

# Bartlett Regional Hospital

Board Quality Committee

December 13, 2022

3:30 p.m.

This virtual meeting is open to the public and may be accessed via the following link:

Join Zoom Meeting

<https://bartletthospital.zoom.us/j/96860834173>

## Agenda

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### Mission Statement

Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.

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### Call to order

Approval of the minutes – [October 2022](#)

### New Business:

[Voice of the Patient](#)

[Infection Control](#)

**Patient Family Engagement**

[Workplace Safety Report](#)

A. Muse

C. Gribbon

A. Muse

E. Price

### Standing Agenda Items:

- [2022 BOD Quality Dashboard](#)
- [2023 BOD Quality Metrics Presentation](#)

D. Koelsch

G. Moorehead

### Executive Session

- [Report of Patient Safety Event](#)

A. Muse

*Motion by xx, to recess into executive session to discuss a matter which by law, municipal charter, or ordinance is required to be confidential or involve consideration of records that are not subject to public disclosure, specifically to a patient safety event.*

**Next Scheduled Meeting: TBD**

### Adjournment

#### Board Quality Strategic Plan Initiative Oversight Summary

##### People:

3.1 Resolve electronic medical record concerns

3.2 Expand workforce development programs

##### Quality and Safety

5.1 Stay current on technology and resources to facilitate risk management, data security, and employee safety

5.2 Develop quality initiatives that exceed accreditation and regulatory requirements



# Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 [www.bartletthospital.org](http://www.bartletthospital.org)

## Board Quality Committee October 24, 2022 Minutes

Called to order at 1:00p.m. by Lindy Jones

Board Members: Hal Geiger, Kenny Solomon-Gross, Lindy Jones, Mark Johnson,

Staff: Gail Moorehead, Autumn Muse, Miranda Dumont, Deb Koelsch, Cassidy Habig, Audrey Rasmussen, Robert Tyk, David Keith, Sam Norton, Tracy Dompeling, Kim McDowell, Dallas Hargrave

Guests: none

*Mark Johnson made a MOTION to approve the minutes from July 13, 2022 Board Quality Meeting. Kenny Solomon-Gross seconded, minutes are approved.*

*Old Business: None*

### New Business:

#### Departmental Annual Quality Assurance/Process Improvement Reports

##### Critical Care

Audrey Rasmussen

Audrey presented the CCU process improvement project for improving the work environment in CCU. She explained that strong morale in a unit has proven to positively affect patient outcomes and improve retention. She named several goals that the department is working on. They initially did a HWE assessment to gauge the current state of employee engagement. Overall the unit scored quite high compared to the national average. The plan is to do a follow up survey in February of 2023. The next plan is to work on collaboration with physicians. Lindy Jones recognized Audrey for retaining and hiring staff during this time. Mark Johnson asked about the Beacon award which the CCU received last year. Gail asked about expanding this project to other units. Audrey explained that it is not specific to CCU and any unit could do this.

##### Respiratory Therapy

Nelea Fenumiai

Nelea presented the RT PI project surrounding the improvement of Cardiac & Pulmonary Rehab. Nelea found that the Cardiac Rehab program was not seeing enough patients. Their goal was to increase their patient volumes as well as increase the number of patients who graduated the program. The project was put on hold when the Cardiac Rehab Coordinator resigned. They spent 6 months revamping the program. Visits have increased by 66% and 76%. Patient retention has increased by 33%. Nelea explained that the department is also working on expanding the telehealth programs. Dr. Standerwick has taken responsibility for the patients so the patients can get into the program quickly.

### **Laboratory**

**Cassidy Habig**

Cassidy presented the Labs PI project surrounding the Direct Antiglobulin Test (DAT) to reduce the rejection of the specimens. Historically, the blood bank had to reject many specimens. Since June of 2022, there have been zero specimen rejections. Mark Johnson asked how many tests were done a month and if this test is done for outlying communities. Currently the lab does about 15 per month and they do not perform the test for any out of town patients.

### **Strategic Plan Initiative Report**

#### **3.1 Resolve Electronic Medical Record Concerns**

**Sam Norton**

Sam presented on the IT departments goals to meet the Boards strategic plan goals. He explained that the IT plan is to improve the EMR we have and to better integrate it. Meditech will be on site tomorrow to do an assessment of our current system. We have opted to delay the implementation of 2.2. Only a fraction of Meditech customers have updated to 2.2. We believe our attention is better served by optimizing 2.1. Kenny Solomon-Gross asked for clarification on the November 9<sup>th</sup> date. It will be done virtually in two sessions. One for providers and one for nursing staff. Dr. Jones will be present at the demonstration and will also go onsite to see the Meditech ER module in action. Mark Johnson asked if there has been a gap analysis done between the two EMRs. There has not been one completed as of yet. Kenny Solomon-Gross wants to ensure that Dr. Jones is on the advisory committee so he can be the voice of the ED and a liaison to the board. Dr. Jones' agrees to be on the committee. Mark asked if there are deficiencies, is there away to fix those? David Keith expressed that this is the perfect committee for the Quality group and he is confident that we will achieve our goals. Gail asked that Dr. Jones look at all the possibilities for Meditech as far as having our BH and other clinics. Sam plans to revamp the customer service portion of the clinical IT department. He says the current process is broken. Dr. Jones asked that Sam speak to the entirety of the board tomorrow.

## **5.1**

Two goals: 1. Continue to update and maintain our current platforms. 2. Sam is reviewing how we currently do things here at Bartlett and ensuring we are being compliant with security.

#### **Standing Agenda Items:**

##### **2022 BOD Quality Dashboard**

**Gail Moorehead/Deb Koelsch**

Gail went over the patient safety dashboard. She talked about our plans to revamp the falls task force. We are currently right with the national average. She explained the Press Ganey scores.

**Next Scheduled Meeting: TBD**

#### **Board Quality Strategic Plan Initiative Oversight Summary People:**

**3.1 Resolve electronic medical record concerns**

**3.2 Expand workforce development programs**

#### **Quality and Safety**

**5.1 Stay current on technology and resources to facilitate risk management, data security, employee safety**

**5.2 Develop quality initiatives that exceed accreditation and regulatory requirements**

**Adjournment: 2:06 p.m.**

**The next Quality Board meeting date will be set by correspondence.**

# Patient Voice



# Patient and Family Advisory Committee (PFAC)

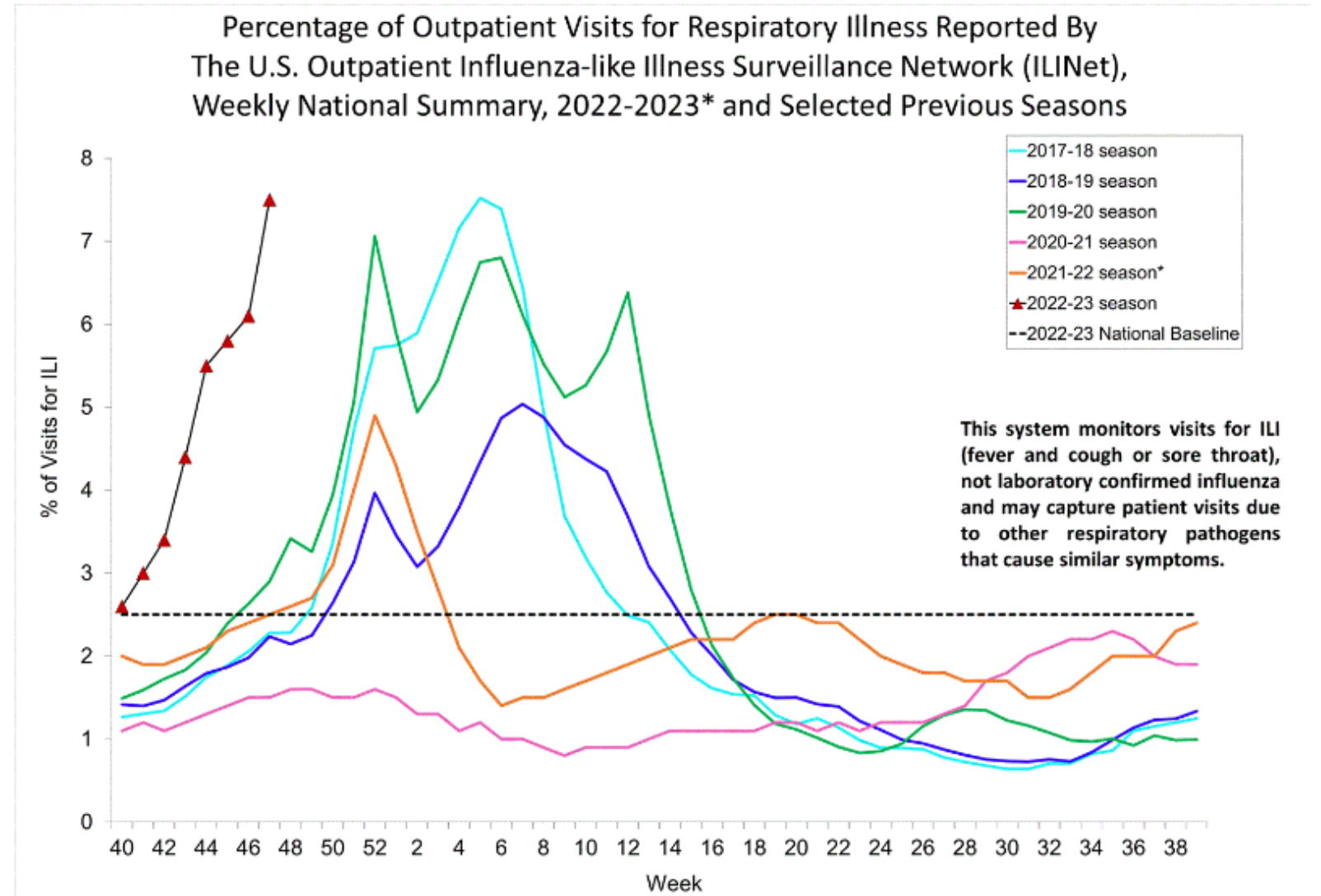
- Bartlett is developing a committee that currently has staff, a community partner, and two ad hoc patient members.
- Our vision and mission includes advancing our care by including the patient and family perspective into how we delivery care, develop and/or improve processes and including patients as equal, informed, and recognized members of their healthcare team.
- The committee uses patient feedback through Press Ganey, Bartlett patient feedback letters, committee member discussions with patients/families and personal experiences to drive our projects.
- Current projects include:
  1. Developing an orientation handout and video for patient admitted to Med/Surg
  2. Putting a focus on DEI (Diversity, Equity, and Inclusion) with patient care and processes
  3. Revamping our patient discharge instructions/education and processes
  4. Addressing health literacy with our patient education, handouts, and community messaging
  5. Replacing the front entrance fish tank with an alterative visual

