

AGENDA

Quality, Patient Care and Patient Experience Committee Meeting of the El Camino Hospital Board

Monday, August 28th, 2017, **5:30 p.m.**
El Camino Hospital, Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Dr. Jeffrey Davis will be participating via teleconference from 4100 Lake Tahoe Blvd. South Lake Tahoe, CA 96150

PURPOSE: To advise and assist the El Camino Hospital (ECH) Board of Directors (“Board”) in constantly enhancing and enabling a culture of quality and safety at ECH, and to ensure delivery of effective, evidence-based care for all patients. The Quality Committee helps to assure that excellent patient care and exceptional patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1. CALL TO ORDER	David Reeder, Chair Quality Committee		5:30 – 5:31pm
2. ROLL CALL	David Reeder, Chair Quality Committee		5:31 – 5:32
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	David Reeder, Chair Quality Committee		5:32 – 5:33
4. CONSENT CALENDAR ITEMS: <i>Any Committee Member or member of the public may pull an item for discussion before a motion is made.</i> Approval a. Minutes of the Open Session of the Quality Committee Meeting (August 7, 2017) Information b. Research Article c. Patient Story d. 2017 CALNOC Annual Performance Excellence Awards e. FY18 Pacing Plan f. Progress Against FY 2018 Committee Goals	David Reeder, Chair Quality Committee	<i>public comment</i>	Motion Required 5:33 – 5:36
5. REPORT ON BOARD ACTIONS ATTACHMENT 5	David Reeder, Chair Quality Committee		Discussion 5:36 – 5:39
6. QUALITY PROGRAM UPDATE: INFECTION CONTROL ATTACHMENT 6	Carol Kemper, MD Medical Director, Infection Control		Discussion 5:39 – 5:59
7. FY17 QUALITY DASHBOARD ATTACHMENT 7	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		Discussion 5:59 – 6:14
8. PT. EXPERIENCE (HCAHPS) ATTACHMENT 8	Michelle Gabriel, Director of Performance Improvement		Discussion 6:14 – 6:24
9. ED PT. SATISFACTION (PRESS GANEY) ATTACHMENT 9	Michelle Gabriel, Director of Performance Improvement		Discussion 6:24 – 6:34

A copy of the agenda for the Regular Committee Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

AGENDA ITEM	PRESENTED BY	ESTIMATED TIMES
10. ECH STRATEGIC FRAMEWORK <u>ATTACHMENT 10</u>	William Faber, MD, Chief Medical Officer	Discussion 6:34 – 6:44
11. PUBLIC COMMUNICATION	David Reeder, Chair Quality Committee	Information 6:44 – 6:47
12. ADJOURN TO CLOSED SESSION	David Reeder, Chair Quality Committee	Motion Required 6:47 – 6:48
13. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	David Reeder, Chair Quality Committee	6:48 – 6:49
14. CONSENT CALENDAR <i>Any Committee Member may pull an item for discussion before a motion is made.</i> Approval <i>Gov't Code Section 54957.2.</i> a. Minutes of the Closed Session of the Quality Committee Meeting (August 7, 2017)	David Reeder, Chair Quality Committee	Motion Required 6:49 – 6:52
15. Health and Safety Code Section 32155, report related to Medical Staff quality assurance matters: - Annual Patient Safety Report	Sheetal Shah, Risk Manager	Discussion 6:52 – 7:02
16. Health and Safety Code Section 32155, report related to Medical Staff quality assurance matters: - Red/Orange Alert and RCA Updates	William Faber, MD, Chief Medical Officer	Discussion 7:02 – 7:12
17. ADJOURN TO OPEN SESSION	David Reeder, Chair Quality Committee	Motion Required 7:12 – 7:13
18. RECONVENE OPEN SESSION/REPORT OUT To report any required disclosures regarding permissible actions taken during Closed Session.	David Reeder, Chair Quality Committee	7:13 – 7:14
19. ADJOURNMENT	David Reeder, Chair Quality Committee	Motion Required 7:14 – 7:15pm

Upcoming FY 18 Meetings

- October 2, 2017
- October 30, 2017
- December 4, 2017
- February 5, 2018
- March 5, 2018
- April 2, 2018
- April 30, 2018
- June 4, 2018

**Minutes of the Open Session of the
 Quality, Patient Care and Patient Experience Committee Meeting of the
 El Camino Hospital Board
 Monday, August 7, 2017
 El Camino Hospital, Conference Rooms A&B
 2500 Grant Road, Mountain View, California**

Members Present

Dave Reeder
 Robert Pinsker, MD; Jeffrey Davis, MD;
 Nancy Carragee, Wendy Ron,
 Katie Anderson, Mikele Bunce,
 and Melora Simon

**Nancy Carragee joined the meeting at 5:41pm*

**Rober Pinsker, MD left the meeting at 6:50pm*

**Mikele Bunce left the meeting at 7pm*

Members Absent

Peter Fung, MD;

Members Excused

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 7th of August, 2017 meeting.

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER	The meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital (the “Committee”) was called to order by Chair Dave Reeder at 5:35 p.m.	<i>None</i>
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call.	<i>None</i>
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member may have a conflict of interest with any of the items on the agenda. No conflict of interest was reported.	<i>None</i>
4. CONSENT CALENDAR ITEMS	<p>Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. No items were removed.</p> <p><u>Motion:</u> To approve the consent calendar: Minutes of the Open Session the Quality Committee Meeting (May 1, 2017) and Minutes of the Open Session of the Quality Committee Meeting (June 5, 2017)</p> <p><u>Movant:</u> Anderson</p> <p><u>Second:</u> Ron</p> <p><u>Ayes:</u> Anderson, Bunce, Davis, Pinsker, Reeder, Ron, Simon</p> <p><u>Noes:</u> None</p> <p><u>Abstentions:</u> None</p> <p><u>Absent:</u> Fung, Carragee</p> <p><u>Excused:</u> None</p> <p><u>Recused:</u> None</p>	<i>The Open Minutes of the May 1, 2017 and June 5, 2017 meetings were approved.</i>

Agenda Item	Comments/Discussion	Approvals/Action
5. APPOINTMENT VICE CHAIR	Chair Reeder asked if Jeffrey Davis, MD if he would be Vice Chair and he agreed.	
6. REPORT ON BOARD ACTIONS	<p>Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee and briefly highlighted the Board's current priorities to include:</p> <ul style="list-style-type: none"> • Dan Woods official start date is August 31st, 2017 • District Board decided to add two additional subject matter members to be part of the hospital board making the total number of members of 10 (5 district board members and 5 subject matter members) • One member from the Board has resigned due to new work obligations in Napa. 	<i>None</i>
7. QUALITY PROGRAM UPDATE: CARDIO THORACIC SURGERY	<p>Pei Tsau, MD, Cardio Thoracic Surgeon updated the Committee on the cardiac surgery volume, STS outcomes and benchmarking, and the FY2017 process improvement projects. Dr. Tsau reported that El Camino Hospital participates in the STS Registry and is the only program to earn 3-stars in any quality domain for Isolated CABG procedures. She further reported that El Camino's overall score in quality of AVR program is 97.8% which places our program in the top 5% of the country. Our readmission rate is 4%, nationally it is 9.8%. Our CVS Program is amongst the highest rated programs in the San Francisco bay area.</p> <p>Dr. Tsau asked for feedback and questions from the Committee and a brief discussion ensued.</p>	<i>None</i>
8. FY17 QUALITY DASHBOARD	Catherine Carson, RN, Sr. Director/Chief Quality Officer reviewed the newly annotated FY17 quality dashboard with the committee. Ms. Carson discussed the ongoing challenge of falls prevention noting that 1/3 of falls were assisted to the floor and highlighted the focus on bed alarms. She reported Pain Reassessment has a continuous improvement, no trends in Medication Error despite a slight increase in in near miss reporting, LOS has dropped over the past3 months while our Readmission Rate remains below the goal, and SMART phrases for bolus documentation usage has increased.	<i>None</i>
9. COMMITTEE RECRUITMENT	Cheryl Reinking, RN, Chief Nursing Officer recommended that Ina Bauman be appointed to join the committee. She provided a brief summary of Ina stating she was registered nurse for 14 years and then worked in outside sales. Ina opened her own recruiting practice which specialized in clinical (MD) recruiting for the biotech industry. She is now retired and currently serving as a board member of North Tahoe Hebrew Congregation in Tahoe Vista, CA. Ina is actively involved with the Bonnie Addario Lung Cancer	<i>Recommended appointment of Ina Bauman to the Committee</i>

Agenda Item	Comments/Discussion	Approvals/Action
	<p>Research Foundation and El Camino Hospital Foundation.</p> <p>She is available to join at the next meeting on August 28th, 2017. But has 2 meetings that she would need to call in for the FY 2018 dates.</p> <p>Motion: To recommend the Board appoint Ina Bauman to the committee. Bauman Movant: Anderson Second: Simon Ayes: Anderson, Bunce, Carragee, Davis, Pinsker, Reeder, Ron, Simon Noes: None Abstentions: None Absent: Fung Excused: None Recused: None</p>	
<p>10. FY17 ORGANIZATIONAL GOAL ACHIEVEMENT UPDATE</p>	<p>Cheryl Reinking, CNO, briefly went over the FY17 Organizational goals that are updated through May. She reported all ECH organizational goals for FY17 were met and the final report is not published yet. El Camino Hospital did very well on the budget.</p>	<p><i>None</i></p>
<p>11. REVIEW PROPOSED NEW FORMAT FOR QUARTERLY QUALITY AND SAFETY REVIEW</p>	<p>Catherine Carson, RN, Sr. Director of Quality Improvement and Patient Safety proposed new format for quarterly quality and safety review to the Committee. She explained a new schema of reporting a greater number of quality indicators in a staggered fashion throughout the year, giving the committee a more complete picture of our quality, and also improving the statistical significance of data and validity of trending in doing so. The expanded reporting program will begin in August of 2017.</p> <p><i>*The Committee asked to add The Quality and Safety Dashboard to the Black April meeting content.</i></p>	<p><i>None</i></p>
<p>12. PATIENT AND FAMILY CENTERED CARE UPDATE</p>	<p>Michelle Gabriel, Director of Performance Improvement briefly discussed the Patient and Family Centered Care update. She shared plans for developing a Patient Experience Strategy through blending PaCT and their commitment to patient experience by using the organizational goal for patient satisfaction on improving experience with goal alignment and developing systems to support improving experience. Michelle proposed a governance model to improve patient, family, and/or visitor's experience. She also reported the progress in the recruitment of the manager of Patient Experience.</p>	<p><i>None</i></p>

Agenda Item	Comments/Discussion	Approvals/Action
13. BPCI PROGRAM	<p>William Faber, MD, Chief Medical Officer provided an update on the BPCI Program. He described the new accepted responsibilities of ECH with Pneumonia and COPD and losses to our Total Joint Replacement, Hip & Femur, and Stroke. He further explained the program’s learnings and competencies to help manage Medicare Losses by establishing an expanded network of high-performing post-acute providers, case management and interventions for high risk patient population, and enabling benchmarking through data capture and analytic capability.</p> <p>He reminded the committee that ECH participated in the BPCI programs as a learning lab and to develop the infrastructure to service pay-for-value reimbursement models. He reported that ECH has learned a great deal and has developed significant infrastructure that we continue to use for BPCI patients, even though we have exited some of the programs and therefore avoid over a million dollars a year in penalties. Even though pay-for-value products have not yet significantly emerged in this market, the infrastructure ECH has developed for BPCI has been redeployed successfully in the management of our sizeable Medicare losses, and at the same time has improved the quality of patient care. The fundamental reason ECH did not perform well in BPCI programs was a lack of a gain-sharing structure like a CIN to align the financial incentives of physicians with ECH. We were being compared to the performance of systems that have this means of alignment.</p> <p>Dr. Faber and Grace Benlice asked for feedback and questions from the Committee and a brief discussion ensued.</p>	<i>None</i>
14. PUBLIC COMMUNICATION	None.	<i>None</i>
15. ADJOURN TO CLOSED SESSION	<p><u>Motion:</u> To adjourn to closed session at 7:20 p.m. <u>Movant:</u> Anderson <u>Second:</u> Simon <u>Ayes:</u> Anderson, Carragee, Davis, Reeder, Ron, Simon <u>Noes:</u> None <u>Abstentions:</u> None <u>Absent:</u> Bunce, Fung, Pinsker <u>Excused:</u> None <u>Recused:</u> None</p>	<i>Adjourned to closed session at 7:20 p.m.</i>
16. AGENDA ITEM 20: RECONVENE OPEN SESSION/ REPORT OUT	Open Session was reconvened at 7:21 pm. <i>Agenda Items 16 – 19 were addressed in closed session.</i>	

Agenda Item	Comments/Discussion	Approvals/Action
17. AGENDA ITEM 17 ADJOURNMENT	The meeting was adjourned at 7:40pm. <u>Motion:</u> To adjourn at 7:40 p.m. <u>Movant:</u> Davis <u>Second:</u> Simon <u>Ayes:</u> Anderson, Carragee, Davis, Reeder, Ron, Simon <u>Noes:</u> None <u>Abstentions:</u> None <u>Absent:</u> Bunce, Fung, Pinsker <u>Excused:</u> None <u>Recused:</u> None	<i>Meeting adjourned 7:40pm</i>

Attest as to the approval of the foregoing minutes by the Quality Committee of El Camino Hospital:

Dave Reeder
Chair, ECH Quality, Patient Care and
Patient Experience Committee

ORIGINAL ARTICLE

Contamination of Healthcare Workers' Hands with *Clostridium difficile* Spores after Caring for Patients with *C. difficile* Infection

C. Landelle, PharmD, PhD;^{1,2} M. Verachten, BSc;¹ P. Legrand, MD;³ E. Girou, PharmD, PhD;¹
F. Barbut, PharmD, PhD;⁴ C. Brun Buisson, MD^{1,5}

(See the commentary by Pop-Vicas and Baier, on pages 16–17.)

