July 1, 2020

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:00AM on Thursday July 9, 2020, in the Kaweah Delta Lifestyle Center, 5105 W. Cypress Avenue, Conference Room A, or via GoTo Meeting form your computer, tablet or smartphone. https://global.gotomeeting.com/join/553689117 or call (224) 501-3412 Access Code: 553-689-117.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:01 AM on Thursday, June 11, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A, pursuant to Health and Safety code 32155 & 1461. Board members and Quality Council closed session participants will access closed meeting via Confidential GoTo Meeting phone number provided to them.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting immediately following the 7:01AM Closed meeting on Thursday July 9, 2020, in the Kaweah Delta Lifestyle Center, Conference Room A or via GoTo Meeting via computer, tablet or smartphone. https://global.gotomeeting.com/join/553689117 or call (224) 501-3412 Access Code: 553-689-117.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

Due to COVID 19 visitor restrictions to the Medical Center - the disclosable public records related to agendas can be obtained by contacting the Board Clerk at Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA via email: cmoccio@kdhcd.org, via phone: 559-624-2330 or on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk, Executive Assistant to CEO

DISTRIBUTION:
Governing Board, Legal Counsel, Executive Team, Chief of Staff
http://www.kaweahdelta.org

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, July 9, 2020

5105 W. Cypress Avenue

The Lifestyle Center; Conference Room A

Call in option: 1-244-501-3412 Access Code: 553-689-117

ATTENDING: Board Members; Herb Hawkins – Committee Chair, David Francis; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Interim CNO; Anu Banerjee, PhD, VP & Chief Quality Officer, Byron Mendenhall, MD, Chief of Staff; Monica Manga, MD, Professional Staff Quality Committee Chair; Daniel Hightower, MD, Secretary/Treasurer; Harry Lively, MD, Past Chief of Staff; Lori Winston, MD, DIO & VP of Medical Education; Tom Gray, MD, Quality and Patient Safety Medical Director; Sandy Volchko, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance Officer, and Michelle Adams, Recording.

OPEN MEETING – 7:00AM

1. **Call to order** – *Herb Hawkins, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:01AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair;*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Anu Banerjee, PhD, VP & Chief Quality Officer*
4. **Adjourn Open Meeting** – *Herb Hawkins, Committee Chair*

