

## Brooke Army Medical Center

### **Brooke Army Medical Center Annual Infection Control Program Plan January – December 2004**

#### **PURPOSE OF INFECTION CONTROL**

The purpose of the Infection Control Service (ICS) is to improve the ability of Brooke Army Medical Center to provide the best patient care in the safest possible environment by limiting transmission of infectious diseases. This goal is achieved through collaborative, organization-wide standardization, and continued critical evaluation of hospital and community infection control (IC) practices.

The Infection Control Service surveillance, prevention, and infection control strategies and initiatives are performed in accordance with JCAHO Accreditation Standards and the New Patient Safety Goal # 7 Health Care Acquired Infection.

#### **INFECTION CONTROL VISION STATEMENT**

To minimize and reduce the risk of health care-acquired infections (HCAI) in patients while protecting healthcare workers from occupational exposures and all personnel, patients, and visitors from infectious hazards within BAMC to include 4 East, 4 North and 4 South (ISR), Occupational Health Clinic at the Corpus Christi Army Depot (CCAD), McWethy Troop Clinic, and the Family Medicine Service Clinic at Camp Bullis.

#### **INFECTION CONTROL MISSION STATEMENT**

To foster increased participation and responsibility of each healthcare worker in the Infection Control Program at the user level.

To educate healthcare workers about essential protection programs against occupational exposures and hazards in the work place.

To promote disease prevention, infection prevention and control, and HCAI reduction.

To ensure safety, health, and welfare for all customers within the health care environment.

To improve the quality of care in an economically sound, effective manner for all customers.

To evaluate practices, processes, procedures, and products based on established infection control principles and proven efficacy in practices.

To continue to be a viable community resource by participating with the Emergency Medical System/ Hospital Disaster Group (EHDG) and EHDG Infection Control (IC) Subcommittee for infection control planning in response to a natural or bio-terrorist event that may potentially overwhelm its resources.

To comply with the Centers for the Disease Control (CDC) hand hygiene guidelines as the JCAHO National Patient Safety Goal.

#### **SCOPE OF SERVICE**

Infection Control is a Medical Center-wide quality improvement activity, involving all departments, services, wards, and clinics, to include the Occupational Health Clinic at the Corpus Christi Army Depot (CCAD), McWethy Troop Clinic, and the Family Medicine Service Clinic at Camp Bullis. The Chief of Infection Control, the two Infection Control Practitioners, and the Medical Director determine the specific focus of surveillance, education, and consultation efforts on an ongoing basis, dependent on hospital epidemiology, community disease surveillance and real or perceived world threats.

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The major purpose of the practice of infection control is to minimize the morbidity, mortality, and economic burden associated with health care associated infection through prevention and control endeavors in both patient and staff populations. Using epidemiological principles, the team collects and analyzes pertinent data in order to determine risk factors associated with infection and to define mechanisms of transmission. The infection control team uses this information to seek opportunities for improvement; and then plans, implements, and evaluates control strategies. As a resource within BAMC and the community, the ICS educates other professionals as well as the public about infection risks and measures to reduce and/or minimize risks.

### **AUTHORITY AND RESPONSIBILITIES**

The Commander has overall authority and responsibility for the Infection Control Program.

The ICS Medical Director and the Chief, ICS have primary responsibility for implementing and managing the Infection Control Program.

The ICS Medical Director, the ICS Chief, and team members have authority to institute any surveillance, prevention, and control measures or studies when there is reason to believe that any patient or personnel may be in danger from a potential or actual outbreak of, or exposure, to infectious disease.

Currently, the ICS consists of the Chief, ICS, 1.5 FTE Infection Control Practitioners, and a Licensed Practical Nurse (91C). The NCOIC is currently deployed in support of Iraqi Freedom. The Chief also serves as the Regional Medical Command IC consultant and assists the Army Consultant. The burn unit has an Infection Control Nurse that is solely dedicated to the burn unit. She is not under the direct supervision of the Chief of the ICS. However, the ICS has oversight over the burn unit and its performance of infection control activities.

All employees have responsibility for controlling health care acquired infections.