OBJECTIVE. We determined the percentage of healthcare workers' (HCWs') hands contaminated with *Clostridium difficile* spores after caring for patients with *C. difficile* infection (CDI) and risk factors associated with contamination.

DESIGN. Prospective study.

SETTING. A French university hospital.

METHODS. We compared the hand contamination rate among HCWs caring for patients with CDI (exposed group; $n = 66$) with that among an unexposed group ($n = 44$). Spores of *C. difficile* were recovered from the hands of HCWs after rubbing their fingers and palms in alcohol shortly after patient care. Associations between hand contamination and HCW category, type (patient or environment), and risk level (high or low risk) of HCW contacts and their respective duration as well as use of gloves were analyzed by bivariate and multivariate analysis.

RESULTS. *C. difficile* spores were detected on 24% of HCWs' hands in the exposed group and on 0% in the unexposed group ($P < .001$). In the exposed group, logistic regression, which adjusted for high-risk contact (ie, exposure to fecal soiling), contact with the environment, and contact with or without use of gloves, revealed that high-risk contact (adjusted odds ratio [aOR] per 1 contact increment, 2.78; 95% confidence interval [CI], 1.42–5.45; $P = .003$) and at least 1 contact without use of gloves (aOR, 6.26; 95% CI, 1.27–30.78; $P = .02$) were independently associated with HCW hand contamination by *C. difficile* spores.

CONCLUSIONS. Nearly one-quarter of HCWs have hands contaminated with *C. difficile* spores after routine care of patients with CDI. Hand contamination is positively associated with exposure to fecal soiling and lack of glove use.

Infect Control Hosp Epidemiol 2014;35(1):10-15

Clostridium difficile, a gram-positive spore-forming anaerobic bacillus, is a major nosocomial enteropathogen responsible for 15%–25% of antibiotic-associated diarrhea and virtually all cases of pseudomembranous colitis in adults.^{1,2} The main established risk factors for *C. difficile* infection (CDI) are receipt of antibiotic therapy, age older than 65 years, severity of underlying disease, length of hospital stay,³ and a prior room occupant with CDI.⁴

Symptomatic patients are known to excrete a large number of organisms in feces, as vegetative organisms or as spores, and bacterial spores are found in abundance in the environment of patients with CDI.^{3,5-7} *C. difficile* frequently contam-

inates multiple skin sites, including the groin, chest, abdomen, forearms, and hands of patients with CDI, and can be easily transmitted during contact of those sites.⁸ Acquisition of spores on gloved hands may occur after contact with commonly touched environmental surfaces (ie, bed rail, bedside table, telephone, and call button) or after contact with commonly examined skin sites.⁹ Transmission of *C. difficile* strains occurs most commonly via the hands of healthcare workers (HCWs).^{3,5,10-12} Several guidelines recommend the use of gloves and washing with soap and water rather than alcohol-based hand rub for mechanical removal of spores from hands in all settings,¹³⁻¹⁵ whereas the Society for Healthcare Epide-

Affiliations: 1. Infection Control Unit, Centre Hospitalier Universitaire (CHU) Albert Chenevier–Henri Mondor, Assistance Publique–Hôpitaux de Paris, Université Paris–Est Créteil, France; 2. Infection Control Program, Geneva University Hospitals, Geneva, Switzerland; 3. Department of Bacteriology-Virology, CHU Albert Chenevier–Henri Mondor, Assistance Publique–Hôpitaux de Paris, Université Paris–Est Créteil, France; 4. National Reference Laboratory for *Clostridium difficile*, Hôpital Saint-Antoine, Assistance Publique–Hôpitaux de Paris, Paris, France; 5. Medical Intensive Care Unit, CHU Albert Chenevier–Henri Mondor, Assistance Publique–Hôpitaux de Paris, Université Paris–Est Créteil, France.

Received June 13, 2013; accepted September 17, 2013; electronically published November 26, 2013.

© 2013 by The Society for Healthcare Epidemiology of America. All rights reserved. 0899-823X/2014/3501-0003\$15.00. DOI: 10.1086/674396

miology of America (SHEA) guideline advocates hand washing rather than alcohol-based hand rub only during outbreaks or in hyperendemic settings.¹⁶

In prior studies, the proportion of HCWs having hand contamination with both vegetative forms and spores of *C. difficile* after care of patients with CDI varied between 14% and 59%.^{3,10,17} Because vegetative forms of *C. difficile* are killed when exposed to air, whereas their spores are resistant to oxygen, desiccation, and most disinfectants¹⁸ and may persist in the hospital environment for long periods of time,⁵ we developed an experimental method for recovery of *C. difficile* spores by means of alcohol that allowed the destruction of vegetative forms of *C. difficile*.

The aim of this study was to determine the percentage of HCWs' hands that are contaminated with *C. difficile* spores after care of patients with CDI and to analyze risk factors associated with contamination.

METHODS

This prospective study was performed from June through August 2007 in a 950-bed French university hospital, at a time when the overall incidence of CDI was 1.3 cases per 10,000 bed-days, with 68% of cases classified as hospital acquired. This hospital was not affected by the highly virulent epidemic-related 027/BI/NAP1 strain.

Observational Study

Two groups of HCWs were observed for 8 weeks in 1 intensive care unit, 1 surgical ward, and 4 medical wards. The exposed group was comprised of HCWs who took care of a patient with CDI diagnosed during the study period. A CDI case patient was defined as a patient with a diarrheic stool (ie, a stool that took the shape of the sample container) and a toxin test result positive for *C. difficile* toxin(s) by use of the ImmunoCard Toxins A&B assay (Meridian Bioscience). Contact precautions were implemented as soon as results were obtained and until 48 hours after the end of diarrhea. Infection control measures consisted of (1) placing patients into a single-bed room with dedicated equipment; (2) donning a disposable gown with full-length sleeves and a pair of gloves on entering the room; (3) hand hygiene with alcohol-based solution (Sterillium; Bode Chemie) before wearing gloves, before an aseptic task and after body fluid exposure, and hand washing with medicated soap and water followed by use of alcohol-based hand rub after glove removal; and (4) daily environmental cleaning with a hypochlorite-based disinfectant according to French guidelines.¹⁴

The unexposed group comprised HCWs who took care of control ("non-CDI") patients. A minimum of 2 control patients per case patient were included. A control patient was defined as a patient not having diarrhea or a history of CDI and hospitalized in a ward where no patient with CDI had been identified at the time of the observation. However, these

patients were not screened for asymptomatic carriage of *C. difficile*.

The same trained observer (M.V.) observed all HCWs while in patient rooms. Staff members were informed that they were being observed as part of a study but were unaware of the study objectives; none refused to be observed. Observations were performed daily (except on weekends) while the diarrhea persisted.

The following data were collected on a standardized questionnaire: (1) bacteriological and clinical characteristics of the case patient (date of CDI onset, date of contact precaution implementation, and presence of diarrhea during observation); (2) HCW category (physicians or medical students, nurses or student nurses, nursing assistants, housekeepers, and other, e.g., physical therapists, radiology technicians, psychologists, and social workers); (3) room cleaning before observation; (4) level of risk of patient contact (high or low; high-risk contact was defined by the possibility for the HCWs' hands to be highly contaminated with fecal material [ie, patient washing, diaper change, bed linen change, handling of bedpan, digital rectal exam, colonoscopy, cleansing enema, and care of urogenital or perineal area], and low-risk contact was defined as all other patient care activities not meeting the criteria for high-risk contact); (5) duration of high- or low-risk contact; (6) type of contact (with patient or with environment); (7) use of gloves (contact with gloves or contact without gloves); and (8) compliance with hand hygiene (ie, use of alcohol-based products before donning gloves and between patient care activities).

Sampling of HCWs' Hands

We developed a method of spore salvage. Twelve milliliters of Schaedler broth (bioMérieux) was inoculated with 2 colonies of a nontoxigenic strain of *C. difficile* serogroup D (ATCC strain 43597) and incubated anaerobically at 37°C for 5 days. Twelve milliliters of 95% ethanol was added, and the mix was incubated at room temperature for 1 hour. After centrifugation at 3,000 g for 20 minutes, the supernatant was discarded, and the pellet containing spores was suspended in 2.2 mL of sterile water. Spore purity was checked by microscopy. Spores were enumerated by plating 100 μ L of pure suspension and 10-fold serial dilutions (10^{-1} to 10^{-5}) on TCCA (0.1% taurocholate, 250 mg/L cycloserine, and 8 mg/L cefoxitin agar) plates, which were incubated anaerobically at 37°C for 48 hours. One hundred microliters of pure suspension and each dilution were added to 100 mL of 95% ethanol. Filtration through a membrane filter with a pore size of 0.20 μ m (Millipore; Billerica) was performed. Filters were placed on TCCA plates. TCCA plates were incubated at 37°C in an anaerobic atmosphere for 48 hours. Colonies of *C. difficile* were initially identified by their macroscopic appearance and odor, followed by latex agglutination testing (Oxoid *C. difficile* Test kit; Thermo Scientific). For each sample that

TABLE 1. Distribution of Samples by Healthcare Worker Category

Category	Exposed group (n = 66)	Unexposed group (n = 44)
Physicians or medical students	13 (19.7)	10 (22.7)
Nurses and student nurses	26 (39.4)	21 (47.7)
Nursing assistants	19 (28.8)	13 (29.5)
Housekeepers	5 (7.6)	...
Other	3 (4.5)	...

NOTE. Data are no. (%).

was positive for *C. difficile*, the colonies of *C. difficile* were enumerated (as colony-forming units [CFUs] per plate), and concentration was calculated per 100 μ L. The initial and final counts of *C. difficile* spores were compared, and the recovery rate was high (more than 90% of initial count). We validated this method by experimental contamination of hands (data not shown). HCWs' hands were sampled by the same trained technician (M.V.) at the end of the observation period, just after removing gloves and before performance of hand hygiene with soap and water. Fingers of the dominant hand were rubbed for 1 minute in 80 mL of 95% ethanol, and the palm was rubbed for 30 seconds in square petri dishes (10 cm \times 10 cm) with 20 mL of 95% ethanol. Each container was rinsed with 10 mL of 95% ethanol. Alcohol was then filtered through a membrane filter with a pore size of 0.22 μ m. Filters were placed on TCCA plates, which were incubated at 37°C in an anaerobic atmosphere for 48 hours. Colonies of *C. difficile* were identified by their macroscopic appearance and odor, followed by latex agglutination testing. *C. difficile* colonies growing on each sample were counted (as CFUs per plate).

Statistical Analysis

Categorical variables were expressed as numbers and percentages and were compared using the Pearson χ^2 test or the Fisher exact test, as appropriate. Continuous variables were expressed as medians with interquartile range and were compared using the Mann-Whitney *U* test.

Multivariable logistic regression was used to identify risk factors associated with HCW hand contamination by *C. difficile* spores in the exposed group and estimate their adjusted odds ratios (aORs) and 95% confidence intervals (CIs). Variables with $P < .05$ in the bivariate analyses were selected. Correlation was assessed between dependent-selected variables by Spearman's ρ test. If a correlation was detected between 2 variables, only 1 variable was entered in the model. Nonnormally distributed continuous variables were transformed into categorical variables on the basis of the median value. The calibration of the final model was tested using the Hosmer-Lemeshow test. All statistical tests were 2-tailed, and $P < .05$ was considered statistically significant. Analyses were performed with PASW software, version 18 (SPSS).

RESULTS

During the study observation period, 7 CDI case patients and 16 control patients were included and were cared for by 66 exposed and 44 unexposed HCWs, respectively. All 110 HCWs had their hands sampled. The majority of participating HCWs were nurses and nursing assistants (Table 1).

