TO: Medical Executive Committee, January 5, 2021 FOR REVIEW AND APPROVAL, please

These policies were approved at the November 17th, 2020 Infection Prevention/Blood Committee for approval purposes

NOTE: Total pages = 115 pages and have been split to 2 handouts.

Policies and Procedures –

HANDOUT 1 – pages 1 to 53 as highlighted.

Please review the following identified policies and procedures:

1. **Infection Prevention Program Plan and Assessment**
2. **Pneumococcal Prevention and Control Plan**
3. **Employee Food and Drink in Patient Care Area**
4. **Negative Pressure Room Monitoring**
5. **Refrigerator/Freezer Logs**
6. **EVS, Cleaning of Medical Waste Transport Containers**
7. **EVS, Chemotherapy Waste Handling**

HANDOUT # 1 - pages 1 to 53

Implementation:	*11/2016*
Effective:	*Upon Approval*
Last Reviewed:	*N/A*
Last Revised:	*08/2020*
Next Review:	*1 year after approval*
Owner:	*Jamie Jolly: Sr Mgr Infection Prevention*
Policy Area:	*Infection Prevention*
References:	
Applicability:	*CA - Providence LCM MC Torrance*

Infection Prevention Program Plan and Risk Assessment

PURPOSE

The purpose of the Infection Prevention Program (IPP) is to identify infections and to reduce the risks of disease transmission via the development and implementation of preventive measures. The mission of this program is to facilitate safe, cost-effective care of our patients, staff, and visitors. In particular, the IPP is designed to reduce or prevent the acquisition of healthcare -associated infections (HAIs) by providing education, training, and support to all staff with regard to the principles and practices of infection prevention. The IPP plan is updated annually and is revised as necessary to accommodate real-time technological advances, new information, and ~~revelatory~~regulatory findings. The IPP team oversees Providence Little Company of Mary Medical Center Torrance (PLCMMCT), Torrance Transitional Care Center/Unit (TCC), and Home Health (HH) on the same license.

~~THE INFECTION PREVENTION PROGRAM INCLUDES:~~

1. ~~Scope of Service~~
2. ~~Authority / Responsibility / Program Management / Resource Allocation~~
3. ~~Data Collection~~
4. ~~Environment~~
5. ~~Caregiver Health~~
6. ~~Mitigation of Infection Risks~~
7. ~~Intervening Directly to Prevent Transmission of Infectious Diseases~~
8. ~~Education and Training of Healthcare Workers~~
9. ~~Education of Patients~~
10. ~~Reporting Systems~~
11. ~~Emergency Management~~
12. ~~Transitional Care Unit~~
13. ~~Home Health~~

14. Resources
15. Comprehensive Infection Prevention Surveillance Plan
16. Organizational Flowchart

Scope of Service

A. Infection prevention is a facility-wide patient safety component involving all departments. The Manager of Infection Prevention, supported by the Infection Prevention and Blood (IPB) Committee, determines the specific focus of surveillance, education, and consultation efforts on an on-going basis, depending on hospital epidemiology, community disease trends, and real or perceived local or global threats.

B. Epidemiologic data is used to plan, implement, evaluate, and improve infection prevention strategies. Prevention efforts will include, but are not limited to, activities such as:

1. Measuring, monitoring, evaluating, and reporting infection data and program effectiveness.
2. Addressing outbreaks, epidemics, and unusual occurrences in a timely manner.
3. Complying with mandates of licensing and accrediting agencies.
4. Focusing on high volume services or procedures and/or populations that may be at high risk for infection.
5. Identifying and reporting communicable diseases in accordance with California Code of Regulations (CCR) Title 17. [IC.02.01.01].
6. Working collaboratively with the local health officer and appropriate Departments of Public Health.

Authority / Responsibility / Program Management / Resource Allocation [IC.01.01.01; CMS 482.42(A), California Health and Safety Code Section 1288.45 and 1288.95]

The IPB Committee, through its chairperson or physician members, is given authority by the Executive Committee to institute any appropriate control measures or studies. Likewise, the IPB Committee may recommend corrective action concerning an infection event that poses risks to any patient, visitor, or staff member.

A. **MEMBERS OF THE INFECTION PREVENTION COMMITTEE**

1. Physician Chair: Dr. Eric Yang, Infectious Disease (voting member).
2. Manager of Infection Prevention: Jamie Jolly, RN, CIC (voting member).
3. Infection Preventionists: Rebecca Clarkson RN, MSN, CIC; Rachel Frederick RN, BSN, CCRN; and Cecile Chantrapornlert, RN, at TCC.
4. Stakeholder Representatives may include: Medical Staff, Administration, Nursing Leadership, Quality Management, Surgical Services, Women's Services, Caregiver Health, Emergency Services, Food Services, Microbiology, Pharmacy, Environmental Services, Sterile Processing, Facilities Services, Outpatient Services, or Respiratory Services.
5. Other direct and indirect patient caregivers are invited as needed.

B. **DUTIES AND RESPONSIBILITIES OF THE INFECTION PREVENTION COMMITTEE**

1. Success of a ministry-wide IPP requires collaboration with all interdisciplinary teams, hospital departments, and units. This collaboration is vital for gathering and interpreting data, designing interventions, and effectively implementing those interventions. Participation of Senior Leadership in the IPP aids in decision-making and execution of corrective action.

2. The IPB Committee oversees a ministry-wide IPP. All ministry components and functions are integrated into Infection Prevention activities. The IPB Committee:

   a. Reviews and approves the Infection Prevention Risk Assessment and the IPP Plan, subsequently defining epidemiologically important issues, setting specific annual objectives, and modifying the IPP Plan to meet those objectives as needed.

   b. Reviews surveillance data for trends in infections, clusters, hospital-acquired infections (HAIs), or any unusual pathogens that exceed established thresholds.

   c. Recommends corrective action(s).

   d. Reviews, in conjunction with pharmacists, antibiotic susceptibility/resistance trends and makes recommendations for judicious use of antibiotics as appropriate.

   e. Reviews and issues reports on infection control risk assessments (ICRA) as required for construction and renovation projects.

   f. Institutes appropriate control measures or studies, including patient testing, patient isolation, or environmental sampling when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, or the community.

   g. Reviews Infection Prevention Policies and department-specific infection-related policies at least every three (3) years, unless otherwise specified. Remains current with regulatory guidelines and standards related to infection prevention.

   h. Submits reports to the Medical Executive Committee quarterly to convey findings and recommendations, which then reports to the Regional Ministry Board.

C. **RESPONSIBILITIES OF THE INFECTION PREVENTION DEPARTMENT [IC.01.01.01], [CMS 482.42 (1) (a)]**

1. The Manager of Infection Prevention has been given authority through the IPP and is responsible for:

   a. Implementing and enforcing policies concerning the management of infections and communicable diseases.

   b. Reporting to the Administrative Director of Quality & Patient Safety.

   c. Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases.

   d. Coordinating infection prevention activities and projects within the hospital.

   e. Facilitating on-going monitoring of program activities and intervention effectiveness.

   f. Coordinating with other Infection Preventionists to order patient isolation or patient testing per public health authorities.

   g. Observing the following hours of operation:

      1. Normal operating hours are Monday through Friday, 8AM – 5PM.

      2. During holidays and after hours, the house supervisor notifies the Infection Preventionist on-

call for escalated concerns by hospital staff for consultation.

h. Consulting with California Department of Public Health (CDPH) for public health issues or suspected communicable diseases.

2. The Infection Preventionists have the responsibility for day-to-day operational tasks, which include but are not limited to:

a. Instituting appropriate surveillance, precautions, isolation, and ordering/ requesting cultures.

b. Maintaining ongoing communication with nursing departments, surgical services, clinical support services, laboratory, and ancillary departments regarding patients with infections and those at greatest risk for HAIs or other epidemiological issues within the community.

c. Sharing HAI information with ministry leadership, nursing leadership, risk management, and quality departments. Information sharing may occur via event reporting, multidisciplinary case-review drill downs, clinical monitoring, committee reports, and/or verbal communication on an on-going basis.

d. Working cooperatively with the quality and risk departments to identify and respond to sentinel events pertaining to infection control issues.

e. Collaborating with multidisciplinary teams to implement infection prevention-based quality and performance improvement strategies.

f. Quarantining or securing areas within the ministry that are deemed unsafe per infection prevention standards.

D. **QUALIFICATION MAINTENANCE FOR INFECTION PREVENTION MEMBERS [IC.01.01.01]**

1. The Manager of Infection Prevention maintains Certification in Infection Prevention and Control (CIC) through the national certification Board of Infection Control and Epidemiology (CBIC).

2. Infection Preventionists maintain competency and remain current through educational opportunities available through various professional organizations relevant to the position. These educational opportunities may include webinars, self-learning modules, CIC credentialing, and hospital programs.

3. The Manager of Infection Prevention maintains membership in the National Association for Professionals in Infection Control and Epidemiology (APIC) and the local APIC Chapter.

4. The IPB Chairperson or designated hospital epidemiologist participates in continuing medical education training programs offered by the Centers for Disease Control (CDC) and Society for Healthcare Epidemiologists of America (SHEA), or other recognized professional organizations, as needed. Documentation of attendance is placed in the physician's credentialing file.

E. **RESOURCE ALLOCATION [IC.03.01.01]**

Hospital Senior Leadership allocates necessary resources for the IPP and provides systems to support Infection Prevention activities. Staffing the Infection Prevention department, factoring expertise and quantity, is determined by the goals and objectives of the IPP.

1. Senior leadership reviews, on an ongoing basis, the resources and the effectiveness of the hospital's infection prevention activities and supports the department.

2. 2018 staffing includes:

a. 0.66 FTE Infection Prevention & Control Manager

b. 2.0 FTE Infection Preventionists at PLCMMCT

c. 1.0 FTE Infection Preventionist at TCC

3. Electronic systems used to access information include EPIC and Theradoc. The Infection Prevention department has computers for each staff member, current software to support analysis, a designated printer, a confidential fax, an electronic rounding tool and a copier.

4. The ministry laboratory staff regularly collaborates with Infection Preventionists for standard monitoring, providing additional services in special cases as required.

5. Equipment, supplies, and resource materials are provided to support Infection Prevention activities.

6. Infection Prevention personnel have appropriate access to medical and other relevant records and have working relationships with the Quality Department, who can provide information on the adequacy of the institution's compliance to regulations, standards, and guidelines.

7. Support is provided to assist in compliance of reporting required infection surveillance information to external organizations.

F. **SHARED RESPONSIBILITIES OF THE INFECTION PREVENTION PROGRAM**

1. The prevention of infections is a shared responsibility among all clinical and non-clinical staff in the hospital.

a. Medical Staff Responsibilities:

1. The Medical Directors and Medical Staff provide expertise from their respective areas and disciplines, in conjunction with the members of the IPB Committee, to help prevent and manage infections.

b. Department Specific Responsibilities:

1. The Managers/Directors are responsible for monitoring employees and assuring compliance with Infection Prevention policies and procedures. Responsibilities include but are not limited to:

a. Revising and updating departmental policies relating to Infection Prevention in collaboration with the Infection Prevention personnel.

b. Ensuring proper patient care practices and product safety.

c. Ensuring proper documentation and necessity of invasive devices (central lines, ventilators, and urinary catheters).

d. Orienting existing and new staff on Infection Prevention issues and risks specific to their job duties, i.e. use of safe sharps and medical waste handling, Infection Prevention policies, and National Patient Safety Goals (NPSG).

e. Coordinating with Infection Prevention to plan and implement educational or in-service programs on the prevention of infections.

f. Monitoring compliance with hand hygiene policies.

g. Assuring that healthcare workers use safe and effective practices for all cleaning, disinfection, and sterilization, as appropriate for their job functions.

h. Monitoring compliance with use and documentation related to high-level disinfection, as appropriate for their job functions.

i. Monitoring cleanliness of departments.

c. **Caregiver Responsibilities: All healthcare workers of the organization have**

responsibilities in preventing the spread of infection and:

1. Adhering to hand hygiene guidelines.
2. Adhering to Infection Prevention policies for prevention of HAIs (Infection Prevention policies are located on intranet).
3. Avoiding food and drink in areas where blood or bodily fluids are handled.
4. Using safe sharps and safe handling procedures to avoid blood-borne pathogen exposure.
5. Participating in the review of Infection Prevention data within their departments.
6. Completing orientation and annual education review and test.
7. Participating fully in the Caregiver Health Program (annual Quantiferon-Gold [Q-Gold] screening and Influenza Vaccination program).
8. Complying with required immunizations.
9. Notifying the Infection Prevention department of infection-related issues or potential concerns.
10. Not reporting to work when sick or with signs and symptoms of illness.

G. **COLLABORATION**

1. The Infection Prevention Manager and Infection Preventionists are involved in regulatory agency meetings and in Providence Health System Teams.
   a. Regulatory agency involvement includes:
      1. In-person meetings with Los Angeles County Department of Public Health (CDPH) liaison.
      2. CDC/National Health and Safety Network (NHSN) webinars and meetings.
      3. CDPH webinars and meetings.
   b. Providence Health System involvement:
      1. Infectious Disease Clinical Decision Team (ID CDT).
      2. Infection Prevention Action Community (IPAC).
      3. CLABSI, CAUTI and C. diff System Teams.
      4. Others as identified.

Data Collection

A. **SURVEILLANCE AND MONITORING INCLUDES BUT IS NOT LIMITED TO:**

1. Monitoring high-volume/high-risk & low-volume/high-risk procedures.
2. Evaluating or consulting on new programs.
3. Monitoring construction/renovation projects in conjunction with Plant Operations, Environment of Care, Safety, and Risk Management teams.
4. Compiling and analyzing surveillance data, presenting findings, and making recommendations to the IPB Committee, to other departments, and to medical leadership as appropriate.
5. Using baseline surveillance data to determine if an outbreak/cluster is occurring.
6. Investigating trends of infections, clusters, and unusual infections.