Department/Service/Ward/Clinic Officers-in-charge (OIC) officially appoint Infection Control Coordinators. The Infection Control Coordinators' responsibilities include:

- (1) To act as a point of contact (POC) for their unit for IC issues.
- (2) To monitor IC related work practices within their patient care work environment.
- (3) To report questions/concerns to hospital ICS staff.
- (4) To attend initial training and bi monthly meetings

### **GOALS AND OBJECTIVES**

#### **I. Maintain infection control guidelines in concert with current standards and literature.**

##### **A. Publications**

1. *It's a Bug's Life: Quarterly Newsletter: March-June-Sept- December*
2. Semi-annual Antibigram reported to IC FMT.
3. Infection Control Issues are placed on Outlook Infection Control Folder and on the Intranet site.

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### **B. Documentation**

Documents are reviewed every two years for currency and reported to IC and EOC FMTs.

#### **40-94 Sexually Transmitted Diseases Control: PM IC FMT**

#### **40-110 Viral Hepatitis Prevention and Control: PM IC FMT**

40-135 Blood and Body Fluid Exposure Management: PM IC FMT 7 May 2003

40-136 Communicable and Occupational Disease Reporting: PM IC FMT 12 Mar 2003

40-164 Human Immune Deficiency Virus Testing: PM IC FMT 12 Mar 2003

40-167 Administration of the Influenza & Pneumococcal Vaccine to Inpatients: ID IC FMT 1 May 2002

#### **40-169 Bloodborne Pathogen Exposure Control: PM IC FMT**

40-401 Tuberculosis (TB) Prevention and Control: PM IC FMT 15 October 2003

PAM 40-2 Infection Control Manual: IC-FMT 10 October 2003

SOPs are not required, if the area standards do not differ from the BAMC Pam 40-2.

Multidose medications policy in BAMC Pam 40-2 and Pharmacy will be updated

40-48 Hazardous Waste Management Program: EOC FMT

40-403 Management of Regulated Medical Waste (RMW): PM EOC FMT 28 Dec 1999

40-202 Canine Visitation Program: Ministry: EOC FMT

## **II. Establish and validate the surveillance system.**

### **A. Surgical Site Infections (SSI)**

**1. CT Coronary Artery Bypass Graft (CABG) and/or Valve Replacement Operations.** These will be surveyed due to the high-risk nature of the procedure and the cluster of SSI from July-November 2003

*Population to be surveyed:* All patients having a CABG/Valve replacement in the OR at BAMC with a primary closure.

*Length of time population will be surveyed:* 1 Dec 2003 – 30 Nov 2004. Each patient will be surveyed up to 30 days post-op. If there is an implant, they will be followed for 1 year.

*Case finding methodology:*

Infections will be identified through a review of wound cultures, antibiotics prescribed, readmissions, review of CT clinic post-op visits, or a report from the provider. Inpatient and outpatient records will be reviewed initially to obtain surgical data for the specific patient, then as needed.

*Risk Adjustment:*

*NNIS Criteria (CDC wound classification, length of surgery, and ASA score)*

*Types of rates generated:* Overall rate, then for each risk category at the end of the year. Both leg and chest infection will be tracked. Data will be entered into the AICE Program (IC data base).

*Method of analysis:* Risk category rates will be compared to NNIS and BAMC.

*Threshold:* NNIS system medians or BAMC mean, whichever is lower for respective rates. These rates will not be compared with past surveillance because of change of data collection methods.

*Reporting and Feedback:* Quarterly, semi-annual, and yearly reports will be presented to the Chief of CT Services, ICS Medical Director, and Chief of OR. Rates will be presented quarterly if the denominator is greater than 50. Provider specific rates will be provided to the Service Chief only, if requested.

### **2. GYN Hysterectomy Procedures**

*Rationale:* GYN procedures will be surveyed to identify and correct deficiencies found in 2003

*Definition:* CDC NNIS current definitions for SSI.

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*Population to be surveyed:* All patients having total abdominal hysterectomies (TAH) and total vaginal hysterectomies (TVH). Additional procedures of bilateral salpingo-oophorectomy (BSO), anterior and/or posterior repair (A and P Repair), and other procedure will be a reported subset.

*Length of time population will be surveyed:* 1 Feb 2003 - 30 Apr 2004. Each patient will be surveyed up to 30 days post-op.

*Case finding methodology:* Infections will be identified through a review of wound cultures, antibiotics prescribed, readmissions, review of clinic post-op visits, or a report from the provider. Inpatient and outpatient records will be reviewed initially to obtain surgical data for the specific patient, then as needed.

*Risk Adjustment:* NNIS Criteria (CDC wound classification 1 and 2 only, length of surgery, and ASA score).