C. difficile spores were recovered from 24% (16/66) samples obtained from hands of exposed HCWs and from none (0/44) of those obtained from unexposed HCWs ($P < .001$). A mean of 2 CFUs (range, 1–6) of *C. difficile* were recovered per positive hand, with the highest numbers found following high-risk care (eg, patient washing and diaper change).

Hand contamination was more common among nursing assistants (42%) than among other HCW categories (19% for nurses and 23% for physicians), consistent with the fact that nursing assistants had more high-risk contacts (47%) than did other HCW categories (15% for nurses and 4% for physicians).

The 66 HCWs in the exposed group had 386 contacts observed with CDI case patients or their environment. In bivariate analysis (Table 2), HCWs with contaminated hands were more likely than their counterparts to have a higher number of contacts overall ($P = .003$) as well as with the patient ($P = .02$) or with his or her environment ($P = .02$). Hand contamination was also associated with a higher number ($P < .0001$) and a longer duration of high-risk contacts ($P < .0001$). As all CDI patients were under contact precautions, HCWs had to put on gloves to care for patients. Because HCWs with contaminated hands had a higher number of contacts than did HCWs with noncontaminated hands, they also had a higher number of contacts with use of gloves ($P = .04$). However, 7.8% (30/386) contacts occurred with ungloved hands. HCWs with contaminated hands had a higher number of contacts without use of gloves than did HCWs with noncontaminated hands ($P = .03$).

Since high-risk contact was correlated with duration of high-risk contact and contact with the patient was correlated with contact with the patient's environment ($P < .001$), only the variables depicting high-risk contact and contact with environment were selected for multivariate analysis. Log linearity was verified only for high-risk contact.

Logistic regression, which adjusted for high-risk contact, contact with the environment, contact with use of gloves, and contact without use of gloves, revealed that high-risk contact (aOR per 1 contact increment, 2.78; 95% CI, 1.42–5.45; $P = .003$) and at least 1 contact without use of gloves (aOR, 6.26; 95% CI, 1.27–30.78; $P = .02$) were independently associated with HCW hand contamination by *C. difficile* spores (Table 3).

DISCUSSION

This study demonstrates that a high proportion of HCWs may carry *C. difficile* spores on their hands after caring for patients with CDI, contrary to HCWs caring for patients without CDI. Contamination of exposed HCWs' hands was

TABLE 2. Bivariate Analysis of Risk Factors Associated with Healthcare Worker Hand Contamination by *Clostridium difficile* Spores after Care of a Patient Having *C. difficile* Infection (Exposed Group)

Variable	Contaminated hands (n = 16)	Noncontaminated hands (n = 50)	P
Healthcare worker category			.12
Physicians or medical students	3 (18.8)	10 (20.0)	
Nurses and student nurses	5 (31.3)	21 (42.0)	
Nursing assistants	8 (50.0)	11 (22.0)	
Other	0	8 (16.0)	
Room disinfection ^a	5 (31.3)	15 (30.0)	NS
Total no. of contacts	9 (4–14)	4 (2–6)	.003
No. of contacts by risk level			
High risk	3 (1–5)	0 (0–1)	<.0001
Low risk	4 (3–8)	3 (2–5)	.16
Contact duration by risk level, minutes			
High risk	12 (3–23)	0 (0–1)	<.0001
Low risk	6 (4–10)	6 (3–8)	.44
No. of contacts with patient or environment			
With patient	3 (1–4)	1 (1–3)	.02
With environment	5 (2–9)	2 (1–4)	.02
No. of contacts with and without use of gloves			
With gloves	7 (3–13)	4 (2–6)	.04
Without gloves	0 (0–1)	0 (0–0)	.03
No. of times alcohol-based hand rub was used or forgotten during care ^b			
Rub used	0 (0–1)	0 (0–1)	.7
Rub forgotten	6 (3–13)	3 (2–5)	.07
No. of glove withdrawals during care	1 (1–2)	1 (1–1)	.19

NOTE. Data are no. (%) for categorical variables and median (interquartile range) for continuous variables. NS, nonsignificant.

^a Before observation.

^b Before final sampling of healthcare workers' hands.

associated with high-risk contact (ie, direct exposure to fecal soiling) and contact without use of gloves.

To our knowledge, this is the first study focusing on carriage of viable *C. difficile* spores on HCWs' hands. Because of their resistance and persistence, bacterial spores could be the principal form of transmission. Three prior studies have looked for contamination of HCWs' hands with *C. difficile* after the care of patients with CDI, and these studies reported carriage rates varying between 14% and 59%.^{3,10,17} These studies assessed both vegetative forms and spore contamination on hands. However, no previous study has assessed the respective contribution of vegetative versus spore forms to hand contamination. Since vegetative forms are killed in room air, it is possible that only spores were present on hands. The highest *C. difficile* hand carriage rate (59%) was reported by McFarland et al,³ who obtained extensive cultures at various sites (hand-surface imprints and fingernail impressions on plates and swabs obtained by wiping the interior surface of rings) from the hands of 35 HCWs, immediately after direct contact with a CDI patient. Struelens et al¹⁷ recovered *C. difficile* from the hands of 2 (29%) of 7 HCWs caring for patients with CDI; samples were obtained by imprint of fingertips immediately after direct contact with affected patients. Samore et al¹⁰ reported a 14% hand carriage rate for *C. difficile*

among 73 HCWs by taking fingertip-inprint cultures from HCWs while inside an affected patient's room or within 30 minutes of leaving the room. The time elapsed between care and sampling might explain the lower proportion of hand contamination in this study. The 24% hand contamination rate recorded in our study is consistent with these prior results, taking into account that our study design aimed at recovering only spores. This relatively high rate suggests that recovery of spores from hands after rinsing with alcohol and filtration is an efficient method for detecting only viable spores of *C. difficile*.

In the exposed group, HCWs having contaminated hands had performed a significantly higher number of contacts as well as high-risk contacts than did those with noncontaminated hands. Duration of high-risk contact was positively associated with hand contamination. To our knowledge, this is the first time that duration of contact has been reported as a risk factor for hand contamination. This finding contrasts with those of McFarland et al,³ who reported that acquisition of *C. difficile* occurred after contacts ranging from direct exposure to fecal soiling to practices generally considered to pose little risk (such as taking the patients' temperature, physical examination, or feeding patients). While prior studies did not identify HCW category, we also found that the hands of

TABLE 3. Multivariate Analysis of Risk Factors Associated with Healthcare Worker Hand Contamination by *Clostridium difficile* Spores after Care of a Patient Having *C. difficile* Infection (Exposed Group)

Variable	Multivariate model	
	aOR (95% CI)	P
No. of high-risk contacts	2.78 (1.42–5.45)	.003
More than 2 contacts with environment	0.33 (0.03–3.48)	.35
More than 4 contacts with gloves	0.59 (0.05–6.17)	.66
At least 1 contact without gloves	6.26 (1.27–30.78)	.02

NOTE. The Hosmer-Lemeshow χ^2 test was 0.52 ($P = .99$), indicating good calibration of the final model. aOR, adjusted odds ratio; CI, confidence interval.

nursing assistants were more frequently contaminated with *C. difficile* spores, in accordance with their exposure to more high-risk contacts than other HCW categories.

Hand contamination was also associated with number of contacts with the environment of case patients. Numerous studies have documented environmental contamination with *C. difficile* in the rooms of CDI patients.^{3,5,9,12,19,20} Samore et al¹⁹ reported that the frequency of positive HCW hand culture was strongly correlated with the intensity of environmental contamination. Using real-time polymerase chain reaction to quantify contamination, Mutters et al²¹ reported a significant correlation between *C. difficile* counts on HCWs' hands and those on the room floor as well as those in the near-patient environment. Furthermore, contaminated gloves could be responsible for environmental contamination. Manian et al²² reported that during a CDI outbreak HCWs failed to remove their potentially stool-contaminated gloves prior to touching clean surfaces, which in turn might have contributed to contamination of blood pressure cuffs.

Several studies have demonstrated that the appropriate use of gloves can prevent transmission of *C. difficile* and reduce the incidence of CDI.^{3,23} When caring for patients with CDI, HCWs should don gloves immediately upon entering the patient room according to our hospital protocol. Several explanations may account for the contamination of HCWs' hands despite the wearing of gloves. First, HCWs may have contaminated their hands during the withdrawal of gloves. Although glove removal technique was not evaluated, there was no association between hand contamination and glove removal in our study. Second, gloves may not provide absolute protection against hand contamination because barrier protection could be compromised during use.²⁴

An important observation in our study was that 7 (44%) of 16 HCWs with contaminated hands and 9 (18%) of 50 HCWs without contaminated hands had at least 1 contact without gloves. Furthermore, HCWs with contaminated hands performed a higher number of contacts without gloves than did HCWs with noncontaminated hands. Glove use is the only CDI prevention recommendation with the highest strength of recommendation and quality of evidence rating.

European and CDC guidelines recommend hand hygiene with soap and water after the removal of gloves.^{13,15} The current SHEA guidelines for prevention of CDI during acute care¹⁶ recommend hand washing only in outbreak or hyperendemic settings and hand hygiene with soap and water or alcohol in routine or endemic settings. Although soap and water is superior to removing *C. difficile* spores from hands of volunteers compared with alcohol-based hand rub products, the rationale for this recommendation^{16,25} is based on a lack of studies in acute care settings demonstrating an increase in CDI with alcohol-based hand rub products or a decrease in CDI with soap and water as well as the lower overall compliance with hand hygiene when using soap and water. Our real-life study identifies contact with ungloved hands as a risk factor for HCW hand contamination and suggests that routine hand washing with soap and water after care of CDI patients should be recommended in all settings.

Our study has some limitations. First, as few patients developed CDI during the study period, the same HCW could be observed on several days and, as a result, improve their infection control practices and adherence to glove use. Thus, we may have underestimated the frequency of hand contamination. Second, samples were not obtained from HCWs' hands before entry into the room. However, Mutters et al²¹ found no difference in *C. difficile* counts on the hands of HCWs working in either a *C. difficile*-positive ward or a *C. difficile*-negative ward. We thus included in our study a group of HCWs unexposed to patients with CDI as a control group expected to have no hand contamination with *C. difficile* but without matching on high-risk care. Third, the exact number of spores needed to result in infection is not known, so the exact risk of transmission of CDI by a HCW having hands contaminated with spores is unknown. Finally, we evaluated only the proportion of HCWs with *C. difficile* spores on their hands after routine care of patients with CDI and risk factors of contamination; further studies are needed to determine how long spores can remain viable on HCWs' hands.

ACKNOWLEDGMENTS

We are grateful to the staff of the wards who participated in the study and Dr Andrew Stewardson for his assistance.

Potential conflicts of interest. All authors report no conflicts of interest relevant to this article. All authors submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest, and the conflicts that the editors consider relevant to this article are disclosed here.

Address correspondence to C. Landelle, PharmD, PhD, Infection Control Program, Geneva University Hospitals and Medical School, CH-1211 Geneva 14, Switzerland (caroline.landelle@gmail.com).

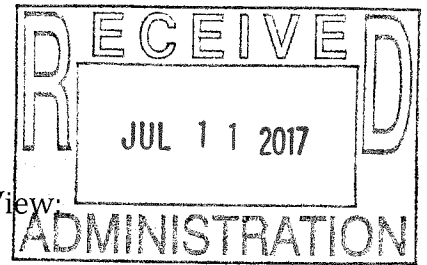
REFERENCES

- Barbut F, Petit JC. Epidemiology of *Clostridium difficile*-associated infections. *Clin Microbiol Infect* 2001;7:405–410.
- Bartlett JG. Narrative review: the new epidemic of *Clostridium*

