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

<table>
<thead>
<tr>
<th>Targeted Class</th>
<th>CY 2019 Target</th>
<th>CY 2019 Rate</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I: (All)</td>
<td>0.48</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Open Heart</td>
<td>0.74</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td>0.83</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td>0.73</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Pacemaker</td>
<td>0.51</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>C-Section</td>
<td>New all class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal</td>
<td>0.26</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Colon</td>
<td>7.83</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>0</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Colon</td>
<td>0.781</td>
<td>↑</td>
<td>0.754</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>0.722</td>
<td>↑</td>
<td>0.726</td>
</tr>
</tbody>
</table>

**SIR: observed/predicted**

- Class I surgeries in 2019 were _____ target.
- Colon SIR was above VBP threshold.
- CABG SSI _____ % below target.

Analysis
- Analysis of the 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 tracked for all classes.
- Present data to OR committee and Department of Surgery.
- Application to ACS ERAS for colon surgeries.

### Effectiveness

- 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

### 4. Management and reducing risk for acquiring and transmitting infectious agents like multi-drug resistant organisms (MDROs) and *Clostridium difficile* (CDIFF)

<table>
<thead>
<tr>
<th>2019 BHMC target</th>
<th>2019 Final</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRE # of patients with MDRO</td>
<td>0.01</td>
<td>↑0.05</td>
</tr>
<tr>
<td>VRE # of patient days x 1000</td>
<td>0.1</td>
<td>↓0.08</td>
</tr>
<tr>
<td>RAS</td>
<td>0.04</td>
<td>↑0.16</td>
</tr>
<tr>
<td>MDR-Pseudomonas/CRPA</td>
<td>MDRO rate</td>
<td>2018</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------</td>
<td>------</td>
</tr>
<tr>
<td>ESBL K. Pneumo</td>
<td>0.13</td>
<td>↑ 0.17</td>
</tr>
<tr>
<td>ESBL E.coli</td>
<td>0.09</td>
<td>↑ 0.20</td>
</tr>
<tr>
<td>MRSA bacteremia rate</td>
<td>0.08</td>
<td>↑ 0.09</td>
</tr>
<tr>
<td>CDIFF rate</td>
<td>3.32</td>
<td>↓ 2.34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MRSA bacteremia SIR</th>
<th>SIR: observed predicted</th>
<th>2018</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDIFF SIR</td>
<td>0.852</td>
<td>↓ 0.304</td>
<td>0.748</td>
</tr>
</tbody>
</table>

**Analysis**
- 39% decrease in CDIFF cases from CY 2018 to CY 2019 with a 29.5% decrease in rate and below threshold of Value Based Purchasing national benchmark.
- 7% decrease in MRSA bacteremia cases but it is still above VBP achievement threshold.
- Increase in epidemiological important MDROs highlight need for further surveillance methods and antimicrobial stewardship.
- New organisms including Carbapenem resistant *Pseudomonas aeruginosa* and *Candida auris* identified nationally and locally as potential for nosocomial transmission.
- 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.
- 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.
- 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 and in-person education provided to residents and medical students.

<table>
<thead>
<tr>
<th>5. Reduction of healthcare worker risk of infection secondary to non-compliance with standard precautions and failure to follow protocols and use safety devices or PPE. 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.</th>
<th>2018 target</th>
<th>2018 Rate</th>
<th>2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</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.

### 6. Improve Hand Hygiene Performance

<table>
<thead>
<tr>
<th>Hand Hygiene (Observed)</th>
<th>2019 BHMC target</th>
<th>2019 Rate</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed compliance of hand hygiene exceeded the goal of 90%.</td>
<td></td>
<td></td>
<td></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. Prevent unprotected exposure to pathogens and increase employee knowledge of disease transmission (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>HAI Cluster</th>
<th>2019 BHMC target</th>
<th>2019 Rate</th>
<th>2020 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**
- Water organism cluster and Candida auris nosocomial transmission identified as two epidemiologically significant events in CY 2019. Root cause analyses completed for both incidents. Changes in practice included multiuse ultrasound gel to single patient use packets of ultrasound gel, enteral flushing with sterile water instead of tap water, and environmental cultures in NICU for examination of cleaning practices.
- There were two TB exposures, two meningitis exposures, five varicella, three pertussis, and two influenza exposure for CY 2019. Each exposure was followed by Employee Health. There were no transmissions.
• Increase in vaccine preventable communicable diseases seen in Broward county and Florida per Department of Health.
• 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.
• Hemorrhagic fever disease
  • Long term care patients
  
**Performance:**
• Review of daily isolation log with real time education to staff.
• 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 2019 were followed up by Employee Health and resulted in zero transmissions.
• No TB conversions from exposures.
• CDC and Department of Health visit with recommendations made to update cleaning chemicals.

<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 90% goal</td>
<td>&gt;90%</td>
</tr>
</tbody>
</table>

**Analysis**
• There were _____ vaccinated at BHMC in 2019. This is an increase from 2,649 in 2018 which is a _____ % increase.
• CY 2019 data increase in physician numbers due to sharing of information at each Broward Health hospital.
• 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>9. PMR</th>
<th>2018 Rate</th>
<th>2019 Rate</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis Water/Dialysate Cultures/Endotoxins</td>
<td>99%</td>
<td>99.73%↑</td>
<td>100%</td>
</tr>
<tr>
<td>98%</td>
<td>99.72%↑</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Analysis/Effectiveness
• August cultures above threshold for one machine. Taken out of service, re-cleaned and re-cultures negative.
• 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 100% 100% reported 100%

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

Sterilizer/Steris Monitoring 100% 100% 100%

There were no adverse outcomes to patients regarding sterilizers. There were no biological recalls.

Immediate Use Steam Sterilization Monitoring 3% 0.09%↓ 0.1%

One Tray use n/a 2% 2%

Sterile Processing Department continuously strives for zero “flash” and reports at Infection Prevention and Control Committee monthly. Added tracking for One Tray for trends and monitoring.

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 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></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Program policies and procedures completed</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Epidemiologist Clinical 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>75%</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 CY2020 was completed with the multidisciplinary Infection Prevention and Control Committee for review, recommendations and approval.
• The effectiveness of the Infection Control Plan as outlined in the Annual Appraisal and Evaluation of the Program to be 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 Regional Quality Council 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 remediated for ICRA compliance during CY 2019

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.

The Joint Commission Standards Evaluation 2019

<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>1. The hospital identifies the</td>
<td>1. Authority statement in the IC Annual Plan.</td>
</tr>
</tbody>
</table>
| The hospital identifies the individual(s) responsible for the infection prevention and control program. | individual(s) with clinical authority over the infection prevention and control program. | 2. Medical Director of Epidemiology, Infectious Disease physician  
3. Staff position descriptions, experience, licenses and certifications |
| --- | --- | --- |
| 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. | 1. Medical Director of Epidemiology, Infectious disease physician available 24/7, 365 days a year.  
2. Other district organizations provide collegial/expert support. |
| 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. | 1. Comprehensive surveillance and analysis of epidemiological data is completed by 2 full time epidemiologists on a daily basis.  
2. Epidemiologists identify and intervene to assist the facility and its various departments in preventing transmission of infection.  
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. |
| 4. For hospitals that use Joint Commission accreditation for deemed status purposes: The individual with clinical authority over the infection prevention and control program is 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 | 1. The Medical Director of Infectious Diseases, Epidemiology department Director, Clinical 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 Regional 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.  

| 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) | 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 |
| 2. Does the organization provides laboratory resources when needed to support the infection control program? (See IC.01.05.01, EP 2) | 2. The Epidemiology team receives daily Candidate reports from the Laboratory and Microbiology for surveillance and analysis.  
- Surveillance Report  
- Quest Diagnostic reporting  
- Phone alerts |
| 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) | 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. |

**IC.01.03.01**  
Does the organization identify risks for acquiring and transmitting infections?  

| 1. The organization identifies risks for acquiring and transmitting infection based on the following:  
Its geographic location, community and population | 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 |
1. The care, treatment and services it provides. (see also NPSG.07.03.01, EP 1)
2. The analysis of surveillance activities and other infection control data. (see also NPSG.07.03.01, EP 1; TS.03.03.01, EP 2)
3. 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)
4. 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)

<table>
<thead>
<tr>
<th>IC.01.04.01</th>
<th>Do the organization’s written infection prevention and control goals include the following:</th>
<th>The Infection Control Plan and Risk Assessment guide the Epidemiology department.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Addressing its prioritized risks.</td>
<td>1. Risks are prioritized by the Risk Assessment.</td>
</tr>
<tr>
<td></td>
<td>2. Limiting unprotected exposure to pathogens</td>
<td>2. Standard/Transmissions based precautions are followed. An electronic alert system identifies patients previously admitted with select MDROs.</td>
</tr>
<tr>
<td></td>
<td>3. Limiting the transmission of infections associated with procedures.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>4. Limiting the transmission of infection associated with the use of medical equipment, devices, and supplies.</td>
<td>4. Infections associated with medical devices are prevented by the maintenance of hand sanitizers, PPE and hospital improved disinfection wipes throughout clinical areas.</td>
</tr>
<tr>
<td></td>
<td>5. Improving compliance with hand hygiene guidelines. (See also NPSG.07.01.01)</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IC.01.05.01</th>
<th>Does the organization have an infection prevention and control plan?</th>
<th>1. The organization follows CDC hand hygiene guidelines and CDC/NHSN definitions of organization acquired infections and</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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>2. 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>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>
<td>3. The Infection Control Plan is updated annually and reviewed and approved by the Infection Control Committee.</td>
</tr>
<tr>
<td></td>
<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>4. The Organization has a policy for investigating outbreaks. (Outbreak Management Plan).</td>
</tr>
<tr>
<td></td>
<td>4. The organization follows CDC hand hygiene guidelines and CDC/NHSN definitions of organization acquired infections and</td>
<td></td>
</tr>
<tr>
<td></td>
<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</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<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</td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th><strong>IC.01.06.01</strong></th>
<th>Does the organization prepare to respond to an influx of potentially infectious patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The organization 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>2.</td>
<td>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>
</tr>
<tr>
<td>3.</td>
<td>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>
</tr>
<tr>
<td><strong>IC.02.01.01</strong></td>
<td>Does the organization implements its infection and control plan</td>
</tr>
<tr>
<td>1.</td>
<td>The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.</td>
</tr>
<tr>
<td>2.</td>
<td>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>
</tr>
<tr>
<td>3.</td>
<td>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>
</tr>
<tr>
<td>5.</td>
<td>The organization investigate outbreaks of infectious disease? (See IC.01.05.01, EP 5)</td>
</tr>
<tr>
<td>6.</td>
<td>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>
</tr>
<tr>
<td>7.</td>
<td>The hospital implement its methods to communicate responsibilities for preventing and controlling infection to licensed practitioners and staff.</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).

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.

Computer technology will be utilized for analysis, trending and tracking of infection surveillance data (MEDMINED).

Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.

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.

The organization educates and uses standard precautions and personal protective equipment for employees.

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.
<table>
<thead>
<tr>
<th>IC.02.02.01</th>
<th>Does the organization reduce the risk of infections associated with medical equipment, devices and supplies?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>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>2.</td>
<td>Does the organization implement 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>Does the organization implement infection prevention &amp; control activities when doing the following:</td>
</tr>
<tr>
<td>4.</td>
<td>Surveillance rounds conducted by Epidemiology and EoC that routinely monitor the disposal and storing of medical equipment.</td>
</tr>
<tr>
<td>1.</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>2.</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>
</tbody>
</table>

13. In 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 who has an infection requiring monitoring, treatment, and/or isolation, does it inform the receiving organization?

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?

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 others via phone, HL7 and fax.

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.

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.
<table>
<thead>
<tr>
<th>IC.02.03.01</th>
<th>Does the organization work to prevent the transmission of infectious diseases among patients, licensed independent practitioners and staff?</th>
</tr>
</thead>
<tbody>
<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 potential testing, prophylaxis/treatment or counseling?</td>
</tr>
</tbody>
</table>

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.

<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>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>
</tr>
<tr>
<td>3.</td>
<td>The organization provides influenza vaccination at sites accessible to licensed independent practitioners</td>
</tr>
<tr>
<td>4. &amp; 5.</td>
<td>The goal of increasing vaccination rates by year</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 Outbreak management plan, as well as the Blood borne pathogen plan, outlines the organization’s response to patient exposures and potential follow-up.
and staff.

4. 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)

5. Does the organization set incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020?


6. Does the organization have a written description of the methodology used to determine influenza vaccination rates? (See IC.02.04.01, EP 1)

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?

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)

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?

IC.03.01.01
Does the organization evaluate the effectiveness of its infection prevention and control plan?

1. Does the organization evaluate the effectiveness of its infection prevention and control plan annually and whenever risks significantly change?

2. Does the evaluation include a review of the following: The infection prevention and control plan's prioritized risks?

3. Findings from the evaluation are communicated at least annually to the individuals or interdisciplinary group that manages the patient safety program.

4. The organization uses the findings of 1&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&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.
National Patient Safety Goals Standards Evaluation 2019

<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>Comply with 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>
</tr>
<tr>
<td></td>
<td>1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 1-5)</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>
</tr>
<tr>
<td></td>
<td>2. Set goals for improving compliance with hand hygiene guidelines. (2. See also IC.03.01.01 EP3)</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 surveillance rounds</td>
</tr>
<tr>
<td></td>
<td>3. Use compliance with hand hygiene guidelines based on established goals.</td>
<td>4. Target of 90% identified. Will accomplish through continuous education on the importance of hand hygiene.</td>
</tr>
<tr>
<td>NPSG.07.03.01</td>
<td>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.</td>
<td>1. An annual risk assessment of MDRO transmission is conducted and data tracked during the year.</td>
</tr>
<tr>
<td></td>
<td>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)</td>
<td>2. On hire and annually staff is educated on the basics of infection prevention and MDROs.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<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>
<td>4. Surveillance, isolation reports, and alert tab provides reports on MDRO transmission and influx of patients with an MDRO.</td>
</tr>
<tr>
<td></td>
<td>4. Implement a surveillance program for multi-drug-resistant organisms based on the risk assessment.</td>
<td>5. A Performance Measurement Report (PMR) is tracked for MDROs of significance using NHSN LAB ID definition.</td>
</tr>
<tr>
<td></td>
<td>4. Measure and monitor multi drug-resistant organism prevention processes and outcomes, including the following:</td>
<td>6. PMR compliance also tracked for CDC isolation guidelines are followed which is conducted during surveillance.</td>
</tr>
<tr>
<td></td>
<td>a. Multi drug-resistant organism infection rates using evidence-based metrics</td>
<td>7. The Infection Prevention and Control Committee as well as other meetings provides information to key stakeholders.</td>
</tr>
<tr>
<td></td>
<td>b. Compliance with evidence-based guidelines or best practices</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>c. Evaluation of the education program provided to staff and licensed independent practitioners. Note: Surveillance may be targeted rather than organization-</td>
<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</td>
</tr>
</tbody>
</table>
5. Provide multi drug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

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).

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.

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.

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.

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### NPSG.07.03.01 cont’d

- 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.
- Patient/Family education is provided using patient FAQ sheets and is documented in the patient chart.
- CLABSI policies and practices meet applicable regulatory requirements and are aligned with evidence based standards, professional organization guidelines and best practices
- 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.
- 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 to the Epidemiologist, or on-call Epidemiologist 24 hours/7 days a week.

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### 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. 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 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.

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.
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 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. This 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 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.
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.
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 wide-spread consensus. During
the on-site survey, surveyors will explore
the source of the practices the hospital
follows.

NPSG.07.06.01
Implement evidence based
practices to prevent catheter
associated urinary tract
infections (CAUTI)

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.

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

1. Staff is educated upon hire and annually or
when job responsibilities are changed to
include care of urinary catheters.
2. Patient/Family education is provided using
patient FAQ sheets and is documented in the
patient chart.
3. HOUDINI protocol is utilized.
- 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. (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

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.
Epidemiology Accomplishments CY 2019

**Hand Hygiene / isolation precautions**

1. Participation in multiple committee meetings discussing the importance of hand hygiene. These include but are not limited to: ICC, MCE, SFCH ICC, RQC, GME, OR Committee, Department of Surgery, Department of OB, Department of Pediatrics and Nursing Leadership.

2. Quality Management completes 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 and nail care distributed.

4. Increased number of hand sanitizer stations at elevators and entrances of facility.

**CAUTI**

1. 15.7% decrease in indwelling catheter days.

2. Six Sigma CAUTI Project led by Janis Smith Love, 4 Atrium Nurse Manager took a high level approach including working with all four CNOs and CMOs and corporate IT:
   a. add CAUTI maintenance bundle documentation and to EMR
   b. HOUDINI order is no longer able to be unchecked
   c. Standardizing Foley care products
   d. Updating CAUTI fast facts
   e. All RN and PCA competencies on foley care and insertion
   f. Healthstream CAUTI education re-assigned
3. Nurse leader emphasis on daily rounding focused on discussion related to indication and potential alternatives to indwelling urinary catheter.

4. Daily discussion of line necessity at safety huddle.

5. BARD point prevalence review of insertion and maintenance of catheters with improved results from CY18.

6. Epidemiology staff education focused on NHSN surveillance definitions.


8. CAUTI prevention education provided to all staff via Health stream.

**CLABSI**

1. 12.5% 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. Medline and Biopatch point prevalence completed. Data shared with appropriate stakeholders.

6. Daily chlorhexidine bathing provided to all patients with central lines.

7. Central line dressing changes occur every 7 days and as needed.

8. Emphasis on daily rounding focused on discussion related to indication and potential alternatives to central line.

9. Education through Centurion Angel program assigned to all nursing. Dialysis and port dressing kits available.

10. Trial of Tegaderm CHG dressing completed.

11. Alcohol impregnated disinfecting ports utilized on all central lines.

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. Daily surveillance of isolates.

3. Daily surveillance of Emergency Department visits.

4. Guide for weight based dosing disseminated to medical staff and Anesthesia
5. BARD Chloraprep training
7. Sage re-education 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. Update to MDRO alert for inpatients.
7. Hand hygiene program.

**Education**
1. CDC education on NHSN definitions by Epi staff.

2. HIIN in person training including IP Boot Camp and Florida Professionals in Infection Control.

3. CDC, HIIN multiple webinars attended.

4. Participation in new hire orientation for all staff.

5. Participation in interdisciplinary rounds.

6. Education provided to nursing huddles, rehabilitation services and transportation related to hand hygiene and isolation precautions.

**Project participation**

1. Candida auris containment strategy with Department of Health and CDC

**New Policies and committees**

1. PI teams:
   a. CAUTI Six Sigma

2. Update of International CRE Screening to add C.auris

**Surgical Services Report**

**CY 2019**

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>61</td>
</tr>
<tr>
<td>Outpatient</td>
<td>3,045</td>
</tr>
<tr>
<td>Inpatient</td>
<td>6,676</td>
</tr>
<tr>
<td>Short Stay Patient</td>
<td>921</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,720</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of Surgery</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean (Class I)</td>
<td>4,558</td>
</tr>
<tr>
<td>Clean-Contaminated (Class II)</td>
<td>4,209</td>
</tr>
<tr>
<td>Contaminated (Class III)</td>
<td>1,188</td>
</tr>
<tr>
<td>Infected (Class IV)</td>
<td>764</td>
</tr>
<tr>
<td><strong>Total Surgeries</strong></td>
<td><strong>10,720</strong></td>
</tr>
</tbody>
</table>

**Top 10 Class 1- Surgical Procedure 2017-2019**

<table>
<thead>
<tr>
<th></th>
<th>CY 2017</th>
<th>CY 2018</th>
<th>CY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary Artery Bypass Graft</td>
<td>152</td>
<td>Coronary Artery Bypass Graft</td>
<td>226</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertion IV Access catheter</td>
<td>123</td>
<td>Insertion IV Access Catheter</td>
<td>211</td>
</tr>
<tr>
<td></td>
<td>Procedure Description</td>
<td>CY 2017</td>
<td>CY 2018</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>3</td>
<td>Replacement Total Hip Anterior</td>
<td>115</td>
<td>Replacement Total Hip Anterior</td>
</tr>
<tr>
<td>4</td>
<td>Arthroplasty Knee</td>
<td>69</td>
<td>Arthroplasty Knee</td>
</tr>
<tr>
<td>5</td>
<td>Arthroscopy Knee</td>
<td>69</td>
<td>Replacement Total Knee</td>
</tr>
<tr>
<td>6</td>
<td>Mastopexy</td>
<td>54</td>
<td>Arthroscopy Knee</td>
</tr>
<tr>
<td>7</td>
<td>Arthroscopy Knee with Menisectomy</td>
<td>52</td>
<td>Arthroscopy Shoulder Rotator Cuff Repair</td>
</tr>
<tr>
<td>8</td>
<td>Mammoplasty Augmentation</td>
<td>47</td>
<td>Laminectomy Lumbar with TLIF</td>
</tr>
<tr>
<td>9</td>
<td>Capsulotomy with Exchange Implant</td>
<td>42</td>
<td>ORIF Ankle</td>
</tr>
<tr>
<td>10</td>
<td>Arthroscopy Shoulder rotator cuff repair</td>
<td>41</td>
<td>Microdiskectomy Lumbar with Metrx</td>
</tr>
</tbody>
</table>

**Top 10 Class 2 Surgical Procedures 2017-2019**

<table>
<thead>
<tr>
<th></th>
<th>Procedure Description</th>
<th>CY 2017</th>
<th>CY 2018</th>
<th>CY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Cesarean section</td>
<td>1193</td>
<td>Cesarean Section</td>
<td>1171</td>
</tr>
<tr>
<td>2.</td>
<td>Circumcision (Peds)</td>
<td>212</td>
<td>Circumcision(Peds)</td>
<td>236</td>
</tr>
<tr>
<td>3.</td>
<td>Rehab Oral</td>
<td>190</td>
<td>Rehab Oral</td>
<td>219</td>
</tr>
<tr>
<td>4.</td>
<td>Tracheostomy</td>
<td>129</td>
<td>Tracheostomy</td>
<td>143</td>
</tr>
<tr>
<td>5.</td>
<td>Tonsillectomy &amp; Adenoidectomy</td>
<td>119</td>
<td>Davinci Laparoscopic Cholecystectomy</td>
<td>120</td>
</tr>
<tr>
<td>6.</td>
<td>Laparotomy Exploratory</td>
<td>112</td>
<td>Tonsillectomy and Adenoidectomy</td>
<td>116</td>
</tr>
<tr>
<td>7.</td>
<td>Davinci Laparoscopic Cholecystectomy</td>
<td>107</td>
<td>Laparotomy Exploratory</td>
<td>93</td>
</tr>
<tr>
<td>8.</td>
<td>Laparoscopic Appendectomy</td>
<td>91</td>
<td>Laparoscopic Appendectomy</td>
<td>85</td>
</tr>
<tr>
<td>9.</td>
<td>Myringotomy PE tubes Adenoidectomy (Peds)</td>
<td>74</td>
<td>Dilation and Curettage Hysteroscopy</td>
<td>82</td>
</tr>
<tr>
<td>10.</td>
<td>Myringotomy PE tubes (peds)</td>
<td>66</td>
<td>Myringotomy PE Tubes Adenoidectomy (Peds)</td>
<td>68</td>
</tr>
</tbody>
</table>
**Tuberculosis (TB) risk assessment worksheet**

This model worksheet should be considered for use in performing TB risk assessments for healthcare 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:</th>
<th>(# of confirmed diagnosed cases of TB/number of admissions*100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2019</td>
<td>6/28,912 = 22.66 per 100,000 patients</td>
</tr>
<tr>
<td>CY 2018</td>
<td>8/26,469 = 30.22 per 100,000 patients</td>
</tr>
<tr>
<td>CY 2017</td>
<td>4/26,922 = 14.85 per 100,000 patients</td>
</tr>
</tbody>
</table>

**Community rate: (from dept. of health)**

↑ 3.5 (2018) 67 confirmed cases
3.2 (2017)
3.1 (2016)
4.5 (2015)
2.9 (2014)

**State rate:**

↑ 2.8 (2018)
2.7 (2017)
3.2 (2016)
3.0 (2015)
3.0 (2014)

**National rate:**

2.8 (2018)
2.8 (2017)
2.9 (2016)
3.0 (2015)
3.0 (2014)

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

| Yes |

---

1 of 7
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>2019</td>
<td>281</td>
<td>6</td>
</tr>
<tr>
<td>2018</td>
<td>440</td>
<td>8</td>
</tr>
<tr>
<td>2017</td>
<td>352</td>
<td>4</td>
</tr>
<tr>
<td>2016</td>
<td>345</td>
<td>7</td>
</tr>
<tr>
<td>2015</td>
<td>403</td>
<td>16</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

<table>
<thead>
<tr>
<th>Inpatient settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many inpatient beds are in your inpatient setting?</td>
</tr>
<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>
</tr>
<tr>
<td>2019: 6</td>
</tr>
<tr>
<td>2018: 8</td>
</tr>
<tr>
<td>2017: 4</td>
</tr>
<tr>
<td>2016: 7</td>
</tr>
<tr>
<td>2015: 16</td>
</tr>
<tr>
<td>2014: 15</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? (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>
<tbody>
<tr>
<td>If yes, which HCWs are included in the TB screening program? (Check all that apply.)</td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
</tr>
<tr>
<td>Mid-level practitioners (nurse practitioners [NP] and physician’s assistants [PA])</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
</tr>
<tr>
<td>Administrators</td>
<td></td>
</tr>
<tr>
<td>Laboratory workers</td>
<td></td>
</tr>
<tr>
<td>Respiratory therapists</td>
<td></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></td>
</tr>
<tr>
<td>Janitorial staff</td>
<td></td>
</tr>
<tr>
<td>Maintenance or engineering staff</td>
<td></td>
</tr>
<tr>
<td>Transportation staff</td>
<td></td>
</tr>
<tr>
<td>Dietary staff</td>
<td></td>
</tr>
<tr>
<td>Receptionists</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td></td>
</tr>
<tr>
<td>o Others __________</td>
<td></td>
</tr>
</tbody>
</table>

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)

No
Assay for Mycobacterium Tuberculosis for HCWs?

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%
- 2019 0.7%
- 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 0.6% to 0.7% – Even though the percentages were up and down over the last five years, the numbers remain below the threshold benchmark of 1%. We have continued to recommend TST and annual fit testing for all employees.

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

| Does the health-care setting have a written TB infection-control plan? | Yes and BH Policy |
| Who is responsible for the infection-control program? | Medical Director of Epidemiology/ chairman of infection control committee. |
| When was the TB infection-control plan first written? | 06/05 |
| When the TB infection-control plan was last reviewed or updated? | 1/2020 |
| Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., >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 *M. tuberculosis*)? | All infection control policies reviewed yearly. |
| Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)? | Yes |
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

Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name: ___

| 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 anti-tuberculosis 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 anti-tuberculosis 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>Which of the following tests are either conducted in-house at your health-care setting’s laboratory or sent out to a reference laboratory?</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 / 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
Delivery Room (Caesarean) – 20 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)

✓ 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

UVGI

✓ Portable room-air cleaners

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

82

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

Yes
appropriate expertise (e.g., certified industrial hygienist) for consultation on design specifications, installation, maintenance, and evaluation of environmental controls?

| Are environmental controls regularly checked and maintained with results recorded in maintenance logs? | Yes |
| Are all rooms checked daily for negative pressure when in use? | Yes |
| Is the directional airflow in all 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 all room pressure is not negative?

- Patient is transferred

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

Yes

8. Respiratory-Protection Program

Does your health-care setting have a written respiratory-protection program? Yes

Which HCWs are included in the respiratory protection program? (Check all that apply)

- Physicians
- Mid-level practitioners (NPs and PAs)
- Nurses
- Administrators
- Laboratory personnel
- Service personnel

Janitorial staff
Maintenance or engineering staff
Transportation staff
Dietary staff

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>Halyard Health Inc.</td>
<td>N-95 #62355</td>
<td>Routine contact with infectious TB patients</td>
</tr>
<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? Yes; On hire by employee health

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

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?

1) Departments were identified by Safety department that had not been having yearly fit testing.

What actions were taken to address the problems identified during the previous TB risk assessment?
1) Employees were sent to Employee Health to be fit tested and it was added to yearly job requirement.

| Did the risk classification need to be revised as a result of the last TB risk assessment? | No |

* 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 Medical Center
Comprehensive Infection Control Risk Assessment
Calendar Year 2019

Scoring Criteria:

A Risk Priority Number will be assigned for each event. Infection control will use a Pareto Analysis of the Risk priority numbers assigned to identify the main focus areas for the Infection Control plan of Calendar Year 2018.

Issues considered for **probability** include, but are not limited to:
1. Known risk
2. Historical data
3. Literature review or benchmark statistics

Issues considered for **response** include, but are not limited to:
1. Time needed to respond
2. Scope of response capability
3. Historical evaluation of response success

Issues considered for **life threat** include, but are not limited to:
1. Potential for staff death or injury
2. Potential for patient death or injury

Issues considered for **permanent harm** include, but are not limited to:
1. Potential impairment in cognitive functioning not related to underlying illness
2. Potential impairment in motor functions & ability to perform ADLs
3. Potential impairment in organ function
4. Potential chronic pain

Issues considered for **patient care impact** include, but are not limited to:
1. Interruption in usual patient care workflow
2. Employees unable to report to work
3. Surge demand for patient care service
4. Potential for exposure to an infectious agent
5. Change in level of patient care
6. Interruption of critical services
7. Change inpatient treatment
8. Change in services or setting
9. Increased potential for acquiring MDRO

Issues considered for **preparedness** include, but are not limited to:
1. Status of current plans, policies, procedures & practices
2. Demonstrated compliance with above
3. Annual Training status
4. Demonstrated staff awareness
5. Availability of alternate sources for critical supplies/services
Issues considered for **internal resources** include, but are not limited to:
1. Types of supplies on hand/will they meet need?
2. Volume of supplies on hand/will they meet need?
3. Staff availability
4. Interdepartmental Coordination
5. Availability of support services & staff
6. Internal resources ability to respond in a timely manner

Issues considered for **external resources** include, but are not limited to:
1. Types of agreements with community agencies
2. Coordination with local and state agencies
3. Coordination with proximal health care facilities
4. Coordination with treatment specific facilities
5. Community resources

The summary section provides the specific and overall Infection Control relative risk.
## CY 2019 Infection Control Risk Assessment

### HAI Risks

#### SEVERITY = (MAGNITUDE - MITIGATION)

<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>PATIENT CARE IMPACT</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
<th>EXTERNAL RESPONSE</th>
<th>RPN RISK PRIORITY NUMBER</th>
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<tbody>
<tr>
<td>Likelihood this will occur</td>
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<td>Functional losses &amp; permanent injury</td>
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<tr>
<td>Time, effectiveness, resources</td>
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<tr>
<td>Community/Communication, Mutual Aid staff and supplies</td>
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<td>C. Diff Infection</td>
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<tr>
<td>No Internal Notification of HAI's</td>
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</tbody>
</table>
HEALTHCARE ACQUIRED INFECTION RISKS CY 2019

- Outbreak: 288 (35.8%)
- C. Diff: 128 (51.7%)
- Surgical Site: 108 (65.2%)
- Central Lines: 72 (74.1%)
- Catheter Associated: 72 (83.1%)
- VAE: 48 (89.1%)
- Active TB, Unknown at MDRO: 36 (93.5%)
- MDRO: 36 (98.0%)
- Notification of No Internal Notification of MDRO: 8 (99.0%)

RISK PRIORITY NUMBER

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%

0 50 100 150 200 250 300 350 400
<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>SEVERITY = (MAGNITUDE - MITIGATION)</th>
<th>RPN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Likelihood this will occur</td>
<td>Possibility of death</td>
<td>Functional losses &amp; permanent injury</td>
</tr>
<tr>
<td>SCORE</td>
<td>0 = N/A</td>
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<td>2 = Moderate</td>
</tr>
<tr>
<td>Bioterrorism</td>
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<tr>
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<tr>
<td>Active TB Admits</td>
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<tr>
<td>Homeless person</td>
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<tr>
<td>HIV/AIDS</td>
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<tr>
<td>Long Term Care Patients</td>
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<tr>
<td>Community Aquire MDRO</td>
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<td>Pandemic Flu</td>
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<tr>
<td>Food Associated Outbreak</td>
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<tr>
<td>Flood</td>
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<tr>
<td>Hemorrhagic Fever Disease (i.e Ebola)</td>
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</tr>
<tr>
<td>Waterborne Outbreak</td>
<td>1</td>
<td>1</td>
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</tbody>
</table>
COMMUNITY RISKS CY 2019

- Bioterrorism: 108, 25.7%
- Long Term Care: 72, 42.9%
- Pandemic Flu: 54, 60.0%
- Hemorrhagic Fever: 48, 72.9%
- Seasonal Flu: 16
- Flood: 12
- Community Acquired: 12
- Waterborne: 8
- Food Associated: 6
- Homeless person: 6
- Active TB Admits: 6
- HIV/AIDS: 100.0%
## CY 2019 INFECTION PREVENTION/CONTROL RISK ASSESSMENT

**HEALTH CARE WORKER RELATED RISKS**

<table>
<thead>
<tr>
<th>EVENT</th>
<th>SCORE</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>IMPACT PATIENT CARE</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
<th>EXTERNAL RESPONSE</th>
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<tbody>
<tr>
<td>Non-compliance with Seasonal Flu Immunization</td>
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<td>Employee Knowledge Deficit of Disease Transmission</td>
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<td>Non-compliance with Hand Hygiene</td>
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<td>Failure to Follow Protocols and Use Safety Devices or PPE</td>
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<tr>
<td>Delay in Proper Isolation Precautions</td>
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<td>Sharps Injuries</td>
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<td>Non-compliance with Standard Precautions</td>
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<td>3</td>
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</tbody>
</table>
HEALTHCARE WORKER RELATED RISKS CY 2019

- Non-compliance with Standard: 72
- Non-compliance with Hand: 48 (46.9%)
- Failure to Follow Protocols and Use: 48
- Employee Knowledge Deficit of: 36
- Sharps: 32
- Delay in Proper Isolation: 16
- Non-compliance with Seasonal Flu: 4

Percentage:
- 28.1%
- 46.9%
- 65.6%
- 79.7%
- 92.2%
- 98.4%

RISK PRIORITY NUMBER
## CY 2019 INFECTION PREVENTION/CONTROL RISK ASSESSMENT
### ENVIRONMENTAL RISKS

<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>IMPACT PATIENT CARE</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
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<tbody>
<tr>
<td>SCORE</td>
<td>Likelihood this will occur</td>
<td>Possibility of death</td>
<td>Functional losses or injury</td>
<td>Individual or Interruption of services</td>
<td>Preplanning</td>
<td>Time, effectiveness, resources</td>
<td>Community/ Mutual Aid staff and supplies</td>
<td>RISK PRIORITY NUMBER</td>
</tr>
<tr>
<td>Inadequate Supplies of Personal Protective Equipment</td>
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<td>Improper Environmental Cleaning</td>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>48</td>
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<tr>
<td>Failure of Negative Pressure Ventilation</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
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<tr>
<td>Inadequate Preconstruction IC Planning &amp; Risk Assessment</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>16</td>
</tr>
</tbody>
</table>
ENVIRONMENTAL RISKS CY 2019

- Inadequate Supplies of Personal Protective Equipment
- Improper Environmental Cleaning
- Improper Disinfection of Equipment
- Inadequate High Level Disinfection
- Air Quality Fallouts
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 2019 statistics, our overall payor mix was Medicare 13.8 %, Medicaid 3.3%, Managed Care HMO/PPO Medicare 16.0%, HMO Medicaid 15.2%, Managed Care HMO Other/PPO 21.8%, Commercial/WC/H 4.7%, Self Pay 20.0%, Charity 5.1%

In 2019 the median age of population served is fifty 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 Broward County community rate of tuberculosis as
of 2019 was 2.9 per 100,000 people, 2018 was 3.5 per 100,000 people and in 2017 was 3.2 per 100,000 people. For CY 2019, BHN saw a rate of 51.69 (7 confirmed diagnosed cases of TB / 13,542 admissions) per 100,000 patients, in 2018 it was 22.20 (3 confirmed diagnosed cases of TB/13,509 admissions) per 100,000 patients and in 2017 it was 21.65 (3 confirmed diagnosed cases of TB/13,857 admissions) per 100,000 patients. 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.

**The top ten principle surgical procedures performed in CY 2019 were:** replacement total hip anterior, vitrectomy, balloon angioplasty, replacement total knee, creation of AV fistula, fusion anterior cervical spine, microdisectomy cervical, open reduction internal fixation hip nail, and insertion of IV access catheter, Exploratory Laparotomy.

**The top ten inpatient principle diagnoses in CY 2019 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 2019 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 dyscrasias, 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
     - 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.difficle)
   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 to 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 2020

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 2020
*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.
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>
| CLABSI    | Inpatients with central lines | 1. Determine risk factor for HAI  
2. Decrease HAI  
3. Decrease sepsis  
4. Decrease line days | BHN target rate: 0.784 | IP Nurses Physicians Pharmacists | 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,  
7. Nurse driven action plans  
8. CHG bathing  
9. Skills fair  
10. Peripheral draws for blood specimens  
11. Guardian Angel Program  
12. Discuss each CLABSI infection to determine lessons learned. |
<table>
<thead>
<tr>
<th>SSI</th>
<th>Patients who had surgery</th>
<th>1. Determine risk factor for HAI 2. Decrease HAI 3. Decrease sepsis 4. SSI PI team</th>
<th>BHN target rate: hysterectomy: 0.722 colon: 0.781</th>
<th>IP Nurses Physicians Pharmacists</th>
<th>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, microbiology results/monitor labs, identify and verify infections, analyze data. 4. Utilize MedMined data mining program to assist with identifying potential clusters 5. Review antibiogram and discuss at IPCC and Antimicrobial Stewardship committee 6. Continue active surveillance for CRE in international patients who were hospitalized &gt;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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDRO (including MRSA bacteremia) and CDIFF</td>
<td>All patients</td>
<td>1. Determine risk factor for HAI 2. Decrease HAI 3. Decrease sepsis 4. Decrease readmissions</td>
<td>BHN Target MRSA bacteremia: 0.815 CDIFF: 0.852</td>
<td>IP Nurses Physicians Pharmacists</td>
<td>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 &gt;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.</td>
</tr>
</tbody>
</table>
| CAUTI | Inpatients with Foley catheters | 1. Determine risk factor for HAI  
2. Decrease HAI  
3. Decrease sepsis  
4. Decrease foley days | BHN target rate: CAUTI: 0.828 | IP  
Nurses  
Physicians  
Pharmacists | 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. Nurse driven catheter removal protocol with order  
7. Nurse driven action plans.  
8. Education,  
10. Discuss each CAUTI case to determine lessons learned. |
|---|---|---|---|---|---|
| VAE | Inpatients on a ventilator | 1. Determine risk factor for HAI  
2. Decrease HAI  
3. Decrease sepsis  
4. Decrease vent days | BHN target rate:  
VAC: 3.40  
IVAC: 0.00  
VAP: 0.28 | IP  
Respiratory Nurses  
Physicians  
Pharmacists | 1. Prospective surveillance of vent settings to catch changes in ventilator settings  
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. Multidisciplinary approach with physicians and respiratory and nursing. |
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.
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. Utilize HAS report system to track and trend occurrences and follow up with managers and conduct education as needed.

