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Providence Mission Hospital

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Owner	[redacted]: Senior Manager Infection Prevention
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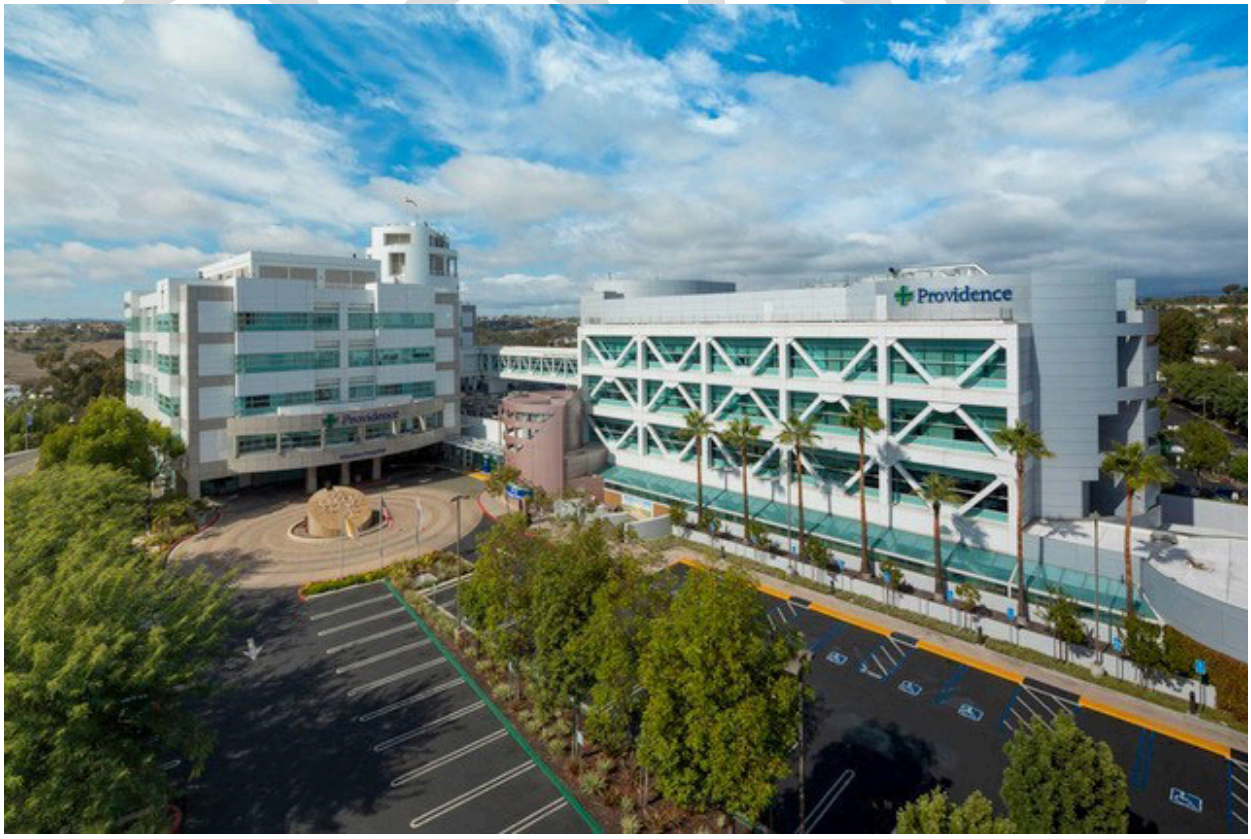
CY 2023 Providence Mission and Mission Laguna Beach Infection Prevention Program Plan Evaluation



Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving

all, especially those who are poor and vulnerable.

Vision

Health for Better World

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INTRODUCTION

The Infection Prevention and Control (IPC) program at Providence Mission Hospital, Mission Viejo and Laguna Beach conducts activities based on patients and caregiver risks for the acquisition and transmission of pathogenic organisms. Evidence-based guidelines and best practices for preventing the spread of healthcare-associated infections (HAI) are implemented and their effectiveness, evaluated.

Calendar year 2023 presented new challenges and changes as the region entered into endemic SARS-CoV-2. . All efforts continued to focus on managing the risks presented by the pandemic and addressing personal protective equipment, visitor management, staffing and patient management.

ACRONYMS

The Joint Commission – TJC

National Patient Safety Goal – NPSG

General Acute Care Hospital Relicensing Survey – GACHRLS

Severe Acute Respiratory Syndrome – Coronavirus - SARS – CoV

CHOC – Children's Hospital of Orange County

SCOPE OF PROGRAM

The infection prevention program is multidisciplinary and functions in conjunction with all facilities, clinics, departments, and services associated with Providence Mission Hospital to assess and integrate quality care practices and infection prevention and control principles. This includes but is not limited to acute patient care units and support services/departments at the Providence Mission Viejo, Laguna Beach, and CHOC at Mission Hospital campus.

PURPOSE OF THE PROGRAM

The purpose of the Infection Surveillance, Prevention and Control Program is to

1. Identify and reduce the risks of healthcare-associated infections (HAIs) in patients, healthcare personnel, and visitors.
2. Prevent the transmission of communicable diseases among the population served by Providence Mission Hospital at Mission Viejo and Laguna Beach.
3. Partner with the Antimicrobial Stewardship Program (ASP) to decrease the emergence of and to

contain the spread of multi-drug resistant organisms (MDRO) and *Clostridioides difficile* within the healthcare setting.

4. Conduct an evaluation of the program at a minimum annually.

PROGRAM EVALUATION [TJC IC.03.01.01]

The Joint Commission accreditation requires the hospital evaluates the effectiveness of the infection prevention and control plan. The hospital evaluates the effectiveness of its infection prevention and control plan annually and whenever risks significantly change. The evaluation includes a review of the following:

1. The infection prevention and control plan's prioritized risks
2. The infection prevention and control plan's goals
3. Implementation of the infection prevention and control plan's activities

Infection Prevention Program Plan and Risk Analysis

Each year an Infection Prevention Program Plan is compiled to succinctly describe and document the review and analytical processes which establishes programmatic priorities based upon identified risks for transmitting and/or acquiring infectious agents within the healthcare setting. Findings from the evaluation are communicated at least annually to the key stakeholders or interdisciplinary group that manages the patient safety program. The hospital then uses the findings of this evaluation to revise the infection prevention and control plan for the coming year.

Risk Assessment

Risk assessments are conducted annually and as needed, to proactively evaluate the impact patient care services, infection prevention practices, and surveillance methodologies have on controlling and/or reducing healthcare-associated infections and disease transmission and the prevalence of epidemiologically significant organisms. These assessments follow standard guidelines and are supported by scientific evidence and evidence-based guidelines.

Policy Development and Review

Policies and procedures are reviewed and/or revised on a specified cycle, annually or every 3 years or when changes occur in rules and regulations, CMS Conditions of Participation (CoPs) and/or Conditions for Coverage (CfCs) evidence-based standards and guidelines and peer-reviewed literature. A personal protective equipment risk assessment was added as an addendum to the overall risk assessment and COVID Prevention Plan were developed in response to the ongoing SARS-CoV-19 Pandemic. **See Table 1.**

Educational Programs [IC.02.05.01, NPSG.07.01.01; GACHRLS HSC §1288.95]

A variety of educational programs are provided for caregiver orientation, in-service, and continuing education.