- difficile*-associated enteric disease. *Ann Intern Med* 2006;145:758–764.
3. McFarland LV, Mulligan ME, Kwok RY, Stamm WE. Nosocomial acquisition of *Clostridium difficile* infection. *New Engl J Med* 1989;320:204–210.
 4. Shaughnessy MK, Micielli RL, DePestel DD, et al. Evaluation of hospital room assignment and acquisition of *Clostridium difficile* infection. *Infect Control Hosp Epidemiol* 2011;32:201–206.
 5. Kim KH, Fekety R, Batts DH, et al. Isolation of *Clostridium difficile* from the environment and contacts of patients with antibiotic-associated colitis. *J Infect Dis* 1981;143:42–50.
 6. Riggs MM, Sethi AK, Zabarsky TF, Eckstein EC, Jump RL, Donskey CJ. Asymptomatic carriers are a potential source for transmission of epidemic and nonepidemic *Clostridium difficile* strains among long-term care facility residents. *Clin Infect Dis* 2007;45:992–998.
 7. Kaatz GW, Gitlin SD, Schaberg DR, et al. Acquisition of *Clostridium difficile* from the hospital environment. *Am J Epidemiol* 1988;127:1289–1294.
 8. Bobulsky GS, Al-Nassir WN, Riggs MM, Sethi AK, Donskey CJ. *Clostridium difficile* skin contamination in patients with *C. difficile*-associated disease. *Clin Infect Dis* 2008;46:447–450.
 9. Guerrero DM, Nerandzic MM, Jury LA, Jinno S, Chang S, Donskey CJ. Acquisition of spores on gloved hands after contact with the skin of patients with *Clostridium difficile* infection and with environmental surfaces in their rooms. *Am J Infect Control* 2012;40:556–558.
 10. Samore MH, Venkataraman L, DeGirolami PC, Arbeit RD, Karchmer AW. Clinical and molecular epidemiology of sporadic and clustered cases of nosocomial *Clostridium difficile* diarrhea. *Am J Med* 1996;100:32–40.
 11. Johnson S, Clabots CR, Linn FV, Olson MM, Peterson LR, Gerding DN. Nosocomial *Clostridium difficile* colonisation and disease. *Lancet* 1990;336:97–100.
 12. Fekety R, Kim KH, Brown D, Batts DH, Cudmore M, Silva J Jr. Epidemiology of antibiotic-associated colitis: isolation of *Clostridium difficile* from the hospital environment. *Am J Med* 1981;70:906–908.
 13. Siegel JD, Rhinehart E, Jackson M, Chiarello L; Healthcare Infection Control Practices Advisory Committee. 2007 *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. <http://www.cdc.gov/hicpac/pdf/isolation/isolation2007.pdf>. Published 2007. Accessed November 1, 2012.
 14. Haut Conseil de la Santé Publique. *Avis Relatif à la Maîtrise de la Diffusion des Infections à Clostridium difficile dans les Établissements de Santé Français*. http://nosobase.chu-lyon.fr/recommandations/hcsp/2008_clostridium_HCSP.pdf. Published 2008. Accessed November 1st, 2012.
 15. Vonberg RP, Kuijper EJ, Wilcox MH, et al. Infection control measures to limit the spread of *Clostridium difficile*. *Clin Microbiol Infect* 2008;14(suppl 5):2–20.
 16. Dubberke ER, Gerding DN, Classen D, et al. Strategies to prevent *Clostridium difficile* infections in acute care hospitals. *Infect Control Hosp Epidemiol* 2008;29(suppl 1):S81–S92.
 17. Struelens MJ, Maas A, Nonhoff C, et al. Control of nosocomial transmission of *Clostridium difficile* based on sporadic case surveillance. *Am J Med* 1991;91:138S–144S.
 18. Rutala WA, Gergen MF, Weber DJ. Inactivation of *Clostridium difficile* spores by disinfectants. *Infect Control Hosp Epidemiol* 1993;14:36–39.
 19. Gerding DN, Olson MM, Peterson LR, et al. *Clostridium difficile*-associated diarrhea and colitis in adults: a prospective case-controlled epidemiologic study. *Arch Intern Med* 1986;146:95–100.
 20. Heard SR, O'Farrell S, Holland D, Crook S, Barnett MJ, Tabachali S. The epidemiology of *Clostridium difficile* with use of a typing scheme: nosocomial acquisition and cross-infection among immunocompromised patients. *J Infect Dis* 1986;153:159–162.
 21. Mutters R, Nonnenmacher C, Susin C, Albrecht U, Kropatsch R, Schumacher S. Quantitative detection of *Clostridium difficile* in hospital environmental samples by real-time polymerase chain reaction. *J Hosp Infect* 2009;71:43–48.
 22. Manian FA, Meyer L, Jenne J. *Clostridium difficile* contamination of blood pressure cuffs: a call for a closer look at gloving practices in the era of universal precautions. *Infect Control Hosp Epidemiol* 1996;17:180–182.
 23. Johnson S, Gerding DN, Olson MM, et al. Prospective, controlled study of vinyl glove use to interrupt *Clostridium difficile* nosocomial transmission. *Am J Med* 1990;88:137–140.
 24. Rego A, Roley L. In-use barrier integrity of gloves: latex and nitrile superior to vinyl. *Am J Infect Control* 1999;27:405–410.
 25. Dubberke ER, Gerding D. *Rationale for Hand Hygiene Recommendations after Caring for a Patient with Clostridium difficile Infection: A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals*. <http://www.shea-online.org/Portals/0/CDI%20hand%20hygiene%20Update.pdf>. Published 2011. Accessed August 24, 2013.

July 6, 2017

To the Hospital Administration at El Camino Hospital in Mountain View:



I would like to share the recent experience I had with your staff members that began on the evening of July 4th.

I came into the Emergency Room around 9:30pm and was greeted by the check in staff. The staff was very attentive after I explained that I was experiencing chest pains.

Immediately, two staff members identifying themselves as physicians came out to ask me questions. Both doctors were attentive, showed concern, and immediately had me brought in for treatment.

Each of the nurses / staff members were communicative, explaining what was happening and was going to happen. It was explained to me that I would have an EKG. The staff was clearly organized, confident, and efficient, as they moved well together like a well oiled machine. They communicated with each other and immediately gave me meds through an IV. It was an impressive scene. As witnesses, my parents were with me in the ER, and saw the same thing I did. Both are retired medical professionals, (former Physical Therapists) and were impressed by the expeditious manner in which the staff conducted themselves. After a series of important questions were asked, the Cardiology Physician, Dr De., came in. My understanding is that she was the on call cardiologist, and was there in a flash as far as I could tell.

I was quickly brought into the operating room, and the procedure to add two stents into my body took place. I felt no pain during this process, (which I think is amazing), and was able to hear everything that was happening during the procedure. The fact that this procedure was done through my wrist absolutely amazes me. I was expecting the worse, as going through my femoral artery was an option. When Dr. De informed me that the procedure was over, I couldn't believe it. I was waiting the entire procedure for pain or discomfort. It never happened.

I was brought to my room around 11pm or so. I was told that Dr. De would see me in the morning. I figured that it would be a 10am or 11am return for a doctor that worked well into the evening. Dr. De came into my room at 6am! Wow, impressive, and not only was she there, she was awesome! Dr. De was direct but not condescending or lecturing with me. She made it very clear how serious my situation is, and what I would need to do to improve my health. She recommended a cardiac recovery program, which I will definitely attend.

I experienced NO pain from the moment I came out of the procedure to the time I am writing this letter. Amazing. However, I can tell you that my life has changed

and I am on the path to improving my lifestyle. A lot of that is credited to the fabulous staff at your El Camino facility.

A couple of other names to note: I apologize for being terrible at remembering names, but a couple stood out to me. Amy and Angie on my first night out of surgery were awesome! Amy demonstrated major concern for removing my wrist band that protected my surgery opening. She explained how important it is that there is no bleeding, (or minimal) before removing the band. She checked on it at least 7-8 times, and had other RN's look at it as well.

I really appreciated (Kay, I hope the name is right!), coming in from the cardiology department to review with me my procedure. She informed me that everyone on-call for the procedure were "on time" to make the surgery happen. Wow. That is also very impressive.

Kudos to the entire team between the Emergency Department to the Cardiology Department. Special thanks to Dr De, who I will see next Thursday. I feel confident when I have a health care issue where I need to go for assistance.

Many thanks and job very well done!

Please share this letter with the staff, as they deserve recognition.

Sincerely,

A solid black rectangular redaction box covering the signature of the patient.

Patient 7/4 - 7/6



August 14, 2017

Cheryl Reinking
El Camino Hospital-Mountain View
2500 Grant Road, 1C32
Mountain View, California 94040
Cheryl_Reinking@elcaminohospital.org

Dear Cheryl,

I hope this letter finds you well. On behalf of everyone at CALNOC, thank you for your continued support of our organization. We appreciate your business and commitment to patient safety and quality.

It gives me great honor to recognize **El Camino Hospital-Mountain View** for performance excellence in the following:

Best Performance in Preventing Hospital Acquired Infections – CLABSI Total Facility

** Click this [link](#) to view the explanation of the awards and their criteria.*

Your excellent work and efforts are exemplary and to be commended! We will be honoring all of our winners at our Annual Conference on October 22-24, 2017 at the Renaissance Seattle Hotel in Seattle, Washington. We hope that you or your representative will register to attend the **2017 CALNOC Conference** so that you may accept the award on behalf of your facility, as well as join us for this event.

As we know it takes some time to organize efforts to send your representative or teams to the conference, we'd like to honor your achievement further, by **extending the early bird rate** for your facility, until **9/15/2017**. Simply apply the promo code "**2017CALNOCBEST**", when you [register](#).

This year's awards presentation will include one (1) photo of your hospital or team to represent your facility's remarkable achievement. Please send your preferred photo via email to corinne.skaric@calnoc.org by Friday, September 15th. If we do not receive your photo by this date, your hospital's logo will be presented as it appears on your website.

Congratulations on an outstanding achievement and I look forward to seeing you at our 2017 Annual Conference, in Seattle.

Best regards,

A handwritten signature in black ink, appearing to read "Tony Sung", is written in a cursive style.

Tony Sung
CEO

**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY 18 Pacing Plan**

FY2018 Q1		
JULY 2017	AUGUST 7, 2017	August 28, 2017 (for September's meeting)
<p>No Board or Committee Meetings</p> <p>Routine Consent Calendar Items:</p> <ul style="list-style-type: none"> ▪ Approval of Minutes ▪ Progress Against FY 2018 Committee Goals Completion Status (Oct 30, March 5, June 4) ▪ FY18 Pacing Plan ▪ Med Staff Quality Council Minutes ▪ Patient Story ▪ Research Article 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY 17 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report <p>Special Agenda Items</p> <ol style="list-style-type: none"> 1. Committee Recruitment 2. Update on Patient and Family Centered Care 3. FY17 Organizational Goal Achievement Update 4. Review proposed new format for Quarterly Quality and Safety Review 5. BPCI program 6. Appoint Committee Vice Chair 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY 17 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report <p>Special Agenda items:</p> <ol style="list-style-type: none"> 1. Committee Recruitment 2. FY 17 Organizational Goal Achievement Update/Approval 3. FY 18 Organizational Goal Metric Approval 4. Review proposed new format for quarterly Quality and Safety review 5. Annual Patient Safety Report 6. Pt. Experience (HCAHPS) 7. ED Pt. Satisfaction (Press Ganey) 8. ECH Strategic Framework
FY2018 Q2		
OCTOBER 2, 2017	OCTOBER 30, 2017 (for November's meeting)	DECEMBER 4, 2017
<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 1. Update on Patient and Family Centered Care 2. FY 17 Organizational Goal Achievement Update/Approval 3. Year-End Review of RCA 4. Readmission Dashboard 5. PSI-90 Pt. Safety Indicators 6. Culture Safety Survey Results <p>(10/25 – Joint Board and Committee Session)</p>	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 1. Peer Review Process Changes Implementation Update 2. Safety Report for the Environment of Care 3. Quarterly Quality and Safety Review 4. CDI Dashboard 5. Core Measures 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 1. Update on Patient and Family Centered Care 2. Credentialing Process Report 3. Pt. Experience (HCAHPS) 4. ED Pt. Satisfaction (Press Ganey)

**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY 18 Pacing Plan**

FY2018 Q3		
JANUARY 2018	FEBRUARY 5, 2018	MARCH 5, 2018
No Meeting	Standing Agenda Items: <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: <ol style="list-style-type: none"> 1. Update on Patient and Family Centered Care 2. Quarterly Quality and Safety Review 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 	Standing Agenda Items: <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: <ol style="list-style-type: none"> 1. iCare Update 2. Proposed FY19 Organizational Goals 3. CDI Dashboard 4. Core Measures
FY2018 Q4		
APRIL 2, 2018	APRIL 30, 2018 (for May's meeting)	JUNE 4, 2018
Standing Agenda Items: <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: <ol style="list-style-type: none"> 1. Update on Patient and Family Centered Care 2. Proposed FY 19 Committee Goals 3. Proposed FY 19 Committee Meeting Dates 4. Review Committee Charter 5. Proposed FY 19 Organizational Goals 6. Leapfrog Survey Results 7. Value Base Purchasing Report (4/25 – Joint Board and Committee Session)	Standing Agenda Items: <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: <ol style="list-style-type: none"> 1. Proposed FY 19 Committee Goals 2. Proposed FY 19 Organizational Goals 3. Review Biennial Committee Self-Assessment Results 4. Quarterly Quality and Safety Review 5. Pt. Experience (HCAHPS) 6. ED Pt. Satisfaction (Press Ganey) 	Standing Agenda Items: <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: <ol style="list-style-type: none"> 1. Update on Patient Centered Care 2. Approve FY19 Pacing Plan 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators



FY18 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

The purpose of the Quality, Patient Care and Patient Experience Committee (“Quality Committee”) is to advise and assist the El Camino Hospital (ECH) Board of Directors (“Board”) in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Quality Committee helps to assure that exceptional patient care and patient experiences are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods, and assuring appropriate resource allocation to achieve this purpose.

