Banner Health

Title: Banner Health Infection Prevention Plan	
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Discrete Operating Unit/Facility:
Banner Baywood Medical Center
Banner Behavioral Health Hospital
Banner Boswell Medical Center
Banner Casa Grande Medical Center
Banner Churchill Community Hospital
Banner Del E Webb Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Fort Collins Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Heart Hospital
Banner Ironwood Medical Center
Banner Lassen Medical Center
Banner Ocotillo Medical Center
Banner Payson Medical Center
Banner Thunderbird Medical Center
Banner--University Medical Center Phoenix
Banner--University Medical Center South
Banner--University Medical Center Tucson
East Morgan County Hospital
McKee Medical Center
North Colorado Medical Center
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional Medical Center
Torrington Community Hospital
Washakie Medical Center
Wyoming Medical Center

Ambulatory Services
B--UMCT Physician Offices and Clinics
Banner Behavioral Health Outpatient Services
Banner Health Clinics
Banner Imaging Services
Banner MD Anderson Cancer Center
Banner Medical Group
Banner Sleep Center
Banner Urgent Care Services
Banner--University Medical Group
Banner--University Medical Group Phoenix
Occupational Health/Employee Health Services
Rural Health Clinics
University of Arizona Cancer Center
Banner Home Care and Hospice (BHCH)
Home Health
Home Infusion Therapy
Home Medical Equipment
Home-Based Palliative Care
Hospice
Olive Branch Senior Center
Telehealth
Banner Pharmacy Services
Pharmacy Acute and Ambulatory Care
Pharmacy Prep and Dispensing
Pharmacy Specialty, Home Delivery, Central Fill
Retail Pharmacy
Research
Research Clinical Trials - BAI
Research Clinics

I. Purpose/Expected Outcome:

A. **Purpose:** The purpose of the Banner Health Infection Prevention Plan is by design to outline Banner Health's commitment and systematic approach to infection prevention at all levels of the organization consistent with its Mission, Values, Core Behaviors and Vision. The Banner Health Infection Prevention Program supports the organization's mission, vision, and values through the use of targeted surveillance, prevention activities and control of infections. Infection Prevention is integrated into the organization's overall safety and clinical quality strategies as demonstrated by strategic goal setting and committee relationships.

B. **Population:** All Banner Health Employees

C. Mission: Making health care easier, so life can be better.

D. Values: Banner's Values define the culture of Banner Health and how these values are demonstrated through actions and behaviors:
1. Customer Obsessed
2. Relentless Improvement
3. Courageously Innovate
4. Disciplined Focus
5. Foster Accountability
6. Continuously Earn Trust

E. Guiding Principles: Banner Health's approach to infection prevention is based on the following principles:
1. Patient/Customer Focus
   a. We are committed to meeting and exceeding the expectations of those we serve and engaging patients and their families in their care and services provided.
2. Leadership
   a. Our infection prevention commitment is established and demonstrated by our leaders.
3. Teamwork
   a. We actively encourage and involve everyone in the organization to communicate and work together to meet the needs of those we serve.
   b. The Infection Prevention Program recognizes preventing infections is a community effort and partners with community agencies to provide resources and safe care of patients with communicable diseases.
4. Continuous Improvement
   a. We understand that our outcomes are a result of our processes and that improving outcomes requires improving processes.
5. Evidence-based decision-making
   a. We rely on data from our own sources as well as credible research done elsewhere as the basis for our decisions.
6. Clinical Innovation
   a. We utilize the rapid identification and deployment of strategies leveraging Banner's operating model and the science of care delivery to ensure an extraordinary patient experience, which is safe, efficient, and effective.
7. Values and Core Behaviors
   a. Our values and core behaviors set us apart as a leader in health care delivery and are essential to deliver an excellent care experience.
8. Culture of Safety
   a. Infection Prevention is a core responsibility for all staff. We promote a culture of safety which encourages, instills, and inspires accountability and responsibility.
   b. Banner Leadership support staff involved in infection incidents.