COVID-19
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 positive COVID-19.
2. Initiate infection control measures based on CDC or other evidence based recommendations.
3. Consult with Florida Department of Health as necessary
4. Continued education
5. PPE supplies
6. IP rounds facility wide to ensure compliance with PPE
7. Include COVID status during reviews of mortality cases
8. Contact tracing (patients)
9. Contact tracing (staff)

**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 failure to follow protocols and use safety devices or PPE as the two top highest risk for healthcare worker related risks. The rest of the top 5 risks identified in the Pareto analysis were non-compliance with seasonal flu immunization, 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>
<th>Population</th>
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<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>
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<td>2. Hand Hygiene Poster campaign</td>
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<td>Compliance reported at monthly IPCC.</td>
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<td>3. Just in time education and reinforcement</td>
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<td>4. Hand Hygiene education at New Hire Orientation</td>
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<td>5. LEAPFROG Hand Hygiene:</td>
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<td>“Hand hygiene compliance data on at least 200 hand hygiene opportunities each month in each patient care unit”</td>
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<td>Added to each unit PMR and to be reported to IC committee</td>
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<td>6. LEAPFROG Hand Hygiene:</td>
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</table>
“Hospital conducts audits of the volume of alcohol based hand sanitizers that is delivered with each activation of a wall mounted dispenser (manual and automated) on a sample of dispensers in your patient care unit at all of the following times— upon installation, whenever the brand of product/system changes and whenever adjustments are made to the dispensers”

7. LEAPFROG Hand Hygiene
“Quarterly audits are conducted on a sample of dispensers in your patient care units to ensure that the process is followed— refill paper towels, soap dispensers, and alcohol based hand sanitizers dispensers when they are empty or near empty, replace batteries in automated paper towel dispensers, soap dispensers, and alcohol based hand sanitizer dispensers (if automated dispensers are used in the patient care units)

<table>
<thead>
<tr>
<th>Non-compliance with seasonal flu immunization</th>
<th>All employees, physicians, students, volunteers</th>
<th>Increase compliance by 10% each year until 90% goal of 2020.</th>
<th>BHN target 88%</th>
<th>IP EH Administration</th>
</tr>
</thead>
</table>

1. Collaborate with corporate on plan on influenza vaccination including mandatory masking and health insurance incentive.
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.
| Failure to follow protocols and use safety devices or PPE | All employees, physicians, students, volunteers | Decrease needle sticks, splashes, other preventable exposures. | BHN target: 90% | IP 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. |
| Sharps Injuries | All employees, physicians, students, volunteers | Decrease needle sticks | BHN target: 90% | IP EOC EH | 1. Education by Employee Health at New Hire Orientation  
2. EH to monitor |

**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 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>
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</tr>
</thead>
<tbody>
<tr>
<td>Long term patients</td>
<td>All patients</td>
<td>BHN has nearby high admitting SNFs.</td>
<td>Length of stay</td>
<td>IP Nursing Case management Physicians</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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 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. |
| Seasonal flu and pandemic flu | All patients | BHN will offer influenza vaccination to all qualified patients. | BHN target 88% | IP Nursing Quality | 1. Inpatients vaccinated during flu season per Centers for Medicaid and Medicare Services (CMS) protocol unless contraindicated.  
3. Patients with influenza placed on Droplet isolation precautions per policy.  
4. If pandemic flu, work with Florida Department of Health and Emergency Preparedness. |

**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 sterilization of equipment and improper disinfection of equipment (high level disinfection) as the highest risk. The remaining risks identified in the Pareto Analysis were: inadequate supplies of PPE, improper Sharps handling, Improper Disinfection of Equipment (low level disinfection), improper cleaning of the environment, Improper Handling of Biohazard waste, Inadequate pre-construction IC planning and Risk Assessment and Inadequate compliance with pre-construction IC planning and Risk Assessment.

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Team</th>
<th>Methodology</th>
</tr>
</thead>
</table>

14
<table>
<thead>
<tr>
<th>Improper environmental cleaning</th>
<th>EVS staff</th>
<th>Compliance with proper cleaning protocols and products.</th>
<th>BHN target: 90%</th>
<th>EVS</th>
<th>1. Partnership with epidemiology and EVS. 2. EVS maintains pivotal role in Infection Prevention and Control Committee.</th>
</tr>
</thead>
<tbody>
<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. 2. Education on hospital approved disinfectants in general orientation, nursing 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>BHN target: 90%</td>
<td>All employees</td>
<td>1. EoC rounds to check biohazard waste. 2. DoH inspections.</td>
</tr>
<tr>
<td>Inadequate compliance with IC Preconstruction</td>
<td>All staff</td>
<td>.Compliance</td>
<td>BHN target: 90%</td>
<td>Contracted staff</td>
<td>1. Daily rounds on preparation of Construction area. 2. Report findings to Facilities Manager/Project Director 3. Facilities to report all ICRA project to Infection Control Committee 4. Facilities to report to Infection Control committee compliance with ICRA</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. Central processing to report monthly to IC the compliance with the following:
   a. STERIS automated washer/disinfector machine
➢ The VERIFY All clean washer indicator strips are placed on every level (3 strips)
➢ The VERIFY All clean washer indicator strips are clear/no evidence of soil (3 strips)
b. STERIS Ultrasonic machine
   ➢ The VERIFY ultrasonic indicator is placed on 5 areas (5 indicators)
   ➢ The VERIFY ultrasonic indicators are clear/no evidence of soil (5 indicators)
3. Immediate use steam sterilization report sent monthly to Infection Control by Central Processing Department (will include use of 1 Tray)
4. Infection Control to investigate any cases reported regarding improper sterilization.
5. 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 report monthly to IC the compliance with monthly temperature, humidity and air pressure in surgical environment per standards.
3. Facilities to report monthly to IC, the airborne isolation monthly report

**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).
EVALUATION OF THE SURVEILLANCE, PREVENTION AND CONTROL OF INFECTION PROGRAM PLAN CALENDAR YEAR 2019

This Program Evaluation is based in part on outcomes achieved during calendar year 2019. 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, Licensed Independent Practitioner (LIP), 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.

**Ventilator Associated Event includes VAC, IVAC, PVAP.

<table>
<thead>
<tr>
<th>UNIT</th>
<th>Total infections for each unit CY 18</th>
<th>Total infections for each unit CY 19</th>
<th>CY19 CLABSI</th>
<th>CY19 SSI</th>
<th>CY19 CAUTI</th>
<th>CY19 MRSA bac</th>
<th>CY19 CDiff</th>
<th>CY19 VAC**</th>
</tr>
</thead>
<tbody>
<tr>
<td>MICU</td>
<td>21</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>SICU</td>
<td>9</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>3SE</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>0</td>
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<td>1</td>
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<tr>
<td>3NE</td>
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<td>0</td>
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</tr>
<tr>
<td>REHAB</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>CSCU -5</td>
<td>6</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>0</td>
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<tr>
<td>NEUROTELE-6</td>
<td>7</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>NSD</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>SCU – 7E</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<tr>
<td>MI OF – 7W</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>
</tr>
<tr>
<td>SMCU -8</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SURGTELE -9</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>CICU</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>OR(Colon&amp; Hys)</td>
<td>15</td>
<td>12</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total CY 2019</strong></td>
<td>84</td>
<td>13</td>
<td>12</td>
<td>18</td>
<td>10</td>
<td>27</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total YTD 2018</strong></td>
<td>90</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

** Medicare 13.8%**
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 CY2019 Broward Health North Infection Control Risk Assessment, 2019 Annual Plan Evaluation and 2019 PMR data analysis (targets adopted to reduce 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2019 BHN target</strong></td>
</tr>
<tr>
<td>CLABSI</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>CAUTI</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>VAE</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*There were three PVAP infections in CY 2018.*

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.
- 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 manager and instituted an action plan. Manager to identify trends in employees. Competency on dressing changes. Dialysis Coordinator to proactively discuss...
Effectiveness

- **CLABSI**
  - Increase in number of CLABSI from CY 2018 (11) to CY 2019 (13).
  - 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**
  - Increase in CAUTI from 5 in 2018 to 18 in 2019.
  - There was a decrease increase in Foley days (12,600- CY 2018) and (11,685- CY 2019).
  - 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 HOUHINI 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, ICU 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 were three PVAP in 2019 that was followed by a mini-root cause analysis, meeting with stakeholders, and review of best practices with unit staff.
  - VAP: 0.70-CY 2018 compared to 0.60-CY 2019
  - VAC: 1.8-CY 2018 compared to 2.0 – CY 2019
  - IVAC: 1.63- CY 2018 compared to 0.4-CY 2019
  - 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>2019 BHN target</th>
<th>2019 Final</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI Class I</td>
<td>0.27</td>
<td>0.31</td>
<td>0.37</td>
</tr>
<tr>
<td>SSI Class II</td>
<td>0.09</td>
<td>1.37</td>
<td>0.77</td>
</tr>
<tr>
<td>SIR: observed predicted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>0.762</td>
<td>0.00</td>
<td>0.762</td>
</tr>
<tr>
<td>Colon</td>
<td>0.781</td>
<td>0.00</td>
<td>0.781</td>
</tr>
</tbody>
</table>

**Analysis**

- Class II surgeries Target is 0.20 –CY 2019 and our final number is 1 for CY 2019.
- 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 with an opportunity to discuss lessons learned

**Improvement Solutions**

- New Performance Improvement team for 2019 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, and 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>2019 BHN target</th>
<th>2019 Final</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRE</td>
<td>0.04</td>
<td>0.01</td>
<td>0.027</td>
</tr>
<tr>
<td>VRE</td>
<td>0.07</td>
<td>0.01</td>
<td>0.063</td>
</tr>
<tr>
<td>RAS</td>
<td>0.00</td>
<td>0.01</td>
<td>0.0</td>
</tr>
<tr>
<td>ESBL K. Pneumo</td>
<td>0.09</td>
<td>0.01</td>
<td>0.072</td>
</tr>
<tr>
<td>ESBL E.coli</td>
<td>0.08</td>
<td>0.13</td>
<td>0.045</td>
</tr>
<tr>
<td>MRSA rate</td>
<td>3.10</td>
<td>3.12</td>
<td>3.69</td>
</tr>
<tr>
<td>CDIFF rate</td>
<td>0.01</td>
<td>3.17</td>
<td>3.105</td>
</tr>
<tr>
<td>MRSA bacteremia SIR</td>
<td>SIR: observed predicted</td>
<td>0.07</td>
<td>1.68</td>
</tr>
<tr>
<td>CDIFF SIR</td>
<td>0.924</td>
<td>0.529</td>
<td>0.514</td>
</tr>
</tbody>
</table>

**Analysis**

- Decrease in CDIFF overall from CY 2018 to CY 2019. CY 2018: 3.45 compared to CY 2019: 3.17
- Overall MRSA bacteremia CY 2018: 0.12 compared to CY 2019: 0.12
- 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 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.
- 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 2019.

### 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>Compliance of education</th>
<th>2019 BHN target</th>
<th>2019 Final</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></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.
- 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.

### 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>MDRO Trends/Identification</th>
<th>2019 BHN target</th>
<th>2019 final</th>
<th>2020 Goal/ Expectation</th>
</tr>
</thead>
</table>

#### Analysis
- There were 2 TB exposures, no meningitis exposures, 2 varicella exposure, no disseminated shingles exposures, and no mumps exposure for CY 2019. Each exposure was followed by Employee Health. There were no detected 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 intermediate 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:
• 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. This practice is being reviewed and revised by IRU medical leadership team.
• 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 2019 were followed up by Employee Health and resulted in zero transmissions.

<table>
<thead>
<tr>
<th>6. Improve hand hygiene and equipment disinfection</th>
<th>2019 BHN Target</th>
<th>2019 Final</th>
<th>2020 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>100%</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.
• 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.

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>HCW Influenza immunization rate</td>
<td>71%</td>
<td>85%</td>
<td>88%</td>
</tr>
</tbody>
</table>

**Analysis**

• CY 2019 data will include a robust increase in physician numbers due to sharing of information at each Broward Health hospital.
• CY 2019 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>2019 Target</th>
<th>2019 Final</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endotoxin</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Water Cultures</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Dialysate Culture</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### Transmission based precautions initiated

- Reporting to state, federal, local public health authorities
  - 100%
  - 100%
  - 100%

#### Acevide-C Log Monitoring

- 100%
- 100%
- 100%

### 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.
- Sterile Processing action plan in place to ensure compliance.
- 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 2019.
- 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></th>
<th>2019 Target</th>
<th>2019 Final</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>
The Comprehensive 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, employee health nurse 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 2019

### 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.

### Analysis

- The Comprehensive Infection Control Risk Assessment for CY2020 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 Medical Council 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, employee health nurse 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 2019

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<tr>
<th>STANDARD</th>
<th>ELEMENTS OF PERFORMANCE</th>
<th>EFFECTIVENESS</th>
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</table>
| IC.01.01.01 | Does the organization identify an individual(s) with clinical authority over the infection prevention and control program? | 1. Authority statement in the IC Annual Plan.  
2. Dr. Indulekha Gopal, Medical Director of Epidemiology, Infectious Disease physician  
3. Staff position descriptions, experience, licenses and certifications |
| | 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. | 1. Medical Director of Epidemiology, Infectious disease physician available 24/7, 365 days a year.  
2. Other district organizations provide collegial/expert support (Epidemiologist on call) |
| | 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) | 1. Comprehensive surveillance and analysis of epidemiological data is completed by 2 full time epidemiologists on a daily basis.  
2. Epidemiologists identify and intervene to assist the facility and its various departments in preventing |
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.

transmission of infection.

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.

4. "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:
   - 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?"

<table>
<thead>
<tr>
<th>IC.01.02.01</th>
<th>Does the organization leaders allocate needed resources for the infection prevention and control program.</th>
</tr>
</thead>
<tbody>
<tr>
<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>
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<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>
<td></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>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>IC.01.03.01</th>
<th>Does the organization identify risks for acquiring and transmitting infections?</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>2. The care, treatment and services it provides. (see also NPSG.07.03.01, EP 1)</td>
<td></td>
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<tr>
<td>3. The analysis of surveillance activities and other infection control data. (see also NPSG0.07.03.01, EP 1; TS.03.03.01, EP2)</td>
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</tr>
<tr>
<td>4. Does the organization reviews and identifies its risks at least annually and whenever</td>
<td></td>
</tr>
</tbody>
</table>

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

2. The Epidemiology team receives daily Candidate reports from the Laboratory and Microbiology for surveillance and analysis.
   - Surveillance 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.

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<thead>
<tr>
<th>IC.01.03.01</th>
<th>Does the organization identify risks for acquiring and transmitting infections?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&amp; 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.</td>
<td></td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th>IC.01.04.01</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do the organization’s written infection prevention and control goals include the following:</strong></td>
<td><strong>The Infection Control Plan and Risk Assessment guide the Epidemiology department.</strong></td>
</tr>
<tr>
<td>1. Addressing its prioritized risks.</td>
<td>1. Risks are prioritized by the Risk Assessment.</td>
</tr>
<tr>
<td>2. Limiting unprotected exposure to pathogens</td>
<td>2. Standard/Transmissions based precautions are followed. An electronic alert system identifies patients previously admitted with select MDROs.</td>
</tr>
<tr>
<td>3. Limiting the transmission of infections associated with procedures.</td>
<td>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.</td>
</tr>
<tr>
<td>4. Limiting the transmission of infection associated with the use of medical equipment, devices, and supplies.</td>
<td>4. Infections associated with medical devices are prevented by the maintenance of hand sanitizers, PPE and hospital improved disinfection wipes throughout clinical areas.</td>
</tr>
<tr>
<td>5. Improving compliance with hand hygiene guidelines. (See also NPSG.07.01.01)</td>
<td>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.</td>
</tr>
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<thead>
<tr>
<th>IC.01.05.01</th>
<th>Does the organization have an infection prevention and control plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. When developing infection prevention and control activities, the organization uses evidence based, national guidelines or, in the absence of such guidelines, expert consensus.</strong> 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>
<td><strong>1. The organization follows CDC hand hygiene guidelines and CDC/NHSN definitions of organization acquired infections and</strong> 2. 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>3. The organization describes, in writing, the process for investigating outbreaks of infectious diseases. ( see also IC.02.01.01, EP 5 ) 4. Are all organization components and functions integrated into infection prevention and control activities? ( see HR.01.04.01, EPs 2 and 4 ) 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>3. The Infection Control Plan is updated annually and reviewed and approved by the Infection Control Committee.</td>
</tr>
<tr>
<td>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.</td>
<td>4. The Organization has a policy for investigating outbreaks. (Outbreak Management Plan).</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>IC.01.06.01</th>
<th>The organization prepares to respond to an influx of potentially significant from, at a minimum, infection control personnel, medical staff, nursing and leadership. ( see also NPSG.07.03.01, EP 1) 5. 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)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Does the organization obtain current clinical and epidemiological information from its resources regarding new infections that could</strong></td>
<td>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</td>
</tr>
<tr>
<td>IC.01.06.01 cont’d</td>
<td>The organization prepares to respond to an influx of potentially infectious patients.</td>
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</tr>
<tr>
<td>1. 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>
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<tr>
<td>2. 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>
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<thead>
<tr>
<th>IC.02.01.01</th>
<th>Does the organization implements its infection and control plan</th>
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<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>
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<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>
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<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>
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<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>
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<tr>
<td>4. The organization investigates outbreaks of infectious disease? (See IC.01.05.01, EP 5)</td>
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<tr>
<td>5. 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>
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<tr>
<td>6. 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>
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<tr>
<td>7. Does the organization reports infection surveillance, prevention and control information to the appropriate staff within the organization?</td>
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<td>8. Does the organization report infection surveillance, prevention,</td>
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<td>9. Does the organization report infection surveillance, prevention,</td>
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<tr>
<td>10. The Infection Control Program is directed by a full time Infectious Disease physician and managed by a Regional Manager of Epidemiology, Safety &amp; Quality, 3 Staff Epidemiologists (1 FT and 2 per diem), and a Clinical 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 nursing, microbiology, environmental services, surgery, education, quality, safety, facilities, employee health nurse and other departments as needed.</td>
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<tr>
<td>1. Computer technology will be utilized for analysis, trending and tracking of infection surveillance data (MEDMINED).</td>
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<tr>
<td>1. Continuing education opportunities are encouraged and financially supported by leadership on an ongoing basis.</td>
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<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>
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<tr>
<td>2. The organization educates and uses standard precautions and personal protective equipment for employees.</td>
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<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>
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<td>4. The organization investigates outbreaks whenever suspect clusters or reports are obtained through surveillance activities.</td>
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<tr>
<td>5. 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>
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</table>
| 6. 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.
**IC.02.01.01 cont’d**

Does the organization implements its infection and control plan?

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<td>IC.02.01.01</td>
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**IC.02.01** Does the organization reduce the risk of infections associated with medical equipment, devices and supplies? |

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<tr>
<td></td>
<td><strong>1.</strong> 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>
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<td></td>
<td><strong>2.</strong> Does the organization implement 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>
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<tr>
<td></td>
<td><strong>3.</strong> Does the organization implement infection prevention &amp; control activities when doing the following: Disposing of medical equipment, devices, and supplies?</td>
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<td><strong>4.</strong> Does the organization implement infection prevention &amp; control activities when doing the following: Storing medical equipment, devices, and supplies? Note: Surveillance may be targeted rather than hospital wide.</td>
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<td><strong>5.</strong> When reprocessing single-use devices, the organization implements infection prevention and control</td>
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<td></td>
<td><strong>1.</strong> 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”.</td>
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<td><strong>2.</strong> 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>
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<tr>
<td></td>
<td><strong>1.</strong> 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</td>
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<td></td>
<td><strong>3 &amp; 4.</strong> Surveillance rounds conducted by Epidemiology and EoC that routinely monitor the disposal and storing of medical equipment.</td>
</tr>
</tbody>
</table>
IC.02.03.01
Does the organization work to prevent the transmission of infectious diseases among patients, licensed independent practitioners and staff?

| 1. | 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? |
| 2. | 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? |
| 3. | 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? |
| 4. | When patients have been exposed to an infectious disease, the organization provides them with or refers them for assessment and potential testing, prophylaxis/treatment or counseling? |

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.

IC.02.04.01
Does the organization offer vaccination against influenza to licensed independent practitioners and staff?

| 1. | Does the organization establish an annual influenza vaccination program that is offered to licensed independent practitioners and staff? |
| 2. | 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) |
| 3. | The organization provides influenza vaccination at sites accessible to licensed independent practitioners and staff. |
| 4. | 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) |
| 5. | Does the organization set incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020? |

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 vaccine 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.
6. The hospital uses Joint Commission/NHSN recommendations to calculate influenza vaccination rates for LIP’s, staff and contracted staff.
7. 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.
### IC.02.04.01 cont’d

Does the organization offer vaccination against influenza to licensed independent practitioners and staff?

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<tr>
<td>6.</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>
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<tr>
<td>7.</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>
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<tr>
<td>8.</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>
<td>8. Yes. Annual rates have increased.</td>
</tr>
<tr>
<td>9.</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>
<td>9. Yes. Rates are sent out weekly during flu season by Employee Health through administration.</td>
</tr>
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### IC.03.01.01

Does the organization evaluate the effectiveness of its infection prevention and control plan?

<table>
<thead>
<tr>
<th></th>
<th>1. Does the organization evaluate the effectiveness of its infection prevention and control plan annually and whenever risks significantly change?</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Does the evaluation include a review of the following: The infection prevention and control plan’s prioritized risks?</td>
<td>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.</td>
</tr>
<tr>
<td>3.</td>
<td>Findings from the evaluation are communicated at least annually to the individuals or interdisciplinary group that manages the patient safety program.</td>
<td>2. The Plan is implemented as planned.</td>
</tr>
<tr>
<td>4.</td>
<td>The organization 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)</td>
<td>3. The Infection Prevention and Control Committee and Quality Council evaluate infection rates and the annual evaluation of program goals.</td>
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<td>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

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<tr>
<th>STANDARD</th>
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<tbody>
<tr>
<td><strong>NPSG.07.01.01</strong>&lt;br&gt;Comply with either the current Centers for Disease Control and Prevention guidelines.</td>
<td>1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention guidelines.</td>
<td>1. The organization follows CDC Hand Hygiene guidelines.</td>
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<tr>
<td></td>
<td>2. Hand Hygiene is encouraged and promoted by...</td>
<td>2. Hand Hygiene is encouraged and promoted by...</td>
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Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines. Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 1-5)
2. Set goals for improving compliance with hand hygiene guidelines. (2. See also IC.03.01.01 EP3)
3. Use compliance with hand hygiene guidelines based on established goals.

| NPSPG.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.
4. Measure and monitor multi drug-resistant organism prevention processes 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.
5. Provide multi drug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.
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 | 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 infection. 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.

| NPSG.07.03.01 cont’d | standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).  
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.  
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. 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 |
| 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 |
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).

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, 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.
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 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. 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

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

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](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
## NPSG.07.06.01 cont'd

Implement evidence based practices to prevent catheter associated urinary tract infections (CAUTI)

**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. (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. **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 2019 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.

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. 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 2019**

<table>
<thead>
<tr>
<th>Location of Patient</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>63</td>
</tr>
<tr>
<td>Outpatient</td>
<td>1894</td>
</tr>
<tr>
<td>Inpatient</td>
<td>4164</td>
</tr>
<tr>
<td>SSP</td>
<td>676</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of Surgery</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean (Class I)</td>
<td>4557</td>
</tr>
<tr>
<td>Clean-Contaminated (Class II)</td>
<td>1113</td>
</tr>
<tr>
<td>Contaminated (Class III)</td>
<td>437</td>
</tr>
<tr>
<td>Infected (Class IV)</td>
<td>487</td>
</tr>
<tr>
<td>Total Surgeries</td>
<td>6594</td>
</tr>
</tbody>
</table>

**Top 12 Surgical Procedure 2019**

<table>
<thead>
<tr>
<th>1.</th>
<th>Replacement Total Hip Anterior</th>
<th>518</th>
<th>Creation AV Fistula</th>
<th>148</th>
<th>Insertion Catheter Hemodialysis</th>
<th>121</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Vitrectomy</td>
<td>362</td>
<td>ORIF Hip Nail</td>
<td>148</td>
<td>Laporscopic Cholecetomy Cholangio</td>
<td>109</td>
</tr>
<tr>
<td>3.</td>
<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>4.</td>
<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>
### Tuberculosis (TB) risk assessment worksheet CY 2020

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>
<th>Community rate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.9 (2019)</td>
<td></td>
</tr>
<tr>
<td>3.5 (2018)</td>
<td></td>
</tr>
<tr>
<td>3.2 (2017)</td>
<td></td>
</tr>
<tr>
<td>3.1 (2016)</td>
<td></td>
</tr>
<tr>
<td>4.5 (2015)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State rate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6 (2019)</td>
</tr>
<tr>
<td>2.8 (2018)</td>
</tr>
<tr>
<td>2.7 (2017)</td>
</tr>
<tr>
<td>3.2 (2016)</td>
</tr>
<tr>
<td>3.0 (2015)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National rate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7 (2019)</td>
</tr>
<tr>
<td>2.8 (2018)</td>
</tr>
<tr>
<td>2.8 (2017)</td>
</tr>
<tr>
<td>2.9 (2016)</td>
</tr>
<tr>
<td>3.0 (2015)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility rate: CY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>(# of confirmed diagnosed cases of TB/number of admissions)</td>
</tr>
<tr>
<td>7/13,542 = 51.69 per 100,000 Patients 2019</td>
</tr>
<tr>
<td>3/13,509 = 22.20 per 100,000 Patients 2018</td>
</tr>
<tr>
<td>3/13,857 = 21.65 per 100,000 patients 2017</td>
</tr>
</tbody>
</table>

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>2019:</td>
<td>40</td>
</tr>
<tr>
<td>2018:</td>
<td>38</td>
</tr>
<tr>
<td>2017:</td>
<td>30</td>
</tr>
<tr>
<td>2016:</td>
<td>16</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

<table>
<thead>
<tr>
<th>Inpatient settings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How many inpatient beds are in your inpatient setting?</td>
<td>409</td>
</tr>
</tbody>
</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. | CY 2019 7  
CY 2018 3  
CY 2017 2 |
| 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. | For 2019, there were 40 possible cases of MTB, with 7 cases confirmed positive, 5 pulmonary and 2 cases of extra-pulmonary infection. Our risk classification is medium risk. |
| 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.) | 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: Pharmacy, Radiology |
| ✓ 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 |
| 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 |
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? †

<table>
<thead>
<tr>
<th>Year</th>
<th>Conversion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-- (raw #:19)</td>
</tr>
<tr>
<td>2018</td>
<td>0.2%</td>
</tr>
<tr>
<td>2017</td>
<td>0.7%</td>
</tr>
<tr>
<td>2016</td>
<td>0.3%</td>
</tr>
<tr>
<td>2015</td>
<td>0.3%</td>
</tr>
<tr>
<td>2014</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

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)

- Increased. Although the percentages were up and down over the last five years, the numbers are below the threshold.
- Decreasing.
- Remained the same.

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 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.
- 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.

### 4. TB Infection-Control Program

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the health-care setting have a written TB infection-control plan?</td>
<td>Yes – in the Infection Control Plan and a Broward Health policy</td>
</tr>
<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>01/1994</td>
</tr>
<tr>
<td>When the TB infection-control plan was last reviewed or updated?</td>
<td>1/2020</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>
</tbody>
</table>

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

- [✓] Physicians
- [✓] Laboratory personnel
- [✓] Health and safety staff
### 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>
<th>Yes. Dr. Indulekha Gopal, Infection Control Committee Chairman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on review of the medical records, what is the average number of days for the following:</td>
<td></td>
</tr>
<tr>
<td>• Presentation of patient until collection of specimen</td>
<td>1</td>
</tr>
<tr>
<td>• Specimen collection until receipt by laboratory</td>
<td>1</td>
</tr>
<tr>
<td>• Receipt of specimen by laboratory until smear results are provided to healthcare provider</td>
<td>1</td>
</tr>
<tr>
<td>• Diagnosis until initiation of standard antituberculosis treatment</td>
<td>1</td>
</tr>
<tr>
<td>• Receipt of specimen by laboratory until culture results are provided for healthcare provider</td>
<td>1</td>
</tr>
<tr>
<td>• Receipt of drug susceptibility results until adjustment of antituberculosis treatment, if indicated (can take up to a few weeks)</td>
<td></td>
</tr>
<tr>
<td>• Admission of patient to hospital until placement in airborne infection isolation (AII)</td>
<td>1</td>
</tr>
<tr>
<td>Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized?</td>
<td>Review of laboratory results, outbreak investigations and other means of surveillance.</td>
</tr>
<tr>
<td>What mechanisms are in place to correct lapses in infection control?</td>
<td>Process improvements, outbreak investigation, literature search, multidisciplinary team work, reporting through committee process within the facility.</td>
</tr>
<tr>
<td>Based on measurement in routine QC (Quality Control) exercises, is the infection-control plan being properly implemented?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is ongoing training and education regarding TB infection-control practices provided for HCWs?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Which of the following tests are either conducted in-house at your health-care setting’s laboratory or sent out to a reference laboratory?</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>
<tr>
<td>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?</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Environmental control</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ All rooms (airborne infection isolation rooms)</td>
</tr>
<tr>
<td>✓ Local exhaust ventilation (enclosing devices and exterior devices)</td>
</tr>
<tr>
<td>✓ General ventilation (e.g., single-pass system, recirculation system.)</td>
</tr>
<tr>
<td>✓ Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] filtration and ultraviolet germicidal irradiation [UVGI])</td>
</tr>
</tbody>
</table>

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

Operating Rooms: 20 ACH
All Rooms: 12 ACH
Cath Lab: 15 ACH
Bronchoscopy Room (in GI suite): 12 ACH
Interventional Radiology Procedure Room - 15 ACH

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 |

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

| MICU room #1 |
| PACU Room #16 |
| Rm: 363 |
| Rm: 618 |
| Rm: 620 |
| Rm: 622 |
| Rm: 820 |
| Rm: 822 |
| Rm: 824 |
| Rm: 828 |
| Rm: 916 |
| Rm: 918 |
| Rm: 920 |
| Rm: 922 |
| CCU Room #8 |
| ENDO Room 3 (Bronch Suite) |
| ED Green Pod Room 3 |
| ED Orange Pod Room 46 |
| ED Purple Pod Room 31 |
| ED Yellow Pod Room 15 |
| B Side Room 19 |
| C Side Room 26 |
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

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>Yes</td>
</tr>
<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>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, Students</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>- ✓ Contract staff</td>
<td></td>
</tr>
<tr>
<td>- ✓ Construction or renovation staff</td>
<td></td>
</tr>
<tr>
<td>- ✓ Service personnel</td>
<td></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>
<tr>
<td>Kimberly Clark KC200</td>
<td>N-95 62355</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 |
<table>
<thead>
<tr>
<th>What method of fit testing is used? Describe.</th>
<th>Hood/Taste</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

| 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? | 05/2019 |

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.
5. Reptrak concurrent monitoring of compliance with mandatory requirement (including PPD testing). Entry to the facility is restricted until all mandatory requirements are fulfilled.

* 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 North

Comprehensive Infection Control Risk Assessment
Calendar Year 2020

Scoring Criteria:

A Risk Priority Number will be assigned for each event. Infection control will use a Pareto Analysis of the Risk priority numbers assigned to identify the main focus areas for the Infection Control plan of Calendar Year 2018.

Issues considered for **probability** include, but are not limited to:
1. Known risk
2. Historical data
3. Literature review or benchmark statistics

Issues considered for **response** include, but are not limited to:
1. Time needed to respond
2. Scope of response capability
3. Historical evaluation of response success

Issues considered for **life threat** include, but are not limited to:
1. Potential for staff death or injury
2. Potential for patient death or injury

Issues considered for **permanent harm** include, but are not limited to:
1. Potential impairment in cognitive functioning not related to underlying illness
2. Potential impairment in motor functions & ability to perform ADLs
3. Potential impairment in organ function
4. Potential chronic pain

Issues considered for **patient care impact** include, but are not limited to:
1. Interruption in usual patient care workflow
2. Employees unable to report to work
3. Surge demand for patient care service
4. Potential for exposure to an infectious agent
5. Change in level of patient care
6. Interruption of critical services
7. Change inpatient treatment
8. Change in services or setting
9. Increased potential for acquiring MDRO

Issues considered for **preparedness** include, but are not limited to:
1. Status of current plans, policies, procedures & practices
2. Demonstrated compliance with above
3. Annual Training status
4. Demonstrated staff awareness
5. Availability of alternate sources for critical supplies/services
Issues considered for **internal resources** include, but are not limited to:

1. Types of supplies on hand/will they meet need?
2. Volume of supplies on hand/will they meet need?
3. Staff availability
4. Interdepartmental Coordination
5. Availability of support services & staff
6. Internal resources ability to respond in a timely manner

Issues considered for **external resources** include, but are not limited to:

1. Types of agreements with community agencies
2. Coordination with local and state agencies
3. Coordination with proximal health care facilities
4. Coordination with treatment specific facilities
5. Community resources

The summary section provides the specific and overall Infection Control relative risk.
<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>PATIENT CARE IMPACT</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
<th>EXTERNAL RESPONSE</th>
<th>SEVERITY = (MAGNITUDE - MITIGATION)</th>
<th>RPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood this will occur</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = High</td>
<td>1 = High</td>
<td>1 = High</td>
<td>1 = High</td>
<td>1 = Low</td>
<td></td>
</tr>
<tr>
<td>Possibility of death</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Low</td>
<td></td>
</tr>
<tr>
<td>Functional losses &amp; permanent injury</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = Low</td>
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</tr>
<tr>
<td>Individual or systemic</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Interruption of services</td>
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<tr>
<td>PREPAREDNESS</td>
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<td>EVENT RISK NUMBER</td>
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<tr>
<td>Central Lines BSI</td>
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<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>MDRO</td>
<td>3</td>
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<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>Catheter Associated UTI</td>
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<td>3</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Surgical Site Infection</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Active TB, Unknown at time of admission</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Notification of Community Acquired Infections</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
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</tr>
<tr>
<td>VAE</td>
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<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Outbreak</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>C. Diff Infection</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>No Internal Notification of HAI's</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>COVID-19</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>54</td>
<td></td>
</tr>
</tbody>
</table>
HEALTHCARE ACQUIRED INFECTION RISKS CY 2020

- Outbreak: 72 (61.1%)
- C. Diff: 36 (55.6%)
- Multi Drug Resistant: 27 (55.6%)
- Surgical Site: 72 (61.1%)
- Central Lines: 4 (25.9%)
- Active TB, Unknown at: 4 (25.9%)
- Catheter Associated: 72 (44.4%)
- Ventilator Associated: 8 (16.7%)
- Notification of No Internal Notification of: 24 (50.0%)
- Covid: 54 (39.0%)
<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>SEVERITY = (MAGNITUDE - MITIGATION)</th>
<th>RPN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Likelihood this will occur</td>
<td>Possibility of death</td>
<td>Functional losses &amp; permanent injury</td>
</tr>
<tr>
<td></td>
<td>0 = N/A, 1 = Low, 2 = Moderate, 3 = High</td>
<td>1 = Low</td>
<td>2 = Moderate</td>
</tr>
<tr>
<td>Bioterrorism</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Seasonal Flu</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Active TB Admits</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Displaced person</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Long Term Care Patients</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Community Aquire MDRO</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pandemic Flu</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Food Associated Outbreak</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Emerging Infectious Disease/Other Epidemic/Influx</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Flood</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hemorrhagic Fever Disease (i.e. Ebola)</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Waterborne Outbreak</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
COMMUNITY RISKS CY 2020

- Bioterrorism: 12
- Seasonal Flu: 6
- Active TB Admits: 2
- Displaced person: 4
- HIV/AIDS: 2
- Long Term Care: 72
- Community Aquire: 18
- Pandemic Flu: 22.2%
- Food Associated: 22.2%
- Emerging Infectious: 20.4%
- Flood: 18
- Hemorrhagic Fever: 11.1%
- Waterborne Outbreak: 100.0%
<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>IMPACT PATIENT CARE</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
<th>EXTERNAL RESPONSE</th>
<th>RPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-compliance with Seasonal Flu Immunization</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Employee Knowledge Deficit of Disease Transmission</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Non-compliance with Hand Hygiene</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Failure to Follow Protocols and Use Safety Devices or PPE</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Delay in Proper Isolation Precautions</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sharps Injuries</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Annual Fit Testing Not Completed</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Failure To Recognize Employee Outbreak</td>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

SEVERITY = (MAGNITUDE - MITIGATION)

1 = Low
2 = Moderate
3 = High
HEALTHCARE WORKER RELATED RISKS CY 2020

Non-compliance with Seasonal Flu: 22.0%
Employee Knowledge Deficit of: 11.0%
Non-compliance with Hand: 16.0%
Failure to Follow Protocols and Use: 22.0%
Delay in Proper Isolation: 8.0%
Sharps: 9.0%
Annual Fit Testing Not: 4.0%
Failure To Recognize Employee: 2.0%

## CY 2020 INFECTION PREVENTION/CONTROL RISK ASSESSMENT

### ENVIRONMENTAL RISKS

<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>SEVERITY = (MAGNITUDE - MITIGATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>LIFE THREAT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Likelihood this will occur</td>
</tr>
<tr>
<td>SCORE</td>
<td></td>
<td>1 = Low 2 = Moderate 3 = High</td>
</tr>
<tr>
<td>Inadequate Supplies of Personal Protective Equipment</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Improper handling of Biohazardous Waste</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Improper Sharps Handling</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Improper Sterilization of Equipment</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Improper Disinfection of Equipment (high level disinfection)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Improper Disinfection of Equipment (low level disinfection)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Improper Environmental Cleaning</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Failure of Negative Pressure Ventilation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate Preconstruction IC Planning &amp; Risk Assessment</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
5 CY 2020

- Improper Environmental Cleaning: 9.3%
- Inadequate Preconstruction IC Planning & Risk Assessment: 9%
- Improper Sharps Handling: 13.0%
- Improper Disinfection of Equipment (high level disinfection): 25.9%
- Improper Environmental Cleaning: 9.3%
- Inadequate Preconstruction IC Planning & Risk Assessment: 3%
Purposes:
The Infection Control Plan is a system-wide interdisciplinary team approach that uses evidence based guidelines and methodologies to identify, reduce, prevent, and control healthcare associated infections. A risk assessment is completed at least annually to identify priorities that will mitigate the acquisition and transmission of infections and communicable diseases among patients and staff.
The Infection Control plan is an integral part of the quality and patient safety program and contributes to the organizational effectiveness through its commitment to improve outcomes and processes associated with the delivery of healthcare.
This is the BHIP specific addendum to the plan.
SCOPE:
This applies to Broward Health Imperial Point healthcare workers (employees, allied healthcare practitioners, students, and volunteers), contractors, patients and visitors.

POLICY:
The infection prevention and control plan includes but is not limited to:
• Define activities to minimize, reduce or eliminate the risks of infection based upon the needs of the population.
• Establish the Infection Control plan and evaluate effectiveness annually.
• Report to external organizations as required by law.
• Investigate outbreaks, institute control measures and report to leadership.

PROGRAM ADMINISTRATION:
The Infection Prevention and Control program is under the guidance of the Broward Health Leadership. The responsibility for monitoring the Infection Control program is vested in the System Infection Control Committee (ICC), through its Chairperson, members and Infection Control Director.

INFECTION CONTRL COMMITTEE – (ICC):
The ICC functions as the central decision and policy-making for the Infection Control program. It provides support, guidance and oversight for relevant activities including limiting unprotected exposure to pathogens throughout the organization by using standard precautions, enhancing hand hygiene, and minimizing the risk of transmitting infections associated with procedures, the use and reprocessing of medical equipment, and devices. ICC reviews surveillance data and makes recommendations, reviews and approves policies and procedures related to infection prevention, approves the annual surveillance plan and forwards to leadership for final approval. The ICC meets regularly and as needed according to the organizations bylaws. A summary of the committee meeting with recommended actions (minutes) is forwarded to leadership and/or appropriate committee for review and approval.