STAFF: William Faber, MD, Chief Medical Officer

The CMO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair’s consideration. Additional clinical representatives may participate in the meetings upon the recommendation of the CMO and at the discretion of the CEO and the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurse, and members from the community advisory councils or the community at-large. The CEO is an ex-officio member of this Committee.

GOALS	TIMELINE by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)	METRICS
1. Review the Hospital’s organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care and Patient Experience Committee.	<ul style="list-style-type: none"> • Q1 FY18 – Goals • Q3 FY18 - Metrics 	<ul style="list-style-type: none"> • Review, complete, and provide feedback given to management, the Governance Committee, and the Board.
2. Alternatively (every other year) review peer review process and medical staff credentialing process. Monitor and follow through on the recommendations made through the Greeley peer review process.	<ul style="list-style-type: none"> • Q2 FY18 	<ul style="list-style-type: none"> • Receive update on implementation of peer review process changes • Review Medical Staff credentialing process
3. Develop a plan to review the new Quality, Patient Care and Patient Experience Committee dashboard and ensure operational improvements are being made to respond to outliers.	<ul style="list-style-type: none"> • Q1 – Q2 FY18 – Proposal • Q2 FY18 – Implementation • Month Q1 – Q4 FY18 	<ul style="list-style-type: none"> • Receive a proposed format for quarterly Quality and Safety Review; make a recommendation to the Board and implement new format. • Monthly review of FY18 Quality Dashboard
4. Oversee the development of a plan with specific tactics and monitor the HCAHPs scores for Patient and Family Centered Care.	<ul style="list-style-type: none"> • Q2 FY18 	<ul style="list-style-type: none"> • Review the plan and approve
5. Monitor the impact of interventions to reduce hospital-acquired infections.	<ul style="list-style-type: none"> • Quarterly 	<ul style="list-style-type: none"> • Review process toward meeting quality (infection control) organizational goal

SUBMITTED BY:

David Reeder

Chair, Quality Committee

William Faber, MD

Executive Sponsor, Quality Committee

Approved by the ECH Board of Directors on June 14, 2017

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Report on ECH and ECHD Board Actions Quality, Patient Care, and Patient Experience Committee Meeting Date: August 28, 2017
Responsible party:	Cindy Murphy, Director of Governance Services
Action requested:	For Information
Background:	IN FY16 we added this item to each Board Committee agenda to keep Committee members informed about Board actions via a verbal report by the Committee Chair. This written report is intended to supplement the Chair's verbal report.
Other Board Advisory Committees that reviewed the issue and recommendation, if any:	None.
Summary and session objectives :	To inform the Committee about recent Board actions
Suggested discussion questions:	None.
Proposed Committee motion, if any:	None. This is an informational item
LIST OF ATTACHMENTS:	Report on ECH and ECHD August 2017 Board Actions

August 2017 ECH Board Actions*

1. August 9, 2017
 - a. Appointed Ms. Ina Bauman as patient advocate member of the Quality, Patient Care and Patient Experience Committee
 - b. Approved the FY18 Board Education Plan, including attendance at the Estes Park Institute Conference in San Francisco October 29 – November 1, 2017. All Board and Committee members are invited and encouraged to attend.
 - c. Approved the proposed FY18 Competency Matrix for use in evaluating gaps on the ECH Board. The Competency Matrix will be referred to the District Board for consideration.
 - d. FY 18 Executive Individual Incentive Goals approved.
 - e. FY 18 Executive Base Salaries approved as revised.
 - f. Director Peter Fung, MD, was appointed to serve on the Silicon Valley Medical Development LLC Board of Managers.
 - g. Approved the FY17 Period 12 Financials

June 2017 ECHD Board Actions*

1. August 16, 2017 – Appointed Neysa Fligor to serve as District Board Director until after the November 2018 District General Election.

*This list is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.



El Camino Hospital[®]

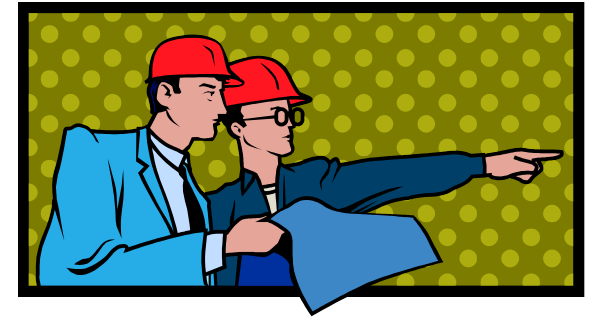
THE HOSPITAL OF SILICON VALLEY

Infection Control Quality Report

August 28, 2017

*Carol A. Kemper, MD FACP
Medical Director Infection Control*

FY2017 Construction Summary: Mountain View and Los Gatos



FY 2017 Yearly Summary	Mountain View	Los Gatos	Total
New Infection Control Risk Assessment (ICRA) Construction Permits <ul style="list-style-type: none"> • Construction Site evaluation by Infection Prevention (IP) Nurse and Project Coordinator prior to start of construction • Permit approved and issued by IP Nurse 	71	63	134
Construction Site Assessments <ul style="list-style-type: none"> • Daily construction work site rounding by IP Nurse • Check compliance of ICRA permit guidelines and barrier set-up 	548	595	1,143

FY 2017: Mountain View Infection Prevention/Quality Tracers

FY2017: 4th Quarter (April – June 2017)

4/28/2017	5/26/2017	6/23/2017
<ul style="list-style-type: none"> •Maternal Connections •Labor & Delivery •Mother Baby Unit •NICU •Imaging Services •Patient Registration 	<ul style="list-style-type: none"> •Behavioral Health (1 South) •Cardiovascular & pulmonary Wellness •Outpatient Lab •Nutrition Services 	<ul style="list-style-type: none"> •Emergency Department •Endoscopy •Cancer Center •Infusion Center •Oak : Accounting, Financial Planning, Contracting, Patient Accounts, Payroll, Women's Health Administration

FY 2017 3rd Quarter: (January – March 2017)

1/27/2017	2/24/2017	3/24/2017
<ul style="list-style-type: none"> •Surgical/ Pediatrics (4A) •Med/ Surgical Oncology (4B) •Lucille Packard Children's Hospital 	<ul style="list-style-type: none"> • CCU (3AC) • PCU (3AP) • Telemetry (3B) • Telemetry/Stoke (3C) • Mother/Baby Unit (3CW) 	<ul style="list-style-type: none"> • Operating Room (2A) • PACU (2A) • Pre-Op/ Short Stay (2B) • Interventional Services (2B) • Medical Unit (2C)

FY 2017 2nd Quarter: (October – December 2016)

11/11/2016	12/2/2016
<ul style="list-style-type: none"> •Nutritional Services/ kitchen 	<ul style="list-style-type: none"> • Nutritional Services/ kitchen

FY 2017 1st Quarter: (July – September 2016)

7/1/2016	7/20/2016
<ul style="list-style-type: none"> •Senior Center 	<ul style="list-style-type: none"> • Nutritional Services/ kitchen

FY 2017: Los Gatos Infection Prevention/Quality Tracers

FY2017: 4th Quarter (April – June 2017)

4/21/17	5/19/17	6/9/17
<ul style="list-style-type: none"> •Administration •Clinical Effectiveness •Conference Center •HIMS •OR •PACU •OPS 	<ul style="list-style-type: none"> •Imaging Services •Inpatient Rehab •Men' s Clinic •Ortho Pavilion •Women' s Hospital 	<ul style="list-style-type: none"> • Central Services • Clinical Lab • EVS • Facilities • Lobby • Nutrition Services/Kitchen • Pathology • Pharmacy • PPI • Registration • Sterile processing

FY2017: 2nd Quarter (October 2016 –December 2016)

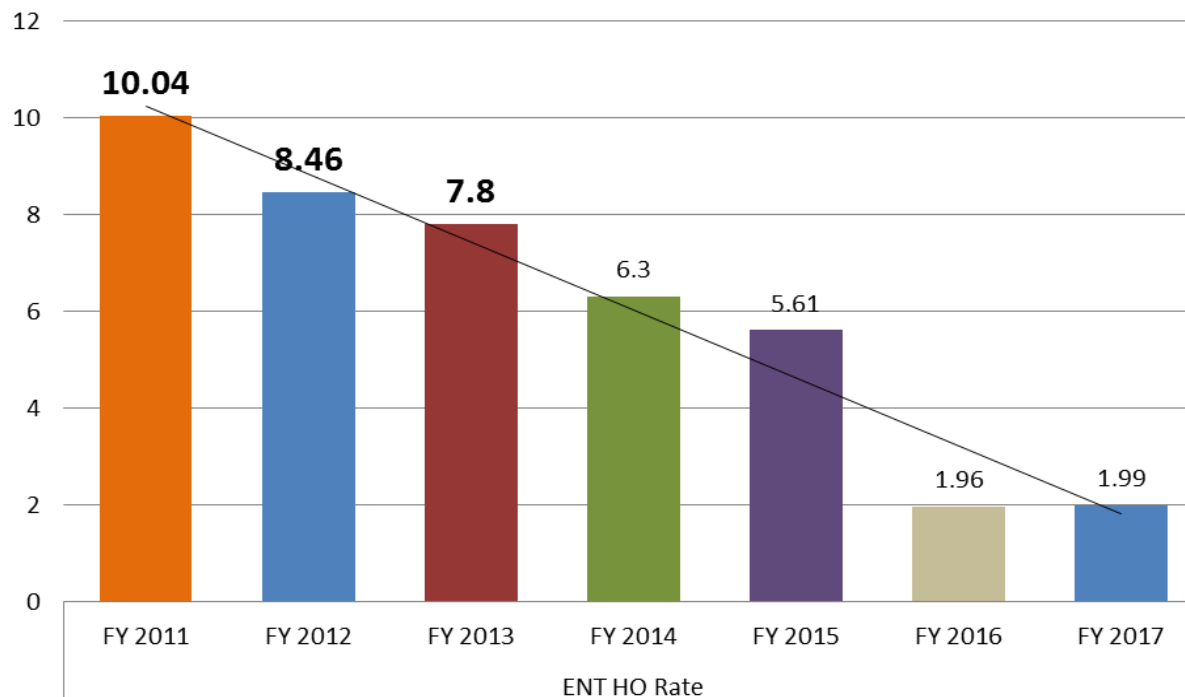
10/23/16	11/4/16	11/29/16
<ul style="list-style-type: none"> • Out-patient surgery • Pharmacy • Ortho Pavilion • Labor and Delivery • Central Supply • Endoscopy • Operating Room 	<ul style="list-style-type: none"> • Operating Room • Sterile Processing department 	<ul style="list-style-type: none"> • Nutritional Services/kitchen
12/2/16		
<ul style="list-style-type: none"> • Endoscopy • Interventional Radiology 		

ECH Infection Control Highlights: FY2017: MRSA, ESBL, *C. difficile*

- **Hospital onset MRSA, multi-drug resistant organisms (MDRO) and C difficile infections remain low**
 - **MRSA: 6 enterprise hospital-onset cases (rate .50)**
 - Several likely represent unrecognized pre-existing colonization
 - **MDRO: 1 enterprise hospital-onset case (rate .11)**
 - *15% of high risk admissions are colonized with ESBL*
- **C difficile: FY2016-2017 rates the lowest ever (<2.0)**
 - Continued emphasis on hand washing & PPE
 - Surveillance screening of higher-risk admissions for C difficile colonization, using newer molecular techniques
 - Upgraded EVS services
 - In 2015, 3 Xenex UVC sterilization systems purchased
 - Re-emphasis on patient bathing and hygiene

Sustained Success in Enterprise *C. difficile* Hospital-Onset Rate FY2011-FY2017

Enterprise HO *C. diff* Rate



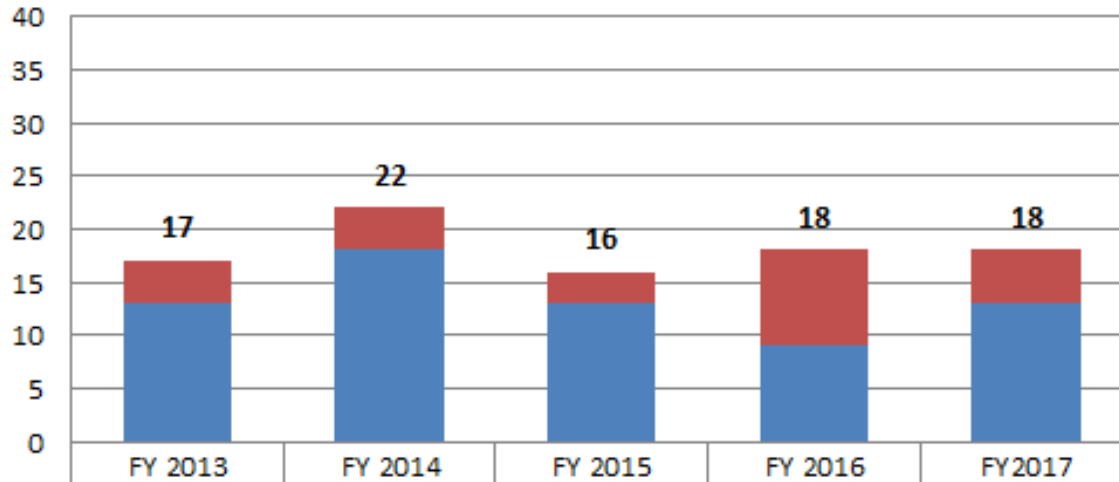
Ongoing Efforts at Monitoring and Prevention of Surgical Site Infections (SSI)