*Types of rates generated:* Overall, monthly and quarterly incidence rates; and at the end of the study period, the rate will be risk stratified. Data will be entered into the AICE Program

*Method of analysis:* Risk category rates will be compared to published NNIS data.

*Threshold:* NNIS system medians or BAMC mean, whichever is lower for respective rates.

*Reporting and Feedback:* Quarterly reports will be presented to the Chief of Services, ICS Medical Director, Chief of OR, Chief of OB/GYN, and wards. Rates will be presented quarterly if the denominator is greater than 50. Provider specific rates will be provided to the Service Chief only, if there appears to be a problem.

### **B. Ventilator Associated Pneumonia (VAP)**

*Rationale:* VAP infections have high morbidity and mortality rates and are costly infections.

*Definition:* CDC NNIS definition for pneumonia using the new guidelines.

*Population to be surveyed:* Patients on the ventilator for at least 48 hours on 3 South, 2 North, and 2 South and 4 North/South. There must be no clear evidence that pneumonia is present within 48 hours prior to intubation.

*Length of time population will be surveyed:* Concurrent surveillance 1 Jan-31 Dec 2004. Each patient will be surveyed up to three days after extubation or until discharge or death.

*Case finding methodology:* Report of infection by healthcare worker, microbiology results, antibiotic use, radiological reports, physician progress notes, and discharge summary diagnosis. A computer-generated, line listing report of all patients on the ventilator will be run Monday-Wednesday-Friday from the Respiratory Therapy (RT) office by the IC NCOIC or designated individual.

*Risk Adjustment:* Ventilator days. At approximately the same time each day, a tally will be collected on the number of patients on ventilators. The evening night supervisor will provide this report daily and place it in the IC box on the 3<sup>rd</sup> floor.

*Types or rates generated:* Quarterly incidence density rates (if ventilator days > 100) per 1,000 ventilator days per critical care unit (CCU).

*Method of analysis:* Rates will be compared with published NNIS data and BAMC benchmark.

*Threshold:* NNIS system pooled mean for respective rates. (2003 NNIS has only pooled mean data) A chi square will be done to calculate the p value if the rate is above the pooled mean.

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*Reporting and Feedback:* Quarterly reports will be presented to the intensive care units (ICUs), ICS Medical Director, RT, Director of the ISR, Chief Nurse of ISR and Chief of Critical Care.

### **C. Central Line Associated Blood Stream Infections (CL BSIs)**

*Rationale:* Bacteremias will be surveyed due to high morbidity and mortality associated with them. The medical ICU will be monitored concurrently due to the high BAMC rate of ICU infections over the last three years, specifically >50-75<sup>th</sup> percentile as compared with NNIS.

*Definition:* CDC NNIS definition for laboratory confirmed bloodstream infection.

*Population to be surveyed:* Patients in the following ICUs:

3 South 1 Jan-31 Dec 2004

3 North 2<sup>nd</sup> Qtr and 3<sup>rd</sup> Qtr: To establish a baseline

2 North 1<sup>st</sup> Qtr and 4<sup>th</sup> Qtr 2004

2 South 1<sup>st</sup> Qtr and 4<sup>th</sup> Qtr 2004

Patients with central venous lines who develop a nosocomial bloodstream infection defined as one or more blood cultures drawn at least 48 hours after admission and insertion of central line will be surveyed. There **must be no evidence** that a bloodstream infection is present within 48 hours prior to insertion.

*Length of time population will be surveyed:* Concurrent surveillance 1 Jan-31 Dec 2004.

*Case finding methodology:* Infections will be identified through a concurrent review of blood cultures as provided to the ICS by the microbiology laboratory.

*Risk Adjustment:* Central line days. Each day at approximately the same time, the number of patients with central lines will be tallied. The evening night supervisor will provide this report daily and place it in the IC box on the 3<sup>rd</sup> floor.

*Types or rates generated:* Quarterly incidence density rates will be generated for nosocomial central line associated bacteremia per 1,000 central line days per each ICU.

*Method of analysis:* Rates will be compared with the published NNIS data and BAMC benchmark.

*Threshold:* NNIS system 50<sup>th</sup> percentile for respective rates

*Reporting and Feedback:* Quarterly reports will be presented to ICUs, ICS Medical Director, and Chief of Critical Care. Department specific rates will be provided to respective Department Chiefs.

### **D. Environmental Surveys**

*Criteria:* BAMC environmental checklist reviewing global cleanliness and IC compliance.

