MEMORANDUM

TO: The Transitional Care Hospital Board:

Edward D. Miller, M.D., Co-Chair
George Keith Martin, Rector
William H. Goodwin Jr.
Victoria D. Harker
Andrew K. Hodson, M.D.

Stephen P. Long, M.D., Co-Chair
William P. Kanto Jr., M.D.
Constance R. Kincheloe
Charles W. Moorman
The Hon. Lewis F. Payne

Ex Officio Advisory Members:
Teresa A. Sullivan
Nancy E. Dunlap, M.D.
Dorrie K. Fontaine
Robert S. Gibson, M.D.

Patrick D. Hogan
R. Edward Howell
Richard P. Shannon, M.D.
John D. Simon

and

The Remaining Members of the Board of Visitors and Senior Advisor:
Frank B. Atkinson
Hunter E. Craig
Allison Cryor DiNardo
Helen E. Dragas
Kevin J. Fay
Frank E. Genovese
Marvin W. Gilliam Jr.

John A. Griffin
Bobbie G. Kilberg
John L. Nau III
Timothy B. Robertson
Linwood H. Rose
Blake E. Blaze
Leonard W. Sandridge Jr.

FROM: Susan G. Harris

RE: Minutes of the Meeting of the Transitional Care Hospital Board
on November 14, 2013

The Transitional Care Hospital (TCH) Board met, in Open Session, at
8:30 a.m., Thursday, November 14, 2013, on the Fourth Floor of the
Emily Couric Clinical Cancer Center; Dr. Long and Dr. Miller, Co-
Chairs, presided.
George Keith Martin, Rector, William H. Goodwin Jr., Victoria D. Harker, Michael M.E. Johns, M.D., William P. Kanto Jr., M.D., Constance R. Kincheloe, and The Honorable Lewis F. Payne were present.

Teresa A. Sullivan, Nancy E. Dunlap, M.D., Dorrie K. Fontaine, Robert S. Gibson, M.D., Patrick D. Hogan, R. Edward Howell, and Richard P. Shannon, M.D., all ex officio members, also were present.


Dr. Long opened the meeting and called on Ms. Hereford to provide the Operations and Finance report.

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Operations and Finance Report

Ms. Hereford reported on the fiscal year 2014 financial performance of the TCH through the month of September. She noted that 52 patients were derived from the Medical Center during fiscal year 2014, first quarter, and derived 75% of the TCH's volume. If those same patients had stayed at the medical center for their entire length of stay, the Medical Center would have experienced a loss of $680,000 on care provided to those patients. Their move to the TCH contributed to a length of stay reduction at the Medical Center of .23 days during this period. Ms. Hereford highlighted the work of three TCH employees.

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Vice President’s Remarks

Mr. Howell recognized and thanked Dr. Jonathon Truwit for his years of service with the University. Mr. Truwit is leaving the University to join Froedtert Health System and the Medical College of Wisconsin.

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The following motion was approved, and the Transitional Care Hospital Board commenced in Executive Session at 8:40 a.m.:

That the Medical Center Operating Board go into closed meeting to discuss proprietary, business-related information pertaining to the Transitional Care Hospital, specifically, confidential information and data related to the adequacy and quality of professional services, competency and qualifications for professional staff privileges, and patient safety in clinical care, all for the purpose of improving
patient care; and consultation with legal counsel regarding compliance with relevant federal reimbursement regulations, licensure, and accreditation standards where disclosure at this time would adversely affect the competitive position of the Transitional Care Hospital. The foregoing motion is authorized by Sections 2.2-3711 (A) (1), (7) and (22) of the Code of Virginia. The closed meeting of the Medical Center Operating Board is further privileged under Section 8.01-581.17 of the Code of Virginia.

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At 8:50 a.m., the Transitional Care Hospital Board left Executive Session and adopted the following resolution certifying that its discussions in Executive Session had been conducted in accordance with the exemptions permitted by the Virginia Freedom of Information Act:

That we vote on and record our certification that, to the best of each Board member’s knowledge, only public business matters lawfully exempted from open meeting requirements and which were identified in the motion(s) authorizing the closed session, were heard, discussed or considered in closed session.

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On motion, the Transitional Care Hospital board approved the following resolutions:

Approval of Credentialing and Recredentialing Actions

The Transitional Care Hospital Board approved the following Credentialing and Recredentialing actions:

1. **NEW APPOINTMENTS TO THE CLINICAL STAFF**

   **RESOLVED, the recommendations of the Clinical Staff Executive Committee for appointment to the Clinical Staff of the University of Virginia Transitional Care Hospital and the granting of specific privileges to the following practitioners are approved:**

   **Allen, John C., M.D., Physician in the Department of Medicine; Moonlighting Staff Status; Period of Appointment: September 20, 2013, through July 30, 2014; Privileged in Medicine.**

   **Buda, Andrew J., M.D., Cardiologist in the Department of Medicine; Consulting Staff Status; Period of Appointment: September 18, 2013, through September 4, 2014; Privileged in Medicine.**

   **Chaplin, Ashley, M.D., Physician in the Department of Medicine; Moonlighting Staff Status; Period of Appointment: September 18, 2013, through July 31, 2014; Privileged in Medicine.**
Chaudhary, Jyoti, M.B.B.S., Hospitalist in the Department of Medicine; Attending Staff Status; Period of Appointment: October 17, 2013, through October 13, 2014; Privileged in Medicine.

Gomez, Justin, M.D., Physician in the Department of Medicine; Moonlighting Staff Status; Period of Appointment: September 20, 2013, through July 30, 2014; Privileged in Medicine.

Haskal, Ziv J., M.D., Radiologist in the Department of Medicine; Consulting Staff Status; Period of Appointment: October 3, 2013, through September 30, 2014; Privileged in Radiology and Medical Imaging.

Inofuentes, Amber, M.D., Hospitalist in the Department of Medicine; Attending Staff Status; Period of Appointment: September 12, 2013, through August 31, 2014; Privileged in Medicine.

McManus, Kathleen, M.D., Physician in the Department of Medicine; Moonlighting Staff Status; Period of Appointment: September 20, 2013, through July 30, 2014; Privileged in Medicine.

Maluf, Daniel, M.D., Surgeon in the Department of Surgery; Consulting Staff Status; Period of Appointment: October 9, 2013, through October 8, 2014; Privileged in Surgery.

Mealor, Augustus, M.D., Physician in the Department of Medicine; Moonlighting Staff Status; Period of Appointment: September 20, 2013, through August 31, 2014; Privileged in Medicine.

Reddy, Ashvini, M.D., Ophthalmologist in the Department of Ophthalmology; Consulting Staff Status; Period of Appointment: September 13, 2013, through August 28, 2014; Privileged in Ophthalmology.

Rubin, Amy S., M.D., Physician in the Department of Medicine; Moonlighting Staff Status; Period of Appointment: October 2, 2013, through July 31, 2014; Privileged in Medicine.

Shaw, Andrew, M.D., Physician in the Department of Medicine; Moonlighter Staff Status; Period of Appointment: September 20, 2013, through July 30, 2014; Privileged in Medicine.

Steers, William, M.D., Urologist in the Department of Urology; Consulting Staff Status; Period of Appointment: October 18, 2013, through October 17, 2014; Privileged in Urology.

Volodin, Leonid, M.D., Hematologist Oncologist in the Department of Medicine; Consulting Staff Status; Period of Appointment: September 25, 2013, through September 2, 2014; Privileged in Medicine.
2. REAPPOINTMENTS TO THE CLINICAL STAFF

RESOLVED, the recommendations of the Clinical Staff Executive Committee for reappointment to the Clinical Staff of the University of Virginia Transitional Care Hospital and the granting of specific privileges to the following practitioners are approved:

Dokun, Ayotunde, M.D., Endocrinologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: November 14, 2013, through June 30, 2014; Privileged in Medicine.

Gupta, Anuja, M.B.B.S., Obstetrician and Gynecologist in the Department of Obstetrics and Gynecology; Consulting Staff Status; Period of Reappointment: November 1, 2013, through October 31, 2014; Privileged in Obstetrics and Gynecology.

Hays, Rachel, M.D., Gastroenterologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: November 1, 2013, through November 3, 2013; Privileged in Medicine.

Mann, James A., M.D., Gastroenterologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: November 1, 2013, through October 31, 2015; Privileged in Medicine.

Southerland, Andrew, M.D., Neurologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: November 30, 2013, through June 30, 2014; Privileged in Neurology.

Vranic, Gayle, M.D., Nephrologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: November 30, 2013, through June 30, 2014; Privileged in Medicine.

Warren, Cirle A., M.D., Epidemiologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: November 25, 2013, through November 24, 2014; Privileged in Medicine.

Wilder, Robert P., M.D., Physiatrist in the Department of Physical Medicine and Rehabilitation; Consulting Staff Status; Period of Reappointment: November 16, 2013, through November 15, 2013; Privileged in Physical Medicine and Rehabilitation.

Yang, Zequan, M.D., Surgeon in the Department of Medicine; Consulting Staff Status; Period of Reappointment: December 20, 2013, through July 1, 2014; Privileged in Surgery.

3. STATUS CHANGES FOR CLINICAL STAFF

RESOLVED, the recommendations of the Clinical Staff Executive Committee for the status change in privileges to the following Clinical Staff Member are approved:
Hayes, John, M.B.B.S., Nephrologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: October 8, 2013, through October 7, 2014; Privileged in Medicine.

Isbell, James M., M.D., Surgeon in the Department of Surgery; Consulting Staff Status; Date of Title Change: July 1, 2013, through May 8, 2014; Privileged in Surgery.

Leslie, Catherine, M.D., Psychiatrist in the Department of Psychiatry and Neurobehavioral Sciences; Consulting Staff Status; Period of Reappointment: November 25, 2013, through November 24, 2014; Privileged in Psychiatry and Neurobehavioral Sciences.

Purow, Benjamin W., M.D., Neurologist in the Department of Neurology; Consulting Staff Status; Period of Reappointment: November 1, 2013, through October 31, 2015; Privileged in Neurology.

Rosner, Mitchell H., M.D., Nephrologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: August 1, 2013, through August 1, 2015; Privileged in Medicine.

Weiss, Geoffrey, M.D., Hematologist Oncologist in the Department of Medicine; Consulting Staff Status; Period of Reappointment: November 12, 2013, through November 11, 2014; Privileged in Medicine.

4. RESIGNATIONS OF CLINICAL STAFF

RESOLVED, the recommendations of the Clinical Staff Executive Committee for the resignation and expiration of privileges to the following Clinical Staff are approved:

Hu, Daniel C., M.D., Nephrologist in the Department of Medicine; Effective Date of Resignation September 1, 2013.

Johns, Dearing W., M.D., Cardiologist in the Department of Medicine; Effective Date of Resignation October 5, 2013.

APPROVAL OF UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL QUALITY PLAN AND INFECTION CONTROL AND PREVENTION PLAN

RESOLVED, the Medical Center Operating Board approves the fiscal year 2014-2016 Quality Improvement and Patient Safety Plan for the University of Virginia Transitional Care Hospital as approved by the Transitional Care Hospital Clinical Staff Executive Committee on June 26, 2013;

RESOLVED FURTHER, the Medical Center Operating Board approves the fiscal year 2014 Infection Control and Prevention Plan for the University of Virginia Transitional Care Hospital as approved by the
Transitional Care Hospital Clinical Staff Executive Committee on
September 25, 2013.