- **Los Gatos SSI Task Force formed 2016 to address increasing SSIs**
 - Improved LG SSI rates this year (9→ 5 cases)
 - Examined OR procedures and scrubs, performed OR tracers
 - Surgical attire and room traffic remain a concern
- **Focus on reducing “flash sterilization” (IUSS) at both campuses**
 - Huge success, multiple months with few to none
- **Infection Control team investigates every suspect SSI (OR procedures and staffing, peri-op antibiotics, wound care, etc.)**
- **Track post-op infections for 29 NHSN defined surgical procedures**
 - Additionally trend post-operative infections that don't meet NHSN criteria
 - Monthly post-discharge surveillance with mailings to MD offices
- **We get back NSHN Standardized Infection Rates (SIR)**
 - Our data is “risk adjusted” to other hospitals with a SIR goal < 1.0

Improvement in Overall Surgical Site Infections FY 2013- FY 2017 Total Surgical SSI cases

**FY17:
Enterprise
Rate: 0.23**

**FY16:
Rate: 0.25**



	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Enterprise Total Cases	17	22	16	18	18
■ LG Total SSI Cases	4	4	3	9	5
■ MV Total SSI Cases	13	18	13	9	13

Mountain View Surgical Site Infections by Procedure			
FY 2014	FY 2015	FY 2016	FY 2017
18 cases	13 cases	9 cases	13 cases
6 LAMI/FUSN	3 HIP	3 HIP	2 HIP
3 COLON	2 COLON	2 Colon	3 Colon
3 BILI	2 Lami	2 HYST	2 HYST
2 VHYST	2 CRANI	1 Fusion	2 CRANI
1 CABG	1 HYST	1 Pacemaker	1 Pacemaker
1 KNEE	1 Fusion		1 XLap
1 XPLAP	1 BILI		1 Csection
1 CSEC	1 Rectal		1 FX

Los Gatos Surgical Site Infections by Procedure			
FY 2014	FY 2015	FY 2016	FY 2017
4 cases	3 cases	9 cases	5 cases
3 BILI	1 Fusion	2 Fusion	1 Fusion
1 Knee	1 Knee	2 Knee	3 Knee
	1 Small Bowel	1 LAMI	1 LAMI
		1 Hip	
		1 Colon	
		2 BILI	

MV NHSN SSI Trends for 5 years: NHSN SIR Rate Goal < 1.0

FY2017: 13 SSI/ 5866 procedures = 0.22

FY2016: 9 SSI/5644 procedures=0.16

FY2015 13 SSI/6885 procedures = 0.19

FY 2014: 18 SSI/ 6728 procedures = 0.27

FY 2013: 13 SSI/ 6069 procedures = 0.21

Summary Year Half	Procedure Count	Number of SSI	Number Expected	SIR Rate < 1.0
2013H1	3306	9	54	0.166
2013H2	3371	5	56	0.090
2014H1	3314	11	52	0.212
2014H2	3405	10	51	0.196
2015H1	3148	3	29	0.102
2015H2	2354	5	22	0.230
2016H1	2005	3	19	0.159
2016H2	1944	6	19	0.315

LG NHSN SSI Trends for 4 years: NHSN SIR Rate Goal < 1.0

FY2017: 5 SSI/1680 = 0.29

FY2016: 9 SSI/ 1570 procedures=0.57

FY2015: 3 SSI/ 1741 procedures = 0.17

FY2014: 3 SSI/ 1734 procedures x 100 = 0.17

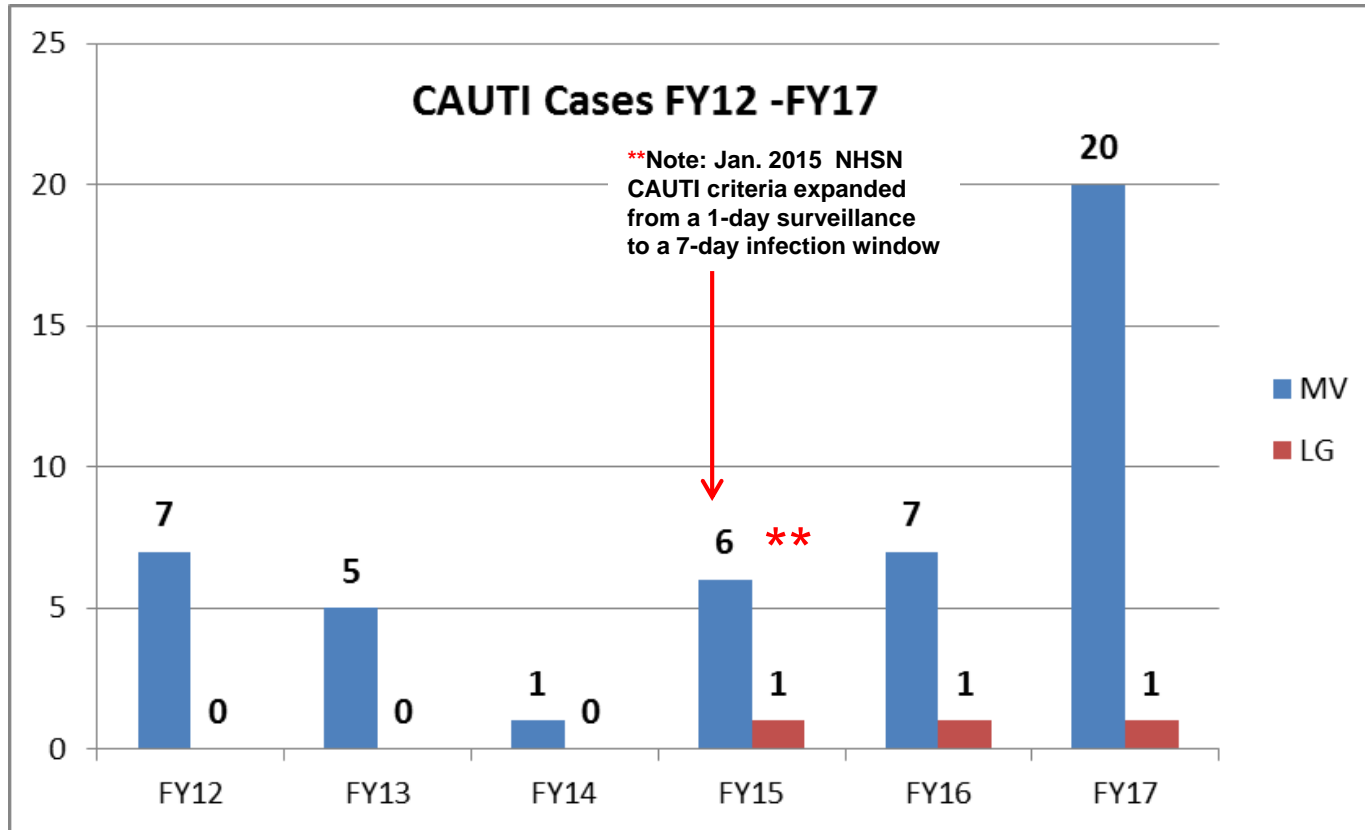
FY2013: 4 SSI/ 1733 procedures x 100 = 0.23

Summary Year Half	Procedure Count	Infection Count All	Number Expected All	SIR Rate < 1.0
2013H1	775	1	13	0.079
2013H2	900	1	16	0.062
2014H1	1558	3	23	0.129
2014H2	805	1	12	0.083
2015H1	856	3	8	0.361
2015H2	713	3	8	0.393
2016H1	781	5	8	0.586
2016H2	508	1	5	0.196

Successful Prevention of XDRO transmission in hospital

- **World-wide emergence of extensively drug-resistant bacteria**
- **“CP-CRE”: a dangerous carbapenemase-producing organism (encoded by a transmissible plasmid)**
- **Identified the first CP-CRE case in Santa Clara County in August 2015 – a traveler from India**
- **Despite contact isolation precautions, suspected transmission occurred to another patient**
- **This event prompted a new policy and more aggressive procedure**
 - “Extensive contact precautions” with 1:1 nursing and dedicated equipment
 - Screening of at-risk admissions for CRE
 - To date, 9 patients with CP-CRE have been identified at ECH
 - *More than 80 at-risk admissions screened 2017*
 - *No further hospital transmission has been identified*

ECH Infection Control Concerns FY2017 CA-UTI Data



CA-UTI Reduction Task Force /CA-UTI Improvement 3A Team

Daily tracking of Foley use & justification, w/ staff education

Root Cause Analysis of all cases

Provided education to high risk areas (e.g., OR Nursing Team and ED)

Renewed focus on patient hygiene, daily baths, clean sheets

CAUTI Prevention Strategies: Identifying Gaps in Care and Process Improvement

- **Infection Control team reviews Foley justification with Floor managers every weekday - despite IP Team efforts, CAUTI's continued to occur**
- **Infection Control team reviews every aspect of any suspect case and communicates back to managers and the CA-UTI Task Force**
 - Gaps in insertion (ED and OR) and daily maintenance are occurring
 - Improvement in daily justification and reduced Foley usage needed
 - Gaps in patient bathing and hygiene
 - We advocate for a process change to include daily bathing with linen change
- **CAUTI A-3 Rapid Improvement Team Developed October 2016**
 - Created Educational Flyer regarding proper urinary catheter bag placement while patient in bed, up to chair or ambulating with FWW
 - Created Educational Flyer created regarding hygiene/cleaning for males
 - Trialing & Implementation of new products: Sure Step Indwelling Urinary Catheter Kit, Foley Wipes, Condom Catheter, Bard's Coude Kit, Bard Straight Catheter Set, Pure Wick External Female Urinary System
 - Evaluating newer soap and bathing products

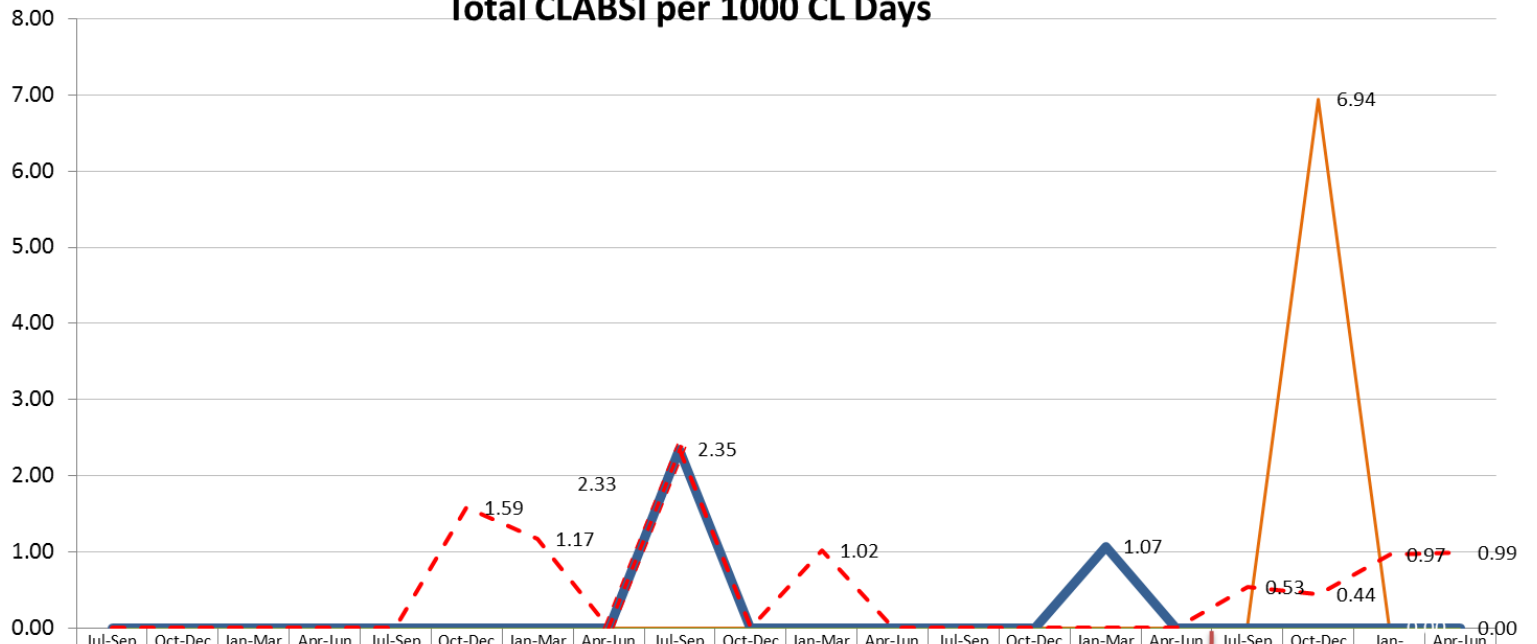
Total CLABSI per 1000 CL Days

FY 17
Rate: 0.57

FY16
Rate: 0.08

FY15
Rate: 0.71

FY14
Rate: 0.48



	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sep 14	Oct-Dec 14	Jan-Mar 15	Apr-Jun 15	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16	Oct-Dec 16	Jan-Mar 17	Apr-Jun 17
— LG ICU BSI Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.94	0.00	0.00
— MV ICU BSI Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.35	0.00	0.00	0.00	0.00	0.00	1.07	0.00	0.00	0.00	0.00	0.00
— LG non-ICU BSI Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
- - - MV non-ICU BSI Rate	0.00	0.00	0.00	0.00	0.00	1.59	1.17	0.00	2.33	0.00	1.02	0.00	0.00	0.00	0.00	0.00	0.53	0.44	0.97	0.99
LG ICU BSI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
MV ICU BSI	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0
LG non-ICU BSI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MV non-ICU BSI	0	0	0	0	0	2	2	0	3	0	2	0	0	0	0	0	1	1	2	2
Ent Total Goal	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