# Flu - RSV - COVID

December 2022

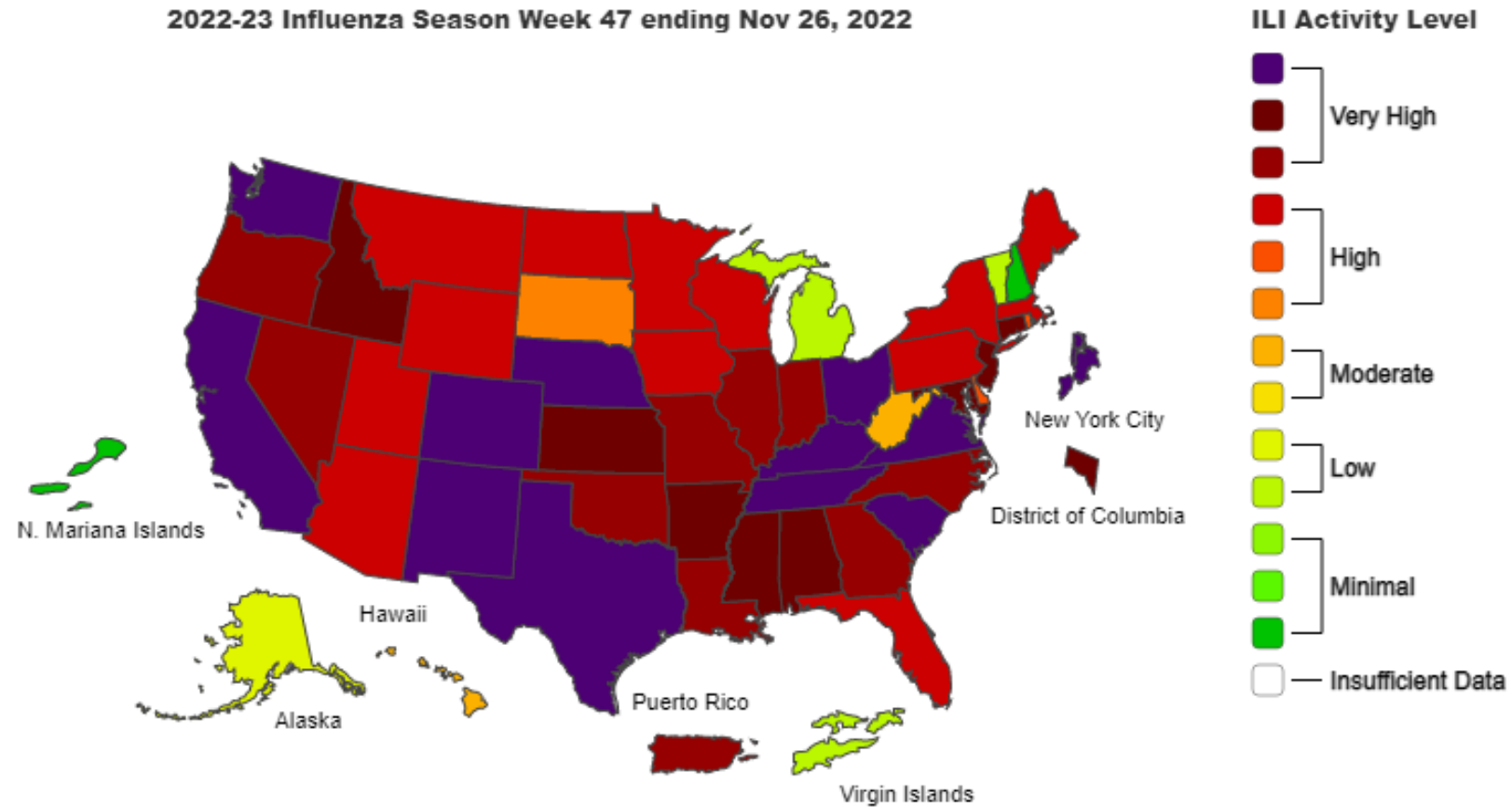


# Flu View

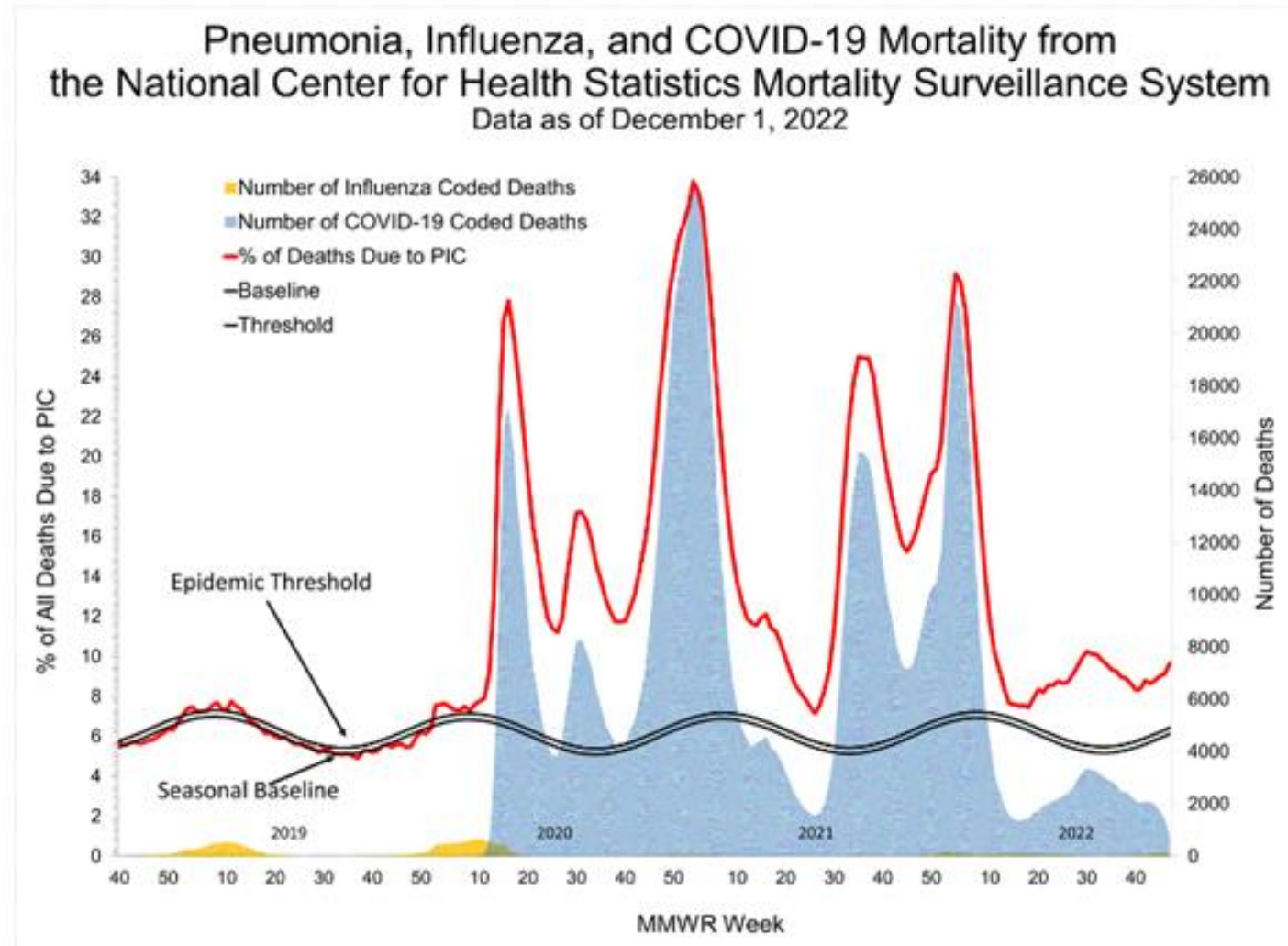




# Flu View



# Pneumonia – Influenza – COVID – Excess Death



# Objective data: Wastewater testing

# National

— Wastewater — Clinical cases daily avg █ Clinical daily cases

☒ Show cases

Total results

Last 6 months

Last 6 weeks

**Wastewater:**  
Effective SARS-  
CoV-2 virus  
concentration  
(copies / mL of  
sewage)