On motion, the meeting was adjourned at 8:50 a.m.

SGH:ddr
These minutes have been posted to the University of Virginia’s
Board of Visitors website.
http://www.virginia.edu/bov/mcobminutes.html
ATTACHMENTS
Transitional Care Hospital

QUALITY IMPROVEMENT

AND

PATIENT SAFETY PLAN

FY 2014 - 2016

Privileged and Confidential Quality Assurance Document
Privileged under Virginia Code Section 8.01-581.17

Approved by Quality Committee: June 17, 2013
Approved by CSEC: June 26, 2013
Approved by MCOB:
The Quality Improvement and Patient Safety Plan

for the

University of Virginia Transitional Care Hospital

has been reviewed and approved by:

R. Edward Howell
Vice President and Chief Executive Officer
UVA Transitional Care Hospital

Jonathon D. Truwit, M.D.
President, TCH Clinical Staff
UVA Transitional Care Hospital

Robert “Bo” Cofield
Associate Vice President
UVA Transitional Care Hospital

George Hoke, M.D.
Medical Director, TCH Clinical Staff
Chair, Quality Committee
UVA Transitional Care Hospital

Michele D. Hereford, RN, FACHE
Chief of LTACH Operations
UVA Transitional Care Hospital

Christine K Matt, RN
Director of Quality
UVA Transitional Care Hospital
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Introduction

The purpose of the Quality Improvement and Patient Safety Plan for the University of Virginia Transitional Care Hospital (TCH) is to describe the organization’s structure and systematic approach for quality, performance and safety planning, maintenance and improvement. The term “Quality Improvement” includes systems and processes related to the care, treatment and services for our patients, outcomes, and our overall performance.

It outlines the structure and processes by which the organization will seek to eliminate preventable harm, improve patient care, outcomes and experience, and reduce error and waste. This multi-year Quality/Performance Improvement and Patient Safety Plan describes the organizational structure necessary to achieve improvement and communicate results both internally and externally. In addition, the plan outlines improvement methodologies to be utilized, processes and outcomes to be monitored, and the education and training planned to increase skill and capacity to achieve and sustain improvements.

This document serves as a resource and guide for all Transitional Care Hospital staff and faculty to facilitate their understanding and participation in the TCH quality monitoring and improvement activities. It has been developed and approved by the Transitional Care Hospital leadership to establish metrics that monitor progress in achieving and maintaining the strategic goals of:

I CARE, I HEAL, I BUILD.

These goals emphasize the power that each individual has to contribute to the betterment of our care and services to patients and their families. We also embrace a strong interdisciplinary team approach to review our practices and outcomes together and jointly plan course corrections and implement new programs.

Continuous performance improvement requires the involvement of our interdisciplinary team to measure current performance against established targets in order to identify priority areas for focused improvement efforts. The priorities may be amended throughout the year in response to unusual or urgent situations but should always support the University of Virginia Health System’s mission, vision and values.
**UVAHS Mission, Vision and Values**

The UVA Transitional Care Hospital’s Quality Improvement and Patient Safety Plan supports the Mission, Vision and Values of the University of Virginia Health System which are described below.

**Mission:**
The Mission of the UVA Health System is to provide excellence, innovation and superlative quality in the care of patients, the training of health professionals, and the creation and sharing of health knowledge.

**Vision:**
In all that we do, we work to benefit human health and improve the quality of life. We will be:
- Our local community’s provider of choice for its healthcare needs
- A national leader in quality, patient safety, service and compassionate care
- The leading provider of technologically-advanced, ground-breaking care throughout Virginia
- Recognized for translating research discoveries into improvements in clinical care and patient outcomes
- Recognized for fostering innovative care delivery and teaching/training models that respond to the evolving health environment

**Values:**
This institution exists to serve others, and does so through the expression of our core Values:
- **Respect** To recognize the dignity of every person
- **Integrity** To be honest, fair and trustworthy
- **Stewardship** To manage resources responsibly
- **Excellence** To work at the highest level of performance, with a commitment to continuous improvement
Scope and Prioritization of Improvement Efforts

Quality improvement, patient safety and excellent customer service are the responsibility of every individual who is part of the UVA Transitional Care Hospital. The program includes the collective efforts of the staff of the Transitional Care Hospital and of the Contractual Services/Agreements that are associated with all direct patient care services and indirect services that affect patient health, safety and satisfaction.

Performance improvement and patient safety initiatives are prioritized based upon the effort’s impact on and compatibility with our:

- Mission
- Strategic plan
- Quality of care and patient safety and satisfaction goals
- Compliance with regulatory and accreditation agencies

Priorities are also based on high risk, high volume, or problem-prone areas considering the incidence, prevalence, and severity of problems in those areas and their effect on health outcomes, patient safety, and quality of care. Criteria for prioritization of improvement activities include:

- Significant potential to improve patient safety
- Significant potential to improve the quality of care
- Significant potential to increase patient / customer satisfaction
- Significant potential to impact efficiency
- Significant potential to impact expense or revenue
- Processes that cross multiple departments, disciplines, or services
- Advances in capabilities to do future improvement projects (i.e., pilot programs)
- Practices which improve compliance with regulatory requirements.

Opportunities for improvement may also be selected based on information derived from one or more of the following mechanisms:

- Organizational goals or important functions of the hospital or health system
- Evaluation of findings from root cause or failure mode analyses
- Data (from internal or external sources) which indicate performance problems in a given process that affects a substantial proportion of patients or employees or represents a substantial risk
- External data or feedback from various customers or supplier groups related to hospital processes
- Data indicating performance or resource utilization problems from:
  - Local area (unit, discipline or program) quality improvement activities
  - Risk management activities
  - Care management activities
  - Operational or quality activities
Ongoing Monitoring of Key Processes and Services

It is important to continuously monitor key aspects of patient care services to ensure that processes are stable and that nationally accepted standards for quality are met. This facilitates the identification of areas for improvement or further study of publicly reported indicators or high risk processes. It is also necessary to continuously monitor the following to comply with regulatory and accreditation standards, such as the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC):

- Adverse events related to using moderate sedation
- Use of blood and blood components
- All reported and confirmed transfusion reactions
- Results of resuscitation
- Restraint use
- Significant medication errors and adverse drug reactions
- Patient perception of the safety and quality of care
- Staff opinions and needs, staff perceptions of risk to individuals, staff suggestions for improving patient safety and staff willingness to report adverse events
- Number and severity of fall-related injuries
- Organ procurement conversion rate
- Infection prevention
- Medical record review (includes active and closed record reviews)
- Risk management activities
- Appropriate care measures as defined by CMS and TJC

Goals and Objectives

The goals of Quality Improvement and Patient Safety Plan are to eliminate preventable harm, to improve patient care, outcomes and experience, and to reduce error and waste in healthcare delivery throughout the continuum of care. Initiatives and activities are to be guided by this plan, which delineates a framework of formal structures, committees and teams, and systematic approaches to:

- Understand practice and processes which support clinical care
- Identify clinical and operational opportunities for improvement
- Plan and implement change
- Measure effectiveness of redesigned practices or processes
- Evaluate outcomes
- Sustain improvement
**Evaluation of Effectiveness**

The plan is evaluated at least annually for its effectiveness in achieving its goals and objectives. In addition to quarterly reports to the Medical Center Operating Board, an annual assessment of quality improvement and patient safety activities, improvements made, care delivery processes modified, and projects in progress will be compiled and forwarded to the Board for review in the first quarter of each fiscal year. The Quality Improvement and Patient Safety Plan will be updated or modified as indicated by these assessments.

**Structure and Accountability**

The University of Virginia Medical Center Operating Board (MCOB) and University of Virginia Board of Visitors (BOV) maintain ultimate responsibility for the quality of care delivered within the University of Virginia Transitional Care Hospital (TCH). The TCH has interdisciplinary structures and processes to monitor activities and implement improvement activities consistent with strategic goals. The organizational committee structure (Appendix B) assures that information is effectively communicated throughout the organization. The TCH Clinical Staff Executive Committee (CSEC) and the TCH Quality Committee (QC) establish organization-wide priorities and monitor the effectiveness of activities or interventions to improve performance and patient safety.

The CSEC is charged to review data, approve priority quality and safety initiatives and goals, and to provide strategic oversight for the quality improvement activities which assure patient safety, the adequacy and quality of professional services, the environment of care, and patient satisfaction with clinical care and services. It is accountable for the direction and oversight of quality monitoring and improvement activities. The CSEC is supported in this responsibility by the MCOB, which coordinates the reporting of quality improvement and patient safety performance and activities. The responsibilities of the CSEC and its subcommittees are detailed in Appendix C.

The Quality Assurance and Performance Improvement (QAPI) Department includes Quality and Performance Improvement, Patient Safety and Satisfaction, Risk Management, and Environment of Care/Emergency Management activities. Performance Improvement staff may support these efforts as leaders, facilitators, and educators as appropriate to projects. In addition they may assist clinical and administrative leaders to review quality data, identify opportunities for improvement, develop unique indicators, and implement/monitor performance improvement activities. The Patient Safety and Risk Management activities include gathering, assessing and communicating data from QRs, clinical case reviews and significant event analyses. Through a Memorandum of Understanding, the UVA Medical Center Clinical Staff office supports credentialing and privileging activities of the Clinical Staff.

Performance improvement teams may be convened to address issues affecting both clinical practice and patient care processes in which many disciplines contribute to care, or which require coordination between multiple service areas. Improvement teams are designed to identify opportunities to improve care and services, implement actions and evaluate effectiveness as close to the point of patient care as possible.
The teams strive to foster engagement of key stakeholders, including the Attending Physician Staff, Transitional Care Hospital clinical and support staff and UVA Health System contractual partners in improvement activities relevant to their clinical or operational area. Institutional improvement teams are led by clinical staff with content expertise, and are facilitated by QPI staff.

With all teams, the clinical and administrative leadership, working with practitioners in each patient care area, identifies opportunities for improvement and routine monitoring to assure optimal outcomes. Activities align through the routine inclusion of efforts which directly support institutional quality improvement and patient safety priorities. Both the institutional priorities and the timelines and strategies for their achievement are set by the clinical and administrative leadership, along with iterative strategies to achieve the optimal outcomes (Appendix A). Current and goal performance is displayed on the Transitional Care Hospital Quality Dashboard, which is available to all employees on the Journey to Excellence Board, and is updated regularly when new information is reported. (Appendix D).

**Improvement Methodologies**

All performance improvement projects, conducted at an institutional level, utilize a structured methodology and have a charter with clearly defined goals and sponsors. The charters for priority projects are available to all hospital staff in the TCH O-Team folders (as the TCH intranet site is developed, tools, plans and dashboards will be accessible through a link to that site). The format for charters is found in Appendix E.