<p>FY 2015 rate: 0.71 CLABSIs: 6 cases (MV: 1-ICU/5-non-ICU)</p>	<p>FY2016 rate: 0.08: CLABSIs:1 case (MV: 1 case)</p>	<p>FY2017 rate: 0.57 CLABSIs: 7 cases (MV: 6/LG: 1)</p>
--	---	---

CLABSI Prevention Strategies –

- **MV CLABSI Task Force 2016**

- *Instituted best practice for CVC care in all locations*
- *Emphasis on hand hygiene and bathing, scrub the hub, dressing care and line maintenance*
- *Staff Education with rolling cart and 1 hour CE class completed 2016*
- *CVC dressings were changed May 2016 (Tegaderm Sorbaview)*
- *Ongoing weekly audits of dressing changes and line justification*

- **Infection Control team reviews all aspects of any suspect CLABSI**

- *Communicate back to managers and Task Force any deficiencies*
- *Our review suggests 3 of 7 CLABSI were contaminated line draws*

- **Newer interventions and recommendations**

- *Rolling out Curoc protectors for all Central lines on all units, Oncology and Infusion Center*
- *Ensure any nurse accessing a PICC or CVC is trained to do so*
- *Immediate retraining and annual competencies for nursing staff accessing lines*
- *Daily bathing and sheet changes*

Quality and Safety Dashboard (Monthly)

Date Reports Run: 7/11/2017		Baseline	FY17 Goal	Trend	Comments	
SAFETY EVENTS		Performance	FY2016	FY2017 goal		
1	<p>Patient Falls Med / Surg / CC Falls / 1,000 CALNOC Pt Days Date Period: June 2017</p> <p>★Organizational Goal Pain reassessment within 60 mins after pain med administration Date Period: June 2017</p> <p>Medication Errors (Overall: reached to patients and near miss) Errors / 1000 Adj Total Patient Days Date Period: June 2017</p>	6/5070 1.18	1.51		Number of falls dropped in June. Maybe attributable to increased concurrent audit of fall risk, signage, arm bands, skid socks, and use of bed and chair alarms by a light duty nurse.	
2	<p>★Organizational Goal Pain reassessment within 60 mins after pain med administration Date Period: June 2017</p>	6987/7816 89.3%	59.8% (Jan-Jun 2016)		Reassessment rate between 5-60 minutes continued to improve to over 90.6% in June.	
3	<p>Medication Errors (Overall: reached to patients and near miss) Errors / 1000 Adj Total Patient Days Date Period: June 2017</p>	41/13978 2.93	2.68		Both errors that reach the patient and near miss reporting increased in June.	
EFFICIENCY		Performance	Jan-Jun 2016 (6-month avg)	FY 2017 goal		
4	<p>★Organizational Goal Average Length of Stay (days) (Medicare definition, MS-CC, ≥ 65, inpatient) Date Period: Jul 2017</p>	<p>FY17 5169 FY18 July 2017 461</p> <p>4.71</p>	4.78	4.87		LOS increased due to several long stay patients discharged in July. Note FY18 began w/July 1st.
5	<p>★Organizational Goal 30-Day Readmission (Rate, LOS-Focused) (ALOS-Linked, All-Cause, Unplanned) Date Period: June 2017</p>	<p>FYTD 570/5173 June 2017 54/445</p> <p>11.02</p>	10.76	At or below 12.24		Readmission rate increased to goal in June.

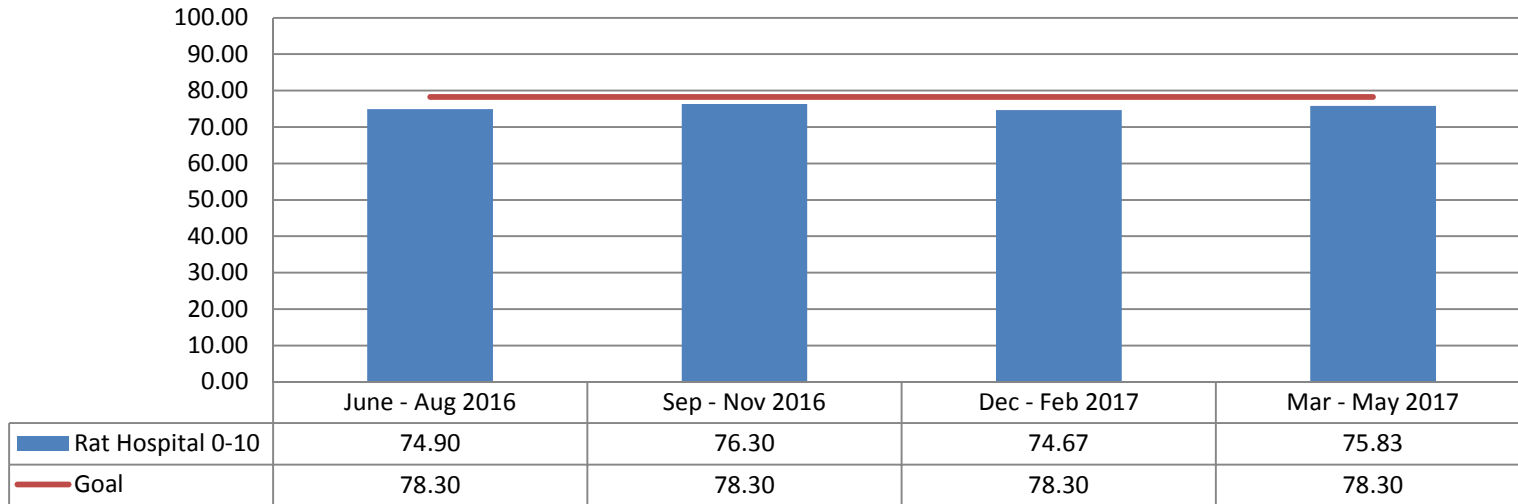
Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2016 Definition	FY 2017 Definition	Source
Patient Falls	Sheetal Shah; Cheryl Reinking	Falls Committee	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment, including bedside mat). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include Assisted Falls (when staff attempts to minimize the impact of the fall, it is still a fall). <i>Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included. It is NOT considered a fall according to the CALNOC definition.</i>		QRR Reporting and Staff Validation
Pain Reassessment within 60 minutes after pain med administration	Chris Tarver; Cheryl Reinking		Pain Reassessment is measured as documentation on the iCare EHR Flowsheet in at least one of the 9 designated flowsheet rows, for designated medications marked as "given" on the MAR. The designated medications cover 95% of the PRN pain medications administered as "PRN" (pharmacy class/medication IDs). Exclusion criteria is as follows: Epidural route, Endoscopy Unit, Interventional Services, and the "PRN reasons" of "shivering, none (NULL) and other".		EPIC report
Medication Errors	Sheetal Shah; Cheryl Reinking	Medication Safety Committee; P&T Committee	5 Rights MEdication Errors: [# of Med Errors (includes: Duplicate Dose, Omitted Dose, Incorrect Patient, Incorrect Medication, and Incorrect Route, Incorrect Dose, Incorrect Time, Incorrect Medication order, Medication Reconciliation) divided by Adjusted Total Patient Days (includes L&D & Nursery)]* 1,000 <i>Near miss and reached patients.</i>		QRR Reporting and Staff Validation
Average Length of Stay	Cheryle Reinking; Mick Zdeblick	LOS Steering Committee	Average LOS of Medicare FFS, Patients discharged from an Acute Care or Intensive Care unit. Excludes expired patients. Includes final coded patients aged 65 and older at the time of the encounter. The baseline period is from Jan-June 2015 and the performance period is from Jan-June 2016.		EDW Data Pull, Department of Clinical Effectiveness
30-Day Readmission (LOS-Focused)	Margaret Wilmer; Cheryle Reinking	Readmission Committee	Percent of Medicare inpatient discharges return for an unplanned IP stay for any reason within 30 days, aged ≥65. Excludes patients who die, leave AMA or are transferred to another acute care facility; excludes admits to ECH Rehab and Psych admissions and for medical treatment of cancer.		EDW Data Pull, Department of Clinical Effectiveness

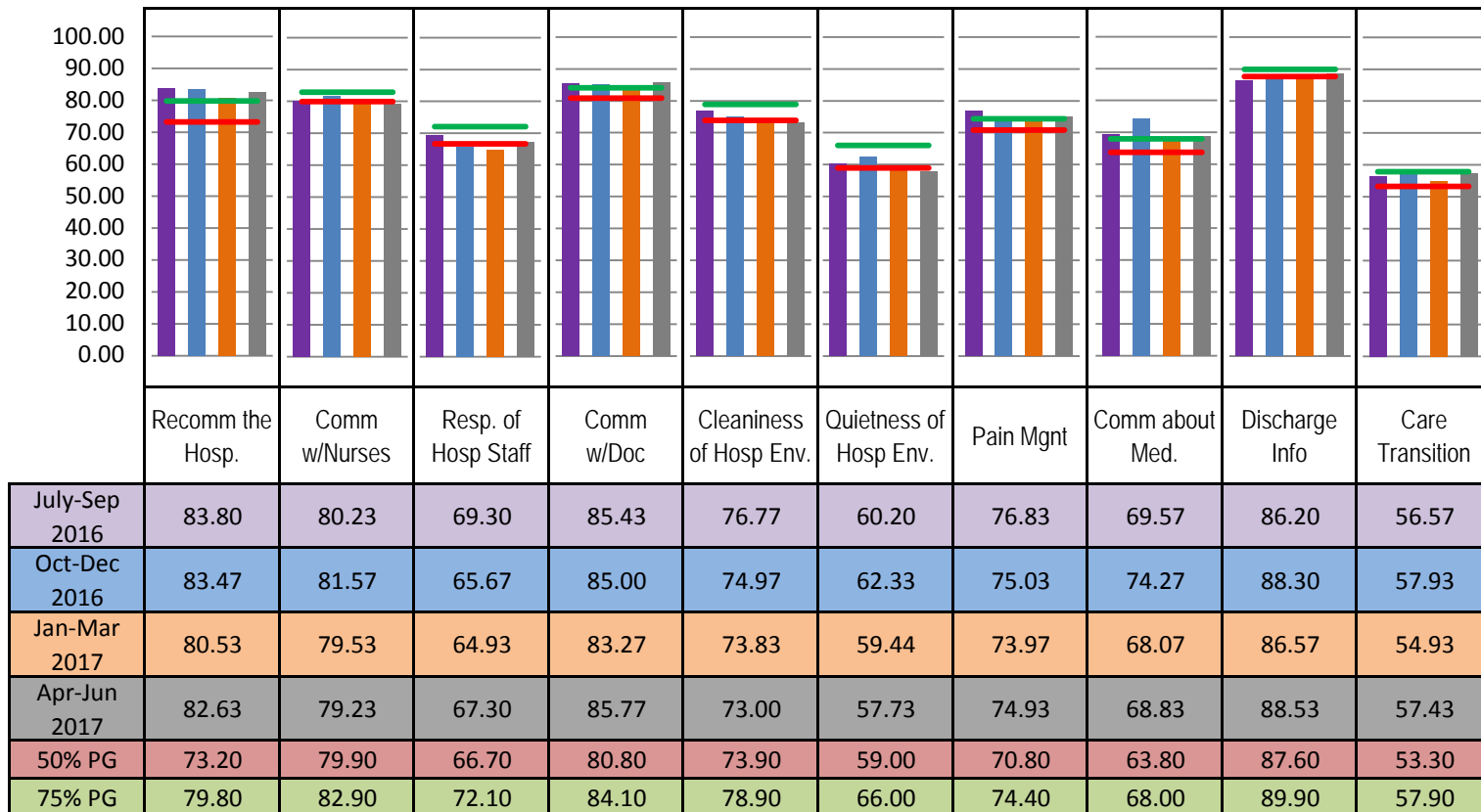
Date Reports Run: 3/12/2017		Baseline	FY17 Goal	Trend	Comments												
6	<p>★Organizational Goal</p> <p>IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock (Patients lacking initial hypotension or lactate <3 excluded) Date Period: June 2017</p>	<p>Goal: 70% (Min); 75%(Max); 80% (Stretch)</p>			<p>Significant improvement in ED physician ordering of fluid bolus w/1 2 hrs of time of presentation.</p>												
		Number of Sampled Cases	18	19		21	23	30	30	29	30	30	30	30	30	30	
		Cases with 30ml/kg ordered or NICOM with 3 hours TOP	0	0		0	1	0	0	0	2	1	0	0	0	0	0
		Cases with 30ml/kg ordered (or NICOM) ordered with 2 hours TOP	9	17		9	14	17	17	24	21	26	26	25	25	28	
		% Compliance with 30ml/kg ordered within 2 hours of TOP	50%	89%		43%	61%	57%	57%	83%	70%	87%	87%	83%	83%	93%	
Min Goal		70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%			
COMPLICATIONS		Performance		FY 2016	FY 2017												
7	<p>Surgical Site Infection (SSI) SSI per 100 Clean/Clean-contaminated Surgical Procedures Date Period: June 2017</p>	2/585	0.34	0.20	0.18 (goal for FY 16)			<p>Total of 2 SSI (both at MV) 1-craniotomy and 1-hip fracture.</p>									
SERVICE		Performance		FY 2016	FY 2017 goal												
8	<p>Communication with Nurses (HCAHPS composite score, top box) Date Period: May 2017</p>	162/202	80.2%	78.0%	78.5%												
9	<p>Responsiveness of Hospital Staff (HCAHPS composite score, top box) Date Period: May 2017</p>	132/196	67.3%	64.9%	66.8%												
10	<p>★Organizational Goal</p> <p>Pain management (HCAHPS composite score, top box) Date Period: May 2017</p>	103/137	75.0%	72.5%	73% min 74% max 76% stretch												
11	<p>Communication About Medicines (HCAHPS composite score, top box) Date Period: May 2017</p>	90/137	65.6%	72.9%	68.3%												