5,000

*powered by Biobot Analytics*

4,000

3,000

2,000

1,000

0

Jan '21

Jan '22

1.5M

**Clinical:**

Daily new cases

1M

500k

0

Source: Wastewater data from Biobot Analytics, Inc.; Clinical data from USAFacts

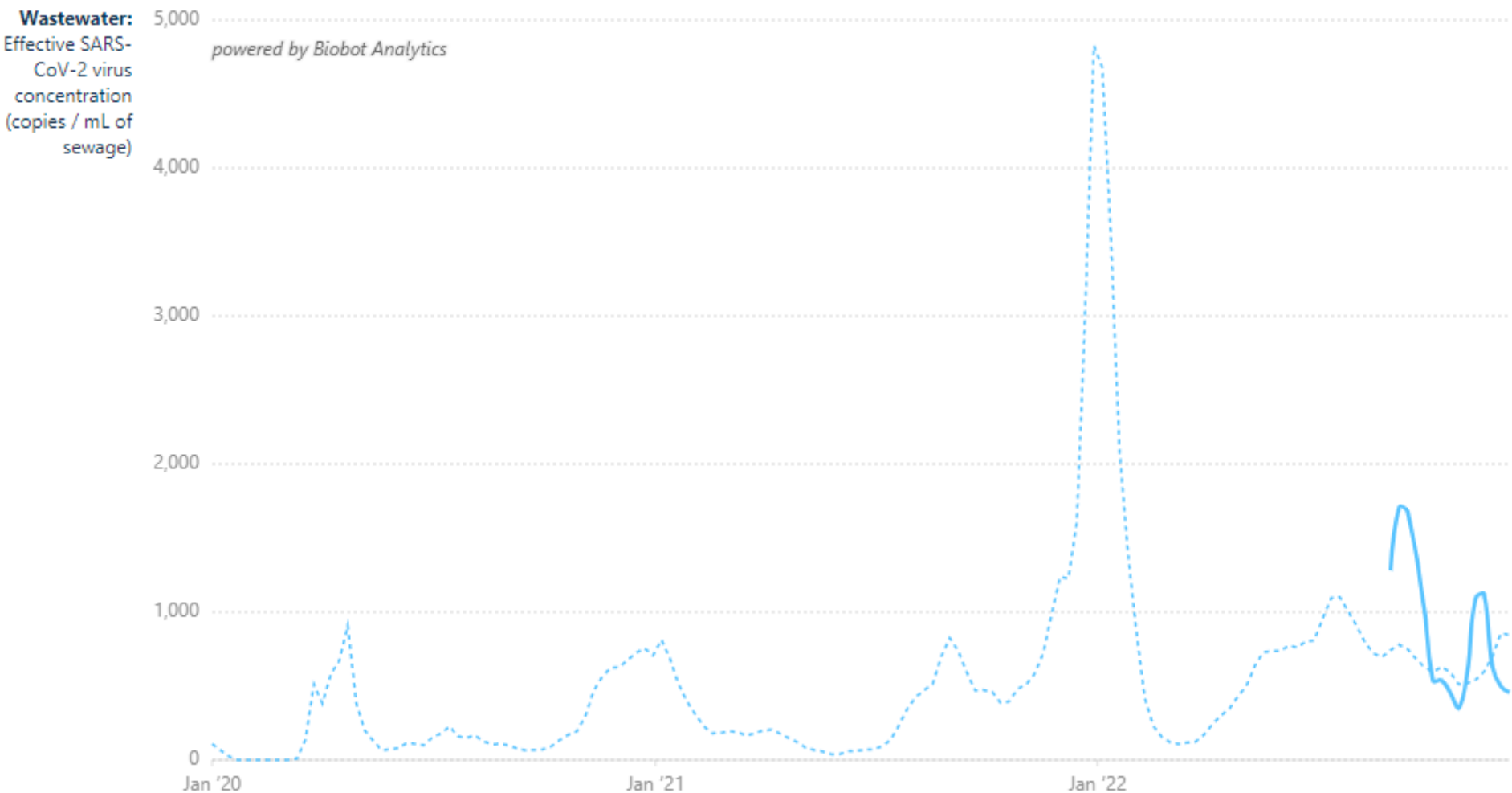


> About the data

# Juneau

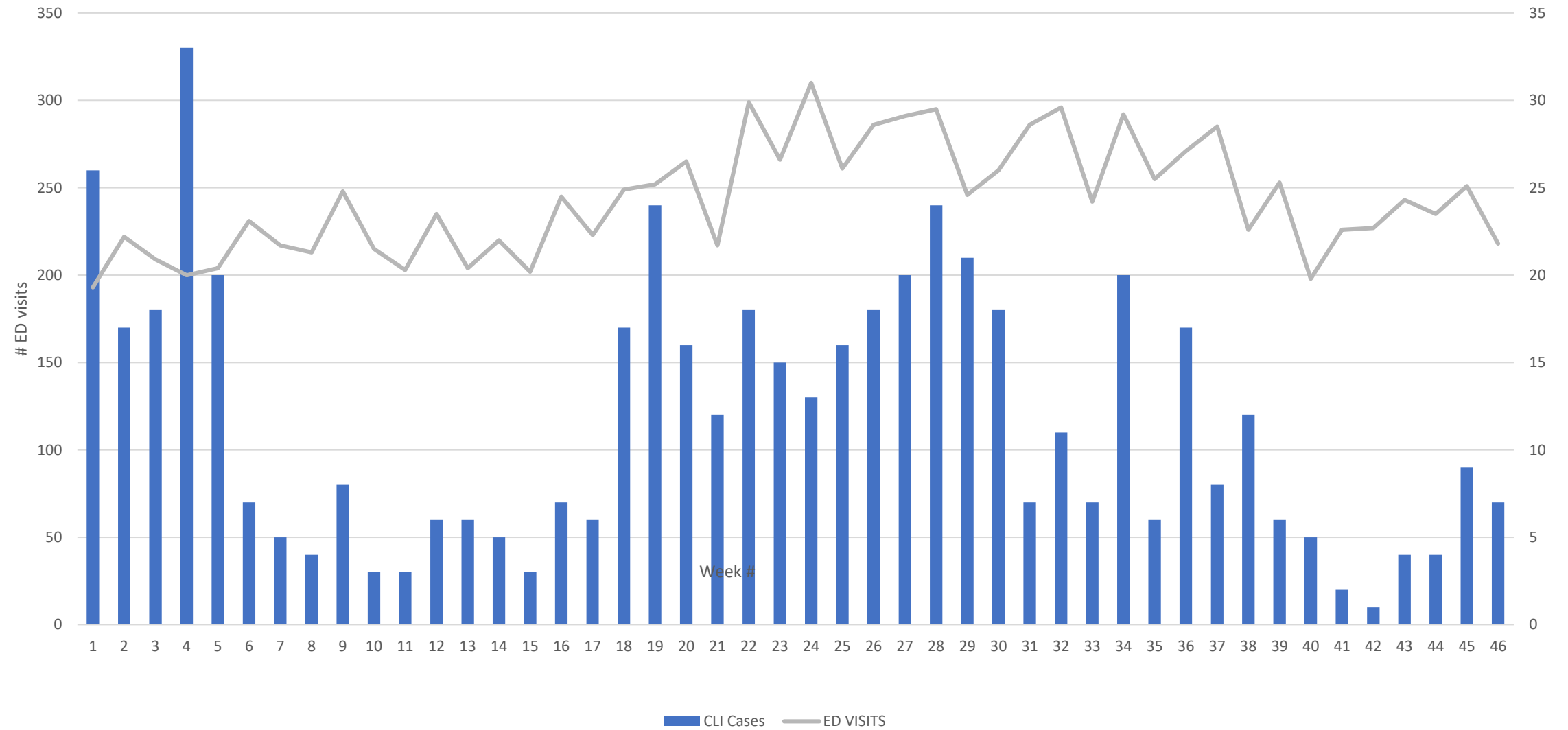
## City and Borough of Juneau, AK

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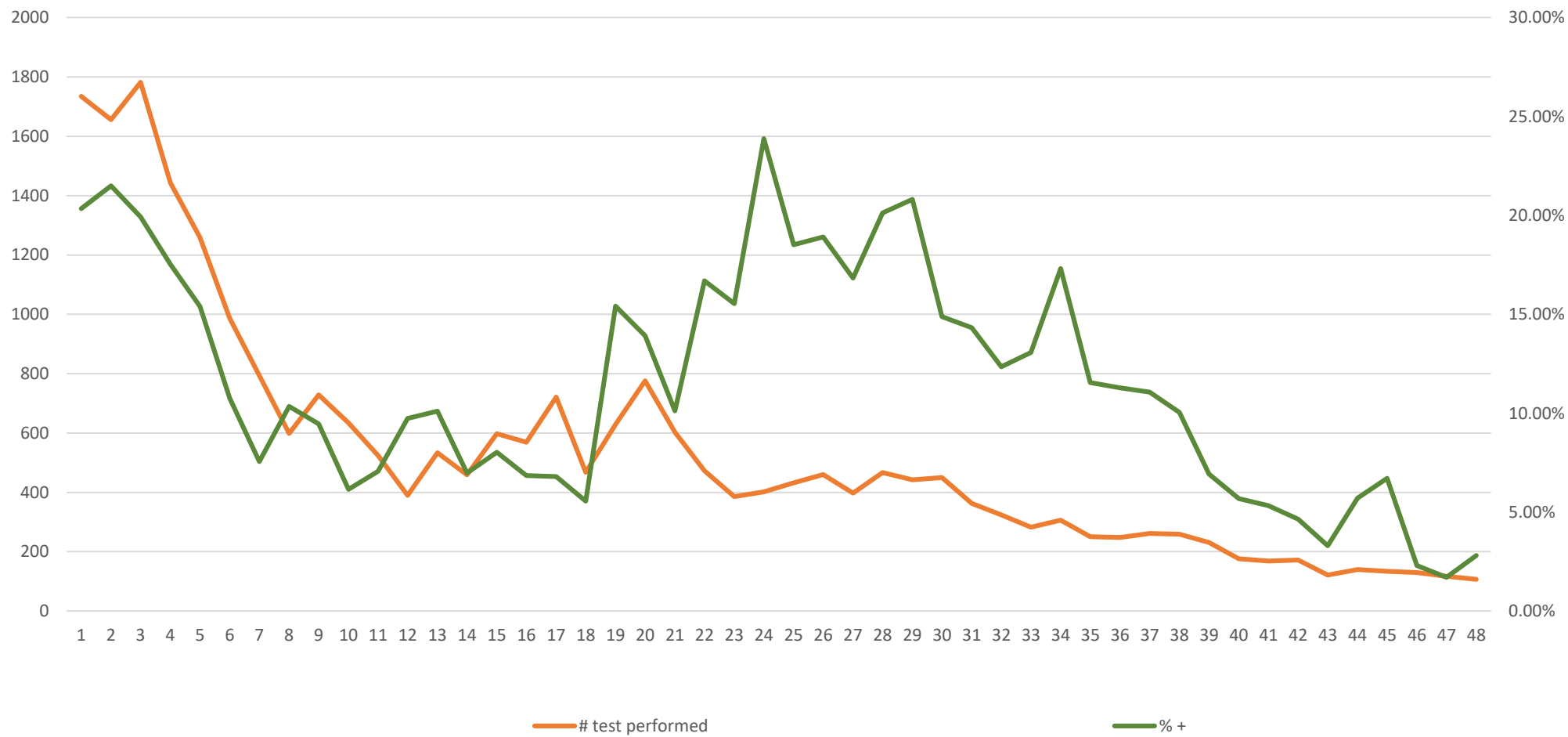