The Quality Improvement and Patient Safety Plan is designed to support the development of new processes and services as needed, and to monitor, evaluate and improve existing ones for the Transitional Care Hospital (including provider-based clinics). The Transitional Care Hospital uses several methodologies for its performance improvement (PI) activities, including but not limited to:

- **FOCUS - PDCA** (our primary model for improvement)
- Failure Mode and Effects Analysis (FMEA)
- Root Cause Analysis
- Peer Review

**FOCUS - PDCA**

This is the method of choice for most interdisciplinary performance improvement teams. It is reviewed during staff orientation and ongoing education programs. Involvement in project and competency with the application of the method is assessed as part of annual staff performance.
**FOCUS** is defined as:
- **F** ind a Performance Improvement Opportunity – determined by a variation in data collected on key indicators or from an identified priority for improvement
- **O** rganize a team of individuals who understand the process to be improved
- **C** larify current knowledge of the process – collect data and analyze existing data related to the process; develop a flow diagram or cause-and-effect diagram to explain the process
- **U** ncover the special cause variation (and remove it if possible), and the common cause variation
- **S** tart the PDCA Cycle

**PDCA** is defined as:
- **P** lan – Using the results of data collection and assessment, develop a plan for improving the process and include specific measures the team will use to evaluate effectiveness of change
- **D** o – Implement the changes on a trial or pilot basis
- **C** heck (or **S** tudy) – Gather and analyze data on the solution to check (or study) the results or effectiveness of the change(s)
- **A** ct – Standardize the solution and capitalize on new opportunities. Identify system changes and training needs for full implementation. Implement the solution and plan for ongoing monitoring. Continue development of incremental improvements to refine the solution

**Failure Mode and Effects Analysis**
Failure Mode and Effects Analysis (FMEA) is used as a proactive approach to risk reduction. Once a process is selected for review an eight step approach is initiated:

- Diagram the current process
- Identify points of potential failure
- Identify possible effects of a failure point
- Prioritize points of failure
- Identify why breakdowns might occur
- Redesign the process
- Test the new process
- Monitor the effectiveness of the redesigned process

The actual or potential failures in systems are assessed for likelihood to occur and severity of affect (consequences) should they occur.

**Root Cause Analysis**
Root Cause Analysis (RCA) is the organizational method used to conduct retrospective investigation of an actual or potential event to identify root and proximate cause(s) and develop risk reduction strategies for those causes (e.g. for sentinel or significant adverse events).

A root cause analysis focuses primarily on systems and processes, not individual performance. The analysis progresses from special causes to common causes in clinical or organizational processes.
The analysis identifies changes that could be made in systems and processes (whether through redesign or development of new systems or processes) that would reduce the risk of such events reoccurring. The root cause analysis includes participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review – the frontline clinical staff, nurses, therapists, technicians and other employees. The team uses current literature and recommendations for best practices when considering change in practice or service.

**Adverse Event Review**

Adverse events are serious, largely preventable, incidents or outcomes which happen while a patient is receiving care from clinical and hospital staff. Adverse events are reviewed by Patient Safety staff (in conjunction with care providers and TCH Management) and a harm score is assigned (Appendix F). Cases which are sentinel and other significant events are reviewed with hospital leaders.

Root Cause Analyses (RCAs) of sentinel events (as defined in Appendix G) are completed as soon as possible and not longer than 45-days after the discovery of the event. Identified Quality/Patient Safety/Hospital staff present aggregated information about care and services identified from focus reviews, RCAs and findings from significant events to the Quality Committee and CSEC.

**Peer Review**

Peer review for any discipline is accomplished by committees or an assigned peer within the appropriate department or division.

A. **Clinical Staff**
   
   Each Clinical Staff department is responsible for monitoring and evaluating the quality and appropriateness of patient care rendered by Licensed Independent Practitioners granted privileges for that department as established and described in the Clinical Staff Bylaws and Transitional Care Hospital Policies.

B. **Nursing Staff**
   
   Nursing is responsible for monitoring and evaluating the quality of nursing care provided to patients as established in the Professional Nursing Staff Organization (PNSO) bylaws. Registered nurses conduct the peer review and render recommendations to the Director for Clinical Operations for changes in practice.
**Measurements and Communication**

The Transitional Care Hospital Quality Dashboard (Appendix D) is a tool used to communicate the performance improvement and patient safety priorities for the organization, associated measures, and progress toward achieving goals. The Dashboard is designed using specific indicators relevant for groups such as the MCOB, clinical staff, professional nursing, therapies, pharmacy, and ancillary staff.

In addition, we will utilize executive summaries to organize the various quality improvement and patient safety efforts underway, and to demonstrate how these efforts align with the institutional priorities. These summaries “connect the dots” between efforts that support or impact a specific goal. These summaries will also be used to communicate key findings and the actions taken to address these findings in order to promote shared learning throughout the hospital.

**Data Collection**

Data are collected to evaluate performance on an ongoing basis. Multiple methods are used to collect data, including:

- QR Track (an electronic reporting system to record near-miss and actual events)
- Medical record review
- Observation of practice such as infection control compliance
- Employee Engagement Survey
- Patient Satisfaction Survey
- Patient grievance process
- Benchmark or comparative databases, such as those provided by the National Healthcare Safety Network, and the National Association of Long Term (Acute) Care Hospitals Health Information System.

**Data Aggregation and Analysis**

Aggregating and analyzing data at specific points in time provides ongoing information on performance, thus enabling the organization to judge particular process stability and clinical outcomes. Accumulated data are represented in such a way that current performance levels, patterns, or trends can be identified.

Data analysis is used to answer these questions:

- What is the current level of performance (percent compliance, quartile measurement, etc)?
- How stable are current processes (statistical process control)?
- Are there areas that could be improved (statistical analysis)?
- Was a strategy to stabilize or improve performance effective (outcomes analysis)?
- Did the change meet design specifications for processes (reassessment)?
Analysis of Data Trends and Patterns
When the organization detects or suspects significant undesirable performance or variation in practice, an analysis is initiated to determine where to focus improvement efforts and what level of investigation is required. Analysis is initiated when comparisons show that:

- Levels of performance, patterns, or trends vary significantly and undesirably from those expected or that of other comparable organizations
- Performance varies significantly and undesirably from recognized standards
- A significant or adverse event has occurred

Comparative Databases
The UVA Transitional Care Hospital utilizes comparative databases for periodic assessment of performance against that of similar organizations, patient care standards, and best practices and incorporates strategies to meet or exceed performance into quality improvements. The comparative databases chosen by the hospital to use as the reference for quality outcomes should offer similar size and patient population to assure appropriate analysis. Comparative databases that are available and used for monitoring and completing specific improvement projects, include:

- Press Ganey and Associates (PG)
- National Healthcare Safety Network (NHSN)
- The Joint Commission Oryx Non-Core Measures (TJC) – when available
- Center of Medicare and Medicaid Services (CMS)

Data collected on identified measures are compared against pre-established thresholds and, if not met, will trigger actions to improve care or service. The metrics representing the Transitional Care Hospital priorities are reported on the Transitional Care Hospital Dashboard.

Comparative data may take the form of:

- Standards: Universally recognized norms that denote positive practice(s)
- Thresholds: Specified, pre-established levels based on current professional literature, national standards, or clinical practice guidelines
- Targets: Specific reference reflecting intended performance such as mean or percentile ranking of a comparative group
**Education and Training**

In order to accomplish the goals of this plan, it is critical to build both skill and capacity in the Transitional Care Hospital to use quality improvement tools and methodologies to improve clinical outcomes, reduce preventable harm and drive change. Transitional Care Hospital employees are educated on the Quality Improvement and Patient Safety Plan and associated methodologies and responsibilities during orientation to the Transitional Care Hospital. Team Training is available for staff at the initiation and implementation of projects.

**Records and Confidentiality**

All proceedings, minutes, records, reports and data related to Quality Improvement and Patient Safety efforts that are reviewed, evaluated and which form the basis of recommendations of any committee or group established by the University of Virginia Transitional Care Hospital are confidential communications that are privileged under Virginia Code Section 8.01-581.17.

All documents are labeled “Confidential Quality Information” and may not be disclosed outside of QPI processes (see TCH Policy #0132). Information considered by committees, teams, or other groups related to Quality and Performance Improvement and Patient Safety shall be maintained for a minimum of three years and disposed of by shredding after the elapsed time period. Sharing of aggregate data among areas, departments, committees, teams and/or sites within the UVA Health System or with those responsible for Quality Improvement and Patient Safety activities does not constitute a violation of confidentiality or a waiver of privilege.
UVAHS Glossary of Terms

Action Plan: A plan for risk reduction strategies; it identifies changes that can be implemented to reduce risk, or formulates a rationale for not undertaking such changes; and where improvement actions are planned, identifies who is responsible for implementation, when the action will be implemented (including any pilot testing), and how the effectiveness of the actions will be evaluated. (Measures of Success).

Adverse Drug Event (ADE): An injury caused by a medication (or lack of medication).

Adverse Drug Reaction (ADR): Any noxious or unintended response to a drug that occurs at doses used for prophylaxis, diagnosis, or treatment, excluding therapeutic failures and intentional overdoses. Reportable ADRs are those that result in change or discontinuation of drug therapy, treatment of the ADR, an initial or prolonged hospital stay, or death.

Credentialing: The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization.

Credentials: Documented evidence of licensure, education, training, experience, or other qualifications.

Critical Result: A test result that is abnormal to a degree that may indicate a life-threatening situation (also known as critical value).

Critical Test: A test or examination that always requires rapid communication of results, whether those results are normal or abnormal.

Disaster: A type of emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain care, safety, or security functions.

Date of Event Discovery: The date a variance or error is discovered by any member of the Medical Center staff.

Elopement: When an adult patient, meeting the following criteria and circumstances, leaves the premises of the Transitional Care Hospital without the permission or awareness of the patient’s caregivers:
- Any patient under legal restriction, such as an ECO, TDO or involuntary commitment order.
- Any patient with whom there is a documented and/or clinically assessed competency or mental status issue related to physiologic, psychological, or psychiatric etiology.

Emergency: An unexpected or sudden event that significantly disrupts the organization’s ability to provide care, treatment, or services or the environment of care itself or that results in a sudden, significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity.
**Emergency Operations Plan (EOP):** An organization's written document that describes the process it would implement for managing the consequences of emergencies, including natural and human-made disasters, which could disrupt the organization’s ability to provide care, treatment, and services.

**Environmental Tours:** Activities routinely used by the organization to determine the presence of unsafe conditions and whether the organization’s current processes for managing environmental safety risks are practiced correctly and are effective.

**Error:** Failure of a planned action to be completed as intended, or the use of a wrong plan to achieve the desired outcome.

**Failure Mode and Effect Analysis (FMEA):** A systematic approach to identify and prevent process problems before they occur, to proactively design flaws out of a process.

**GME Trainee:** Any resident or fellow in a post-graduate specialty training program, including those for physicians, dentists, pharmacists, clinical psychologists, radiation physicists and chaplains.

**Fall:** Any event where a person is found on the floor and it is unknown how he/she got there: any unplanned lowering of the patient to the floor; or the actual observation of a fall, with or without injury. Fall Level of Injury severity* is classified as:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>No injuries (no signs or symptoms) resulting from the fall; if an x-ray, CT scan or other post fall evaluation results in a finding of no injury.</td>
</tr>
<tr>
<td>Minor</td>
<td>Resulted in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion</td>
</tr>
<tr>
<td>Moderate</td>
<td>Resulted in suturing, application of steri-strips/skin glue, splinting, or muscle/joint strain.</td>
</tr>
<tr>
<td>Major</td>
<td>Resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of a fall.</td>
</tr>
<tr>
<td>Death</td>
<td>Patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall).</td>
</tr>
</tbody>
</table>

*Adopted from the National Database of Nursing Quality Indicators (NDNQI)

**Indicator:** See Performance Measure

**Informed Consent:** Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of the consent. A patient must be apprised of the nature, risks, and alternatives of a medical procedure or treatment before the physician or other health care professional begins any such course. After receiving this information, the patient then either consents to or refuses such a procedure or treatment.