During the hospital stay if the patient is placed in isolation precautions, is infected or colonized with specific organisms (i.e., MRSA, VRE, *Clostridioides difficile*), and/or has a healthcare-associated infection (i.e., surgical site infection, device-associated infection) the patient is given information which addresses frequently asked questions. Patient and visitors are also provided information on hand hygiene practices. The education is documented in the electronic medical record, EPIC.

As part of the ongoing pandemic, periodic caregiver updates on the SARS-CoV-19 pandemic are shared with all caregivers and providers. This and other information are available to caregivers on the Caregiver SharePoint site.

Surveillance [TJC IC.01.05.01, IC.02.01.01, CMS §482.13, 482.42, 482.51, GACHRLS HSC §1288.8]

Communicable Disease Reporting

Communicable/Infectious disease exposure investigation and follow-up [GACHRLS HSC §70737] become an immediate priority whenever a patient and/or caregiver is involved in an exposure to a communicable disease.

Notifiable conditions [GACHRLS HSC §70737] monitoring and reporting is conducted on an ongoing basis throughout the year in accordance with the Title 17 provisions of the California Administrative Code and Orange County Health Care Agency (OCHCA) requirements.

The outcome of Calendar Year 2023 reporting is presented below. The reportable cases sharply decreased from 1,484 in 2022 to 375 in 2023 as a result of changes to COVID-19 reporting requirements.

Reportable Diseases List MH, LB	**CY22**	**CY23**
Rabies Prophylaxis	21	47
Campylobacteriosis	13	17
Candida auris	3	7
Chlamydia	17	39
Coccidioidomycosis	4	19
COVID-19*	1262	57
Cryptococcus	0	1
Encephalitis, Viral	2	4
Encephalitis, Unknown	0	1
EVALI	5	5
Giardiasis	0	1
Gonococcal infections	10	8
Hepatitis A	4	2
Hepatitis B	17	16
Hepatitis C	38	38
HIV/AIDS	2	5
Influenza (admit to ICU/deaths)	6	10
Legionellosis	8	9
Lyme Disease	0	2
Malaria	0	1
Meningitis, Bacterial	6	6

Meningitis, Fungal	1	0
Meningitis, Viral	12	8
Meningitis, Unknown	0	2
Meningoencephalitis	2	4
Monkeypox	9	0
Other**	6	3
Rickettsial Disease	0	1
Salmonellosis	13	17
Scombroid Fish Poisoning	1	4
Shigellosis	4	6
Syphilis	11	13
Tuberculosis, Extra-Pulmonary	0	2
Tuberculosis, Pulmonary	4	8
Tuberculosis, Both	0	1
Tuberculosis, Empiric Treatment	1	4
West Nile Virus	1	5
Yersiniosis	1	2
Total	**1484**	**375**
*** Reporting deaths and inpatient COVID-19 cases only, as of Jan. 2022. As of December 2022, only COVID deaths are reported.**		
****"Other" category in CY22 includes rubella, rule out CJD, brucellosis, meningococcal disease, toxoplasmosis, and trichomoniasis; CY23 includes brucellosis and encephalomyelitis of unknown etiology.**		

Surgical Site Infections (SSI)

Surgical site infections (SSI) are identified using the CDC NHSN surveillance definitions. When a SSI is identified, a notification is provided to the surgeon's office and surgeon by the IP Medical Director. If trends in SSI are identified by IP caregivers, it is reported to the appropriate committee and the IP Medical Director.

Surveillance is conducted for 26 surgical procedures with maintaining surgical site infections (all deep and organ/space infections) for mandatory reporting. The national SIR benchmark of <1 was met for MV as of the end of Q3 2023; SIR was 0.97. The SIR for LB was 1.15. There is lag in reporting as procedures where an implant is placed is under surveillance for 90 days.

Outcome: Deep and organ/space SIRs for select procedures, 2022 – 2023 through Q3

MISSION VIEJO

Procedure	CY	#Infections	#Procedures	SIR	SIR Goal
APPY	**2022**	**1**	**179**	**NA***	**0.00**
APPY	**2023**	**0**	**231**	**NA***	**0.00**
BILI	**2022**	**5**	**50**	**4.15**	**0.45**

BILI	2023	1	43	NA*	0.00
CHOL	2022	0	247	0.00	0.00
CHOL	2023	0	235	0.00	0.00
COLO	2022	1	198	0.22	0.25
COLO	2023	3	241	0.83	0.25
CSEC	2022	0	585	NA*	0.30
CSEC	2023	1	603	NA*	0.30
FUSN	2022	0	391	0.00	0.32
FUSN	2023	2	437	1.05	0.32
FX	2022	3	382	1.16	0.36
FX	2023	2	380	0.63	0.36
GAST	2022	1	104	0.90	0.00
GAST	2023	1	77	NA*	0.00
HPRO	2022	1	174	0.92	0.16
HPRO	2023	0	153	NA*	0.16
KPRO	2022	0	45	NA*	0.00
KPRO	2023	1	45	NA*	0.00
REC	2022	0	48	NA*	0.00
REC	2023	1	47	NA*	0.00
SB	2022	3	148	1.04	0.00
SB	2023	2	142	0.96	0.00
XLAP	2022	0	245	0.00	0.00
XLAP	2023	2	221	NA*	0.00

LAGUNA BEACH

Procedure	CY	#Infections	#Procedures	SIR	SIR Goal
APPY	2022	0	47	NA*	0.00
APPY	2023	0	54	NA*	0.00
CHOL	2022	0	23	NA*	0.00
CHOL	2023	0	15	NA*	0.00
COLO	2022	0	35	NA*	0.25
COLO	2023	0	30	NA*	0.25
FUSN	2022	0	38	NA*	0.32
FUSN	2023	0	22	NA*	0.32
FX	2022	0	57	NA*	0.36
FX	2023	0	56	NA*	0.36
HPRO	2022	3	212	2.85	0.16

HPRO	**2023**	**0**	**195**	**NA***	**0.16**
KPRO	**2022**	**1**	**279**	**NA***	**0.00**
KPRO	**2023**	**2**	**269**	**NA***	**0.00**
LAM	**2022**	**0**	**44**	**NA***	**0.00**
LAM	**2023**	**0**	**32**	**NA***	**0.00**
SB	**2022**	**2**	**14**	**NA***	**0.00**
SB	**2023**	**0**	**13**	**NA***	**0.00**

*** The SIR is only calculated if the number of predicted infections is ≥1.**

MRSA Screening

MRSA Screening is a requirement of Senate Bill 1058 where a process is in place to screen select patients for MRSA within 24 hours of admission if the following criteria is met. Patients screened include those admitted or transferred to the ICU, inpatient dialysis, those in a GACH in the last 30 days, surgical patients (inpatient and outpatients) undergoing a total joint surgical procedure and discharged patients screened on admission and found to be negative on admission.

Outcome: MRSA screening is to be completed on every patient admitted to the hospital. Currently there is no electronic report generated to validate the screening process.

Surveillance of Multi-Drug Resistant Organisms [TJC Standard IC.01.04.01]

Daily surveillance is conducted to monitor both community-onset and hospital-onset MRSA and VRE, *C. difficile* infections, and other MDROs such as *Candida auris*, Extended Spectrum Beta-Lactamase (ESBL) producing organisms, Carbapenem-Resistant Enterobacteriaceae (CRE), CR-Pseudomonas and other multidrug-resistant gram-negative bacteria. All LabID events with MRSA and VRE bacteremia and *C. difficile* infections were reviewed. Other multi-drug resistant organisms are flagged electronically (Epic).