no variant data available

## 2022 COVID Like Illness / ED Visits

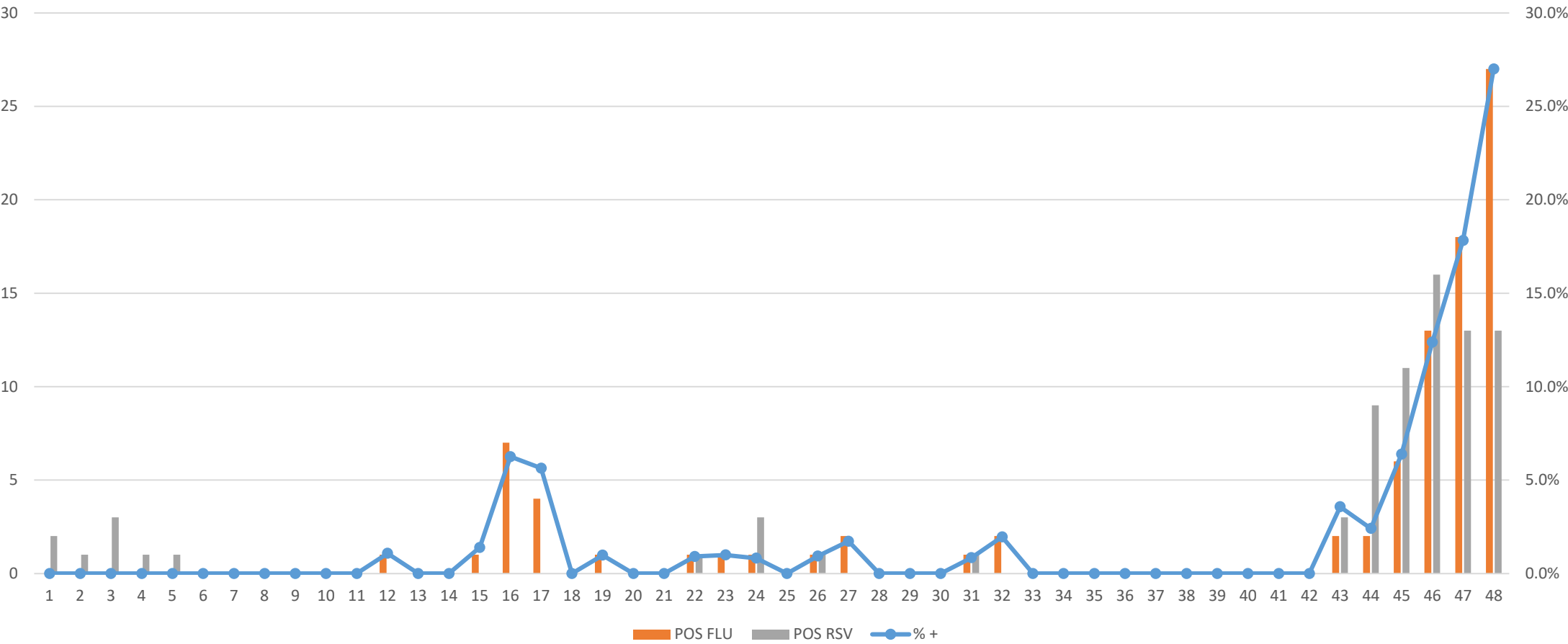


COVID tests: Percent Positive

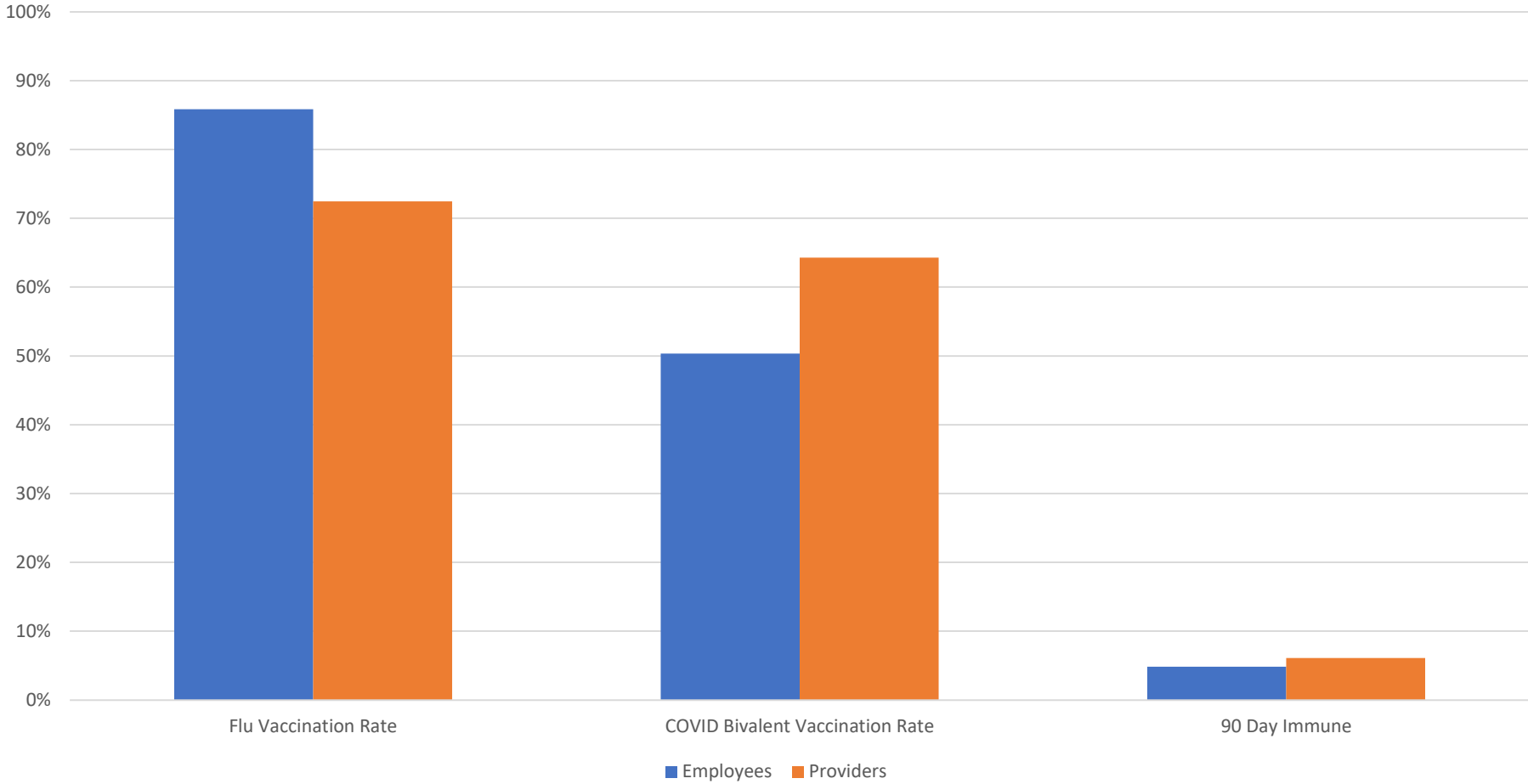


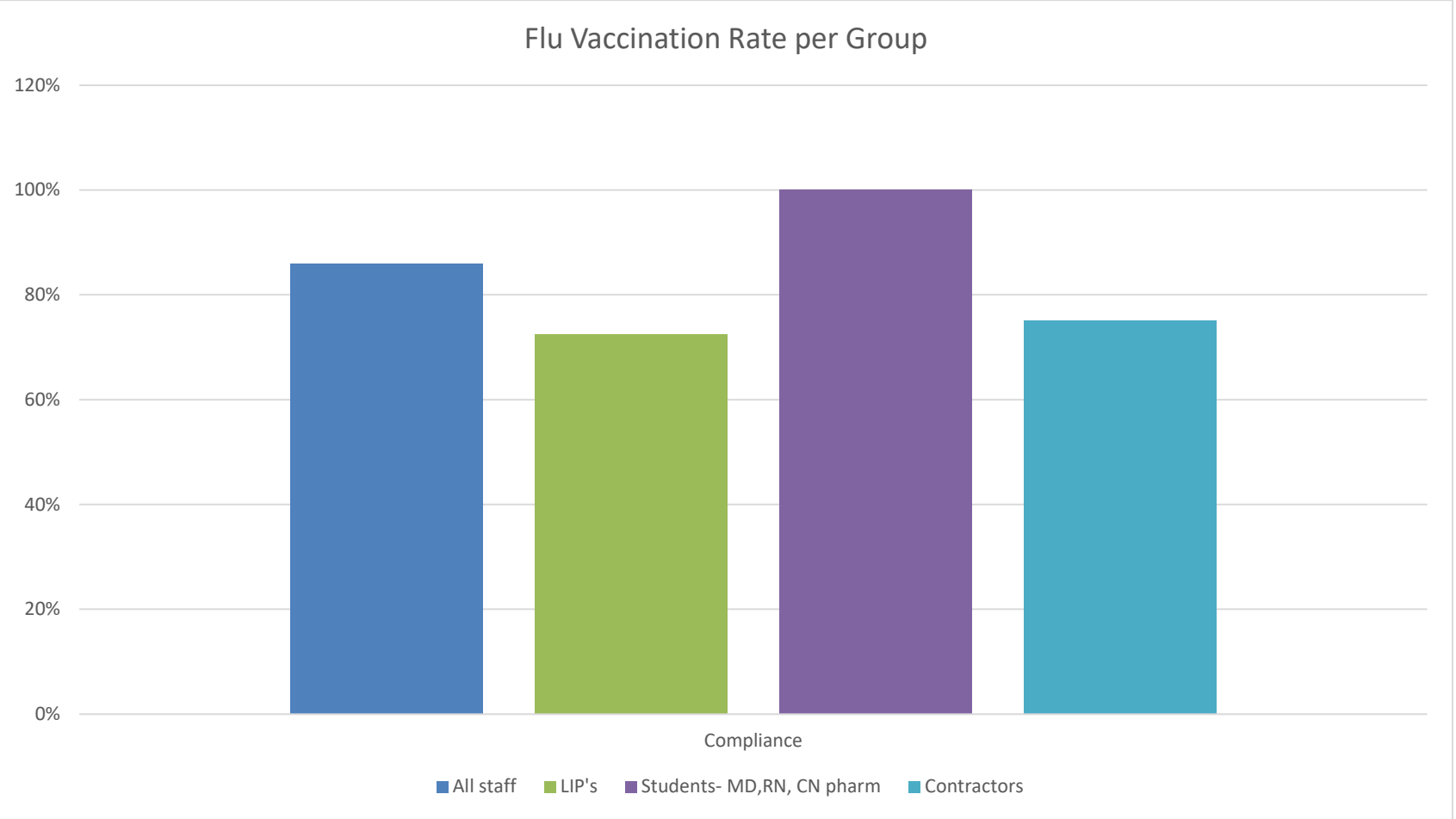


Flu & RSV positives & Test Positivity



BRH's Vaccination Rates





**BARTLETT REGIONAL HOSPITAL**  
**INFECTION PREVENTION and CONTROL PLAN 2022**  
**Evaluation**

This plan is developed with input and collaboration from the following:

- Infection Prevention and Control Committee
- Medical Staff
- Quality and Process Improvement
- Department Managers

**Infection Prevention and Control Plan Reviewed by:**

	Signature	Date
Infection Prevention and Control Committee Chair	David Miller MD	1/7/2022
Quality and Process Improvement Director	Gail Moorehead MSN, NPD-BC, CMSRN, CPHQ	1/7/2022
Infection Preventionist		1/7/2022

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	Charlee Gribbon RN, MPH, CIC	
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## Bartlett Regional Hospital

### Infection Prevention and Control Plan 2022

**Mission:** To provide a safe environment across the continuum of settings for all patients, visitors, and healthcare workers through the prevention of infection transmission and the provision of a safe environment.

**Objectives:** The objectives of the Bartlett Regional Hospital (BRH) Infection Prevention and Control Program (IPC) are:

- 1 Early identification of infections, both expected and unexpected.
- 2 Timely implementation of interventions when infections or risks thereof are identified.
- 3 Analysis of organizational and individual practices that impact transmission of infection.
- 4 Implementation of evidence-based practices known to reduce the transmission of infection.
- 5 Education of healthcare workers, patient, families, and visitors on infection risk-reduction practices.
- 6 Limitation of unprotected exposure to pathogens throughout the organization.
- 7 Interact with community health agencies through activities such as surveillance and emergency preparedness to respond to community outbreaks and special pathogens (novel strains such as COVID-19, or Ebola).
- 8 Manage effectively the seasonal influx of potentially infectious patients during Southeast Alaska's tourist season.
- 9 Enhancement of hand hygiene practices by all persons within the hospital system.
- 10 Minimization of the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices.
- 11 Incorporation of guidelines and recommendations published by regulatory or accrediting agencies, and professional organizations, to provide current evidence-based infection prevention strategies and policies.
- 12 Provision of Employee Health services, including appropriate screening, testing, immunization, counseling, and education for staff and others who have the potential for exposure to communicable disease.

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## Infection Prevention and Control Program Oversight and Organization Authority and Responsibility

**PURPOSE:** To institute any surveillance, prevention, and control measures when there is reason to believe that any patient or personnel may be in danger of a hospital acquired infection or infectious disease (IC 01.01.01)

### A. The Infection Prevention and Control (IPC) Committee:

A.1. The Infection Prevention team is made up of the Chair of the Infection Prevention and Control Committee (IPCC), which directs the IPC program and one full-time Infection Preventionist.