CLOSED MEETING – 7:01AM

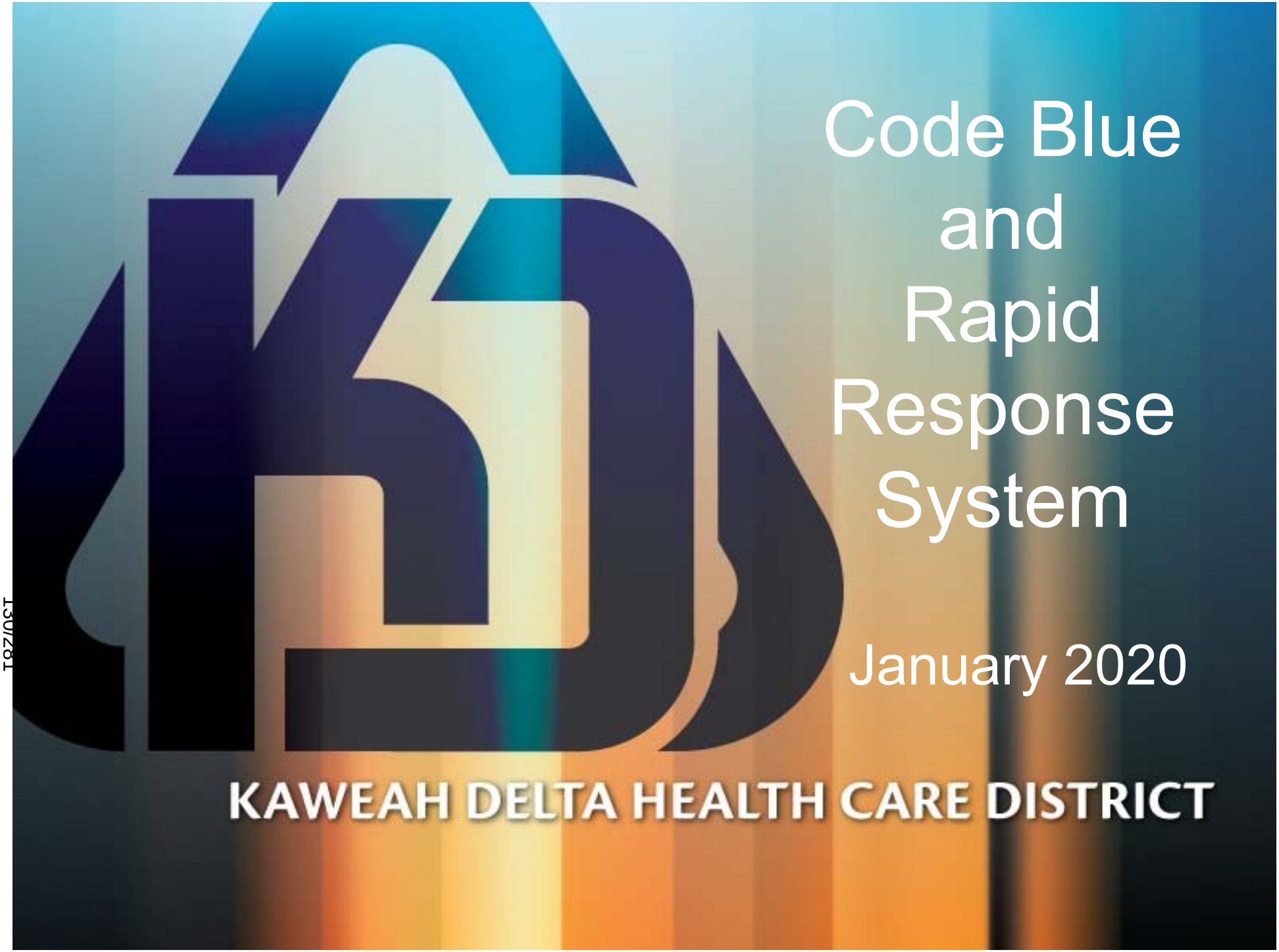
1. **Call to order** – *Herb Hawkins, Committee Chair & Board Member*
2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Monica Manga, MD, and Professional Staff Quality Committee Chair*
3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 –– *Anu Banerjee, PhD, VP & Chief Quality Officer*