**Measure of Success:** A performance of process measure used in corrective action plans to measure the success of a risk reduction strategy.
**Medical Error:** A preventable adverse event related to a health care intervention or failure to intervene appropriately.

**Medication Error:** Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional or patient. Such events are related to professional practice: prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, documentation, and use.

**Monitoring:** Performance measurement systems have an ongoing data quality monitoring process in place so that data quality is continuously monitored based on pre-specified data quality standards. It may be in the form of a periodic internal data quality study or on-site data auditing.

**Outcome measure:** A measure that indicates the result of the performance (or non-performance) of a function(s) or process(es).

**Patient Safety Indicator:** Indicators of patient safety based on best practices developed by the Agency for Healthcare Research and Quality (AHRQ).

**PEO:** Patient Experience Officer

**Performance measure (Indicator):** A quantitative tool (for example, rate, ratio, index, percentage) that provides an indication of an organization’s performance in relation to a specified process or outcome. See process measure and outcome measure.

**PPES:** Professional Practice Evaluation Subcommittee of the Credentials Committee

**Process:** A series of linked steps that result in an outcome.

**Process measure:** A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.

**Project:** A planned undertaking by designated staff, generally intended to improve a process or outcome. The work can usually be accomplished in a specific time frame and includes an owner, action plan and measurable outcomes. Projects can be charged by a MC Committee or Leader and should be registered with QPI.

**Proximate Cause:** An act or omission that naturally and directly produces a consequence; the superficial or obvious cause for an occurrence. Treating only the proximate cause may lead to short term improvement, but will not prevent the variation from reoccurring.

**PSO:** Patient Safety Officer
**Read-Back**: A method used to ensure understanding of information being communicated, often used between members of a caregiving team. The process involves the receiver of a verbal or telephone order writing down the complete order or test result or entering it into a computer and then reading it back and receiving confirmation from the individual who gave the order or test result.

**Restraint**: Any method (chemical or physical) of restricting an individual's freedom of movement, including seclusion, physical activity, or normal access to his or her body that (1) is not a usual and customary part of a medical diagnostic or treatment procedure to which the individual or his or her legal representative has consented, (2) is not indicated to treat the individual's medical condition or symptoms, (3) does not promote the individual's independent functioning or (4) is a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

A *restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, mitts that do not restrict finger movement inside the device and are not tied down, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).*

**Root Cause**: The underlying, most fundamental reason for the failure or inefficiency of a process.

**Root Cause Analysis**: A process for identifying basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event (3-5 "Whys")

**Sentinel Event**: An unexpected or unexplained occurrence or process variance resulting in death or permanent loss of limb/function, or risk thereof.

**System**: A set or collection of processes interacting to achieve a goal.

**Variance**: An unplanned or unexpected occurrence that is the result of a deviation from accepted routines or normal processes, and that may or may not result in an adverse patient outcome or the occurrence of an unusual or unexpected patient response to standard treatment.

**Variation**: Change or deviation from the norm, not consistent.
Appendix A – Priorities, Goals and Objectives

The following priorities are those identified for fiscal year 2014. The broader multi-year quality plan follows these priorities and demonstrates a commitment to address key areas of quality and patient safety performance for the UVA Transitional Care Hospital.

<table>
<thead>
<tr>
<th>UVA Transitional Care Hospital Quality and Safety Priorities FY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic</strong></td>
</tr>
<tr>
<td><strong>Rescue (Reducing Harm)</strong></td>
</tr>
<tr>
<td>Mortality Rate</td>
</tr>
<tr>
<td><strong>Appropriate Care Process (Improving Care Outcomes)</strong></td>
</tr>
<tr>
<td>Pneumococcal Immunization Rate</td>
</tr>
<tr>
<td>Ventilator Wean Success By Final Discharge</td>
</tr>
<tr>
<td><strong>Patient Safety Indicators (Eliminating Preventable Harm)</strong></td>
</tr>
<tr>
<td>CAUTI (Catheter Associated Urinary Tract Infection)</td>
</tr>
<tr>
<td>CLABSI (Central Line Associated Infection)</td>
</tr>
<tr>
<td>VAP (Ventilator Associated Pneumonia)</td>
</tr>
<tr>
<td>HAPU* (Hospital Acquired Pressure Ulcer Stage 3 and 4)</td>
</tr>
<tr>
<td>Patient Falls with &gt; Moderate Injury*</td>
</tr>
<tr>
<td><strong>Efficiency (Reducing waste)</strong></td>
</tr>
<tr>
<td>Unplanned Readmissions to a STACH (Short Term Acute Care Hospital)</td>
</tr>
<tr>
<td>Admit Time by 1400</td>
</tr>
<tr>
<td><strong>Organizational Opportunities for Improvement</strong></td>
</tr>
<tr>
<td>Patient Satisfaction – Overall</td>
</tr>
<tr>
<td>Likelihood to Recommend - Patient Satisfaction</td>
</tr>
<tr>
<td>Pain Management - Patient Satisfaction</td>
</tr>
<tr>
<td>Privacy - Patient Satisfaction</td>
</tr>
</tbody>
</table>
Appendix B – Governing Body: Medical Center Operating Board

The Medical Center Operating Board shall be the governing board of the Transitional Care Hospital, responsible to oversee and direct the operations of the Transitional Care Hospital as delegated by the Board of Visitors.

**MEDICAL CENTER**

Stephen P. Long, M.D., Co-Chair

**OPERATING BOARD**

Edward D. Miller, M.D., Co-Chair

William H. Goodwin Jr.

Victoria D. Harker

Andrew K. Hodson, M.D.

Michael M.E. Johns, M.D.

William P. Kanto Jr., M.D.

Constance R. Kincheloe

George Keith Martin

Charles W. Moorman

The Hon. Lewis F. Payne

**Ex Officio Advisory Members:**

Teresa A. Sullivan

Nancy E. Dunlap, M.D.

Dorrie K. Fontaine

Robert S. Gibson, M.D.

Patrick D. Hogan

R. Edward Howell

Richard P. Shannon, M.D.

John D. Simon
Appendix C – Organizational Committee Structure

UVA Medical Center Operating Board (MCOB)
Co-Chair: Edward Miller, M.D.
Co-Chair: Stephen P. Long, M.D.

Transitional Care Hospital Clinical Staff Executive Committee (CSEC)
Chair: Jonathon Truwit, M.D.

UVA Medical Center Operating Board Quality Subcommittee
Co-Chairs: R.E. Howell, CEO
Nan Dunlap, M.D., Dean SOM

Nominating Committee
Chair: Jonathon Truwit, M.D.

By-Laws Committee
Chair: Jonathon Truwit, M.D.

Ethics Committee
Chair: Charles Brooks, M.D.

Credentials Committee
Chair: Sharon Esau, M.D.

Patient Care Committee
Chair: Sharon Esau, M.D.

Quality Committee
Chair: George Hoke, M.D.
APPENDIX D – COMMITTEE DESCRIPTIONS

BYLAWS COMMITTEE

The Bylaws Committee shall ensure that the Bylaws of the Clinical Staff are consistent with the Transitional Care Hospital’s operational needs, current Joint Commission Standards, applicable CMS Conditions of Participation and other CMS requirements and the policies, procedures, rules and regulations of the Transitional Care Hospital.

Membership: The President of the Clinical Staff shall serve as Chair.

- Staff Support is provided by the Clinical Staff Office
- Only Members of the Clinical Staff serving on the Bylaws Committee shall be eligible to vote on Bylaws Committee matters.

Meetings: The Bylaws Committee shall meet as necessary but at least annually.

Duties and Responsibilities:

- Review the Bylaws on at least on an annual basis;
- review proposed Bylaws amendments that may be proposed by Members of the Clinical Staff;
- develop draft revisions and recommendations regarding proposed amendments to the Bylaws;
- present proposed revisions to the Clinical Staff Executive Committee and the MCOB for review and approval; and
- provide each Member with a current copy of the Bylaws.
CREDENTIALS COMMITTEE

The Credentials Committee shall review and evaluate the qualifications of each Applicant for initial appointment, reappointment, or modification of appointment, to the Clinical Staff, in accordance with the procedures outlined in the Credentials Manual and these Bylaws. The Credentials Committee shall recommend to the Clinical Staff Executive Committee and the MCOB appointment or denial of all Applicants to the Clinical Staff and the granting of Clinical Privileges.

When appropriate, the Credentials Committee shall interview a Member or Applicant and/or the Chair of the involved Department in order to resolve questions about appointment, reappointment, or change in privileges. The Credentials Committee shall review and make recommendations for revisions to the Credentials Manual from time to time; provided however, the Chair of the Credentials Committee, in consultation with the President and the Chief Executive Officer, shall have authority to amend the Credentials Manual.

Membership: The President-Elect shall serve as chair of the Credentials Committee. Members are as indicated by the Bylaws.

- Staff support is provided by the Clinical Staff Office
- Only Members of the Clinical Staff serving on the Credentials Committee shall be eligible to vote on Credentials Committee matters.

Meetings: The Credentials Committee shall meet monthly or as otherwise deemed necessary by the Chair.

Duties and Responsibilities:

- Oversees credentialing and privileging for Members of the Clinical Staff and for Allied Health Professionals to ensure that data related to qualifications and performance is collected and regularly assessed
- Ensures that information from Departmental peer review processes and performance improvement data collection is assessed and considered for each applicant who will be Members of the Clinical Staff or Allied Health Professionals
- Refers Members of the Clinical Staff to the Physician Wellness Program and works cooperatively with the program in determining appropriate privileges for certain practitioners
- Refers Allied Health Professionals to the Employee Assistance Program and works cooperatively with the program in determining appropriate privileges for certain practitioners
- Recommends Applicants for appointment to the Clinical Staff
- Participates in investigation of and fair hearing process for Members of the Clinical Staff under Articles VIII of the Clinical Staff Bylaws
- Conducts an annual review of credentialing/re-credentialing policies and procedures to comply with The Joint Commission/NCQA standards and other regulatory requirements
**ETHICS COMMITTEE**

The Ethics Committee is an interdisciplinary committee charged with assisting leadership in ensuring consistency between Mission and Values, organizational behaviors and clinical practice. The Credentials Committee is required by Section 13.4 of the Amended and Restated Clinical Staff Bylaws and reports directly to the Clinical Staff Executive Committee. It has three primary functions, which include conducting education on ethical issues, recommending policies that are ethically important and conducting case reviews with respect to ethical issues.

**Membership:** Representatives from the Clinical Staff, Nursing Staff, Chaplaincy Department, Care Management. The Director of Risk Management and a representative from the University General Counsel’s Office will be ex-officio members.

- Staff support is provided by Ethics Committee Chair’s administrative staff

**Meetings:** The Ethics Committee shall meet as necessary but at least annually.

**Duties and Responsibilities:**

- Recommends new or revised policies and guidelines that concern organizational or clinical ethical issues
- Provides institutional direction regarding education related to ethical issues
- Provides an ethics consult service to clinicians, patients and families
- Provides organizational guidance and oversight to ensure compliance with patient’s rights regulations
- Establishes an education program for current and potential committee members to ensure a comfortable working knowledge of basic ethical principles and how to apply them at the individual and institutional level
- Identifies ethical issues within the organization and makes recommendation for change
- Provides an annual report to the Clinical Staff Executive Committee
**NOMINATING COMMITTEE**

The Nominating Committee is required pursuant to Section 13.5 of the Amended and Restated Clinical Staff Bylaws and reports directly to the Clinical Staff Executive Committee. It shall provide nominees for Officers of the Clinical Staff and for the Clinical Staff Representatives, as provided in the Clinical Staff Bylaws.