A.1.1. In accordance with Medical Staff Bylaws and/or Rules and Regulations, the physician members of the Infection Prevention and Control Committee are appointed by the Chief of the Medical Staff.

A.1.2. The appointed term is reevaluated on a yearly basis.

A.1.3. The IPC Program will identify and evaluate potential risk factors (including environmental factors) and monitor trends in incidence of epidemiologically relevant infections at BRH. This is achieved through effective surveillance, evaluation and communication to senior leadership, hospital stakeholders, medical staff, employees, and community.

A.1.4. The ICP Plan is updated on an annual basis, reviewed and approved by the IPC Committee. This update is based on a review of the prior calendar year's activities, surveillance program, risk assessments and goals (IC 01.05.01). The review of the prior calendar year's activities, surveillance program, risk assessments and goals will be completed and approved by the IPC Committee during the first quarter of the upcoming calendar year and will be implemented in second quarter of the calendar year. (IC 01.03.01)

A.2. Members of the Infection Prevention and Control (IC) Committee and/or the Infection Preventionist have the authority to institute surveillance, prevention, and control measures.

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- A.2.1. Where there is reason to believe that any patient or personnel may be in danger of acquiring a hospital acquired infection or communicable disease; control measures may include closure of rooms, units, departments, enhanced cleaning methods, and/or management of hospital visitors.
- A.2.2. The Chair of the IPC Committee and/or the Infection Preventionist (or designee) have the authority to establish controls to reduce and stop the spread of infection and communicable disease, including the ordering of microbiological cultures, respiratory pathogens and TB testing when indicated.
- A.3. The IPC committee oversees the infection prevention process through evaluation, analysis and interpretation of the infection prevention data. The performance-improvement framework is used to design, measure, assess and improve the organization's performance of the surveillance, prevention and control of infection. The committee is responsible for approving and documenting the selection of surveillance programs designed to improve the quality of care.
  - A.3.1. Clinical interaction through education, quality improvement efforts, and communication is maintained to increase the effective application of infection prevention and control principles.
  - A.3.2. The BRH leadership provides adequate resources (human, informational, physical, and financial) to support infection prevention and control activities. (IC 01.02.01)
- A.4. BRH services include emergency care, surgical services, critical care, obstetrics, general medical, diagnostic imaging (mammography, CT, MRI, ultrasound and radiology), laboratory, chemo/infusion therapy, oncology, hematology, physical/occupational/speech therapy, mental health inpatient treatment, outpatient psychiatric, chemical dependency residential and outpatient treatment, and sleep studies.
  - A.4.1. New programs or services within the hospital will have to be evaluated by an Infection Control Risk Assessment (ICRA). More frequent reviews may be initiated depending on emerging diseases, changes in services or identification of specific risks in populations served. If significant change occurs, the IPC Program will respond in a timely manner, review/approve a plan with the multidisciplinary IPC Committee and re-prioritize risks as necessary.

A.5. Time-sensitive or critical issues:

A.5.1. The scheduled quarterly meeting of the IPC Committee may not be timely to address time-sensitive issues. In the event that time-sensitive issues endanger life or create a patient or employee safety concern, immediate action will be taken to alert those necessary to correct the situation.

A.5.2. Issues or situations of any level of criticality may be brought to the attention of the committee members through the Infection Preventionist, Case Managers, Department Directors, other medical or unit staff, or the Quality/ Risk Management department.

A.5.2.1. Critically significant situations should be brought to the attention of the IPC Committee physician chair as soon as they are identified.

A.5.2.2. The level of criticality should guide committee decisions for referral or action when an infection safety issue is identified.

A.5.2.3. Actions appropriate for the IPC Committee chair to take may include:

A.5.2.3.1.1. Calling an *ad hoc* IPC Committee meeting, if appropriate for timely response.

A.5.2.3.1.2. Directly contacting the physician chair of the committee that has authority over the situation.

A.5.2.4. The IPC Committee chair may directly contact another staff (physician or Senior Leaders) who has authority to correct the critical situation without further delay.

A.5.2.5. When a safety issue is identified, and the committee requires additional information or resources, the committee will bring the issue immediately to the attention of one of these functioning committees:

A.5.2.5.1.1. Committee Chair of the specific Service Line wherein the threat is occurring.

A.5.2.5.1.2. Medical Staff Quality Improvement Committee (MSQIC) Chair.

A.5.2.5.1.3. Medical Staff Executive Committee Chair.

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A.5.3. IPC Committee and medical staff will collaborate with others as appropriate to make decisions based on patient/employee safety.

A.5.4. All situations that are identified, their level of criticality, actions taken, and any follow up recommendations will be reported through the IPC Committee to the MSQIC and/or Hospital Quality Council (HQC), as appropriate.

A.6. The Infection Prevention and Control Committee reviews and approves, annually all hospital-wide and department-specific policies and procedures related to the infection surveillance, prevention, and control programs of the IPC Committee and all departments.

A.7. Physicians, Quality Management, Nurses and the Infection Preventionist actively pursue continuing education in Infection Prevention and Control and collaborate with local, state, and national experts in infection prevention to maintain a working knowledge base. Competency and continuing education is required and is maintained annually.

A.8. The IPC Committee operates as a review organization, and so is entitled to the protections offered by Alaska Statute (AS 18.23.030) and federal law.

A.9. The minutes of the Infection Prevention Control Committee are forwarded to the Medical Staff Executive Committee.

B. The Infection Preventionist is designated as the Infection Prevention and Control Officer, and is responsible to develop and implement policies governing control of infection and communicable disease.

B.1. In the absence of the Infection Preventionist (after hours or during periods of leave), the House Supervisor will assume responsibility for daily infection prevention and surveillance, ensuring that isolation protocols are initiated and/or discontinued for patients as indicated.

B.2. The Infection Preventionist will monitor infection prevention activities throughout the organization, with special emphasis on the surgical suite, central sterile processing, environmental services, the kitchen, and nursing units. This monitoring will include regular surveillance and observation activity. (NPSG 07.05.01)

- B.2.1. The IP will monitor hand hygiene compliance facility-wide on a monthly basis.
  - B.2.1.1. Department managers will assist in recruiting and retaining unit Hand Hygiene Champions.
  - B.2.1.2. IC will report compiled information obtained from these observations to department leaders, facility leadership, and all staff.
- B.2.2. The Infection Preventionist will notify the appropriate regulatory agency, to include but not limited to, the Alaska Department of Health and Social Services (DHSS), State of Alaska (SOA) Section of Epidemiology (SOE), or Centers for Disease Control and Prevention (CDC) of any mandatory reportable disease or epidemiological important organism in a timely manner. (IC.01.05.01 & IC.02.01.01)
  - B.2.2.1. The IC program at BRH will use an epidemiological approach consisting of surveillance, routine analysis, and emerging threat identification through collaboration with microbiology, DHSS, SOA Section of Epidemiology, CDC, community partners, and employees.
  - B.2.2.2. BRH will communicate with community partners (DHSS, SOA, other facilities, physician's offices, clinics, and other hospitals) of known or discovered infectious events or patient movement in a timely manner for continual surveillance, education, and prevention of infectious disease transmission.
- B.2.3. The Infection Preventionist will act in an advisory and supportive role to ensure the Occupational Health and Safety Program Specialist is coordinating the health and safety program for patients, employees, visitors, and contractors during renovation, construction, and maintenance at the hospital.
- B.2.4. The Infection Preventionist will act in an advisory and supportive role to ensure that high quality disinfection, sterilization, and safe use of non-critical, semi-critical, and critical reusable medical equipment (RME) is maintained.
- B.2.5. The Infection Preventionist will oversee and provide guidance to Employee Health and Infection Prevention that includes but is not limited to: Respiratory Protection Program, Immunization screening, TB screening, and correct PPE utilization (IC.02.04.01).

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B.2.6. The Infection Preventionist will assist in the organizational Emergency Preparedness to include, but not limited to, pandemic respiratory viral illness, emerging special pathogens, influx of infectious patients, and natural disasters. (IC.01.06.01).

B.2.7. IPC will participate in the Clinical Product Review Committee to facilitate and approve new safety engineered devices/supplies.

### ***Risk Assessment and Prioritization of Goals (IC 01.04.01)***

The Infection Prevention and Control Committee, in collaboration with hospital leadership, identifies risks for transmitting and acquiring infection within the organization, based on the many factors discussed below. The Committee will develop a risk assessment at least annually, or when significant changes materially change risk prioritization (noted below), using information from all applicable committees and individuals as appropriate. Consideration will be given to those issues that are high risk, high volume, and/or problem prone, and to new techniques or procedures, or related to emerging trends. The Committee will develop action plans to address these issues (see current Risk Assessment and Prioritization List). The factors to be addressed in the risk assessment include, at a minimum: Hospital Acquired Infections, Antimicrobial Stewardship, Hand Hygiene, influenza and novel respiratory pathogens, medical devices, occupational exposures, and infectious organisms/diseases.

### ***Geographic Location and Community Environment***

Bartlett Regional Hospital is a community-owned acute care hospital licensed for a total of 58 inpatient beds and 8 residential substance abuse treatment facility beds in the Rainforest Recovery Center. In addition to the communities of Juneau and Douglas, we serve all the Southeast Alaska communities of Yakutat, Skagway, Haines, Sitka, Hoonah and Angoon. The primary and secondary service area has a combined population estimate of 46,653. Bartlett serves a 29,991-square-mile region in the northern part of Southeast Alaska. Juneau, the largest city in the region and the capital of Alaska is accessible only by water or air. The population of the city and borough of Juneau is 31,848 ([US Census, 2021](#)). This includes 5.8 % who are under 5 years of age, 21.5% persons who are under 18 years, and 12.5 % that are over 65 years of age. (US Census, 2021) The underserved and disadvantaged population includes: 7.9% with a [disability and under 65 years of age](#); and 11.8 % under 65 years of age without health insurance. (US Census, 2021) Additionally, 7.7% of Juneau residents are living in poverty (US Census, 2021).

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### ***Characteristics of the Population Served***

Bartlett Regional Hospital is the largest provider of hospital services in Southeast Alaska. It serves a diverse community of residents. Tourism expands the service area population by approximately 30% from May to September each year, welcoming visitors from 50 or more countries. These include the workers for the fisheries, mining and tourism agencies that are seasonal; approximately 27,000 people work seasonally in Southeast Alaska every year; 70% are non-residents, and many are foreign born from high TB incidence countries. The fisheries, mining and cruise ships provide tight living quarters for their seasonal employees, which may increase the incidence of any disease. The cruise lines bring tourists and workers from many different countries. BRH must consider ship quarantine or influx of infectious diseases. This seasonal influx in local population presents ongoing significant potential for mass trauma and communicable disease outbreak, requiring BRH to maintain careful surveillance, awareness of global emerging infectious disease trends (Pandemic or Novel strains of Influenza, COVID-19, MDR Tuberculosis, CRE, Ebola, etc.) and to maintain an updated emergency management and surge capacity plan.