Outcome: Results below are for both MV and LB combined.

	#CY23 Pt-days	CY23 HO	#CY23 Rate	#CY22 Pt-days	CY22 HO	#CY22 Rate
MRSA	84,699	36	0.43	83,054	29	0.35
VRE	84,699	4	0.05	83,054	1	0.01
ESBL	84,699	36	0.43	83,054	26	0.31
CRE	84,699	7	0.08	83,054	6	0.07
VISA	84,699	0	0.00	83,054	0	0.00
VRSA	84,699	0	0.00	83,054	0	0.00
CR-Psa	84,699	16	0.19	83,054	9	0.11
Candida auris	84,699	1	0.01			

- Rate per 1,000 patient-days

ESBL, MRSA, CRE, VRE, and CR-Psa HO rates increased in 2023 compared to 2022. HO rates remained the same or decreased for VISA, and VRSA. *Candida auris* data were collected for 2023 with a HO rate of 0.01.

MISSION VIEJO		

	CY23 Pt-days	CY23 HO	CY23 SIR	#CY22 Pt-days	#CY22 HO	CY22 SIR
MRSA (blood)	**75,645**	**0**	**0.00**	**72,992**	3	0.86
VRE (blood)*	**75,645**	**0**	**0.00**	**72,992**	1	0.01
C. difficile	72,230	16	0.368	69,526	18	0.56
LAGUNA BEACH						
MRSA (blood)	9,054	0	NA**	10,062	0	NA**
VRE (blood)*	9,054	0	0.00	10,062	0	0.00
C. difficile	9,054	3	1.557	10,062	0	0.00

- SIR unavailable on NHSN. Rate per 1,000 patient-days.
- *SIR cannot be calculated as the number of predicted cases is <1.
- **ARU not counted in SIR [16 MV *C. difficile* events with 3 of those in ARU]

At Mission Viejo, there were no cases of HO-MRSA in the blood in 2023, decreasing the SIR from 0.86 in 2022 to 0.00 in 2023. There were no cases of VRE in the blood, yielding a rate of 0.00. There was a decrease in HO-*C. difficile* infections at Mission Viejo in 2023 compared to 2022. There were 16 cases of HO *C. difficile* (including 3 ARU HO cases) which is less than the 18 cases in 2022. This decreased our SIR from 0.556 in 2022 to 0.368 in 2023.

At Laguna Beach, there were no cases of HO-MRSA or VRE bacteremia, There were 3 HO cases of *C. difficile* at Laguna Beach, increasing our SIR from 0.00 in 2022 to 1.56 in 2023

Inter-departmental Oversight [TJC IC.02.02.01 - IC.02.04.01]

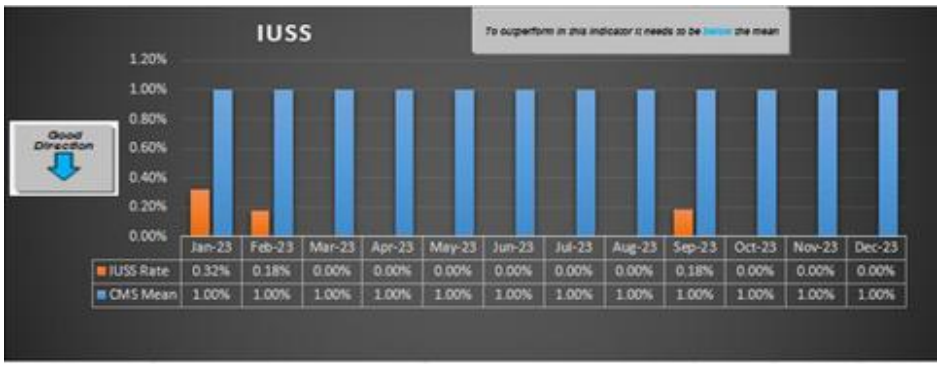
Sterilization and Disinfection

Standardized protocols are developed and monitored in compliance with CDC and Association for the Advancement of Medical Instrumentation (AAMI) guidelines.

Immediate-Use Steam Sterilization (IUSS) is monitored. IUSS in not used for lack of instrumentation or scheduling concerns.

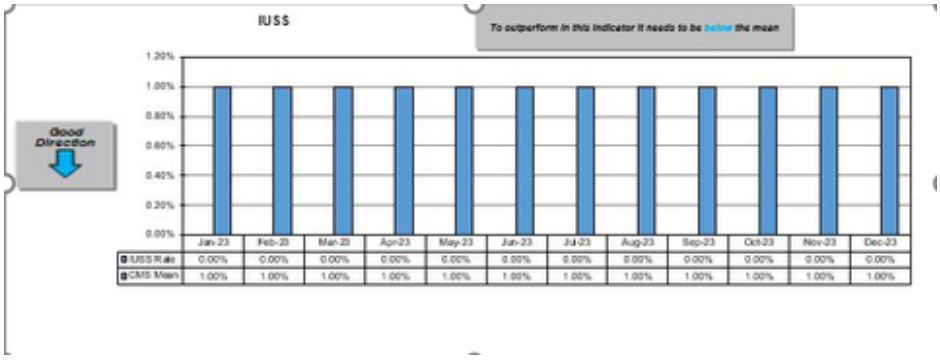
Mission Viejo and NSI

Overall IUSS % CY 2023 Mission Viejo-NSI: 0.08%. Goal = <1%



Laguna Beach

Overall IUSS % CY 2023 Mission Laguna Beach=0.00%. Goal = <1%



Endoscope Processing at Mission Viejo

Total Scopes Processed: 15,910

Total Scope Quality Events: 81

% of Scope Quality Events: 0.51%

Environment of Care

Facilities Engineering – Ventilation System

Air handling systems are monitored to ensure that there is proper air exchange, positive and negative air pressure differentials, HEPA filter integrity, and preventive maintenance and cleaning where appropriate.

Construction and Renovation [GACHRLS HSC §70739]

Infection Prevention collaborates with Facilities and Construction vendors to create protective measures and ensure infection control protocols are met prior to the initiation of construction and/or renovation projects. The Infection Control Risk Assessment (ICRA) is utilized to determine the risk of the project and an infection control construction permit will be developed based on the ICRA. Infection Prevention audits construction and renovation and repair activities to verify compliance with the ICRA updating the ICRA as the project progresses.

Water Management

Water systems are managed in accordance with Environment of Care standards EC.02.05.01 and EP 1-13, and the ANSI/ASHRAE standard 188 for the purpose of preventing the growth and survival of Legionella and other waterborne bacteria in the utility water systems.

Water quality testing is contracted through an external consultant and is carried out based on the frequency outlined in the Providence Mission Water Management Plan.

Emergency Management [TJC IC 01.06.01]

The Infection Prevention department collaborates with the Emergency Management team in the development and implementation of the preparedness, response, mitigation, and recovery phases of the Emergency Management Plan for Providence Mission Hospital.

The influx of infectious patients continued with the ongoing SARS-CoV-19 pandemic. Ongoing monitoring of

personal protective equipment, donning and doffing, and hand hygiene were reinforced. Guidance from the CDPH, senate and assembly bills, CDC and CalOSHA were implemented as required related to caregivers not coming to work with symptoms of COVID, following return to work protocols, and notification of exposed patients and caregivers.