9. Learning
    a. We encourage organizational learning and support sharing knowledge within Banner Health and other health care organizations to improve quality and patient safety through infection prevention.

II. Definitions:

A. Facility – Any Banner Health hospital, skilled nursing facility, acute rehabilitation, urgent care, physician/provider office, home health, hospice, clinic, or other setting where care is provided.

B. Healthcare Associated Infection (HAI) – An infection as defined by NHSN.

C. NHSN – National Healthcare Safety Network is the national reporting and benchmarking division of the Centers for Disease Control and Prevention for infection prevention.

D. Process Improvement (PI) – Process Improvement is a series of actions taken to identify, analyze and improve existing processes to meet new goals and objectives.

E. Process Owner – A process owner is an individual responsible for their respective level of business operations. A level of business operation could include a whole Facility, a department or a specific service within a department or across a Facility or the organization.

F. Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program Activities – For the purpose of this plan, "Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program" means activities designed and implemented to improve the delivery of care and services.

G. Surveillance - The surveillance system of the Infection Prevention Program is a process of data collection, collation, and analysis for the purposes of characterizing risk groups and factors and identifying control and process improvement strategies.

III. Policy:

A. Banner Health bases its decisions on its values and applies the Guiding Principles throughout the organization in its Infection Prevention Program Model.

B. Banner Health follows the most current NHSN definitions for the classification of infections.

C. Leaders, medical staff, employees, contractors, vendors, volunteers, and students are all responsible for ensuring a safe environment and minimizing the risk of infection through compliance with clinical practices and policies.

D. Infection Prevention Authority/Structure
1. Authority Statement
    a. The Infection Prevention Committee or its appropriate members have authority delegated from organizational leadership to institute infection prevention measures, studies, enforce policies and act on a suspected or defined problem when indicated by findings or through surveillance mechanisms.
2. Governance.
    a. The Banner Health Board of Directors has the ultimate responsibility and accountability for quality of care and services provided by Banner Health. The Senior Leadership Team and facility-based Infection Prevention Committees serve as the oversight bodies for infection prevention and have the following duties and delegated responsibilities:

i. Monitor non-financial measures of organizational infection prevention performance.
ii. Ensure use of a systematic approach to infection prevention activities and assess ongoing improvement in the quality of services delivered by the corporation.
iii. Review and make recommendations to the Board regarding a system-wide infection prevention plan.
iv. Evaluate and make recommendations to the Board concerning healthcare technologies including, but not limited to, genomics, biotechnology, future clinical services delivery, and therapeutics.
v. Evaluate and make recommendations to the Board with respect to ethical implications relating to the activities and services of the corporation, including infection prevention and clinical innovation.
vi. Act for the Board with respect to proposals of management and the local institutions and their medical staffs concerning medical staff policies, patient care policies, and compliance with standards of government and accreditation agencies having jurisdiction over the corporations' institutions as to such policies which require the involvement of the Board of Directors.
vii. Act for the Board of Directors on matters and activities pertaining to the medical staffs of each local institution operated by the corporation to the extent permitted by law and applicable accreditation standards, including any matter which requires action by the Board of Directors, including the adoption, amendment or repeal of medical staff bylaws, rules and regulations, and medical credentialing criteria.
viii. Act for the Board of Directors to the extent permitted by law and applicable accreditation standards, and otherwise make recommendations to the Board of Directors on any matter affecting medical staff membership or privileges, including application for appointment to the medical staff; application for reappointment to a medical staff; request for delineated clinical privileges; and denial, curtailment, limitation or revocation of any of the foregoing.
ix. Review reports regarding infection metrics and the quality of care being provided in respective Facilities.
x. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.

b. In some communities, Advisory Boards provide advice and counsel to management and medical staff leadership on a variety of issues, including infection prevention activities and outcomes.