7. Conducting or facilitating infection prevention and control environmental and isolation rounds.
8. Using the EPIC clinical documentation system, Theradoc, Infoview, and any other database as appropriate.
9. Reviewing microbiology notification of Acid-Fast Bacilli (AFB) and other unusual/significant pathogens.
10. Reviewing reports from the laboratory.
11. Reviewing reports from information systems including the admit list with diagnosis, the daily census, and readmission information.
12. Reviewing the daily isolation list and performing isolation rounds.
13. Reviewing reports from other facilities with knowledge of an infection that may have occurred at this facility.
14. Reviewing public health reports.
15. Reviewing ongoing and regular review of surveillance data.
16. Working with case management or other staff reports of suspected or known infections.
17. Reviewing Caregiver Health reports reflecting epidemiologically significant healthcare worker infections and/or unusual employee related trends.

B. INFECTION DEFINITION

1. Healthcare Associated Infections (HAIs) are identified using the most current definitions for healthcare associated infections. Acute care uses CDC/NHSN, TCC uses NHSN and McGeer, and HH uses APIC HICPAC Surveillance definitions. HAI outcomes are trended over time (quarterly, annually, and yearly).
2. HAI Outcome Measures:
    a. HAI data (summary events data or numerator/denominator) is entered into NHSN when applicable and analysis reports are pulled for review, trending, and graphing.
    b. Examples include:
        1. Device-associated HAI measures:
            a. Standardized Infection Ratio (SIR) = observed over expected infections.
            b. Standardized Utilization Ratio (SUR).
        2. Multi-Drug Resistant Organism (MDRO) LabID event measures (*Clostriodos difficile* [C. diff] infections, *Methicillin-resistant Staphylococcus aureus* [MRSA] and *Vancomycin-resistant Enterococcus* [VRE bacteremia]):
            a. Standardized Infection Ratio.
        3. Procedure-associated HAI Infections:
            a. Standardized Infection Ratio.

Environment

A. PLCMMCT HAS DEVELOPED SPECIFIC POLICIES AND PROCEDURES TO ADDRESS THE HOSPITAL ENVIRONMENT, INCLUDING:

1. Ventilation, temperature, humidification, and water control issues, including measures taken to maintain a safe environment during internal or external construction or renovation.
    a. Performing Infection Control Risk Assessments (ICRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment. [CMS 482.42]
    b. ICRAs are to be approved by an Infection Preventionist and Plant Operations and Maintenance personnel with input from unit/department managers as appropriate.
    c. Rounds of the construction/renovation site are conducted to evaluate compliance with ICRA requirements. The IPB committee and Infection Preventionists have the authority to stop any project that is out of compliance with the requirements.
    d. Prior to beginning any construction or renovation, the Infection Prevention department reviews the final design.
2. Maintaining safe air handling systems in areas of special ventilation such as operating rooms and airborne isolation rooms (see Plant Operations Policies).
3. Food Safety in Nutritional Care Services: conducting active surveillance of dish-washing and sanitizing equipment, effective cleaning and sanitizing of all ice machines, food purchasing and storage, maintenance of a sanitary environment for food safety and preparation, safe cooling of all potentially hazardous foods, appropriate hand hygiene, and safe discarding of potentially hazardous foods.
4. Techniques for safely cleaning and disinfecting the environment:
    a. Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations, and storage units is be provided by Environmental Services. Regular disinfection of all surfaces in common areas in the facility such as elevators, meetings rooms, and lounges is also provided by Environmental Services.
    b. Regular removal of accumulations of bodily fluids is performed by EVS or Nursing. Nursing is responsible for removal of intravenous substances. Cleaning and disinfection of movable medical equipment and transportable medical devices is handled by end user. Nursing cleans and disinfects point-of-care testing devices such as glucometers and temperature reading units.
5. Textile reprocessing, storage, and distribution.
6. Sterile processing and evaluation of failures.
7. Storage and disposal of regulated and non-regulated waste.
8. Pest or vector control.

Caregiver Health

The Caregiver Health program reduces the risk of disease transmission among healthcare workers, Licensed Independent Practitioners (LIPs), contract workers, students, and volunteers. [H&SC 1288.7; IC.02.03.01, CMS 482.24(a) (1)]

A. The caregiver health program includes processes for health screening, childhood illness/immunization, tuberculosis screening, immunization for hepatitis B and influenza, and evaluation and assessment of post-exposure follow-up.

B. The IPB Committee reviews and approves all policies and procedures developed in the caregiver health

program that relate to the transmission of infections in the hospital. The Blood-borne Pathogen Exposure Control Plan and the Aerosol Transmissible Disease Exposure Control Plan are both reviewed annually.

C. At the time of initial employment, all employees have a baseline health screening, which includes the following:

   1. Medical history, including immunization status, and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases.
   2. Tuberculosis screening via Q-Gold testing.
   3. Screening for vaccine-preventable diseases.

D. Employees are offered appropriate immunizations for communicable diseases based on regulatory requirements and the California Occupational Safety and Health Administration (Cal/OSHA), or Advisory Committee on Immunization Practices (ACIP) recommendations for healthcare workers.

E. The Influenza Vaccine Program for employees is provided on-site without charge. If a caregiver declines the vaccination, a declination statement is obtained to gather information regarding areas of improvement within the vaccine program. Influenza vaccination rates are calculated using the CDC and National Quality Foundation (NQF) performance measure evaluation criteria. Physicians, LIPs, and volunteers are included in the influenza vaccination program, and their compliance is reviewed.

F. The caregiver health program has policies and procedures for the evaluation and/or referral of ill employees, including assessment of disease communicability, indications for work restrictions, and management of employees, LIPs, students and volunteers who have been exposed to infectious diseases, to include post-exposure prophylaxis and work restrictions.

G. The caregiver health program tracks immunizations and tuberculosis screening.

H. Infection Prevention personnel are freely available to the caregiver health program for consultation regarding exposures or infectious disease concerns.

Mitigation of Infection Risks

The ministry has developed specific policies and procedures that address the following:

A. **PATIENTS WITH INFECTIONS PRESENT ON ADMISSION:**

   1. Measures are in place for early identification of patients who require isolation, per CDC guidelines.
   2. Respiratory hygiene and cough etiquette are encouraged for everyone, beginning at the entrances to the hospital and outpatient settings. Employees are urged to discourage ill family members from visiting.
   3. Appropriate personal protective equipment is available for all healthcare workers and visitors.

B. **INVASIVE PROCEDURES OR DEVICE-RELATED RISKS FOR INFECTION:**

   1. Surgery-related infection policies related to antibiotic prophylaxis, surgical prep, aseptic practices, and sterilization of instruments.
   2. Central line policies dictating insertion, care, and maintenance of a central line in addition to the use of bundles for prevention and the removal of unnecessary lines.
   3. Ventilator policies encouraging the use of bundles for infection prevention.
   4. Urinary catheter policies establishing insertion, care, and maintenance of indwelling catheters, removal of unnecessary lines, and the use of prevention bundles.

C. **OTHER HOSPITAL INFECTION RISK MITIGATION MEASURES INCLUDE:**

1. Promotion of hand hygiene among staff, employees, and visitors.
2. Protocols to prevent infections caused by resistant organisms.
3. Isolation precautions.
4. Use of disinfectants, antiseptic agents, and germicides according to manufacturers' instructions.
5. Appropriate use of medical equipment, portable air filtration equipment, and treatment booths.

Intervening Directly to Prevent Transmission of Infectious Diseases

A. Infection Prevention personnel review microbiology and laboratory results in addition to line lists to identify unusual clusters or higher incidences of certain microorganisms.

B. Baseline surveillance data (historic trends) are used to determine if an outbreak is occurring. When an outbreak occurs, the Infection Prevention team seeks resources and authority to ensure a comprehensive and timely investigation in conjunction with implementation of appropriate control measures.

Education and Training of Caregivers [IC.02.01.01]

A. Infection Prevention educational support is available to caregivers, LIPs, contract workers, students, and volunteers upon hire and annually through on-going educational opportunities.

B. Infection Preventionists, with knowledge of epidemiology and infectious diseases, actively participate in the planning and implementation of educational programs.

C. Educational programs are evaluated periodically for effectiveness with attendance records kept by individual departments. Infection Prevention maintains records for department specific presentations. Unit Managers document on-going in-services provided for their caregivers.

D. The goal of the educational programs is to meet the department/group needs and to provide learning opportunities for staff, tailoring them to a wide range of educational backgrounds and work responsibilities.

E. Education and in-service recommendations specifically designed for physicians are organized through the Medical Staff Office Continuing Medical Education representative.

F. The Infection Prevention personnel serve as consultants to staff, physicians, LIPs, patients, families, volunteers, students, and visitors regarding risks and risk reduction measures associated with disease transmission and benefits of control measures.

G. Infection Prevention provides informal education and serves as a consultant to the staff during environmental rounds.

H. The Infection Preventionists participate in new employee orientation and annual updates by developing, reviewing, and selecting appropriate materials.

I. Department-specific in-services are prepared and presented by the Infection Prevention team.

J. Infection Prevention continually performs just-in-time education during rounds and in response to inquiry.

Education of Patients [NPSG.07.04.01 – 07.06.01]

A. Infection Preventionists provide educational and informational materials to support patient education on

Infection Prevention topics.

B. The hospital provides patients with information regarding Infection Prevention measures for CDC hand hygiene practices, respiratory hygiene practices, and contact precautions,according to the patient's condition.

C. Surgical patients are provided education by the caregivers on measures to be taken to prevent surgical infections.

D. Patients who require a central line are provided education by the caregivers on how to prevent central line-associated bloodstream infections.

E. Patients who require a urinary catheter are provided education by the caregivers on how to prevent catheter-associated urinary tract infections.

F. Patients identified with multi-drug resistant organisms or C. diff are provided instructions regarding precautions to prevent the spread of the infection to others by their caregivers. [Health & Safety Code Sections 1255.8 & 1288.55].

Reporting Systems

A. **INFECTION CLASSIFICATION AND ANALYSIS:**

1. A database of HAIs is maintained as part of Infection Prevention surveillance.
2. An intensive review is performed when appropriate. HAIs that could possibly qualify as sentinel events are reported to Risk Management and to the Quality Department.
3. A list of employee exposures and sharps injuries is maintained by the Caregiver Health office and reviewed periodically by Infection Prevention.

B. **PUBLIC HEALTH REPORTING:**

1. Disease cases are reported as required to CDPH as well as unusual events or clusters. The Infection Prevention department maintains an Infection Line List in which significant infections are recorded. [CMS 482.42(a)(2)] [CCR Title 17].
2. Reports of suspected or known tuberculosis patients are made to CDPH. Infection Prevention personnel maintain contact with the case management department to support required approval of the patient's discharge plan.
3. Reports of infection-related unusual events are made to CDPH as appropriate in conjunction with hospital leadership.
4. The occurrence of communicable diseases among patients is reviewed with the IPB Committee quarterly.
5. Mandated reporting on select HAIs is performed via NHSN in compliance with state and federal directives.
6. In conjunction with Risk Management, the Infection Prevention Department complies with Food and Drug Association (FDA) requirements to report communicable diseases associated with human cells, tissues, and cellular and tissue-based products (HCT/Ps). (Based on FDA 21 CFR Part 1271).

Emergency Management [IC.01.06.01)

As part of emergency management activities, PLCMMCT/TCC/HH is prepared to respond to an influx, or the risk of an influx, of potentially infectious patients.

A. ~~THE ORGANIZATION PLAN FOR A POTENTIAL SURGE UTILIZES THE FOLLOWING PROCEDURES:~~

1. ~~Emergency Management Plan.~~
2. ~~Communicable Diseases; Influx of Infectious Patients.~~
3. ~~Outbreak Investigation.~~
4. ~~Isolation Policies.~~
5. ~~Hospital's Plan for Provision of Care.~~
6. ~~Pandemic Influenza and Seasonal Influenza.~~
7. ~~Bioterrorism Agents Exposure Control Plan.~~

B. ~~THE ORGANIZATION UTILIZES EXTERNAL RESOURCES TO PREPARE FOR DISASTER:~~

1. ~~Infection Prevention personnel remain current with information about the emergence of epidemics or new infections through California Health Alert Network (CAHAN), CDPH alerts, CDC and APIC alerts, and email and fax alerts from the Local Health Officer.~~
2. ~~Infection Preventionists disseminate critical information to staff and other key practitioners verbally as well as through hospital intranet, email, flyers, and alternative methods of communication such as hand-held radios.~~
3. ~~The facility participates in the local public health's "Redinett" system; staff review email alerts on issues identified in Los Angeles County area Emergency Departments.~~
4. ~~The facility participates in state and local disaster drills.~~

~~Transitional Care Unit~~

A. ~~The TCC has 115 licensed beds and offers transitional care for patients after leaving the hospital, skilled nursing facility, or other healthcare facilities. Patients come from different facilities around the South Bay, including PLCMMCT and Torrance Memorial.~~

B. ~~TCC has its own executive leadership team, and also receives support from the Executive Leadership Team from the main acute care hospital. The manager of Infection Prevention oversees Infection Prevention activities at TCC.~~

C. ~~Infection Prevention uses NHSN and McGeer definitions when performing surveillance and identifying HAIs. The Infection Preventionist at TCC uses Theradoc, Epic, and other resources when performing this surveillance. Infections are tracked and are reported quarterly at the IPB meetings.~~

D. ~~Education is provided to patients and family members in isolation by the Infection Preventionist and staff. Caregivers are regularly in-serviced on Infection Prevention topics, including isolation precautions, hand hygiene, and prevention of HAIs.~~

~~Home Health~~

THE INFECTION PREVENTION PROGRAM INCLUDES:

I. **Scope of Service**

II. **Authority / Responsibility / Program Management / Resource Allocation**

III. **Data Collection**

IV. **Environment**

V. Caregiver Health

VI. Mitigation of Infection Risks

VII. Intervening Directly to Prevent Transmission of Infectious Diseases

VIII. Education and Training of Healthcare Workers

IX. Education of Patients

X. Reporting Systems

XI. Emergency Management

XII. Transitional Care Unit

XIII. Home Health

XIV. Resources

XV. Comprehensive Infection Prevention Surveillance Plan

XVI. Organizational Flowcharts

I. Scope of Service

A. Infection prevention is a facility-wide patient safety component involving all departments. The Manager of Infection Prevention, supported by the Infection Prevention and Blood (IPB) Committee, determines the specific focus of surveillance, education, and consultation efforts on an ongoing basis, depending on hospital epidemiology, community disease trends, and real or perceived local or global threats.