In response to the Ebola outbreak in Uganda, Providence Mission Hospital assembled a team of multi-disciplinary members to begin preparing for the event a PUI or positive patient would arrive. Training materials were reviewed at the division. Ongoing efforts to prep caregivers for a high consequence, high contagious disease will continue in 2024.

Product and Program/Product Line Evaluation

Products used in patient care activities are reviewed to determine if their design and construction, or potential use poses an infection risk. Infection Prevention staff at the division level participate in PSJH's Value Analysis Committee.

Caregiver Health Services [TJC IC.02.03.01]

The Caregiver Health Services Program conducts pre-employment physical examination assessment, annual health assessments, immunization programs, tuberculosis surveillance, prophylaxis for exposure to infectious disease, and the management of work restrictions for employees with transmissible etiologic agents.

Outcome: CY 2023 Caregiver and Volunteer Exposures - Providence Mission Hospital (Mission Viejo and Laguna Beach)

Item	Caregivers	Volunteer	Students	Comments
TB Converters	3	1	0	
TB Exposures	512 from 9 exposure events	0	0	
Varicella/Shingles (Zoster) Exposures	650 from 14 exposure events	0	0	
Scabies Exposures	389 from 3 exposure events	0	0	
Influenza Exposures	97	0	0	
Mumps Exposures	13 from 1 exposure event	0	0	
Lice Exposures	59 from 1 exposure event	0	0	
COVID Exposures	1565	0	0	
Blood/Body Fluid Exposures	52	0	0	

Antimicrobial Stewardship Program (ASP) [GACHRLS HSC §1288.85, 1288.8]

Patterns of antimicrobial resistance are routinely monitored and compiled by Pharmacy into an annual antibiogram available on the Providence available in the Electronic Health Record, EPIC.

A new ASP pharmacy role was filled Sept 2022.

CY 2023 Goals, Performance Indicators and Strategies [TJC IC.03.01.01]

The organization has identified high-risk priorities that were of focus for 2023. The outcomes of these priorities and evaluations are outlined in the table below.

Priority Item	Action / Strategy	Measurement	Performance Indicator/Goal	2023 Outcome	2023 Evaluation
HIGH PRIORITY FOCUS AREAS					
Hand Hygiene Compliance	Develop or revise an existing monitoring tool. Train unknown observers ("secret shoppers") to monitor compliance on entry and exit in and out of patient's room and procedure areas. Enforce system-wide hand hygiene policies. Report monthly compliance to patient care units and department for placement on Caring Reliably boards as well as overall compliance for Laguna Beach and Mission Viejo campuses. Report monthly compliance at the Daily Safety Huddle.	Minimum number of audits per unit per month, based on ADC, by the "secret shopper" observers.	**≥ 90%**	**Overall Compliance = 83% (23,067/ 27,868)** **Mission Viejo 82% (19,162/ 23,235)** **Laguna Beach 84% (3,905/ 4,633)** **See Table 2 below.**	Target not met. However, compliance in 2023 was 83% (23,067/27,868) compared to 79% (7658/9736) in 2022. Though we fell short of the 90% benchmark between the two facilities, there was a substantial compliance improvement rate as well as total number of observations. In 2022, a major reboot was started utilizing LeapFrog grading metrics. These metrics led to an increase in Secret Shopper recruitment, training, and monthly audit thresholds and this continued into 2023, where we began including volunteers and COPE scholars to aid in collecting observations
Colon Surgery	Maintain compliance with surgical infection	CDC NHSN benchmarks and healthcare-	**2023 Indicator: 2021 CDC**	**Through Q3 2023: 3 COLO SSIs**	Target not met. 25th percentile NHSN goal is 0.34

	prevention bundles in collaboration with Surgical Excellence Teams (SET) Meeting with surgical multi-disciplinary teams to identify current issues and discuss prevention efforts. Standardize and complete pre-op antibiotic order sets working with pharmacy, IP/ID, perioperative services, and surgeons. Monitor cleaning processes in the OR. Ongoing education of caregivers on SSI prevention strategies Educate patients and families on their role in SSI prevention prior to undergoing a surgical procedure.	associated infections definitions.	**NHSN 25th percentile goal** **COLO SIR = 0.340**	**at both MV and LB.** **SIR = 0.83 for MV** **LB did not have any COLO infections.**	while Providence Mission Hospital had a SIR of 0.83 through Q3. Surveillance will continue and best practices reinforced. SET interdisciplinary team/committee to be continued in 2024. ACOE placed for SSI Bundle compliance monitoring via Epic to improve gap analysis.
Abdominal Hysterectomy	Maintain compliance with surgical infection prevention bundles in collaboration. Ongoing education of caregivers on SSI prevention strategies.	CDC NHSN healthcare-associated infections definitions.	**2023 Indicator: 2021 CDC NHSN 25th percentile goal** **HYST SIR = 0.310**	**Through Q3 2023: No HYST SSIs at either MV or LB.** **SIR = N/A for both MV and LB.**	Target met. Surveillance will continue through March 2024.
Laboratory Confirmed Central Line-Associated	Provide subject matter expertise to the Providence Mission Hospital	CDC NHSN healthcare-associated infections	**System Goal Outstanding # of Infection MV: 10**	**10 CLABSIs at MV. 1 CLABSI at LB.**	**Infection goal not met but SIR target met for MV.** The SIR of 0.751

Bloodstream Infection (housewide)	HAI Performance Improvement Team Engage bedside caregivers in addressing daily need for central lines and maintenance. Provide infection prevention education/in-services for caregivers. Caregivers to educate patients and families about CLABSI prevention. Continue daily CHG bathing in the ICUs and routinely in other areas throughout the hospital. Continue passive disinfection of IV ports using disinfecting port protectors. Perform monthly audits of central line bundle elements by IPTRNs. Vascular Access Team (VAT) nurses will do majority of central line dressing changes and aim to expand the team to the non-ICU areas for central line maintenance. Collaborate with Critical Care and discuss at Safety	definitions. Providence System goals	**LB: 0 SIR** **MV SIR: 1.2142** **LB SIR: 0.4470**	**MV SIR: 0.751.** **LB SIR: N/A** **See Graph 1 below**	at Mission Viejo was lower than the MV SIR system benchmark of 1.2142. There were 10 infections during CY23 at MV compared to 4 in CY22. The goal (system benchmark) of 10 or less infections was met in CY2023.The MV housewide Standardized Utilization Ratio for CY23 was 0.746, which decreased from the SUR of 0.7610 in CY22. **Infection goal not met and unable to calculate SIR at LB.** There was one CLABSI at LB in the ICU. The goal of 0 infections at LB was not met in CY2023. There is no calculation for the LB CY2023 SIR. The LB housewide standardized utilization ratio for CY2023 was 0.439, a decrease from the CY2022 LB SUR of 0.506. Drill downs were conducted on all cases and discussion of findings and opportunities were discussed at HAI

	Huddle/rounds to reduce inappropriate utilization of lines. Provide education to medical staff on evidence-based guidelines for central line selection. Provide unit-specific monthly reports on infections and line utilization. Collaborate with the unit's assigned IPTRN to perform a drill-down when a CLABSI is identified; highlight missed opportunities to work on future prevention efforts with caregivers.				meetings.
Catheter-Associated Urinary Tract Infection (CAUTI)	Provide subject matter expertise to the Providence Mission Hospital HAI Performance Improvement Team. Engage bedside caregivers in implementation and monitoring compliance for insertion and maintenance. Provide infection prevention education/in-services for caregivers about CAUTI and the importance of infection prevention.	CDC NHSN healthcare-associated infections definitions. Providence System goals	**System Goal Outstanding# of Infection** **MV: 5** **LB: 0** **SIR** **MV SIR: 0.4467** **LB SIR: 0.3650**	**9 CAUTIs at MV. No CAUTIs at LB.** **MV SIR = 0.371** **LB SIR = N/A** **See Graph 2 below**	**Infection goal not met but SIR target met for MV.** The MV SIR of 0.371 is below the system benchmark of 0.4467. There were nine CAUTIs at MV in CY23 compared to 11 in CY22. The number of infections for MV exceeded the goal (9 CAUTIs, system benchmark of 5). The MV SUR for CY23 was 0.813, which was slightly decreased from the CY22 SUR of 0.830.