3. Infection Prevention Officer
   a. The Senior Director of Infection Prevention serves as the system Infection Prevention and Control Officer and has authority and responsibility to:
      i. Provide strategic direction and oversight for the infection prevention program
      ii. Act as a consultant to facilities in the event of outbreaks or epidemiologically significant infection events.
      iii. Appoint facility-based infection prevention and control officers

4. Infection Prevention Committee
   a. Each hospital has an Infection Prevention Committee that meets a minimum of quarterly or in accordance with individual state regulation.
   b. The Infection Prevention Committee is a hospital committee with medical staff and leader participation.
   c. The Infection Prevention Committee is co-chaired by a physician and the facility Infection Prevention and Control Officer.
   d. In some instances, the Infection Prevention Committee may be part of another existing committee, such as the Pharmacy and Therapeutics or Quality and Safety Committee. In

these instances, the agenda will reflect the Infection Prevention Committee separately, with associated minutes and actions.

E. The Infection Prevention program functions under the direction of the Senior Director of Infection Prevention, the facility-based Infection Prevention Officer, the Infection Prevention Committee Chairman, and incorporates involvement of other hospital leaders. The program includes all inpatient and ambulatory care services, including diagnostic and service areas, and support services. Infection Preventionists serve in an advisory/consultative role to all areas and staff. The Infection Prevention Program interfaces with and is an integral part of the organization-wide program to assess and improve quality patient care and patient safety. The Infection Prevention Program has primary responsibility for:
   1. Developing and implementing policies governing control of infections and communicable diseases.
   2. Reduce risk of infections related to procedures, medical equipment, and devices (NPSG 7).
   3. Developing and implementing an organization wide hand hygiene program (NPSG 7).
   4. Assure clean and sanitary environment (CMS).
   5. Facilitate hospital compliance with Conditions of Participation of the Medicare and Medicaid Program, Joint Commission Standards, OSHA requirements and other federal, state and regulatory agencies.
   6. Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases based on results of risk assessments.
   7. Reduce potential transmission of organisms to patients, staff, and others (NPSG 7).
   8. Facilitate screening, referral and treatment of staff, students and volunteers for immunity to infectious diseases (TJC Standard and state regulation).
   9. Collaborate with Emergency Management to develop and test a plan for influx of infectious patients (TJC Standard).
   10. Provide education resources for patients, caregivers, healthcare providers and visitors on infection prevention (NPSG 7 and CMS).
   11. Collaborate with liaisons in public health to prevent and control communicable diseases.
   12. Communicate findings of infection control activities to the Board, hospital administration, medical staff, and employees, and make recommendations for prudent infection prevention and control measures based on the analysis of data.

F. <u>Surveillance Methodology</u>
   1. The Infection Prevention team coordinates activities related to the surveillance of infections within the hospital. Surveillance is done to identify healthcare associated and potentially communicable infections or conditions and to prevent the transmission of infections using direct observations, chart reviews, laboratory reports, staff communication, the study of Department of Health communiqués, NHSN and the infection prevention software system. The surveillance systems utilized are:
      a. Priority-directed Surveillance – monitoring of specific patient populations at risk for infection such as surgical patients, ventilated patients, patients receiving central line intravenous therapy, patients with indwelling urinary catheters. Routine microbiological sampling of the air and environment are done at least weekly on all sterilizers with biological indicators, and monthly sampling of dialysis water and dialysate.
      b. Targeted Surveillance – monitoring of high-risk patients in specific care settings, such as ICU and NICU.
      c. Problem-oriented Surveillance – monitoring of infections occurring at or above expected levels within the hospital, monitoring of epidemiologically significant infections such as influenza, SARS-CoV-2, MRSA, VRE, C. difficile or other antibiotic resistant organisms, vaccine preventable diseases, or other reportable diseases.

d. Outbreak Investigations – coordinating activities related to outbreak investigation of healthcare associated infections within the services provided by Banner. The focus of an outbreak may be associated with the specific groups of patients, locations, treatment modalities, contaminated products or devices, healthcare providers, and/or healthcare practices.