B. Epidemiologic data is used to plan, implement, evaluate, and improve infection prevention strategies. Prevention efforts include, but are not limited to, activities such as:

1. Measuring, monitoring, evaluating, and reporting infection data and program effectiveness.
2. Addressing outbreaks, epidemics, and unusual occurrences in a timely manner.
3. Complying with mandates of licensing and accrediting agencies.
4. Focusing on high volume services or procedures and/or populations that may be at high risk for infection.
5. Identifying and reporting communicable diseases in accordance with California Code of Regulations (CCR) Title 17. [IC.02.01.01].
6. Working collaboratively with the local health officer and appropriate Departments of Public Health.

II. Authority / Responsibility / Program Management / Resource Allocation [IC.01.01.01; CMS 482.42(A), California Health and Safety Code Section 1288.45 and 1288.95]

The IPB Committee, through its chairperson or physician members, is given authority by the Executive Committee to institute any appropriate control measures or studies. Likewise, the IPB Committee may recommend corrective action concerning an infection event that poses risks to any patient, visitor, or staff member.

A. MEMBERS OF THE INFECTION PREVENTION COMMITTEE

1. Physician Chair: Dr. Eric Yang, Infectious Disease (voting member).
2. Manager of Infection Prevention: Jamie Jolly, RN, CIC (voting member).

3. Infection Preventionists: Rebecca Clarkson RN, MSN, CIC; Rachel Frederick RN, BSN, CCRN; and Cecile Chantrapornlert, RN, at TCC.
4. Stakeholder Representatives may include: Medical Staff, Administration, Nursing Leadership, Quality Management, Surgical Services, Women's Services, Caregiver Health, Emergency Services, Food Services, Microbiology, Pharmacy, Environmental Services, Sterile Processing, Facilities Services, Outpatient Services, or Respiratory Services.
5. Other direct and indirect patient caregivers are invited as needed.

B. DUTIES AND RESPONSIBILITIES OF THE INFECTION PREVENTION COMMITTEE

1. Success of a ministry-wide IPP requires collaboration with all interdisciplinary teams, hospital departments, and units. This collaboration is vital for gathering and interpreting data, designing interventions, and effectively implementing those interventions. Participation of Executive Leadership in the IPP aids in decision-making and execution of corrective action.
2. The IPB Committee oversees a ministry-wide IPP. All ministry components and functions are integrated into Infection Prevention activities. The IPB Committee:
   a. Reviews and approves the Infection Prevention Risk Assessment and the IPP Plan, subsequently defining epidemiologically important issues, setting specific annual objectives, and modifying the IPP Plan to meet those objectives as needed.
   b. Reviews surveillance data for trends in infections, clusters, hospital-acquired infections (HAIs), or any unusual pathogens that exceed established thresholds.
   c. Recommends corrective action(s).
   d. Reviews, in conjunction with pharmacists, antibiotic susceptibility/resistance trends and makes recommendations for judicious use of antibiotics as appropriate.
   e. Reviews and issues reports on infection control risk assessments (ICRA) as required for construction and renovation projects.
   f. Institutes appropriate control measures or studies, including patient testing, patient isolation, or environmental sampling when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, or the community.
   g. Reviews Infection Prevention Policies and department-specific infection-related policies at least every three (3) years, unless otherwise specified. Remains current with regulatory guidelines and standards related to infection prevention.
   h. Submits reports to the Medical Executive Committee quarterly to convey findings and recommendations, which then reports to the Regional Ministry Board.

C. RESPONSIBILITIES OF THE INFECTION PREVENTION DEPARTMENT [IC.01.01.01], [CMS 482.42 (1) (a)]

1. The Manager of Infection Prevention has been given authority through the IPP and is responsible for:
   a. Implementing policies concerning the management of infections and communicable diseases.
   b. Reporting to the Administrative Director of Quality & Patient Safety.
   c. Developing a system for identifying, reporting, investigating, and controlling

infections and communicable diseases.

d. Coordinating infection prevention activities and projects within the hospital.

e. Facilitating ongoing monitoring of program activities and intervention effectiveness.

f. Coordinating with other Infection Preventionists to implement recommendations per public health authorities.

g. Observing the following hours of operation:

1. Normal operating hours are Monday through Friday, 8AM – 5PM.

2. During holidays and after hours, the house supervisor notifies the Infection Preventionist on-call for escalated concerns by hospital staff for consultation.

h. Consulting with California Department of Public Health (CDPH) for public health issues or suspected communicable diseases.

2. The Infection Preventionists have the responsibility for day-to-day operational tasks, which include but are not limited to:

a. Instituting appropriate surveillance, precautions, isolation, and requesting cultures.

b. Maintaining ongoing communication with nursing departments, surgical services, clinical support services, laboratory, and ancillary departments regarding patients with infections and those at greatest risk for HAIs or other epidemiological issues within the community.

c. Sharing HAI information with ministry leadership, nursing leadership, risk management, and quality departments. Information sharing may occur via event reporting, multidisciplinary case review drill downs, clinical monitoring, committee reports, and/or verbal communication on an ongoing basis.

d. Working cooperatively with the quality and risk departments to identify and respond to sentinel events pertaining to infection control issues.

e. Collaborating with multidisciplinary teams to implement infection prevention-based quality and performance improvement strategies.

f. Quarantining or securing areas within the ministry that are deemed unsafe per infection prevention standards.

D. QUALIFICATION MAINTENANCE FOR INFECTION PREVENTION MEMBERS [IC.01.01.01]

1. The Manager of Infection Prevention maintains Certification in Infection Prevention and Control (CIC) through the national Certification Board of Infection Control and Epidemiology (CBIC).

2. Infection Preventionists maintain competency and remain current through educational opportunities available through various professional organizations relevant to the position. These educational opportunities may include webinars, self-learning modules, CIC credentialing, and hospital programs.

3. The Manager of Infection Prevention maintains membership in the National Association for Professionals in Infection Control and Epidemiology (APIC) and the local APIC Chapter.

4. The IPB Chairperson or designated hospital epidemiologist participates in continuing

medical education training programs offered by the Centers for Disease Control (CDC) and Society for Healthcare Epidemiologists of America (SHEA), or other recognized professional organizations, as needed. Documentation of attendance is placed in the physician's credentialing file.

E. RESOURCE ALLOCATION [IC.03.01.01]

Hospital Senior Leadership allocates necessary resources for the IPP and provides systems to support Infection Prevention activities. Staffing the Infection Prevention department, factoring expertise and quantity, is determined by the goals and objectives of the IPP.

1. Executive leadership reviews, on an ongoing basis, the resources and the effectiveness of the hospital's infection prevention activities and supports the department.
2. 2020 staffing includes:
   a. 0.66 FTE Infection Prevention & Control Manager
   b. 2.0 FTE Infection Preventionists at PLCMMCT
   c. 1.0 FTE Infection Preventionist at TCC
3. Electronic systems used to access information. The Infection Prevention department has computers for each staff member, current software to support analysis, a designated printer, a confidential fax, an electronic rounding tool and a copier.
4. The ministry laboratory staff regularly collaborates with Infection Preventionists for standard monitoring, providing additional services in special cases as required.
5. Equipment, supplies, and resource materials are provided to support Infection Prevention activities.
6. Infection Prevention personnel have appropriate access to medical and other relevant records and have working relationships with the Quality Department, who can provide information on the adequacy of the institution's compliance to regulations, standards, and guidelines.
7. Support is provided to assist in compliance of reporting required infection surveillance information to external organizations.

F. SHARED RESPONSIBILITIES OF THE INFECTION PREVENTION PROGRAM

1. The prevention of infections is a shared responsibility among all clinical and non-clinical staff in the hospital.
   a. Medical Staff Responsibilities:
      1. The Medical Directors and Medical Staff provide expertise from their respective areas and disciplines, in conjunction with the members of the IPB Committee, to help prevent and manage infections.
      2. The Medical Staff works cooperatively with the Infection Prevention department in considering practices, processes, and other evidence-based improvements.
      3. The Medical Staff works in conjunction with regulatory and public health agencies when appropriate.
   b. Department-Specific Responsibilities:
      1. The Managers/Directors are responsible for monitoring caregivers and assuring

compliance with Infection Prevention policies and procedures. Responsibilities include but are not limited to:

III. Revising and updating departmental policies relating to Infection Prevention in collaboration with the Infection Prevention personnel.

IV. Ensuring proper patient care practices and product safety.

V. Ensuring proper documentation and necessity of invasive devices (central lines, ventilators, and urinary catheters).

VI. Orienting existing and new staff on Infection Prevention issues and risks specific to their job duties, i.e., use of safe sharps and medical waste handling, Infection Prevention policies, and National Patient Safety Goals (NPSG).

VII. Coordinating with Infection Prevention to plan and implement educational or in-service programs on the prevention of infections.

VIII. Monitoring compliance with hand hygiene policies.

IX. Assuring that healthcare workers use safe and effective practices for all cleaning, disinfection, and sterilization, as appropriate for their job functions.

X. Monitoring compliance with use and documentation related to high-level disinfection, as appropriate for their job functions.

XI. Monitoring cleanliness of departments.

a. Caregiver Responsibilities: All healthcare workers of the organization have responsibilities in preventing the spread of infection and:

1. Adhering to hand hygiene guidelines.
2. Adhering to Infection Prevention policies (Infection Prevention policies are located on the intranet).
3. Avoiding food and drink in areas where blood or bodily fluids are handled.
4. Using safe sharps and safe handling procedures to avoid blood-borne pathogen exposure.
5. Participating in the review of Infection Prevention data within their departments.
6. Completing orientation and annual education review and test.
7. Participating fully in the Caregiver Health Program and complying with required immunizations.
8. Notifying the Infection Prevention department of infection-related issues or potential concerns.
9. Not reporting to work when sick or with signs and symptoms of illness.

XII. COLLABORATION

1. The Infection Prevention Manager and Infection Preventionists are involved in regulatory agency meetings and in Providence Health System Teams.

a. Regulatory agency involvement includes:

1. In-person meetings with Los Angeles County Department of Public Health (CDPH) liaison.
2. CDC/National Health and Safety Network (NHSN) webinars and meetings.

3. CDPH webinars and meetings.

b. Providence Health System and Regional involvement.

I. **Data Collection**

A. **SURVEILLANCE AND MONITORING INCLUDES BUT IS NOT LIMITED TO:**

1. **Monitoring high-volume/high-risk & low-volume/high-risk procedures.**
2. **Evaluating or consulting on new programs.**
3. **Monitoring construction/renovation projects in conjunction with Plant Operations, Environment of Care, Safety, and Risk Management teams.**
4. **Compiling and analyzing surveillance data, presenting findings, and making recommendations to the IPB Committee, to other departments, and to medical leadership as appropriate.**
5. **Using baseline surveillance data to determine if an outbreak/cluster is occurring.**
6. **Investigating trends of infections, clusters, and unusual infections.**
7. **Conducting or facilitating infection prevention and control environmental and isolation rounds.**
8. **Using the EPIC clinical documentation system, Theradoc, Infoview, and any other database as appropriate.**
9. **Reviewing microbiology notification of Acid-Fast Bacilli (AFB) and other unusual/ significant pathogens.**
10. **Reviewing reports from the laboratory.**
11. **Reviewing the isolation list and performing rounds.**
12. **Reviewing reports from other facilities with knowledge of an infection that may have occurred at this facility.**
13. **Reviewing public health reports.**
14. **Reviewing ongoing and regular review of surveillance data.**
15. **Working with Case Management or other staff reports of suspected or known infections.**
16. **Reviewing Caregiver Health reports reflecting epidemiologically-significant healthcare worker infections and/or unusual caregiver related trends.**

B. **INFECTION DEFINITION**

1. **HAIs are identified using the most current definitions for healthcare-associated infections. Acute care uses CDC/NHSN, TCC uses NHSN and McGeer, and HH uses APIC-Healthcare Infection Control Practices Advisory Committee (HICPAC) Surveillance definitions. HAI outcomes are trended over time.**
2. **HAI Outcome Measures:**
   a. **HAI data (summary events data or numerator/denominator) is entered into NHSN when applicable and analysis reports are pulled for review, trending, and graphing.**
   b. **Examples include:**
      1. **Device-associated HAI measures:**

a. Standardized Infection Ratio (SIR) = observed over expected infections.

b. Standardized Utilization Ratio (SUR) = observed over expected device days.

2. Multi-Drug Resistant Organism (MDRO) LabID event measures (*Clostridioides difficile* [C. diff] infections, *Methicillin-resistant Staphylococcus aureus* [MRSA], *Vancomycin-resistant Enterococcus* [VRE bacteremia], *Carbapenem-resistant Enterobacteriaceae* [CRE]):

a. Standardized Infection Ratio.

3. Procedure-associated HAI Infections:

a. Standardized Infection Ratio.

II. Environment

A. PLCMMCT HAS DEVELOPED SPECIFIC POLICIES AND PROCEDURES TO ADDRESS THE HOSPITAL ENVIRONMENT, INCLUDING:

1. Ventilation, temperature, humidification, and water control issues, including measures taken to maintain a safe environment during internal or external construction or renovation.

a. Performing Infection Control Risk Assessments (ICRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment. [CMS 482.42]

b. ICRAs are to be approved by an Infection Preventionist and Plant Operations and Maintenance personnel with input from unit/department managers as appropriate.

c. Rounds of the construction/renovation site are conducted to evaluate compliance with ICRA requirements. The IPB committee and Infection Preventionists have the authority to stop any project that is out of compliance with the requirements.

d. Prior to beginning any construction or renovation, the Infection Prevention department reviews the final design.

2. Maintaining safe air handling systems in areas of special ventilation such as operating rooms and airborne isolation rooms (see Plant Operations Policies).

3. Techniques for safely cleaning and disinfecting the environment.

4. Textile reprocessing, storage, and distribution.

5. Sterile processing and evaluation of failures.

6. Storage and disposal of regulated and non-regulated waste.

7. Pest or vector control.

III. Caregiver Health

The Caregiver Health program reduces the risk of disease transmission among healthcare workers, Licensed Independent Practitioners (LIPs), contract workers, students, and volunteers. [H&SC 1288.7; IC.02.03.01, CMS 482.24(a) (1)]

A. The caregiver health program includes processes for health screening, childhood illness/ immunization, tuberculosis screening, immunization for hepatitis B and influenza, and evaluation and assessment of post-exposure follow-up.