**Membership:** The Nominating Committee shall consist of (a) the immediate past president of the Clinical Staff, who shall serve as Chair of the Nominating Committee, and (b) two (2) Members of the Active Clinical Staff chosen by the President, subject to confirmation by the Chief Executive Officer and the Dean.

- Staff support is provided by the Clinical Staff Office

**Meetings:** The Nominating Committee shall meet as necessary.

**Duties and Responsibilities:**

- Solicits and provides nominees for the positions of President and President-elect of the Clinical Staff in accordance with the requirements of the Clinical Staff Bylaws
- Solicits and provides nominees for the Clinical Staff Representative seats on the Clinical Staff Executive Committee in accordance with the requirements of the Clinical Staff Bylaws
- Provides an annual report to the Clinical Staff Executive Committee
Patient Care Committee

The Patient Care Committee is an interdisciplinary committee charged with coordination and implementation of the Plan for Provision of Care for the hospital. This committee reports directly to the Clinical Staff Executive Committee and addresses clinical practice issues that extend beyond the scope of practice for a single professional discipline (medicine, nutrition, nursing, pharmacy, therapies, care management, etc.) throughout the Transitional Care Hospital.

Membership: TCH Medical Director (chair), Director of Clinical Operations (associate chair), and Representation from clinical disciplines such as but not limited to nursing, respiratory therapy, rehab therapies, infection control, wound/ostomy, and education

- Staff Support is provided by clinical operations

Meetings: The Patient Care Committee shall meet monthly or as otherwise deemed necessary by the Chairs, but not less than quarterly

Duties and Responsibilities:

- Recommends practice standards for patient care across the continuum of care
- Provides oversight to practices related to procedural sedation
- Provides direction and oversight for an effective Patient Education process
- Provides organizational guidance regarding staff training and competency for clinical care
- Approves nutritional and other clinical procedures, protocols and guidelines
- Recommends clinical policies for approval
- Provides direction and oversight for related work groups/subcommittees, including but not limited to: TCH Practice Council, TCH Professional Development Council, Pharmacy and Therapeutics Committee, and Transfusion Committee
- Approves and communicates criteria for competence for the Hospital
- Collaborates with the Quality Committee to monitor and improve patient care
- Annually reviews and revises the Plan for Provision of Care and makes a report to the Medical Center Operating Board regarding the effectiveness of and recommended revisions to the Plan
QUALITY COMMITTEE

The Quality Committee is an interdisciplinary committee responsible for defining, prioritizing, overseeing and monitoring the performance improvement activities within the Transitional Care Hospital. The primary duties of the Quality Committee include analyzing and aggregating institutional performance data, monitoring performance improvement efforts for effectiveness, and making recommendations to the Patient Care Committee and the Clinical Staff Executive Committee for changes in clinical practice. The Quality Committee coordinates the acquisition of performance improvement information from local/hospital teams to improve organizational performance. It provides direction and oversight for related work groups/subcommittees, including but not limited to: TCH Quality Council, Infection Control, Environment of Care/Safety; Patient Safety, Patient Satisfaction/Grievance, Medical records review, clinical policies.

Membership: TCH Medical Director (chair), Director of Quality (associate chair), and Representation from clinical disciplines such as but not limited to nursing, respiratory therapy, rehab therapies, infection control, wound/ostomy, pharmacy and hospitalists

- Staff Support is provided by Quality Department

Meetings: The Quality Committee shall meet monthly or as otherwise deemed necessary by the Chair, but not less than quarterly.

Duties and Responsibilities:

- Prioritizes performance improvement projects utilizing the strategic goals institutional performance data and trends and approved benchmark data
- Individual members accept accountability for removing barriers, assigning resources and ensuring implementation and compliance for approved recommendations resulting from performance improvement projects
- Collaborates with other committees and departments to facilitate performance improvement and ensure compliance with Joint Commission standards, Medicare Conditions of Participation and other regulatory performance improvement standards
- Monitors aggregate data for patterns and trends to identify and respond to opportunities for process/practice improvement and/or staff learning needs
- Provides Institutional direction and oversight for education related to performance improvement methods and projects
- Communicates performance improvement goals, activities and results
- Recognizes and celebrates successful performance improvement efforts
- Oversees, evaluates and revises annually the Quality Improvement and Patient Safety Plan
- Provides an annual report to the Medical Center Operating Board on the effectiveness of the Quality Improvement and Patient Safety Plan and recommended revisions
- Provides support and coordination of activities to resolve operational or service issues identified by the subcommittees through participation and leadership in institutional quality improvement activities
Appendix E – Transitional Care Hospital Quality Dashboard

Sample – Data Not Valid

High Level Dashboard - Supported by Graphs

<table>
<thead>
<tr>
<th>Organizational Goals</th>
<th>Avg FY-</th>
<th>FY-Q</th>
<th>YTD Avg</th>
<th>FY 20-</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and Patient Safety (I Heal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter Associated Urinary Tract Infections (CAUTI): Rate per 1000 Foley days</td>
<td>6.39</td>
<td>1.89</td>
<td>6.99</td>
<td>≤ 3.6</td>
<td></td>
</tr>
<tr>
<td>Central Line Associated Blood Stream Infections (CLABSI): Rate per 1000 Central Line days</td>
<td>2.37</td>
<td>1.59</td>
<td>1.89</td>
<td>≤ 2.0</td>
<td></td>
</tr>
<tr>
<td>Ventilator Associated Pneumonia (VAP): Rate per 1000 Vent days</td>
<td>1.68</td>
<td>1.68</td>
<td>1.74</td>
<td>≤ 0.5</td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Pressure Ulcer (HAPU): Rate per 1000 Patient Days</td>
<td>4.15</td>
<td>0.49</td>
<td>1.12</td>
<td>≤ 4.5</td>
<td></td>
</tr>
<tr>
<td>Ventilator Wean Success: Percent of Patients with &quot;Vent Wean&quot; Goal Weaned by Discharge</td>
<td>75.4%</td>
<td>86%</td>
<td>78%</td>
<td>&gt; 70%</td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Deep Vein Thrombosis (DVT): Rate per 1000 Patient Days</td>
<td>0.17</td>
<td>0.49</td>
<td>0.12</td>
<td>≤ 5.0</td>
<td></td>
</tr>
<tr>
<td>Discharge Disposition of Patients Weaned From Ventilator: Per Cent Discharged to &quot;Home&quot;</td>
<td>30.0%</td>
<td>21.1%</td>
<td>21%</td>
<td>&gt; 20%</td>
<td></td>
</tr>
<tr>
<td>Patient Falls with Injury: Rate per 1000 Patient Days</td>
<td>0</td>
<td>0.00</td>
<td>0.13</td>
<td>≤ 3.0</td>
<td></td>
</tr>
<tr>
<td>Mortality Rate</td>
<td>5.41%</td>
<td>13.8%</td>
<td>6%</td>
<td>≤ 8%</td>
<td></td>
</tr>
</tbody>
</table>

Patient Progression (I Build)

| Percent of Patients Discharged to Short-term Acute Care Hospital (Unplanned) | 12.4    | 12.1% | 19.8%   | ≤ 7%   |        |
| Percent New Admission Arrival Time before 1600 | 82%     | 86%   | 76.5%   | ≥ 75%  |        |

Patient Satisfaction (I Care)

| Likely to Recommend: Average Score | 4.6     | 5.0   | 4.8     | ≥ 4.5 Raw Score |
| Overall Rating of Care Received: Average Score | 4.7     | 5.0   | 4.7     | ≥ 4.5 Raw Score |

Color Key: Red = Not at Target; Blue = Within .5 pts of Target; Green = Meet or Exceed Target
### Appendix F – Harm Scores

<table>
<thead>
<tr>
<th>Harm Score Categories*</th>
<th>Level of Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category A:</strong> Unsafe Condition (Non event)</td>
<td></td>
</tr>
<tr>
<td><strong>Category B1:</strong> Near Miss -No Harm; Didn’t reach patient caught by chance</td>
<td></td>
</tr>
<tr>
<td><strong>Category B2:</strong> Near Miss-No Harm; Didn’t reach patient because of active recovery efforts by caregivers</td>
<td></td>
</tr>
<tr>
<td><strong>Category C:</strong> No Harm – Reached Patient; no monitoring required</td>
<td></td>
</tr>
<tr>
<td><strong>Category D:</strong> No Harm – Reached Patient; monitoring required</td>
<td></td>
</tr>
<tr>
<td><strong>Category E:</strong> Harm – Temporary; intervention needed</td>
<td></td>
</tr>
<tr>
<td><strong>Category F:</strong> Harm – Temporary; required hospitalization or prolonged current hospitalization</td>
<td></td>
</tr>
<tr>
<td><strong>Category G:</strong> Harm – Permanent;</td>
<td></td>
</tr>
<tr>
<td><strong>Category H:</strong> Harm – Permanent; intervention required to sustain life</td>
<td></td>
</tr>
<tr>
<td><strong>Category I:</strong> Death</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Appendix G – Sentinel Event Definition and Related Processes (RCA)

**Definition:**
A Sentinel Event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

- The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and response.

A defined subset of Sentinel Events is subject to review by the Joint Commission and may be reported on a voluntary basis. These are events that affect recipients of care and result in an unanticipated death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition, OR is one of the following even if the outcome was not death or major permanent loss of function:

- Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
- Abduction of any patient receiving care, treatment, and services
- Rape
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient, wrong body part, or wrong side
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Prolonged fluoroscopy with cumulative dose > 1500 rads to a single field or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose
- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- Any elopement of a patient that results in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- Any intrapartum maternal death
- A patient fall that results in death or major permanent loss of function as a direct result of the inquiries sustained in the fall
- Unanticipated death or major permanent loss of function associated with a health care-associated infection
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function
Root Cause Analysis Credibility and Action Planning

A Root Cause Analysis will be conducted within 45 days of the event or discovery of event, will be considered acceptable for accreditation purposes if it has the following characteristics:

- The analysis focuses primarily on systems and processes, not individual performance (no “blame”);
- The analysis progresses from special causes in clinical processes to common causes in organizational processes;
- The analysis repeatedly digs deeper by asking "Why?" and when answered "Why?" again, and so on;
- The analysis identifies changes that could be made in systems and processes (either through redesign or development of new systems or processes) that would reduce the risk of such events reoccurring in the future; and
- The analysis must be deemed thorough and credible.

To be thorough, the root cause analysis must include the following:
- A determination of the human and other factors most directly associated with the sentinel event, and the process(es) and systems related to its occurrence;
- An analysis of the underlying systems and processes through a series of "Why?" questions to determine where redesign might reduce risk;
- An inquiry into all areas appropriate to the specific type of event as described in the current edition of "Minimum Scope of Review of Root Cause Analysis" (below);
- Identification of risk points and their potential contributions to this type of event; and
- A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

To be credible, the root cause analysis must:
- Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review;
- Be internally consistent, i.e., not contradict itself or leave obvious questions unanswered;
- Provide an explanation for all findings of “not applicable” or “no problem”; and
- Include consideration of any relevant literature.