*Location:* Each unit with the ICS, IC Coordinator, or the NCOIC of the area

*Frequency:* performed at least annually.

*Reporting and Feedback:* Identified discrepancies will be reported to the ICFMT **only** if assistance is needed.

### **E. Hand Hygiene Compliance**

*Rationale:*

1. For over 150 years, scientists have associated decreased morbidity and mortality rates with the practice of cleaning one's hands.

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2. JCAHO Safety Goal 7 for 2004 requirement
3. BAMC Handwashing prevalence performed in 2003 show a low rate of compliance among physicians and nursing personnel

*Definition:* Compliance is defined as performing hand cleansing after and/or before the following opportunities:

- providing patient care
- before donning sterile gloves
- after contact with the patient
- after removing gloves
- after contact with equipment /furnishings in the patient's room
- moving from a contaminated body site to a clean body site during care.

*Population to be surveyed by the Infection Control Staff:* All inpatient units. All units to include clinics are responsible to monitor their handwashing compliance.

*Length of time population will be surveyed:* Monitor each unit for at least 40-50 observed opportunities every other month.

*Types or rates generated:* A rate of compliance will be calculated by  $X/Y \times K$ .

X= Number of opportunities observed

Y= Number of opportunities available

K = constant of 100 %

Compliance rates will be stratified by the following:

- 1) Overall hospital rate
- 2) Rate by floor
- 3) Overall rate by physicians
- 4) Overall rate by nursing personnel.

*Method of analysis:* Rates will be compared with BAMC benchmark.

*Threshold:* The goal is to be higher than 90% compliance.

*Reporting and Feedback:* Reports will be presented to the Wards, Chief, DOM, Chief, DOS, Chief, OB/GYN, DCCS, Chief, DON\_March-May-July-Sept-Nov.

## F. Significant Pathogens

### 1. Vancomycin-Resistant *Enterococcus* (VRE)

*Definition:* Nosocomial VRE is defined as isolation of the organism after  $\geq 48$  hours of admission or within 30 days of a prior hospitalization.

*Case finding methodology:* Identified via concurrent microbiology surveillance. Identify nosocomial vs. community infection. ISR rates will be counted separately from the BAMC rate.

*Precautions:* All newly identified VRE isolates will be entered into AICE and command interest for tracking on CHCS. The admission screen will read "Special: contact infection control and gaining unit."

*Reporting:* On patient readmission, the Pre-Admission and Disposition (PAD) office, Pre-Admission Clinic, or the Emergency Department (ED) will notify the ward and the ICS office (phone 6-2130) that the patient requires special precautions. Incidence will be presented as quarterly rate per 10,000 occupied bed days (OBD).

### 2. Methicillin-Resistant *Staphylococcus aureus* (MRSA)

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*Definition:* Nosocomial MRSA is defined as isolation of the organism after  $\geq 48$  hours of admission or within 30 days of a prior hospitalization. If the patient is identified with MRSA in the clinic and then hospitalized, it will be counted as community-acquired infection upon admission.

*Case finding methodology:* Identified via concurrent microbiology surveillance. Identify nosocomial vs. community infection. ISR rates will be counted separately from the BAMC rate.

*Precautions:* All newly identified MRSA isolates will be entered into AICE and command interest for tracking on CHCS. The admission screen will read "Contact: contact infection control and gaining unit."

*Reporting:* On patient readmission, the PAD office, Pre-Admission Clinic, or the ED will notify the ward and the ICS office (phone 6-2130) that the patient requires contact precautions. Incidence will be presented as quarterly rate per 10,000 OBD.

### **3. *Clostridium difficile* (C diff) Diarrhea**

*Definition:* Nosocomial *C. difficile* is defined as diarrhea that develops in a patient after  $\geq 48$  hours of admission or within one week of a prior hospitalization

*Case finding methodology:* Identified via microbiology surveillance of *C.difficile* toxin assays.

*Precautions:* All newly identified *C. diff* isolates will be entered into AICE and command interest for tracking on CHCS. The admission screen will read "Contact: contact infection control and gaining unit."

*Reporting:* Incidence presented as quarterly rate per 10,000 OBD.

### **4. Other Multi-Drug Resistant Organisms (MDROs)**

*Definition:* A nosocomial MDRO is defined as a gram negative rod species, that is susceptible to  $\leq$  two antibiotics, which may themselves be from two different classes, 48 hours or/after admission or within 7 days of a prior hospitalization. If the patient is identified with MDRO in the clinic and then hospitalized, it will be counted as community-acquired infection upon admission.