POPULATION SERVED:
Patient Population Served:
All age categories from infants to geriatric with the vast majority of the patients in the adult and geriatric age groups. • Patients’ health status range from healthy (self-care) to critically ill, and represent a full range of dependence on health resources including specialized services i.e. Cancer, Ophthalmology, etc. • Local, national and international patients from private residences, acute care facilities, nursing homes, extended care, rehabilitation, progressive care, and correction facilities. • Care is provided regardless of socioeconomic backgrounds, ability to pay, education level and cultural background.

BHIP offers a wide range of emergency, inpatient and outpatient services. Admitted patients have demographics which may influence their risk for infections, such as Tuberculosis, HIV, Hepatitis, Sexually transmitted diseases, Vector-borne infections, Multi Drug Resistant Organisms (MDRO’s) and emerging pathogens.
GOALS:
The goal of the Infection Control program is to reduce the risk of acquiring and transmitting health care associated infections. Families, patients, and visitors are encouraged to participate in the infection control program, including cough etiquette, hand hygiene, and prevention of surgical site infections. Priorities and goals are identified by the ICC based on the result of a comprehensive risk assessment, annual appraisal of the program, results of surveillance and monitoring activities. Priorities and goals are based on probability of condition occurring, risk (health, financial, legal and regulatory), organization preparedness and this is reviewed at least annually.

OBJECTIVES:
The objectives of the Infection Control program include but are not limited to the following

- Identify and prioritize infection risk and develop strategies to prevent transmission of infection.
- Establish surveillance activities, monitor technique and practices, and provide recommendations based on the analysis of data and nationally approved standards.
- Communicate pertinent infection control performance improvement findings, identified problems and recommendations to the appropriate department, individuals, and committees.
- Minimize risk of transmission of infections associated with the use of equipment, and medical devices.
- Review sterilization and disinfection practices, monitoring, and documentation.
- Limit unprotected exposure to pathogens throughout the facilities.
- Promote/monitor hand hygiene.
- Assist the Employee Health program and Workers Compensation Program, as needed.
- Provide infection prevention education to staff, as needed.
- Comply with all infection control regulatory agencies requirements.
- Monitor and report communicable diseases to the local Health Department
- Provide Infection Control consultation during demolition, construction, renovation projects and collaborate with the Environment of Care Committee
- Formulate, update IC policies and procedures.
- Participate in the Antimicrobial Stewardship Program.

SURVEILLANCE AND MONITORING ACTIVITIES:
Monitoring activities are based on regulatory requirements
Surveillance Definitions – NHSN case definitions are used to ensure accurate and consistent statistics. These definitions are published annually and include surgical site infections, blood stream infections, central line associated blood stream infections, catheter associated urinary tract infections, and ventilator associated events.

1. Surgical Site Infections (SSI's)
Focused Surgical Site Infection surveillance is performed based upon the goals of the facility.

2. **Device Associated Infections – (Outcomes and Processes)**
   Device associated infections are monitored monthly, as appropriate
   - Central Line Associated Blood Stream Infections (CLABSI)
   - Catheter Associated Urinary Tract Infections (CAUTI)
   - Ventilator Associated Events (VAE)

3. **Laboratory-based Surveillance - (community acquired/hospital acquired)**
   Monthly surveillance based upon NHSN requirements will include Methicillin-resistant Staphylococcus aureus Bacteremia (MRSA) and Clostridiosis difficile, as appropriate

4. **Target Surveillance**
   Target Surveillance is based upon the facilities goals and may include:
   - Surgical Outcomes
   - Employee Infections
   - Multi-Drug Resistant Organisms (MDROs)

5. **Outbreak Investigation**
   An investigation will be conducted whenever an outbreak is suspected. Outbreaks are investigated following a systematic approach. Actions may include:
   - establish the severity of the problem
   - review program and procedures
   - institute control and prevention measures
   - provide appropriate training as needed
   - communicate to Leadership, Risk Management, and Health Authorities as required

6. **Monitoring the following activities per facilities goals:**
   - Hand Hygiene
   - Device Bundles
   - Isolation
   - Sterilization and High Level Disinfection
   - Immediate Use Steam Sterilization (IUSS) and Biologicals monitoring
   - Influenza Vaccine
   - Emerging Pathogens
   - Infection Control Standards
   - Safe Injection Practices
   - Renovation and Construction Projects
   - Tuberculosis

Infection Prevention and Control Program is to prevent infections from occurring in patients, visitors, physicians and employees. The following strategies have been implemented to achieve our goals and objectives based on evidence-based national guidelines from relevant organizations (CDC, APIC, SHEA).
1. **Standard Precautions**
   Standard Precautions represent the minimum infection prevention measures that apply to all patient care, regardless of suspected or confirmed infection status of the patient in any setting where healthcare is delivered. Standard Precautions include:
   - Hand Hygiene.
   - Use of Personal Protective Equipment (e.g., gloves, gowns, facemasks), depending on the anticipated exposure.
   - Respiratory Hygiene and Cough Etiquette.
   - Safe Injection Practices.
   - Safe handling of potentially contaminated equipment.
   - Cleanliness of the facility and patient environment.

2. **Hand Hygiene**
   Continues to be the most important practice for the Infection Control and the Patient Safety Program.
   Secret shoppers monitor hand hygiene compliance. Compliance is reported to leadership.

3. **Transmission-Based Precautions**
   Transmission-Based Precautions are intended to supplement Standard Precautions in patients with known or suspected colonization or infection of highly transmissible or epidemiologically important pathogens. For diseases that have multiple routes of transmission, a combination of Transmission-Based Precautions may be used. Whether used singularly or in combination, they are used in addition to Standard Precautions. The three categories of Transmission-Based Precautions include:
   - Contact Precautions
   - Droplet Precautions
   - Airborne Precautions

4. **Implementation and Monitoring of best practices for device associated infections (bundles and checklists).**
   Incorporate recommendations from the following regulatory agencies: The Joint Commission (TJC), Institute for Healthcare Improvement (IHI), Association for Professionals in Infection Control and Epidemiology (APIC), Infectious Diseases Society of America (IDSA) Compendium, Association of perioperative Registered Nurses (AORN) and Occupational Safety and Health Administration (OSHA), Florida Department of Health, Centers for Disease Control and Prevention (CDC), National Healthcare Safety Network (NHSN), Center for Medicare and Medicaid Services (CMS).

5. **Tracking and trending of multiple drug resistant organisms (Antimicrobial Stewardship Program)**
   Multiple drug resistant and epidemiologically significant organisms are included in the surveillance program. Trending MDROs is part of the Antimicrobial Stewardship Program.
6. Education
Ongoing education and training of staff is a requirement. Education is provided on hire and annually through Computer Based Learning (CBL) system and as needed.

7. Disinfection and Sterilization of reusable medical equipment
Evidence-based national guidelines, best practices, and adherence to manufacturer recommendations are used in disinfection/sterilization processes. Single use devices are disposed of after each patient use.

8. Employee Health Program
The Employee Health Program includes recommendations for screening and immunizations to reduce the risk of infection to employees.
   - Annual Seasonal Influenza Vaccination Program
   - Tuberculosis Surveillance (initial and annual TB testing program) Determination of risk for TB is based upon the Center for Disease Control (CDC) standards
   - Exposure Management Program, Employee Health is responsible for the management of employee exposure

9. Infection Control Risk Assessment
An annual Risk Assessment is performed to determine priorities of goals and objectives for the infection prevention program. The Risk Assessment is based on regulatory requirements and prior outcomes. Based on the potential impact, the probability of the occurrence of a problem/condition, and the organization’s ability to deal with the problem/condition a numeric score is generated. The numerical risk is determined by multiplying the score of each section to get a total numerical risk level. The risk assessment is reviewed and approved by the ICC annually.

10. Evaluation/Assessment:
The Surveillance, Prevention, and Control of Infection Plan is evaluated annually and revised as necessary. The evaluation is reviewed and approved by the ICC Chairman, Chief Executive Officer, BHIP, and Chief Nursing Officer, BHIP.
   - Implementation of the annual plan and prioritized goals
   - Achievement of desired targets for infection reduction
   - Compliance with policy, standards and regulations
   - Success/failure in meeting goals and objectives
   - Identifying trends related to infections and MDROs
Evaluation of 2019 objectives/goals

<table>
<thead>
<tr>
<th>2019 Objectives</th>
<th>Met</th>
<th>Not Met</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Rates</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA: 0.47</td>
<td>0.362</td>
<td>0.36</td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>VRE: 0.09</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRE: 0.03</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESBL : 0.06</td>
<td></td>
<td>0.36</td>
<td></td>
</tr>
<tr>
<td><strong>SIR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA BAC 0.815</td>
<td>0.283</td>
<td>1.47</td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>CDIFF 0.852</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI : Target :</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYST: 0.722</td>
<td>0.493</td>
<td>0.342</td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>COLO: 0.781</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLABSI: Target :</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate 2.13</td>
<td>0.75</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>SIR 0.784</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI: Target:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate 1.15</td>
<td></td>
<td>1.480</td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>SIR 0.828</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VAE: Target:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAP 0.00</td>
<td>1.19</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>Decrease amount of sharps injuries</td>
<td>X</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>5% decrease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decrease needle sticks, splashes,</td>
<td>X</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>other preventable exposures.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene Compliance 90%</td>
<td>97%</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>Flu Vaccination Increase compliance by</td>
<td>90%</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>10% each year until 90% goal by2020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with proper cleaning</td>
<td>UK</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>protocols and products. 90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with proper disinfection</td>
<td>UK</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>protocols and products.90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce misuse of red bag biohazard</td>
<td>UK</td>
<td></td>
<td>Carried over to 2020</td>
</tr>
<tr>
<td>waste. 90%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix A
Goals and Objectives CY 2020
*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 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 2. Decrease HAI 3. Decrease sepsis 4. Continue participating in FHA HIIN 5. Decrease readmissions</td>
<td>BHIP: Target Rates MRSA: 0.4 VRE: 0.04 CRE: 0.00 ESBL : 0.06 CDIFF: 1.03 SIR MRSA BAC: 0.733 CDIFF: 0.766</td>
<td>IP Nurses Physicians Pharmacists</td>
<td>1. Daily review of surveillance log, review of all microbiology results/monitor labs, identify and verify infections 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 infections 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 7. Cohort if necessary on case by case basis 8. Intense analysis of all C. diff bacteremia cases including antibiotic indications and all room changes 9. IP rounds facility wide 10. IP rounds for isolation and disinfection compliance 11. Nurse driven actions 12. Infections are reviewed by RMO if indicated</td>
</tr>
<tr>
<td>SSI</td>
<td>Patients who had surgery</td>
<td>1. Determine risk factors for HAI</td>
<td>BHIP target rate:</td>
<td>IP Surgical Services</td>
<td>1. Monitor infection rates of all surgeries and report to hospital leadership</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
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<td>1. Daily review of surveillance log, review of all microbiology results/monitor labs, identify and verify infections 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 infections 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 7. Cohort if necessary on case by case basis 8. Intense analysis of all C. diff bacteremia cases including antibiotic indications and all room changes 9. IP rounds facility wide 10. IP rounds for isolation and disinfection compliance 11. Nurse driven actions 12. Infections are reviewed by RMO if indicated</td>
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<tr>
<td>SSI</td>
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<td>1. Determine risk factors for HAI</td>
<td>BHIP target rate:</td>
<td>IP Surgical Services</td>
<td>1. Monitor infection rates of all surgeries and report to hospital leadership</td>
</tr>
</tbody>
</table>
| CLABSI | Inpatients with central lines | 2. Decrease HAI  
3. Decrease sepsis  
4. Continue participating in FHA HIIN  
5. Decrease line days | SIR  
HYST: 0.649  
COLO: 0.702 | Nurses  
Physicians  
Anesthesiologists  
Pharmacists  
Surgeons | 2. Monitor all total hip and report to appropriate stakeholders.  
3. Monitor COLO and HYST infections and report to NHSN and stakeholders.  
4. Daily surveillance of ED log, OR schedule.  
5. Review for weight based dosing 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 meeting to determine lessons learned.  
9. Review patient temperature and normothermia during surgery and upon admission to PACU.  
10. Review to monitor for appropriate administration of antibiotic prophylaxis prior to surgery.  
11. Review blood sugars pre-op and during surgery if indicated.  
12. Infections are reviewed by RMO if indicated.  
13. Audits completed with medical device company and report findings back to stakeholders.  
14. 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 | BHIP target rate: VAP: 0.00 | IP Respiratory Nurses Physicians Pharmacists | 1. Daily surveillance 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 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. Redundation 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 local agencies 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 patients</td>
<td>All patients</td>
<td>BHIP will be prepared for an emerging infectious disease or influx of infectious patients.</td>
<td>EM Drills 100%</td>
<td>IP ED EP Nursing</td>
<td>1. Continue utilizing infectious disease screening tool for all patients during triage to screen for all potentially infectious patients. 2. Work with Emergency Preparedness in drills and PPE training for emerging infectious diseases. 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 Epidemiology as needed.</td>
</tr>
<tr>
<td>Long term</td>
<td>All patients</td>
<td>BHIP has</td>
<td>Length of</td>
<td>IP</td>
<td>1. Active surveillance for infectious diseases</td>
</tr>
</tbody>
</table>
patients nearby high admitting SNFs.

Stay

Nursing Case management Physicians

Seasonal flu and pandemic flu All patients BHIP will offer influenza vaccination to all qualified patients. BHIP target: 95% IP Nursing Quality

1. Inpatients vaccinated during influenza season per Centers for Medicaid and Medicare Services (CMS) protocol unless contraindicated.
2. Patients with influenza placed on isolation precautions per policy.
3. If pandemic flu, work with Health and Emergency Preparedness.

Community acquired MDRO All patients Identify community onset infections for prompt isolation. Placing patients on transmission based precautions. BHIP target: 90% IP Nursing Physicians Case management

1. Identification of patients admitted with MDROs as early as possible and within the first 3 days of admission based on the NHSN definition.
2. Education at New Hire Orientation.
3. Review of daily isolation log and review of patient diagnosis to ensure that patient is placed on correct transmission based precautions.

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. 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. 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. 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. 2. EH to monitor 3. New hire video / healthstream 4. Collaboration with managers</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 % decrease</td>
<td>IP, EH Administration</td>
<td>1. IP rounds to reinforce protocols, use of safety devices, proper PPE 2. Revised isolation signs to standardize with rest of Broward Health recommendations, isolation as well 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.</td>
</tr>
<tr>
<td>Non-Compliance</td>
<td>All</td>
<td>Strive for 100 % of HIP</td>
<td>HIP</td>
<td>IP</td>
<td>1. Monitor compliance</td>
</tr>
</tbody>
</table>
### with hand hygiene

- employees, physicians, students, volunteers

### hand hygiene compliance.

### target: 95%

### Administration

#### 2. Just in time education and reinforcement

#### 3. Hand Hygiene education at New Hire Orientation

#### 4. Follow any further directive from corporate

---

### Non-Compliance with seasonal flu immunization

<table>
<thead>
<tr>
<th>All employees, physicians, students, volunteers</th>
<th>Increase compliance by 10% each year until 90% goal of 2020</th>
<th>BHIP target: 90%</th>
<th>IP EH Administration Medical Staff Clin Edu</th>
</tr>
</thead>
</table>

---

**Other Identified Events:**

**Non-compliance with standard precautions**

1. 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. 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>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.</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 education.</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.</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.
ANNUAL APPRAISAL FOR CY2020

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 2019. 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 CY2019

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Target</th>
<th>CY 17</th>
<th>CY18</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>
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<tbody>
<tr>
<td>Central Line Related BSI, laboratory confirmed ALL NHSN Reportable units</td>
<td># of Infections</td>
<td>2.13</td>
<td>3420</td>
<td>4233</td>
<td>317</td>
<td>353</td>
<td>271</td>
<td>226</td>
<td>138</td>
<td>204</td>
<td>297</td>
<td>277</td>
<td>282</td>
<td>251</td>
<td>157</td>
<td>210</td>
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<tr>
<td>Catherter Associated UTI ALL NHSN Reportable units</td>
<td># of CA-UTI</td>
<td>1.15</td>
<td>4272</td>
<td>3326</td>
<td>217</td>
<td>164</td>
<td>256</td>
<td>246</td>
<td>294</td>
<td>251</td>
<td>216</td>
<td>259</td>
<td>216</td>
<td>300</td>
<td>140</td>
<td>265</td>
<td>2547</td>
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<tr>
<td>Hospital Onset C Difficile Infection</td>
<td># new cases</td>
<td>5.24</td>
<td>10</td>
<td>4</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>4</td>
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<tr>
<td>Hospital Onset MRSA Bacteremia</td>
<td># of Pts with HCA MRSA Bact</td>
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<td>1</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>2</td>
<td></td>
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<tr>
<td>VAC</td>
<td># of Vent Days</td>
<td>3.05</td>
<td>2801</td>
<td>2910</td>
<td>90</td>
<td>23</td>
<td>36</td>
<td>103</td>
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<td>79</td>
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<td>45</td>
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<td>HVAC</td>
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<td>79</td>
<td>45</td>
<td>45</td>
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<td>840</td>
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<tr>
<td>PVAP</td>
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<td>709</td>
<td>90</td>
<td>23</td>
<td>36</td>
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<td>45</td>
<td>80</td>
<td>840</td>
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<tr>
<td>Colon SSI/VMS/VBP</td>
<td># of infections</td>
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<td>4</td>
<td>0</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>119</td>
</tr>
<tr>
<td>Hyster SSI/CMS/VBP</td>
<td># of infections</td>
<td>0.77</td>
<td>3</td>
<td>2</td>
<td>0</td>
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<td>0</td>
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</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 CY2019

Analysis

Adults

The CLABSI rate in the adult population for CY2019 was 1.13 per 1000 central line days. This is an increase from a rate of 2.4 per 1000 central line days in CY2018. There was a reduction in line days from 4,223 in CY2018 to 3554 in 2019.

The NHSN SIR for CY2019 was 0.81 which is a decrease from 3.4 in CY2018. The SIR less than 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

- 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)

BHIP NHSN - CAUTI
SIR ~ All Reporting Units
CY 2019

Analysis

Adults
The CAUTI rate in the adult population at BHIP for CY2019 was 1.74 per 1000 urinary catheter days. This is an increase from the previous CY2018 rate of 1.2 per 1000 urinary catheter days. There was a reduction in urinary catheter days from 3,220 in CY2018 to 2866 in CY2019.

The NHSN SIR for CY2019 is 1.60 which is an increase from 0.56 in CY2018. The SIR is 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
• 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

<table>
<thead>
<tr>
<th>VAP Adult</th>
<th>#VAC # of Days x 100</th>
<th>3.85</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Adults
The VAP rate in the adult population at BHIP for CY2019 was 1.19 which is an increase from 0 in CY2018. We has also had an increase in ventilator days from 701 ventilator days in CY2018 to 840 in 2019.

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 CY2019, the colon surgical site infection rate was 0.89%. This number represents 1 infection out of 112 colon surgical procedures. For CY2018, the colon surgical site infection rate was 3.03%. This number represents 4 infections out of 132 colon surgical procedures.

The NHSN SIR for CY2019 is 0.34 which is an increase from 0.3 for CY2018. The SIR is below 1, which indicated that there were less infections identified than predicted based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

Hysterectomy Surgical Site Infections
Analysis
Hysterectomy Surgical Site Infections
For CY2019, the hysterectomy surgical site infection rate was 0.38%. This number represents 1 infection out of 260 hysterectomy surgical procedures. For CY2018, the hysterectomy surgical site infection rate was 0.85%. This number represents 2 infections out of 235 hysterectomy surgical procedures.

The NHSN SIR for CY2019 was 0.49 which is a decrease from 1.08 in CY2018. 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.

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.
- 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 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 CY2019, the infection rate for organisms that were culture positive for MRSA bacteremia was 0.06%. This number represents 2 infections out of 30,867 patient days. For CY2018, infection rate for organisms that were culture positive for MRSA bacteremia was 0.03%. This number represents 1 infection out of 30934 patient days.

The NHSN SIR for CY2019 was 2.04 which is an increase from 0.58 in CY2018. 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.

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 CY2019, our infection rate for hospital onset C. difficile infection 1.6%. This number represents 5 infections out of 30867 patient days. For CY2018, our infection rate for hospital onset C. difficile infections was 5.8%. This number represents 18 infections out of 30934 patient days.

The NHSN SIR for CY2019 was 0.27 which is a decrease from 0.94 in CY2018. 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.

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.
- 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 Hospital Improvement Innovation Network (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 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 CY2020 was presented to the Infection Control Committee for review, recommendations and approval.
• The annual appraisal CY2020 was presented for approval to the Infection Control Committee and will be presented to the Medical Executive Committee.
• The goals of the program are revised whenever risks significantly change or when assessment of the intervention failure is identified.
• The National Patient Safety Goals included in the Plan are also evaluated on an ongoing basis and effectiveness documented.
• The Infection Control Committee meets quarterly. The Committee structure includes the Committee chair (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 2019.
• 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 in order to receive education and competency related to Epidemiology/Infection Prevention and Control on an ongoing basis.

**CY2019 Epidemiology Accomplishments**

Continued to monitor programs put into place during 2018-2019

**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.

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 existing and new hire RNs.
- 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

Education
• CDC education on NHSN definitions by Epidemiology nurse.
• Continuous education through webinars, attendance at meetings and online education.

Coordinator of Epidemiology: _______________________________

CNO, COO, or CFO: _______________________________
Infection Control Committee Chairman: _____________________________

Date:
**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>V 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><strong>Community rate:</strong></td>
</tr>
<tr>
<td>↓ 2.9 (2019) 2.8 (2018)</td>
</tr>
<tr>
<td><strong>State rate:</strong></td>
</tr>
<tr>
<td>↓ 2.6 (2019) 2.8 (2018)</td>
</tr>
<tr>
<td><strong>National rate:</strong></td>
</tr>
<tr>
<td><strong>Facility rate: CY 2019</strong></td>
</tr>
<tr>
<td>(# of confirmed diagnosed cases of TB/number of admissions)</td>
</tr>
<tr>
<td>3/2761 = 1.08 per 1,000 patients</td>
</tr>
</tbody>
</table>
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></th>
<th>Suspected</th>
<th>Confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>2018</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>2017</td>
<td>54</td>
<td>7</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>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many inpatient beds are in your inpatient setting?</td>
<td>175</td>
</tr>
<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>CY 2019: 3</td>
</tr>
<tr>
<td>Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting (&gt;200 beds)? (See Appendix C.)</td>
<td>In CY 2019, there were 3 confirmed MTB patient cases; therefore BHIP is classified as a “low risk” facility.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the health-care setting have a TB screening program for HCWs?</td>
<td>Yes</td>
</tr>
</tbody>
</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:
2019 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%  
 (2019) -  
 (2018) - 0%  
 (2017) - 0%  

<table>
<thead>
<tr>
<th>Number of employee exposures</th>
<th>2019: 2018: 2017: 5</th>
</tr>
</thead>
</table>

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>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the health-care setting have a written TB infection-control plan?</td>
<td>Yes – in the Infection Control Plan and a Broward Health policy</td>
</tr>
<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>5/2020</td>
</tr>
<tr>
<td>Does the written infection-control plan need to be updated based on the time 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 M. tuberculosis)?</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>
<tr>
<td>If yes, which groups are represented on the infection-control committee?</td>
<td>✓ Physicians &lt;br&gt; ✓ Nurses &lt;br&gt; ✓ Epidemiologists &lt;br&gt; ✓ Engineers &lt;br&gt; ✓ Pharmacists &lt;br&gt; ✓ Laboratory personnel &lt;br&gt; ✓ Health and safety staff &lt;br&gt; ✓ Administrator &lt;br&gt; ✓ Risk assessment &lt;br&gt; ✓ Quality control (QC) &lt;br&gt; ✓ Environmental staff &lt;br&gt; ✓ Respiratory &lt;br&gt; ✓ Clinical education &lt;br&gt; ✓ Facilities management</td>
</tr>
</tbody>
</table>

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. Marah Lee, DO</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized?</td>
<td>Review of laboratory results, outbreak investigations and other means of surveillance.</td>
</tr>
<tr>
<td>What mechanisms are in place to correct lapses in infection control?</td>
<td>Process improvements, outbreak investigation, literature search, multidisciplinary team work, reporting through committee process within the facility.</td>
</tr>
<tr>
<td>Based on measurement in routine QC (Quality Control) exercises, is the infection-control plan being properly implemented?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is ongoing training and education regarding TB infection-control practices provided for HCWs?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 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)

<table>
<thead>
<tr>
<th>Environmental control</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ All rooms</td>
</tr>
<tr>
<td>✓ Local exhaust ventilation (enclosing devices and exterior devices)</td>
</tr>
<tr>
<td>✓ General ventilation (e.g., single-pass system, recirculation system.)</td>
</tr>
<tr>
<td>✓ Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] filtration and ultraviolet lighting)</td>
</tr>
</tbody>
</table>

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)

| ✓ 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 |

UVGI

| ✓ Portable room-air cleaners |
How many AII rooms are in the health-care setting? | 46
---|---
1. 3rd floor-4
2. PCU-23
3. 5th floor-3
4. GI 3
5. ICU 10
6. Bronc 1
7. ED Rm 2

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>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>Janitorial staff, Maintenance or engineering staff, Transportation staff, Dietary staff, Respiratory Therapist</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>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? 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>3M corporation</td>
</tr>
<tr>
<td>Manufacturer</td>
<td>Model</td>
</tr>
<tr>
<td>3M corporation</td>
<td>N-95</td>
</tr>
<tr>
<td>Model</td>
<td>#1860 &amp; 1860S</td>
</tr>
<tr>
<td>Specific application</td>
<td></td>
</tr>
<tr>
<td>Routine Contact with Infectious TB patients</td>
<td></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? If yes, when is it conducted?</td>
<td>On hire by employee health</td>
</tr>
<tr>
<td>Does your health-care setting provide periodic fit testing for HCWs? If yes, when and how frequently is it conducted?</td>
<td>Yearly</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
### How frequently is the TB risk assessment conducted or updated in the health-care setting?

<table>
<thead>
<tr>
<th></th>
<th>Yearly</th>
</tr>
</thead>
</table>

### When was the last TB risk assessment conducted?

<table>
<thead>
<tr>
<th></th>
<th>04/2019</th>
</tr>
</thead>
</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.

### Did the risk classification need to be revised as a result of the last TB risk assessment?

<table>
<thead>
<tr>
<th></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).
Broward Health Imperial Point
Comprehensive Infection Control Risk Assessment
CY 2019

Scoring Criteria:

\[
\text{Aspect Specific Risk} = \frac{\text{probability}}{3} \times \left[ (n \text{ Life Threat} + n \text{ Permanent Harm} + n \text{ Impact} \right. \\
\left. \text{Patient Care} + n \text{ Preparedness} + n \text{ Internal Response} + n \text{ External Response}/18) \right]
\]

Relative Risks that are greater than or equal to 30% will be made a Goal/Objective for the Calendar Year

Issues considered for **probability** include, but are not limited to:
1. Known risk
2. Historical data
3. Literature review or benchmark statistics

Issues considered for **response** include, but are not limited to:
1. Time needed to respond
2. Scope of response capability
3. Historical evaluation of response success

Issues considered for **life threat** include, but are not limited to:
1. Potential for staff death or injury
2. Potential for patient death or injury

Issues considered for **permanent harm** include, but are not limited to:
1. Potential impairment in cognitive functioning not related to underlying illness
2. Potential impairment in motor functions & ability to perform ADLs
3. Potential impairment in organ function
4. Potential chronic pain

Issues considered for **patient care impact** include, but are not limited to:
1. Interruption in usual patient care workflow
2. Employees unable to report to work
3. Surge demand for patient care service
4. Potential for exposure to an infectious agent
5. Change in level of patient care
6. Interruption of critical services
7. Change inpatient treatment
8. Change in services or setting
9. Increased potential for acquiring MDRO

Issues considered for **preparedness** include, but are not limited to:
1. Status of current plans, policies, procedures & practices
2. Demonstrated compliance with above
3. Annual Training status
4. Demonstrated staff awareness
5. Availability of alternate sources for critical supplies/services
Issues considered for **internal resources** include, but are not limited to:

1. Types of supplies on hand/will they meet need?
2. Volume of supplies on hand/will they meet need?
3. Staff availability
4. Interdepartmental Coordination
5. Availability of support services & staff
6. Internal resources ability to respond in a timely manner

Issues considered for **external resources** include, but are not limited to:

1. Types of agreements with community agencies
2. Coordination with local and state agencies
3. Coordination with proximal health care facilities
4. Coordination with treatment specific facilities
5. Community resources

The summary section provides the specific and overall Infection Control relative risk.
### CY 2019 INFECTION CONTROL RISK ASSESSMENT
#### HAI/ADMISSION RELATED RISKS

#### SEVERITY = (MAGNITUDE - MITIGATION)

<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>PATIENT CARE IMPACT</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
<th>EXTERNAL RESPONSE</th>
<th>RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Likelihood this will occur</td>
<td>Possibility of death</td>
<td>Functional losses &amp; permanent injury</td>
<td>Individual or systemic Interruption of services</td>
<td>Preplanning</td>
<td>Time, effectiveness, resources</td>
<td>Community/Communication, Mutual Aid staff and supplies</td>
<td>Relative Risk*</td>
</tr>
<tr>
<td>SCORE</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 - 100%</td>
</tr>
<tr>
<td>Central Lines BSI</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = High</td>
<td>1 = High</td>
<td>17%</td>
</tr>
<tr>
<td>MDRO</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>1 = High</td>
<td>56%</td>
</tr>
<tr>
<td>Catheter Associated UTI</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = Low or none</td>
<td>3 = Low or none</td>
<td>9%</td>
</tr>
<tr>
<td>Surgical Site Infection</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = High</td>
<td>1 = High</td>
<td>19%</td>
</tr>
<tr>
<td>Active TB, Unknown at time of admission</td>
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<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>3 = High</td>
<td>1 = Low</td>
<td>1 = High</td>
<td>3 = Low or none</td>
<td>26%</td>
</tr>
<tr>
<td>No Notification of Community Acquired Infections</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>1 = Low</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>26%</td>
</tr>
<tr>
<td>VAE</td>
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<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>1 = High</td>
<td>1 = High</td>
<td>33%</td>
</tr>
<tr>
<td>Outbreak</td>
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<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>19%</td>
</tr>
<tr>
<td>C. Diff Infection</td>
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<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
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<td>33%</td>
</tr>
<tr>
<td>No Internal Notification of HAI's</td>
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<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>9%</td>
</tr>
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</table>
### CY 2019 INFECTION CONTROL RISK ASSESSMENT
#### COMMUNITY RISKS

<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>IMPACT PATIENT CARE</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
<th>EXTERNAL RESPONSE</th>
<th>RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Likelihood this will occur</td>
<td>Possibility of death</td>
<td>Functional losses &amp; permanent injury</td>
<td>Individual or Interruption of services</td>
<td>Preplanning</td>
<td>Time, effectiveness, resources</td>
<td>Community/ Mutual Aid staff and supplies</td>
<td>Relative Risk*</td>
</tr>
<tr>
<td><strong>SCORE</strong></td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
<td>0 = N/A</td>
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<td>0 - 100%</td>
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<tr>
<td></td>
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<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = High</td>
<td>1 = High</td>
<td>1 = High</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
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</tr>
<tr>
<td></td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = Low or none</td>
<td>3 = Low or none</td>
<td>3 = Low or none</td>
<td></td>
</tr>
<tr>
<td>Bioterrorism</td>
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<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
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<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>Active TB Admits</td>
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<td>1</td>
<td>1</td>
<td>1</td>
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<td>22%</td>
</tr>
<tr>
<td>Displaced person</td>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>26%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>33%</td>
</tr>
<tr>
<td>Long Term Care Patients</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>44%</td>
</tr>
<tr>
<td>Community Acquire MDRO</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>33%</td>
</tr>
<tr>
<td>Pandemic Flu</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>19%</td>
</tr>
<tr>
<td>Food Associated Outbreak</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>11%</td>
</tr>
<tr>
<td>Emerging Infectious Disease/Other Epidemic/Influx</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>41%</td>
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<tr>
<td>Flood</td>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>17%</td>
</tr>
<tr>
<td>Waterborne Outbreak</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>EBOLA (Hemorrhagic Fever Diseases)</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>EVENT</td>
<td>SCORE</td>
<td>LIFE THREAT</td>
<td>PERMANENT HARM</td>
<td>IMPACT PATIENT CARE</td>
<td>PREPAREDNESS</td>
<td>INTERNAL RESPONSE</td>
<td>EXTERNAL RESPONSE</td>
<td>RISK</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------</td>
<td>-------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>--------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Non-compliance with Seasonal Flu Immunization</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>11%</td>
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<tr>
<td>Employee Knowledge Deficit of Disease Transmission</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>13%</td>
</tr>
<tr>
<td>Non-compliance with Hand Hygiene</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>13%</td>
</tr>
<tr>
<td>Failure to Follow Protocols and Use Safety Devices or PPE</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>13%</td>
</tr>
<tr>
<td>Delay in Proper Isolation Precautions</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9%</td>
</tr>
<tr>
<td>Non-compliance with Isolation Precautions</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9%</td>
</tr>
<tr>
<td>Sharps Injuries</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>19%</td>
</tr>
<tr>
<td>Employee Knowledge Deficit of Disease Prevention</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9%</td>
</tr>
<tr>
<td>Non-compliance with Standard Precautions</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9%</td>
</tr>
<tr>
<td>Annual Fit Testing Not Completed</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9%</td>
</tr>
<tr>
<td>Failure To Recognize Employee Outbreak</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>11%</td>
</tr>
</tbody>
</table>

**SEVERITY = (MAGNITUDE - MITIGATION)**

- **LIFE THREAT**: Likelihood this will occur
- **PERMANENT HARM**: Possibility of death
- **IMPACT PATIENT CARE**: Physical losses and damages
- **PREPAREDNESS**: Individual or Interruption of services
- **INTERNAL RESPONSE**: Preplanning
- **EXTERNAL RESPONSE**: Time, effectiveness, resources
- **Community/Mutual Aid staff and supplies**: Relative Risk

**Relative Risk**

- 0 = N/A
- 1 = Low
- 2 = Moderate
- 3 = High

**Non-compliance with Seasonal Flu Immunization**

- 1 = Low
- 2 = Moderate
- 3 = High

**Employee Knowledge Deficit of Disease Transmission**

- 1 = Low
- 2 = Moderate
- 3 = High

**Non-compliance with Hand Hygiene**

- 1 = Low
- 2 = Moderate
- 3 = High

**Failure to Follow Protocols and Use Safety Devices or PPE**

- 1 = Low
- 2 = Moderate
- 3 = High

**Delay in Proper Isolation Precautions**

- 1 = Low
- 2 = Moderate
- 3 = Low or none

**Non-compliance with Isolation Precautions**

- 1 = Low
- 2 = Moderate
- 3 = Low or none

**Sharps Injuries**

- 1 = Low
- 2 = Moderate
- 3 = Low or none

**Employee Knowledge Deficit of Disease Prevention**

- 1 = Low
- 2 = Moderate
- 3 = Low or none

**Non-compliance with Standard Precautions**

- 1 = Low
- 2 = Moderate
- 3 = Low or none

**Annual Fit Testing Not Completed**

- 1 = Low
- 2 = Moderate
- 3 = Low or none

**Failure To Recognize Employee Outbreak**

- 1 = Low
- 2 = Moderate
- 3 = Low or none
HCW Related Risks 2019

Non-compliance with Hand Hygiene
Failure to Follow Protocols and Use Safety Devices or PPE
Non-compliance with Seasonal Flu Immunization
Non-compliance with Isolation Precautions
Sharps Injuries
Non-compliance with Standard Precautions
Employee Knowledge Deficit of Disease Transmission
Failure To Recognize Employee Outbreak
Delay in Proper Isolation Precautions
Employee Knowledge Deficit of Disease Prevention
Annual Fit Testing Not Completed
### CY 2019 INFECTION PREVENTION/CONTROL RISK ASSESSMENT

#### ENVIRONMENTAL RISKS

<table>
<thead>
<tr>
<th>EVENT</th>
<th>PROBABILITY</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>IMPACT PATIENT CARE</th>
<th>PREPAREDNESS</th>
<th>INTERNAL RESPONSE</th>
<th>EXTERNAL RESPONSE</th>
<th>RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate Supplies of Personal Protective Equipment</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>11%</td>
</tr>
<tr>
<td>Improper handling of Biohazardous Waste</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>19%</td>
</tr>
<tr>
<td>Improper Sharps Handling</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>22%</td>
</tr>
<tr>
<td>Improper Sterilization of Equipment</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>11%</td>
</tr>
<tr>
<td>Improper Disinfection of Equipment</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>26%</td>
</tr>
<tr>
<td>Improper Environmental Cleaning</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>26%</td>
</tr>
<tr>
<td>Failure of Negative Ventilation</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>13%</td>
</tr>
<tr>
<td>Inadequate Preconstruction IC Planning &amp; Risk Assessment</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9%</td>
</tr>
<tr>
<td>Inadequate Compliance with Preconstruction IC Planning &amp; Risk Assessment</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9%</td>
</tr>
</tbody>
</table>

**SEVERITY = (MAGNITUDE - MITIGATION)**

- **LIFE THREAT**: Possibility of death
- **PERMANENT HARM**: Functional losses or injury
- **IMPACT PATIENT CARE**: Individual or Interruption of services
- **PREPAREDNESS**: Preplanning
- **INTERNAL RESPONSE**: Time, effectiveness, resources
- **EXTERNAL RESPONSE**: Community/Mutual Aid staff and supplies

**Relative Risk**

0 - 100%
Environmental Risks 2019

Categories

- Improper Environmental Cleaning: 26%
- Improper Sharps Handling: 18.2%
- Inadequate Supplies of Personal Protective Equipment: 11%
- Improper Disinfection of Equipment: 25.9%
- Improper handling of Biohazardous Waste: 22%
- Improper Sterilization of Equipment: 22%
- Failure of Negative Ventilation: 19%
- Inadequate Preconstruction IC Planning & Risk Assessment: 11%
- Inadequate Compliance with Preconstruction IC Planning & Risk Assessment: 13%
- Failure of Negative Ventilation: 9%
- Inadequate Compliance with Preconstruction IC Planning & Risk Assessment: 9%

Percentage:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

- Improper Environmental Cleaning: 26%
- Improper Sharps Handling: 18.2%
- Inadequate Supplies of Personal Protective Equipment: 11%
- Improper Disinfection of Equipment: 25.9%
- Improper handling of Biohazardous Waste: 22%
- Improper Sterilization of Equipment: 22%
- Failure of Negative Ventilation: 19%
- Inadequate Preconstruction IC Planning & Risk Assessment: 11%
- Inadequate Compliance with Preconstruction IC Planning & Risk Assessment: 13%
- Failure of Negative Ventilation: 9%
- Inadequate Compliance with Preconstruction IC Planning & Risk Assessment: 9%
### 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 67,000 patients in CY2019.
Per Fiscal Year 2019 statistics, our payer mix was Medicare 15.1%, Medicaid 6.3%, Commercial (includes HMO/PPO, Managed Care Medicaid, Managed Cared Medicare) 68.6%, Charity & Self pay 9.9%.

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 CY2019** include: excision of stomach, percutaneous endoscopic approach, Resection of Gallbladder, Percutaneous Endoscopic Approach, Resection of Uterus, Open Approach, Dilation of Left Ureter with Intraluminal Device, Endoscopic, laparoscopic cholecystectomy with cholangiography, inguinal hernia repair, resection of appendix, percutaneous endoscopic approach, laparoscopic inguinal hernia repair, and resection of uterus, supracervical open approach.

The **Top 10 adult inpatient principle diagnosis for CY2019** include: maternal care for low transverse scar from previous cesarean delivery, sepsis, post-term pregnancy, chronic obstructive pulmonary disease with acute exacerbation, morbid severe obesity due to excess calories, acute kidney failure, pneumonia, urinary tract infection, sickle cell disease with crisis, and first degree perineal laceration during delivery.