Measure Name	Definition Owner	Work Group	FY 2016 Definition	FY 2017 Definition	Source
IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock	Catherine Carson			Percentage of Randomly Sampled ED Patients (LG & MV) who had IVF >=30 ml/kg ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock (Patients Lacking Initial Hypotension or Lactate <3 Excluded)	EPIC Chart Review
Surgical Site Infection	Catherine Nalesnik; Carol Kemper, MD	Infection Control Committee	(Number of Deep Organ Space infections divided by the # of all surgery cases)*100 counted by the month procedure under which infection was attributed to and not by the month it was discovered. All Surgery Cases in the 29 Surgical Procedural Categories required by the California Department of Public Health.		IC Surveillance and NHSN Data Reporting
Nov 2 cases: 1 Colon w/ resection and tumor debulking, developed abscess & perforated bowel.					
Communication with Nurses	Michelle Gabriel; Meena Ramchandani; Cheryl Reinking	Patient Experience Committee	Percent of inpatients responding "Always" to the following 3 questions [% Top Box]: 1. During hospital stay, how often did the nurses treat you with courtesy and respect? 2. During hospital stay, how often did nurses listen carefully to you? 3. During hospital stay, how often did nurses explain things in a way you can understand? CMS Qualified values are pulled from the Avatar website. Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		Press Ganey Tool
Responsiveness of Hospital Staff	Michelle Gabriel	Patient Experience Committee	Percent of inpatients responding "Always" to the following 2 questions [% Top Box]: 1. During hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? 2. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted (for patients who needed a bedpan)? CMS Qualified values are pulled from the Avatar website. Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		Press Ganey Tool
Pain management	Chris Tarver, Meena Ramchandani	Patient Experience Committee	Percent of inpatients responding "Always" to the following 2 questions [% Top Box]: 1. Pain well controlled, 2. Staff do everything help with pain		Press Ganey Tool
Communication About Medicines	Michelle Gabriel; Cheryl Reinking; Bob Blair	Patient Experience Committee	Percent of inpatients (who received meds) responding "Always" to the following 2 questions [% Top Box]: 1. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? 2. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? CMS Qualified values are pulled from the Avatar website. Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		Press Ganey Tool

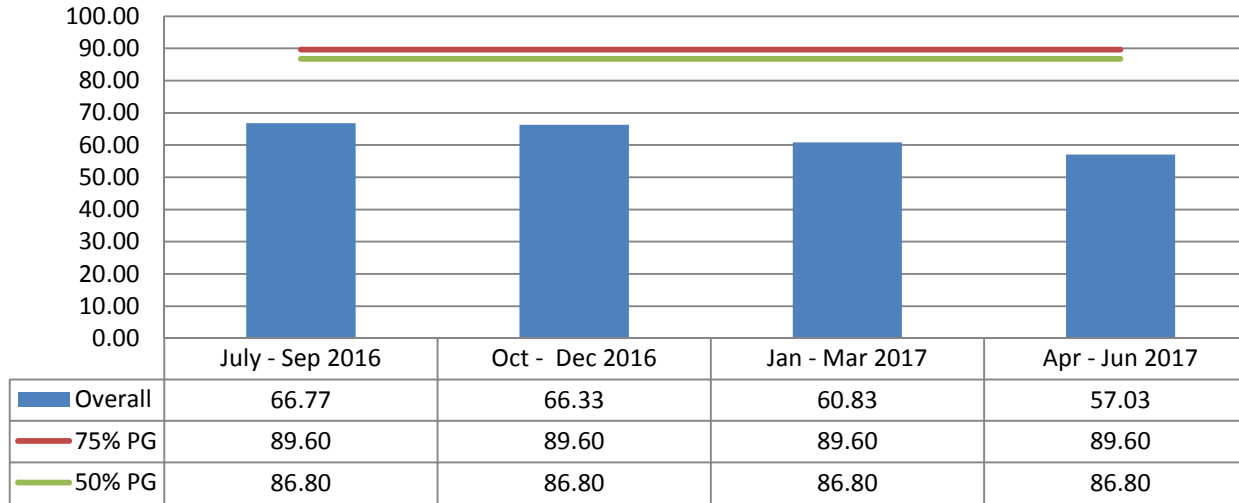
ECH HCAHPS Rate Hospital 0-10



ECH HCAHPS Individual Question



ED Overall



ED Individual Question



ED Question

Overall

Arrival

- Waiting time before noticed arrival
- Helpfulness of first person
- Comfort of waiting area
- Waiting time to treatment area
- Waiting time to see doctor

Nurses

- Nurses courtesy
- Nurses took time to listen
- Nurses attention to your needs
- Nurses information regarding treatments
- Nurses concern for Privacy

Doctors

- Doctors Courtesy
- Doctor took time to listen
- Doctor informative regarding treatment
- Doctors concern for comfort

Tests

- Courtesy of person who took blood
- Concern blood draw comfort
- Waiting time for radiology test
- Courtesy of radiology staff
- Concern for comfort radiology test

Family or Friends

- Courtesy shown family/friends
- Adequacy of info to family/friends
- Let family/friend be with you

Personal/Insurance info

- Courtesy during personal/Insurance Info
- Privacy during personal/insurance Info
- Ease giving personal/Insurance Info

Personal Issues

- Informed about delays
- Staff cared about you as person
- How well pain was controlled
- Information about home care
- Safe/secure felt in ER/ED

Overall Assessment

- Overall rating ER care
- Likelihood of recommending

manatt



El Camino Hospital[®]

THE HOSPITAL OF SILICON VALLEY

Strategic Framework: 2017-2020

Quality Committee Meeting

August 28, 2017

Refined ECH Mission, Vision, and Values

Vision

To lead the transformation of healthcare delivery in Silicon Valley

Mission

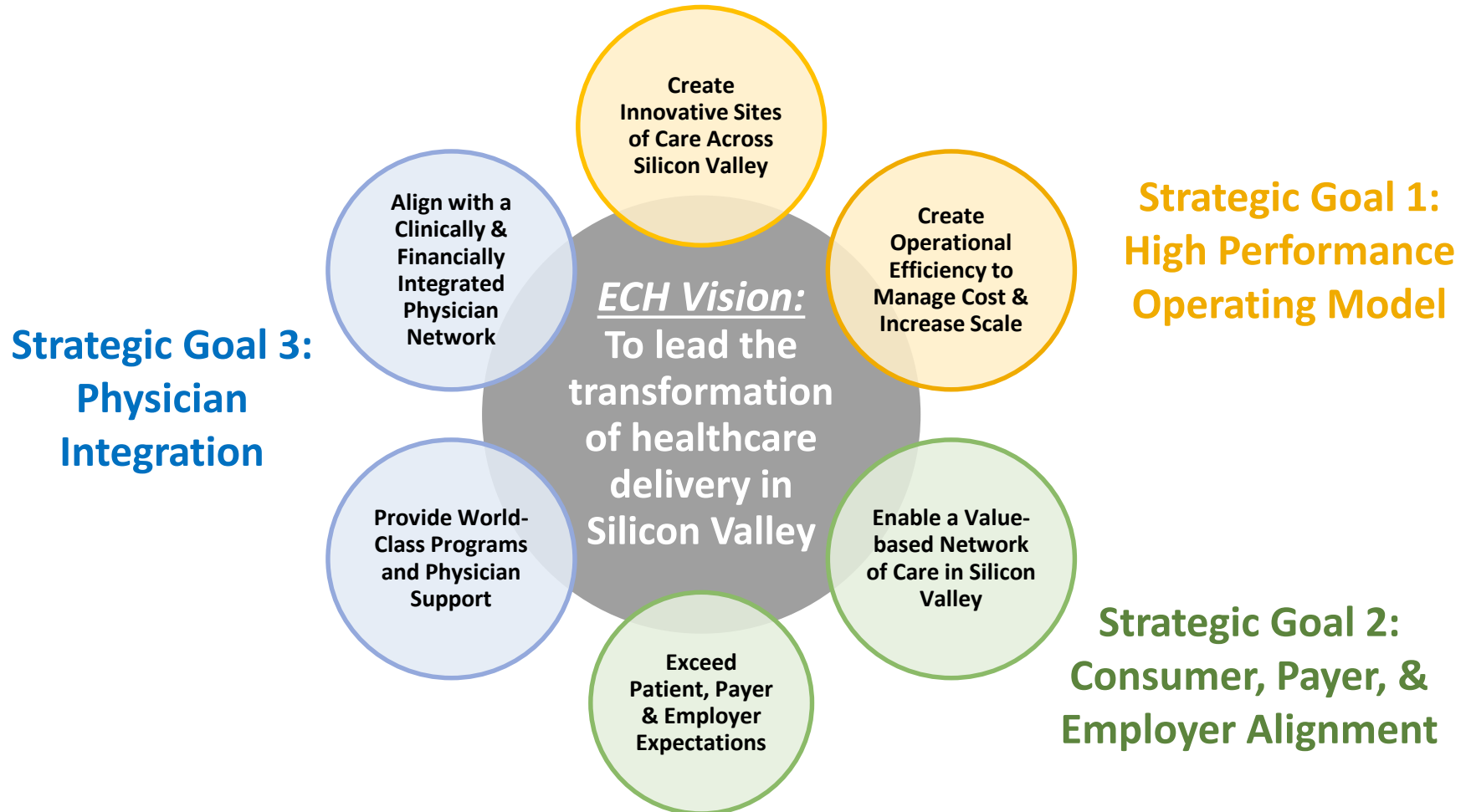
Our mission is to heal, relieve suffering and advance wellness as your publicly accountable health partner

Values

- **Quality.** We pursue excellence to deliver evidence based care in partnership with our patients and families.
- **Compassion.** We care for each individual uniquely with kindness, respect and empathy.
- **Community.** We partner with local organizations, volunteers and a philanthropic community to provide healthcare services across all stages of life.
- **Collaboration.** We partner for the best interests of our patients, their families and our community using a team approach.
- **Stewardship.** We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.
- **Innovation.** We embrace solutions and forward thinking approaches that lead to better health.
- **Accountability.** We take responsibility for the impact our actions have on the community and each other.

Components of Vision

This vision requires ECH to look to a future as a health services provider caring for consumers, patients, and families across the care continuum.



Strategic Framework