*Case finding methodology:* Identified via concurrent microbiology surveillance. Identify nosocomial vs. community infection.

*Precautions:* All newly identified MDRO isolates will be entered into AICE and placed in contact isolation at minimum.

*Reporting:* Incidence presented as quarterly rate per 10,000 OBD

### **G. Blood Contamination Rate**

*Purpose:* Not all microorganisms recovered from blood cultures are clinically significant. Contamination of cultures with the patient's flora introduced into the blood during collection can occur. Because of the contamination rate, it is often difficult to differentiate between true bacteremia and contamination. Our rate from the last three years has been above the national norm of 2%.

*Population to be surveyed:* All patients in the clinics and hospital will be surveyed.

*Length of time population will be surveyed:* 1 Jan – 31 Dec 2004.

*Criteria:* Contaminants identified as single isolates of either CNS or *Corynebacterium* species, non-pathogenic bacilli, *Streptococci viridans*, and *P. acnes*

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*Reporting:* Annually in Jan/Feb 2005. The report from 2003 will determine educational needs for 2004

*OPR:* Microbiology: Linda Harrison

### **H. Standing Order Vaccination Program for Inpatients**

*Population to be surveyed:* Number of inpatient contacts that received a Pneumovax and/or Influenza immunization reported by DON PI.

*Reporting:* Incidence of Pneumovax and/or Influenza immunizations reported quarterly to IC FMT. The number of contacts over the total discharges per month will be used as a rate for assessment purposes. Pneumovax offered yearly. Influenza offered October – March of each year.

POC: Department of Nursing PI

### **I. Environmental Sampling**

#### **1. Sterilizers**

##### **a. Steam Sterilizers**

*Criteria:* 100% Negative for *B. stearothermophilus* daily.

*Reporting:* Written report monthly; oral report by exception only.

*OPR:* Central Materials Services (CMS) and Operating Room (OR)

##### **b. Steris**

*Criteria:* 100% Negative for *B. stearothermophilus* in every load.

*Reporting:* Written report monthly; oral report by exception only.

*OPR:* OR, CMS, GI, Pulmonary , Anesthesia and Urology Clinics

##### **c. Vapor Phase Hydrogen Peroxide (STERRAD)**

*Criteria:* 100% Negative for *B. subtilis* daily.

*Reporting:* Written report monthly; oral report by exception only.

*OPR:* CMS

#### **2. Dialysis Machines**

*Criteria:* Total viable bacterial count for dialysate (dialysis machine effluent) should not exceed any more than 2,000 colony-forming units (cfu)/milliliter (ml)/month.

Total viable bacterial count used to prepare dialysate or to reprocess hemodialyzers should not exceed 200 cfu/ml/month.

*Reporting:* Written reports monthly; oral report by exception only.

*OPR:* Dialysis unit

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### **J. Employee Health**

*Criteria:* OSHA, JCAHO, and BAMC Pam 40-2

*Program Elements:*

1. Hospital acquired percutaneous and mucous membrane exposures reported to Environment of Care (EOC) and IC FMTs.
2. Tuberculosis (TB) PPD Skin Conversions reported to EOC and IC FMTs.
3. TB Risk Assessment reported to ICFMT.
4. Communicable Disease Reporting to Texas Department of Health (TDH) and report to IC FMT by exception only.
5. Healthcare Worker (HCW) exposure to communicable disease, other than above blood/body fluid exposures, at BAMC report to IC FMT by exception only.

*Reporting:* Quarterly report to IC FMT.

*OPR:* Department of Preventive Medicine

### **K. Contractor Compliance**

*Criteria:* Contractual agreements, CDC, OSHA

*Reporting:* Monthly report to EOC

1. Construction
2. Housekeeping
3. Laundry
4. Waste
5. Ventilation

### **III. Education programs.**

*Criteria:* OSHA, JCAHO

Hospital Newcomer's Orientation: Monthly in Auditorium. First session 20 minutes in the morning to all newcomers and 45 minutes in the afternoon to providers.