The Alaska Department of Health and Social Services [2019](#) TB Summary Brief Report shows that Alaska's TB infection rate was 7.9 cases per 100,000 people, representing a slight decrease from the previous year (AK SOE, 2020). Alaska still has the highest TB incidence rate in the nation, and is nearly three times the national average of 2.7 cases per 100,000 people. Southeast Alaska's incidence rate has decreased from 2.7 to 1.4 cases per 100,000.

### ***Results of Analysis of Bartlett Regional Hospital Infection Prevention Data***

Bartlett Regional Hospital conducts hospital-wide surveillance for all types and categories of infection. The surveillance results from surgical site infections (SSI), device-related infections (Central Line Associated Blood Stream Infection[CLABSI], Catheter Associated Urinary Tract Infection [CAUTI], Ventilator Associated Events [VAE], Methicillin-Resistant Staphylococcus Aureus [MRSA], and *Clostridioides difficile* [CDI]) rates and communicable disease exposure events are reviewed for variance and reported to hospital leaders, the Patient Safety Committee, the Critical Care Committee, and medical staff as appropriate. A yearly Infection Prevention and Control Plan and a summary analysis of the prior year's plan, goals, strategies, activities, and issues are submitted annually to the Governing Board.

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### ***Evaluation of the Infection Control and Prevention Plan***

Plan evaluation is an ongoing process that is measured and reported annually by comparing the described measurable objective to the observations/measurements as described in the plan. If the objective is met, then that particular goal is considered to be met for the plan year.

### ***Care, Treatment, and Services Provided***

Bartlett Regional Hospital's current strategic plan notes twenty-four services that are provided on campus. High-risk and high volume services are included in the risk assessment process.

### ***Employee Health***

Bartlett Regional Hospital provides a safe working environment for its approximately 745 employees and 79 licensed independent providers. 567 (76 %) are full or part time scheduled and working on campus. This is accomplished through coordination of Infection Prevention policies and practices, and through the services provided by the Employee Health Program such as Hepatitis B vaccination, TB testing, and screening for immunity to vaccine-preventable diseases. Employees that handle or contact hazardous drugs participate in the medical surveillance program. Employee illnesses are categorized and logged daily by the Central Staffing Office and Employee Health Nurse, and analyzed by Employee Health. The goal is to identify and mitigate infectious conditions that may pose a risk to patients, visitors, or staff, and to ensure that staff are immune to vaccine-preventable diseases.

### ***Emergency Preparedness***

Bartlett Regional Hospital maintains readiness to respond to both internal and external threats and emergencies through its Emergency Management Plan, Emergency Management Team, Environment of Care Committees, and Infection Prevention Committee and Policy Manual.

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**2022 Eval**

# Infection Prevention and Control Plan

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## 2022 Infection Control Plan Goals

Infection Prevention Goal #1	Measurable Objective	Strategies	Responsible Parties	Measurement/ Evaluation Goal Met or Unmet.
<p>► Improve compliance with CDC Hand Hygiene Guidelines</p> <p>(NPSG 07.01.01, EP1).</p>	<p>BRH hand hygiene rates will be improved by 10% over 2021's hand hygiene compliance rate by 9/30/2022.</p> <p>Directors of units that have direct contact with patients will contribute to data collection, with the shared goal of observing 200 hand hygiene moments per unit, per month.</p>	<p>1. Enlist Hand Hygiene Observations from directors of patient care areas.</p> <p>2. Utilize Smartsheets to collect data and share compliance rates.</p> <p>3. Plan and implement Hand Hygiene awareness and educational campaign.</p> <p>4. Work with Patient and Family Engagement Team to increase patient feedback regarding Hand Hygiene.</p> <p>5. Implement more touch free hand hygiene stations throughout the hospital.</p>	<p>Nursing Administration, Directors &amp; Supervisors, Patient Care staff, Infection Prevention.</p>	<p>BRH hand hygiene compliance rate will increase by 10% over 2021 (65%) hospital wide rates.</p> <p><u>Goal Met: 88% compliance</u></p> <p>Patient reported (Press-Ganey) hand hygiene scores will increase by 5% over 2021's reported rates. (72.3%)</p> <p><u>Goal Met:</u> <u>Q2 2022 =80.8%</u> <u>Q3 2022 =85.57%</u></p> <p>Observations collected in each unit, per month will meet or exceed 200.</p> <p><u>Goal Partially Met</u> <u>300 observations in OB 2/22</u> <u>191 observations in OB 4/22</u></p>

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Infection Prevention Goal #2	Measurable Objective	Strategies	Responsible parties	Measurement/ Evaluation
► Reduce surgical site infections by reducing risk of infection.	Reduce surgical site infection rate at or below 0.3 per 100 procedures by 12/31/2022.	1. Monitor staff compliance with pre procedural bathing, oral care and nasal decolonization. 2. Utilize dietary consult pre-op to reduce risk of perioperative hyperglycemia. 3. Ensure compliance with best practices to reduce surgical site infections (Normothermia, correct pre-op antibiotics, etc.) 4. Increase Hand Hygiene compliance.	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	Measure surgical site infection rates and compare to 2021.  Rate will be $\leq 0.3$ infections per 100 procedures.  <u>Goal not met</u> <u>Rate is 0.5 infections per 100 procedures</u> <u>8 infections</u> <u>1591 procedures</u>
Infection Prevention Goal #3	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
► Decrease the risk of acquiring health care associated C. difficile. (NPSG 07.03.01)	Limit the risk of HAI C. difficile transmission and reduce HAI CDI rates to 2 infections per 10,000 patient days by 12/31/2022.	1. Ensure adherence to testing only symptomatic patients. 2. Utilize 2 step testing to identify only toxigenic cases. 3. Increase utilization of Sterile Meryl for all terminal cleaning. 4. Ensure appropriate cleaning and disinfection products	Nursing, EVS, Infection Prevention, pharmacy, medical staff, laboratory and all staff.	Measure C. difficile infection rates and compare to 2021 baseline.  There will be no increase in HAI- C. Difficile rates for 2021. <u>Goal Met</u>

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		(sporicidal) are available for C. difficile rooms and area is cleaned per protocol. 5. Prohibit unnecessary antibiotic use. 6. Increase hand hygiene compliance		<u>2 HAI CDIFF infections</u> <u>Rate 1.98 per 10,000 PD</u>
Infection Prevention Goal #4	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
► Prepare for and protect staff, patients and our community from respiratory pathogens in an efficient and safe manner. (IC.02.04.01)	1. Maintain full time/ part time scheduled staff influenza & COVID vaccination at rates 98 % or greater for the 2022-2023 season.	1. Participation in the influenza and COVID-19 prevention plan is mandatory. 2. Unvaccinated staff are required to wear barrier masks. 3. Enforce standard precautions are in use for any aerosol-generating procedure. 4. Continue to monitor and report pertinent information regarding illness trends in the community and at BRH.	Leadership, all staff, IC, and employee health	Full time/ part time scheduled staff compliance rate will be at 98% or greater by November 30, 2022.  Report data via NHSN.  <u>Goal not met (as of 11/4/22)</u> <u>555 FT or PT employees</u> <u>471 have been vaccinated</u> <u>(84%)</u> <u>35 have declined</u> <u>48 unknown</u>

~~January 7~~ November 8<sup>th</sup>, 2022

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<http://dhss.alaska.gov/dph/Epi/id/Pages/tb.aspx>

United States Census Bureau. (2020) Quick Facts: Juneau City and Borough, Alaska. Retrieved from: <https://www.census.gov/quickfacts/juneaucityandboroughalaskacounty> (Census)

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Number and rate<sup>(1)</sup> of nonfatal occupational injuries and illnesses by selected industry, All U.S., private industry, 2019 - 2021, Bartlett Hospital 2019 - 11/25/2022

Characteristic	Private		Hospitals						Alaska Hospitals			Bartlett Hospital							
	Number	Rate	Number			Rate			Rate			Number				Rate			
	2021	2021	2019	2020	2021	2019	2020	2021	2019	2020	2021	2019	2020	2021	2022	2019	2020	2021	2022
Recordable Injuries and Illnesses																			
Total cases	2,607,900	2.7	221,400	303,900	240,700	5.5	7.6	6.1	6.3	9.7	4.4	21	7	15	15	4.53	1.36	2.855	3.192
Cases with days away from work, job transfer, or restriction	1,617,300	1.7	89,900	183,200	125,100	2.2	4.6	3.2	1.6	5.5	2	2	1	2	1	0.43	0.19	0.38	0.21
Cases with days away from work <sup>(6)</sup>	1,062,700	1.1	52,100	148,400	90,000	1.3	3.7	2.3	1.3	5.1	1.7	2	1	2	1	0.43	0.19	0.38	0.21
Cases with job transfer or restriction	554,600	0.6	37,700	34,800	35,100	0.9	0.9	0.9	0.3	0.4	-	0	0	0	0	0	0	0	0
Other recordable cases	990,700	1.0	131,600	120,700	115,600	3.3	3	2.9	4.6	4.2	2.4	19	6	13	14	4.09	1.16	2.47	2.98
Injuries																			
Total cases	2,242,700	2.3	207,200	189,600	188,600	5.2	4.7	4.8	Data Not Available			16	4	14	15	3.45	0.78	2.66	3.19
Sharps Injuries (Bartlett Hospital)												4	3	14	11	0.86	0.58	2.66	2.34
Illnesses																			
Total cases	365,200	37.7	14,300	114,300	52,100	35.5	286.3	131.6				5	3	1	0	1.08	0.58	0.19	0
Illness categories																			
Skin disorders	11,700	1.2	1,400	1,800	1,200	3.4	4.4	3.1				0	1	0	0	0	0.19	0	0
Respiratory conditions	269,600	27.8	1,600	95,900	41,000	3.9	240.2	103.5				0	0	0	0	0	0	0	0
Poisoning	1,200	0.1	100	-	-	0.1	0.1	0.1				0	0	0	0	0	0	0	0
Hearing loss	12,000	1.2	-	100	-	0.1	0.2	0.1				0	0	0	0	0	0	0	0
All other illness cases	70,800	7.3	11,200	16,600	9,800	27.9	41.5	24.7				5	2	1	0	1.08	0.39	0.19	0

**Footnotes:**

(1) Incidence rates represent the number of injuries and illnesses per 100 full-time workers (10,000 full-time workers for illness rates) and were calculated as: (N / EH) X 200,000 (20,000,000 for illness rates) where, N= number of injuries and illnesses, EH= total hours worked by all employees during the calendar year, 200,000= base for 100 full-time equivalent workers (working 40 hours per week, 50 weeks per year) 20,000,000= base for 10,000 full-time equivalent workers (working 40 hours per week, 50 weeks per year).

(2) Data are coded using the North American Industry Classification System (NAICS). For more information on the version of NAICS used in this year, see our Handbook of Methods concepts page: <https://www.bls.gov/opub/hom/soii/concepts.htm>.

(3) Excludes farms with fewer than 11 employees.

(4) Data for Mining (Sector 21 in the North American Industry Classification System) include establishments not governed by the Mine Safety and Health Administration (MSHA) rules and reporting, such as those

(5) Data for employers in railroad transportation are provided to BLS by the Federal Railroad Administration, U.S. Department of Transportation. These data do not reflect the changes Occupational Safety and Health Administration made to its recordkeeping requirements effective January 1, 2002; therefore estimates for these industries are not comparable with estimates for other industries.