	Caregivers to educate patients and families about CAUTI prevention. Collaborate with the IPTRNs and discuss at Caregiver Huddle/ rounds to engage staff to follow the urinary catheter removal protocol and perform monthly audits of maintenance bundle. Provide education/training on the use of alternatives to indwelling catheters such as the external catheter for women and the condom catheter/ external catheter for men. Ongoing efforts to promote a Foley-free Emergency Department. In 2023, Providence Mission Hospital participated in the Providence System's Device Associated Infection assessment. Practices from insertion, maintenance, bathing, pericare, catheter care, and incontinence management were observed.				**Infection goal met but unable to calculate SIR at LB.** There were no CAUTIs at LB during CY2023. The LB SUR for CY23 was 0.582 which was slightly increased from the SUR of 0.567 in CY22. Regular rounding is done to determine Foley catheter need and a drill down is conducted with the patient care team on all cases to determine opportunities for improvement. Reinforcement of best practices will continue to prevent future infections.

	Interviews were conducted among RNs, providers, PCTs, and lab techs. Care team huddles, MDRs, shift huddles were attended to listen into discussions. After observations were shared, the organization used PI tools to focus on one improvement project for 2023; two-person insertion practices on 3W and determining the appropriate indication prior to insertion. Provide unit-specific monthly reports on infections, device utilization, and audit results for placement on Caring Reliably Boards. Collaborate with the unit's assigned IPTRN to perform a drill-down when a CAUTI is identified; highlighting missed opportunities to work on future prevention efforts with staff. Foley-free for surgical procedures less than 2 hours. Consistent				

	implementation of protocol and procedure to remove Foley catheters inserted in the OR prior to discharging patients who meet the criteria to the unit.				
Hospital-Onset Clostridioides difficile	Caregivers compliant with standard and transmission-based precautions, which include the use of appropriate PPE, to reduce the risk of infection on both suspected and confirmed pathogens. Ongoing education at orientation and annual caregiver update, and as needed. Compliance with placing patients on Contact Enteric Precautions. IP and Microbiology will strive to improve communication on notifying MDROs to the IP department via fax, phone calls, or other means of sharing the information. MDRO activity will be more closely monitored by IP to better identify infections. IP staff will	NHSN Laboratory Identification Protocol	**Goal: 14 (MV)** **SIR Goal < 1.00**	**19 CDI (16 at MV and 3 at LB)** **MV SIR = 0.368** **LB SIR = 1.557** **See Graph 3 below**	SIR target met at MV and not met at LB. CDIs decreased at MV in CY23 compared to CY22 (16 vs.18). CDI increased at LB in CY23 compared to CY22 (3 vs. 0). The number of infections exceeded the goal of 14 for MV. The MV SIR goal was met, but the LB SIR goal was not met for CY23. A drill down is conducted on all cases to determine opportunities for improvement. Cases are discussed with stakeholders at HAI PI meetings. Continue surveillance and reinforcement of best practices to prevent infections.

	continue their collaboration with EVS on room cleaning and disinfection.				
Increase IP rounding to influence practices and behaviors of caregivers	Using tool enable rounding with purpose.	IP Rounding tool	**Rounding on all units/ department by IPs daily**	**Completed**	Goal met. Unit and department rounding were completed at least weekly by the infection preventionist. Opportunities for education were identified and provided.
Sustain eligible caregiver/ provider compliance with the influenza vaccine ≥ 90%.	Caregiver vaccinated between September 2022 and April 2023. Provide influenza vaccination at no cost to caregivers as soon as vaccine is available. Continue to direct patients and visitors to the respiratory hygiene stations and that they are properly stocked by EVS. Timely and appropriate placement of suspected or confirmed influenza patients in Droplet Precautions. Compliance with isolation precaution policy and procedure and the "Influenza: Seasonal	Vaccine during the flu season along with declinations	**≥ 90% of staff vaccinated**	**Caregivers** **MV = 67%** **LB = 60%** **Providers** **MV = 62%** **LB = 54%** **See Graph 4 before**	Target not met. Unvaccinated caregivers were required to mask. As a result of the pandemic, universal masking by all caregivers and providers significantly impacted the number of influenza cases. This may have given the false impression that since masks are being worn, there was a reduced need for the vaccine.

	Influenza Plan" and the Emergency Management policy, "High-Risk Biological Event/ Influx of Infectious Patients" (Pandemic Influenza) and the Pandemic Preparedness Plan. Caregivers who choose not to participate will continue to follow the masking requirement. Ease the way of caregivers by having flu champions administer the vaccine on the unit. Influenza vaccination rates shared at Medical Staff committee meetings.				
Sterilization and disinfection practices – Quality Assurance Endoscope Monitoring	Cleanliness verification monitoring of high-risk endoscopes using ATP and borescope.	Weekly endoscope cleaning verification	**≤10% of the high-risk endoscope needs to be reprocessed post cleaning verification**	**Total Endoscopes Processed = 15,910 at MV Total Endoscope Quality Events = 81 (0.51%) at MV**	Target met.

Policy/ Procedure/ Plan No.	**Title**	**New Revised Archive**	**Revisions**
Feb 7, 2023			

12900735	Chickenpox, Measles and Selected Communicable Diseases: Patient Management	Revised	• Added info on shingles exposure and updated references.
12901069	Decolonization Using CHG Bathing and Nasal Product	Revised	• Removed CHG wipe and nasal decolonization swab instructions; caregiver to follow manufacturer's IFUs. Updated title and policy to further clarify steps. Updated term, "special contact precautions" to "contact enteric precautions" per Epic.
13239386	Ebola Virus Disease Protocol	Revised	• Adopting division policy
12901270	Post-Exposure Management of Communicable Diseases	Revised	• Updated referenced policy names, terminology ("employees" to "caregivers"). Added info on shingles exposure workup. Updated title to reflect updated content.
13082866	Guidelines for Ambulation of Contact Isolation Patients in the Acute Rehab Unit	Revised	Removed instructions on standard and TBP precautions, as ARU to follow hospital guidelines.
12901702	Hand Hygiene	Revised	Policy mirrors system/division policy
13075169	Isolation Precautions: Standard and Transmission Based (Contact, Droplet, and Airborne)	Archive	Archive; adopt division policy.
13074712	Isolation: Overview	Revised	Updated names/terminology (Providence Mission Hospital, CHOC at Mission Hospital, contact enteric precautions); deleted references to archived policies, updated references and attachments per CDC guidelines
12901501	Lice (Pediculosis) Care and Treatment of Patient and Employee	Revised	Updated terminology (Providence Mission Hospital, "caregivers") and references. Added; do not wash treated hair for 24-48 hrs. Added; exposed caregiver to return to work once cleared by Caregiver Health.
12901689	Pertussis: Patient Management and Occupational Health Guidelines	Revised	Updated terminology (Providence Mission Hospital, caregivers), IP dept extension. Updated references.