B. The IPB Committee reviews and approves all policies and procedures developed in the

caregiver health program that relate to the transmission of infections in the hospital. The Blood-borne Pathogen Exposure Control Plan and the Aerosol Transmissible Disease Exposure Control Plan are both reviewed annually.

C. At the time of initial employment, all caregivers have a baseline health screening, which includes the following:

1. Medical history, including immunization status, and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases.
2. Tuberculosis screening.
3. Screening for vaccine-preventable diseases.

D. Caregivers are offered appropriate immunizations for communicable diseases based on regulatory requirements and the California Occupational Safety and Health Administration (Cal/OSHA), or Advisory Committee on Immunization Practices (ACIP) recommendations for healthcare workers.

E. The Influenza Vaccine Program for caregivers is provided on-site without charge. If a caregiver declines the vaccination, a declination statement is obtained to gather information regarding areas of improvement within the vaccine program. Influenza vaccination rates are calculated using the CDC and National Quality Foundation (NQF) performance measure evaluation criteria. Physicians, LIPs, and volunteers are included in the influenza vaccination program, and their compliance is reviewed.

F. The caregiver health program has policies and procedures for the evaluation and/or referral of ill caregivers, including assessment of disease communicability, indications for work restrictions, and management of caregivers, LIPs, students and volunteers who have been exposed to infectious diseases, to include post-exposure prophylaxis and work restrictions.

G. The caregiver health program tracks immunizations and tuberculosis screening.

H. Infection Prevention personnel are freely available to the caregiver health program for consultation regarding exposures or infectious disease concerns.

IV. Mitigation of Infection Risks

The ministry has developed specific policies and procedures that address the following:

A. PATIENTS WITH INFECTIONS PRESENT ON ADMISSION:

1. Measures are in place for early identification of patients who require isolation, per CDC guidelines.
2. Respiratory hygiene and cough etiquette are encouraged for everyone, beginning at the entrances to the hospital and outpatient settings. Caregivers are urged to discourage ill family members from visiting.
3. Appropriate personal protective equipment is available for all healthcare workers and visitors.

B. INVASIVE PROCEDURES OR DEVICE-RELATED RISKS FOR INFECTION:

1. Surgery-related infection policies related to antibiotic prophylaxis, surgical prep, aseptic practices, and sterilization of instruments.
2. Central line policies dictating insertion, care, and maintenance of a central line in addition to the use of bundles for prevention and the removal of unnecessary lines.

3. Ventilator policies encouraging the use of bundles for infection prevention.
4. Urinary catheter policies establishing insertion, care, and maintenance of indwelling catheters, removal of unnecessary lines, and the use of prevention bundles.

C. OTHER HOSPITAL INFECTION RISK MITIGATION MEASURES INCLUDE:

1. Promotion of hand hygiene among staff, caregivers, and visitors.
2. Protocols to prevent infections caused by resistant organisms.
3. Isolation precautions.
4. Use of disinfectants, antiseptic agents, and germicides according to manufacturers' instructions.
5. Appropriate use of medical equipment, portable air filtration equipment, and treatment booths.

V. Intervening Directly to Prevent Transmission of Infectious Diseases

A. Infection Prevention personnel review microbiology and laboratory results in addition to line lists to identify unusual clusters or higher incidences of certain microorganisms.

B. Baseline surveillance data (historic trends) are used to determine if an outbreak is occurring. When an outbreak occurs, the Infection Prevention team seeks resources and authority to ensure a comprehensive and timely investigation in conjunction with implementation of appropriate control measures.

VI. Education and Training of Caregivers [IC.02.01.01]

A. Infection Prevention educational support is available to caregivers, LIPs, contract workers, students, and volunteers upon hire and annually through ongoing educational opportunities.

B. Infection Preventionists, with knowledge of epidemiology and infectious diseases, actively participate in the planning and implementation of educational programs.

C. Educational programs are evaluated periodically for effectiveness with attendance records kept by individual departments. Infection Prevention maintains records for department specific presentations. Unit Managers document ongoing in-services provided for their caregivers.

D. The goal of the educational programs is to meet the department/group needs and to provide learning opportunities for staff, tailoring them to a wide range of educational backgrounds and work responsibilities.

E. Education and in-service recommendations specifically designed for physicians are organized through the Medical Staff Office Continuing Medical Education representative.

F. The Infection Prevention personnel serve as consultants to staff, physicians, LIPs, patients, families, volunteers, students, and visitors regarding risks and risk reduction measures associated with disease transmission and benefits of control measures.

G. Infection Prevention provides informal education and serves as a consultant to the staff during environmental rounds.

H. The Infection Preventionists participate in new caregiver orientation and annual updates by developing, reviewing, and selecting appropriate materials.

I. Department-specific in-services are prepared and presented by the Infection Prevention team.

J. Infection Prevention continually performs just-in-time education during rounds and in

response to inquiry.

VII. Education of Patients [NPSG.07.04.01 – 07.06.01]

A. Infection Preventionists provide educational and informational materials to support patient education on Infection Prevention topics.

B. The hospital provides patients with information regarding Infection Prevention measures for CDC hand hygiene practices, respiratory hygiene practices, and contact precautions, according to the patient's condition.

C. Surgical patients are provided education by the caregivers on measures to be taken to prevent surgical infections.

D. Patients who require a central line are provided education by the caregivers on how to prevent central line-associated bloodstream infections.

E. Patients who require a urinary catheter are provided education by the caregivers on how to prevent catheter-associated urinary tract infections.

F. Patients identified with multi-drug resistant organisms or C. diff are provided instructions regarding precautions to prevent the spread of the infection to others by their caregivers. [Health & Safety Code Sections 1255.8 & 1288.55].

VIII. Reporting Systems

A. INFECTION CLASSIFICATION AND ANALYSIS:

1. A database of HAIs is maintained as part of Infection Prevention surveillance.
2. An intensive review is performed when appropriate. HAIs that could possibly qualify as sentinel events are reported to Risk Management and to the Quality Department.
3. A list of caregiver exposures and sharps injuries is maintained by the Caregiver Health office and reviewed periodically by Infection Prevention.

B. PUBLIC HEALTH REPORTING:

1. Disease cases are reported as required to CDPH as well as unusual events or clusters. The Infection Prevention department maintains an Infection Line List in which significant infections are recorded. [CMS 482.42(a)(2)] [CCR Title 17].
2. Reports of suspected or known tuberculosis patients are made to LA TB Control. Infection Prevention personnel maintain contact with the case management department to support required approval of the patient's discharge plan.
3. Reports of infection-related unusual events are made to LACDPH as appropriate in conjunction with hospital leadership.
4. The occurrence of communicable diseases among patients is reviewed with the IPB Committee quarterly.
5. Mandated reporting on select HAIs is performed via NHSN in compliance with state and federal directives.
6. In conjunction with Risk Management, the Infection Prevention Department complies with Food and Drug Association (FDA) requirements to report communicable diseases associated with human cells, tissues, and cellular and tissue-based products (HCT/Ps). (Based on FDA 21 CFR Part 1271).

IX. **Emergency Management (IC.01.06.01)**

As part of emergency management activities, PLCMMCT/TCC/HH is prepared to respond to an influx, or the risk of an influx, of potentially infectious patients.

A. **THE ORGANIZATION PLAN FOR A POTENTIAL SURGE UTILIZES THE FOLLOWING PROCEDURES:**

1. **Emergency Management Plan.**
2. **Communicable Diseases: Influx of Infectious Patients.**
3. **Outbreak Investigation.**
4. **Isolation Policies.**
5. **Hospital's Plan for Provision of Care.**
6. **Pandemic Influenza and Seasonal Influenza.**
7. **Bioterrorism Agents Exposure Control Plan.**

B. **THE ORGANIZATION UTILIZES EXTERNAL RESOURCES TO PREPARE FOR DISASTER:**

1. **Infection Prevention personnel remain current with information about the emergence of epidemics or new infections through California Health Alert Network (CAHAN), CDPH alerts, CDC and APIC alerts, and email and fax alerts from the Local Health Officer.**
2. **Infection Preventionists disseminate critical information to staff and other key practitioners verbally as well as through hospital intranet, email, flyers, and alternative methods of communication such as hand-held radios.**
3. **The facility participates in the local public health's "Redinett" system; staff review email alerts on issues identified in Los Angeles County area Emergency Departments.**
4. **The facility participates in state and local disaster drills.**

X. **Transitional Care Unit**

A. **The TCC has 115 licensed beds and offers transitional care for patients after leaving the hospital, skilled nursing facility, or other healthcare facilities. Patients come from different facilities around the South Bay, including PLCMMCT and Torrance Memorial.**

B. **TCC has its own executive leadership team, and also receives support from the Executive Leadership Team from the main acute care hospital. The manager of Infection Prevention oversees Infection Prevention activities at TCC.**

C. **Infection Prevention uses NHSN and McGeer definitions when performing surveillance and identifying HAIs. The Infection Preventionist at TCC uses Theradoc, Epic, and other resources when performing this surveillance. Infections are tracked and are reported quarterly at the IPB meetings.**

D. **Education is provided to patients and family members in isolation by the Infection Preventionist and staff. Caregivers are regularly in-serviced on Infection Prevention topics, including isolation precautions, hand hygiene, and prevention of HAIs.**

XI. **Home Health**

A. The Home Health (HH) department serves patients in the South Bay, Long Beach, and Southern Los Angeles. Onboarding and annual education is provided to all staff members reinforcing infection prevention strategies, including but not limited to:

1. Establishing and maintaining a clean field.
2. Appropriate hand hygiene.
3. Donning and doffing personal protective equipment (PPE) and isolation precautions.
4. Invasive device management.
5. Preventing exposure to blood and body fluids.
6. Safe injection practices.

B. Clinical staff is the first line of defense in surveillance, control and infection prevention. Infection Prevention assists in identifying infections, while ~~case management~~Case Management alerts HH staff to particular drug-resistant organisms. Surveillance is especially focused on central lines, urinary catheters, surgical and/or nonsurgical wounds, donning and doffing PPE, and bag usage.

C. Infections are tracked and are reported ~~quarterly~~regularly at the IPB Committee meetings.

D. Please see the Home Health Infection Control and Prevention Plan for more detailed information.

~~Resources~~

~~A. REFERENCES:~~

1. ~~Association for Professionals in Infection Control and Epidemiology, Text of Infection Control and Epidemiology, 4th edition, 2014.~~
2. ~~California Department of Public Health (CDPH) AFL 09-07 and 13-03.~~
3. ~~CDC Guidelines as listed in document.~~
4. ~~Centers for Medicare and Medicaid Services (CMS) Conditions of Participation.~~
5. ~~FDA – 21 CFR Part 1271 (www.fda.gov/cber/tissue/docs.htm)~~
6. ~~Health & Safety Code Sections 1255.45 & 1288.95~~
7. ~~Health & Safety Code Sections 1255.8 & 1288.55~~
8. ~~Health & Safety Code Sections 1255.5 & 1288.9~~
9. ~~McGeer. Definitions of infection surveillance in long-term care facilities, 2012.~~

~~B. EVIDENCE-BASED GUIDELINE AND RECOMMENDATION ORGANIZATIONS~~

1. ~~Centers for Disease Control and Prevention (CDC)~~
2. ~~Association for Professionals in Infection Control and Epidemiology (APIC)~~
3. ~~Society for Healthcare Epidemiology of America (SHEA)~~
4. ~~The Joint Commission (TJC)~~
5. ~~Occupational Safety and Health Administration (OSHA)~~
6. ~~Association of Perioperative Registered Nurses (AORN)~~
7. ~~California Department of Public Health (CDPH)~~
8. ~~Los Angeles County Department of Health Services (LACDHS)~~
9. ~~Center for Medicare/Medical Services (CMS)~~

~~Comprehensive Infection Prevention Surveillance Plan~~

I. Resources

A. REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology, Text of Infection Control and Epidemiology, 4th edition, 2014.
2. California Department of Public Health (CDPH) AFL 09-07 and 13-03.
3. CDC Guidelines as listed in document.
4. Centers for Medicare and Medicaid Services (CMS) Conditions of Participation.
5. FDA – 21 CFR Part 1271 (www.fda.gov/cber/tissue/docs.htm)
6. Health & Safety Code Sections 1255.45 & 1288.95
7. Health & Safety Code Sections 1255.8 & 1288.55
8. Health & Safety Code Sections 1255.5 & 1288.9

9. McGeer. Definitions of infection surveillance in long-term care facilities, 2012.

B. EVIDENCE-BASED GUIDELINE AND RECOMMENDATION ORGANIZATIONS

1. Centers for Disease Control and Prevention (CDC)
2. Association for Professionals in Infection Control and Epidemiology (APIC)
3. Society for Healthcare Epidemiology of America (SHEA)
4. The Joint Commission (TJC)
5. Occupational Safety and Health Administration (OSHA)
6. Association of Perioperative Registered Nurses (AORN)
7. California Department of Public Health (CDPH)
8. Los Angeles County Department of Health (LACDH)
9. Center for Medicare/Medical Services (CMS)

II. Comprehensive Infection Prevention Surveillance Plan

Surveillance Description	Regulatory Agency / Rational	Monitoring and Evaluation
~~EPIDEMIOLOGICAL SIGNIFICANT ORGANISMS~~ EPIDEMIOLOGICAL SIGNIFICANT ORGANISMS	~~Monitor Multi-Drug Resistant Organism (MDRO) NPSG 07.03.01, Health & Safety Code Sections 1288. & 1288.95~~ ~~CMS Conditions of Participation 482.42~~ ~~Risk for transmission among patients, employees, and visitors.~~ Monitor Multi-Drug Resistant Organism (MDRO) NPSG 07.03.01, Health & Safety Code Sections 1288. & 1288.95 CMS Conditions of Participation 482.42 Risk for transmission among patients, caregivers, and visitors	~~Continuous review of all positive cultures is performed by Infection Prevention Department. Surveillance for Healthcare Associated Infections (HAIs), significant organisms, and diseases is shared with hospital leadership and key stakeholders for review.~~ ~~Reported quarterly to Infection Prevention Committee.~~ Continuous review of all positive cultures is performed by Infection Prevention Department. Surveillance for Healthcare Associated Infections (HAIs), significant organisms, and diseases is shared with hospital leadership and key stakeholders for review Reported quarterly to Infection Prevention Committee
Resistant Bacteria		
~~Methicillin-Resistant Staphylococcus Aureus (MRSA)~~ ~~Vancomycin-Resistant Enterococcus (VRE)~~ ~~Resistant Acinetobacter~~ ~~Extended-Spectrum Beta Lactamase (ESBL)~~	~~MRSA and VRE Bloodstream infections – Health and Safety Code sections 1288. & 1288.95.~~ ~~CDPH requires reporting to NHSN LabID method.~~ ~~Active Surveillance Cultures~~	~~Monitor for outbreaks or increase in incidence hospital-wide and/or specific units.~~ Monitor for outbreaks or increase in incidence hospital-wide and/or specific units Active Surveillance Cultures (ASC)