The **Top 10 adult emergency department diagnosis for CY2019** include: other chest pain, urinary tract infection, headache, unspecified chest pain, unspecified abdominal pain, essential, primary hypertension, low back pain, dizziness and giddiness, threatened abortion, and bronchitis.

The **Top 10 pediatric principle surgical procedures for CY2019** include: unlisted procedure dentaoalveolar structures, resection of appendix, percutaneous endoscopic approach, circumcision with clamp, percutaneous skeletal fixation distal radial fracture epiphyseal separation, circumcision age greater than 28 days, removal of deep implant, laparoscopic appendectomy, skeletal fixture of humeral fracture, tonsillectomy and adenoidectomy less than age 12, and drainage of buttock.

The **Top 10 pediatric inpatient principle diagnosis for CY2019** include: single live born, delivered by cesarean, single live born infant, delivered vaginally, pneumonia, acute bronchiolitis due to respiratory syncytial virus, twin live born infant delivered by cesarean, acute pyelonephritis, fever, urinary tract infect, rhabdomyolysis, and dehydration.

The **Top 10 pediatric emergency department diagnosis for CY2019** include: acute upper respiratory infection, viral infection, vomiting, non-infective gastroenteritis and colitis, fever, flu, due to other identified influenza virus with other respiratory manifest, unspecified injury of head, flu due to unidentified influenza virus with other respiratory manifestations, and acute bronchiolitis.

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 an 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 for adults and one (1) critical care/trauma bed for pediatrics. Approximately 4,000 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) All (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 All 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 All 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 All room (Room 401). There are currently 11 rooms which can be converted into All 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 Medical-Surgical Unit with primarily adult and geriatric patients. There is one All 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 All 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 is one All room available (NICU10). 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 All rooms 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 5,400 surgical procedures are performed annually. This department 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-one hundred (2,100) 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. A 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. Approximately 1,500 Caesarian procedures are performed annually.

14. 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.

15. 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.

16. 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.

17. An three (3) bed dialysis unit is available for dialysis treatments to be completed for inpatients. This unit is located on the 2nd floor in the Legacy Building adjacent to the ICU/CCU unit. This is area is only opened while patients are receiving dialysis.

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. In November 2019, the Chairman of the ICC was appointed to Medical Director of Infection Prevention and Control and the Antimicrobial Stewardship 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 CY2020*

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 Perioperative 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 CEO, BHCS CNO, Medical Director of Infection Prevention and Control and the Antimicrobial Stewardship Program

Date: 3/12/2020

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 surgical site infections (SSI) constituted the highest risk and multi drug resistant organisms (MDRO) as the second highest risk in the HAI/Admission risk portion of the risk assessment. The top 5 risks identified in the Pareto analysis were SSI, MDRO, 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>
</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 through July 2019 | BHCS target rate:  
  Colon: 4.53  
  Hyst: 0.00  
  SIR:  
  Colon: 1.89  
  Hyst: 0.82  
  hyst: 0.722  
  colon: 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 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, re-dosing 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 Committee meeting |
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.
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 until 11/19 and then Medical Director of Infection Prevention and Control and the Antimicrobial Stewardship Program.
14. Infections are reviewed by RMO if indicated.
15. Create action plans based on results of audits.

<table>
<thead>
<tr>
<th>MDRO (including MRSA bacteremia) and C. diff</th>
<th>All patients</th>
<th>1. Determine risk factor for HAI</th>
<th>BHCS: Target Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2. Decrease HAI</td>
<td>MRSA: 0.02</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Decrease sepsis</td>
<td>VRE: 0.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Continue participating in</td>
<td>CRE: 0.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FHA HIIN</td>
<td>ESBL: 0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Decrease readmissions</td>
<td>CDIFF: 3.71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SIR</td>
<td>MRSA bac: 0.91</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IP Nurses Physicians Pharmacists</th>
<th>1. Daily review of surveillance including ED visit log, review of all microbiology results/monitor labs, identify and verify infections, analyze data.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Utilize MedMined data mining program to assist with identifying potential clusters.</td>
</tr>
<tr>
<td></td>
<td>3. Review Antiobiogram and discuss at ICC and Antimicrobial Stewardship committee.</td>
</tr>
<tr>
<td></td>
<td>4. Continue contact precautions for active infection and 6 month history of infection.</td>
</tr>
<tr>
<td></td>
<td>5. Utilize Respiratory Viral Panel (Biofire) to</td>
</tr>
<tr>
<td>CDIFF: 0.51</td>
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</tbody>
</table>
| prevent antibiotics for viruses.  
6. C. diff: Place patient on enhanced contact precautions per policy and monitor compliance with bleach based disinfection.  
7. Cohort if necessary on case by case basis.  
8. Intense analysis of all C. diff and MRSA bacteremia cases including antibiotic indications and all room changes.  
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 until 11/19 and then Medical Director of Infection Prevention and Control and the Antimicrobial Stewardship Program.  
13. Infections are reviewed by RMO if indicated.  

| CLABSI | Inpatients with central lines |  
|---|---|---|
| CLABSI | Inpatients with central lines |  
1. Determine risk factor for HAI  
2. Decrease HAI  
3. Decrease sepsis  
4. Continue participating in FHA HIIN  
5. Decrease line days  
BHCS target rate: 0.73  
SIR: 0.46  
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. Education, HIIN  
7. Nurse driven action plans, include use of CHG bathing in the ICU  
8. CHG bathing at PM for all nursing unit. Continued use of Theraworx every 12 hours in ICU/CCU. |
<table>
<thead>
<tr>
<th>CAUTI</th>
<th>Inpatients with Foley catheters</th>
<th>1. Determine risk factor for HAI</th>
<th>BHCS target rate:</th>
<th>IP Rounds Facility wide.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2. Decrease HAI</td>
<td>0.46</td>
<td>Daily surveillance to monitor labs, identify and verify infections, analyze data.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Decrease sepsis</td>
<td>SIR: 0.85</td>
<td>Collect patient demographic data, line days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Continue participating in FHA HIIN</td>
<td></td>
<td>Identify risks, assess daily need/removal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Decrease foley days</td>
<td></td>
<td>Nurse driven catheter removal protocol.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Monitor bundle compliance including foley below level of bladder, not on floor, foley bag not more than ⅓ full, secured to thigh, etc.</td>
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<tr>
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<td></td>
<td>Educate on best practices in nursing orientation and rounding.</td>
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<td></td>
<td></td>
<td>Nurse driven action plans.</td>
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<td></td>
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<td>Education through Webinar and the HIIN.</td>
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<td></td>
<td>Discuss each CAUTI with nurse manager to determine opportunities/lessons learned.</td>
</tr>
</tbody>
</table>

- Peripheral draws for blood specimens.
- Discuss each CLABSI with nurse manager to determine opportunities/lessons learned.
- Discuss each CLABSI infection in Patient Safety Quality Council meeting.
- All infections reviewed by Chief of Infection Prevention and Epidemiology until 11/19 and then Medical Director of Infection Prevention and Control and the Antimicrobial Stewardship Program.
- 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.
11. Discuss each CAUTI infection in Patient Safety Quality Council meeting.
12. Perform RCA on all infections
13. All infections reviewed by Chief of Infection Prevention and Epidemiology until 11/19 and then Medical Director of Infection Prevention and Control and the Antimicrobial Stewardship Program.
14. Infections are reviewed by the RMO if indicated.
15. Participate in AHRQ Safety Program for ICUs: Prevention CLABSI and CAUTI.
16. Audits completed with medical device company and report findings back to stakeholders.
17. Create action plans based on results of audits.

### VAE

<table>
<thead>
<tr>
<th>Event</th>
<th>Inpatients on a ventilator</th>
<th>1. Determine risk factor for HAI</th>
<th>Decrease HAI</th>
<th>Decrease sepsis</th>
<th>Continue participating in FHA HIIN</th>
<th>Decrease vent days</th>
<th>BHCS target rate: VAP: 0.00</th>
<th>IP Respiratory Nurses Physicians Pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td>VAE</td>
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</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.
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.
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. 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 bioterrorism to be the highest risk with seasonal flu as the two highest risk for community related risks. The rest of the top 3 risks identified in the Pareto Analysis were Community Acquired MDRO, and Long Term Care Patients. All risks from the community are evaluated and Epidemiology works closely with the Health Department.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Group</th>
<th>Description</th>
<th>Department</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bioterrorism (Emerging Infectious Disease)</strong></td>
<td>All patients</td>
<td>BHCS will be prepared for Bioterrorism and emerging infectious disease or influx of infectious patients.</td>
<td>EM Drills 100%</td>
<td>1. Continue utilizing infectious disease screening tool for all patients during triage to screen for all potentially infectious patients.</td>
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<td>3. Communicate with the Florida Department of Health as necessary.</td>
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<td>4. Continue with established drills and EM updates and education.</td>
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<td></td>
<td>5. Consult with Chief of Infection Prevention and Epidemiology Medical Director of Infection Prevention and Control and the Antimicrobial Stewardship Program as needed.</td>
</tr>
<tr>
<td><strong>Seasonal flu</strong></td>
<td>All patients</td>
<td>BHCS will offer influenza vaccination to all qualified patients.</td>
<td>BHCS target: 90%</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>IP Nursing Quality</td>
<td>2. Patients with influenza placed on Droplet isolation precautions per policy.</td>
</tr>
<tr>
<td><strong>Community acquired MDRO</strong></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>1. Identification of patients through daily surveillance admitted with MDROs and alert tab.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>IP Nursing Physicians Case management</td>
<td>2. Assess staff need for education.</td>
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<td>3. Communication with SNF and LTC admitters.</td>
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<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>
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<tr>
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<td>5. Education at New Hire Orientation.</td>
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<tr>
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<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>
### Long term patients

<table>
<thead>
<tr>
<th>All patients</th>
<th>BHCS has nearby high admitting SNFs.</th>
<th>Length of stay</th>
<th>IP Nursing Case management Physicians</th>
</tr>
</thead>
</table>
| **1.** Active surveillance for incoming patients include blood and urine cultures as indicated.  
**2.** Communication with physicians and transferring/accepting facilities to identify infections. |

### Pandemic flu

<table>
<thead>
<tr>
<th>All patients</th>
<th>BHCS will offer influenza vaccination to all qualified patients.</th>
<th>BHCS target: 90%</th>
<th>IP Nursing Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> If pandemic, work with Florida Department of Health and Emergency Preparedness.</td>
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</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.

#### Pandemic Flu
2. Work with Emergency Preparedness with drills and PPE training.  
3. 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.

Communicable Disease/Reportable to Florida Department of Health.
4. Continue to review and monitor ED and Medmined for positive cultures
5. Continue to report positive cultures to the 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 for independent HCWs as the highest risk. The remaining 4 risks identified in the Pareto analysis were non-compliance with hand hygiene for staff, blood and body fluid exposure, delay in proper isolation precautions and failure to follow protocols and use of safety devices or PPE. 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>
</table>
| Non-compliance with hand hygiene for independent HCWs | All LIPs | Strive for 100% of hand hygiene compliance. | BHCS target: 90% | IP Administration RMO Chief of Staff | 1. Monitor compliance in all areas of hospital.  
2. Updated poster campaign by corporate marketing.  
3. Compliance reported at Patient Safety Quality Council monthly meetings.  
4. Compliance reported at the quarterly ICC }
5. Updated BHCS Hand Hygiene plan.
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.
7. Just in time education and reinforcement.
9. Meetings with RMO to engage medical staff.

<table>
<thead>
<tr>
<th>Non-compliance with hand hygiene for staff HCWs</th>
<th>All employees, physicians, students, volunteers</th>
<th>Strive for 100% of hand hygiene compliance.</th>
<th>BHCS target: 90%</th>
<th>IP Administration</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood and body fluid exposure</th>
<th>All employees, physicians, students, volunteers</th>
<th>Decrease needle sticks, splashes, other preventable exposures.</th>
<th>BHCS target: 90%</th>
<th>IP EH Administration</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

1. Monitor compliance in all areas of hospital.
2. Updated poster campaign by corporate marketing.
3. Compliance reported at Patient Safety Quality Council monthly meetings.
4. Compliance reported at the quarterly ICC meeting.
5. Updated BHCS Hand Hygiene plan.
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.
7. Just in time education and reinforcement.
9. Meetings with RMO to engage medical staff.
<table>
<thead>
<tr>
<th>Delay in Proper Isolation Precautions</th>
<th>All employees, physicians</th>
<th>Decrease time to place patients on transmission based precautions.</th>
<th>BHCS target: 90%</th>
<th>IP Administration</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Infection control and Clinical Education to educate all nursing on the need to place order for isolation in computer system.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>3. Daily review of isolation log.</td>
</tr>
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<td>4. Will educate nursing on a case by case basis on the requirements for isolation.</td>
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<td></td>
<td>5. Monitor disease alert and evaluate timeliness of implementation of transmission based precautions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6. Monitor isolation log, chart for sticker, sign and PPE on door.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Failure to follow protocols and use safety devices or PPE</th>
<th>All employees, physicians, students, volunteers</th>
<th>Decrease needle sticks, splashes, other preventable exposures.</th>
<th>BHCS target: 90%</th>
<th>IP EH Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td>1. IP rounds to reinforce protocols, use of safety devices, proper PPE.</td>
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<td></td>
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<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>
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<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>
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<td></td>
<td></td>
<td>4. Just in time education and remediation as needed.</td>
</tr>
</tbody>
</table>
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.

Environmental Risks
Goal #4: Reduction of environmental risk.
*Pareto analysis reveals improper sterilization of equipment/medical device as the highest risk priority. The remaining top 4 risks identified in the Pareto Analysis were: improper environmental cleaning, improper handling of biohazardous waste, inadequate high level disinfection of medical devices and inadequate supplies of personal protective equipment.

<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 sterilization of equipment / medical device</td>
<td>OR staff</td>
<td>Compliance with all sterilization policies and follow all AMMI and AORN guidelines</td>
<td>BHCS: 100%</td>
<td>IP Surgical Services</td>
<td>1. Monitor compliance in Surgical Services, Women’s Services and Radiology department.</td>
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<td></td>
<td>Director, NM Sterile</td>
<td>2. IP and Quality Manager Rounding.</td>
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<td>3. Rounding completed by Director and NM of Surgical Services.</td>
</tr>
<tr>
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<td></td>
<td></td>
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<td></td>
<td>4. Education to all Surgical Services Staff and</td>
</tr>
</tbody>
</table>


| Improper environmental cleaning | EVS staff | Compliance with proper cleaning protocols and products. | BHCS target: 90% | EVS | 1. Partnership with epidemiology and EVS. 
2. EVS maintains pivotal role in Infection Prevention and Control Committee. 
3. IP Rounding 
4. IP Education to EVS staff |
| 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. 
3. Education of Staff |
| Improper high level disinfection of medical devices | All staff | Compliance with proper disinfection protocols and products. | BHCS target: 90% | All employees | 1. GI and Radiology department to monitor all high level disinfection process 
2. Follow and adhere to all policies regarding high level disinfection 
3. Follow all manufactures instruction for use with all AERs. 
4. Infection Control to investigate any cases reported of improper high level disinfection. |
| Inadequate supplies of PPE | All staff | Maintain adequate supplies of all PPE in all departments. | BHCS target: 90% | Materials | 1. Materials management responsible for maintaining par levels of PPE on each nursing unit in the facility. 
2. Utilize new PPE calculator from the CDC to |
**Other Identified Events**

**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 Preconstruction IC Planning and & Risk Assessment**
1. Partnership with facilities regarding early notification of future construction projects.

**Surgical Services Environmental controls (air exchange, temp, humidity monitoring fallout)**
1. Facilities to monitor and any alarms to sound in PBX and notify surgical services and Women’s Services Manager.
2. Notification of alarms to managers of department on off hours.
ANNUAL EVALUATION AND 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. In November 2019, the Chairman was appointed to Medical Director of Infection Prevention and Control Program and Antibiotic Stewardship Program. 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 2019. 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.

### HOUSE WIDE INFECTIONS FOR CY2019

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<tr>
<th>INDICATOR</th>
<th>Definition</th>
<th>Target</th>
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<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>
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<td>Central Line Associated BSI</td>
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<td>683</td>
<td>645</td>
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<td>Hospital Onset C. Difficile Infection</td>
<td># of new cases + Conf of Pa with Patient Days x 1000</td>
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<td>5.96</td>
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<td>3.20</td>
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<td>Hospital Onset MRSA Bacteremia</td>
<td># of Pa with HA MRSA Bac of Patient Days x 1000</td>
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#### 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>Target</th>
<th>CY17</th>
<th>CY18</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
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Analysis

Adults
The CLABSI rate in the adult population for CY2019 was 0.33 per 1000 central line days. This is a reduction from a rate of 0.917 per 1000 central line days in CY2018. We also had a reduction in line days from 6618 in CY2018 to 5993 to CY2019.

The NHSN SIR for CY2019 was 0.46 which is a reduction from 1.16 in CY2018. The SIR is 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 CY2018 to CY2019 was 64%.
- Reduction in central line days from CY2018 to CY2019 was 9%.
- CY2019 SIR: 0.46
- CY2019 Threshold: 0.784
- Reduction in SIR rate from CY2018 to CY2019 was 60%.

NICU
The CLABSI rate in the NICU population for CY2019 was 0 per 1000 central line days.

Pediatrics
The CLABSI rate in the pediatric population was 0 per 1000 central line days for CY2019.

Analysis

- Infections are identified from prospective surveillance by the Coordinator of Epidemiology.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
- Meetings are held with all infections to determine opportunities and action plans for improvement.
- Reports are submitted to BHCS Infection Prevention and Control Committee and Patient Safety Quality Council.
- Priority is given to device related infections based on risk assessment and analysis of collected data which is evaluated on an ongoing basis to provide immediate intervention when indicated to reduce or prevent infection.
- Rates increased and decreased depending on the unit.
- Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.
- Strive for zero infection.

Action Plans

- We continue to monitor central lines for necessity, educate nursing staff and the medical staff on the use of midlines, when appropriate.
- BHCS participates and follow 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 for patients with central lines.
• 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)

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<td><strong>Target Rate</strong></td>
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<tr>
<td>Mother Baby</td>
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</table>
Analysis

Adults
The CAUTI rate in the adult population at BHCS for CY2019 was 1.11 per 1000 urinary catheter days. This is an increase from the previous CY2018 rate of 0.36 per 1000 urinary catheter days. We had a reduction in urinary catheter days from 5553 in CY2018 to 5425 in CY2019.

The NHSN SIR for CY2019 was 1.06 which is a increase from 0.73 in CY2018. The SIR is 1, which is what is expected based on the NHSN definition. The SIR is a standardized infection ratio which is risk adjusted based on national data.

- **Increased in infection rate from CY2018 to CY2019 was 208%.**
- **Reduction in urinary catheter days from CY2018 to CY2019 was 2%**
- **CY2019 SIR: 1.06**
- **CY2019 Threshold: 0.828**
- **Increase in SIR rate from CY2018 to CY2019 was 45%**

Pediatrics
The CAUTI rate in the pediatric population at BHCS was 0 per 1000 urinary catheter days for CY2019.

Analysis

- Infections are identified from prospective surveillance by the Coordinator of Epidemiology.
- Infection rates are monitored for trends above the benchmark which would require immediate investigation, identification of opportunities for improvement and implementation of corrective action items.
- Meetings are held to review all infections to determine opportunities and action plans for improvement.
- Reports are submitted to BHCS Infection Prevention and Control Committee and Patient Safety Quality Council.
- Priority is given to device related infections based on risk assessment and analysis of collected data which is evaluated on an ongoing basis to provide immediate intervention when indicated to reduce or prevent infection.
- Rates increased and decreased depending on the unit.
- Epidemiology will continue to monitor and communicate findings with the appropriate stakeholders.
- Strive for zero infection.

Action Plans

- Continue to monitor urinary catheter for necessity, educate nursing staff and the medical staff, when appropriate.
- Continue to utilize the HOUDINI protocol for indications for urinary catheter.
- BHCS participates and follow the 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 until discontinuation of the use of Theraworx in
July 2019. Daily bathing for patient with urinary catheters is completed with soap and water.

- Continued surveillance and enforcement of the urinary catheter bundle compliance during rounding.

III. Surgical Infections Report

Surgical Site Infections Class I CY2019

Analysis

Class I Surgical Site Infections
For CY2019, the surgical site infection rate was 0.36. This is the first year that BHCS is monitoring Class I only infections and not include Class II as in the previous years. This rate will be benchmarked in the following years.

A SIR is not able to be provided by NHSN at this time.
Surgical Site Infections II CY2019

Class II Surgical Site Infections
For CY2019, the surgical site infection rate was 0.45%. This is the first year that BHCS is monitoring only Class II infections and not including Class I infections as in the previous years. This rate will be benchmarked in the following years.

A SIR is not able to be provided by NHSN at this time.
Colon Surgical Site Infections

NHSN COLON SSI SIR

Analysis

Colon Surgical Site Infections

For CY2019, the colon surgical site infection rate was 4.79. This number represents 7 infections out of 146 colon surgical procedures. For CY2018, the colon surgical site infection rate was 5.04. This number represents 7 infections out of 139 colon surgical procedures.

The NHSN SIR for CY2019 was 1.89 which is a decrease from 2.04 in CY2018. The SIR is above 1, which indicates 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.

- Decrease in infection rate from CY2018 to CY2019 was 5%.
- CY2019 SIR: 1.89
- CY2019 Threshold: 0.781
- An increase in the SIR was 8%.
Hysterectomy Surgical Site Infections

For CY2019, the hysterectomy surgical site infection rate was 0.64%. This number represents 2 infections out of 313 hysterectomy surgical procedures. For CY2018, the hysterectomy surgical site infection rate was 0%.

The NHSN SIR for CY2019 was 0.82 which is an increase from 0 in CY2018. The SIR is below 1, which indicates that there were less infections identified than predicated based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

- Increase in infection rate from CY2018 to CY2019.
- CY2019 SIR: 0.82.
- CY2019 Threshold: 0.722
- Increase in SIR.
C-section Surgical Site Infections

For CY2019, the C-section surgical site infection rate was 0.46%. This number represents 7 infections out of 1529 C-section surgical procedures. For CY2018, the C-section surgical site infection rate was 0.4%. This number represents 5 infections out of 1261 C-section surgical procedures.

- Slight increase in infection rate from CY2018 to CY2019 was 15%.
- A SIR is not provided by NHSN.
Total Hip Surgical Site Infections

Target: 0

Total Knee Surgical Site Infection

Target: 0
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.
- Continue to review and track all surgical site infections 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.
- Meetings are held to review all infections to determine opportunities and action plans for improvement.
- Reports are submitted to BHCS Infection Prevention and Control Committee and Patient Safety Quality Council.
- 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 until July 2019.
- All surgical site infections are reviewed with Director of Surgical Services and NM to identify opportunities for improvement.
- Ongoing education of surgical staff on proper wound classification.
- BHCS participates in HIIN for best practices.
- SSI bundles, including CHG bathing the night before and the morning of, glucose monitoring, removal of hair with clippers prior to going to the operating room, use of Chloraprep perioperative skin prep, and appropriate use of antibiotics.
- 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.
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 CY2019, our infection rate for organisms that were culture positive for MRSA Bacteremia was 0.04%. This number represents 2 infections out of 47,988 patient days. For CY2018, our infection rate for 0.20%. This number represents 1 infection out of 41,191 patient days.

The NHSN SIR for CY2019 was 0.91 which is an increase from 0.52 in CY2018. The SIR is below 1, which indicates that there were less infections identified than predicted based on the NHSN definition. This is a standardized infection ratio which is risk adjusted based on national data.

- Decrease in overall MRSA infection rate from CY2018 to CY2019 was 33%.
- Increase in VRE infections rate from 0 in CY2018 to 0.04 in CY2019.
- Increase in MRSA Bacteremia infection rate was 100%; however, this is based on two positives.
- CY2019 SIR: 0.91
- CY2019 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 CY2019, our infection rate for hospital onset C. difficile infection 3.2. This number represents 13 infections out of 40,609 patient days. For CY2018, our infection rate for hospital onset C. difficile infections was 4.12. This number represents 17 infections out of 41,191 patient days.

The NHSN SIR for CY2019 was 0.51. The NHSN SIR rate for CY2018 was 0.56 which is a decrease from CY2018. 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 13 cases of hospital acquired C. difficile. There was one infection that was determined to be likely to be patient to patient transmission as it occurred on the same nursing unit with less than 4 days in between infection.

• Decrease in C. difficile infection rate from CY2018 to CY2019 was 22%.
• CY2019 SIR: 0.51
• CY2019 Threshold: 0.852
• Decrease in SIR from CY2018 to CY2019 was 9%.
Action Plans for All MDRO Infections

- Continue to implement hand hygiene, at the bedside, for all visitors to the NICU.
- Instituted hand scrub for all visitors, staff, HCWs and physicians 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 are 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 monitors 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 Infection Prevention and Control.
- Participation in Antimicrobial Stewardship Program.
- Enforcing strict hand washing with soap and water when exiting rooms with patients on Enhanced Contact Isolation.
- Adherence to high touch surface cleaning with hypochlorite based solution for C. diff patients.
- 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.
- Continue to utilize 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.

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 nurse 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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</table>

## Hand Hygiene Compliance

![Hand Hygiene Compliance Chart]

- Compliance Rate: 92% for Nurses, 67% for Physicians, 0% for Resident and Medical Students, 93% for FCA, 94% for Students, 94% for Dialysis, 33% for Therapy (Dialysis), 55% for Dietician, 65% for Dietary, 45% for EVS, 40% for Case Management, 15% for Radiology, 5% for Transportation, 20% for Anesthesiologists, 30% for Other, 50% for PA/NP, 40% for Other.
- HH: 83%, 23%, 47%, 22%, 35, 62, 16, 0, 0, 20
- Obs: 98%, 183, 222, 88, 241, 85, 48, 42, 68, 16, 0, 0, 25
VI. Communicable Diseases

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

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

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 CY2019 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.

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 2019.
• 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.

**CY2019 Epidemiology Accomplishments**

**Education and Celebration**

• Nursing Grand Rounds on Health Associated Infections
• Need2Know Education Flyers created on the following topics
  - Midlines v PICC line
  - Appropriate urine collection
  - Herd immunity
  - Perineal and foley catheter care
  - ICU and Central Line bathing and Preoperative Bathing
  - Overview of Hepatitis A
  - Hepatitis A information for medical providers
  - Nursing Education of Hepatitis A
  - NICU Hand Scrub
  - How to use CHG bathing cloths
  - TB information and update

**Hand Hygiene 2019**

• Continued to utilize a recognition program to identify HCWs who perform hand hygiene by providing a business card with a life saver candy and a “thank you for being a life saver”.
• Stress importance at New Hire Orientation.
• Just in time education provided whenever opportunity arises.

**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.
• Continue to ensure that all urinary catheters inserted with urimeters to prevent breaking closed system.
• CAUTI rate graphs provided monthly at Patient Safety Quality Council meetings.
• Point Prevalence rounding with Device Representative. Results presented to stake holders and leadership for evaluation.
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.
- Point Prevalence rounding with Device Representative. Results presented to stake holders and leadership for evaluation.

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.
- Presentation of all surgical site infections at the Surgical Site Infection Prevention Committee meeting with focus on risk factors and adherence to evidence based practice to reduce infections.
- SSI rate graphs provided monthly at Patient Safety Quality Council meetings, Department of Surgery and OB/GYN Perinatal Committee meetings.
- Discussion of SSI at Patient Safety Quality Council meetings.
- Continued weight based dosing for pre op antibiotics as per evidence based practice.
- SSI Gap analysis created to identify areas of opportunity in order to care for patients using best practices.
- Identified need for improvement with perioperative prep and organized implementation of Trainer the train program for Chloraprep for all surgical services department, Women’s services and Radiology departments.

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.
- 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.
• Multidisciplinary meeting held including NM of unit regarding one case of transmission of C. diff. Focused enhanced cleaning on nursing unit so that all rooms were cleaned with Virespet, bleach product. All nursing stations and WOWs were also cleaned with bleach based wipes.

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:
Tuberculosis (TB) risk assessment worksheet of CY19

This model worksheet should be considered for use in performing TB risk assessments for healthcare 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 healthcare 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**

<table>
<thead>
<tr>
<th>Community rate:</th>
<th>↑ 3.5 (2018)</th>
<th>3.2 (2017);</th>
</tr>
</thead>
<tbody>
<tr>
<td>State rate:</td>
<td>↑ 2.8 (2018)</td>
<td>2.7 (2017);</td>
</tr>
<tr>
<td>National rate:</td>
<td>2.8 (2018)</td>
<td>2.8 (2017);</td>
</tr>
<tr>
<td>Facility rate: CY 2019 (# of confirmed diagnosed cases of TB/number of admissions)</td>
<td>↑ 3/17193=17.44 per 100,000 patients</td>
<td></td>
</tr>
</tbody>
</table>

Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?  
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>2019</td>
<td>29</td>
<td>3</td>
</tr>
<tr>
<td>2018</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>2017</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>2016</td>
<td>20</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)?

### 2. Risk Classification

#### Inpatient settings

How many inpatient beds are in your inpatient setting?

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2019</td>
<td>3</td>
</tr>
<tr>
<td>CY2018</td>
<td>2</td>
</tr>
<tr>
<td>CY 2017</td>
<td>3</td>
</tr>
<tr>
<td>CY2013</td>
<td>9</td>
</tr>
</tbody>
</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.

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 2019, there were 3 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. |
| 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%  
(2019): 0.95%  
(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) | Increasing |
| 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? | No |
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

| Does the health-care setting have a written TB infection-control plan? | Yes – in the Infection Control Plan and a Broward Health policy |
| Who is responsible for the infection-control program? | Medical Director of Infection Control Program and Chairman of Infection Control Committee. |
| When was the TB infection-control plan first written? | 06/05 |
| When the TB infection-control plan was last reviewed or updated? | 2/2020 |
| Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., >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 M. tuberculosis)? | Yes |
| Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)? | Yes |
| If yes, which groups are represented on the infection-control committee? (Check all that apply.) | Laboratory personnel
- Physicians
- Nurses
- Epidemiologists
- Engineers
- Pharmacists
- Nutritional staff
- Health and safety staff
- Administrator
- Risk assessment
- Quality control (QC)
- Environmental staff
- Respiratory
- 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: | Yes, Dr. Melvin Kohan, Medical Director of Infection Control Program and Infection Control Committee Chairman |
Based on review of the medical records, what is the average number of days for the following:

<table>
<thead>
<tr>
<th>Event</th>
<th>Average Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation of patient until collection of specimen</td>
<td>1</td>
</tr>
<tr>
<td>Specimen collection until receipt by laboratory</td>
<td>1</td>
</tr>
<tr>
<td>Receipt of specimen by laboratory until smear results are provided</td>
<td>1</td>
</tr>
<tr>
<td>Diagnosis until initiation of standard antituberculosis treatment</td>
<td>1</td>
</tr>
<tr>
<td>Receipt of specimen by laboratory until culture results are provided</td>
<td>1</td>
</tr>
<tr>
<td>Receipt of drug susceptibility results until adjustment of antituberculosis treatment, if indicated</td>
<td>1</td>
</tr>
<tr>
<td>Admission of patient to hospital until placement in airborne infection isolation (AI)</td>
<td>1</td>
</tr>
</tbody>
</table>

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. In addition, the nursing unit and the physician who ordered the test is notified.

### 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?

Inpatient rooms: (Med Surg, tele, etc)  6 ACH
Emergency Department: 12 ACH  
Operating Rooms: 15 ACH  
C-section in South Tower 15 ACH  
All Rooms: 12 ACH  
Bronchoscopy Room (in GI suite): 12 ACH  
Endoscopy Rooms – 12 ACH  
Interventional Radiology Procedure Room - 15 ACH

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: 13,14,20,34,35</td>
<td></td>
</tr>
<tr>
<td>ICU rooms: 1, 8</td>
<td></td>
</tr>
<tr>
<td>CCU rooms: 1, 8</td>
<td></td>
</tr>
<tr>
<td>3 East: 352</td>
<td></td>
</tr>
<tr>
<td>3 South: 381, 395</td>
<td></td>
</tr>
<tr>
<td>4 East: 438, 452</td>
<td></td>
</tr>
<tr>
<td>4 West: 401, 409, 410, 411, 412, 415, 416, 417, 418, 423, 424, 425</td>
<td></td>
</tr>
<tr>
<td>M/B (2nd floor South): 212 &amp; 228</td>
<td></td>
</tr>
<tr>
<td>NICU (2nd floor South): 10</td>
<td></td>
</tr>
<tr>
<td>L&amp;D (1st floor South): 5</td>
<td></td>
</tr>
<tr>
<td>3 Peds: 301</td>
<td></td>
</tr>
<tr>
<td>PICU (in Peds unit): 5</td>
<td></td>
</tr>
<tr>
<td>Bronch room (in GI suite): 1</td>
<td></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>
</table>
| Which HCWs are included in the respiratory protection program? (Check all that apply) | ✓ 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). |
| Manufacturer | Model | Specific application |
| Kimberly Clark | N-95 & #62126 & #62355 | Routine contact with infectious TB patients |
| 3M corporation | N-95 & #1860 & 1860S | Routine Contact with Infectious TB patients |
| 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? | Yes  
On hire by employee health |
| Does your health-care setting provide periodic fit testing for HCWs? If yes, when and how frequently is it conducted? Yearly |
| 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 or if needed based on influx of positive patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was the last TB risk assessment conducted?</td>
<td>02/2019</td>
</tr>
<tr>
<td>What problems were identified during the previous TB risk assessment? No problems were identified.</td>
<td></td>
</tr>
<tr>
<td>What actions were taken to address the problems identified during the previous TB risk assessment? Not applicable.</td>
<td></td>
</tr>
</tbody>
</table>
Did the risk classification need to be revised as a result of the last TB risk assessment?

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

No. Our risk remained the same.

* 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 \( M. \) \( \text{tuberculosis} \) infections in Health-Care Settings).

Broward Health Coral Springs

Comprehensive Infection Control Risk Assessment
Calendar Year 2020

Scoring Criteria:

A Risk Priority Number will be assigned for each event. Infection control will use a Pareto Analysis of the Risk priority numbers assigned to identify the main focus areas for the Infection Control plan of Calendar Year 2020.

Issues considered for **probability** include, but are not limited to:
1. Known risk
2. Historical data
3. Literature review or benchmark statistics

Issues considered for **response** include, but are not limited to:
1. Time needed to respond
2. Scope of response capability
3. Historical evaluation of response success

Issues considered for **life threat** include, but are not limited to:
1. Potential for staff death or injury
2. Potential for patient death or injury

Issues considered for **permanent harm** include, but are not limited to:
1. Potential impairment in cognitive functioning not related to underlying illness
2. Potential impairment in motor functions & ability to perform ADLs
3. Potential impairment in organ function
4. Potential chronic pain

Issues considered for **patient care impact** include, but are not limited to:
1. Interruption in usual patient care workflow
2. Employees unable to report to work
3. Surge demand for patient care service
4. Potential for exposure to an infectious agent
5. Change in level of patient care
6. Interruption of critical services
7. Change inpatient treatment
8. Change in services or setting
9. Increased potential for acquiring MDRO

Issues considered for **preparedness** include, but are not limited to:
1. Status of current plans, policies, procedures & practices
2. Demonstrated compliance with above
3. Annual Training status
4. Demonstrated staff awareness
5. Availability of alternate sources for critical supplies/services
Issues considered for **internal resources** include, but are not limited to:
1. Types of supplies on hand/will they meet need?
2. Volume of supplies on hand/will they meet need?
3. Staff availability
4. Interdepartmental Coordination
5. Availability of support services & staff
6. Internal resources ability to respond in a timely manner

Issues considered for **external resources** include, but are not limited to:
1. Types of agreements with community agencies
2. Coordination with local and state agencies
3. Coordination with proximal health care facilities
4. Coordination with treatment specific facilities
5. Community resources

The summary section provides the specific and overall Infection Control relative risk.
## CY 2020 Infection Control Risk Assessment
### HAI Risks

### CY 2020 Infection Control Risk Assessment

#### HAI Risks

<table>
<thead>
<tr>
<th>Event</th>
<th>Probability</th>
<th>Severity = (Magnitude - Mitigation)</th>
<th>RPN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Likelihood this will occur</td>
<td>Possibility of death</td>
<td>Functional losses &amp; permanent injury</td>
</tr>
<tr>
<td>Central Lines BSI</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
</tr>
<tr>
<td></td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
</tr>
<tr>
<td></td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
</tr>
<tr>
<td>MDRO</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
</tr>
<tr>
<td></td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
</tr>
<tr>
<td></td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
</tr>
<tr>
<td>Catheter Associated UTI</td>
<td>1 = Low</td>
<td>1 = Low</td>
<td>1 = Low</td>
</tr>
<tr>
<td></td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
<td>2 = Moderate</td>
</tr>
<tr>
<td></td>
<td>3 = High</td>
<td>3 = High</td>
<td>3 = High</td>
</tr>
<tr>
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HEALTHCARE ACQUIRED INFECTION RISKS CY 2020

- Surgical Site: 288 (47.4%)
- MDRO: 144 (25.8%)
- Central Lines: 48 (8.3%)
- Catheter Associated: 48 (8.3%)
- C. Diff: 24 (4.2%)
- VAE: 16 (2.8%)
- Active TB, Unknown at time of Acquired: 12 (2.1%)
- Blood culture: 8 (1.4%)
- Outbreak: 8 (1.4%)
- No Internal Notification of Community Acquired: 6 (1.1%)
- Other HAI (conjunctivitis, flu, non): 4 (0.7%)
- Internal Notification of Other HAI: 2 (0.4%)

RISK PRIORITY NUMBER
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<tr>
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<th>PROBABILITY</th>
<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>IMPACT PATIENT CARE</th>
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<th>INTERNAL RESPONSE</th>
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COMMUNITY RISKS CY 2020

- Bioterrorism: 108, 41%
- Seasonal Flu: 48, 59.3%
- Community Aquire MDRO: 36, 16%
- Long Term Care Patients: 12, 12%
- Pandemic Flu: 8, 8%
- Hemorrhagic Fever Disease (i.e. Ebola): 6, 6%
- Food Associated Outbreak: 3, 3%
- HIV/AIDS: 2, 2%
- Active TB Admits: 2, 2%
- Homeless person: 2, 2%
- Waterborne Outbreak: 2, 2%

RISK PRIORITY NUMBER

- 0.0%
- 10.0%
- 20.0%
- 30.0%
- 40.0%
- 50.0%
- 60.0%
- 70.0%
- 80.0%
- 90.0%
- 100.0%

Broward Health Coral Springs
## CY 2020 Infection Prevention/Control Risk Assessment
### Health Care Worker Related Risks

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<th>LIFE THREAT</th>
<th>PERMANENT HARM</th>
<th>IMPACT PATIENT CARE</th>
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<td>Possibility of death</td>
<td>Physical losses and damages</td>
<td>Individual or Interruption of services</td>
<td>Preplanning</td>
<td>Time, effectiveness, resources</td>
<td>Community/ Mutual Aid staff and supplies</td>
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HEALTHCARE WORKER RELATED RISKS CY 2020

- Non-compliance with Hand Hygiene
- Blood and body fluid
- Delay in Proper Isolation
- Employee Knowledge Deficit of Disease
- Failure to Follow Protocols and Use Safety Devices or
- Non-compliance with Hand Hygiene for Independent
- Annual Fit Testing Not
- Non-compliance with Seasonal Flu
- Failure to Recognize Employee

RISK PRIORITY NUMBER

- 48
- 32
- 12
- 8
- 8
- 8
- 2
- 2

Percentage:
- 0.0%
- 10.0%
- 20.0%
- 30.0%
- 40.0%
- 50.0%
- 60.0%
- 70.0%
- 80.0%
- 90.0%
- 100.0%
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ENIRONMENTAL RISKS CY 2020

- Improper Sterilization of Equipment/Medical Device
- Improper Environmental Cleaning
- Improper handling of Biohazardous Waste
- Improper Sterilization of Equipment/Medical Device
- Improper Disinfection of Equipment/Medical Device
- Inadequate Supplies of Personal Protective Equipment
- Improper Sharps Handling
- Inadequate High Level Disinfection of Medical Devices
- Surgical Services - Environmental controls (air exchange, failure of Negative Pressure Ventilation)
- Failure of Air Quality Fallouts
- Failure of Preconstruction IC Planning & Risk Assessment
- Surgical Services - Environmental controls (air exchange, failure of Negative Pressure Ventilation)
- Surgical Services - Environmental controls (air exchange, failure of Negative Pressure Ventilation)

Risk Priority Number:
- 216
- 108
- 32
- 32
- 24
- 16
- 16
- 16
- 8
- 6
- 6

Risk Priority Percentages:
- 45.0%
- 67.5%
- 74.2%
- 80.8%
- 85.8%
- 89.2%
- 92.5%
- 95.8%
- 97.5%
- 100.0%
## CY 2020 Infection Control Risk Assessment

### Community Risks

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<th>Permanant Harm</th>
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<td>Hemorrhagic Fever Disease (i.e. Ebola)</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Waterborne Outbreak</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
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
Yvonne Russell, Regional Security Lieutenant
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 2019 performance goals and plan objectives
- Priorities and goals for calendar year 2020

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>Regional Security Lieutenant</td>
<td>Security</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Director</td>
<td>Quality &amp; EPI</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>AVP</td>
<td>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>
</tr>
<tr>
<td>Nurse Managers</td>
<td>Critical Care &amp; Adult Care</td>
<td>EoC Committee Member</td>
</tr>
</tbody>
</table>
The following table includes the name of those individuals who manage the Environment of Care programs.