12901699	Respiratory Hygiene / Cough Etiquette	Revised	• Added; masks will be available at respiratory hygiene stations. Added; N95 respirators are available upon request. Removed language around respiratory etiquette for visitors, as ill visitors should be not allowed to visit patients.
12901707	Scabies	Revised	• Updated terminology (Providence Mission Hospital) and references
12901714	Sharps Disposal	Revised	• Updated terminology (Providence Mission Hospital). Removed archived policy reference. Updated info on when full sharps container should be replaced (2/3 instead of 3/4) per EVS policy. Added info on one-hand technique.
13239333	Standard Precautions & Transmission-Based Precautions	Revised	Adopting division policy
13239345	Surveillance and Reporting of Communicable Diseases and Healthcare-Associated Infections (HAIs)	Revised	Adopting division policy
12901717	Visitor Infection Prevention	Reviewed	No content changes; edited language.
13082873	Mission Hospital and Laguna Infection Prevention Risk Assessment CY2023	Revised	IP risk assessment for CY 2023
13082876	CY 2023 Providence Mission and Mission Laguna Beach Infection Prevention Program Plan	Revised	IP Program Plan for CY 2023
13603684	CY 2022 Providence Mission and Mission Laguna Beach Infection Prevention Program Plan Evaluation	Revised	Program evaluation for CY 2022. SSI data through Q3 as the surveillance window has not closed; will re-submit final report in May 2023.
May 2, 2023			
13432680	Creutzfeldt-Jakob Disease (CJD) and Prion Disease: Prevention of Transmission	Revised	Deleted steps under Pathology that do not occur at Mission Hospital (freeze or process tissues for suspected/ known/"high-risk" CJD) and updated

			references.
13432683	Influenza: Seasonal Influenza Plan	Revised	Deleted definitions of each HCW personnel and updated to "workforce personnel." Incorporated patient placement/cohorting and RTW guidelines from CMH. Updated references
13432702	Tuberculosis Control Plan CY 2023	Revised	Updated TB Control Plan with data from 2022; Mission Hospital remains a low risk facility despite seeing a slight increase in the number of TB cases as reflected in OC.
13603684	CY 2022 Providence Mission and Mission Laguna Beach Infection Prevention Program Plan Evaluation	Revised	Updated with final 2022 SSI data
August 1, 2023			
14097880	Reportable Diseases	Revised	Added definition of OCHCA and updated Attachment A (list of reportable conditions per OCHCA)
14097982	Construction and/or Renovation: Infection Control	Revised	Updated the policy to include Class V projects. Updated attachments per system RESO and IP.
November 7, 2023			
13953776	Catheter Associated Urinary Tract Infection (CAUTI) Prevention	New	Adopt system policy
13953639	Central Line Associated Blood Stream Infection (CLABSI) Prevention	New	Adopt system policy
14642590	Cleaning and Disinfection of Equipment	Revised	Minor revisions; added statement at the beginning of the policy that all caregivers play a role in maintaining compliance with regards to cleaning. Updated Cleaning Grid.
14625979	Aerosol Transmissible Disease (ATD) Exposure Control Plan	Revised	Division policy; Made a Division Plan and eliminated reference to specific ministries or regions. Editorial changes that do not affect the content of the ATD. Updated references where available.
14625919	Bloodborne Pathogens Exposure Control Plan	Revised	Division policy; This plan was made a South Division

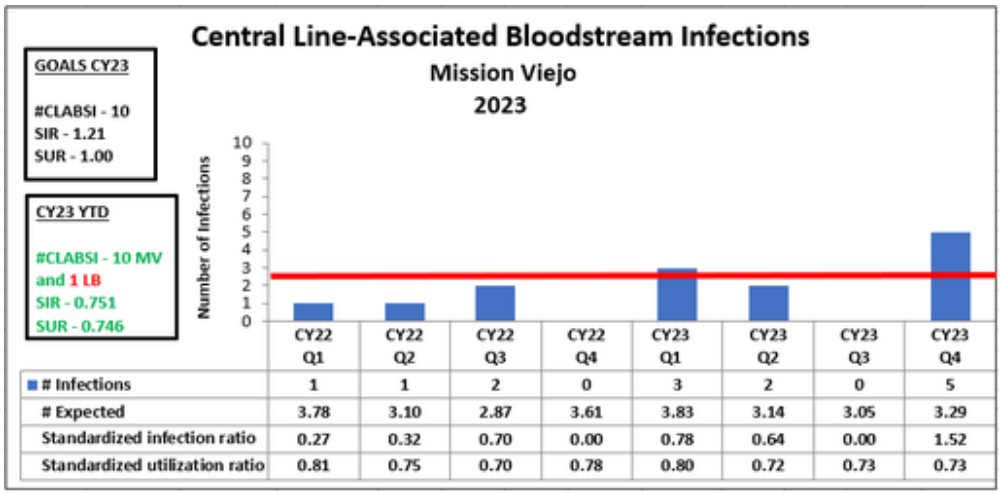
			Plan Title change to Bloodborne Pathogens Exposure Control Plan. Added to the list of caregivers with occupational exposure to bloodborne pathogens. Expanded list of caregivers with occasional or rare occupational exposure with blood and body fluids. Editorial changes that did not impact the original content. Updated references
10782343	MRSA Testing	Archive	Archive local policy
14222850	MRSA Active Surveillance Screening	Revised	Adopt division policy; Add: For CHOC at Mission Hospital patients, continue to screen fracture surgery patients upon discharge. Policy was made applicable for the South Division. Procedure was deleted along with specific responsibilities. Minor editorial changes that did not impact the content of the policy.
14222828	Tuberculosis Management and Discharge (GOTCH Bill)	Revised	Adopt division policy. Will continue to maintain local policy, as the division policy is more specific to discharge process. Made the policy division-wide Deleted reference to LA County Included collaboration with Case Management for patient discharge process Minor editorial changes not impacting the intent of the policy
14626039	Outbreak Investigation and Management Plan	Revised	Adopt division policy Title change to a Plan. to emphasize that this is more than a policy. Expanded to be a South Division plan. Expanded purpose to give more general details with objectives. Expanded the definition section Added section on the procedure to follow and responsibilities of key facility stakeholders. This is outlined in the table with person responsible and duties/procedures to be completed. Expanded and reformatted the Procedure/General Instructions