(6) Days-away-from-work cases include those that result in days away from work with or without job transfer or restriction.

(7) Less than 50 cases

NOTE: Dashes indicate data that do not meet publication guidelines.

SOURCE: Bureau of Labor Statistics, U.S. Department of Labor, Dec 1, 2022

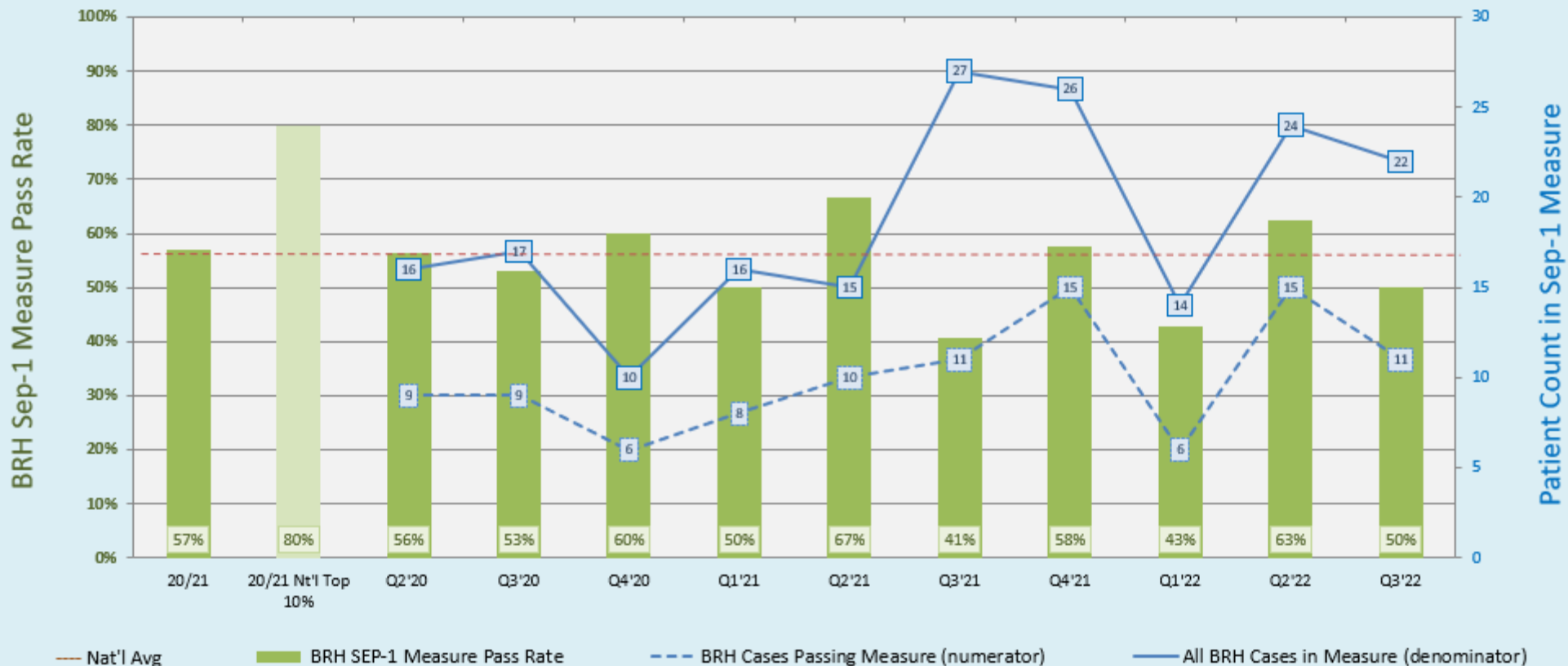
SOURCE: OSHA Form 300A, U.S. Department of Labor, Bartlett Regional Hospital Summary of Work-Related Injuries and Illnesses (NOTE: 2022 numbers not yet submitted, subject to change)