2. A risk assessment identifying risks for acquiring and transmitting infections is completed at a minimum of annually and whenever a significant change occurs as a result of an outbreak, epidemic or change in services. These risks are evaluated by the Infection Prevention Committee, and then prioritized based on the previous year's infection prevention and control data and surveillance methods described in the Surveillance Methodology section. These prioritized risks are incorporated into the infection prevention plan, improvement strategies identified and defined, and goals set for the surveillance period. The risk assessment is reviewed a minimum of quarterly.

3. Banner's surveillance metrics will include the following, as applicable. Additional facility-based surveillance metrics may be added in response to the facilities ongoing risk assessment and state-specific surveillance and reporting requirements.
   a. Acute Care Hospitals
      i. Central Line Associated Bloodstream Infection (CLABSI) in all units
      ii. Catheter Associated Urinary Tract Infection in all units (CAUTI), excluding NICU
      iii. Surgical Site Infection (SSI) in colon and abdominal hysterectomy, knee arthroplasty, hip arthroplasty, and coronary artery bypass graft surgery
      iv. Methicillin Resistant Staphylococcus aureus (MRSA) infection via LabID methodology
      v. Clostridium difficile Infection (CDI) via LabID methodology
      vi. Monitoring of multidrug resistant and emerging pathogens of special interest
      vii. Hand Hygiene
      viii. COVID workplace safety (universal masking, safe zones, eye protection, distancing, etc.)
   b. Ambulatory Care Settings (e.g., clinics, homecare, hospice)
      i. Hand Hygiene (all)
      ii. Intravascular device-related bloodstream infection (home care, hospice, infusion)
      iii. Safe injection practices (where relevant)
      iv. COVID workplace safety (e.g., universal masking, safe zones, eye protection, distancing, etc.)

   c. Process measures at all facilities that perform these processes
      i. High Level Disinfection
      ii. Sterilization
      iii. Sterile Compounding quality control and cultures (pharmacy, infusion)

4. Infection Prevention staff are responsible for completing surveillance activities and reporting in accordance with NHSN definitions and state and federal requirements.
   a. Cerner electronic medical record system is utilized for surveillance documentation
   b. Reporting is completed into the NHSN secure portal each month

G. Analysis and Performance Improvement
   1. Appropriate improvement action is determined by analyzing and interpreting these data over time, using an understanding of variation principles. Process owners are responsible for continuously standardizing and simplifying processes to reduce variation and waste. They are also responsible for proactively recognizing and implementing proven or evidence-based practices for existing processes, using current literature sources and benchmarking activities internally as well as externally.

2. If processes are unstable, process owners investigate and work to remove the cause of the variation. If the variation results in a significant event, they are analyzed and acted on according to policy.

3. When data indicates a need to identify and correct the root cause of a problem, or there is an opportunity to move to a new level of performance, improvement projects are established. In these cases, teams, formal and informal, apply improvement processes that systematically move through the following five steps:
   a. Define the project
   b. Measure current performance
   c. Analyze to identify causes
   d. Improve
   e. Control

4. To assure that the changes required for improvement are successful, the human aspects of change are also addressed using a change model that addresses the need for effective change leadership, creating a shared need, shaping a shared vision, mobilizing commitment, implementing the change monitoring results, and anchoring the change in systems and structure.

5. Communication of improvement opportunities, new processes or practices are reported up and down the organization through defined reporting structures which include department, Facility and system-wide councils.

6. When current processes are not able to achieve customer expectations and/or established performance goals, new processes and services are designed and implemented utilizing evidence-based and innovative practices. A systematic approach involves multiple departments and disciplines working collaboratively, using information from patients, staff, payors, and others, along with current comparative information/data from other organizations.

7. When performance issues may be related to the professional practice of an individual medical staff member, the performance issue is referred to medical staff committees for review and determination of appropriate action, if any.