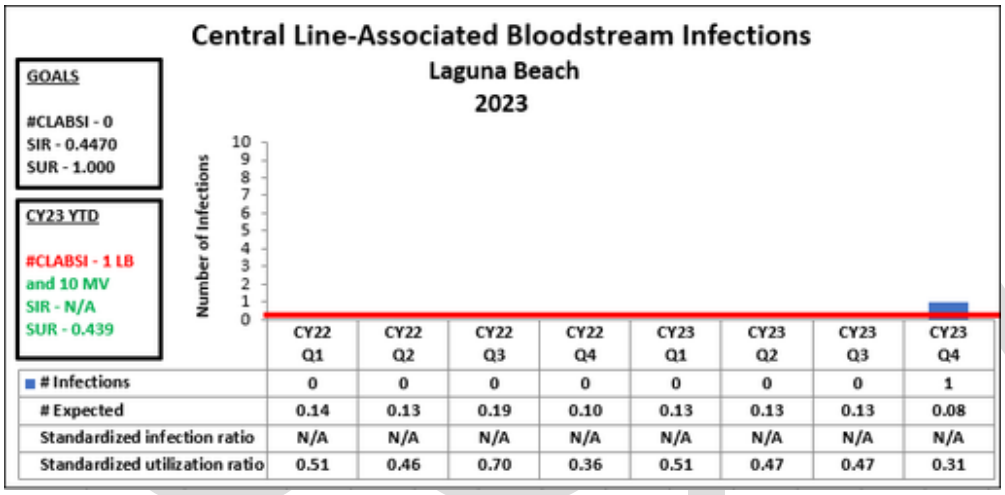
			Updated the references General edits that do not impact the content of the plan.
11471400	Unusual Occurrence / Outbreak Management	Archive	Retire local policy; adopting division policy

Table 2: 2023 Hand Hygiene Compliance – Mission Viejo and Mission Laguna Beach

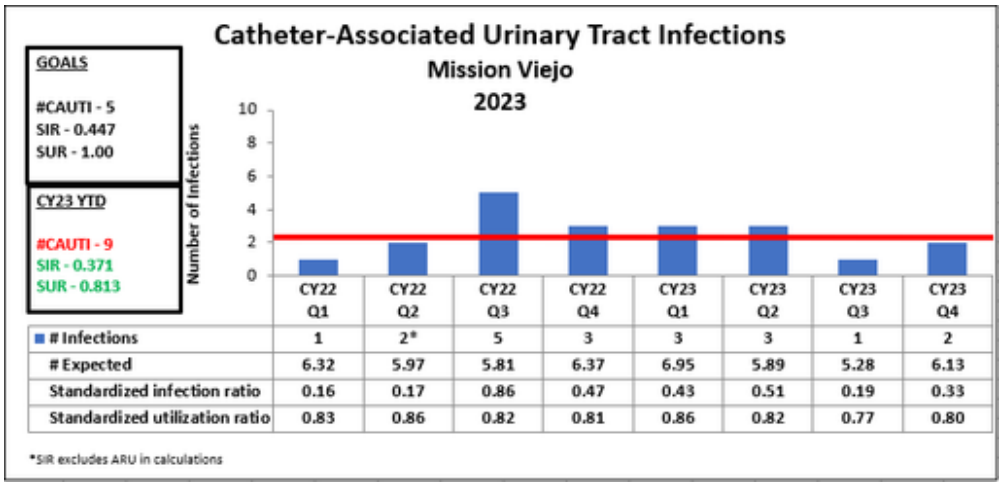
Unit	Expected Number of Observations	Total		
		Compliance Rate	Num	Denom
MY 3 East - Surgical	100	83%	2380	2864
MY 3 West - Medical	100	87%	2263	2603
MY Acute Rehab Unit	100	85%	789	929
MY Cardiac Cath Lab	50	78%	193	247
MY Cardiac Telemetry	100	73%	1313	1793
MY CICU	100	73%	871	1200
MY DSU	75	77%	784	1024
MY ED	100	92%	1190	1295
MY Endoscopy Inpatient	50	96%	506	528
MY Endoscopy Outpatient (GI Lab Offsite)	50	78%	211	272
MY Imaging / Radiology Pavilion	50	55%	43	78
MY Interventional Radiology	50	79%	268	341
MY Labor & Delivery	37	79%	504	637
MY L&D OR	7	85%	52	61
MY L&D PreOp/PACU	7	63%	40	64
MY Neuroscience & Spine Institute OR	15	100%	7	7
MY NSI PreOp/PACU	15	74%	1237	1675
MY Obstetrics	100	93%	838	903
MY OR	50	45%	45	100
MY PreOp/PACU	100	99%	1229	1240
MY Progressive Care and Stroke Unit	100	89%	1808	2033
MY RICU	22	77%	30	39
MY Same Day Care Unit	22	70%	555	794
MY Surgical ICU (SICU)	100	79%	848	1071
MY Telemetry Sepsis North	100	61%	128	211
MY Telemetry Sepsis South		69%	442	638
MY Women's Wellness Center	50	100%	588	588
Total		82%	19162	23235
LB BHU In Patient	75	100%	760	760
LB ED	50	47%	244	522
LB Endoscopy/GI Lab	7	100%	187	187
LB ICU	22	85%	128	151
LB Imaging Services/Radiology	50	86%	334	387
LB Medical / Surgical Unit	100	87%	1874	2153
LB OR	25	81%	87	107
LB PreOp/PACU	25	80%	291	366
Total		84%	3905	4633
HOUSEWIDE TOTAL		83%	23067	27868

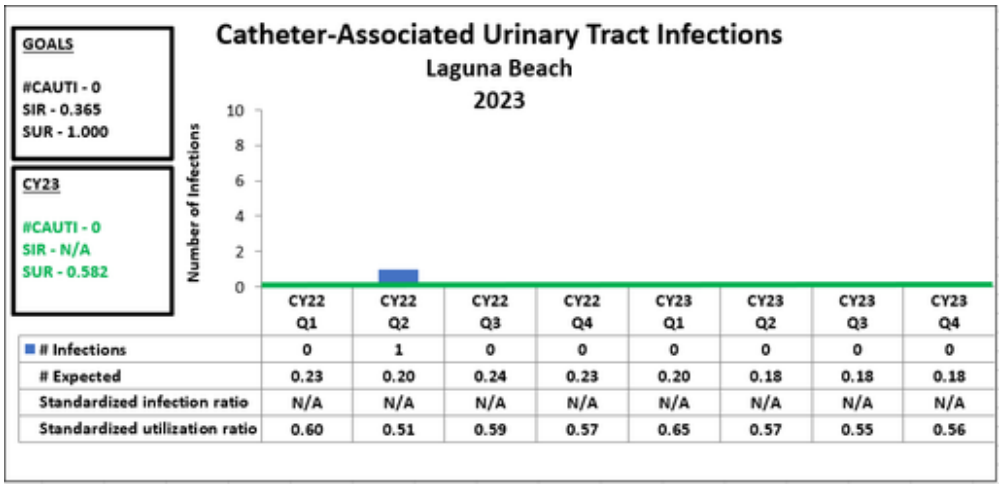
Graph 1: Mission Viejo and Mission Laguna Beach – 2023 Central Line-Associated Infections (CLABSI)