An action plan will be considered acceptable if it:
- Identifies changes that can be implemented to reduce risk or formulates a rationale for not undertaking such changes; and
- Identifies, in situations where improvement actions are planned, who is responsible for implementation, when the action will be implemented (including any pilot testing), and how the effectiveness of the actions will be evaluated.
University of Virginia

Transitional Care Hospital

Infection Prevention and Control Plan

Fiscal Year 2014
# University of Virginia Transitional Care Hospital
## Infection Prevention and Control Program Description and Fiscal Year 2014 Performance Improvement Plan

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1. INTRODUCTION

The Infection Prevention and Control Program is a component of the Transitional Care Hospital Quality/Performance Improvement (Q/PI) Program. Consistent with the Transitional Care Hospital’s mission the Infection Prevention and Control Program focuses on preventing healthcare associated infections (HAI) in patients and staff as well as preventing the spread of antibiotic-resistant organisms. The Infection Prevention and Control Subcommittee (IPCS), reporting to the Quality Committee, works collaboratively with the Quality/Performance Improvement Department staff and with departments and patient care areas to prioritize, coordinate and implement proactive risk reduction strategies to decrease the risk of HAI, spread of antibiotic resistant organisms, and the institutional threats posed by unique infectious agents.

The purpose of this document is to describe the organizational structure and models for institutional infection control monitoring, and the systematic approach to infection prevention and control planning, analysis, improvement, and maintenance.

2. STRUCTURE & REPRESENTATION

The UVA Transitional Care Hospital leadership works collaboratively to provide a systematic and organizational approach to Infection Prevention and Control. Transitional Care Hospital leaders ensure that necessary structures and processes are established to implement and monitor infection control and surveillance activities. The Infection Prevention and Control program is overseen by the Hospital Epidemiologist and the Infection Prevention & Control Subcommittee. Program activities are carried out by 0.5 FTE Infection Preventionist (IP). Program activities include streamlining processes, controlling costs, improving effectiveness, and meeting regulatory requirements for infection control.

The Infection Prevention & Control Subcommittee is the oversight body for the Infection Prevention and Control Program and reports to the Clinical Staff Executive Committee (CSEC) via the Quality Committee. The Clinical Staff Executive Committee appoints the co-chairs and approves the membership of the Infection Prevention & Control Subcommittee. The Hospital Epidemiologist is directly accountable for the Infection Prevention and Control Program and serves as a member of the Infection Prevention & Control Subcommittee.

The Infection Prevention & Control Subcommittee is an interdisciplinary team that includes but is not limited to representation from Infectious Diseases, Nursing, Internal Medicine, Management, Employee Health, Environmental Services and Quality/Performance Improvement. It works collaboratively with the Patient Safety Subcommittee and the Safety and Security Subcommittee. The Infection Prevention and Control Office provides staff support, program coordination, data analysis, and reporting to support the Subcommittee. When the Subcommittee appoints work groups, it provides a team charge, a timeline, and recruits membership to promote staff participation across the organization.

3. SCOPE OF SERVICE
The Infection Prevention and Control Program focuses on preventing healthcare associated infections in patients, staff, and visitors and on preventing the spread of antibiotic-resistant organisms. Specific services of Infection Prevention and Control include, but are not limited to, the following:

- Infection Preventionist (IP) performs targeted surveillance using CDC definitions and enters infections into the National Healthcare Safety Network database. Inpatient hospitals are surveyed for the following healthcare associated infections:

  **Bloodstream infections (BSIs)** – Central line-associated BSI’s

  **Urinary Tract Infection** – Catheter-related and MDRO

  **Ventilator Associated Pneumonia**

  **Multi-drug Resistant Organisms (MDROs):** Vancomycin resistant *Enterococcus* (VRE), Methicillin resistant *Staphylococcus aureus* (MRSA), Carbapenem Resistant *Enterobacteriaceae* (CRE)

  **Others** –*C. difficile*, Influenza, *Aspergillus* and *Legionella*.

- Analyzes trended data and evaluates specific case reports of HAI. A report of the previous quarter’s HAI is presented quarterly to the Infection Prevention & Control Subcommittee. House wide rates per 1000 patient care days are reported quarterly for: *C difficile*, MRSA, VRE and CRE. In addition, ventilator associated pneumonia, catheter associated urinary tract infections, and central line associated bloodstream infections per 1000 device days are reported quarterly. Infection rates and comparisons for infections by device-days from National Healthcare Safety Network (NHSN) system are provided on a quarterly basis.

- Recommends actions to reduce and control outbreaks of HAI. Outbreaks are detected by analyzing surveillance data for unexpected increases in HAI rates. If an outbreak is detected, appropriate measures for control and prevention are recommended to the involved units/personnel and reported to the Infection Prevention & Control Subcommittee.

- Coordinates and oversees transmission-based precautions in response to pathogens that are suspected or identified in the healthcare setting and community.

- The Infection Prevention and Control Program reviews and recommends policies and procedures to the Infection Prevention and Control Subcommittee. Appropriate policies are approved by the Subcommittee and forwarded to the Quality Committee and/or Patient Care Committee for approval and operationalization.

- Prioritizes quality and performance improvement (Q/PI) projects related to infection control and submits proposals to the Quality Committee monthly meetings.

- Recommends content for patient and family education related to infection prevention and control.

- Communicates infection prevention and control goals and strategies for improvement to staff via defined institutional communication processes, such as direct communication between IPs and unit personnel, mass email communications, IP in-services at unit and institutional staff/practice meetings, participation in Quality Improvement Teams, presentations at Professional Nursing Staff Organization (PNSO), meetings, etc.
TCH utilizes the Infection Control Manual on the Health System website. The TCH ICP ensures the appropriate interpretation and application of pertinent practices in infection control, which is reflected in the Infection Control Manual. The review process of the Infection Control Manual will be completed every 3 years. When important changes are made to the manual, areas affected by those changes will be notified. The plan is to evaluate and adapt the infection control manual for TCH specifically, using the Medical Center Infection Control Manual as a resource.

### 4. ORGANIZATIONAL GOALS, OBJECTIVES, MONITORS, & INDICATORS-METRICS

#### KEY ASPECTS OF CARE and SERVICE

<table>
<thead>
<tr>
<th>Goal or Objective</th>
<th>Limit unprotected exposure to pathogens throughout the hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Identify and isolate patients with influenza-like illness</td>
<td>Patient care staff</td>
</tr>
<tr>
<td>Monitor healthcare associated influenza cases</td>
<td>Infection Control</td>
</tr>
<tr>
<td>Immunize healthcare workers against influenza and furlough when infected</td>
<td>Employee Health</td>
</tr>
<tr>
<td>Identify and isolate patients in negative pressure rooms; have staff wear N-95 respirators or PAPRs when caring for patients with suspected/confirmed tuberculosis</td>
<td>Patient care staff</td>
</tr>
<tr>
<td>Fit-test at-risk employees for N-95 respirator use upon hire and annually or train employees for PAPR use</td>
<td>Employee Health</td>
</tr>
<tr>
<td>Monitor healthcare worker PPD conversion rates</td>
<td>Employee Health</td>
</tr>
<tr>
<td>Offer treatment to untreated latently infected employees</td>
<td>Employee Health</td>
</tr>
<tr>
<td>Maintain appropriate PPD compliance rate among employees</td>
<td>Employee Health and Hospital Administration</td>
</tr>
</tbody>
</table>
## ORGANIZATIONAL GOALS, OBJECTIVES, MONITORS, & INDICATORS-METRICS

### KEY ASPECTS OF CARE and SERVICE

<table>
<thead>
<tr>
<th>Goal or Objective</th>
<th>Strategy</th>
<th>Responsible Party</th>
<th>Indicator or Metric (Success Measure)</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limit unprotected exposure to pathogens throughout the hospital</td>
<td>Refer employees with active tuberculosis for treatment</td>
<td>Employee Health</td>
<td>Rate at which referral is made for employees with active tuberculosis (100%)</td>
<td>Employee Health</td>
</tr>
<tr>
<td></td>
<td>Conduct periodic risk assessments for MDRO acquisition and transmission</td>
<td>Infection Control</td>
<td>Completed risk assessments</td>
<td>Infection Control</td>
</tr>
<tr>
<td></td>
<td>Based on results of risk assessment, hospital educates staff and licensed</td>
<td>Infection Control</td>
<td>New hire and annual mandatory training module completion rates (100% compliance)</td>
<td>Infection Control with Center for Organizational Development (COD)</td>
</tr>
<tr>
<td></td>
<td>independent practitioners about HAIs, MDROs and prevention strategy at hire and annually thereafter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify and isolate MRSA- or VRE-colonized/infected inpatients transferred from outside facilities</td>
<td>Patient care staff and Infection Control</td>
<td>Lack of spread of healthcare associated MRSA/VRE</td>
<td>Infection Control</td>
</tr>
<tr>
<td></td>
<td>Identify and isolate patients with diarrheal illness that could be <em>Clostridium difficile</em></td>
<td>Patient care staff, bed coordination center and Infection Control</td>
<td>Healthcare associated <em>C. difficile</em> rate (&lt;1 case per 1000 pt days)</td>
<td>Infection Control</td>
</tr>
<tr>
<td></td>
<td>Identify and isolate patients with other illnesses/conditions requiring isolation per CDC transmission-based precaution guidelines in collaboration with the Bed Coordination Center via use of the Resistant Organism List and Bed Tracking system</td>
<td>Patient care staff, Infection Control and Bed Coordination Center</td>
<td>Lack of healthcare associated spread of these illness/conditions</td>
<td>Infection Control and Bed Coordination Center</td>
</tr>
<tr>
<td></td>
<td>Prevent spread of bloodborne pathogens (BBPs) to employees and patients by educating all healthcare workers about Standard Precautions and sharp safety</td>
<td>Patient care managers ensure compliance</td>
<td>Compliance rate of new hires with orientation training (100%)</td>
<td>Center for Organizational Development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infection Control provides updated educational materials</td>
<td>Retraining compliance rate for employees with potential BBP exposure (100%)</td>
<td>Center for Organizational Development</td>
</tr>
</tbody>
</table>
### KEY ASPECTS OF CARE and SERVICE

<table>
<thead>
<tr>
<th>Goal or Objective</th>
<th>Limit unprotected exposure to pathogens throughout the hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td></td>
<td>Patient Safety Coordinator also assist with education</td>
</tr>
<tr>
<td>Prevent acquisition of healthcare associated <em>Legionella</em> among patients and staff</td>
<td>Infection Control develops method; Physical Plant implements</td>
</tr>
<tr>
<td>Prevent healthcare associated <em>Aspergillus</em> infections</td>
<td>Physical Plant repairs any breaches in walls, ceiling tiles and floors and maintain HEPA filter and air pressurization; unit staff complies with policy</td>
</tr>
<tr>
<td>For licensed independent practitioners, staff, students/trainees, and volunteers, screen for and offer on hire and annually immunization against (when available) infectious diseases that have epidemiological importance in the healthcare environment</td>
<td>Employee Health and WorkMed provide all new hires with questionnaire and offers vaccination when appropriate (including influenza vaccine offered free of charge every year and hepatitis B vaccination), also performs annual TB screening</td>
</tr>
<tr>
<td>Ensure appropriate referrals for assessment, testing, immunization, counseling, or prophylaxis/treatment for healthcare workers who have an infectious disease or the risk of one that might put patients at risk</td>
<td>Employee Health</td>
</tr>
<tr>
<td><strong>Goal or Objective</strong></td>
<td><strong>Limit unprotected exposure to pathogens throughout the hospital</strong></td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Participate in proactive infection control risk assessment (ICRA) related to construction and renovation</td>
<td>IP and/or Hospital Epidemiologist is primary infection control representative on a multidisciplinary team</td>
</tr>
<tr>
<td>Ensure appropriate referrals for assessment, testing, immunization, and counseling for individuals within the hospital who have been exposed to the following infectious diseases at work: meningococcus, tuberculosis, pertussis, varicella zoster virus, scabies, SARS, measles, rubella and H1N1 influenza</td>
<td>Infection Control performs exposure work-ups; Employee Health performs assessment, testing, immunization, counseling, and/or referrals</td>
</tr>
<tr>
<td>Reduce the risk associated with bringing animals into the hospital, specifically therapy animals and pets brought by patients.</td>
<td>Transitional Care Hospital Policy #246 provides guidelines regarding animals</td>
</tr>
</tbody>
</table>
## 4. ORGANIZATIONAL GOALS, OBJECTIVES, MONITORS, & INDICATORS-METRICS