~~Resistant Gram Negatives Carbapenem Resistant Enterobacteriaceae (CRE)~~ Methicillin-Resistant Staphylococcus Aureus (MRSA) Vancomycin Resistant Enterococcus (VRE) Resistant Acinetobacter Extended Spectrum Beta Lactamase (ESBL) Resistant Gram Negatives Carbapenem-Resistant Enterobacteriaceae (CRE)	~~(ASC) for MRSA required per CDPH Health & Safety Code Sections 1288 & 1288.95.~~ ~~Risk of transmission to patients, employees, and visitors.~~ ~~All CRE events reported to LACDPH.~~ MRSA and VRE Bloodstream infections – Health and Safety Code sections 1288. & 1288.95 CDPH requires reporting to NHSN LabID method Active Surveillance Cultures (ASC) for MRSA required per CDPH Health & Safety Code Sections 1288 & 1288.95 All CRE events reported to LACDPH and NHSN Risk of transmission to patients, caregivers, and visitors	for MRSA: • ICU admissions • Readmissions within 30 days • SNF admissions • Dialysis patients • Any patient with a previous history of MRSA Since April 2015, weekly ASCs performed for ERCP and EUS scopes and reported to System office~~.~~ Case-by-case evaluation for HAI ~~Case-by-case evaluation for HAI.~~
Vancomycin Intermediate-Resistant Staph Aureus (VISA) Vancomycin Resistant Staph Aureus	Reportable to LACDPH~~.~~ Risk of transmission to patients, ~~employees~~caregivers, and visitors~~.~~	Monitor microbiology cultures to detect emergence of these pathogens~~.~~
Unusual ~~or~~Or Significant Organisms		
Aspergillus, Legionella, Listeria	~~Reported clusters/outbreaks to LAC DPH.~~ ~~Risk of transmission to patients, employees, and visitors.~~ Reported clusters/outbreaks to LAC DPH Risk of transmission to patients, caregivers, and visitors	Monitor for outbreaks or increase in incidence within community or as a hospital -acquired pathogen. Case-by-case evaluation for HAI~~.~~
~~MRSA, VRE, and CRE LabID Events~~ ~~MRSA bloodstream central line infections~~ ~~VRE bloodstream central line infections~~	~~Use LabID method to enter into NHSN.~~ ~~Report to CDPH and CMS.~~ ~~Risk for poor patient outcome.~~ Use LabID method to enter into NHSN	Ongoing monitoring of cultures for MRSA and VRE in the blood. Case-by-case evaluation for HAI~~.~~

MRSA, VRE, and CRE LabID Events MRSA bloodstream central line infections VRE bloodstream central line infections	Report to CDPH and CMS Risk for poor patient outcome	
~~Clostridiodes~~Clostridioides difficile infection: LabID events are entered in NHSN and analysis reports are pulled and reviewed ~~(# of infections per 10,000 patient days for HAI and SIR)~~	~~Health and Safety Code sections 1288. & 1288.95 CDPH and CMS requires reporting to NHSN using NHSN LabID method~~ ~~Risk for transmission to patients, employees, and visitors.~~ Health and Safety Code sections 1288. & 1288.95 CDPH and CMS requires reporting to NHSN using NHSN LabID method Risk for transmission to patients, caregivers, and visitors.	~~All positive, non-duplicate positive C. difficile lab results are entered into NHSN. The NHSN algorithm determines community versus hospital onset.~~ ~~Monitor the number and SIR of hospital onset.~~ ~~All hospital onset cases reviewed at interdisciplinary drilldowns.~~ All positive, non-duplicate positive C. difficile lab results are entered into NHSN. The NHSN algorithm determines community versus hospital onset. Monitor the number and SIR of hospital onset. All hospital onset cases reviewed at interdisciplinary drilldowns.
Emerging Pathogens: • Measles • Pertussis • Ebola • MERS • Zika Virus • MCR-1 • Candida auris	~~Report cases to LAC DPH.~~ ~~Risk of transmission to patients, employees, and visitors.~~ Report cases to LAC DPH. Risk of transmission to patients, caregivers, and visitors.	~~Monitor for cases.~~ ~~No Ebola or MERS cases in 2018.~~ Monitor for cases.
Special Investigations		
All ~~healthcare associated Respiratory Syncytial Virus (RSV), rotavirus, Tuberculosis (TB), vaccine preventable~~epidemiologically important infections ~~and other epidemiologically important infections~~ are investigated~~.~~	~~CDPH requires reporting of diseases to LAC DPH.~~ ~~Prevent transmission of infections among patients, LIPS, and staff.~~ CDPH requires reporting of diseases to LAC DPH Prevent transmission of infections among patients, LIPS, and staff	~~Cases-by-case evaluation.~~ ~~Reported to Public Health as applicable.~~ Cases-by-case evaluation Reported to Public Health as applicable
Outbreaks of infectious diseases~~.~~	The Joint Commission (TJC) IC.02.01.01	Once a cluster or outbreak is identified, it is confirmed with

		Infectious Disease Physician and/or LACDPH.
Reportable Disease Surveillance		
List of reportable diseases is posted on LAC DPH website and in the Infection Prevention Manual.	California Code No 17 and CDPH Reportable diseases and pathogens are sent to local health department LACDPH.	Monitor admissions and ED visits for trends or community -onset infection or diseases.
HEALTHCARE ASSOCIATED INFECTIONS SURVEILLANCE (HAI) **HEALTHCARE ASSOCIATED INFECTIONS SURVEILLANCE (HAI)**	Joint Commission IC.02.01.01 CMS Conditions of Participation 482.42 Joint Commission IC.02.01.01 CMS Conditions of Participation 482.42	Ongoing review of all positive cultures is performed by Infection Prevention Department for surveillance forof HAIs, which are then provided to seniorexecutive leadership, individual unit managers, and quarterly to the Infection Prevention/Blood Committee.
Central Line Associated Blood Stream Infection (CLABSI)		
CLABSI surveillance is ministry wide. Data analysis reports are pulled from NHSN (SIR, CLABSI rate/1000 CL days, CL utilization ratio) Standardized Utilization Ratio (SUR) is collected for central lines. Standardized Utilization Ratio (SUR) with Central Line Insertion Practice (CLIP) data is entered in NHSN for CDPH (process measure). CLABSI surveillance is ministry-wide. Data analysis reports are pulled from NHSN. Standardized Utilization Ratio (SUR) is collected for central lines. SUR with Central Line Insertion Practice (CLIP) data is entered in NHSN for CDPH (process measure).	NPSG 07.04.01 CLABSI Health and Safety Code sections 1288 & 1288.95 CLIP forms required for all ICU's including adult, pediatric, and NICU device-related infection risk. High potential for adverse outcomes. NPSG 07.04.01 CLABSI Health and Safety Code sections 1288 & 1288.95 CLIP forms required for central line insertions High potential for adverse outcomes	Benchmarks are from NHSN, CMS, and Providence Health System. Tracking and trending is done ministry-wide. Every CLABSI is reported to the corresponding unit and investigated. Benchmarks are from NHSN, CMS, and Providence Health System. Tracking and trending is done ministry-wide Every CLABSI is reported to the corresponding unit and investigated.
Ventilator Associated Event (VAE)		

~~VAE surveillance in critical care units.~~ ~~Ventilator Associated Pneumonia data is monitored in ICU and NICU.~~ ~~Standardized Utilization Ratio is collected based on ventilator days.~~ VAE surveillance in critical care units. Ventilator Associated Pneumonia data is monitored in ICU and NICU	~~High potential for adverse patient outcomes.~~ ~~Device related infection risk.~~ High potential for adverse patient outcomes. Device related infection risk	~~No CDC benchmark for VAE comparison for adult ICUs.~~ ~~CDC Benchmark Pooled Mean used for ICU and NICU.~~ No CDC benchmark for VAE comparison for adult ICUs CDC Benchmark Pooled Mean used for ICU and NICU
Catheter Associated Urinary Tract Infections (CAUTI)		
~~CAUTI surveillance is ministry-wide.~~ ~~Infections that meet the CDC surveillance definition are entered into NHSN.~~ CAUTI surveillance is ministry-wide Infections that meet the CDC surveillance definition are entered into NHSN	~~NPSG 07.04.01 – 07.06.01~~ ~~Health and Safety Code sections 1288 & 1288.95~~ ~~Device-related infection risk.~~ NPSG 07.04.01 – 07.06.01 Health and Safety Code sections 1288 & 1288.95 Device-related infection risk	~~Benchmarks are from NHSN, CMS, and Providence Health System.~~ ~~Tracking and trending is done ministry-wide.~~ ~~Any HAI CAUTI is reported to the corresponding unit and investigated at multidisciplinary drilldowns.~~ Benchmarks are from NHSN, CMS, and Providence Health System. Tracking and trending is done ministry-wide Every CAUTI is reported to the corresponding unit and investigated at multidisciplinary drilldowns
Surgical Site Infections (SSI) HAI		
~~SSI surveillance is hospital-wide.~~ ~~All SSIs are reviewed and documented for trending.~~ ~~Procedures mandated for reporting by CDPH are tracked and SSI data is entered in NHSN.~~ ~~Denominator data and events are entered into NHSN.~~ ~~SSI is linked to the date of surgery in NHSN.~~ SSI surveillance is hospital-wide All SSIs are reviewed and documented for trending Procedures mandated for	~~NPSG 07.05.01 SSI~~ ~~CDPH requires denominator data on 29 surgical populations or procedure codes.~~ ~~CDPH requires deep and organ space surgical site infections to be reported to the state using NHSN.~~ ~~Superficial surgical site infections are collected and reported internally.~~ ~~EPIC report is used to collect surgical information.~~ ~~High potential for adverse~~	~~SSIs are found by reviewing readmissions, wound cultures, notification from another hospital, notification from a unit, and EPIC surgery readmission/repeat surgeries report.~~ ~~NHSN SIR is utilized and trended over time.~~ ~~All SSIs are reported to the corresponding medical staff committee and at multidisciplinary drilldowns.~~ ~~All SSIs are reviewed to determine if there are clusters of infections related to surgeon, service,~~

reporting by CDPH are tracked and SSI data is entered in NHSN Denominator data and events are entered into NHSN SSI is linked to the date of surgery in NHSN	~~patient outcome.~~ NPSG 07.05.01 SSI CDPH requires denominator data on 29 surgical populations or procedure codes CDPH requires deep and organ space surgical site infections to be reported to the state using NHSN Superficial surgical site infections are collected and reported internally EPIC report is used to collect surgical information High potential for adverse patient outcome	~~pathogens, product etc.~~ SSIs are found by reviewing readmissions, wound cultures, notification from another hospital, notification from a unit, and EPIC surgery readmission/repeat surgeries report NHSN SIR is utilized and trended over time All SSIs are reported to the corresponding medical staff committee and at multidisciplinary drilldowns All SSIs are reviewed to determine if there are clusters of infections related to surgeon, service, pathogens, product etc.
Sentinel Event Surveillance		
Sentinel Event Surveillance	The Joint Commission (TJC) defines a sentinel event as a patient safety event that reaches a patient and results in death, permanent harm, or severe temporary harm, and intervention is required to sustain life~~.~~	~~Ongoing surveillance for any possible HAI-related sentinel events. HAI related deaths identified by Patient Safety Program Manager South Bay and reviewed at Weekly Mortality Review Committee. Refer identified cases to Risk Management.~~ Ongoing surveillance for any possible HAI-related sentinel events. HAI related deaths are identified by Patient Safety Program Manager South Bay Refer identified cases to Risk Management
~~**ENVIRONMENTAL MONITORING**~~ **ENVIRONMENTAL MONITORING**	~~The Joint Commission (TJC) IC.02.02.01 Minimize the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices.~~ The Joint Commission (TJC) IC.02.02.01 Minimize the risk of transmitting infections associated with the use of procedures, medical	~~Verify compliance with Infection Prevention program via Just-in-Time education performed when deficiencies identified. Reports quarterly to Infection Prevention/Blood Committee.~~ Verify compliance with Infection Prevention program via just-in-time education performed when deficiencies identified Reports regularly to Infection Prevention/Blood Committee

	equipment, and medical devices	
~~Hand Hygiene and personal protective equipment surveillance. Rates are reported as # of yes divided by number of opportunities.~~ Hand Hygiene and personal protective equipment surveillance Rates are reported as # of yes divided by number of opportunities.	~~NPSG 7.01.01 The Joint Commission (TJC) IC.01.04.01 Improve compliance with Hand Hygiene: Goal is 95%. Limit unprotected exposure to pathogens throughout the hospital.~~ NPSG 7.01.01 The Joint Commission (TJC) IC.01.04.01 Improve compliance with Hand Hygiene: Goal is 95%. Limit unprotected exposure to pathogens throughout the hospital	Monthly audits are performed and tracked ministry-wide~~.~~
Isolation Practices: Infection Prevention conducts isolation rounds~~.~~	Minimize risk to caregivers and visitors for acquiring an HAI or pathogen~~.~~	Confirm patients are in correct precautions~~.~~ Just-in-~~Time~~time education performed when isolation sign is not correct, or if non-compliance with personal protective equipment (PPE) is observed~~.~~
Environmental Cleaning: ATP and/or Fluorescent Environmental Testing	Minimize risk of transmitting infection with use of medical equipment, devices, and supplies~~.~~	~~ATP/Fluorescent testing to high-touch surfaces by EVS. Report submitted quarterly to IPB Committee.~~ ATP/Fluorescent testing to high-touch surfaces by EVS Report submitted regularly to IPB Committee
Environment of Care Rounds	Minimize risk of transmitting infection with use of medical equipment, devices, and supplies~~.~~	Performed on clinical units, at a minimum, every 6 months/non-clinical units annually. Managers receive list of deficiencies~~.~~
Environment of Care Rounds: Dietary	~~Compliance with Food and Safety Code 2009. Monitoring of food preparation for safe handling of food.~~ Compliance with Food and Safety Code 2009 Monitoring of food preparation for safe handling of food	~~Compliance audit performed routinely by Infection Prevention and/or Clinical Dietician and Dietary Leadership; physical inspection rounds using the Food Safety and Sanitation Audit Tool. Education on Infection Prevention topics as needed.~~ Compliance audit performed