8. All proceedings, records, and materials related to Infection Prevention and associated improvement activities are confidential in accordance with appropriate federal and state statutes.

9. When performance issues may be related to the performance of a staff member, they will be handled through the appropriate Banner Health Human Resources policies and/or procedures.

H. A program evaluation is completed at a minimum of annually. Performance data and the evaluation are used in conjunction with the risk assessment to determine priority focus areas each calendar year.

IV. Procedure/Interventions:

A. The Infection Prevention Committee is responsible for oversight and actions on the following:
   1. <u>Annually</u>
      a. Review and approval of the Infection Prevention Program plan annually and if a change in surveillance is warranted.
      b. Review and approve the annual infection prevention report and program evaluation.

   2. <u>Quarterly</u>

a. Review and approval of risk assessment at a minimum of quarterly and when indicated due to an outbreak, epidemic or surveillance change.
b. Review surveillance data and reports, and take necessary actions to improve performance
    i. Receive reports from improvement teams and departments as warranted (i.e., Critical Care for CAUTI and CLABSI)
    ii. Surgical Site Infections (SSI)
        (i) Colon procedures (COLO)
        (ii) Abdominal hysterectomy (HYST)
        (iii) Knee arthroplasty (KPRO)
        (iv) Hip arthroplasty (HPRO)
        (v) Coronary Artery Bypass Graft (CABG/CBGB)
c. Review and approve reports on process and quality control
    i. Procedural areas
        (i) Immediate Use Sterilization Rates
        (ii) Positive Biological Indicator Events
        (iii) Point of Use Cleaning Process
        (iv) High Level Disinfection compliance
            (a) Ultrasound (US)
            (b) Endoscopy (ENDO)
            (c) CSPD
            (d) TEE Probes
            (e) PFT
            (f) Sleep Lab
    ii. Low Level Disinfection
        (i) EVS clean Scores

    iii. Laboratory
        (i) Blood culture contamination rates
        (ii) Antibiogram
    iv. Environmental Risks
        (i) Legionella
        (ii) Pharmacy Compounding Room/Clean surface Sampling
        (iii) Pharmacy Compounding Room/Clean air sampling
        (iv) HO Aspergillus spp.

    v. Occupational/Employee Health
        (i) Sharps injury reports
        (ii) Bloodborne pathogen exposure reports
        (iii) Employee Hepatitis B
        (iv) Influenza Immunization rates
        (v) Employee Varicella
        (vi) Employee MMR

        (vii) TB skin test (TST) or blood assay for M. Tuberculosis (BAMT) and respiratory protective PPE compliance reports for acceptable use of PAPRs/CAPRs (as indicated by facility TB Risk Assessment)
        (viii) TST/BAMT test conversion rates
        (ix) Other communicable disease exposures
        (x) COVID HAI > 14 days

vi. Construction and Facilities Departments on environmental control monitoring (i.e. procedural areas temperature/humidity/air flow, ICRA compliance, AIIR monitoring, water intrusions and abatement, etc.)

d. Other facility specific data (i.e., dialysis/dialysate info)

3. As needed
   a. Review and approve policies and procedures.
   b. Pharmacy clean room quality control cultures, including surface, air and fingertip as required by USP 797.

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. Banner Home Care IC Program

VII. References:

Arizona Statutes: A.R.S. § 36-401 – 445
Colorado Statutes: C.R.S.A. § 25-3-109
Nebraska Statutes: Title 172 NAC, Chapter 5
Nevada Statutes: NRS 439.865
Wyoming Statutes: W.S. 35-2-910
CMS Conditions of Participation
The Joint Commission

VIII. Other Related Policies/Procedures:

A. N/A

IX. Keywords and Keyword Phrases:

A. ACHC
B. Board
C. Care Management
D. Infection Prevention
E. Infection Prevention Plan
F. Surveillance

X. Appendix:

A. N/A