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<th>Monitor healthcare associated infection rates by body site utilizing CDC definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Monitor healthcare associated bloodstream infections (BSI)</td>
<td>Infection Control</td>
</tr>
<tr>
<td>Monitor catheter related healthcare associated urinary tract Infections (UTI)</td>
<td>Infection Control</td>
</tr>
<tr>
<td>Monitor Ventilator Associated pneumonia (VAP)</td>
<td>Infection Control</td>
</tr>
<tr>
<td>Monitor selected “other” healthcare associated infections: MRSA, VRE, CRE, C. difficile, influenza, rotavirus, Legionella, Aspergillus</td>
<td>Infection Control</td>
</tr>
</tbody>
</table>
### KEY ASPECTS OF CARE and SERVICE

<table>
<thead>
<tr>
<th>Goal or Objective</th>
<th>Detect/investigate and interrupt the progress of healthcare associated outbreaks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Detect and investigate healthcare associated outbreaks</td>
<td>Infection Control, patient care staff</td>
</tr>
<tr>
<td>Interrupt the progress of healthcare associated outbreaks</td>
<td>Infection Control, patient care staff</td>
</tr>
<tr>
<td>Reduce central line associated BSI rate to as close to zero as possible. Implement IHI BSI bundle house wide</td>
<td>Infection Control, patient care staff and administration</td>
</tr>
</tbody>
</table>
**4. ORGANIZATIONAL GOALS, OBJECTIVES, MONITORS, & INDICATORS-METRICS**

- **KEY ASPECTS OF CARE and SERVICE**

<table>
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<tr>
<th>Goal or Objective</th>
<th>Minimize risk of transmission of infections associated with procedures, medical equipment, devices and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Ensure appropriate storage, cleaning, disinfection, sterilization, and disposal of supplies and equipment by publishing generic guidelines in the infection control manual; reviewing area-specific policies and procedures for appropriateness.</td>
<td>Patient care staff; Infection Control maintains standards and approves policies/procedures</td>
</tr>
<tr>
<td>Ensure appropriate use of personal protective equipment by providing educational material via computer based learning module for all new hires and existing staff regarding Standard Precautions (SP) and by having staff address breaches of SP when observed (see TCH Policy # 134)</td>
<td>Infection Control provides updated educational materials</td>
</tr>
<tr>
<td>Educate staff regarding proper disposal of disposable equipment via computer based learning module for all new hires and existing staff regarding regulated medical waste disposal (see Infection Control manual) or reuse after proper processing of equipment that is deemed by the manufacturer as disposable (see TCH policy #222)</td>
<td>Infection Control provides updated educational materials Clinicians and Supply Chain Management are responsible for issues related to reprocessing single-use devices</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Indicator or Metric (Success Measure)</strong></th>
<th><strong>Data Source</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>For scope processing per manufacturer’s recommendations if there has been breach of protocol and instruments have been used on patients, IC follows-up to determine whether or not a patient has developed an infection as a result of the breach.</td>
<td>Endoscope Processing Department</td>
</tr>
<tr>
<td>Compliance rate of new hires with orientation training (100%) Retraining compliance rate for employees with potential BBP exposure (100%)</td>
<td>Compliance rate of new hires with orientation training (100%) Retraining compliance rate for employees with potential BBP exposure (100%)</td>
</tr>
<tr>
<td>Compliance rate of new hires with orientation training (100%) Retraining rate for employees with potential BBP exposure (100%)</td>
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</tr>
</tbody>
</table>
### KEY ASPECTS OF CARE and SERVICE

<table>
<thead>
<tr>
<th>Goal or Objective</th>
<th>Enhance hand hygiene throughout the hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td></td>
</tr>
<tr>
<td>Maintain hand hygiene among staff members according to CDC hand hygiene guidelines.</td>
<td></td>
</tr>
<tr>
<td><strong>Responsible Party</strong></td>
<td></td>
</tr>
<tr>
<td>Infection Control, Patient Care Staff, Quality /Performance Improvement Staff</td>
<td></td>
</tr>
<tr>
<td><strong>Indicator or Metric</strong> (Success Measure)</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene compliance rates; hand hygiene audit completion rates</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td></td>
</tr>
<tr>
<td>&gt;90% hand hygiene compliance for hand hygiene compliance on inpatient units</td>
<td></td>
</tr>
<tr>
<td>&gt;90% audit completion rate organization wide</td>
<td></td>
</tr>
</tbody>
</table>
### 4 ORGANIZATIONAL GOALS, OBJECTIVES, MONITORS, & INDICATORS-METRICS

#### KEY ASPECTS OF CARE and SERVICE

<table>
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<th>Goal or Objective</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Communication with and education for staff, students/trainees, volunteers, visitors, clients, and families regarding Infection Prevention and Control (including their responsibilities for preventing spread of infection)</td>
<td>A) Hospital leadership and staff</td>
</tr>
<tr>
<td></td>
<td>B) Infection Control</td>
</tr>
<tr>
<td>Communication system is present for reporting infection surveillance, prevention, and control to:</td>
<td></td>
</tr>
<tr>
<td>A) Federal, state, and local public health authorities</td>
<td>A) Infection Control/Clinical Laboratory</td>
</tr>
<tr>
<td>B) Accrediting bodies (e.g., sentinel events)</td>
<td>B) Infection Control and QPI</td>
</tr>
<tr>
<td>C) Referring or receiving organization when a patient was transferred or referred and the presence of a healthcare associated infection was not known at the time</td>
<td>C) Infection Control</td>
</tr>
</tbody>
</table>
### ORGANIZATIONAL GOALS, OBJECTIVES, MONITORS, & INDICATORS-METRICS

#### KEY ASPECTS OF CARE and SERVICE

<table>
<thead>
<tr>
<th>Goal or Objective</th>
<th>Applicable policies and procedures are in place throughout the organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Generic Infection Control policies and procedures are housed in the Infection Control Manual and Transitional Care Hospital Policy Manual, as necessary.</td>
<td>Infection Control</td>
</tr>
<tr>
<td>Each service or patient care area shall be responsible for developing any area-specific procedures needed to supplement the TCH Infection Control Manual. All area-specific policies shall be reviewed and approved by the TCH Hospital Epidemiologist whenever any change in procedure is proposed and routinely at least every three years. Area-specific exposure control plans will be maintained by each area and reviewed annually by the Infection Control designee.</td>
<td>Patient Care/Service staff and Infection Control</td>
</tr>
</tbody>
</table>
ORGANIZATIONAL GOALS, OBJECTIVES, MONITORS, & INDICATORS-METRICS

EXTERNAL BENCHMARKING PROJECT PARTICIPATION

HAI data is collected and submitted to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). This system enables comparison of device-associated healthcare associated infection rates for acute care hospitals for catheter-associated bloodstream infections, catheter associated urinary tract infections, and ventilator associated pneumonia. In July of 2013, TCH was changed from LTAC ICU critical care beds to LTAC ward beds as a location for reporting infections to NHSN. TCH will be "benchmarked" against other LTACH's who are also categorized as LTAC ward beds. TCH continues to participate with the mandatory CMS LTCH Quality Reporting Program. The 2 patient care units will collect device day's denominator data (e.g. CL days, ventilator days and indwelling urinary catheter days) that will enable them to receive device associated infection rates and can be benchmarked against the aggregate to start January, 2013 but will report as one collective hospital.

EVALUATION METHODS

In Fiscal year 2014, an Infection Prevention and Control Subcommittee will be formed and charged from the TCH Quality Committee. It will formally evaluate the Infection Prevention and Control Program and Plan. Changes will be made to the Program and Plan in accordance with the prior period’s accomplishments and failures, and the upcoming period’s prioritized goals based on the Infection Control risk assessment for the upcoming period. Once the Infection Prevention and Control Subcommittee has agreed on the appropriateness of the upcoming period’s Program and Plan, it is to be forwarded to the Quality Committee for final approval. As community epidemiology of infectious diseases changes, the Infection Prevention and Control Subcommittee is notified by its public health liaison member, and policies, including the Program and Plan, are altered if necessary.

Semianually the TCH Infection Prevention and Control Practitioner (and will become a task of the Subcommittee) assesses the progress made for initiatives specified in the plan. If significant progress on the plan has not been made, then the Infection Prevention and Control Practitioner/ Subcommittee provides input as to further actions and refers those actions up through the Quality Committee. Infection Prevention and Control assesses the success or failure of every intervention in a step-wise fashion at each critical juncture of the intervention. Infection Prevention and Control is notified of concerns raised by leadership by several direct communication methods. The Hospital Epidemiologist meets with the Chief Medical Officer and/or the TCH Medical Director intermittently to review Infection Control-related issues.

The Hospital Epidemiologist reviews updated national guidelines as they are published. Notification of all recently published guidelines is received by the Hospital Epidemiologist via an automated national email notification service. The Hospital Epidemiologist is notified of changes in regulatory requirements via existing lines of communication from hospital administration and legislative liaisons, as well as from regular national Infection Prevention and Control organization publications.
Sentinel Event Review

An Infection Control-related Sentinel Event is an unexpected or unexplained death or permanent loss of function due to a hospital-acquired infection. Although such events happen infrequently, each event requires immediate attention to understand how and why it occurred, and to prevent the same or similar events from occurring in the future. For any potential Infection Control-related Sentinel Event, a report is made from Infection Control to QPI. QPI will perform a Root Cause Analysis as mandated which will be completed within 45 days of discovery. The Quality & Performance Improvement Program will coordinate the Root Cause Analysis with input from Infection Prevention and Control and results will be reported to the Quality Committee. Infection Prevention and Control Subcommittee operationalizes lessons learned from institutional RCA performed on all cases of Infection Control-related sentinel events.

Data Sampling, Analysis, and Metrics

The Infection Prevention and Control Program conducts targeted surveillance for healthcare associated infections using CDC definitions (for more specific methodology, see scope of service, above).

Data collected on identified measures are compared against pre-established thresholds and, if not met, will trigger actions to decrease infection rates. Rates for device-associated bloodstream infections, ventilator associated pneumonia and urinary tract infections are compared with the NHSN published rates LTACH ward beds, and as a part of The Joint Commission’s ORYX Non-Core Measures Program when it re-emerges.

6 ▶ AUTHORITY and ACCOUNTABILITY

The Hospital Epidemiologist (and Co-Chair of the Infection Prevention and Control Subcommittee) work collaboratively with executive leadership and clinical staff to establish goals, and prioritize projects that are consistent with the institutional mission and strategic goals. Infection Prevention & Control Staff work with directors, managers and interdisciplinary teams to interpret healthcare associated infection rate data, to measure performance, and accomplish the goals set forth by leadership.