Initial and annual training: SYNQUEST Computer-based training

Infection Control Coordinators orientation class: Four-hour didactic classes with CEUs  
**26 February 2004: 22 April 2004: 19 August 2004**

Infection Control Coordinators meeting: Convenes at 1400-1500  
**22 January 2004, 18 March 2004, 20 May 2004, 15 July 2004, 16 September 2004, and 18 November 2004**

Periodic In-services: As needed basis

Annual Brief of New Physician Interns: June 2004

Brief of 91C, 91V, and 91D Students at AMEDD School: Monthly

Critical Care/OR/ED Nurses Class: Two- hour block of instruction in January and as needed

Brief 91 W instructors on as needed basis

### **IV. Participate in research.**

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### **A. Effect of oral *Lactobacillus* GG administration on the density of vancomycin resistant enterococci (VRE) in the stool of colonized patients – A pilot study.**

Principal Investigator: Gunther Hsue, MD, MAJ, MC  
Associate Investigator: Helen K Crouch, MPH, CIC  
Associate Investigator: Linda S Harrison, MS, MT  
Associate Investigator: David Dooley, MD, COL, MC.  
See protocol for details. Continued from 2002

### **B. Ventilator Associated Pneumonia (VAP) Best Practices.**

Principal Investigator: Cindy Abbott, RN, COL, NC  
Associate Investigator: Helen K. Crouch, MPH, CIC  
Associate Investigator: Christopher Florez, BS, CIC  
Jointly with WHMC

### **C. Impact of Eradication of Methicillin-Resistant *Staphylococcus aureus* (MRSA) Nares Colonization on Subsequent MRSA Infection in the ICU patients.**

Principal Investigator: Kepler Davis, MD, CPT, MC  
Associate Investigator: Helen K Crouch, MPH, CIC  
Associate Investigator: Christopher Florez, BS, CIC  
See protocol for details.

### **D. Handwashing : Improving Clinical Outcomes through Evidence-based Practice.**

Principal Investigator: Nursing Research Department  
Pending protocol approval from IRB.

## **V. Identify Departmental Goals and Quality Initiatives**

### **A. 2004 JCAHO Safety Goals**

1. Sentinel Event Reporting
2. Hand Hygiene Compliance

### **B. 2005 JCAHO IC Standards**

1. Incorporate into the unit level Process Improvement (PI) Program
2. Maintain state of readiness

## **VI. List Membership on other Committees and Functions**

### **A. Environment of Care (EOC):** Meets every other month on the 3<sup>rd</sup> Wednesday at 1330 in the Logistic Conference Room.

Primary: Ms. Crouch      Alternate: Mr. Florez

### **B. Hospital Safety:** Meets monthly on the 2<sup>nd</sup> Wednesday at 1500 in the Command Conference Room.

Primary: Mr. Florez      Alternate: Ms. Crouch

### **C. Tri-service Regional Products Board:** Meets monthly on the 2<sup>nd</sup> Monday at 0930 in WHMC and/or BAMC Logistic Conference Room.

Primary: Mr. Florez      Alternate: Ms. Crouch

### **D. Nurse Performance Improvement (PI):** Meets monthly on the 3<sup>rd</sup> Friday at 0830 in the 3<sup>rd</sup> floor DONO classroom.

Primary: Ms. Crouch      Alternative: Mr. Florez

### **E. Nursing Policy and Procedures (P&P):** Do not attend meetings; consult upon request.

Consultant: Ms. Crouch

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**F. Infection Control Functional Management Team (IC FMT):** Meets monthly on the 3<sup>rd</sup> Monday at 0900, other than holidays, in the 7 East Conference Room.

Primary: Dr. Dooley                      Primary: Ms. Crouch                      Alternate: Mr. Florez

**G. City Wide Bioterrorism (BT) EMS/Hospital Disaster Group (EHDG) Infection Control (IC) Subcommittee:** Meets monthly and/or as needed on the 4<sup>th</sup> Thursday at 1630 in Conference Room A of the Methodist Administration Building (Data Point and Fredericksburg).

Primary: Ms. Crouch                      Alternative: Mr. Florez

**H. Hospital Process Improvement Committee (PIC):** Meets monthly on the 3<sup>rd</sup> Wednesday at 1300; location varies.

Primary: Ms Crouch                      Alternative: Dr Dooley

**VII. Projected 2004 Infection Control Team Educational Training**

- A. APIC 2004 Annual Conference: Ms. Bjerke
- B. TSICP IC Fundamental Course: Ms. Bettie Vaughan
- C. APIC ICE 2 Course: Ms. Diane Hidenrite

APPROVED

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