<table>
<thead>
<tr>
<th>Nurse Managers</th>
<th>Salah Foundation Children’s Hospital</th>
<th>EoC Committee Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Manager</td>
<td>Dialysis, Outpatient Clinic &amp; Lab, Ortho Techs</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Manager</td>
<td>Materials Management</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Manager</td>
<td>Laboratory, Sleep/EEG and Respiratory</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Manager</td>
<td>Radiology</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Assistant Manager</td>
<td>Respiratory</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Corporate Director</td>
<td>Safety &amp; Security</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Coordinator</td>
<td>Corporate Dept. of Emergency Preparedness</td>
<td>EoC Committee Member</td>
</tr>
<tr>
<td>Associate Administrator</td>
<td>Administration</td>
<td>EoC Committee Member</td>
</tr>
</tbody>
</table>

<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>Yvonne Russell/ Jaione Alfayate</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</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 15, 2020

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 2019, 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 2020.

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>
</tbody>
</table>
Ensure all employee accidents and injuries are analyzed aimed at reducing risk for recurrence | Met |  

Review of Performance: Performance monitors for 2019 are as follows

Performance Monitor #1: OSHA Recordable Cases

Target: ≤ 6.01/qtr.

Performance: This performance monitor was met one of the four qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - (# injuries X 200,000) / productive manhours-OSHA Recordable Cases</td>
<td>≤ 6.01/qtr</td>
<td>6.16</td>
<td>7.50</td>
<td>5.64</td>
<td>7.60</td>
<td>6.72</td>
<td>7.36</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: There was a 9% decrease in this performance monitor in 2019 compared to 2018, the effectiveness of this performance monitor is reflected by rate not meeting the benchmark in 2019. The performance monitor will continue to be tracked in 2020 for compliance. The 2020 Environment of Care initiative is to reduce preventable employee slip, trip and falls incidents which contributed to this monitor’s performance.

There were two main root causes that contributed to the number of OSHA recordable cases exceeding benchmark.

Firstly, there was an increase in the amount of employee slip, trip and fall incidents in the last two quarters of 2019 resulting in preventable occurrences. Education was distributed to all BHMC employees on how to reduce the risk of these type of incidents.

Secondly, several clusters of employees exposed to contagious diseases resulted in over 113 employees receiving prophylaxis or treatment. Contrary in the root cause in 2018, exposures in 2019 were not due to later detection of suspected patients with communicable infectious diseases and their proper placement in appropriate transmission based precaution environments, but rather patients presenting to the Emergency Department with no signs & symptoms of potentially contagious diseases.
Performance Monitor #2: Contaminated Needle stick Exposure Rate

Target: ≤ 1.65/qtr.

Performance: This performance monitor was met two of the four qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - Contaminated Needle stick Injuries</td>
<td>≤ 40/yr</td>
<td>10</td>
<td>10</td>
<td>6</td>
<td>8</td>
<td>34</td>
<td>47</td>
</tr>
<tr>
<td>Workers Comp - Contaminated Needle stick Injuries/ADP x 10,000</td>
<td>≤ 1.65/qtr</td>
<td>1.79</td>
<td>1.84</td>
<td>1.08</td>
<td>1.43</td>
<td>1.54</td>
<td>2.09</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor goal was met in 2019 with a 26% rate reduction in 2019 compared to 2018 and will continue to be monitored in 2020 for further compliance.

Various stakeholders collaborated with the Safety Officer to focus on negative trends observed in the first 2 quarters of 2019 with employee exposures involving contaminated needle sticks. Re-education on the activation of the insulin syringe safety device included a Healthstream assignment and hands on return demonstration to reinforce correct technique.

Secondly, exposures in pediatric oncology involving blood collection resulted in moving children to a treatment room from the inpatient rooms for phlebotomies. Blood collection was performed using an evidenced based practice of holding a child in a supportive manner and calmer environment. Performance was met benchmark in the last 2 quarters.

Performance Monitor #3: Contaminated Sharps Injuries

Target: ≤ 0.38/qtr.

Performance: This performance monitor was met three of the four qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - Sharp Object Injuries</td>
<td>≤ 12/yr</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Sharp Object Injuries Rate/ADP x 10,000</td>
<td>≤ 0.38/qtr</td>
<td>0.18</td>
<td>N/A</td>
<td>0.18</td>
<td>0.89</td>
<td>0.42</td>
<td>0.32</td>
</tr>
</tbody>
</table>
Overall Effectiveness of the Program’s Effectiveness: This performance monitor goal was not met in 2019 and will continue to be monitored in 2020 for compliance with no trends.

One opportunity identified in the 4th quarter was several different contaminated sharps injuries by Surgical techs in the main OR. As a result of these exposures, all surgical techs had re-competencies completed.

Performance Monitor #4: Back/Shoulder/Neck Injuries relating to Patient Handling Rate

Target: ≤ 0.44/qtr.

Performance: This performance monitor was met two of the four qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - Back/Shoulder Injuries (Patient Handling)</td>
<td>≤ 14/yr</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Back/Shoulder Injuries Rate (Patient Handling/APD x 10,000)</td>
<td>≤ 0.44/qtr</td>
<td>0.89</td>
<td>0.18</td>
<td>0.36</td>
<td>0.54</td>
<td>0.49</td>
<td>0.61</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: Although there was a 20% decrease of the rate in 2019 compared to 2018, this performance monitor was not found to be consistently effective and will continue to be monitored in 2020 for compliance.

This occupational injury category was selected as the 2019 EoC program initiative. Refer to the end of this document for the outcome.

Performance Monitor #5: Employee Slip, Trip and Fall Incident Rate

Target: ≤ 2.34/qtr.

Performance: This performance indicator was met in all four qtrs.
### Performance Monitor Analysis

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - Employee Slip/Trip/Fall Incidents</td>
<td>≤ 60/yr</td>
<td>10</td>
<td>5</td>
<td>12</td>
<td>12</td>
<td>39</td>
<td>30</td>
</tr>
<tr>
<td>Employee Slip/Trip/Fall Rate/APD x 10,000</td>
<td>≤ 2.34/qtr</td>
<td>1.79</td>
<td>0.92</td>
<td>2.22</td>
<td>2.14</td>
<td>1.78</td>
<td>1.34</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: Although the benchmark was met in 2019 for this performance monitor, a negative trend was noted in the last 2 quarters.

Education on prevention of slip, trip and fall incidents was distributed to all BHJMC staff. (see below) Additionally, education on ladder safety and proper use of cell phones to reduce the risk of “distracted walking” was communicated to leaders, staff and physicians. Members of the EoC surveillance inspection teams were reminded to look for potential trip hazards while rounding and report them to Facilities to be corrected. A work group which will focus on slip, trip and fall incident reduction will be formed following in 2020 OSHA’s toolkit for evidence based practices to reduce occurrences.

The EoC Committee approved the reduction of the occupational injury to the be the 2020 initiative. We will continue to monitor in 2020 for compliance and the return to a positive trend.
Performance Monitor #6: # Employees exposed to *M. tb*/total # of Employees/quarter

Target: ≤ 1%/qtr.

Performance: This performance indicator was met in all four qtrs.

Performance Monitor Analysis

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Health - # Employees exposed to <em>M. tb</em>/total # of employees per qtr.</td>
<td>≤ 1%/qtr</td>
<td>18/9508 0.19%</td>
<td>7/9506 0.16%</td>
<td>0/9550 0%</td>
<td>0/9547 0%</td>
<td>0.09%</td>
<td>0.23%</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 2020 for further compliance.

Performance Monitor #7: # of Employees exposed to contagious diseases/# of Employees per quarter

Target: ≤ 1%/qtr.

Performance: This performance monitor was met in all qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Health - # Contagious disease exposures/total # of employees per qtr.</td>
<td>≤ 1%/qtr</td>
<td>72/9508 0.76%</td>
<td>20/9506 0.21%</td>
<td>38/9550 0.40%</td>
<td>11/9547 0.12%</td>
<td>0.37%</td>
<td>0.18%</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 2020 for further compliance.

Performance Monitor #8: # Hemodialysis water/ Dialysate cultures (done/passed)

Target: 100%/yr.

Performance: This performance monitor was met in all qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</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>100%</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 2020 for further compliance.
Performance Monitor #9: # Hemodialysis water Endotoxin-LAL (done/passed)
Target: 100%/yr.
Performance: This performance monitor was met in three of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiology - # Hemodialysis Endotoxin - LAL (done/#passed)</td>
<td>100%/yr</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td>100%</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 and will continue to be monitored in 2020 for further compliance.

The one outlier in the 3rd quarter was due to one dialysis machine with a positive endotoxin result suspected to be a false positive as water cultures for all equipment tested at Davita and BHMC respective laboratories were negative. The machine was reprocessed and follow-up testing was negative for endotoxin.

Performance Monitor #10: Scan Safety-# of Burns from MRI Scanner (new)
Target: <1/qtr.
Performance: This performance monitor was met in all the qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI Scan Safety-# of Burns from MRI Scanner</td>
<td>&lt;1/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 2020 for further compliance.
Performance Monitor #11: MRI Scan Safety—# of Unplanned Metallic Objects in MRI Scanner

Target: <1/qtr.

Performance: This performance monitor was met in all the qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI Scan Safety— # of Unplanned Metallic Objects in MRI Scanner</td>
<td>&lt;1/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 2020 for further compliance.

Performance Monitor #12: Staff Knowledge Score in Safety Management from EoC Surveillance Tours

Target: ≥ 90%/qtr.

Performance: This performance monitor was met in all the qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Safety Management from Surveillance Tours</td>
<td>≥ 90%/qtr</td>
<td>97%</td>
<td>98%</td>
<td>96%</td>
<td>96%</td>
<td>97%</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 2020 for further compliance.
Performance Monitors for 2020 are as follows:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp - (# injuries X 200,000) / productive manhours</td>
<td>≤ 6.01/qtr</td>
</tr>
<tr>
<td>OSHA Recordable Cases</td>
<td></td>
</tr>
<tr>
<td>Workers Comp - Contaminated Needlestick Injuries</td>
<td>≤ 40/yr</td>
</tr>
<tr>
<td>Workers Comp - Contaminated Needlestick Injuries/APDx10,000</td>
<td>≤ 1.65/qtr</td>
</tr>
<tr>
<td>Workers Comp - Contaminated Sharp Injuries</td>
<td>≤ 12/yr</td>
</tr>
<tr>
<td>Workers Comp - Contaminated Sharp Injuries/APDx10,000</td>
<td>≤ 0.38/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.t.b/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>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: Jaime Alfayate / Yvonne Russell

Title: Director of Facilities Management & Support Serv. / Regional Security Lieutenant

Region: Broward Health Medical Center

Review Date: March 26, 2020

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 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: During 2019, the scope of the Security Management Plan was reviewed. The objectives of the Security Management Plan were 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. All opportunities from the 2018 risk assessment were completed. The Security Management Plan and program were found to be effective. Goals have been established to direct the Security Management Plan in 2020.

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 and timely investigation of security incidents</td>
<td>Met</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>Met with Conditions</td>
<td>Changes in the department staff and more detailed post orders improved the overall department performance</td>
<td></td>
</tr>
</tbody>
</table>
Review of Performance: Performance monitors for 2019 are as follows:

Performance Monitors #1: Rate of Bodily Assaults-non-Behavioral Health Services

Target: ≤ 1.00/qtr.

Performance: This performance monitor met benchmark every quarter of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Bodily Assaults (non BHS-Adult)</td>
<td>Informational /qtr</td>
<td>4</td>
<td>15</td>
<td>6</td>
<td>12</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Assault Rate/Census x 1,000 (non-BHS-Adult)</td>
<td>≤ 1.00/qtr</td>
<td>0.06</td>
<td>0.3</td>
<td>0.1</td>
<td>0.19</td>
<td>0.16</td>
<td>0.32</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor goal was met in 2019 with a 50% rate reduction compared to 2018 and will continue to be monitored in 2020 for further compliance.

Performance Monitors #2: Rate of Bodily Assaults-Behavioral Health Services

Target: ≤ 2.50/qtr

Performance: This performance monitor was met three of the four qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Bodily Assaults (BHS)</td>
<td>Informational /qtr</td>
<td>10</td>
<td>18</td>
<td>13</td>
<td>11</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Assault Rate/Census x 1,000 (BHS)</td>
<td>≤ 2.50/qtr</td>
<td>1.9</td>
<td>3.79</td>
<td>2.42</td>
<td>2.03</td>
<td>2.54</td>
<td>1.50</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 2020 for further compliance.
Security was requested primarily for medication assist where their presence to ensure a safer environment when patient’s behaviors places themselves at risk for escalated physical aggression. BHS Staff are conducting increased screening of forensic patients to determine potential for violence based on records while patients are in jail. Thera refusing to accept patients where safety and security of other patients and staff is at risk. Earlier interventions for forensic patients who were admitted prioritizing medications regimens prior to episodes of escalated aggressive behaviors has been effective to reduce risk physical violence.

Performance Monitors #3: Rate of Code Assists-non Behavioral Health Services-Adult

Target: ≤ 1.00/qtr.

Performance: This performance monitor was met in one of the four qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Assists (non-BHS) Adult</td>
<td>Informational/ qtr</td>
<td>70</td>
<td>72</td>
<td>106</td>
<td>65</td>
<td>78</td>
<td>37</td>
</tr>
<tr>
<td>Code Assist Rate/Census x1,000 (non-BHS) Adult</td>
<td>≤ 1.00/qtr</td>
<td>1.08</td>
<td>1.22</td>
<td>1.68</td>
<td>1.00</td>
<td>1.24</td>
<td>0.58</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to not as effective with the rate not meeting the benchmark in 2019. This monitor will continue to be monitored in 2020 to track for compliance. As reflected in the 4th qtr. data, the benchmark was met.

In early 2019, a Workplace Violence Prevention Task Force was formed with multi-disciplinary participation. TJC Sentinel #59 on Violence Against Healthcare Workers was followed. We assessed our current policies and practices including what actions may be need to be taken/modified to reduce the risk of harm to our patients, employees, and physicians.

- Met with frontline staff to discuss the increase trend of aggressive patient behavior noted by Risk and Safety in baseline incident data
- Developed a Code Assist policy and modified an existing debriefing form
- Implemented physical plant improvements that had already been identified in the 2018 Security risk assessment
- Expanded units where staff are required to complete the Broward Health Workplace Violence Prevention training program
- Created an Internal Support team (IST) trained in Crisis Incident Stress Debriefing (CISD) to support post-traumatic incidents as well as workplace violence occurrences. A new dashboard tracks and trends IST CISD referrals.
- Posted additional Zero Tolerance of Aggressive Behavior signs throughout the hospital
Performance Monitors #5: Rate of Code Assists – Women & Children’s Services

Target: ≤ 1.00/qtr.

Performance: This performance monitor was met in two of the qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Assists (non-BHS) Women &amp; Children</td>
<td>Informational/qtr</td>
<td>23</td>
<td>17</td>
<td>10</td>
<td>2</td>
<td>13</td>
<td>N/A</td>
</tr>
<tr>
<td>Code Assist Rate/Census x1,000 (non-BHS) Women &amp; Children</td>
<td>≤ 1.00/qtr</td>
<td>1.22</td>
<td>1.26</td>
<td>0.72</td>
<td>0.19</td>
<td>0.85</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 2020 for continued compliance.

Based on increasing occurrences of aggressive behaviors exhibited in several units of the Women’s and Children’s division in the first half of 2019, actions from both the BHS and non-BHS Adult Care settings aimed at reducing the risk of violence were implemented.

Performance Monitors #5: Rate of Code Assists – Behavioral Health Services

Target: ≤ 1.00/qtr.

Performance: This performance monitor was met in one of the four qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Assists (BHS)</td>
<td>Informational/qtr</td>
<td>7</td>
<td>4</td>
<td>26</td>
<td>8</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Code Assist Rate/Census x1,000 (BHS)</td>
<td>≤ 1.00/qtr</td>
<td>1.34</td>
<td>0.8</td>
<td>4.9</td>
<td>1.48</td>
<td>2.13</td>
<td>1.69</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to not be effective in the rate meeting the benchmark in 2019 and will continue to be monitored in 2020 to ensure improvement towards compliance.

In the quarters where the benchmark was not met, over 40% of the occurrences were repeated aggressive behaviors by the same vulnerable patients who were confused, anxious, and/or
wanted to leave the hospital. Code Assists due to verbal and/or physical aggressive behavior de-escalating techniques allow Security to provide additional de-escalation opportunities which combined with the BHS staff interventions reduce the overall risk of bodily assaults.

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.

Performance Monitors #6: Missing Patient Property

Target: ≥ 2.00/qtr.

Performance: This performance monitor was met in three of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing Patient Property</td>
<td>Informational/qtr.</td>
<td>11</td>
<td>17</td>
<td>7</td>
<td>4</td>
<td>10.00</td>
<td>N/A</td>
</tr>
<tr>
<td>Missing Patient Property/APD</td>
<td>≤ 2.00/qtr</td>
<td>0.51</td>
<td>2.95</td>
<td>1.19</td>
<td>0.71</td>
<td>1.34</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 2020 for further compliance.

Performance Monitors #7: Missing Broward Health Owned Property

Target: ≥ 0.50/qtr.

Performance: This performance monitor was met in three of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing BH Owned Property</td>
<td>Informational/qtr.</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2.00</td>
<td>N/A</td>
</tr>
<tr>
<td>Missing BH Owned Property/APD</td>
<td>≤ 0.50/qtr</td>
<td>0.19</td>
<td>0</td>
<td>0.33</td>
<td>0.54</td>
<td>0.26</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 2020 for further compliance.

Performance Monitors #8: Missing Broward Health Owned Property

Target: ≤ 10.00/qtr.

Performance: This performance monitor was met in all of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraband Search by Security Information/qtr.</td>
<td>38</td>
<td>35</td>
<td>31</td>
<td>33</td>
<td>34.00</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Contraband Search by Security/APD x10,000 ≤ 10.00/qtr</td>
<td>6.67</td>
<td>6.3</td>
<td>6.27</td>
<td>5.89</td>
<td>6.28</td>
<td>N/A</td>
<td></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 2020 for further compliance.

Performance Monitors #9: Staff Knowledge from Security Surveillance Tours

Target: ≥ 90%/qtr.

Performance: This performance monitor was met in all of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Security Management from Surveillance Tours ≥ 90%/qtr</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>98%</td>
<td></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 2020 for further compliance.
Performance Monitors for 2020 are as follows:

<table>
<thead>
<tr>
<th>Performance Monitor</th>
<th>Informational/qtr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Bodily Assaults (non BHS-Adult)</td>
<td></td>
</tr>
<tr>
<td>Assault Rate/Census x 1,000 (non-BHS-Adult)</td>
<td>≤ 1.00/qtr</td>
</tr>
<tr>
<td>Reported Bodily Assaults (BHS)</td>
<td></td>
</tr>
<tr>
<td>Assault Rate/Census x1,000 (BHS)</td>
<td>≤ 2.50/qtr</td>
</tr>
<tr>
<td>Code Assists (non-BHS)</td>
<td></td>
</tr>
<tr>
<td>Code Assist Rate/Census x1,000 (non-BHS)</td>
<td>≤ 1.00/qtr</td>
</tr>
<tr>
<td>Code Assists (non-BHS) - Women and Children</td>
<td></td>
</tr>
<tr>
<td>Code Assist Rate/Census x1,000 (non-BHS) Women and Children</td>
<td>≤ 1.00/qtr</td>
</tr>
<tr>
<td>Code Assists (BHS)</td>
<td></td>
</tr>
<tr>
<td>Code Assist Rate/Census x1,000 (BHS)</td>
<td>≤ 1.00/qtr</td>
</tr>
<tr>
<td>Missing Patient Property</td>
<td></td>
</tr>
<tr>
<td>Missing Patient Property/APD</td>
<td>≤ 1.00/qtr</td>
</tr>
<tr>
<td>Missing BH Property</td>
<td></td>
</tr>
<tr>
<td>Missing BH Owned Property/APD</td>
<td>≤ 0.50/qtr</td>
</tr>
<tr>
<td>Contraband Search by Security</td>
<td></td>
</tr>
<tr>
<td>Contraband Search by Security/APD</td>
<td>≤ 10.00/qtr</td>
</tr>
<tr>
<td>Staff Knowledge Score in Security Management from Surveillance Tours</td>
<td>≥ 90%/qtr</td>
</tr>
</tbody>
</table>

The 2020 performance monitors were selected through the Security Risk Annual Assessment, Broward Health Corporate Security performance monitors, and with Safety Officer input 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.
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 2019, 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 2020.

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</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
chemical and materials inventories

| 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. | Met |  |

Review of Performance: Performance monitors for 2019 are as follows:

Performance Monitors #1: Non-Laboratory Biohazard Waste Rate

Target: ≤ 1.60 lbs/APD/quarter

Performance: This performance monitor was met in all qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Hazardous Materials and Hazardous Waste</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>NonLab Biohazardous Waste (lb)/APD</td>
<td>≤ 1.60 lbs./APD qtr</td>
<td>1.17</td>
<td>1.23</td>
<td>1.33</td>
<td>1.29</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 2020 for further compliance.

Performance Monitor #2: Laboratory Biohazard Waste (without Pathology Waste) Rate

Target: ≤ 0.36 lbs/APD/quarter

Performance: This performance monitor was met in all qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Hazardous Materials and Hazardous Waste</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Biohazardous Waste (lb)/APD without Pathology Waste</td>
<td>≤ 0.36 lbs./APD qtr</td>
<td>0.35</td>
<td>0.36</td>
<td>0.35</td>
<td>0.34</td>
<td>0.35</td>
<td>0.34</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 2020 for further compliance.

Performance Monitor #3: Proper Segregation of Biomedical Waste and Solid Waste

Target: ≥ 90%/quarter

Performance: This performance monitor was met in three of the four qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Hazardous Materials and Hazardous Waste</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proper Segregation of Biomedical Waste and Solid Waste</td>
<td>≥ 90%/qtr</td>
<td>97%</td>
<td>93%</td>
<td>95%</td>
<td>84%</td>
<td>92%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective with a 4% increase in compliance compared to 2018 and will continue to be monitored in 2020 for further compliance.

An increase in noncompliant waste segregation was observed during EoC surveillance rounds in the 3rd qtr. Education on proper segregation of red bag biohazard and solid wastes was distributed. Waste segregation posters were replaced in all Soiled Utility rooms. This topic was emphasized during new hire orientation sessions and in the annual continuing education module.

Performance Monitor #4: Sharps Containers Secured at or below 3/4 Fill Line

Target: ≥ 95%/qtr.

Performance: This performance monitor was met in all qtrs. of 2019.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Hazardous Materials and Hazardous Waste</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharps Containers Secured at or below 3/4 Fill Line</td>
<td>≥95%/qtr.</td>
<td>97%</td>
<td>99%</td>
<td>97%</td>
<td>95%</td>
<td>97%</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 2020 for further compliance.

Performance Monitor #5: Staff Knowledge Score in Hazardous Material and Waste Management assessed during EoC Surveillance Tours

Target: ≥ 90%

Performance: This performance monitor was met in two of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Hazardous Materials and Hazardous Waste</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in HM/HW Management from Surveillance Tours</td>
<td>≥ 90%/qtr</td>
<td>89%</td>
<td>92%</td>
<td>93%</td>
<td>88%</td>
<td>91%</td>
<td>96%</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 2020 for further compliance.

The greatest challenge for staff knowledge was remembering the various ways to obtain Safety Data Sheets and the labelling of secondary chemical containers. Education was distributed to all BHMC employees (see below) and reinforced during the staff interviews conducted during EoC surveillance rounds.
Safety Data Sheets (SDS)

A Safety Data Sheet is your resource for information on how to safely store, handle, transport and dispose of chemicals.

Prior to working with a chemical, read the label for any hazard warnings. For your protection, you need to know how to safely use chemicals.

For your protection, you must know how to obtain a SDS. Select anyone of the methods below:
- Request from manufacturer
- Call 1-800-451-8346 24 hours/7 days and request a fax

Step 2
Enter the product name or manufacturer name in the drop down boxes noted with the X.

Step 3
Read the SDS prior to using a chemical for which you are unfamiliar. Print SDS if needed.
Performance Monitors for 2020 are as follows:

<table>
<thead>
<tr>
<th>Monitor</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Laboratory Biohazardous Waste (lb)/APD</td>
<td>≤ 1.60 lbs./APD qtr</td>
</tr>
<tr>
<td>Laboratory Biohazardous Waste (lb)/APD without Pathology Waste</td>
<td>≤ 0.36 lbs./APD qtr</td>
</tr>
<tr>
<td>Proper Segregation of Biomedical Waste and Solid Waste</td>
<td>≥ 90%/qtr</td>
</tr>
<tr>
<td>Sharps Containers Secured and at or below 3/4 Fill Line</td>
<td>&gt;95%/qtr</td>
</tr>
<tr>
<td>Staff Knowledge of Hazardous Material &amp; Waste Management</td>
<td>≥ 90%/qtr</td>
</tr>
</tbody>
</table>
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 2019, 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 2020.

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</td>
<td>Met</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
compartmentation and means of evacuation

Implement fire alarm, detection and suppression systems that are designed, installed and maintained to ensure reliable performance

Met

Conduct unannounced fire drills to assess effectiveness of trained personnel response and assess function of fire response systems

Met

Review of Performance: 2019 performance monitors are as follows:

Performance Monitors #1 # False Fire Alarms-User Errors, System Problem/Failure

Target: ≤ 14/qtr.

Performance: This performance monitor was met in three of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td># False Fire Alarms-User Errors, System Problem/Failure</td>
<td>≤ 14/qtr</td>
<td>7</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>9</td>
<td>12</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective in 2019 reduced from 2018 by 3 reported incidents and will continue to be monitored in 2020 for further compliance.

Performance Monitors #2: False Fire Alarms Rate per 10,000 sq. ft.

Target: ≤ 0.09/qtr.

Performance: This performance monitor was met in three of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</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>0.04</td>
<td>0.11</td>
<td>0.08</td>
<td>0.07</td>
<td>0.08</td>
</tr>
</tbody>
</table>
Overall Effectiveness of the Program’s Effectiveness: This performance monitor goal was found to be effective in 2019 and will continue to be monitored in 2020 for consistent compliance.

Performance Monitors #3 Monitor: % of Successful Code Red Drills

Target: ≥ 95%/qtr.

Performance: This performance monitor was met in three of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Successful Code Red Drills</td>
<td>≥ 95%/qtr</td>
<td>91%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
<td>96%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: Twenty-five fire drills were conducted in 2019 with a 3% improved drill performance score compared to 2018. This performance monitor was found to be effective in 2019 and will continue to be monitored in 2020.

Performance Monitors #4: % Compliance with Critical Room Pressurization

Target: 100%/qtr.

Performance: This performance monitor was met in two of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Compliance with Critical Room Pressurization Testing</td>
<td>100%/qtr</td>
<td>106/108 = 98%</td>
<td>108/108 = 100%</td>
<td>108/108 = 100%</td>
<td>107/108 = 99%</td>
<td>99%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor goal was not met in 2019 and will continue to be monitored in 2020 for consistent compliance. Any outliers were addressed immediately by Facilities.
Performance Monitors #5: Staff Knowledge and Life/Fire Safety Surveillance Tours

Target: ≥ 90%/qtr.

Performance: This indicator was met in all qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Life/Fire Safety Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Life/Fire Safety Management Surveillance Tours</td>
<td>≥ 90% qtr</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor goal was found to be effective in 2019 and will continue to be monitored in 2020.

Performance Monitors for 2020 are as follows:

<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</td>
<td>100%/qtr</td>
</tr>
<tr>
<td>Staff Knowledge Score in Life/Fire Safety Management Surveillance Tours</td>
<td>≥ 90% qtr</td>
</tr>
</tbody>
</table>
MEDICAL EQUIPMENT MANAGEMENT PROGRAM

Reviewer: Marcos Mantel
Title: Executive Director, Corporate Biomedical Engineering
Region: Broward Health Medical Center
Review Date: April 15, 2020

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 2019, the Medical Equipment Management Plan was reviewed. The objectives for the Medical Equipment 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 2020.

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: 2019 performance monitors are as follows:

Performance Monitor #1: Failed Equipment Performance

Target: ≤ 6%/qtr.

Performance: Target met each quarter in 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Medical Equipment Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bio-Med - Failed Equipment Performance</td>
<td>≤ 6%/qtr</td>
<td>1%</td>
<td>3%</td>
<td>5%</td>
<td>6%</td>
<td>4%</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 2020 for further compliance.

Performance Monitor #2: Improper Care of Equipment:

Target: ≤ 2%/qtr.

Performance: Performance was met in three of the four qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Medical Equipment Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bio-Med - Improper Care of Equipment</td>
<td>≤ 2%/qtr</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
<td>2%</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 2020 for further compliance.

Performance Monitor #3: Missing Equipment Accessories

Target: ≤ 2%/quarter

Performance: Performance was met in all qtrs. of 2019

Performance Monitor Analysis:
Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2020 for further compliance.

Performance Monitor #4: Laser Safety-Quality Assurance

Target: ≤ 2%/qtr.

Performance: Performance was met in all qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Medical Equipment Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laser Safety - Quality Assurance Incidents</td>
<td>≤ 2%/qtr</td>
<td>0.050%</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>0.620%</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 2020 for further compliance.

Performance Monitor #5: Staff Knowledge Score in Medical Equipment Management assessed during EoC Surveillance Tours

Target: ≥ 90% qtr.

Performance: Performance was met in all qtrs. of 2019

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Medical Equipment Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Med Equipment Management Surveillance Tours</td>
<td>≥ 90% qtr</td>
<td>97%</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
<td>99%</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 2020 for further compliance as part of the EoC surveillance rounds.

Performance Monitors for 2020 are as follows:

<table>
<thead>
<tr>
<th>Benchmarks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bio-Med - Failed Equipment Performance</td>
<td>≤ 6%/qtr</td>
</tr>
<tr>
<td>Bio-Med - Improper Care of Equipment</td>
<td>≤ 2%/qtr</td>
</tr>
<tr>
<td>Bio-Med – Missing Equipment Accessories</td>
<td>≤ 2%/qtr</td>
</tr>
<tr>
<td>Laser Safety – Failed Equipment Performance</td>
<td>≤ 2%/qtr</td>
</tr>
<tr>
<td>Staff Knowledge of Medical Equipment Management</td>
<td>≥ 90%/qtr</td>
</tr>
</tbody>
</table>
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 2019, 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 2020.

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>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of Performance: 2019 performance monitors are as follows:

Performance Monitor #1: Any Unscheduled Outages >4hrs

Target: 0/qtr.

Performance: Average quarterly performance in 2019 was 0/qtr.
Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored for trends in 2020.

Performance Monitor #2: Utility Systems Failures

Target: 0/qtr.

Performance: This performance monitor was met in three of the four qtrs. of 2019

Performance Monitor Analysis: In 2019 there was one Utility Systems Failure encountered.

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2020 for further compliance.

Performance Monitor #3: User Errors

Target: 0/qtr.

Performance: This performance monitor was met in three of the four qtrs. of 2019

Performance Monitor Analysis:

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored for trends in 2020.

Performance Monitor #4: Utility Systems Problems

Target: 0/qtr.

Performance: This performance monitor was met in three of the four qtrs. of 2019

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</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>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utility Systems Failures</td>
<td>0/qtr</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utility Systems Problems</td>
<td>0/qtr</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</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 2020 for further compliance.

Performance Monitor #5: (Total WO Count) Work Order Class BS4-LS

Target: 100%/qtr.

Performance: This indicator was met in all qtrs.

Performance Monitor Analysis: In 2019 all BS4-LS work orders were completed on or within scheduled times in all qtrs.

Utilities Management | Benchmark | Q1 CY19 | Q2 CY19 | Q3 CY19 | Q4 CY19 | CY2019 | CY2018 |
---------------------|-----------|---------|---------|---------|---------|--------|--------|
(Total WO Count) Work Order Class BS4-LS | 100%/qtr | 100%    | 100%    | 100%    | 100%    | 100%   | 99.00% |

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2020.

Performance Monitor #6: (Total WO Count) Work Order BS4-IC

Target: 100%/qtr.

Performance: This indicator was met in all qtrs.

Performance Monitor Analysis:
Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will continue to be monitored in 2020 for further compliance.

Performance Monitor #7: Generator Test Results

Target: 100%/qtr.

Performance: This indicator was met in all qtrs.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</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 and will continue to be monitored in 2019 for further compliance.

Performance Monitor #8: 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: This indicator was met in all qtrs.

Performance Monitor Analysis: Performance was met in every quarter of 2019.

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy Efficiency (Benchmark changes per seasonal quarter) kW Hrs per sq. ft. Occupied Space (Old Hospital, Atrium Bldg. and CEP)</td>
<td>Seasonal By Qtr</td>
<td>8.44</td>
<td>8.91</td>
<td>9.14</td>
<td>9.17</td>
<td>8.91</td>
<td>9.15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9.15</td>
<td>9.81</td>
<td>10.75</td>
<td>9.91</td>
<td>N/A</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 be continue to be monitored in 2020 for further compliance.
Performance Monitor #9: Elevator Entrapment (>30min)

Target: < 2/qtr.

Performance: This indicator was met in all qtrs.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevator Entrapment (&gt;30 min)</td>
<td>≤ 2/qtr</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program’s Effectiveness: This performance monitor was found to be effective and will be continue to be monitored in 2020 for further compliance.

Performance Monitor #10: Staff Knowledge Score in Utilities Management Surveillance Tours

Target: ≥ 90%/qtr.

Performance: This indicator was met in all qtrs.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
<th>CY2019</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Knowledge Score in Utilities Management Surveillance Tours</td>
<td>≥ 90%/qtr</td>
<td>96%</td>
<td>97%</td>
<td>95%</td>
<td>97%</td>
<td>96%</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 2020 for further compliance as part of the EoC surveillance rounds.

Performance Monitors for 2020 are as follows:
<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Unscheduled Outages &gt;4hrs.</td>
<td>0/qtr</td>
</tr>
<tr>
<td>Utility Systems Failures</td>
<td>0/qtr</td>
</tr>
<tr>
<td>Utility Systems Problems</td>
<td>0/qtr</td>
</tr>
<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) kW Hrs per sq. ft. Occupied Space (Old Hospital, Atrium Bldg. and CEP)</td>
<td>Seasonal By Qtr</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 17, 2020

**Purpose:** Reduce employee back/neck/shoulder strains due to patient handling activities by 10%

**Scope:** Scope of this hospital-wide initiative included staff and managers from all BHMC departments where Adult patient care was provided in both inpatient and outpatient settings as well as in surgical and invasive procedural suites and Transportation.

**Cause:** An unfavorable trend was noted as 2018 progressed resulting in almost 3x the amount of employee strains during patient handling activities compared to 2017 (14 vs. 5 incidents). The greatest # of occurrences were in Adult Care services where nursing staff and leader turnover contributed to a loss of super-users available for new hire training and a reduced comfort level by unit staff to use the existing mobile safe patient handling (SPH) equipment for patient transfers and repositioning. More employees in the Transportation department were also exhibiting neck and shoulder strains due to repetitive lateral patient transfers.

Successes in critical care units with staff using ceiling lifts and other mobile SPH equipment were not duplicated in other settings.

**Duration:** The monitoring period for this indicator occurred throughout 2019.

**Actions:**
- Met with Adult Care nursing leadership, clinical education and the CNO to discuss strategy combining patient fall reduction and employee back safety initiatives
- Former President of National Safety Patient Handling Organization presented on Safe Patient Handling (SPH) during Nurses Week reinvigorating nurse leaders and staff about BHMC’s SPH Program
• Evaluated two different types of lateral transfer mats in Transportation staff
• Arranged for additional training of Adult Care staff and clinical nurse specialists by Hill-Rom on existing SPH equipment
• Purchased 16 Sara Stedy with sit to stand feature for early patient mobility. This equipment was also targeted to assist with bed to chair and stretcher transfers and toileting functions, a contributory factor for patient falls
• Obtained Hill-Rom beds in selected Medical-Surgical and Critical care units with added repositioning and boosting capabilities reducing the risk of employee muscular-skeletal strains

**Reporting:** Progress on the performance improvement initiative was reported to the EoC Committee every 1-2 months. Performance monitors were reported quarterly to the EoC Committee as well as presented at Nursing Leadership, Regional Quality and Patient Falls Committees.

**Analysis:** Healthstream modules on existing Hill-Rom and Aroj’s Safe Patient Handing equipment were assigned. A policy and competency were developed for the Sara-Stedy. Corporate Value Analysis is working through the process for lateral transfer preferred by the Transportation staff after product evaluations. A review of proper body mechanics was conducted was this team and an emphasis on the importance of a 2 person lateral transfer whenever possible.

Data for this performance monitor revealed there were 10 incidents in 2019 with a 20% rate decrease compared to 2018; exceeding the 10% rate reduction goal that had been established.
2019 ANNUAL EVALUATION OF THE ENVIRONMENT OF CARE FOR BROWARD HEALTH NORTH

Respectfully Submitted
By: Alicia L. Beceña,
MBA, CHEC, CTM
Regional Safety Officer
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.

Broward Health is one of the largest hospital systems in the country, serving our community for 65 years.

**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 2020.

The following is an Executive summary of the Environment of Care performance highlights for CY 2019 followed by recommended Goals for CY 2020 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 2019 performance goals and program objectives.
- Priorities and goals for calendar year 2020.