		routinely by Infection Prevention and/or Clinical Dietician and Dietary Leadership; physical inspection rounds using the Food Safety and Sanitation Audit Tool Education on Infection Prevention topics as needed
Environment of Care Rounds: OR	Minimize risk of transmitting infection with use of medical equipment, devices, and supplies~~.~~	Physical inspection performed routinely by Infection Prevention and/or OR Leadership~~.~~
Construction Rounds for compliance with Infection Control Risk Assessment (ICRA)	Reduce infection risks related to construction~~.~~	Ongoing monitoring, reported to Infection Prevention/Blood Committee~~.~~
Ice Machines Cleaning and Disinfecting	Reduce infection risks related to equipment~~.~~	~~Performed per manufacturers' recommendations by Facilities and presented to Infection Prevention. Plant operations maintain documentation.~~ Performed per manufacturers' recommendations by Facilities and presented to Infection Prevention Plant operations maintain documentation
Renal Dialysis Water Surveillance	Minimize risk with use of equipment, devices, and supplies~~.~~	Bacteriological water surveys collected monthly by ~~Renal Dialysis (~~DaVita~~);~~ and reported to Infection Prevention/ Blood Committee ~~quarterly.~~
Monitor Air Pressure in isolation when airborne isolation room is occupied by a patient with known or suspect airborne disease~~.~~	~~Limit unprotected exposure to pathogens throughout the hospital.~~ ~~ATD Standards / Cal-OSHA~~ Limit unprotected exposure to pathogens throughout the hospital ATD Standards / Cal-OSHA	Nursing submits Plant Operations work order to conduct visible check daily while patient is in Airborne Isolation.
~~**ANTIMICROBIAL STEWARDSHIP**~~ **ANTIMICROBIAL STEWARDSHIP**	CDPH AFL 14-36 December 2014	Real-time-ID Physician reviews antibiotic usage daily with Pharmacy~~.~~ Reported ~~quarterly~~ to Infection Prevention/Blood Committee and Antimicrobial Stewardship Program committee~~.~~
Antibiogram	~~Antimicrobial Stewardship. Provide physician with~~	Microbiology and pharmacy create antibiogram ~~yearly. Ongoing~~

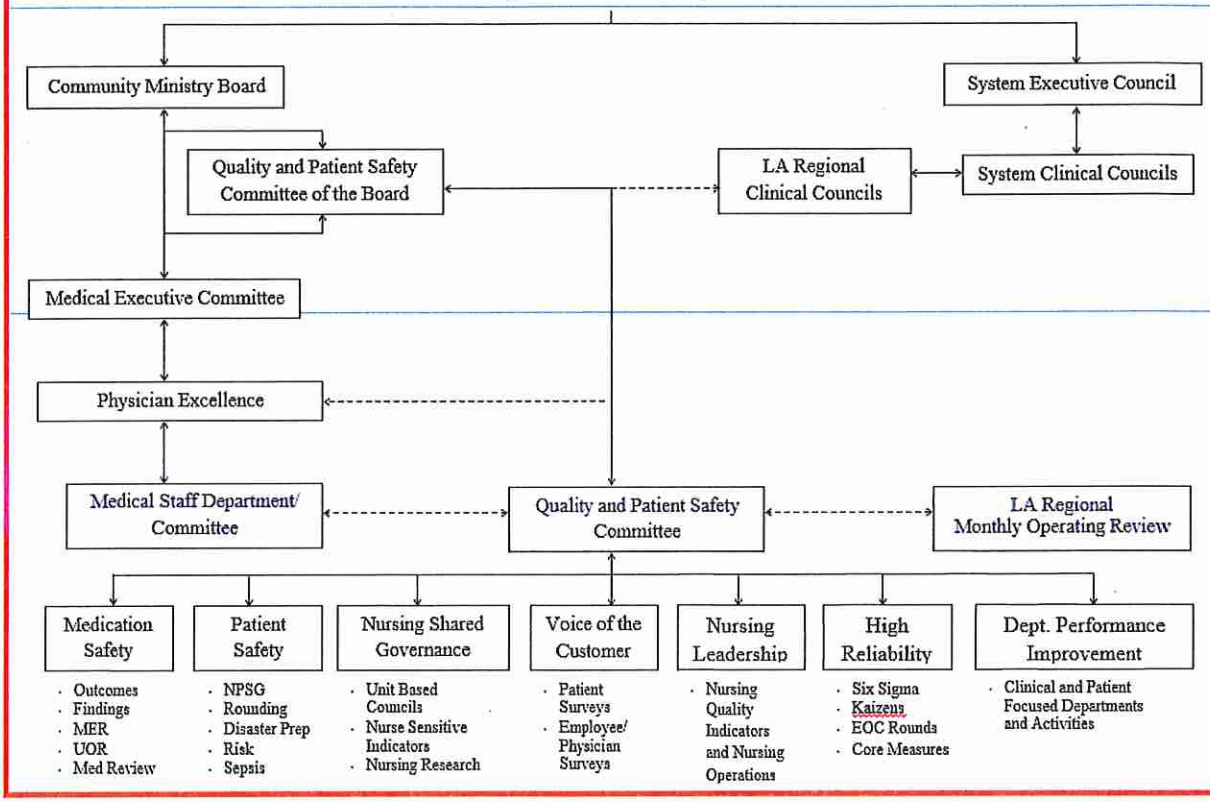
	~~susceptibility data using micro/pharmacy report.~~ Antimicrobial Stewardship Provide physician with susceptibility data using micro/pharmacy report	~~monitoring by Microbiology Supervisor; report semi-~~annually. Ongoing monitoring by Microbiology Supervisor
~~**STERILITY ASSURANCE MONITORING AND HIGH LEVEL DISINFECTION**~~ **STERILITY ASSURANCE MONITORING AND HIGH LEVEL DISINFECTION**	~~Reduce risk of infection related to medical devices. Minimize, reduce and eliminate risk of infection.~~ Reduce risk of infection related to medical devices Minimize, reduce and eliminate risk of infection	Ongoing monitoring. Reported ~~quarterly~~ to Infection Prevention/ Blood Committee~~.~~
~~Immediate Use Steam Sterilization (IUSS)~~ ~~▲ 100% of all sterilized loads (Immediate-use and unwrapped loads)~~ ~~▲ Biological Monitoring~~ ~~▲ Premature release of implantable~~ Immediate Use Steam Sterilization (IUSS) Biological Monitoring on 100% of all sterilized loads (Immediate-use and unwrapped loads) Premature release of implantable	The Joint Commission IC.02.02.01	~~Ongoing monitoring. Immediate-use or unwrapped load percentages reported to Infection Prevention/ Blood Committee. Documentation is kept for positive biological, recalls, breaks in quarantine and number of immediate-use or un-wrapped loads.~~ Ongoing monitoring. Immediate-use or unwrapped load percentages reported to Infection Prevention/ Blood Committee Documentation is kept for positive biological, recalls, breaks in quarantine and number of immediate-use or un-wrapped loads
ERCP and EUS Scopes monitoring~~.~~	Providence Health System (PHS)~~.~~	Effective April 2015 all scopes cultures daily for 30 days then moved to weekly cultures pending recommendation from PHS~~.~~ In 2018, ATP testing was implemented for all scopes and results are reported out at the IPB meeting

~~CAREGIVER HEALTH~~ CAREGIVER HEALTH	Prevent transmission of infections among patients, IPS and staff~~.~~ CDC and Division of Occupational Safety and Health (Cal OSHA)~~.~~	Data collected by Caregiver Health and reviewed by Infection Prevention~~.~~
Exposures, Blood-borne		All Blood-borne pathogen exposures investigated and reported on OSHA log~~.~~
Exposures, communicable diseases		All reported communicable disease exposures investigated for prophylaxis and follow-up~~.~~
Influenza vaccination screening	Health & Safety Code Sections 1288.5-1288.9 requires all healthcare providers to wear a mask if they decline flu vaccination~~.~~	~~Reported to CDPH via NHSN. Reported to Infection Prevention/ Blood Committee yearly.~~ Reported to CDPH via NHSN Reported to Infection Prevention/ Blood Committee
~~Employee~~Caregiver screening for TB and conversions	CDPH	Ongoing evaluation by Caregiver Health and Infection Prevention. Reported to Infection Prevention and Blood Committee~~.~~