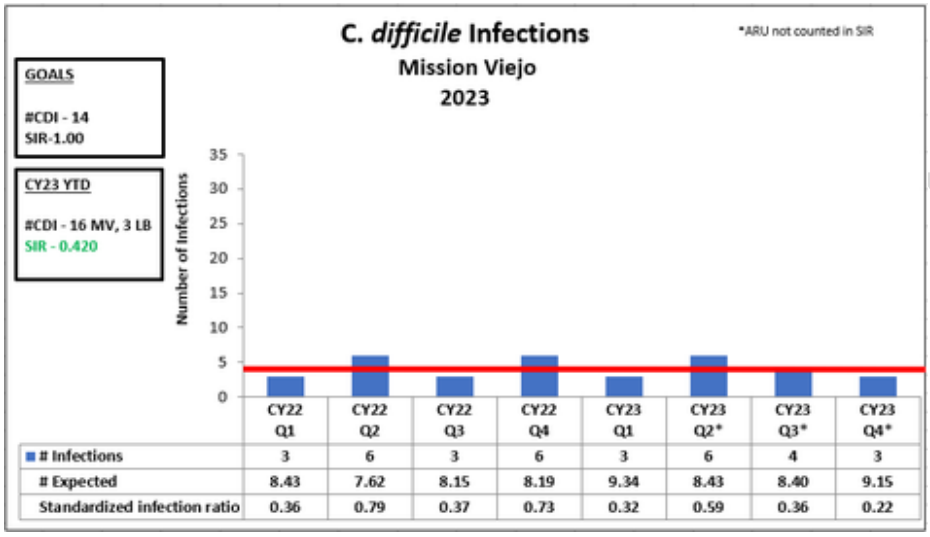
Graph 2: Mission Viejo and Mission Laguna Beach – 2023 Catheter-Associated Urinary Tract Infection (CAUTI)



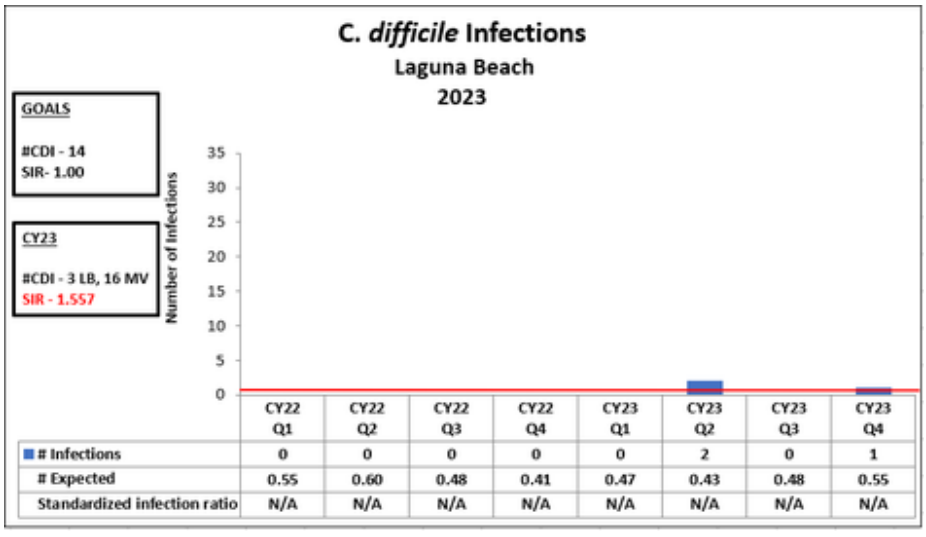


	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	CY23 Q2	CY23 Q3	CY23 Q4
# Infections	0	1	0	0	0	0	0	0
# Expected	0.23	0.20	0.24	0.23	0.20	0.18	0.18	0.18
Standardized infection ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Standardized utilization ratio	0.60	0.51	0.59	0.57	0.65	0.57	0.55	0.56

Graph 3: Mission Viejo and Mission Laguna Beach – 2023 *C. difficile* Infections

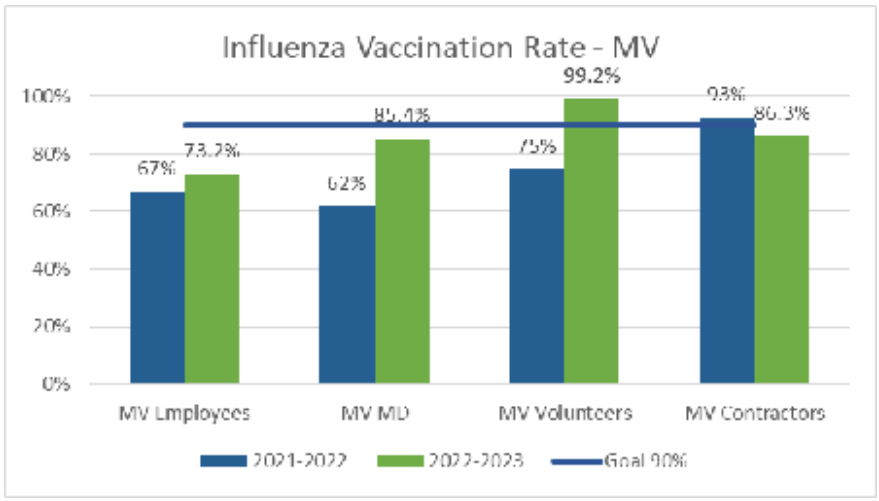


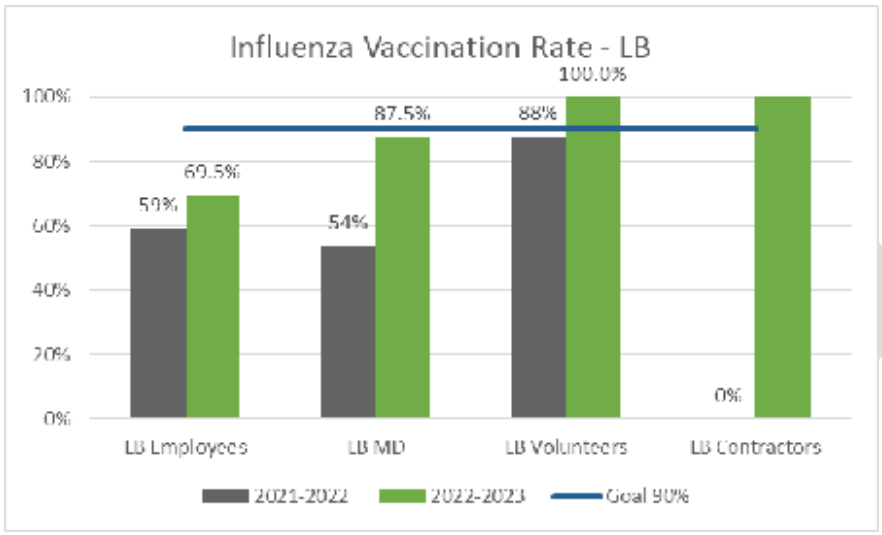
	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	CY23 Q2*	CY23 Q3*	CY23 Q4*
# Infections	3	6	3	6	3	6	4	3
# Expected	8.43	7.62	8.15	8.19	9.34	8.43	8.40	9.15
Standardized infection ratio	0.36	0.79	0.37	0.73	0.32	0.59	0.36	0.22



	CY22 Q1	CY22 Q2	CY22 Q3	CY22 Q4	CY23 Q1	CY23 Q2	CY23 Q3	CY23 Q4
# Infections	0	0	0	0	0	2	0	1
# Expected	0.55	0.60	0.48	0.41	0.47	0.43	0.48	0.55
Standardized infection ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Graph 4: Influenza Vaccination Compliance for 2022-2023 – Mission Viejo and Mission Laguna Beach





Attachments

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Mission Hospital and Laguna Infection Prevention Program Plan Evaluation CY2022

Approval Signatures

Step Description		Date
Board of Trustees	ior Manager n	03/2024
Interdisciplinary - Owner	ior Manager n	03/2024
Medical Staff - Owner	ior Manager n	03/2024
P&P	formance am Manager	02/2024
Owner	ior Manager n	02/2024

Applicability

CA - Providence Mission Hospitals

Standards

No standards are associated with this document