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>Members &amp; Titles</th>
<th>Departments</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice Baca, Corporate Safety Officer</td>
<td>Corporate Safety &amp; Security</td>
<td>Safety Officer &amp; EOC Chair</td>
</tr>
<tr>
<td>Garrett Cole, Corporate Director</td>
<td>Corporate Safety &amp; Security</td>
<td>Corporate Security &amp; Community Health</td>
</tr>
<tr>
<td>Kelly Keys, Corporate Manager</td>
<td>Emergency Preparedness</td>
<td>Member</td>
</tr>
<tr>
<td>Kristen Sanders, EMP Coordinator</td>
<td>Emergency Preparedness</td>
<td>Member</td>
</tr>
<tr>
<td>Suzanne Singh &amp; Andree Rose</td>
<td>Employee Health &amp; Worker's Compensation</td>
<td>Safety Management, Members</td>
</tr>
<tr>
<td>Marci Martin &amp; Ron Ellis</td>
<td>Medical Equipment (BOMED)</td>
<td>Medical Equipment Management, Members</td>
</tr>
<tr>
<td>Howard Scott</td>
<td>Environment</td>
<td>Hazardous Materials &amp; Waste Management</td>
</tr>
<tr>
<td>Susan Newman, Regional COO</td>
<td>Administration</td>
<td>Member</td>
</tr>
<tr>
<td>Scott Ritz, Regional CNO</td>
<td>Administration</td>
<td>Member</td>
</tr>
<tr>
<td>Jesusa Alfonso &amp; Betty Rivera, Regional Managers</td>
<td>Ep derm ogy, Quality &amp; Byses</td>
<td>Member</td>
</tr>
<tr>
<td>R. Scott Payne, Regional Director</td>
<td>Facilities Services</td>
<td>Utility Systems Management, Member</td>
</tr>
<tr>
<td>David Porter &amp; Richard Evans, Managers</td>
<td>Facilities Services</td>
<td>Fire Safety Management &amp; Construction Program</td>
</tr>
<tr>
<td>Anthony (Tony) Frederick, Corporate Security &amp; Ellis O'ree</td>
<td>Protective Services Security</td>
<td>Security Management</td>
</tr>
<tr>
<td>Christine Kesser</td>
<td>Materials Management</td>
<td>Member</td>
</tr>
<tr>
<td>Cliff Lewis</td>
<td>Dietary</td>
<td>Member</td>
</tr>
<tr>
<td>Katly Avedian &amp; Donna Velardi</td>
<td>Laboratory</td>
<td>Members</td>
</tr>
<tr>
<td>Maria Noel &amp; Narda Priest, Regional Manager</td>
<td>Radiology Services</td>
<td>Radiological Safety Officer &amp; Members</td>
</tr>
<tr>
<td>Winn Castro</td>
<td>Pharmacy</td>
<td>Member</td>
</tr>
<tr>
<td>JoAnn Franklin, Regional Manager</td>
<td>Emergency Services</td>
<td>Member</td>
</tr>
<tr>
<td>Genevieve Qua &amp; Georgie Petrow, Regional Managers</td>
<td>Rehabilitation Services, Wound Care &amp; Hyperbaric Chambers</td>
<td>Members</td>
</tr>
<tr>
<td>Carolina Gray &amp; Asia Matthews, Regional Managers</td>
<td>Surgical Services, OR &amp; Laser Safety</td>
<td>Members</td>
</tr>
<tr>
<td>Elleen Dyer, Regional Manager</td>
<td>Risk Management</td>
<td>Member</td>
</tr>
<tr>
<td>Michael McDonough, Regional Manager</td>
<td>Information Services</td>
<td>Member</td>
</tr>
<tr>
<td>Janet Rohnburg, Regional Manager</td>
<td>Trauma Services</td>
<td>Member</td>
</tr>
<tr>
<td>Susan Barrow Manager</td>
<td>Nursing (3NE)</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(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Alicia Becena, Eileen Daly</td>
</tr>
<tr>
<td>Security</td>
<td>Garnett Coke, Elvis Greese</td>
</tr>
<tr>
<td>Hazardous Materials</td>
<td>Alicia Becena, Howard Scott</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>R. Scott Payne, David Porter</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Marcos Mantel, Ronald Ellis</td>
</tr>
<tr>
<td>Utility Systems</td>
<td>R. Scott Payne, David Porter</td>
</tr>
</tbody>
</table>
SAFETY MANAGEMENT PROGRAM

Reviewer: Alicia Becena and Eileen Daly
Title: Safety Management Program
Region: Broward Health North
Review Date: March 2, 2020

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
  - Material Distribution
  - Biomedical Engineering
  - Environmental Services
  - Nursing
  - Workers’ Compensation
  - IS Communications
  - 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 four 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>2019 &amp; 2020 Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>REDUCE STAFF NEEDLE STICKS (to no more than 20)</td>
<td>✓</td>
<td></td>
<td>Met goal as there were 21 less injuries than the previous year 2018</td>
<td>Goal (23) adjusted instead of 20 (2019) as we seek a downward trend</td>
</tr>
<tr>
<td>REDUCE STAFF SLIPS TRIPS FALLS (STFs) (12)</td>
<td>✓</td>
<td></td>
<td></td>
<td>Goal (15) adjusted instead of 12 (2019). The 2020 goal is to be 10% over than the average over the last 3 years</td>
</tr>
<tr>
<td>REDUCE VISITOR FALLS (13)</td>
<td>✓</td>
<td></td>
<td></td>
<td>Goal (13) (2019) adjusted to 23 (2020) as this is a 10% reduction of the 25 (2019)incident</td>
</tr>
<tr>
<td>REDUCE EMERGENCY DEPARTMENT PATIENT FALLS (11)</td>
<td>✓</td>
<td></td>
<td></td>
<td>Goal (11) adjusted to 14 (2020) as this is a 10% reduction of the 16 (2019) incidents</td>
</tr>
<tr>
<td>REDUCE OUTPATIENT DEPARTMENT PATIENT FALLS (4)</td>
<td>✓</td>
<td></td>
<td></td>
<td>Goal (4) adjusted to 7 (2020) as this is a 10% reduction of the 8 (2019) incidents</td>
</tr>
</tbody>
</table>
Review of Performance:

Performance Monitors #1

Monitor: CONTAMINATED NEEDLE STICKS
Target: REDUCE STAFF NEEDLE STICKS BY 5 (from 25)
Performance: Met

Performance Monitor Analysis:

Programs Effectiveness: The Program was effective in reducing needle sticks from 30 (2017) to 25 (2018) to 23 (2019). In 2018 & 2019, Broward Health North implemented a Process Improvement to assist with the reduction by coordinating with the syringe vendor to service staff on proper handling. Employees having an incident were assigned a learning module in HealthStream. This appears to help reduce injuries and therefore we will continue to utilize this Process Improvement and continue to monitor and report occurrences at the EOC Meetings.

Performance Monitors for 2020: Broward Health North has adjusted the performance and set a goal of continuing to reduce Needle Sticks injuries to 23 or less in 2020 as we seek a downward trend equaling at ten (10) percent reduction from the average (26 needle sticks) noted over the three years.

Performance Monitors #2

Monitor: REDUCE STAFF SLIPS TRIPS FALLS (STF)
Target: Reduce Staff Slips, Trips and Falls to 12
Performance: Not Met

Performance Monitor Analysis:

Programs Effectiveness: The program was not effective in reducing Employee Slips, Trips and Falls to 12. However, the number of Slip Trips and Falls did not increase and remained at 17 the same as in 2018 (17). Spill stations previously removed have been reinstated and their use will be monitored throughout 2020 to see if there is an impact on decreasing these types of injuries.
Performance Monitors for 2020: Broward Health North is adjusting the goal of Staff Slips, Trips and Falls from 12 to 15 which is 10 percent less than the average over the last three (3) year results seeking a downward trend for these types of injuries.

Performance Monitors #3

Monitor: VISITOR FALLS
Target: Reduce visitor falls to 13 (adjusted from Risk Quarterly Report to 20)
Performance: Not Met
Performance Monitor Analysis

Performance Monitors #4

Monitor: EMERGENCY DEPARTMENT PATIENT FALLS
Target: Reduce ED Falls to 11.
Performance: Not Met
Performance Monitor Analysis

Performance Monitors #5

Monitor: OUTPATIENT DEPARTMENT PATIENT FALLS
Target: Reduce Outpatient Falls to 4 (adjusted from Risk Only Report to 8)
Performance: Not Met
Performance Monitor Analysis
Performance Monitors for 2020: Broward Health North has adjusted the goal of reducing Outpatient Department Patient Falls to no more than 7.
(Note: Goal to reduce from prior year of 8 minus 10% = 7.2 rounded to 7).

Safety Management Performance Monitors for 2020:
- Reduce Exposures (TB, Meningitis, etc.) by 10% or more
- Needle Sticks to no more than 23
- Reduce Staff Slip, Trip and Fall to no more than 15
- Reduce Visitor Fall to no more than 23
- Reduce ED Fall to no more than 14
- Reduce Outpatient Department Patient Fall to no more than 7

Action items for fall prevention which are either on-going or will be started in 2020 are the following:
- Conduct in-service during huddles and new employee orientation regarding Contaminated Needle Sticks, Slips/Trips & Falls, Exposures and any other identified workplace injuries increasing in incidents in the year
- Work with EVS to eliminate the use of thin floor mats which can easily flip over and replace them with a heavier/thicker area rug.
- Identify slick areas where flooring may need non-skid applications.
- Remove floor mats in vestibules already equipped with non-skid surface.
- Reinstall “Think Safe” signs at points of entry focusing on fall prevention.
- Strategically place “wet floor” spill kits in zones where food items/liquids can fall.
SECUR I TY MANAGEMENT PROGRAM

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 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 CY2020 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>
<th>Not Met</th>
<th>Met with Conditions</th>
<th>Adjusted Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSAULT / BATTERY</td>
<td></td>
<td>✓</td>
<td></td>
<td>Average over the last 3 years equal s 23</td>
</tr>
<tr>
<td>THREAT OF VIOLENCE PENDING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGGRESSIVE BEHAVIOR (patients/visitors)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODE ASSIST (Reduce to 50)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Did not reach established goal of 50. However, drop by 38.5% when compared to 2018</td>
<td>For 2020, reduction to be by 10% of previous year equalling no greater than 267</td>
</tr>
<tr>
<td>MISSING / LOST PROPERTY (Patients)</td>
<td>✓</td>
<td></td>
<td></td>
<td>Reduce to no more than 60 (10% reduction)</td>
</tr>
<tr>
<td>THEFTS: PATIENT BELONGINGS</td>
<td></td>
<td></td>
<td></td>
<td>Group with Missing Lost Patient property</td>
</tr>
<tr>
<td>THEFTS: AUTO VANDALISM BH Property</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECUR I TY MANAGEMENT

- The number of Assault/Battery incidents in 2019 increased to 28 from 25 in CY 2018, and 17 in CY 2017.
- Threat of Violence incidents pending to compare (9 in CY 2017, 8 in CY 2018 and 2019 (Pending #).
• Aggressive Behavior (patients & visitors) incidents increased for 2019 (117) when compared to 102 in CY 2017 and 61.
• The number of Code Assist of 297 in 2019 incidents decreased from 2018 (492) and decreased to the 2017 number of 283.
• Missing Lost Property incidents decreased to 67 in 2019 compared to 117 in CY 2017 and 84 in CY 2018.
• The number of Vehicle Burglary incidents decreased from 8 in CY 2017 to 7 in CY 2018 and 2019 (Pend ing #)
• The number of Contraband searches decreased in 2019 to 96 from 140 in CY 2017 and 144 in CY 2018.
• The number of Vehicle Burglary incidents decreased from 8 in CY 2017 to 7 in CY 2018 and 2019 (Pend ing #)
• The number of Con traband searches decreased in 2019 to 96 from 140 in CY 2017 and 144 in CY 2018.
• The number of Con traband searches decreased in 2019 to 96 from 140 in CY 2017 and 144 in CY 2018.

Performance Monitors #1
Monitor: Code Assist / Aggressive Behaviors
Target: Reduce rate below one (1)
Performance: Met
Performance Monitor Analysis

Program Effectiveness:
The measured security performance performed within threshold. The average performance of 0.18 incidents per 10,000 adjusted patient days exceeded the performance baseline.

Performance Monitors #2
Monitor: Security Procedures
Target: Reduce below 90%
Performance: Met
Performance Monitor Analysis

Program Effectiveness:
The program performed within threshold. The average performance of 0.18 incidents per 10,000 adjusted patient days exceeded the performance baseline.

Performance Monitors for 2020:
Security Management will continue to monitor the program using the established performance indicators including incidents (assaults, aggressive behavior, and threats of violence) in coordination with the safety officer, clinical leaders, and others to establish a program that emphasizes “early intervention” to help deescalate aggressive behaviors. The goal of the program is to decrease violent acts overall and improve the Environment of Care. The following are the 2020 Performance Monitors:

• Security Procedures Performance was 97% (2019) 7% above the target. Therefore, it is recommended for the committee to increase the acceptable performance from 90% to 93% for CY 2020.
• Continue to monitor the average number of “on-related” events in a quarter.
• Breakdown Code Assist vs. Nurse Assist to improve data collection. Security presence can help reduce Workday Violence by implementing early deescalation techniques. Goal to increase Nurse Assist and decrease Code Assist numbers by 10% (no more than 267).
• Continue to develop action plans such as “sweep the room” campaigns which were done to address missing damaged patient property discarded within linen and trash. For 2020, security will add to EOC Reporting the success rate of returns (patient property) completed. In 2019 only 5 (recovered) of 67 Missing Patient Property. Also, a Goal of 10% reduction in the amount of missing patient belongings whose threshold of 2 was exceeded in 2019 (missing items should be no more than 60).
HAZARDOUS MATERIALS & WASTE MANAGEMENT PROGRAM

Title: Hazardous Materials & Waste Management Program

Region: Broward Health North

Review Date: March 9, 2020

**Purpose:** The purpose of the Hazardous Materials and Waste Management Program 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 occupants. Any differences in activities at each site are noted or defined in 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 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 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>Manage Biohazardous Waste (above 95%)</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase Recycled Waste (by 3%)</td>
<td></td>
<td>✓</td>
<td>Exceed target by 2% from 16.4% to 18.4% instead of 3%</td>
<td>Adjusted 3% (2019) to an upward trend for 2020 without a specific percentage</td>
</tr>
<tr>
<td>Maintain zero (0) Code Spills</td>
<td>✓</td>
<td></td>
<td>The facility maintained zero spills but did have a patient come to ED for treatment which contributed to an unpreventable spill</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 Hazardous Waste below target of 1.60 lbs./APD
Target: Below 1.60 lbs./APD (Key Group - Corporate Goal)
Performance: Met

Performance Monitor Analysis

<table>
<thead>
<tr>
<th>HAZMAT MONITOR</th>
<th>Q1CY18</th>
<th>Q2CY18</th>
<th>Q3CY18</th>
<th>Q4CY18</th>
<th>Q1CY19</th>
<th>Q2CY19</th>
<th>Q3CY19</th>
<th>Q4CY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biohazard Waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Encounters</td>
<td>32074</td>
<td>28191</td>
<td>27625</td>
<td>28173</td>
<td>29295</td>
<td>29661</td>
<td>28904</td>
<td>29847</td>
</tr>
<tr>
<td>Lbs of Regulated Medical Waste</td>
<td>27407</td>
<td>22183</td>
<td>17798</td>
<td>16540</td>
<td>18083</td>
<td>18213</td>
<td>19089</td>
<td>20711</td>
</tr>
<tr>
<td>Performance</td>
<td>0.85</td>
<td>0.79</td>
<td>0.62</td>
<td>0.59</td>
<td>0.62</td>
<td>0.65</td>
<td>0.69</td>
<td>0.69</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>1.60</td>
<td>1.60</td>
<td>1.60</td>
<td>1.60</td>
<td>1.60</td>
<td>1.60</td>
<td>1.60</td>
<td>1.60</td>
</tr>
</tbody>
</table>

Program's Effectiveness: The Hazardous Material and Waste Management Program was effective in maintaining our Hazardous Waste below the assigned System wide Goal target rate of less than 1.60 lbs./APD.

Performance Monitors for 2019: Bowerd Health North is committed to maintaining Hazardous Waste below the assigned System wide Goal target rate of less than 1.60 lbs./APD.

Performance Monitors #2

Monitor: Manage Hazardous Waste
Target: Above 95% (# of Areas Surveyed Correctly Managed)
Performance: Not Met

Performance Monitor Analysis

<table>
<thead>
<tr>
<th>Managing Biohazard</th>
<th>Q1CY18</th>
<th>Q2CY18</th>
<th>Q3CY18</th>
<th>Q4CY18</th>
<th>Q1CY19</th>
<th>Q2CY19</th>
<th>Q3CY19</th>
<th>Q4CY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyed</td>
<td>24</td>
<td>35</td>
<td>30</td>
<td>27</td>
<td>22</td>
<td>34</td>
<td>28</td>
<td>31</td>
</tr>
<tr>
<td>Managed Correctly</td>
<td>24</td>
<td>29</td>
<td>27</td>
<td>26</td>
<td>19</td>
<td>31</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>Performance</td>
<td>100%</td>
<td>83%</td>
<td>90%</td>
<td>96%</td>
<td>86%</td>
<td>91%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Program's Effectiveness: The Managing of Hazardous Waste was not effective as performance noted during EOC Rounds was below the target rate of 95% during all quarters.

Performance Monitors for 2020: Bowerd Health North has set a goal of increasing the performance by scheduling the vendor to perform staff education on proper disposal of waste.

Performance Monitors #3

Monitor: Increase Recycled Waste
Target: 16.4%
Performance: MET and Favorable by 2% from established Baseline

Performance Monitor Analysis

Program's Effectiveness: The Hazardous Material and Waste Management Program was effective in increasing our Recycled Waste by 2% collecting a total of 505,016 lbs. of waste equal to 18% for CY 2019.
Performance Monitors #4

Monitor: Maintain zero Code Spills
Target: 0
Performance: Met

Program’s Effectiveness: The Hazardous Material and Waste Management Program was effective in obtaining the goal of port.

Performance Monitors for 2020: Broward Health North will continue to train and educate on spill prevention techniques.

Performance Monitors #4

Monitor: Conduct (1) spill cart training class
Target: 1
Performance: Met

Overall Effectiveness of the Program’s Effectiveness: The Hazardous Material and Waste Management Program was not effective towards completing spill cart training.

Hazardous Materials and Waste Management Performance Monitors for 2020:

- Maintain Biohazardous Waste to below 1.6 lbs./APD
- Manage Bio-Hazardous Waste for a compliance rate of 95%
- Increase Recycled Waste above the previous year of 18.4%
- Continue zero (0) Code Spill through ongoing training and education
- Conduct a minimum of 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:** March 4, 2020

**Purpose:** The Purpose of the Fire Safety Management Program is to minimize the possibility and risks of 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 Program 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.</td>
<td>✓</td>
<td></td>
<td>No ILSM identified</td>
<td></td>
</tr>
<tr>
<td>If interim Life Safety Measures (ILSMs) 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.</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 ILSMs are being used, perform 2 per quarter, per shift.  
**Target:** One fire drill per shift, per quarter.  
**Performance:** Target MET with all fire drills completed at the appropriate times meeting all testing criteria of NFPA. There were 17 fire drills completed exceeding the requirements of one per shift, per quarter.

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CY 17</th>
<th>CY 18</th>
<th>CY 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRE DRILLS COMPLETED</td>
<td>25</td>
<td>16</td>
<td>17</td>
</tr>
</tbody>
</table>

**Programs Effectiveness:** The Fire Safety Management Program was effective in achieving our goal for fire drills. Additionally, extra fire drills were performed for CAP and CARF requirements.
Performance Monitors #2
Monitor: Number of false fire alarms
Target: Less than 10 for calendar year 2019 - MET
Performance: Broward Health North had less construction therefore goal was met favorably.
Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CY 17</th>
<th>CY 18</th>
<th>CY 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER OF FALSE ALARMS</td>
<td>23</td>
<td>13</td>
<td>9</td>
</tr>
</tbody>
</table>

Program's Effectiveness:
Broward Health North was able to reduce the number of False Fire Alarms.

Performance Monitors for 2020: Broward Health North has set a goal to continue reducing amount of false fire alarms for 2020.

Performance Monitors #3
Monitor: Number of actual fires
Target: Zero
Performance: Target NOT met
Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CY 17</th>
<th>CY 18</th>
<th>CY 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER OF ACTUAL FIRES</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Program's Effectiveness: The Fire Safety Management Program was effective in achieving our overall goal. However, there was one electrical outlet having wire damage which caused a call to the fire department. Electrical wiring repaired with no adverse outcomes.

Performance Monitors for 2020: Broward Health North will continue to use zero as a goal for actual fires.

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 2019 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 2020:
- Perform fire drills, 1 per quarter, per shift. If ILSMs 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.
- Increase Staff Participation during Fire Drills including Critical Staff.
- Present during New Employee and Medical Staff Orientation (including All Staff for Critical Subjects)
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 inline 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 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. Radiology, Dialysis, Sterilizer, Lasers, and some Laboratory Analyzer services are 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 2019, 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 Audits
- Parameters
- 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, and review of the stated goals are used to determine 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 for 2019.

Accomplishments-Special Projects
- Coordinate the NK Physical Monitoring Refresh Project – July 2019
- Replace all NK Physical Monitors; refresh project – November 2019
- Started the planning stage for IV Pump refreshments – June 2019
- Deployed new AEDs at all Physician Practices – October 2019
- Deployed Medine Comfort glide Ar bed pumps – September 2019

Strength

Our Scheduled Maintenance (SM) program is unique because we do "environmental" SMs. This helps us achieve close to 100% annual completion of all SMs in all facilities.

The ability to move Bomed 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 2019 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>&lt; 10%</td>
<td>MET</td>
</tr>
<tr>
<td>- Failed Performance*</td>
<td>&lt; 6%</td>
<td>MET</td>
</tr>
<tr>
<td>- Failed Electrical Safety</td>
<td>&lt; 1%</td>
<td>MET</td>
</tr>
<tr>
<td>- New To Inventory (Unreported)</td>
<td>&lt; 5%</td>
<td>MET</td>
</tr>
<tr>
<td>- No Problem Was Found</td>
<td>&lt; 15%</td>
<td>MET</td>
</tr>
<tr>
<td>- Improper Care</td>
<td>&lt; 2%</td>
<td>MET</td>
</tr>
<tr>
<td>- Missing Accessories* new FY 18</td>
<td>&lt; 2%</td>
<td>MET</td>
</tr>
<tr>
<td>- Staff Instruction</td>
<td>&lt; 2%</td>
<td>MET</td>
</tr>
</tbody>
</table>

BROWARD HEALTH
Clinical/Biomedical Engineering Performance Assessment
Calendar Year (January-December) 2019

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Goal</th>
<th>BHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>- W.O. Not Closed</td>
<td>&lt;= 10%</td>
<td>253</td>
</tr>
<tr>
<td>- Failed Performance</td>
<td>&lt;= 6%</td>
<td>404</td>
</tr>
<tr>
<td>- Failed Electrical Safety</td>
<td>&lt;= 1%</td>
<td>62</td>
</tr>
<tr>
<td>- New To Inventory</td>
<td>&lt;= 5%</td>
<td>45</td>
</tr>
<tr>
<td>- Calls Where No Problem Was Found</td>
<td>&lt;= 15%</td>
<td>274</td>
</tr>
<tr>
<td>- Improper Care</td>
<td>&lt;= 2%</td>
<td>193</td>
</tr>
<tr>
<td>- Missing Accessories*</td>
<td>&lt;= 2%</td>
<td>80</td>
</tr>
<tr>
<td>- Staff Instruction</td>
<td>&lt;= 2%</td>
<td>39</td>
</tr>
</tbody>
</table>

Comments:
Recommended Goals for CY 2020
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 2020:

- Replace the NK Monitoring Network – July 2020
- Connect All NK Monitors to Cerner CareAware EMR – July 2020
- Infusion Pumps Replacement with EMR Connectivity – June 2020
- 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 Committee.
UTILITIES MANAGEMENT PROGRAM

Reviewer: R. Scott Payne, David Porter
Title: Utilities Management Program
Region: Broward Health North
Review Date: March 4, 2020

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 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 Objectives: 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>
</tr>
</thead>
<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>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of Performance:

Performance Monitors #1

Monitor: Reduce electric consumption by 2-3%

Target: 18,881,632 kWh calendar year — NOT Met

Performance: Broward Health North used 19,465,600 kWh’s of power in 2017 and in 2018 set a goal to reduce consumption by 2-3% 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. In 2019, 19,895,600 kWh’s were used indicating an increase of 294,000 kWh’s or approximately 1.5%

Performance Effectiveness: A reduction was NOT MET in 2019 as we experienced an increase in weather temperatures specifically in quarter 3. Quarters 1, 2 and 4 were all below the target acceptable performance indicators. Therefore, 75% of the time the established goal was met.

Performance Monitors #2

Monitor: Complete all Regulatory, Infection Control and Life Safety Preventative Maintenance
Target: 100% completion of PMs.

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 17</th>
<th>CY 18</th>
<th>CY 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQUIPMENT PREVENTATIVE MAINTENANCE COMPLETION RATIO</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>INFECTION CONTROL PREVENTATIVE MAINTENANCE COMPLETION RATIO</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>LIFE SAFETY PREVENTATIVE MAINTENANCE COMPLETION RATIO</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</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 2020:

- Implement new work order (Mega-ration) to track utility work orders.
- 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 and continuing to optimize the 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 2019. With the actions planned in the individual objectives, the following goals have been chosen for 2020.

Planning Objectives for CY2020:

Safety Management

Performance Monitors for 2020:

- Reduce Needle Sticks to no more than 23
- Reduce Staff Slip, Trip and Fall to no more than 15
- Reduce Visitor Fall to no more than 23
- Reduce E.D. Fall to no more than 14
- Reduce Outpatient Department Patient Fall to no more than 7

Action items for fall prevention which are either ongoing or will be started in 2020 are the following:

- Conduct in-service during huddles and new employee orientation regarding Contaminated Needle Sticks, Slips/Trips & Falls and other identified Workplace Injuries
- Work with EVS to eliminate the use of thin floor mats which can easily flip over and replace them with a heavier/thicker area rug.
- Identify slick areas where flooring may need non-skid applications.
- Remove floor mats in vestibules already equipped with non-skid surface.
- Reinstall “Think Safe” signs at points of entry focusing on fall prevention.
- Strategically place “wet floor” spill kits in zones were food items/liquids can spill.

Security Management

- Security Procedures Performance was 97% (2019) 7% above the target. Therefore, it is recommended for the committee to increase the acceptable performance from 90% to 93% for CY 2020
- Continue to monitor the average number of “mirrored events” in a quarter.
- Reduce the amount of Code Assists by 10% (no more than 267) by breaking down Code Assists vs. Nurse Assists therefore, improving data collection. Goal to increase Nurse Assist and decrease Code Assist numbers overall.
- Continue to develop action plans such as “sweep the room” campaign which was done to address missing damaged patient property discarded with linen and trash. For 2020, security will add EOC Reporting the success rate of returns (patient property) completed in 2019 only 5 recovered of 67. Missing Patient Property. Also, a Goal of 10% reduction in the amount of missing patient belongings whose threshold of 2 was exceeded in 2019 (missing items should be no more than 60.)

Hazardous Materials & Waste Management

- Maintain Biohazardous Waste to below 1.6 lbs/APD
- Manage Biohazardous Waste for a compliance rate of 95%
- Increase Recycled Waste above the previous year of 18.4%
- Continue zero (0) Code Spills through ongoing training and education
- Conduct DOT Training both initial and refresh (every 3 years).
- Conduct a minimum of one spill training class

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.
- Increase Staff Participation during Fire Drills involving Clinical Staff.
- Present during New Employee and Medical Staff Orientation (including All Staff for Critical Subjects)

Medical Equipment Management

- Replace the NK Monitoring Network – July 2020
• Connect All NK Monitors to Cerner CareAware EMR – July 2020
• Infusion Pumps Replacement with EMR Connectivity – June 2020
• Ensure 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

Utilities Management
• Implement new work order (Megamation) to track utility work orders.
• Complete all Regulatory, Infection Control and Life Safety Preventative Maintenance at the target rate of 100%.
• Reduce electrical consumption by 1% by continuing to replace existing fluorescent indoor lighting with energy efficient LED lighting and continue to optimize the chiller plant.
2019 ANNUAL EVALUATION OF THE ENVIRONMENT OF CARE FOR BROWARD HEALTH IMPERIAL POINT

Respectfully Submitted By:
Alicia L. Beceña, MBA, CHEC, CTM, Regional Safety Officer
And
Steve Fredrickson, Regional Manager Facility Services and The Environment of Care Committee
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.

Broward Health is one of the largest hospital systems in the country, serving our community for 65 years.

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 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.

This annual report is 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 annual evaluation highlights safety activities, Environment of Care Committee accomplishments, opportunities for improvement, and goals for Calendar Year (CY) 2020.

The 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).

The following is an Executive Summary of the Environment of Care performance highlights for 2019 followed by recommended Goals for 2020 for Broward Health Imperial Point.

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 2019 performance goals and plan objectives
- Priorities and goals for calendar year 2020

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: 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.

Information is gathered for each quarter and data is summarized on the EOC Dash Board, and results on the Dash Board are reviewed and analyzed for any trends or performance Indicators that are not meeting the goals.

Committee Members:

<table>
<thead>
<tr>
<th>Title</th>
<th>Department</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randy Gross</td>
<td>Administration</td>
<td>Member</td>
</tr>
<tr>
<td>Netonua (Toni) Reyes, COO</td>
<td>Administration</td>
<td>Member</td>
</tr>
<tr>
<td>Michael Huempfner</td>
<td>Administration</td>
<td>Member</td>
</tr>
<tr>
<td>Alicia L. Becenia, Corporate Safety Officer</td>
<td>Corporate Safety &amp; Security</td>
<td>Safety Officer &amp; EOC Chair</td>
</tr>
<tr>
<td>Garrett Coke, Corporate Director</td>
<td>Corporate Safety &amp; Security</td>
<td>Corporate Security &amp; Community Health</td>
</tr>
<tr>
<td>Anthony (Tony) Frederick</td>
<td>Corporate Security</td>
<td>Member</td>
</tr>
<tr>
<td>Marcos Mantel, Director and Phillip Bradley</td>
<td>Bio Medical Engineering</td>
<td>Medical Equipment Management, Chapter Leader</td>
</tr>
<tr>
<td>Phyllis Ahern</td>
<td>Cardiology</td>
<td>Member</td>
</tr>
<tr>
<td>Barbara Donnelly</td>
<td>Nursing Critical Care</td>
<td>Member</td>
</tr>
<tr>
<td>Ira Lee</td>
<td>Nursing</td>
<td>Member</td>
</tr>
<tr>
<td>Patricia Conklin, Epidemiologist and Ruth Moncilovich</td>
<td>Epidemiology</td>
<td>Member</td>
</tr>
<tr>
<td>Rafael Casares, Regional Manager</td>
<td>Lab Manager</td>
<td>Member</td>
</tr>
<tr>
<td>Dawn Burke</td>
<td>Dietary</td>
<td>Member</td>
</tr>
<tr>
<td>Lisa Havass, Regional Director</td>
<td>Operating Room/Surgery</td>
<td>Member</td>
</tr>
<tr>
<td>Donna Williamson, Regional Director</td>
<td>Quality</td>
<td>Member</td>
</tr>
<tr>
<td>Shevonne Evans, Regional Director</td>
<td>Emergency Room</td>
<td>Member</td>
</tr>
<tr>
<td>Marjie Altamirano, Regional Manager</td>
<td>Risk Management</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>Evaluators and Chapter Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Management</td>
<td>Alicia Beceña &amp; Steve Fredrickson</td>
</tr>
<tr>
<td>Security Management</td>
<td>Shaneque West</td>
</tr>
<tr>
<td>Hazardous Materials and Waste</td>
<td>Steve Fredrickson</td>
</tr>
<tr>
<td>Fire Safety Management</td>
<td>Peter Coughlin</td>
</tr>
<tr>
<td>Medical Equipment Management</td>
<td>Marcos Mantel</td>
</tr>
<tr>
<td>Utility Systems Management</td>
<td>Steve Fredrickson</td>
</tr>
</tbody>
</table>
SAFETY MANAGEMENT PROGRAM

Reviewer: Steve Fredrickson and Alicia Beceña
Title: Safety Management Program
Region: Broward Health Imperial Point
Review Date: February 14, 2020

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 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:
  - Safety
  - Infection Control
  - Risk Management
  - Employee Health Services
  - Facility Services
  - Protective Services
  - Quality Management
  - Laboratory
  - Materiel Distribution
  - Administration
  - Biomedical Engineering
  - Radiation Safety
  - Environmental Services
  - Nursing
  - Workers’ Compensation
  - IS/Communications
  - Surgical Services
  - 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

Review of Program Objectives: The Safety Management Program was effective towards the objectives listed below. Each of these have adjusted objectives listed individually in their Performance Monitors.

<table>
<thead>
<tr>
<th>Objective(s) and/or Goals</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 (Target of 1.65 Adjusted Patient Days)</td>
<td>✓</td>
<td></td>
<td>Overall performance improved from previous 2 years. Rate missed target in Q2 &amp; Q4</td>
<td></td>
</tr>
<tr>
<td>REDUCE NUMBER OF OCCUPATIONAL INJURIES</td>
<td>✓</td>
<td></td>
<td>Overall performance improved from previous year only missing the target in Q1 &amp; Q3</td>
<td></td>
</tr>
<tr>
<td>STAFF KNOWLEDGE (Target &gt; 90%)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REDUCE FOLLOW UP/TURNAROUND TIME OF SAFETY ISSUES FOUND DURING EOC ROUNDS TO THREE (3) DAYS</td>
<td>✓</td>
<td></td>
<td>New Megamation will help track workorder response time</td>
<td></td>
</tr>
<tr>
<td>CONTINUE STAFF EDUCATION ON REDUCING NEEDLE STICK INJURIES</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Below are additional objectives reviewed throughout the year that help continue to provide 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.

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. Reviews and revisions of the Safety Management Plan made during the year will be identified and submitted for EOC approval.

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.

**Review of Performance:**

**Performance Monitors #1**

**Monitor:** CONTAMINATED NEEDLE STICKS

**Target:** REDUCE STAFF NEEDLE STICKS

**Performance:** Met with conditions

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>Contaminated Needle Sticks 2019</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total 2019</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Encounters</td>
<td>20423</td>
<td>19471</td>
<td>19629</td>
<td>19962</td>
<td>79,485</td>
<td>87,867</td>
</tr>
<tr>
<td># of Contaminated Needle Sticks</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Performance</td>
<td>0.98</td>
<td>2.57</td>
<td>0.00</td>
<td>2.00</td>
<td>1.38</td>
<td>1.71</td>
</tr>
<tr>
<td>Acceptable Performance (Adjusted Patient Days)</td>
<td>1.65</td>
<td>1.65</td>
<td>1.65</td>
<td>1.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Var &lt;5%</td>
<td>1.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neg Var &lt;5%</td>
<td>1.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting Target</td>
<td>1.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Program’s Effectiveness:
A slight decrease in number of contaminated needle sticks was reported for CY 2019 (11 total incidents) when compared to CY 2018 (15 incidents). Only Q2 & Q4 were above the 1.65 (APD) acceptable target therefore, 50% of the time performance was below the target. This was also the case in 2017 with 13 needle sticks (formula for measuring needle stick injuries = per 10,000 Adjusted Patient Days (APD) the incident rate 2019 = 1.38 compared to 2018 = 1.71. Acceptable performance was met 50% of the time.

Performance Monitors for 2020: Broward Health Imperial Point will continue to monitor Needle Sticks injuries and seeking a downward trend with a ten (10) percent reduction from the overall average (11.6 incidents) noted over the three years to less than 10.

Performance Monitors #2
Monitor: OCCUPATIONAL INJURIES
Target: Reduce OSHA Recordable Injuries (to less than or = to 6.01)
Performance: Met with conditions (total injuries = #*200,000)/manhours (385,263 per 25 employees)

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours Worked</td>
<td>396725</td>
<td>395696</td>
<td>392217</td>
<td>385156</td>
<td>380,566</td>
<td>385,263</td>
<td>392588</td>
<td>400017</td>
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<tr>
<td># of OSHA Recordables Injuries</td>
<td>10</td>
<td>14</td>
<td>15</td>
<td>13</td>
<td>9</td>
<td>12</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Performance</td>
<td>5.04</td>
<td>7.08</td>
<td>7.65</td>
<td>6.75</td>
<td>4.73</td>
<td>6.23</td>
<td>5.60</td>
<td>7.50</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
</tr>
</tbody>
</table>

Program’s Effectiveness:
The OSHA recordable rate dropped slightly to 6.03 with 47 cases (2019) and is favorable when comparing the last two years results (2018 at 52 with rate was 6.63 and 48 incidents in 2017). The acceptable performance was met 50% of the time during Quarters 1 and 3 of 2019. However, the total number days of worker injuries for CY19 was recorded at 406 compared to 110 in CY 18. Other Occupational injuries/incidents tracked during the 2019 CY are noted as follows:

- 1 Sharp Object
- Slips, Trips and Falls = 13 (2019) compared to 12 in 2018 and 17 in 2017 No trends noted
- Back injuries were up with 13 incidents for 2019 vs. 2 for 2018

Performance Monitors for 2020: Broward Health Imperial Point will continue to monitor Occupational injuries and seek a downward trend equaling a ten (10) percent reduction from the average (116 incidents) noted over the three years to less than 104.

Performance Monitors #3
Monitor: STAFF KNOWLEDGE OF ENVIRONMENT OF CARE (EOC)
Target: 90% Or greater
Performance: Met
Performance Monitor Analysis:
Program Effectiveness: A multidisciplinary team conducted environmental tours of all patient care areas semi-annually which equaled to 28 and 6 in non-Patient care areas. Staff knowledge and awareness of Safety Management assessed during environmental tours was above the 90% performance standard with an ending score of 99%.

Results of the EOC rounds were sent to the department managers and they completed corrective actions on the findings. The total findings were 1832 and one of our goals was to decrease turnaround time to 3 days or less for any issues to be safety related. All safety related issues were addressed accordingly and with the new work order system the follow-up times will help meet our goals which for 2019 were difficult to track.

- 431 general findings for Facilities Services
- 610 Infection control
- 588 Environmental Services
- 203 Life Safety

Overall Effectiveness of the Safety Management Program:

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. Some opportunities for improvement were identified and are included in CY2020 goals.

Some of the other indicators monitored during the year indicated favorable outcomes such as the following Industrial Hygiene items below:

- Hazardous gases and vapors were monitored and managed with all results within the OSHA/NIOSH permissible exposure limits (PELs).
- All Preventive Maintenance (PMs) for air relationships in all clean and soiled areas were maintained. Increased surveillance in all the soiled and clean areas in the Operating rooms and support areas were monitored for 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 were available.
- Temp Trak on all Clinical refrigerators have been or are being installed to improve proper temperature - ongoing project.
- Temp Trak training conducted bi-weekly for all areas using the system.

The Safety Management plan also promoted Patient Safety through awareness programs, addressing sentinel event alerts, National Patient Safety Goals and the ongoing reporting through the EOC Committee.

- The multidisciplinary Environment of Care Committee met four (4) times during the 12-month period.
- Product recalls were checked and recalls requiring action(s) were addressed 100% of the time in CY 2019.

Performance Monitors for 2020: Broward Health Imperial Point will continue to monitor staff knowledge through EOC Rounds, however due to the favorable results over the past few years regarding staff knowledge being at a high we will be adding different Performance Monitor(s) such as Slips, Trips and Falls for 2020 instead of Staff Knowledge of EOC.