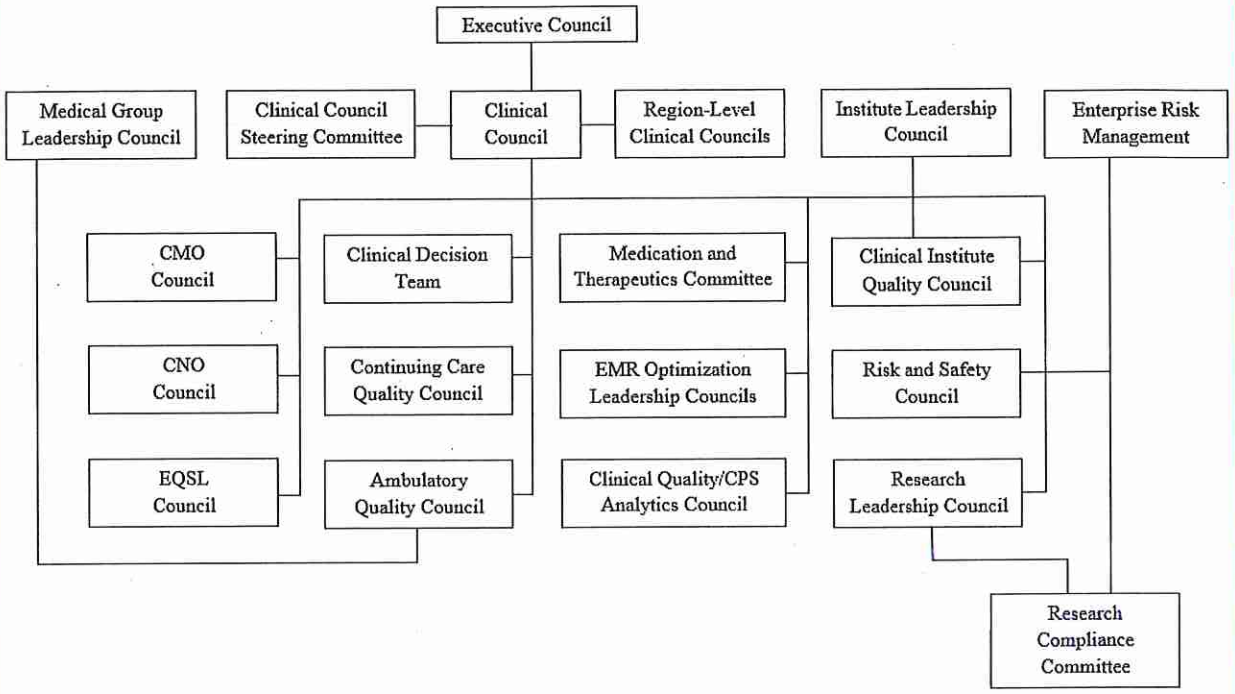
~~Organizational Flowcharts~~

XVI. Organizational Flowcharts

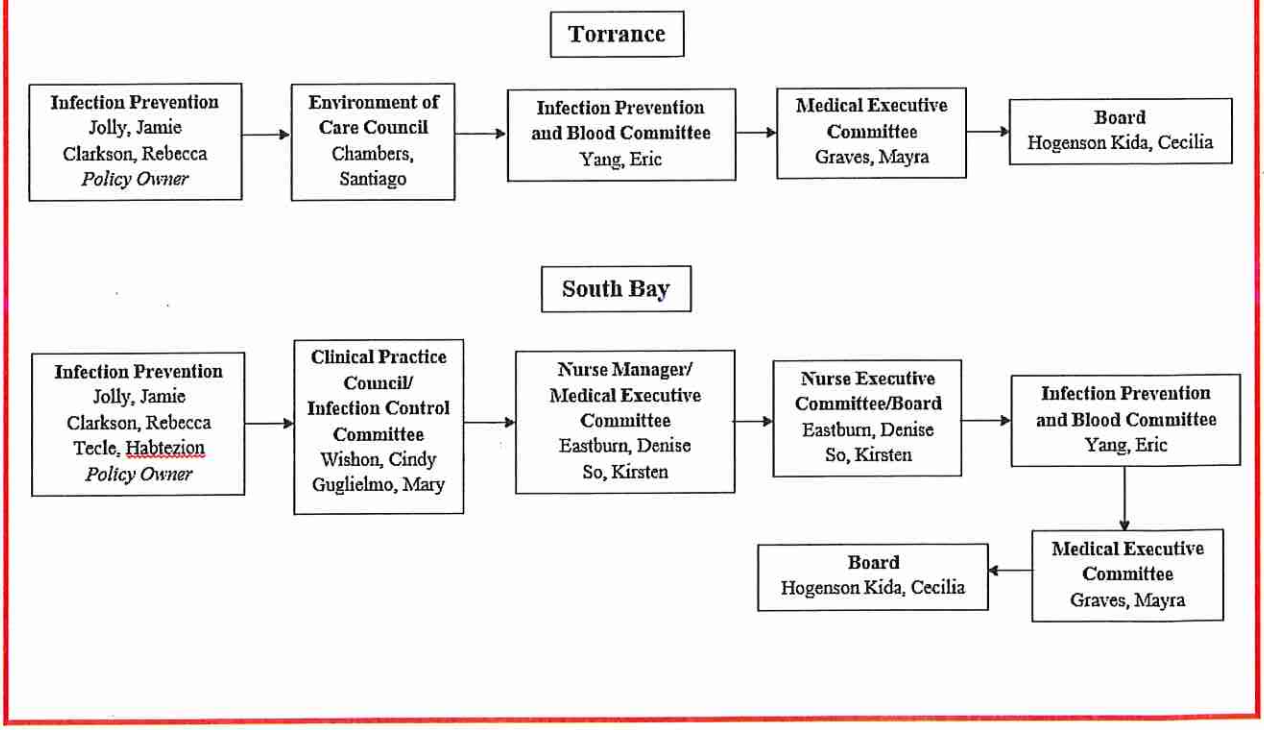
Authority – Accountability – Structure

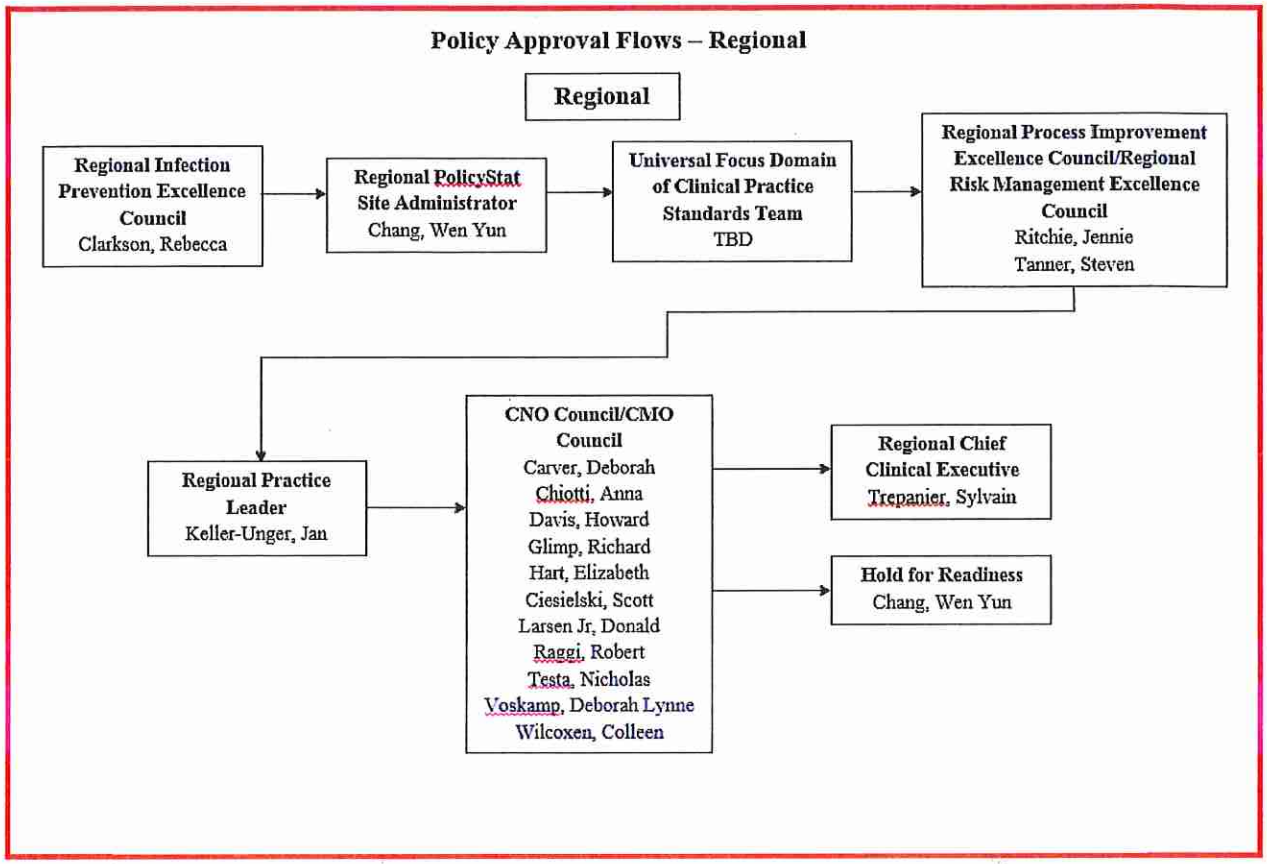


Providence St. Joseph's Health System-Level Clinical Governance Model



Policy Approval Flows – Local





Attachments

2020 Infection Prevention Risk Assessment Torrance.docx

Approval Signatures

Step Description	Approver	Date
Med Staff - Infection Prevention	Mayra Graves: Coord Medical Staff	pending
CNO	Scott Ciesielski: Chief Nrsing Officer South Bay	07/2020
Policy Committee	Patti Hamaguchi: Dir Quality Mgmt So Bay	07/2020
Policy Committee	Jamie Jolly: Mgr Infection Preventn Svcs Sb [RC]	06/2020

Applicability

CA - Providence LCM MC Torrance

Implementation:	*N/A*
Effective:	*Upon Approval*
Last Reviewed:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Jamie Jolly: Sr Mgr Infection Prevention*
Policy Area:	*Infection Prevention*
References:	
Applicability:	*CA - PH&S Little Company of Mary Service Area*

Pneumococcal Prevention and Control Plan

~~***Instructional guidance is listed in italics. Please delete italics upon submission.***~~

POLICY

In keeping with the mission and values of Providence, it is the policy of Providence Health ~~& Services, it is the policy of Providence Health~~ System-South Bay Service Area to adopt this clinical standard for use in the following*:

Providence Little Company of Mary Medical Center Torrance:	
X	Acute Care
X	Transitional Care Center
X	Providence Little Company of Mary Home Health
Providence Little Company of Mary Medical Center San Pedro:	
X	Acute Care
X	Sub-Acute Care Center
X	Psychiatric Unit
X	Acute Rehabilitation
X	Chemical Dependency Unit

* An X indicates that this location will be included in the policy.

PURPOSE

The purpose of this policy is to prevent pneumococcal disease and related complications in at-risk patients, specifically through appropriate vaccination.

BACKGROUND

Pneumococcal disease can cause a multitude of infections, such as meningitis, bloodstream infections,

pneumonia, and ear infections. Pneumococcal bacteria spread from person-to-person by direct contact with respiratory secretions, such as saliva or mucus. The pneumococcal vaccine protects against many types of pneumococcal infections (depending on the specific vaccine), and the Centers for Disease Control (CDC) recommends the vaccine for use in infants, young children, and adults 65 years or older.

PREVENTION AND CONTROL MEASURES

Strategies for the prevention and control of pneumococcal disease include appropriate screening and vaccination of all eligible patients. CDC recommends vaccination of patients age 65 years and older and in persons over that age of 2 years who are at high risk for pneumococcal disease due to underlying medical conditions. These medical conditions include:

A. Sickle cell disease
B. HIV infection
C. Immune-compromising infections
D. Diabetes
E. Chronic heart, liver, kidney, or lung disease
F. Alcoholism
G. Smoking

Vaccination

All patients age 65 years or older or at high risk for pneumococcal disease should receive the vaccination according to current national recommendations. Vaccination is the primary measure to prevent infection or development of illness from pneumococcal disease, thereby preventing complications.

A. Admitted patients are screened and vaccinated in accordance with current national and local recommendations.
    1. All inpatients age 65 years or older, or those patients with certain underlying medical conditions (*please see above*), ~~must~~will be screened for the pneumococcal vaccine. If the vaccine is not administered, the nurse should indicate the reason *(e.g., the patient received the vaccine elsewhere, the patient refused, etc.)*.
    2. Federal and state regulations authorize a registered nurse to administer the pneumococcal vaccine without a physician's order.

Infection Control Measures

In addition to pneumococcal vaccination, the following infection control measures are recommended to prevent person-to-person transmission:

A. Standard Precautions:
    1. During the care of any patient with symptoms of a respiratory infection, healthcare personnel should adhere to Standard Precautions. (*Refer to Standard Precautions and Transmission-based Isolation Precautions policy*)
B. Education:

1. Personnel will be educated about the signs and symptoms of pneumococcal disease, transmission and prevention strategies.

C. Respiratory Hygiene/Cough Etiquette:

1. Respiratory hygiene/cough etiquette will be initiated at the first point of contact with a potentially infected person to prevent the transmission of respiratory tract infections in all settings. Respiratory Hygiene/Cough Etiquette include:

   a. Posting visual alerts instructing patients and persons who accompany them to inform healthcare personnel if they have symptoms of respiratory infection.

   b. Providing tissues or masks to patients and visitors who are coughing or sneezing so that they can cover their nose and mouth.

   c. Ensuring that supplies for hand washing are available where sinks are located; providing dispensers of alcohol hand sanitizer in other locations.

   d. Providing space for coughing persons to sit at least three (3) feet away from others, if tolerated.

D. Restrictions for Ill Visitors and Ill Caregivers:

1. Discourage persons with symptoms of a respiratory infection from visiting patients. Post notices to inform the public about visitation restrictions.

REFERENCES

- CDC. Pneumococcal Vaccination. Last updated 12/14/2018. https://www.cdc.gov/pneumococcal/vaccination.html
- CDC. Pneumococcal Risk Factors and Transmission. Last updated 11/07/2017. https://www.cdc.gov/pneumococcal/about/risk-transmission.html
- CDC. Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Morb Mortal Wkly Rep 2015 / 63(34);944-947. DOI: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6434a4.htm

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Med Staff Comm - IP Blood	Mayra Graves: Coord Medical Staff	pending
Med Staff Comm - IP Blood	Mary Guglielmo: Medical Staff Services Manager	pending
EOC Committee	Jeremy Baker: Exec Dir Cln Qty/Risk/Sfty-sbc	08/2020
Policy Committee	Patti Hamaguchi: Dir Quality Mgmt So Bay	11/2019

Step Description	Approver	Date
Policy Committee	Jamie Jolly: Mgr Infection Preventn Svcs Sb [RC]	11/2019

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

Current Status: *Pending* **PolicyStat ID:** *8597246*

Implementation:	*09/2014*
Effective:	*Upon Approval*
Last Reviewed:	*N/A*
Last Revised:	*05/2017*
Next Review:	*3 years after approval*
Owner:	*Jamie Jolly: Sr Mgr Infection Prevention*
Policy Area:	*Infection Prevention*
References:	
Applicability:	*CA - PH&S Little Company of Mary Service Area*

Employee Food and Drink in Patient Care Areas

POLICY

In keeping with the mission and values of Providence Health & Services, in order to reduce the risk of disease transmission through bloodborne pathogen exposure, this policy serves to define the guidelines for food and drink in patient care areas.

DEFINITIONS

- OPIM - Other Potentially Infectious Materials
- OSHA - Occupational Safety and Health Administration

PROCEDURE / GENERAL INSTRUCTIONS

1. Adapted from the Exposure Control Plan Bloodborne Pathogens:
   A. The consumption of food and drink is prohibited in areas where the potential for exposure to blood or OPIM exists, or where there is potential for contamination of the work surface.
2. Drinks in Patient Care Areas
   A. As long as blood or OPIM is not present, drinks with lids may be allowed:
      i. In the business area of the nurse stations
      ii. Physician dictation areas
      iii. Other area specifically designated by unit managers
   B. Any location must be kept separate from areas where lab specimens or contaminated equipment are handled
3. Employee Requirements:
   A. All beverage containers must have a tight-fitting lid or cover
   B. Cans and open cups are prohibited
   C. All containers shall be removed by the employee, no later than at the end of their shift.
4. Prohibited Practices:
   A. Eating, drinking, smoking, applying cosmetics, and handling contact lenses are prohibited in the

following work areas:

i. Direct patient care areas

ii. Surgery and procedure rooms

iii. Charting pods/areas outside patient rooms

iv. Any area where there is medication, patient care equipment, specimens and/or potential bloodborne pathogens

B. Food in patient care areas

i. Staff shall not keep food and/or eat at nursing stations, or any other patient care area

ii. Eating shall be reserved for break times, and done in specifically designated areas.

REFERENCE(S) / RELATED POLICIES

- U.S. Department of Labor, OSHA/ **Final Rule on Occupational Exposure to Bloodborne Pathogens** – 57:6404
- Document Central policy number: LCT-IC-165
- Related Policies: Exposure Control Plan for Bloodborne Pathogens

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Med Staff - Infection Prevention (Both)	Mayra Graves: Coord Medical Staff	pending
Med Staff - Infection Prevention (Both)	Mary Guglielmo: Medical Staff Services Manager	pending
CNO	Scott Ciesielski: Chief Nrsing Officer South Bay	10/2020
Policy Committee	Patti Hamaguchi: Sr Mgr Perf Improvement	09/2020
Policy Committee	Jamie Jolly: Sr Mgr Infection Prevention	09/2020

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

Implementation:	*04/2016*
Effective:	*Upon Approval*
Last Reviewed:	*N/A*
Last Revised:	*06/2020*
Next Review:	*3 years after approval*
Owner:	*Jamie Jolly: Sr Mgr Infection Prevention*
Policy Area:	*Infection Prevention*
References:	
Applicability:	*CA - PH&S Little Company of Mary Service Area*

Negative Pressure Room Monitoring

In keeping with the mission and values of Providence Health & Services, it is the policy of Providence Health System-South Bay Service Area to adopt this clinical standard for use in the following*

Providence Little Company of Mary Medical Center Torrance:	
X	Acute Care
	Transitional Care Center
	Providence Little Company of Mary Home Health
Providence Little Company of Mary Medical Center San Pedro:	
X	Acute Care
	Sub-Acute Care Center
	Psychiatric Unit
	Acute Rehabilitation
	Chemical Dependency Unit

PURPOSE

The purpose of this policy is to establish guidelines for the monitoring of negative pressure in designated isolation rooms within the hospital.

POLICY

Whenever a negative pressure room/airborne infection isolation room (*AIIR*) is in use for a patient on Airborne Precautions, Plant Operations/Maintenance (*POM*) will monitor air pressure daily with visual indicators (*e.g., smoke tubes, flutter strips*), regardless of the presence of differential pressure sensing devices (*e.g., manometers*). The Daily checks performed by POM will be documented on log sheet maintained in POM Department.