7 ▶ EVALUATION of the QUALITY & INFECTION CONTROL PROGRAM and PI PLAN

The Infection Prevention and Control Program is evaluated for effectiveness by analyzing trended HAI data, Employee Health data, and Standard Precautions/Infection Control retraining compliance.

The Infection Prevention and Control Plan, together with the mission, vision, and strategic goals of UVA Transitional Care Hospital, ensures that Infection Control resources are utilized to meet the prioritized risks for the upcoming year. The Plan is based on the evaluation of the prior year and incorporates new information about the organization’s strategic goals, external requirements, changing epidemiology of the community/population, and evolution of services provided. The Plan is reviewed on an annual basis and revised as needed.

8 ▶ RECORDS and CONFIDENTIALITY
All proceedings, minutes, records, reports and data related to Infection Prevention and Control efforts are confidential and privileged communications. Infection control-related records shall be maintained for a minimum of three years. Sharing of aggregate data among areas, departments, committees, teams and/or sites within UVA Transitional Care Hospital or with those responsible for Infection Prevention and Control activities is appropriate and does not constitute a violation of confidentiality or privilege.
The Plan serves as a description of the prioritized goals of the Transitional Care Hospital’s infection control efforts for FY 2014. Goals are prioritized by considering volume, risk, clinical outcome, likelihood, and cost of healthcare associated infections/infection control breaches as well as external expectation elements.

<table>
<thead>
<tr>
<th>Goal/Objective 1</th>
<th>Implement National Patient Safety Goal – Best practices or evidence-based guidelines to prevent indwelling catheter-associated urinary tract infection (CAUTI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Implement evidence-based bundle of best practices</td>
<td>Patient Care Staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal/Objective 2</th>
<th>Minimize occurrence of healthcare associated, ventilator associated pneumonia (VAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
</tr>
<tr>
<td>Implement evidence-based bundle of best practices</td>
<td>Patient Care Staff</td>
</tr>
</tbody>
</table>
Goal/Objective 3  ▶  Enhance Hand Hygiene Compliance

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Responsible Party</th>
<th>Metric</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform hand hygiene audits</td>
<td></td>
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</tr>
<tr>
<td>• Hospital-wide monthly self hand hygiene compliance audits</td>
<td>• Area Managers: implementing audits and educating staff</td>
<td>Hand hygiene compliance rates; hand hygiene audit completion rates</td>
<td>• 100% audit completion rate organization-wide</td>
</tr>
<tr>
<td>• Quarterly independent audits for both patient care units</td>
<td>• Quality/Performance Improvement: data entry, reporting data to units and Infection Control, and participate in independent audits</td>
<td></td>
<td>• &gt;95% hand hygiene compliance rate</td>
</tr>
<tr>
<td>• Feedback to patient care staff regarding compliance with hand hygiene and audit completion</td>
<td>• Infection Prevention &amp; Control: data analysis to focus educational efforts on most noncompliant groups; assist area managers for educating noncompliant, perform independent audits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Launch house wide educational campaign</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>House wide educational campaign to increase hand hygiene compliance</td>
<td>Patient Care Committee; multidisciplinary hand hygiene committee; Infection Prevention &amp; Control; Patient Safety</td>
<td>Hand Hygiene rates</td>
<td>&gt;95% hand hygiene compliance rate</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Develop automated feedback mechanisms</td>
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<tr>
<td>Brainstorm ways to collect and feedback HH data specific to individuals, and use for performance evaluations and positive/negative consequences</td>
<td>Infection Control/Hospital Leadership</td>
<td>Successful implementation of reporting individual-specific HH compliance data</td>
<td>Successful implementation of this feedback mechanism</td>
</tr>
<tr>
<td>Strategy</td>
<td>Responsible Party</td>
<td>Metric</td>
<td>Measure of Success</td>
</tr>
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<tr>
<td>• Educate staff and LIPs who are involved with in managing central lines about central line-associated bloodstream infections, (CL-BSI) and the importance of prevention. Education occurs upon hire, annually thereafter and when involvement in these procedures is added to an individual's job responsibilities (EP#1)</td>
<td>Center for Organizational Development (COD) in consultation with Hospital Epidemiology for orientation and annual re-training computer based learning modules.</td>
<td>• Compliance with new hire CBL</td>
<td>• ≥90% completion rate</td>
</tr>
<tr>
<td>• Prior to insertion of a central venous catheter, the hospital educates patients, and, their families, as needed about CL-BSI prevention (EP#2)</td>
<td>Patient care staff to educate as the need arises.</td>
<td>• Compliance with annual re-training CBL</td>
<td>• ≥90% completion rate</td>
</tr>
<tr>
<td>• Implement policies and practices aimed at reducing risk of CL-BSI that meet regulatory requirements and are evidence based. (EP#3)</td>
<td></td>
<td>• Compliance with appropriate CBLs for residents and medical students</td>
<td>• ≥90% completion rate</td>
</tr>
<tr>
<td>o Use catheter checklist and a standardized protocol for central venous catheter insertion (EP #6)</td>
<td></td>
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<tr>
<td>o Perform hand hygiene prior to catheter insertion or manipulation (EP #7)</td>
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<tr>
<td>o For adult patients do not insert catheters into the femoral vein unless other sites are not available. (EP #8)</td>
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</tr>
<tr>
<td>o Use standardized supply cart or kit that is all inclusive for the insertion of central lines (EP#9)</td>
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</tr>
<tr>
<td>o Use standardized protocol for maximal barrier precautions during central venous catheter insertion (EP #10)</td>
<td></td>
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</tr>
<tr>
<td>o Use an antiseptic for skin preparation during CL insertion that is cited in scientific literature or</td>
<td></td>
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</tr>
<tr>
<td>• ICP monitor compliance with bundle elements</td>
<td>Chart audits of compliance with bundle elements</td>
<td>&gt;90% completion with use of catheter insertion checklist</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;90% compliance with all elements of bundle</td>
<td></td>
</tr>
</tbody>
</table>
### Goal/Objective 4 ►

**Implement National Patient Safety Goal – Best practices or evidence-based guidelines to prevent central-line associated bloodstream infections (CL-BSI)**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Responsible Party</th>
<th>Metric</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>endorsed by professional organizations. (EP #11)</td>
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<td></td>
</tr>
<tr>
<td>o Evaluate all CL’s routinely and remove non-essential catheters. (EP #13)</td>
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</tr>
<tr>
<td>• Use standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. (EP #12)</td>
<td>TCH Patient Care Committee</td>
<td>• Audit of hub disinfection practices</td>
<td>• ≥90% compliance with hub disinfection prior to access</td>
</tr>
<tr>
<td>• Hospital conducts periodic housewide risk assessments for CL-BSI, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. (EP #4)</td>
<td>Hospital epidemiology – conducting risk assessments, measuring CL-BSI rates, evaluating effectiveness of prevention efforts</td>
<td>• Completed documentation of risk assessment(s)</td>
<td>• Decrease in CL-BSI infection rates</td>
</tr>
<tr>
<td>• Provides CL-BSI rate data and prevention outcome measures to key stakeholders including leaders, licensed independent practitioners, nursing staff and other clinicians (EP #5)</td>
<td>CL-BSI data is to be reported quarterly to the Quality Committee and made available to managers and to other key stakeholders via the TCH Quality Dashboard</td>
<td></td>
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</tr>
<tr>
<td>Goal/Objective 5 ▶</td>
<td>Implement National Patient Safety Goal 07.03.01 – Implement Evidence-based Practices to Prevent HAIs due to multi-drug resistant organisms (MDROs)</td>
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</tr>
<tr>
<td><strong>Strategy</strong></td>
<td><strong>Responsible Party</strong></td>
<td><strong>Metric</strong></td>
<td><strong>Measure of Success</strong></td>
</tr>
<tr>
<td>• Conduct periodic risk assessments for MDRO acquisition and transmission</td>
<td>Infection Control</td>
<td>Successful review and implementation of any necessary changes</td>
<td>Successful review and implementation of any necessary changes with associated reduction in rates for chosen organisms</td>
</tr>
<tr>
<td>• Based on results of risk assessment, educate staff and LIPs about healthcare associated infections, MDROs, and prevention strategies at hire and annually thereafter</td>
<td>Infection Control</td>
<td>Annual CBL completion</td>
<td>≥90% Education of patients/families</td>
</tr>
<tr>
<td>• Educate patients and their families as needed, who are infected or colonized with an MDRO about HAI prevention strategies</td>
<td>Patient care staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement a surveillance program for MDROs based on the risk assessment</td>
<td>Infection Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Measure and monitor MDRO prevention processes and outcomes including the following:</td>
<td>Infection Control; Q/PI &amp; IC monitor compliance with isolation precautions</td>
<td></td>
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</tr>
<tr>
<td>o MDRO infection rates</td>
<td></td>
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<td></td>
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<tr>
<td>o Compliance with best practices</td>
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</tr>
<tr>
<td>o Evaluation of education program provided to staff and licensed independent practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide MDRO process and outcome data to key stakeholders including leaders, licensed independent practitioners, nursing staff and other clinicians.</td>
<td>Antibiotic control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic control</td>
<td>Hospital Leadership and Clinical Team</td>
<td>Antibiotic usage data</td>
<td>Reduction in use of identified antibiotics</td>
</tr>
</tbody>
</table>
The Infection Control Subcommittee is an interdisciplinary subcommittee charged with the coordination, implementation and evaluation of a comprehensive Infection Control Program. It reports to the Quality Committee. The primary goal of this subcommittee is to identify and reduce the risks of acquiring and transmitting infections among patients, employees and visitors.

**Membership:** Hospital Epidemiologist and representation from various clinical and administrative departments within the Transitional Care Hospital. Hospital Epidemiology provides staff support.

**Meetings:** The Infection Control Subcommittee shall meet as necessary, but not less than quarterly.

**Duties and Responsibilities:**
- Develops a coordinated process to lower the risks and improve the (proportional) rates or (numeric) trends of epidemiologically significant infections
- Utilizes surveillance data to identify and prioritize opportunities for improvement related to infection control (e.g., combining surveillance data regarding surgical site infections with OR database information to provide and follow rates)
- Recommends actions to reduce and control outbreaks of healthcare associated infection
- Provides institutional direction for education related to infection control
- Provides recommendations to senior leadership regarding management systems to support the infection control process
- Directs and oversees all aspects of infection control including but not limited to operating room, delivery rooms, recovery rooms, special care units; sterilization procedures by heat, chemicals or otherwise; isolation procedures; prevention of cross infection by anesthesia apparatus or inhalation therapy equipment; testing of Transitional Care Hospital personnel for carrier status; disposal of infectious material
- Provides regular reports to the Quality Committee.
- Ensures the appropriateness of the Transitional Care Hospital Infection Control Manual
The University Of Virginia Transitional Care Hospital
Quality Committee Organizational Chart

Medical Center Operating Board (MCOB)
Co-Chairs: Ed Miller, M.D.
Stephen Long, M.D.

MCOB Quality Subcommittee
Co-Chairs: Nan Dunlap, M.D.;
R. Edward Howell, VP/CEO

Clinical Staff Executive Committee (CSEC)
Chair: Jonathan Truwt M.D.

Quality Committee (QC)
Chair: George Hoke, M.D.

Health Information Management

Infection Control Subcommittee

Patient Safety Subcommittee

Policy Subcommittee

Grievance

Safety & Security Subcommittee