Additional Performance items which we will continue to monitor are the following:

- Environmental rounds weekly by a multidisciplinary group.
- Corrective actions on follow up items identified during EOC round and the goal to decrease turnaround time to 3 days or less for any Safety issues.
- Improved attendance of the multidisciplinary group during weekly rounds
- Continue with daily Monitoring of the Temp Trak system
- Provided staff education (during New Employee Orientation) in Blood and Body fluid protection, safe sharps handling, and avoiding Needle Stick injuries and Slips, Trips and Falls.
- Continue to remove surplus equipment from the facility
**SECURITY MANAGEMENT PROGRAM**

Reviewer: Shaneque West  
Title: Security Captain/Lieutenant  
Region: BHIP  
Review Date: February 14, 2020

**Purpose:** The purpose of the Security Management Plan is to provide safety and security for all patients, everyone who enter the facilities, and property of the regional medical centers and ancillary sites. The Security Management Plan is designed to establish and maintain a security program that protects patients, visitors, and employees from danger. It also helps to guard 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 2019. 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 was effective. Goals have been established to direct the Security Management Plan in CY 2020.

**Scope:** Broward Health (BH) is made up of many diverse medical facilities. The Security Management Program applies to all employees, visitors, students, patients, licensed independent practitioners (LIPs) and all those who enter Broward Health Imperial Point. BH operates under the 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 BH Facilities.

The facilities to which this management plan applies to is Broward Health Imperial Point. Significant differences in activities at each site may be noted in site-specific policies, as appropriate.

Security Management 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 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.

**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 Imperial Point. Therefore, no changes to the plan scope are recommended at this time.

**Review of Program 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.

**Evaluation of the Objectives:** Based on a review of the current Security Management program objectives, these objectives are appropriate for the management of safety within Broward Health Imperial Point. Therefore, no changes to the plan objectives are recommended at this time. Any goals not met will be the for the department in 2020.

<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>CODE ASSIST/AGGRESSIVE BEHAVIORS (RATE 2.5 OR LESS)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SECURITY PROCEDURES (below 90%)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Knowledge</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Review of Performance

Performance Monitor #1

Monitor: Code Assist / Aggressive Behaviors  
Target: Reduce rate below 2.5 Acceptable Performance  
Performance: Met  
Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Code Assist/Aggressive Behavior BH - 2019</th>
<th>2009</th>
<th>3369</th>
<th>2608</th>
<th>2978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Encounters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number Per Quarter</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Performance</td>
<td>1.49</td>
<td>1.48</td>
<td>0.00</td>
<td>0.34</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Performance Monitor #2

Monitor: SECURITY PROCEDURES  
Target: Reduce below 90%  
Performance: Met  
Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Security Procedures</th>
<th>13</th>
<th>13</th>
<th>13</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dept/Area Surveyed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of areas where no security procedures were violated</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Performance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Acceptable Performance 90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Performance Monitor #3

Monitor: STAFF KNOWLEDGE REGARDING SECURITY  
Target: Greater than 90%  
Performance: Met  
Performance Monitor Analysis: Staff knowledge and awareness is addressed during EOC Rounds.  
Program Effectiveness:  
The Security Management staff knowledge responses received a score of 96% which is 6% above the established performance standard. Approximately 396 questions were answered via staff questionnaires provided during EOC Rounds.

Additional Goals and Performance Monitoring of the following was also monitored during 2019:
• Continued rounds on floors to educate staff on combative patients. Also included a PowerPoint presentation to new hires that showed the effectiveness of the security components.
• Implemented new radios for a better communication between Security, Facilities and EVS staff.
• Upgraded cameras to enhanced views of the perimeters. Also, adjusted camera angles to improve views.
• There was a decrease in lost and found items when Security became responsible for these items. However, a slight increase towards the end of the year was noted therefore, a “sweep the room” campaign will be started in 2020.
• Established new door policies and helped decrease code elopements and educating staff.
• Security enhanced daily rounds by improving communication with staff and monitoring BSO rooms.
• Decrease in code assist as MHT tech are assigned and properly trained on mental issues. Also, new sitter positions.
• Bodily Assaults incidents dropped to 9 (2019) compared to 12 in CY18.
• Number of Assault/Battery incidents decreased in the first quarter and second quarters however, in the Q3 & Q4 it increased by 4 then decreased in half.
• Threat of Violence incidents were unpredictable and showed no significant trending pattern. However, we did see a decrease towards the end of the year.
• Code Assist incidents increased due to the use of a new tracking system
• Thefts increased towards the end of the year for CY 2019
• Contraband searches increased significantly from 2018 to 2019. We also saw an increase in drug users admitted which we believe correlates to the increase in contrabands found.

The Overall Effectiveness of the Program:

During 2019 Broward Health worked with a new security provider (HSS) and the goals set showed a positive impact on responding to codes and disturbances. Security tracked incidents and reports by completing HAS reports to show the true number of BHIP disturbances. During the second quarter of the CY 2019 there was a change in the security supervisor which resulted in new goals and accountability metrics.

The increase in code assist was reviewed and new goals set for around the clock rounding to help decrease these incidents and instead help differentiate between inpatient assist/medication assist. Security also worked closely with staff to help identify aggressive behaviors in patients prior to them escalating. Security also worked with staffing admin to increase the use of sitters who are trained in identifying aggressive behaviors before a code needs to be called.

In addition to the annual survey, security also participates in EOC rounds as part of a multidisciplinary team and has ongoing projects and surveys designed to improve the effectiveness of the security management plan. Security will be working closely with nursing on specific floors (PCU) to identify combative/aggressive patients at every shift. This will help security identify rooms needing monitoring and create plans for if/when a patient becomes combative. Additionally, for CY 2020 there will be an increase pixies camera on each floor to better monitor medication dispensaries.

Performance Monitors for 2020:

Security Management will continue to monitor the program using the established performance indicators including violent acts (assaults, aggressive behavior, and threats of violence) in coordination with the safety officer, clinical leaders and others to establish a program that emphasizes “early intervention” to help deescalate aggressive behaviors. The goal of the program is to decrease violent acts overall and to improve the Environment of Care. The following are the 2020 Performance Monitors:

• Continue to educate staff in workplace violence prevention and de-escalation principles by conducting at least 2 additional classes beyond the existing education on Health Stream to reduce Code Assist by 10% from 2019 incidents.
• Budget and purchase additional radios to enhance the communication between departments during CY 2020
• Upgrade cameras on the perimeter and adjust the views of certain cameras for a better footage by Quarter 2
• Implemented a thorough breakdown of the Lost and Found, Patient Belongings, and Valuables System and then initiate an action plan to initiate/refresh the “sweep the room” campaign which has proven to be helpful at other Broward Health facilities.
• Focus on educating all staff on situational awareness and being more conscious about securing personal items as well as doors and/or departments that are not occupied by presenting materials during New Employee Education.
- Increase (by at least 10%) in rounds, locating Baker Act patients and BSO patients on each floor.
- Monitor the change in sitter staff implementing MHT to sit with aggressive patients and the results of these changes to be reported at EOC.
HAZARDOUS MATERIALS & WASTE MANAGEMENT PROGRAM

Reviewer: Steve Fredrickson  
Title: Regional Manager Facility Services  
Region: BHIP  
Review Date: February 2020

**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 addressed the risk 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 program 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. The 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 minimizing 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:** Broward Health has many diverse medical facilities. This management plan applies to patients, staff and Licensed Independent Practitioners and any other person who enter Broward Health imperial Point. 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 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.
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, this scope and objectives are appropriate for Broward Health Imperial Point. 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 have been implemented. Therefore, no changes to the plan 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 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./Adjusted Patient Days (APD)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of Difference Waste Stream</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct at least one class on DOT Waste Manifest</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct at least one EVS Training on SDS Labeling</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

**Performance Monitors #1**

**Monitor:** Maintain Biohazardous Waste  
**Target:** Below 1.60 lbs./Adjusted Patient Days (Key Group - Corporate Goal)  
**Performance:** Met

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>Biohazardous Waste</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Encounters</td>
<td>20243</td>
<td>19471</td>
<td>19629</td>
<td>19962</td>
</tr>
<tr>
<td>Pounds of Regulated Medical Waste</td>
<td>3,239</td>
<td>9,680</td>
<td>8,932</td>
<td>9,909</td>
</tr>
<tr>
<td>Per APD target &lt; or = 1.60 APD-19,962</td>
<td>0.16</td>
<td>0.50</td>
<td>0.46</td>
<td>0.50</td>
</tr>
</tbody>
</table>

**Program Effectiveness:** The maintain of Bio Hazardous waste was favorable for all 4 quarter of 2019. All hazardous waste was removed by licensed waste haulers and manifested for disposal at licensed disposal facilities. There were additional waste streams removed from BH Imperial Point:

- **1456 lbs.** of Universal waste for recycling, this waste included fluorescent lamps, lead, and NiCad batteries.
- **11,594 lbs.** of Pharmaceutical waste (manifested & removed per USEPA requirements.)
• 4525 lbs. of P-listed waste generated, manifested, and removed.
• 1,042,120 lbs. of solid waste (represented 78.8% of the total waste stream).
• 31,760 lbs. Regulated Medical Waste (represents 3.2% of the total waste stream).
• Generated and recycled 238,159 lbs. of Card Board, paper plastic and other recyclable materials (represents 18.0% of the total waste stream).

Performance Monitors #2

Monitor: Staff Knowledge
Target: Greater than 90%
Performance: Met

<table>
<thead>
<tr>
<th>Staff knowledge. Target &gt; 90%</th>
<th>90%</th>
<th>84%</th>
<th>94%</th>
<th>92%</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Program Effectiveness:
Staff knowledge and awareness of Hazardous Materials and Waste Management assessed during environmental tours did meet the 90% performance standard 75% of the time. Answering 561 questions asked.

Overall Effectiveness of the Program’s 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 CY2019.

• Radioactive waste inventory was maintained daily.
• 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 .12 LBS.
• Radioactive waste flow was monitored around the clock, 24/7.
• Annual heavy metals testing with the city if Fort Lauderdale, results negative.
• There were (1) spill cart training conducted this year

Additional Performance Monitors which contributed to the objectives of the program for 2019 were successfully completed:

• Trained Environmental Services staff on the labeling requirements for the SDS program.
• Conducted DOT training on signing/understanding waste manifests.

Performance Monitors for 2020 (Goals):

• Conduct at least two (2) Spill cart trainings.
• Conduct additional training on the Labeling requirements for the SDS program.
• Provide additional DOT training on signing/understanding manifests.
• Staff training on SDS and GHS labeling remains ongoing via Health Stream.
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 can respond appropriately to any fire emergency.

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 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.

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.

**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 Imperial Point.

**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>No ILSM Identified</td>
</tr>
<tr>
<td>Impeded Egress Corridor(s)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>False Alarm activations</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Review of 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.

**Performance Monitors #1**
Monitor: Perform fire drills, 1 per quarter, per shift. If ILSM’s are being used, perform 2 per quarter, per shift when needed.
Target: MET and exceeded One fire drill per shift, per quarter.

**Performance:** Target MET with all fire drills completed at the appropriate times meeting all testing criteria of NFPA. There were 17 fire drills completed exceeding the requirements of one per shift, per quarter.

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CY 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRE DRILLS COMPLETED</td>
<td>18</td>
</tr>
</tbody>
</table>

**Program’s Effectiveness:**
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 18 fire drills conducted with 59 monitored areas. Additionally, all drills were evaluated and exceeded the 80% performance standard with an average score of 99%.

**Performance Monitors #2**
Monitor: Impeded Egress Corridor

Target: MET

**Performance:** All 13 areas monitored at 100% for all quarters.

**Performance Monitor Analysis:** Conducted during EOC Rounds and reported on the Corporate Dashboard.
**Program’s Effectiveness:** The program was effective 3 years in a row, so this performance monitor will be discontinued for 2020 and another one will be put in its place.

**Performance Monitors #3**

**Monitor:** False Fire Alarms

**Target:** MET < 11 Incident of False Alarms

**Performance:** We had a total of 6 false alarms which is below the target rate established for 2019 with Staff knowledge of fire safety averaging 95% for the year.

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>Fire Safety</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>False Alarms # per quarter target &lt;or= 11 per year</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Staff knowledge. Target &gt; or = to 95%</td>
<td>94%</td>
<td>90%</td>
<td>98%</td>
<td>97%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

The Fire Safety Program was considered effective overall during CY2019 as evidenced by performance standards, goals and objectives that were met and the level of regulatory compliance maintained.

**Program’s Effectiveness:**

Broward Health Imperial Point was not able to reduce the number of False Fire Alarms to zero but did reduce the number substantially below the benchmark of 11 incident established for 2019. Only 6 unscheduled activation of the fire alarm was recorded. We will continue to monitor as this is a Corporate Goal through all Broward Health. The ongoing implementation of the hot work permit program and increased awareness and vigilance etc. has help to achieve a decrease in fewer false alarms so this best practice will continue for 2020 and beyond.

**The following information highlights other 2019 performances:**

- Staff knowledge of fire safety assessed during fire drills and EOC rounds exceeded the performance standard of 95% and was met with a score of 96%. There were 1,526 questions asked with 1,466 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.
• The City of Ft. Lauderdale Fire Department conducted a Fire Life Safety inspection and found no violations.
• 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 were 0 fires in CY 19
• The building maintenance program was 100% compliant with respect to the functional status of fire safety features, exceeding the target of 95%.

Other Fire/Life Safety (construction related performance) objectives are as follows:

• 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 and potential fire impacts associated with each construction and facility renovations projects.
• There were no (0) projects that required Interim Life Safety Measures (ILSM).

Overall Program Effectiveness:

An ICES report is submitted on a quarterly basis to the EOC Committee. See the metrics for CY 2019 below:

Results on Goals from CY 2019:
• Approval to reset the Fire alarm after a false activation of the fire alarm system was received and on file.
• Obtained contracts to cover all fire alarm systems and devices.
• On-going - Update all Nodes with new Firmware and Hardware.

Performance Monitors for 2020:
• Continue to train staff on RACE and PASS through Health Stream and during fire drills.
• Continue to update all Nodes with new Firmware and Hardware.
• Continue training anesthesiologists and other surgery staff on preventing surgical fires.
• Refresh Train for current security staff and provide education for new hires on proper fire response.
• Perform fire drill in MRI and other areas (1 per quarter, per shift. If ILSM's are being used, perform 2 per quarter, per shift when needed)
• Decrease the number of False/Unscheduled fire alarms to acceptable performance of 0.5 as established by Corporate team.
• Maintain no actual fires in the facility.
• Increase Staff Participation during Fire Drills including Clinical Staff
• Continue to remove surplus equipment from 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 2019, 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 2019.
Accomplishments-Special Projects

BHIP
- Coordinate the NK Physiological Monitoring Refresh Project – July 2019
- Replace/Install NK Physiological Monitors, refresh project – October 2019
- Started the planning stage for IV Pump replacements – June 2019
- Deployment of new AEDs at all Physician Practices – October 2019
- Deployed Medline Comfort glide Air bed pumps – September 2019

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 2019 Performance Indicators

Quarterly reports to the Environment of Care Committees.

<table>
<thead>
<tr>
<th>Table I</th>
<th>Goal</th>
<th>BHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Work Orders Not Closed</td>
<td>&lt; 10%</td>
<td>MET</td>
</tr>
<tr>
<td>- Failed Performance *</td>
<td>&lt; 6%</td>
<td>MET</td>
</tr>
<tr>
<td>- Failed Electrical Safety</td>
<td>&lt; 1%</td>
<td>MET</td>
</tr>
<tr>
<td>- New To Inventory (Unreported)</td>
<td>&lt; 5%</td>
<td>MET</td>
</tr>
<tr>
<td>- No Problem Was Found</td>
<td>&lt; 15%</td>
<td>MET</td>
</tr>
<tr>
<td>- Improper Care</td>
<td>&lt; 2%</td>
<td>MET</td>
</tr>
<tr>
<td>- Missing Accessories * new FY 18</td>
<td>&lt; 2%</td>
<td>MET</td>
</tr>
<tr>
<td>- Staff Instruction</td>
<td>&lt; 2%</td>
<td>MET</td>
</tr>
</tbody>
</table>

Additional Performance Monitors

Monitor: Staff Knowledge of Medical Equipment

Target: MET

Performance: 90% or greater Correctly Answered Questions during EOC Rounds.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Medical Equipment</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>93%</td>
<td>95%</td>
<td>94%</td>
<td>96%</td>
<td>95%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Program Effectiveness: The average target of 95% was achieved with performance favorable in all four quarters.
### BROWARD HEALTH
Clinical/Biomedical Engineering
ICES (Information, Collection, Evaluation, System)

#### BHIP - CY 2019

<table>
<thead>
<tr>
<th>SAMPLE SIZE:</th>
<th>1 st QTR</th>
<th>2 nd QTR</th>
<th>3 rd QTR</th>
<th>4 th QTR</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNITS IN INVENTORY</td>
<td>2,403</td>
<td>2,421</td>
<td>2,461</td>
<td>2,600</td>
<td></td>
</tr>
<tr>
<td>W.O. OPENED</td>
<td>340</td>
<td>256</td>
<td>356</td>
<td>488</td>
<td></td>
</tr>
<tr>
<td>TOTAL W.O. COMPLETED</td>
<td>344</td>
<td>253</td>
<td>313</td>
<td>469</td>
<td></td>
</tr>
<tr>
<td>INSPECTIONS COMPLETED</td>
<td>147</td>
<td>524</td>
<td>99</td>
<td>1,740</td>
<td></td>
</tr>
<tr>
<td>W.O. INSPECTIONS COMPLETED</td>
<td>491</td>
<td>777</td>
<td>412</td>
<td>2,209</td>
<td></td>
</tr>
<tr>
<td>LABOR HOURS</td>
<td>395</td>
<td>494</td>
<td>191</td>
<td>1,042</td>
<td></td>
</tr>
<tr>
<td>PARTS/ MATERIALS</td>
<td>$7,583</td>
<td>$7,642</td>
<td>$6,239</td>
<td>$20,197</td>
<td></td>
</tr>
<tr>
<td>QA ROUNDS</td>
<td>654</td>
<td>657</td>
<td>659</td>
<td>650</td>
<td></td>
</tr>
<tr>
<td>PARAMETERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical/Biomedical Engineering

#### INDICATORS:

<table>
<thead>
<tr>
<th>W.O. NOT CLOSED</th>
<th>TARGET</th>
<th>1 st QTR</th>
<th>2 nd QTR</th>
<th>3 rd QTR</th>
<th>4 th QTR</th>
</tr>
</thead>
<tbody>
<tr>
<td>W.O. NOT CLOSED</td>
<td>10%</td>
<td>5%</td>
<td>6%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>FAILED PERFORMANCE</td>
<td>6%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>FAILED ELECTRICAL SAFETY</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>NEW TO INVENTORY</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>CALLS WHERE NO PROBLEM WAS FOUND</td>
<td>15%</td>
<td>6%</td>
<td>12%</td>
<td>13%</td>
<td>2%</td>
</tr>
<tr>
<td>IMPROPER CARE</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>MISSING ACCESSORIES</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>STAFF INSTRUCTION</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### Comments:

- 2nd QTR
  - BHIP - 16 INFUSION PUMPS, 10 OF WHICH HAD DEPLETED BATTERIES NOT CHARGING PROPERLY, 6 HAD BROKEN CASES.
- 3rd QTR
  - BHIP FAILED ELECTRICAL SAFETY, 2 CURRIE PUMPS DAMAGED POWER CORDS, 1 HOSPIRA DAMAGED POWER CORD.
  - BHIP IMPROPER CARE 3 ALP’S WITH DAMAGED CASES, 2 LP20’S MISSING TEST PLUG, 4 BROKEN DOOR LEVERS ON HOSPIRA PUMPS.

---

### BROWARD HEALTH
Clinical/Biomedical Engineering Performance Assessment
Calendar Year (January-December) 2019

#### WORK ORDERS

#### FACILITIES

<table>
<thead>
<tr>
<th>W.O. OPENED</th>
<th>W.O. NOT CLOSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHMC</td>
<td>4,186</td>
</tr>
<tr>
<td>BHN</td>
<td>2,360</td>
</tr>
<tr>
<td>BHIP</td>
<td>1,389</td>
</tr>
<tr>
<td>BHCS</td>
<td>2,299</td>
</tr>
<tr>
<td>BHW</td>
<td>362</td>
</tr>
<tr>
<td>CHS/PHY</td>
<td>23</td>
</tr>
<tr>
<td>SYSTEM</td>
<td>511</td>
</tr>
</tbody>
</table>

---

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## BROWARD HEALTH
Clinical/Biomedical Engineering Performance Assessment
Calendar Year (January-December) 2019

### INSPECTIONS

- **BG** (Jun, Jul, Aug, Sept)
- **NB** (Mar, Apr, May)
- **IP** (Oct, Nov)
- **CS** (Jan, Feb)
- **WR** (Nov, Dec)
- **AMB** (Nov, Dec)

### Facilities

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Inspections Completed</th>
<th>Failed Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHMC</td>
<td>4,046</td>
<td>9,434</td>
</tr>
<tr>
<td>BHN</td>
<td>10,172</td>
<td>4,861</td>
</tr>
<tr>
<td>BHIP</td>
<td>66</td>
<td>2,510</td>
</tr>
<tr>
<td>BHCS</td>
<td>66,13</td>
<td>3,968</td>
</tr>
<tr>
<td>BHW</td>
<td>0</td>
<td>2,068</td>
</tr>
<tr>
<td>CHS/PHY</td>
<td>8</td>
<td>1,148</td>
</tr>
<tr>
<td>SYSTEM</td>
<td>10,603</td>
<td>22,678</td>
</tr>
</tbody>
</table>

### USERS

<table>
<thead>
<tr>
<th>Facilities</th>
<th>WO Opened</th>
<th>Calls No Problem Found</th>
<th>Improper Operation</th>
<th>Staff Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHMC</td>
<td>274</td>
<td>303</td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td>BHN</td>
<td>1,437</td>
<td>1,093</td>
<td>153</td>
<td>6</td>
</tr>
<tr>
<td>BHIP</td>
<td>1,021</td>
<td>886</td>
<td>22</td>
<td>11</td>
</tr>
<tr>
<td>BHCS</td>
<td>0</td>
<td>29</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BHW</td>
<td>900</td>
<td>900</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CHS/PHY</td>
<td>29</td>
<td>29</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SYSTEM</td>
<td>567</td>
<td>448</td>
<td>56</td>
<td>39</td>
</tr>
</tbody>
</table>

---

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Recommended Goals for CY 2020

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 2020:

**BHIP**
- Replace the NK Monitoring Network – July 2020
- Connect All NK Monitors to Cerner CareAware EMR – July 2020
- Infusion Pumps Replacement with EMR Connectivity – June 2020
- Assure all staff receives proper medical equipment training 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 Committee.
Utilities Management Program

Reviewer: Steve Fredrickson  
Title: Regional Manager Facility services  
Region: BHIP  
Review Date: February 2020

**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.

<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>Reduce Electric Consumption</td>
<td></td>
<td>✓</td>
<td></td>
<td>Acceptable performance numbers to be reviewed and adjusted accordingly as this was not met for a 3 year in a row</td>
</tr>
<tr>
<td>Complete Generator Testing at 100%</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional objectives of the BHIP Utilities Management Plan include:

- Assure the operational reliability of the utility systems.
- Reduce the potential for hospital-acquired illness.
- Assess 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:

**Performance Monitor #1**

Monitor: *Increase Energy Efficiency and Reduce Electric Consumption*

**Target: NOT Met**

**Performance:** Broward Health Imperial Point had a plan to reduce electrical consumption. However, due to an increase in hot weather patterns throughout the year the goal was not met. Also, a review of the acceptable performance numbers will require some adjustments as this the 3rd year in a row that actual performance fails to achieve the desired outcome except for 2 out of 12 quarters timelines during three consecutive years except once in 2017 and once in 2018.

| Performance Effectiveness: A reduction was NOT MET in 2019 as we experienced an increase in weather temperatures overall. Also, no specific trends were identified when looking at 2019 and other previous years’ data. With the new installation of a 600 Ton Chiller completed in 2019 we will continue to monitor our energy consumptions for any increases/decreases during 2020. We will also discuss whether the acceptable performance rates from previous years are truly valid. After the discussion we will adjust the rate accordingly a create a new benchmark if needed. |

The table below shows the Energy Efficiency 2019 indicators:

<table>
<thead>
<tr>
<th>Energy Efficiency 2019</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Square Footage</td>
<td>304000</td>
<td>304000</td>
<td>304000</td>
<td>304000</td>
</tr>
<tr>
<td>KWh Used</td>
<td>3,247,925</td>
<td>3,000,966</td>
<td>3,517,440</td>
<td>3,133,440</td>
</tr>
<tr>
<td>Performance</td>
<td>10.68</td>
<td>9.87</td>
<td>11.57</td>
<td>10.31</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>8.97</td>
<td>9.47</td>
<td>11.22</td>
<td>9.72</td>
</tr>
</tbody>
</table>

Performance Monitor Analysis:

See Graph/Chart lines F. G. and H for Generator Testing and Other Performance Monitors

**Performance Monitoring #2:**

Monitor: *Generator Testing*

**Target:** 100% MET

**Performance:** All generator testing completed at the target rate of 100%.

**Performance Monitor Analysis:**

See Graph/Chart lines F. G. and H for Generator Testing and Other Performance Monitors
Additional Performance Monitors:

<table>
<thead>
<tr>
<th>Utilities Management</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy Efficiency Rate is kilowatt hours per sq. ft of occupied space. Target &lt; or= 11.11 (kwh/304,000)</td>
<td>9.18</td>
<td>9.87</td>
<td>11.57</td>
<td>10.31</td>
<td>9.25</td>
<td>9.56</td>
</tr>
<tr>
<td>Unscheduled Outages &gt;4 hrs. Target &lt; or= 2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staff knowledge. Target &gt;90%</td>
<td>94%</td>
<td>87%</td>
<td>97%</td>
<td>97%</td>
<td>94%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program

The Utilities Management plan was acceptable and considered effective, stable and sustainable during CY2019 as evidenced by performance standards, goals and objectives that were met and the level of regulatory compliance maintained. No additional actions needed to achieve the expected outcome.

- There was one (1) utility failures for CY 19 with the Domestic Water.
- Two unscheduled Outages in Q3 & Q4
- Staff Knowledge of Utility Systems address during EOC Rounds was at 94% average for 2019 with only Q2 below target of greater than 90%
- 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.
- 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.
- 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.
- We continue to manage the Water Management program with a multi-disciplinary team approach.

Performance Monitors for 2019 (Goals) completed:

- Initiate the electrical study to increase AHU on Emergency power
- Installed a 600 Ton Chiller
- Initiate and completed 30% of the ASCO main power switch replacement
- Monitor electrical consumption and implement a reduction plan by replacing current lighting with LED lighting.

Performance Monitors for 2020:

- Complete Clean Room Project
- Complete Cath Lab project
- Recoat the Roof, approximately 70,000 sq. ft.
- Complete the implement new work order (Megamation) to track Facilities (Utility Systems) work orders.
- Complete electrical study to increase AHU on Emergency power.
- Reduce electric consumption by 1% by continuing to replace existing fluorescent indoor lighting with energy efficient LED lighting during construction and renovation projects
- ASCO main power switch replacement - 30% complete (2019) pending 70% for 2020
**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 2019. With the actions planned in the individual objectives, the following goals have been chosen for 2020:

**Planning Objectives for CY2020:**

**Safety Management**

**Performance Monitors for 2020:**

- Reduce Contaminated Needle Sticks injuries to less than 10
- Reduce Occupational injuries to less than 104.
- Reduce Staff Slip, Trip and Fall’s to no more than 13 (10% less than the average rate of 14 over the last 3 years)
- Environmental rounds weekly by a multidisciplinary group.
- Corrective actions on follow up items identified during EOC round and the goal to decrease turnaround time to 3 days or less for any Safety issues.
- Improved attendance of the multidisciplinary group during weekly rounds

**Action items for fall prevention and contaminated needle stick injury reductions will be started in Quarter 2 of 2020 as follows:**

- Conduct in-service during huddles, new employee and medical staff orientation regarding Contaminated Needle Sticks, Slips/Trips & Falls and other identified Workplace Injuries to help reduce injury rates.

**Security Management**

- Continue to educate staff in workplace violence prevention and de-escalation principles by conducting at least 2 additional classes beyond the existing education on Health Stream to reduce Code Assist by 10% from 2019 incidents.
- Budget and purchase additional radios to enhance the communication between departments during CY 2020
- Upgrade cameras on the perimeter and adjust the views of certain cameras for a better footage by Quarter 2
- Implemented a thorough breakdown of the Lost and Found, Patient Belongings, and Valuables System and then initiate an action plan to initiate/refresh the “sweep the room” campaign which has proven to be helpful at other Broward Health facilities.
- Focus on educating all staff on situational awareness and being more conscious about securing personal items as well as doors and/or departments that are not occupied by presenting materials during New Employee Education.
- Increase (by at least 10%) in rounds, locating Baker Act patients and BSO patients on each floor.
- Monitor the change in sitter staff implementing MHT to sit with aggressive patients and the results of these changes to be reported at EOC

**Hazardous Materials & Waste Management**

- Maintain Biohazardous Waste to below 1.6 lbs./APD
- Manage Bio-Hazardous Waste for a compliance rate of 95%
- Conduct additional DOT Training both initial and refresh (every 3 years).
- Conduct a minimum of one spill cart training

**Fire Safety Management**

- Continue to train staff on RACE and PASS through Health Stream and during fire drills.
- Continue to update all Nodes with new Firmware and Hardware.
- Continue training anesthesiologists and other surgery staff on preventing surgical fires.
- Refresh Train for current security staff and provide education for new hires on proper fire response.
- Perform fire drill in MRI and other areas (1 per quarter, per shift. If ILSM’s are being used, perform 2 per quarter, per shift when needed)
• Decrease the number of False/Unscheduled fire alarms to acceptable performance of 0.5 as established by Corporate team.
• Maintain no actual fires in the facility.
• Increase Staff Participation during Fire Drills including Clinical Staff
• Continue to remove surplus equipment from the facility

**Medical Equipment Management**

• Replace the NK Monitoring Network – July 2020
• Connect All NK Monitors to Cerner Care Aware EMR – July 2020
• Infusion Pumps Replacement with EMR Connectivity – June 2020
• Assure all staff receives proper medical equipment training 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

**Utilities Management**

• Continue with daily Monitoring of the Temp Trak system
• Complete Clean Room Project
• Complete Cath Lab project
• Recoat the Roof, approximately 70,000 sq. ft.
• Complete the implement new work order (Megamation) to track Facilities (Utility Systems) work orders.
• Complete electrical study to increase AHU on Emergency power.
• Reduce electric consumption by 1% by continuing to replace existing fluorescent indoor lighting with energy efficient LED lighting during construction and renovation projects
• ASCO main power switch replacement - 30% complete (2019) pending 70% for 2020
ANNUAL EVALUATION OF THE ENVIRONMENT OF CARE FOR BROWARD HEALTH CORAL SPRINGS, HOSPITAL CY 2019

Respectfully Submitted By: Aida L. Beceña, MBA, CHEC, CTM Regional Safety Officer
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.

Broward Health is one of the largest hospital systems in the country, serving our community for 65 years.

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 2019 performance goals and plan objectives.
- Priorities and goals for calendar year 2020.

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>Alicia Becena</td>
<td>Corporate Safety &amp; Security</td>
<td>Safety Officer &amp; EOC Chair</td>
</tr>
<tr>
<td>Cecile Kaplan, Manager</td>
<td>Epidemiology</td>
<td>Infection Control</td>
</tr>
<tr>
<td>John O'Connell, Director</td>
<td>Facilities</td>
<td>Fire Safety Management &amp; Utilities Management</td>
</tr>
<tr>
<td>Garnett Coke, Director</td>
<td>Corporate Safety / Security</td>
<td>Security Management</td>
</tr>
<tr>
<td>Michael Leopold, COO</td>
<td>Administration</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Roberto Martinez, Manager</td>
<td>Radiology</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Kate Valdez Flores, Administrator</td>
<td>Administration</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Felicia Salas, Manager</td>
<td>Surgery / OR</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Sandra Porter, Daley</td>
<td>Surgery / OR</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Kimberly Carri, 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>Oudene Robinson, Manager</td>
<td>Risk</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Felipe Marique, Manager</td>
<td>Laboratory</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Michael Hughes, Director</td>
<td>Environmental Services</td>
<td>Hazardous Materials &amp; Waste Management</td>
</tr>
<tr>
<td>Joan Davis</td>
<td>Administration</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Kelly Keys</td>
<td>Emergency Management</td>
<td>Committee Member</td>
</tr>
<tr>
<td>Christiana Orinku</td>
<td>Employee Health</td>
<td>Safety Management</td>
</tr>
<tr>
<td>Marcos Mantel</td>
<td>Medical Equipment Management (Bomed)</td>
<td>Medical Equipment Management</td>
</tr>
</tbody>
</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>Aida Becena &amp; John O'Connell</td>
</tr>
<tr>
<td>Security</td>
<td>Garrett Coke</td>
</tr>
<tr>
<td>Hazardous Materials</td>
<td>Michael Hughes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>John O'Connell</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Marcos Mantel</td>
</tr>
<tr>
<td>Utility Systems</td>
<td>John O'Connell</td>
</tr>
</tbody>
</table>
SAFETY MANAGEMENT PROGRAM

Reviewer: Aida Becena
Title: Corporate Regional Safety Officer & EOC Chairperson
Region: Broward Health Coral Springs
Review Date: March 3, 2020

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 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 Injuries ≤ 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>Not</td>
<td></td>
<td>6 less injuries than 2018</td>
</tr>
</tbody>
</table>

Review of Performance: In 2019 we had an increase in OSHA recordable injuries with 84 vs. 71 in 2018. Still the OSHA recordable injuries were considerably better than in 2017 (2017 - 121). However, our performance target for the year is still unfavorable. The contaminated needle stick performance indicator had a 50% favorable performance rate during the 2nd and 3rd quarters of the year and an overall better performance with 6 less injuries than in 2018 (unfavorable performance rates were documented during the first and fourth quarter of 2019) therefore, we will continue to work on improvements for 2020.
Performance Monitors #1

Monitor: Occupational Injuries

Target: 6.01 (Total Hours Worked / OSHA recordable injury's)

Performance: NOT Met - Average Performance 12.07

Performance Monitor Analysis

<table>
<thead>
<tr>
<th>Occupational Injuries</th>
<th>2018 Q1</th>
<th>2018 Q2</th>
<th>2018 Q3</th>
<th>2018 Q4</th>
<th>2019 Q1</th>
<th>2019 Q2</th>
<th>2019 Q3</th>
<th>2019 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours Worked</td>
<td>492033</td>
<td>496059</td>
<td>509466</td>
<td>471011</td>
<td>481836</td>
<td>425401</td>
<td>483729</td>
<td>435750</td>
</tr>
<tr>
<td># of OSHA Recordable Injuries</td>
<td>16</td>
<td>18</td>
<td>24</td>
<td>13</td>
<td>35</td>
<td>24</td>
<td>30</td>
<td>22</td>
</tr>
<tr>
<td>Performance</td>
<td>6.50</td>
<td>7.26</td>
<td>9.42</td>
<td>5.52</td>
<td>14.53</td>
<td>11.28</td>
<td>12.40</td>
<td>10.10</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
<td>6.01</td>
</tr>
</tbody>
</table>

Performance Monitors for 2020: Occupational Injuries will continue to be monitored in 2020 as it remains an area of high interest. Tracking injuries by department/job duties and type of equipment will be implemented and performance indicators discussed during EOC Committee and other Key Group meetings.

Performance Monitors #2

Monitor: Contaminated Needle Sticks

Target: 1.65 (Medical encounters / Number of needle sticks)

Performance: NOT MET - Average was 1.71

Performance Monitor Analysis

<table>
<thead>
<tr>
<th>Contaminated Needle Sticks</th>
<th>2018 Q1</th>
<th>2018 Q2</th>
<th>2018 Q3</th>
<th>2018 Q4</th>
<th>2019 Q1</th>
<th>2019 Q2</th>
<th>2019 Q3</th>
<th>2019 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Encounters</td>
<td>32074</td>
<td>28191</td>
<td>27625</td>
<td>28273</td>
<td>29256</td>
<td>29661</td>
<td>28404</td>
<td>22165</td>
</tr>
<tr>
<td># of Contaminated Needle Sticks</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>8</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Performance</td>
<td>2.18</td>
<td>2.13</td>
<td>2.17</td>
<td>2.12</td>
<td>1.03</td>
<td>2.70</td>
<td>1.76</td>
<td>1.35</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>1.65</td>
<td>1.65</td>
<td>1.65</td>
<td>1.65</td>
<td>1.65</td>
<td>1.65</td>
<td>1.65</td>
<td>1.65</td>
</tr>
</tbody>
</table>

Performance Monitors for 2020: This performance indicator will continue to be monitored in 2020 as we remain above the target performance rate.

Programs Effectiveness:

For all quarters of 2019 the quarterly performance indicators were unfavorable and even increased over 2018. Monitoring and injury investigations have been increased so more detailed cab be obtained as we seek opportunities for improvement.
SECURITY MANAGEMENT PROGRAM

Reviewer: Alicia Becena  
Title: Corporate Regional Safety Officer & EOC Chairperson  
Region: Broward Health Coral Springs  
Review Date: March 3, 2020

**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 auxiliary 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. Broward Health 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 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, the scope is appropriate for the management of safety within Broward Health Coral Springs. Therefore, no changes to the scope are recommended 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. Any goals not met will be a focus for the department in CY2020 by creating action plans and monitoring throughout the year. Other areas for improvement will be addressed when needed.

The Objectives for this Plan are the following and were determined not to need any changes during the annual review:

- 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 Health Care 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>Implement Accepted Practices (i.e. monitor Bodily Assault)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timely Response (Security Procedures)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify Opportunities Improving Performance (CODE Assist/ Aggressive Behavior)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor Facility – Sensitive Areas</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Performance Monitors #1**

**Monitor: Bodily Assault**

**Target:** MET with rate 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 1, 3 & 4 we had 0 assaults and Quarter 2 we had 2 assaults with 21905 medical encounters. In comparison to 2018 (7) Assaults and 2017 (5) Assaults.

---

![Security Management - Performance Monitor #1](image)

**Review of Performance for 2019:** In 2018 our Bodily assault were higher than in 2017 (2017: 5, 2018: 7). However, our performance target for this year is favorable as we saw a drop in assaults.

**Performance Monitors #2**

**Monitor: Security Procedures**

**Target:** Met 90%

**Performance:** 100% The Security Procedures performance indicator was favorable for the entire year.

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>Security Procedures</th>
<th>2018 Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2019 Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dept/Area Surveyed</td>
<td>-</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td># of areas where no security procedures were validated</td>
<td>-</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Performance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Acceptable Performance

<table>
<thead>
<tr>
<th></th>
<th>90%</th>
<th>90%</th>
<th>90%</th>
<th>90%</th>
<th>90%</th>
<th>90%</th>
<th>90%</th>
<th>90%</th>
</tr>
</thead>
</table>

Review of Performance for 2019: The Security Procedures’ performance indicator was above the 90% target for the entire year with 100% of goal met. Quarter 1, 2, 3 & 4 had 8 areas surveyed which were reported to be compliant 100% of the time. In comparison to 2018 no data available and Qtr. 2-4 no compliance issues were noted.

Performance Monitors for 2020: We will continue to monitor the security procedure performance indicator for 2020 during EOC Rounds, but a recommendation will be made to monitor other objectives designed within the Security Management Plan.

Performance Monitors #3

Monitor: Code Assist / Aggressive Behaviors

Target: MET – Acceptable performance 1 (number of code assist / number of medical encounters)

Performance: The performance indicator was below target of one (Favorable) for 75% of the year except Qtr. 3

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Code Assist/AggBehaviors</th>
<th>2019 Q1</th>
<th>2019 Q2</th>
<th>2019 Q3</th>
<th>2019 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Encounters</td>
<td>21778</td>
<td>21905</td>
<td>20602</td>
<td>22165</td>
</tr>
<tr>
<td>Number Per Quarter</td>
<td>7</td>
<td>18</td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>Performance</td>
<td>0.32</td>
<td>0.82</td>
<td>1.35</td>
<td>0.72</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Review of Performance for 2019: The performance indicator was below target of 1 (no more than 1 occurrence per quarter for every 10,000 adjusted patient days (APD) for the entire year; except during quarter 3. The Security Performance Dashboard for 2019’s performance data was noted to be different from the EOC dashboard which therefore, the data will need further clarification in order to understand all of the results.