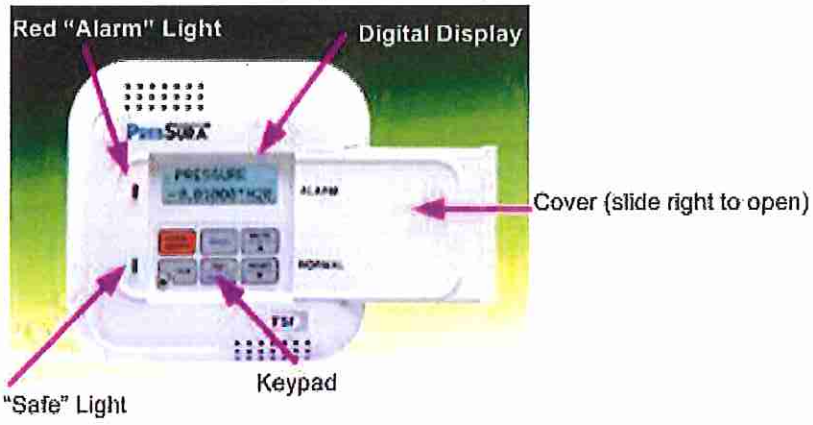
Location of Negative pressure/AIIR rooms:

Copyright © 2020 CA - Providence LCM MC Torrance

- PLCMMC Torrance are: Rooms 111, 120, 211, 220, 228, 310, 317, 322, 340, 342, 391, 408, 429, 463, 464.
- PLCMMC San Pedro are: Rooms ED 10, 11, 12, 263, 281, 381, CCC - 3, CCC - 9.

PROCEDURE

1. Negative pressure ~~are provided for~~room monitoring is performed and maintained on a continuous basis when it is occupied by a patient in airborne precautions or for a suspected or confirmed diagnosis of tuberculosis, varicella, measles, or variola.
2. Nursing will place a work order with POM when an Airborne Isolation patient is admitted into a negative pressure isolation room.
3. Nursing will place a work order with POM daily when an Airborne Isolation patient is in a negative pressure isolation room.
4. On a daily basis POM will inspect the air pressure using a visual indicators (*e.g., smoke tubes, flutter strips*), regardless of the presence of differential pressure sensing devices (*e.g., manometers*) when a negative pressure/AIIR room is occupied by a patient.
5. To maintain negative pressure, all doors and windows must remain closed, except when ~~staff~~a Caregiver enters or exits the room.
6. Nursing personnel and other clinical personnel should check the pressure sensing device **green** light is on before entering the patient room. If a Negative pressure sensing device is not showing green safe light, i.e. the red "alarm" light is on check to see that all doors and windows are closed and also the HEPA filter unit is turned *on.* If not resolved nursing will notify POM immediately to assess the pressure condition in the room.



7. In the event that POM engineer is unable to verify the proper negative pressure, patient must be transferred to another negative pressure room.
8. Air balancing of the Negative pressure room is conducted annually by an HVAC technician to ensure the correct number of air exchanges i.e., six air exchanges per hour
   PLEASE NOTE: At PLCMMC San Pedro, negative pressure/AIIR rooms are equipped with a HEPA filtration unit, which must be turned on by POM to create and maintain sufficient air flow or negative pressure. The HEPA filter unit must be turned on for negative pressure in Rooms 203, 263, 281 and 381. Call POM to turn HEPA filtration unit off when Airborne Precautions are discontinued.

Copyright © 2020 CA - Providence LCM MC Torrance

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Med Staff - Infection Prevention (Both)	Mayra Graves: Coord Medical Staff	pending
Med Staff - Infection Prevention (Both)	Mary Guglielmo: Medical Staff Services Manager	pending
CNO	Scott Ciesielski: Chief Nrsing Officer South Bay	10/2020
EOC	Jeremy Baker: Exec Dir Quality [PH]	09/2020
Policy Committee	Jamie Jolly: Sr Mgr Infection Prevention	09/2020
Policy Committee	Patti Hamaguchi: Dir Quality Mgmt So Bay	06/2020

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

Copyright © 2020 CA - Providence LCM MC Torrance

Providence St. Joseph Health

Implementation:	*06/2003*
Effective:	*Upon Approval*
Last Reviewed:	*N/A*
Last Revised:	*08/2017*
Next Review:	*3 years after approval*
Owner:	*Scott Ciesielski: Chief Nrsing Officer South Bay*
Policy Area:	*Patient Care Services*
References:	
Applicability:	*CA - Providence LCM MC Torrance*

Refrigerator/Freezer Logs

PURPOSE:

The purpose of this policy is to establish a method for recording and reporting variation in food refrigerators/ freezers.

PROCEDURE:

1. All patient food refrigerators/freezers will be monitored daily when the department is open.
2. The temperatures will be documented on the "*Refrigerator/Freezer Temperature Log*".
3. Normal ranges for temperature are:
   A. Food refrigerator - 41 degrees F or below
   B. Food freezer - 0 degrees F or below
4. If the temperature is not within normal range, an asterisk (*) will be placed next to the temperature and the Service Center will be notified for adjustment/ corrections. If Plant Operations and Maintenance (*POM*) determines that the refrigerator/freezer has failed, Nutrition and Food Services will be notified for appropriate follow up.
5. Temperature logs will be maintained for twelve (12) running months.

REFERENCE(S) / RELATED POLICIES:

- Document Central policy number: LCT-PC-140

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Med Staff - Infection Prevention	Mayra Graves: Coord Medical Staff	pending
CNO	Scott Ciesielski: Chief Nrsing Officer South Bay [PH]	08/2020
Policy Committee	Scott Ciesielski: Chief Nrsing Officer South Bay [PH]	08/2020
Policy Committee	Patti Hamaguchi: Sr Mgr Perf Improvement	08/2020

Applicability

CA - Providence LCM MC Torrance

Current Status: *Pending* **PolicyStat ID:** *8483789*

Implementation:	*N/A*
Effective:	*Upon Approval*
Last Reviewed:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Kathleen Montoya: Mgr EVS*
Policy Area:	*Environmental Services*
References:	
Applicability:	*CA - Providence LCM MC Torrance*

EVS: Cleaning of Medical Waste Transport Containers

POLICY

It is the policy of Providence Little Company of Mary Medical Center Torrance Environmental Services (*EVS*) Department to disinfect all reusable equipment used to transport medical waste such as transport barrels and **5**-gallon buckets at least daily if used that day.

PURPOSE

The purpose of this policy is to insure the cleanliness of reusable equipment used to transport biohazardous (*medical*) waste.

PROCEDURE / GENERAL INSTRUCTIONS

1. Using germicidal cloth or wipe, disinfect all interior and exterior surfaces of barrel or 5-gallon bucket including the lid daily.
2. Disinfect castors.
3. Allow to air dry.
4. Responsibility of cleaning is assigned to user of container/EVS

REFERENCE

- Document Central Policy Number: LCT-EVS-082

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Infection Prevention	Mayra Graves: Coord Medical Staff	pending
Policy Committee	Patti Hamaguchi: Sr Mgr Perf Improvement	10/2020
Policy Committee	Kathleen Montoya: Mgr EVS	10/2020

Applicability

CA - Providence LCM MC Torrance

Current Status: *Pending*

PolicyStat ID: *8483782*

Implementation:	*N/A*
Effective:	*Upon Approval*
Last Reviewed:	*N/A*
Last Revised:	*N/A*
Next Review:	*3 years after approval*
Owner:	*Kathleen Montoya: Mgr EVS*
Policy Area:	*Environmental Services*
References:	
Applicability:	*CA - Providence LCM MC Torrance*

EVS: Chemotherapy Waste Handling

POLICY

It is the policy of Providence Little Company of Mary Medical Center Torrance (*PLCMMCT*) Environmental Services (*EVS*) Department to remove all chemotherapy waste from specific points within the hospital using proper safety precautions, and ~~will~~ transport the waste to appropriate storage area for pick up by a licensed biohazardous waste hauler.

PURPOSE

The purpose of this policy is to ensure that all bio-hazardous waste is handled properly, safely and in accordance with Medical Waste Management Act.

PROCEDURE / GENERAL INSTRUCTIONS

1. Chemotherapy waste is collected on a weekly basis, or as needed from the pharmacy and the oncology unit.
2. The EVS technician must wear ~~disposable~~chemo safe gloves to protect himself/herself from contamination.
3. The disposable rigid container containing the chemotherapy waste is to be secured shut to prevent leakage prior to transport to the storage area.
4. At least weekly, the chemotherapy waste will be picked up by a licensed hauler for off-site incineration.
5. The licensed hauler will provide the hospital with a tracking document signed by the incinerator to show that the waste has been properly disposed of.

NOTE: Chemotherapy waste is to be disposed of separately from other biohazardous or hazardous waste to prevent cross contamination.

REFERENCE(S) / RELATED POLICIES

- Medical Waste Management Act
- Document Central Policy Number: LCT-EVS-081

Copyright © 2020 CA - Providence LCM MC Torrance

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Infection Prevention, P&T	Mayra Graves: Coord Medical Staff	pending
Policy Committee	Patti Hamaguchi: Sr Mgr Perf Improvement	09/2020
Policy Committee	Kathleen Montoya: Mgr EVS	08/2020

Applicability

CA - Providence LCM MC Torrance

Copyright © 2020 CA - Providence LCM MC Torrance

Providence Little Company of Mary Medical Center
TORRANCE
Quarterly Transfusion Service Statistics
2nd Quarter 2020

BLOOD PRODUCTS	***April***	***May***	***June***	***Total for Quarter***	***Total YTD 2020***	***Total YTD 2019***
Red Blood Cells						
Allogeneic RBC Irradiated/LR	37	72	46	155	302	238
Allogeneic RBC Leukocyte Reduced	254	390	364	1008	2194	2276
Autologous RBC	0	0	0	0	0	0
Directed Donor RBC	0	0	0	0	1	0
Neonatal aliquot RBC	0	1	4	5	6	14
Deglycerolized RBC	0	0	0	0	2	0
Reconstituted RBC	0	0	0	0	0	0
Total RBC Transfused	291	463	414	1168	2505	2528
Total RBC Crossmatched	467	730	665	1862	4047	4361
Total RBC Transfused	291	463	414	1168	2505	2528
C : T ratio *benchmark <2.0*	**1.61**	**1.58**	**1.61**	**1.59**	**1.62**	**1.73**
Patients transfused	126	158	158	442	959	1028
RBC transfused per patient	2.3	2.9	2.6	2.6	2.6	2.5
Other blood products transfused						
Plateletpheresis LR/Irradiated	31	88	61	180	363	379
Plateletpheresis Leukoreduced	0	0	0	0	6	4
FFP / 24-hour plasma	49	63	54	166	390	762
Cryoprecipitate	25	70	10	105	335	280
Cryopoor plasma	0	0	0	0	0	136
Total	105	221	125	451	1094	1561
Total all products transfused	396	684	539	1619	3599	4089
Type and Screen	595	776	807	2178	4835	5696
Rh immune Globulin	22	14	14	50	89	88
Emergency release	6	3	0	9	20	14
Transfusion Reactions						
Febrile non-hemolytic reaction	0	2	3	5	11	1
Acute hemolytic reaction	0	0	0	0	0	0
Delayed hemolytic reaction	0	0	0	0	0	0
Anaphylactic reaction	0	0	0	0	0	0
Urticarial reaction	0	0	0	0	1	5
Volume overload	0	0	0	0	0	0
Bacterial contamination	0	0	0	0	0	0
TRALI	0	0	0	0	0	0
Unrelated to blood product trxn	0	0	0	0	0	1
Total	0	2	3	5	12	7
Blood product outdates/wastage						
Allogeneic RBC outdates	8	10	0	18	18	14
Autologous RBC outdates	0	0	0	0	4	6
RBC returned, discarded	2	0	1	3	7	13
Cryoprecipitate thawed, not used / outdates	15	10	0	25	35	25
Plasma thawed, not used / outdates	5	1	3	9	17	55
Plateletpheresis ordered, not used / outdates	5	2	7	14	34	42

Providence Little Company of Mary Medical Center
TORRANCE
Quarterly Transfusion Service Statistics
3rd Quarter 2020

BLOOD PRODUCTS	*July*	*August*	*September*	*Total for Quarter*	*Total YTD 2020*	*Total YTD 2019*
Red Blood Cells						
Allogeneic RBC Irradiated/LR	29	30	28	87	389	364
Allogeneic RBC Leukocyte Reduced	294	353	392	1039	3233	3463
Autologous RBC	0	0	0	0	0	0
Directed Donor RBC	0	0	0	0	1	0
Neonatal aliquot RBC	2	2	2	6	12	25
Deglycerolized RBC	0	0	0	0	2	0
Reconstituted RBC	0	0	0	0	0	0
Total RBC Transfused	325	385	422	1132	3637	3852
Total RBC Crossmatched	576	596	709	1881	5928	6692
Total RBC Transfused	325	385	422	1132	3637	3852
C : T ratio *benchmark <2.0*	**1.77**	**1.55**	**1.68**	**1.66**	**1.63**	**1.74**
Patients transfused	130	152	162	444	1403	1515
RBC transfused per patient	2.5	2.5	2.6	2.5	2.6	2.5
Other blood products transfused						
Plateletpheresis LR/Irradiated	33	42	51	126	489	592
Plateletpheresis Leukoreduced	1	0	2	3	9	5
FFP / 24-hour plasma	46	44	52	142	532	986
Cryoprecipitate	15	25	35	75	410	440
Cryopoor plasma	0	0	0	0	0	136
Total	95	111	140	346	1440	2159
Total all products transfused	420	496	562	1478	5077	6011
Type and Screen	770	804	807	2381	7216	8517
Rh immune Globulin	10	19	13	42	131	130
Emergency release	1	3	4	8	28	30
Transfusion Reactions						
Febrile non-hemolytic reaction	2	0	1	3	14	2
Acute hemolytic reaction	0	0	0	0	0	0
Delayed hemolytic reaction	0	0	0	0	0	0
Anaphylactic reaction	0	0	0	0	0	0
Urticarial reaction	0	0	1	1	2	8
Volume overload	0	0	0	0	0	0
Bacterial contamination	0	0	0	0	0	0
TRALI	0	0	0	0	0	0
Unrelated to blood product trxn	0	0	0	0	0	1
Total	2	0	2	4	16	11
Blood product outdates/wastage						
Allogeneic RBC outdates	6	8	0	14	32	32
Autologous RBC outdates	0	0	1	1	5	10
RBC returned, discarded	3	0	1	4	11	18
Cryoprecipitate thawed, not used / outdates	0	0	5	5	40	75
Plasma thawed, not used / outdates	4	4	3	11	28	102
Plateletpheresis ordered, not used / outdates	16	10	10	36	70	63