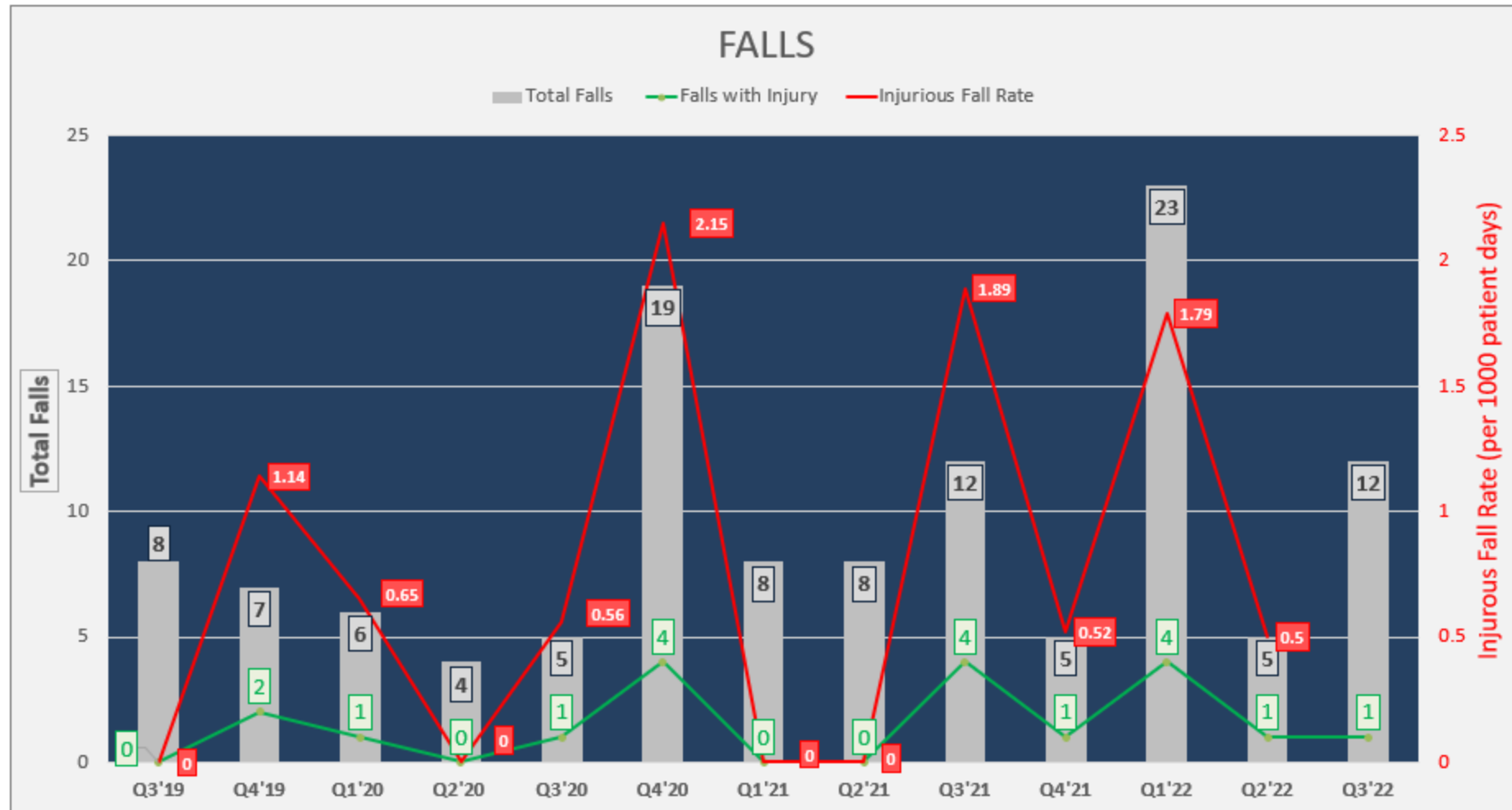
# Board Quality Dashboard

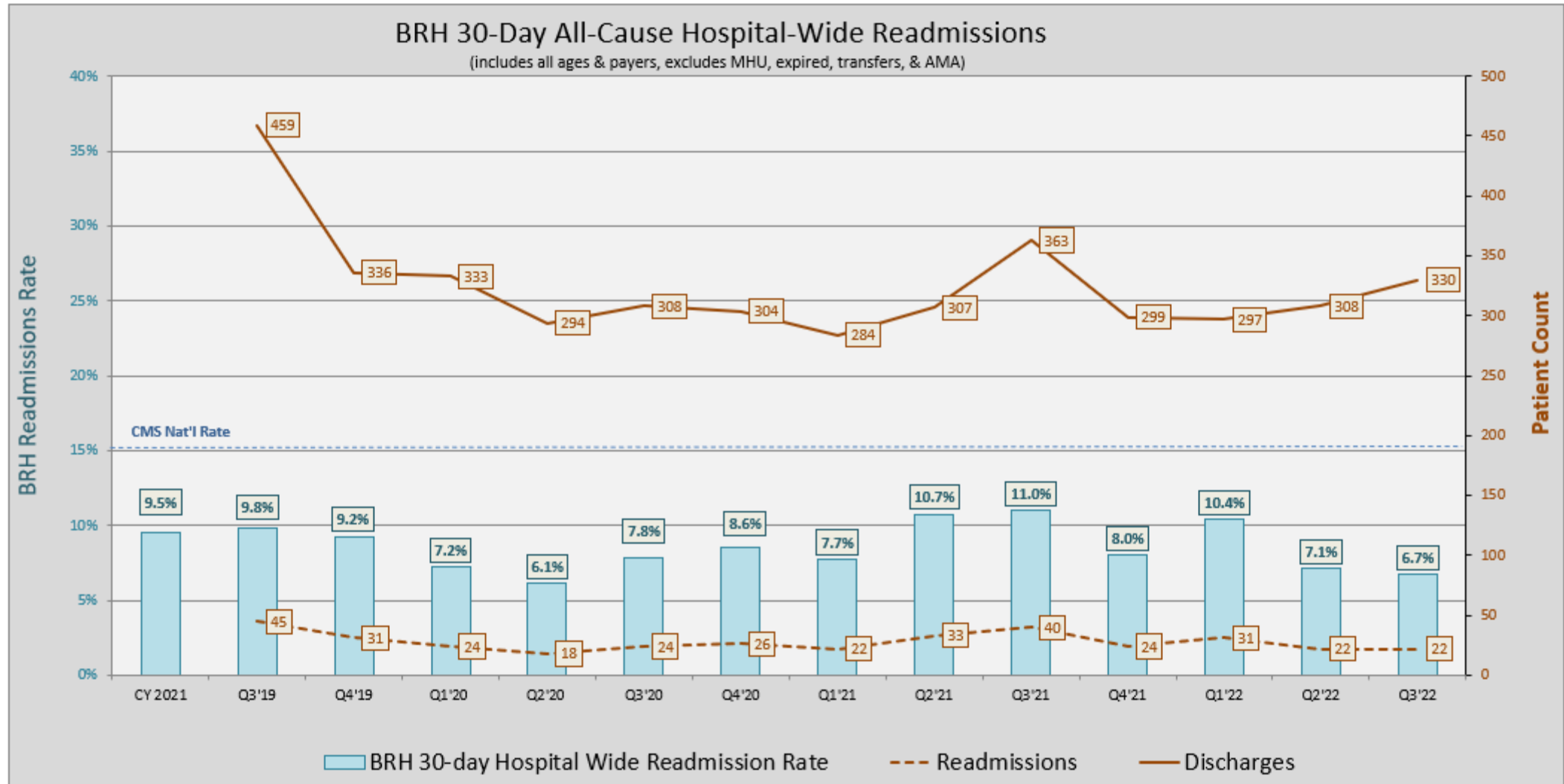
November 2022



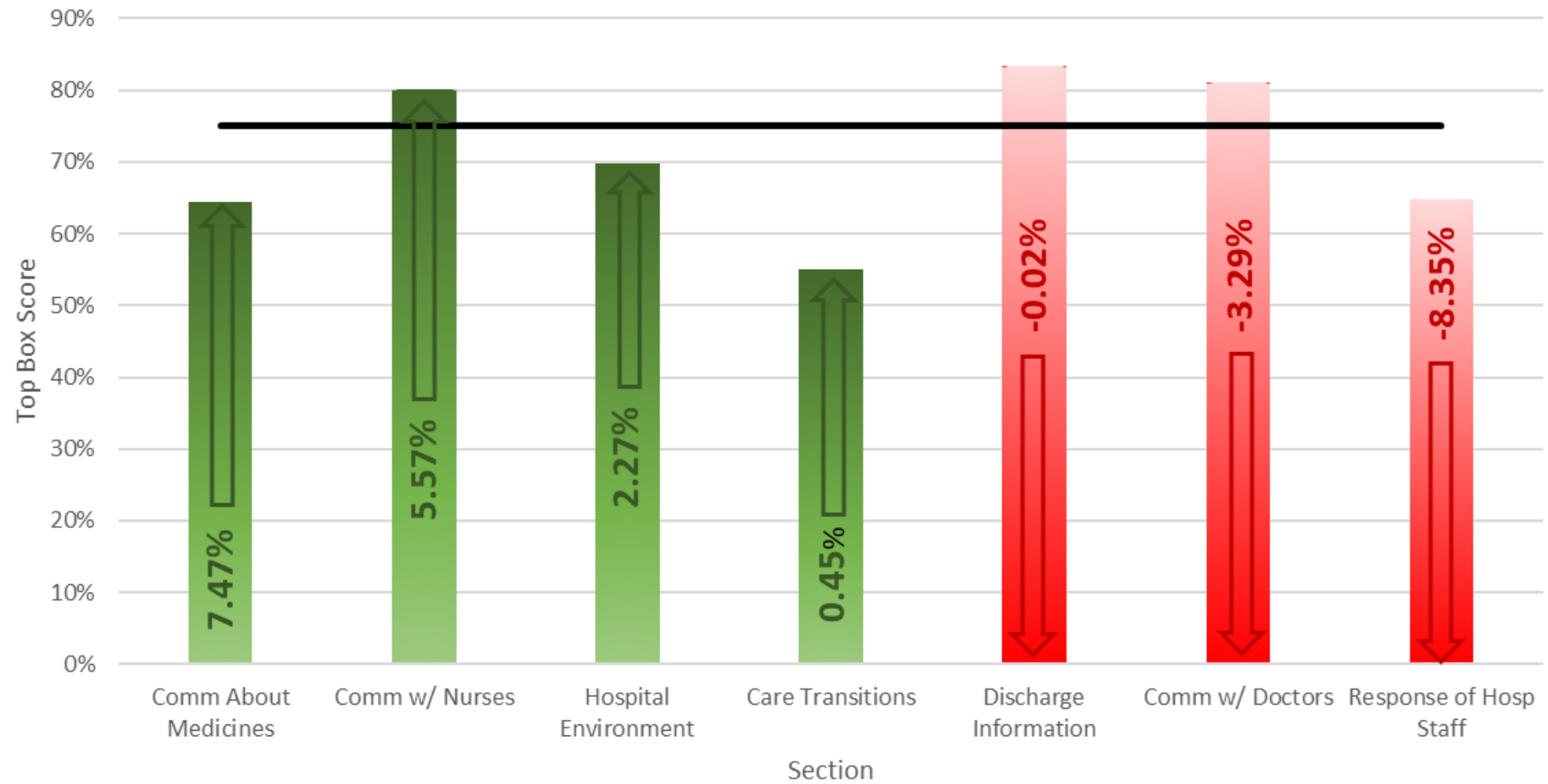
# CMS Sep-1 Severe Sepsis Septic Shock Measure (includes BRH patients who met criteria for the Sep-1 measure)





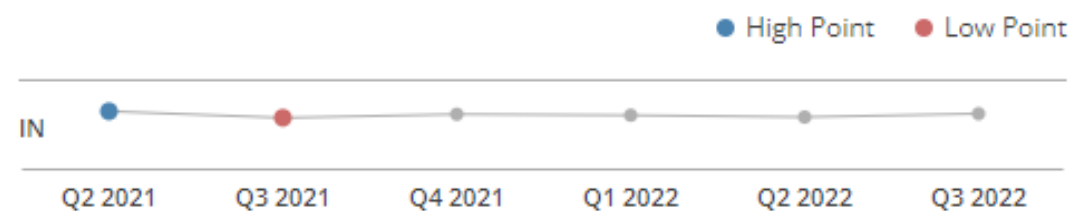
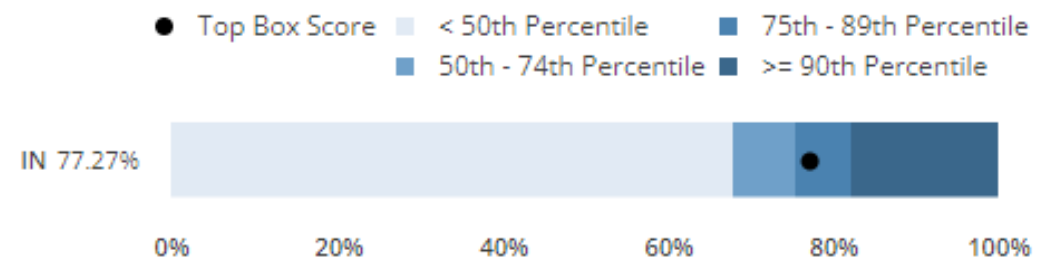


## HCAHPS Section Performance

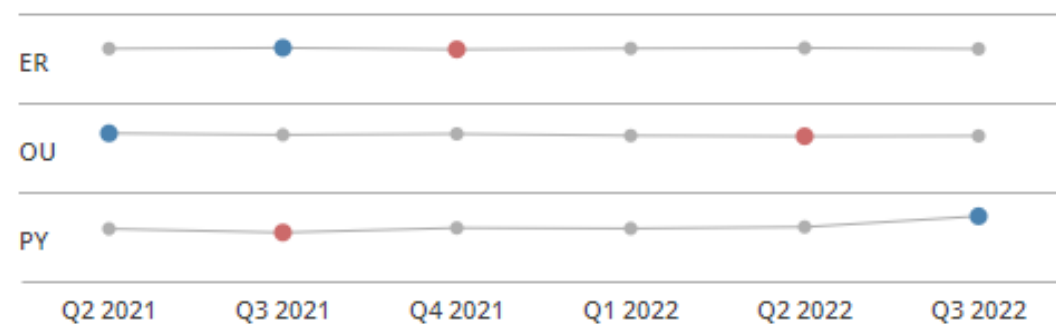
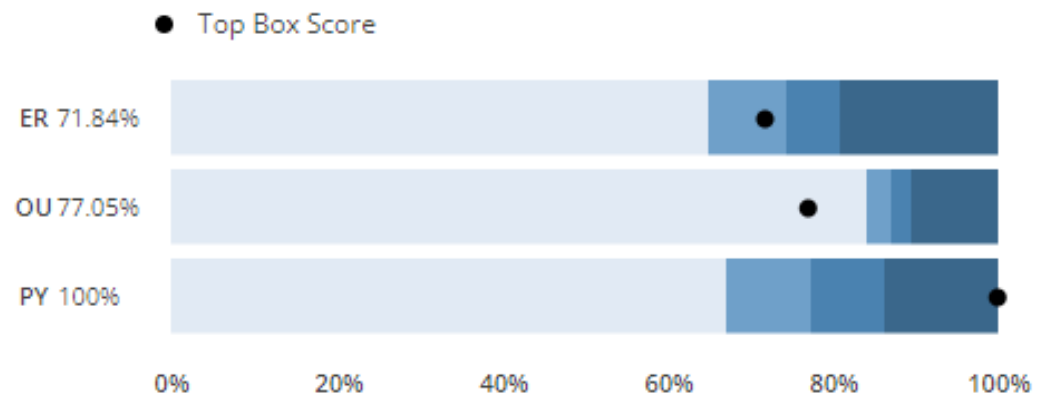


## Service Line Performance ⓘ

Primary Measure: CAHPS Likelihood to Recommend



Secondary Measure: PG Likelihood to Recommend





# The Quality Dashboard



**Bartlett**  
Regional Hospital



## Coming Together for Your Care

- Bartlett provides quality, patient-centered care to over 55,000 people in more than 35 rural communities in the northern part of Southeast Alaska.
- Bartlett is licensed for a total of 57 inpatient beds and 16 residential substance-abuse treatment facility beds.



## About Us

Bartlett is the sole health care organization in Southeast Alaska with Hospital Accreditation by The Joint Commission.



# Our Mission

To provide our community with quality, patient-centered care in a sustainable manner.

At Bartlett, we C.A.R.E.

- Courtesy
- Accountability
- Respect
- Excellence





# The Definitive Dashboard



# Governance Dashboards

- “The Governance Institute includes outcomes, safety, experience and value in its definition of quality” –NRC Governance Institute, 2021
- **How our current dashboards meet these criteria:**
  - Outcomes: Sepsis, Hospital Wide Readmissions,
  - Safety: Patient Falls,
  - Experience: HCAHPS performance,
  - Value:

# Questions to consider:

- How good do we want to be?
- Where is our performance now?
- Where should our performance be?
- When should we expect results?
- How does our strategic plan move us in this direction?
- What resources are we committing to the effort?

# Metrics to consider based on Strategic Plan

- **3. People: Create an atmosphere that enhances employee, physician, and stakeholder satisfaction to improve our ability to recruit and retain. Improve strategic alliances and communication to maintain a community continuum of care**
  - Workforce turnover rates (first-year turnover and vacancy rates)
  - Workforce by status: FT, PT, Casual, Contract(traveler)
- **5. Quality and Safety: Provide excellent community-centered care that improves outcomes, maximizes safety, improves access and affordability and is in compliance with national and state regulations.**
  - IT security data – percent of failed phishing tests, external threats detected
  - Employee Safety – Workplace safety incidents (Joint Commission Standard)
  - Risk Report - # of grievances, care concerns, Adverse events, preventable Harm Events
  - AHHA Safer together Action Plan Goals