Performance Monitors for 2020: We will continue to monitor the Code Assist/Aggressive Behavior performance indicator in case of any increases in 2020.

Overall Effectiveness of the Program: The overall program was effective and targets set by Corporate Key Groups in coordination with the regional environment of care committee who established a measurable performance to ensure improvement of the security standards were adequate. The EOC Committee monitored the rate of which employees called Code Assist, Security Procedures and Bodily Assaults. All Performance Monitors had acceptable performance baseline rates below the thresholds with the exception of one quarter for Code Assists where the target was not met. The Security Procedures monitoring will be discontinued, Key Groups accepts the EOC Recommendation to replace the objective with another such as Contraband Searches or Loss of Patient Belongs.
HAZARDOUS MATERIALS & WASTE MANAGEMENT PROGRAM

Reviewer and Titles: Michael Hughes, EVS Director and Alicia Becena, Corporate – Regional Safety Officer

Region: Broward Health Coral Springs

Review Date: February 27th, 2020

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, Licensed Independent Practitioners (LIPs) and any other persons who enter a Broward Health site. The facilities to which the Hazardous Materials and Waste Management Plan apply 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 exposure 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 Florida 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>Comply with Applicable Regulations</td>
<td></td>
<td></td>
<td>X – Operating Permit for State needs renewal</td>
<td></td>
</tr>
<tr>
<td>Monitor Pounds of Regulated Waste</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Storage of Waste including Biowaste is secured correctly</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Education and Training</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REVIEW OF PERFORMANCE

Performance Monitors #1

Monitor: Maintain Biohazardous Waste below the target of 1.60 lbs / Adjusted Patient Days

Target: 1.60 lbs. (target developed by Corporate Key Group) of regulated medical waste per medical encounter.

Performance: MET performance indicator was below target (Favorable) for the entire year.

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>HAZ MAT MONITOR</th>
<th>2019 Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biohazard Waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Encounters</td>
<td>21778</td>
<td>21905</td>
<td>20602</td>
<td>22165</td>
</tr>
<tr>
<td>Lbs of Regulated Medical Waste</td>
<td>22759</td>
<td>23521</td>
<td>24537</td>
<td>24046</td>
</tr>
<tr>
<td>Performance</td>
<td>1.05</td>
<td>1.07</td>
<td>1.19</td>
<td>1.08</td>
</tr>
</tbody>
</table>
Acceptable Performance | 1.60 | 1.60 | 1.60 | 1.60

Review of Performance: The performance indicator was below target for the entire year, therefore, we met our goal. Our average performance rate for 2019 was 1.08 which is better than 2018 and 2017 at 1.20.

Performance Monitors for 2020: We will continue to monitor Pounds of regulated medical waste per medical encounter during 2020 as it is a very valuable tool to measure our costly regulated waste usage.

Performance Monitors #2
Monitor: Managing Biohazard Waste

Target: 95% or above (# of areas surveyed Correctly Managed & Maintained within compliance)

Performance: Not MET

Performance Monitor Analysis:

<table>
<thead>
<tr>
<th>Managing Biohazard</th>
<th>2019 Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyed</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Managed Correctly</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

| Performance         | 88%     | 100% | 88% | 88% |
| Acceptable Performance | 95%     | 95%  | 95% | 95% |

Review of Performance: Eight (8) areas were observed where biohazard waste was secured. Only during Quarter 2 was the acceptable performance met therefore performance was below target 75% of the time being unfavorable for Q1, Q3 & Q4. Our average score was 91 for 2019, 93.2 for 2018 which was only slightly better than 2017.

Overall Effectiveness of the Program’s Effectiveness: The average performance indicator rate was below target for the 2019, we did not meet our goal. Our average score was 93.2 for 2018 which was slightly better than 2017.

Performance Monitors for 2020: We will continue to monitor Number of areas observed where biohazard waste was secured correctly in 2019 as we did not meet our goal. Additional performance monitors for the Hazardous Materials and Waste Management Plan are the following:

- Inventory of Hazardous Materials / Updated February 17, 2020
- Maintain Waste Manifest and Land Disposal receipts
- Update and Maintain active Safety Data Sheets - Updated February 17, 2020
- Inservice staff on the location of hard copies of SDS and how to obtain them
- Maintain and update Permits Licenses from the State of Florida Department of Health Bio-Medical Waste
- Continue to educate team on Terminal & In between cleaning of the surgery procedure and other areas along with assignment to Health Stream Training
- Continue to have Staff Certified on DOT training scheduled completion for Quarter 2 of 2020
Fire Safety Management Program

Reviewer: John O'Connell
Title: Regional Director of Facilities/EOC Co-Chairman
Region: Broward Health Coral Springs
Review Date: March 3rd, 2020

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: The Scope was evaluated and a determination was made that no changes are required at this time. Any changes found to be applicable to covered people, places, things and procedures will be presented at the Environment of Care Committee for review, feedback and approval.

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. The following objectives were reviewed and deemed appropriate as performance indicators for the program:

- 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>Minimize Risk of Fire Hazards</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protect those who enter from fire, smoke or other risks of combustion</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>False Alarms</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impeded egress corridor</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain Fire Alarm System</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Performance Monitors #1**

**Monitor: False Alarms** Number of false alarms per square foot.

**Target:** The Corporate Key Group established a rate of no more than 0.05 based on square footage.

**Performance:** Met - The false alarm performance indicator was below target (favorable) for all quarters in 2019.

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>False Fire Alarms</th>
<th>2019 Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Square footage</td>
<td>460000</td>
<td>460000</td>
<td>460000</td>
<td>460000</td>
</tr>
<tr>
<td># Per Quarter</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Performance</td>
<td>0.02</td>
<td>0.00</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Review of Performance:** Quarter one we had 1 false alarm for a 0.02 performance rate. Quarter two had 0 false alarms. Quarter three 1 false alarm for a 0.02 performance rate and quarter four had 1 false alarm for a 0.02 performance rate. In 2019 our number of false alarms per square foot were less than in 2018 (2018 - 17), (2019 – 3), our performance target for the year is favorable. Repairs made to the fire alarm system reflected the large decrease in false alarms.

**Performance Monitors for 2020:** We will continue to monitor fire alarm false alarms during 2020.

**Performance Monitors #2**

**Monitor: Impeded Egress Corridor**

**Target:** 100%

**Performance:** Not Met - The Impeded Egress Corridor performance indicator was below target (unfavorable) for the Q1, Q3 and Q4 and at 100% (favorable) for Q2.

**Performance Monitor Analysis:**

<table>
<thead>
<tr>
<th>Impeded Egress Corridor</th>
<th>2019 Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Dept/Area Surveyed</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td># Observed without Obstructions</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Performance</td>
<td>86%</td>
<td>100%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Review of Performance:

The Impeded Egress Corridor performance rate for 2019 was higher than 2018 observations. Quarter one we had 7 areas surveyed with 6 areas compliant for a 86% Performance rate. Quarter two we had 8 areas surveyed with 8 areas compliant for an 100% Performance rate. Quarter three we had 8 areas surveyed with 7 areas compliant for an 88% Performance rate. Quarter four we had 8 areas surveyed with 7 areas compliant for an 88% Performance rate.

Overall Effectiveness of the Program: The performance indicators were met for all except one indicator, Impeded Egress. Our established goal of 100% acceptable performance will continue to be our monitoring baseline and staff education during fire drills and New employee orientation we hope will help improvement performance for 2020.

Performance Monitors for 2020: We will continue to monitor all aspects of Fire Safety as listed below:

- Monitor False Alarms
- Impeded Egress Corridor
- Monitor the success of the implementation of work order (Megamotion) to track fire safety and other work orders.
- Increase staff participation in fire drills
- Continue to conduct fire safety classes at new employee orientation
- Initiate fire safety training at medical staff orientation
MEDICAL EQUIPMENT MANAGEMENT PROGRAM

Reviewer: Marcos Mantel
Title: Regional Director of Medical Equipment (BIOMED)
Region: Broward Health Coral Springs
Review Date: March 3rd, 2020

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 Medical Equipment Management Plan applies to: 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: No changes are required to the scope for this year.

Program Objectives: Were reviewed 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>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improper Care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of Performance: A review of performance indicators in separate areas, and review of the stated goals are used to determine effectiveness of the Plan annually. Evaluation and review of these criteria indicates an effective medical equipment management program. All performance indicators and goals were met for 2019 and include some of the following:

1) Staff Instruction MET Goal by assure staff received proper medical equipment training in order to perform their respective duties in a safe and proficient manner.

2) Worker Orders Not Closed, Failed Performance, Failed Electrical Safety, New Inventory (unreported). No Problem was found, Improper Care, Missing Accessories—All MET GOALS to ensure that all alerts, recalls and hazards pertaining to medical equipment were investigated.

Performance Monitors #1

<table>
<thead>
<tr>
<th></th>
<th>Q1 CY19</th>
<th>Q2 CY19</th>
<th>Q3 CY19</th>
<th>Q4 CY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
<td>1484</td>
<td>2110</td>
<td>561</td>
<td>516</td>
</tr>
<tr>
<td>Failed Inspections</td>
<td>39</td>
<td>47</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Performance</td>
<td>0.03</td>
<td>0.02</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

The number of failed equipment inspections per total inspections performance indicator was below target of 6% for the entire year; therefore, we met our goal. Our average performance rate for 2019 was just improved when compared to 2018 and 2017.

Monitor: The number of failed equipment inspections per total inspections

Target: 6%

Performance: MET - The Failed equipment inspection performance indicator was favorable for the entire year of 2019

Performance Monitor Analysis: Quarter 1 we had 39 failed equipment inspections out of 1484 total inspections for a 3% performance rate. Quarter two we had 47 failed equipment inspections with 2110 total inspections for a 2% performance rate. Quarter three we had 41 failed equipment inspections with 561 total inspections for a 1% performance rate. Quarter four we had 61 failed equipment inspections with 516 total inspections for a 1% performance rate. In comparison 2019 to 2018 we had a 0.03% decrease in failed inspections and when comparing 2017 we had a decrease of 0.06%

Overall Effectiveness of the Program's Effectiveness: The performance indicator was below target for the entire year so we met our goal. Our average performance rate for 2019 was just slightly better for two consecutive years.

Additional Accomplishments & Special Projects:
1. Coordinated the NK Physiological Monitoring Refresh Project – July 2019
2. Replaced/install NK Physiological Monitors, refresh project – Nov 2019
3. Started the planning stage for IV Pump replacements – June 2019
4. Deployment of new AEDs at all Physician Practices – October 2019
5. Deployed Medline Comfort glide Air bed pumps – September 2019

Performance Monitors for 2020: We will continue to monitor the number of failed equipment inspections per total inspections as it is a very valuable method to measure how well our 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 2019

Performance Monitor Analysis for 2019: Quarter one we had 13 improperly cared for medical equipment with 1175 total inspections for a 1% Performance rate. Quarter two we had 63 improperly cared for medical equipment with 1906 total inspections for a 3% Performance rate which was above the 2% acceptable performance. Quarter three we had 6 failed equipment inspections with 823 total inspections for a 1% Performance rate. Quarter four we had 4 failed equipment inspections with 1398 total inspections for a 0% Performance rate.

<table>
<thead>
<tr>
<th># of Performance Inspection Completed</th>
<th>1175</th>
<th>1906</th>
<th>823</th>
<th>1398</th>
</tr>
</thead>
<tbody>
<tr>
<td># Improperly Cared For</td>
<td>13</td>
<td>63</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Performance</td>
<td>0.01</td>
<td>0.03</td>
<td>0.01</td>
<td>0.00</td>
</tr>
<tr>
<td>Acceptable Performance</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Overall Effectiveness of the Program's Effectiveness: The performance indicator was below target for most of the year except in Quarter 2. Overall we met our goal in 2019 as we had a slight percentage improvement over 2018 and remained flat when compared to 2017.

Performance Monitors for 2020: We will continue to monitor the number of improperly cared for medical equipment in 2020 as it is a very valuable method to measure how well our equipment is being maintained.

Some additional 2020 GOALS:
- Replace the NK Monitoring Network – July 2020
- Connect All NK Monitors to Corner CareAware EMR – July 2020
- Migrate from two Telemetry Antenna System to one – June 2020
- New Cath Lab in Tower – March 2020
- Infusion Pumps Replacement with EMR Connectivity – June 2020

Ongoing goals:
1. Assure all staff receives proper medical equipment training in order to perform their respective duties in a safe and proficient manner
2. Ensure that all alerts, recalls and hazards that pertain to medical equipment are investigated
3. Review and revise the Medical Equipment Management Program as necessary
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.

**UTILITIES MANAGEMENT PROGRAM**

Reviewer: John O’Connell  
**Title:** Regional Director of Facilities  
**Region:** Broward Health Coral Springs  
**Review Date:** March 3rd, 2020

**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 the 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 requires any changes 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 surveys. 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>Met 75%</td>
<td>Need to review acceptable performance criteria</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 75% of the year of 2019.

**Performance Monitor Analysis:** Q1, 3,748.00 KWH/ 460,000 SF for a Performance Rate of 8.14. Q2, 3,967.00 KWH/ 460,000 SF for a Performance Rate of 8.62. Q3, 4,402.800 KWH/ 460,000 SF for a Performance Rate of 9.57. Q4, 4,208.400 KWH/ 460,000 SF for a Performance Rate of 9.15.

**Overall Effectiveness of the Program’s Effectiveness:** The performance indicator was at target for the 75% of the year, we met our goal. Our average performance rate for 2019 was marginally lower than 2018. The increase in usage was driven by the increase in the ambient temperature being one of the warmest years on record.

**Performance Monitors for 2020:** We will continue to monitor Energy Efficiency performance indicator. In 2020 as it is a very valuable tool to measure how well or 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, 5 tests scheduled 5 tests completed 100%. Q2, 5 tests scheduled 5 tests completed 100%. Q3, 5 tests scheduled 5 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 2019 was identical to 2018.
Performance Monitors for 2020: Implement new work order (Mega mat on) to track utility work orders. Will reduce energy consumption by replacing fluorescent indoor and outdoor lighting with energy efficient LED lighting.
OVERALL PERFORMANCE SUMMARY FOR THE ENVIRONMENT OF CARE PROGRAM AND PLANNING OBJECTIVES

**Overall Performance Summary:** The EOC Committee meets monthly to improve our performance indicator scores and reporting to the EOC members.

**Planning Objectives for CY2020:**

**Safety Management**

Performance Monitors:
- Monitor and discuss Occupational injuries during Nurse Huddles looking at top three (3) injuries.
- Reduce Contaminated Needle Sticks by 10% less than the average over the last three years.
- Initiate Safety/Environment of Care Presentation at New Employee Orientation and Medical Staff Orientation.
- Focus on Accident Prevention in tracking injuries by department/job duties and type of equipment meeting with multidisciplinary teams to address near misses and occupational accident injuries.

**Security Management** We will Monitor Bodily Assault, Security Procedures.

**Hazardous Materials & Waste Management** We will monitor Pounds of Regulated Waste, Train Staff on Segregating the Different Waste Streams, Increase Recycling by ten (10) percent, and closely Audit the Hazardous Waste Accumulation area outdoors.

Performance Monitors for 2020:
- Inventory of Hazardous Materials / Updated February 17, 2020
- Maintain the Waste Manifest and Land Disposal receipts
- Update and Maintain active Safety Data Sheets - Updated February 17, 2020
- Inserv ice staff on the location of hard copies of SDS and how to obtain them
- Maintain and update Permits/Licenses from the State of Florida Department of Health/Bio Medical Waste
- Continue to educate team on Terminal & In Between cleaning of the surgery procedure and other areas along with assignments to Health Stream training
- Continue to have Staff Certified on DOT training scheduled completion for Quarter 2 of 2020

**Medical Equipment Management:** We will Monitor Failed Equipment Inspection and Improper Care

**Other Project Goals:**
- Replace the NK Monitoring Network – July 2020
- Connect All NK Monitors to Corner CareAware EMR – July 2020
- Migrate from two Telemetry Antenna System to one – June 2020
- New Cath Lab in Tower – March 2020
- Infusion Pumps Replacement with EMR Connectivity – June 2020

**Ongoing goals:**
1. Ensure all staff receives proper medical equipment training in order to perform their respective duties in a safe and proficient manner.
2. Ensure that all alerts, recalls and hazards that pertain to medical equipment are investigated.
3. Review and revise the Medical Equipment Management Program as necessary.

Continue to trend the current performance indicators for another year, reassess the targets and make appropriate changes based on the consensus of the EOC Committee.

**Fire Safety Management**

Performance Monitors for 2020: We will continue to monitor all aspects of Fire Safety as listed below.
- Monitor False Alarms
- Impeded Egress Corridor
• Monitor the successes of the new implementation of work order (Megamation) to track fire safety and other work orders.
• Increase staff participation in fire drills.
• Continue to conduct fire safety class at new employee orientation.
• Initiate fire safety training at medical staff orientation.

Utilities Management: We will monitor Energy Efficiency, implement new work order (Megamation) to track utility work orders. Will reduce energy consumption by replacing fluorescent indoor and outdoor lighting with energy efficient LED lighting.
8.1 INFECTION CONTROL PLAN
8.2 PERFORMANCE IMPROVEMENT PLAN
8.3 SAFETY PLAN

Annual Policy Review and Approval
8.4 ANTIMICROBIAL STEWARDSHIP

Dave Lacknauth
Antibiotic Resistance Cycle

Increased Antibiotic Use

Limited treatment alternatives
- More antibiotics
- Increased mortality

Increase in resistant strains

Increased healthcare resource use

Ineffective empiric therapy
- Increased morbidity
- More antibiotics

Increased hospitalization
- More antibiotics
Purpose of the Broward Health Antimicrobial Stewardship Program

✓ To promote judicious antimicrobial use

✓ Minimize morbidity and mortality associated with drug-resistant infections

✓ To improve and preserve the effectiveness of antimicrobial agents

✓ To improve overall quality of patient care and patient safety.
# BROWARD HEALTH PHARMACY
## ANTIMICROBIAL STEWARDSHIP

<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>YTD total</th>
<th>Quarter 2</th>
<th>Prior Quarter</th>
<th>Prior Year (Q2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>De-escalation</td>
<td>532</td>
<td>157</td>
<td>375</td>
<td>376</td>
</tr>
<tr>
<td>Renal dosing adjustment*</td>
<td>3769</td>
<td>2265</td>
<td>1504</td>
<td>1039</td>
</tr>
<tr>
<td>Bug-Drug mismatch</td>
<td>250</td>
<td>59</td>
<td>191</td>
<td>161</td>
</tr>
<tr>
<td>IV to PO conversion*</td>
<td>1043</td>
<td>296</td>
<td>747</td>
<td>190</td>
</tr>
<tr>
<td>Therapeutic duplication#</td>
<td>503</td>
<td>102</td>
<td>401</td>
<td>45</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>6097</strong></td>
<td><strong>2879</strong></td>
<td><strong>3218</strong></td>
<td><strong>1811</strong></td>
</tr>
</tbody>
</table>

*Includes all adjustments  
*All IV to Enteral interventions
<table>
<thead>
<tr>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended infusion for increased efficacy (Cefepime, Zosyn, Merem)</td>
</tr>
<tr>
<td>Covid Cocktail powerplan developed for standardized ordering template</td>
</tr>
<tr>
<td>Remdesivir power plan implementation for standardized care standards</td>
</tr>
<tr>
<td>Extended pump tubing for patients with COVID-19</td>
</tr>
<tr>
<td>Pharmacist use of AI to target interventions</td>
</tr>
<tr>
<td>Updated recommendations for renally adjusted drugs</td>
</tr>
<tr>
<td>Standardized concentrations of antibiotics</td>
</tr>
<tr>
<td>Developed IV pump libraries to include antibiotics medications</td>
</tr>
<tr>
<td>Ortho Power Plan antibiotic prophylaxis review</td>
</tr>
</tbody>
</table>
## ANTIMICROBIAL STEWARDSHIP INITIATIVES

<table>
<thead>
<tr>
<th>2019-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dalbavancin Emergency Room Implementation</td>
</tr>
<tr>
<td>Antiretroviral Formulary Review/Therapeutic Substitution</td>
</tr>
<tr>
<td>Antibiotic Indication reconciliation and requirement</td>
</tr>
<tr>
<td>Antimalarial Power Plans Implementation</td>
</tr>
<tr>
<td>Pharmacokinetic monitoring changes based on data for evidence based results</td>
</tr>
<tr>
<td>Coartem Power Plan Implementation</td>
</tr>
<tr>
<td>Revision/Addition of pneumococcal vaccine PPV-13 and High dose flu vaccine</td>
</tr>
</tbody>
</table>
"Yes, I do feel better now, thank you, but you were surprisingly resistant, and the prescription says to finish the course either way!"
8.5 BROWARD HEALTH
HOME HEALTH

QUALITY MANAGEMENT
QUALITY PROCESSES & OUTCOMES
HH_CAHPS

2ND QTR - CY 2020
January 1, 2019 to December 31, 2019 Quality Assessments Only (QAO) Interim Performance Report for Quarter 2

This QAO Performance Report is based on assessments completed by your HHA during the period from January 1, 2019 to December 31, 2019

QAO Interim Score for Gold Coast Home Health Services (107073)
Fort Lauderdale, Florida

97.5% (Your HHA would pass the Annual QAO performance requirement because your current QAO score was greater than or equal to the 90% criterion.)
# BROWARD HEALTH HOME HEALTH

CMS iQies – 6.2019 – 5.2020

<table>
<thead>
<tr>
<th>Processes &amp; Outcomes</th>
<th>Q1 CY 20</th>
<th>Q2 CY 20</th>
<th>Q3 CY 20</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managing Daily Activities</strong></td>
<td>CMS</td>
<td>CMS</td>
<td>CMS</td>
<td>CMS</td>
</tr>
<tr>
<td>Improvement in Ambulation - Locomotion</td>
<td>CMS Target Rating 79.9% <strong>Star Rating</strong></td>
<td>94.1</td>
<td>86.8</td>
<td>90</td>
</tr>
<tr>
<td>Improvement in Bed Transferring</td>
<td>CMS Target Rating 81.4% <strong>Star Rating</strong></td>
<td>94.1</td>
<td>86.3</td>
<td>90</td>
</tr>
<tr>
<td>Improvement in Bathing</td>
<td>CMS Target Rating 82.6% <strong>Star Rating</strong></td>
<td>94.1</td>
<td>87.4</td>
<td>91</td>
</tr>
<tr>
<td>Improvement in Dyspnea</td>
<td>CMS Target Rating 83.2% <strong>Star Rating</strong></td>
<td>90.3</td>
<td>88.5</td>
<td>89</td>
</tr>
<tr>
<td><strong>Managing Pain and Treating Symptoms</strong></td>
<td>CMS</td>
<td>CMS</td>
<td>CMS</td>
<td>CMS</td>
</tr>
<tr>
<td>Improvement in Management of Oral Medications</td>
<td>CMS Target Rating 76.2% <strong>VBP</strong></td>
<td>93.8</td>
<td>85</td>
<td>89</td>
</tr>
</tbody>
</table>
### BROWARD HEALTH HOME HEALTH

CMS iQies – 6.2019 – 5.2020

<table>
<thead>
<tr>
<th>Managing Pain and Treating Symptoms</th>
<th>1st Qtr CY 2020</th>
<th>2nd Qtr CY 2020</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in Management of Oral Medications</td>
<td>CMS Target</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rolling 76.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>VBP</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>93.8</td>
<td>85</td>
<td>89</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventing Harm</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Initiation of Care</td>
<td>CMS Target</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rolling 95%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Star Rating</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

| Drug Education on all medications provided to patients/caregiver during all episode of care (EOC)     | CMS Target     |                 |      |
|                                                                                                       | Rolling 99%     |                 |      |
|                                                                                                       | *Star Rating    |                 |      |
|                                                                                                       | 98              | 98              | 98   |

| Discharged to Community                                                                               | CMS Target     |                 |      |
|                                                                                                       | Rolling 72.5%   |                 |      |
|                                                                                                       | VBP             |                 |      |
|                                                                                                       | 89.2%           | 80.8%           | 85   |
**BROWARD HEALTH HOME HEALTH**

CMS iQies – 6.2019 – 5.2020

<table>
<thead>
<tr>
<th>Processes &amp; Outcomes</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing Unplanned Hospital Care</td>
<td></td>
<td></td>
<td>CMS Target 17.6%</td>
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<tr>
<td>CMS Risk Adjusted Hospitalizations</td>
<td></td>
<td></td>
<td>21.1</td>
<td></td>
<td>21.1</td>
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<tr>
<td>Emergency Department Use without Hospitalizations</td>
<td></td>
<td></td>
<td>CMS Target 12.8%</td>
<td></td>
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</tbody>
</table>
## BROWARD HEALTH HOME HEALTH

**CMS iQies – 6.2019 – 5.2020**

<table>
<thead>
<tr>
<th>Home Health HHCAHPS</th>
<th>National Average</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHCAHPS % of patients who reported that their HH team gave care in a professional way</td>
<td>CMS Target Rolling 88%</td>
<td>88.2</td>
<td>68</td>
<td>93</td>
<td>84.4</td>
<td></td>
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</tr>
<tr>
<td>HHCAHPS % of patients who reported that their HH team communicated well with them</td>
<td>CMS Target Rolling 85%</td>
<td>81</td>
<td>48</td>
<td>97.6</td>
<td>89</td>
<td></td>
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</tr>
<tr>
<td>HHCAHPS % of patients who reported that their HH team discussed meds, pain and home safety with them</td>
<td>CMS Target Rolling 83%</td>
<td>88.2</td>
<td>55</td>
<td>84</td>
<td>72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHCAHPS % of patients who gave their HH agency a rating of 9 or 10</td>
<td>CMS Target Rolling 84%</td>
<td>71</td>
<td>46</td>
<td>100</td>
<td>78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHCAHPS % of patients who reported YES, they would definitely recommend HH agency</td>
<td>CMS Target Rolling 78%</td>
<td>65</td>
<td>50</td>
<td>83.3</td>
<td>62.5</td>
<td></td>
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</tr>
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</table>
BROWARD HEALTH HOSPICE

Quality Reported Measures
HIS
HS CAHPS

2nd QTR - CY 2020
## BROWARD HEALTH HOSPICE

<table>
<thead>
<tr>
<th>HOSPICE Quality Reported Measures</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Visits When Death is Imminent</td>
<td>Avg # visits 5</td>
<td>Avg # visits 7</td>
<td>Avg # visits 4.5</td>
<td>Avg # visits 5.75</td>
<td>Avg # visits 4.5</td>
<td>Avg # visits 5.4</td>
<td>Avg # visits 5.4</td>
</tr>
<tr>
<td>A - 3 days</td>
<td>Avg # visits 10</td>
<td>Avg # visits 11.67</td>
<td>Avg # visits 8</td>
<td>Avg # visits 9.5</td>
<td>Avg # visits 11.5</td>
<td>Avg # visits 9.6</td>
<td>Avg # visits 10</td>
</tr>
<tr>
<td>B - 7 days (McKesson Custom Report)</td>
<td>Avg # visits</td>
<td>Avg # visits</td>
<td>Avg # visits</td>
<td>Avg # visits</td>
<td>Avg # visits</td>
<td>Avg # visits</td>
<td>Avg # visits</td>
</tr>
<tr>
<td>RN/LPN</td>
<td>5</td>
<td>5</td>
<td>5.5</td>
<td>4.75</td>
<td>5.50</td>
<td>5.80</td>
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<tr>
<td>Medical Social Worker</td>
<td>2</td>
<td>1.67</td>
<td>0.5</td>
<td>1</td>
<td>.50</td>
<td>.80</td>
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<tr>
<td>Aide</td>
<td>2</td>
<td>2.33</td>
<td>0</td>
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<td>1.20</td>
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<tr>
<td>Chaplain/Spiritual Counselor</td>
<td>0</td>
<td>2.67</td>
<td>2</td>
<td>1.50</td>
<td>1.50</td>
<td>1.60</td>
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<tr>
<td>Provider (physician, ARNP)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>.25</td>
<td>0</td>
<td>.20</td>
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## BROWARD HEALTH HOSPICE

<table>
<thead>
<tr>
<th>Hospice-Level Quality Measures</th>
<th>HIS</th>
<th>Casper Report</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>JLY</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>YTD</th>
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</thead>
<tbody>
<tr>
<td>Treatment Preferences</td>
<td>99.3%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<td>100</td>
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<tr>
<td>Beliefs &amp; Values</td>
<td>97.6%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<td>100</td>
<td>100</td>
<td>100</td>
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</tr>
<tr>
<td>Pain Screening</td>
<td>97.1%</td>
<td>98.8</td>
<td>98.2</td>
<td>98.6</td>
<td>98.3</td>
<td>98.4</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<td>Pain Assessment</td>
<td>92.7%</td>
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<td>100</td>
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<td>100</td>
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<td>100</td>
<td>100</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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</tr>
<tr>
<td>Dyspnea Screening</td>
<td>98.6%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<td>100</td>
<td>100</td>
<td>100</td>
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</tr>
<tr>
<td>Dyspnea Treatment</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<td>100</td>
<td>100</td>
<td>100</td>
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</tr>
<tr>
<td>Bowel Regime</td>
<td>94.4%</td>
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<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<td>100</td>
<td>100</td>
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<td>100</td>
</tr>
<tr>
<td>Hospice Comprehensive Assessment</td>
<td>88.8%</td>
<td>98.8</td>
<td>98.2</td>
<td>98.6</td>
<td>98.3</td>
<td>98.4</td>
<td>98.1</td>
<td>98</td>
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<td>98</td>
<td>98</td>
</tr>
<tr>
<td>Home patients only: Hospice Visits when Death is Imminent - Measure 1</td>
<td>81.6%</td>
<td>78.1</td>
<td>76.5</td>
<td>68.3</td>
<td>73.5</td>
<td>67.6</td>
<td>65.6</td>
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<tr>
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<td>79.1%</td>
<td>87.5</td>
<td>88</td>
<td>87</td>
<td>83.3</td>
<td>86.2</td>
<td>87.5</td>
<td>86.6</td>
<td>86.6</td>
<td>86.6</td>
<td>86.6</td>
<td>86.6</td>
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</tbody>
</table>
## BROWARD HEALTH HOSPICE

<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>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total responses</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hospice Team Communicates</td>
<td>81%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>95</td>
</tr>
<tr>
<td>Getting Timely Care</td>
<td>78%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Treating Family Member with Respect</td>
<td>91%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Getting Support Religious/Emotional</td>
<td>90%</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98</td>
</tr>
<tr>
<td>Getting Help for Symptoms</td>
<td>75%</td>
<td></td>
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<td></td>
<td>97</td>
</tr>
<tr>
<td>Getting Hospice Care Training</td>
<td>76%</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75</td>
</tr>
<tr>
<td>Recommend Hospice</td>
<td>84%</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>83</td>
</tr>
<tr>
<td>Overall Hospice Rating</td>
<td>81%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td>100</td>
</tr>
</tbody>
</table>
GOLD COAST HOME HEALTH

Re-hospitalizations

**CMS Target  15.6%**  

<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>CMS Target 12.3% (CY 2018) 15.6% - Sept 2019</td>
<td>21.9</td>
<td>9.8</td>
<td>16.2</td>
<td>15.8</td>
<td></td>
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</tbody>
</table>

**CY 2019  15.8%**

**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%  
CY 2019 YTD 91%

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>HHCAHPS</td>
<td></td>
<td>JAN</td>
<td>FEB</td>
<td>MAR</td>
<td>APR</td>
<td>MAY</td>
<td>JUN</td>
<td>JUL</td>
<td>AUG</td>
<td>SEP</td>
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<tr>
<td>Responses</td>
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<td></td>
<td></td>
<td>5</td>
<td>8</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

| HHCAHPS % of patients who gave their HH agency a rating of 9 or 10 | CMS Target Rolling 83% | 87.5 | 100 | 100 | 100 | 75 | 75 | 100 | 86 | 91 |

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
8.6 READMISSIONS
Medicare Readmissions

Medicare Average:
No difference from National Average for all hospitals and following diagnoses:  HF, COPD, PN, AMI

Readmissions 07/01/2016 – 06/30/2019
Readmission Prevention Overview

Patient admit
Risk assessment performed in EHR
Discern Alert w/ risk factor
Enter patient care plan with visibility across care providers
Refine patient set with Readmissions dashboard
Manage high risk patients in worklist
Manage outcomes with easy to identify status metrics
Performance Reporting

Essential roles
- Physicians
- Nurses
- Case Managers
- Readmission Preventionists

Targeted conditions
- Acute Myocardial Infarction (AMI)
- Community-Acquired Pneumonia (CAP)
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Heart Failure (CHF)

All-cause high risk assessment
- Identify 30 day readmits
- Identify high risk procedures
- Knees/Hip Replacement
- Coronary Artery Bypass Graft

BOOST Ps assessment
## Discharge Process
- D/C education to patient & caregiver
- Follow up appointment made by CM on COPD, CHF Readmitted patients.
- COPD discharge med packets: ABX, Rescue inhaler and Medrol dose packs.

## High Risk Readmissions
- Readmission Assessments implemented in Cerner.
- High Risk Daily census sent to CM staff daily.
- Implementation of discharge disposition with readmission.
- CM & CMO Disease specific readmissions teams: CHF, COPD, AMI - Intense Analysis data drill down of opportunities.

## Transition of Care
- Readmission follow up calls.
- CM referrals to Pop Health via Ensocare.
- CHF task force with collaboration with Duke university study.
- COPD task force.
- Centralized appointment center for follow up care.
## BROWARD HEALTH
### COST OF READMISSIONS
#### 2% OF MEDICARE

<table>
<thead>
<tr>
<th></th>
<th>FY21 Potential Max Penalty</th>
<th>FY 20 Actual Penalty</th>
<th>FY21 Estimated Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHMC</td>
<td>1,203,600</td>
<td>213,800</td>
<td>TBD</td>
</tr>
<tr>
<td>BHCS</td>
<td>413,600</td>
<td>90,800</td>
<td>TBD</td>
</tr>
<tr>
<td>BHN</td>
<td>891,800</td>
<td>49,000</td>
<td>TBD</td>
</tr>
<tr>
<td>BHIP</td>
<td>368,400</td>
<td>58,300</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,877,400</strong></td>
<td><strong>411,900</strong></td>
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</table>
## Readmission Rates – All Payer (Crimson)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FY19</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHMC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF</td>
<td>21.9%</td>
<td>21.7%</td>
<td>22.6%</td>
</tr>
<tr>
<td>COPD</td>
<td>19.5%</td>
<td>21.2%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>16.6%</td>
<td>10.9%</td>
<td>14.6%</td>
</tr>
<tr>
<td>AMI</td>
<td>16.1%</td>
<td>8.2%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Hip/Knee</td>
<td>4.0%</td>
<td>2.5%</td>
<td>3.6%</td>
</tr>
<tr>
<td>CABG</td>
<td>12.7%</td>
<td>9.4%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BHN</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>HF</td>
<td>21.9%</td>
<td>23.1%</td>
<td>29.6%</td>
</tr>
<tr>
<td>COPD</td>
<td>19.5%</td>
<td>20.5%</td>
<td>15.8%</td>
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<tr>
<td>Pneumonia</td>
<td>16.6%</td>
<td>13.9%</td>
<td>15.6%</td>
</tr>
<tr>
<td>AMI</td>
<td>16.1%</td>
<td>11.8%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Hip/Knee</td>
<td>4.0%</td>
<td>2.2%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BHIP</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HF</td>
<td>21.9%</td>
<td>27.7%</td>
<td>31.3%</td>
</tr>
<tr>
<td>COPD</td>
<td>19.5%</td>
<td>16.2%</td>
<td>25.0%</td>
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BH SYSTEMWIDE HEART FAILURE

% 30 Day Readmits w/ Excludes (Any APR-DRG) - System-AllPhysicians

National Observed Rate 21.7%
BH SYSTEMWIDE
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

% 30 Day Readmits w/ Excludes (Any APR-DRG) - System-All Physicians

National Observed Rate 19.6%
BH SYSTEMWIDE PNEUMONIA

% 30 Day Readmits w/ Excludes (Any APR-DRG) - System-AllPhysicians

National Observed Rate 16.6%
BH SYSTEMWIDE
ACUTE MYOCARDIAL INFRACTION

% 30 Day Readmits w/ Excludes (Any APR-DRG) - System-AllPhysicians

National Observed Rate 15.7%
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
epidemiologically significant.

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
hospital provides or refers them for assessment and potential testing, prophylaxis/treatment, and/or
counseling. Any students who are determined to be involved in a possible exposure incident are reported
to the school liaison for appropriate medical assessment and potential testing, prophylaxis/treatment, and/or
counseling.

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 ICRA 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 Heath 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
## Approval Signatures

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<th>Step Description</th>
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<td>Andrew Ta: EVP, CHIEF MEDICAL OFFICER</td>
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<td>Andrew Ta: EVP, CHIEF MEDICAL OFFICER</td>
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<td>Netonua Reyes: CHIEF OPS &amp; NURSING OFFICER-IP</td>
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<td>Bettiann Ruditz: CHIEF NURSING OFFICER-NBMC</td>
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<td>David Droller: CHIEF, INFECTION PREVENTION/EP</td>
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<td>Gina Milano: COORD, EPIDEMIOLOGY</td>
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<td>Rebecca Ryan: COORD, EPIDEMIOLOGY</td>
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<td>Cecile Kaplan: COORD, EPIDEMIOLOGY</td>
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<td>Rachel Guran: CLINICAL SPECIALST/NURS CLINIC</td>
<td>01/2019</td>
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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.

2. 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
time to time or as provided by law.

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, emergency services, respiratory 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.

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**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
## Approval Signatures

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<td>Andrew Ta: EVP, CHIEF MEDICAL OFFICER</td>
<td>07/2020</td>
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<td>Barry Gallison: CORP DIR, RISK &amp; QUALITY</td>
<td>06/2020</td>
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<tr>
<td></td>
<td>Kimberly Cerri: REG MGR, QUAL, ADMIN, PAT SAF-CS</td>
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<td>Donna Williamson: REG MGR, QUL/EPI/PS/PE-BHIP</td>
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<td>Janet Dougherty: REG DIR, QUAL/EPI/PAT SAFE-BG</td>
<td>06/2020</td>
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<tr>
<td></td>
<td>Jesusa Alfonso: REG MGR, QUAL/EPI/PAT SAFE-NB</td>
<td>06/2020</td>
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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**

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<tr>
<th>Level</th>
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<tr>
<td>1</td>
<td>An event occurred but the patient was not harmed</td>
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<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>
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<tr>
<td>4</td>
<td>An event occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm</td>
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<tr>
<td>5</td>
<td>An event occurred that resulted in permanent patient harm or near death event, such as anaphylaxis</td>
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<tr>
<td>6</td>
<td>An event occurred that resulted in patient death</td>
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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

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<th>Step Description</th>
<th>Approver</th>
<th>Date</th>
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<td>Lee Ghezzi: SVP, QUALITY &amp; CASE MGMT</td>
<td>12/2019</td>
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<td>Andrew Ta: EVP, CHIEF MEDICAL OFFICER</td>
<td>09/2019</td>
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<td>Barry Gallison: CORP DIR, RISK &amp; QUALITY</td>
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<td>Kimberly Cerri: REG MGR, QUAL,ADMIN,PAT SAF-CS</td>
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<td>Donna Williamson: REG MGR, QUL/EPI/PS/PE-BHIP</td>
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