4. **Adjourn Closed Meeting** – *Herb Hawkins, Committee Chair*

OPEN MEETING – Immediately following the 7:01AM Closed Meeting

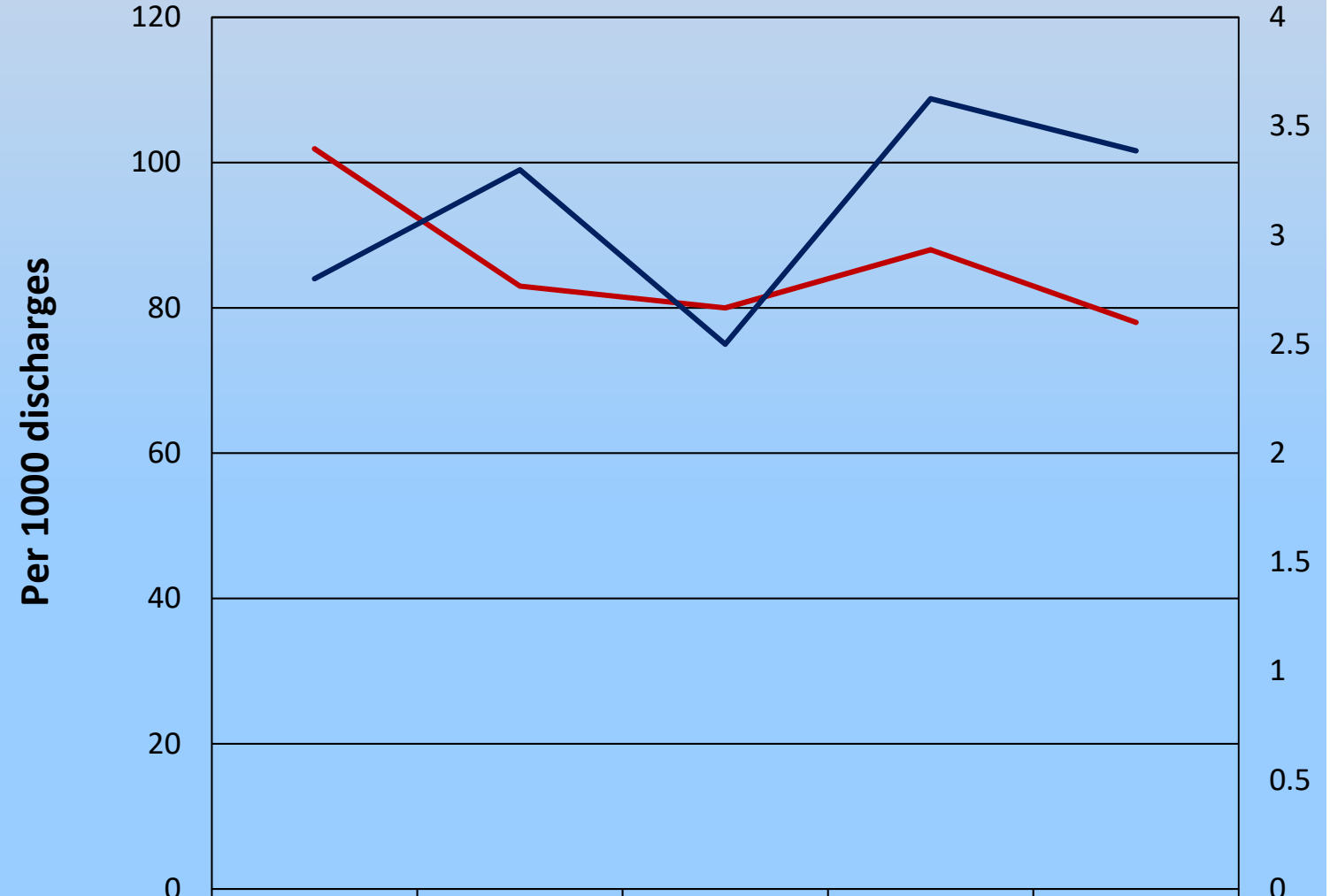
1. **Call to order** – *Herb Hawkins, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.
3. **Written Quality Reports –** A review of key quality metrics and actions associated with the following improvement initiatives:
   - 3.1. **Rapid Response Team Quality Report**
   - 3.2. **Stroke Program Quality Report**
   - 3.3. **Rehabilitation Quality Report**
   - 3.4. **Orthopedics Quality Report**
   - 3.5. **Sepsis Quality Focus Team Update**
   - 3.6. **Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report**
4. **National Quality Forum Safe Practice #9: Nursing Workforce –** An evaluation and analysis of nurse staffing, skill mix and adverse events. *Mary Laufer, DNP, RN, NE-BC, Director of Nursing Practice*
5. **Infection Prevention Quality Report –** A review of key infection measures and associated action plans for improvement. *Shawn Elkin, MPA, BSN, RN, PHN, CIC, Manager of Infection Prevention.*
6. **Safety Culture Update –** A review of safety culture survey scores, and updates on quality improvement initiatives. Sandy Volchko, DNP, RN, CPHQ, CLSSBB, Director of Quality and Patient Safety.
7. **Update: Fiscal Year (FY) 2020 Clinical Quality Goals -** A review of current performance and actions focused on the FY 2020 clinical quality goals. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety*
8. **Adjourn Closed Meeting** – *Herb Hawkins, Committee Chair*

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.


Code Blue
and
Rapid
Response
System
January 2020
KAWEAH DELTA HEALTH CARE DISTRICT

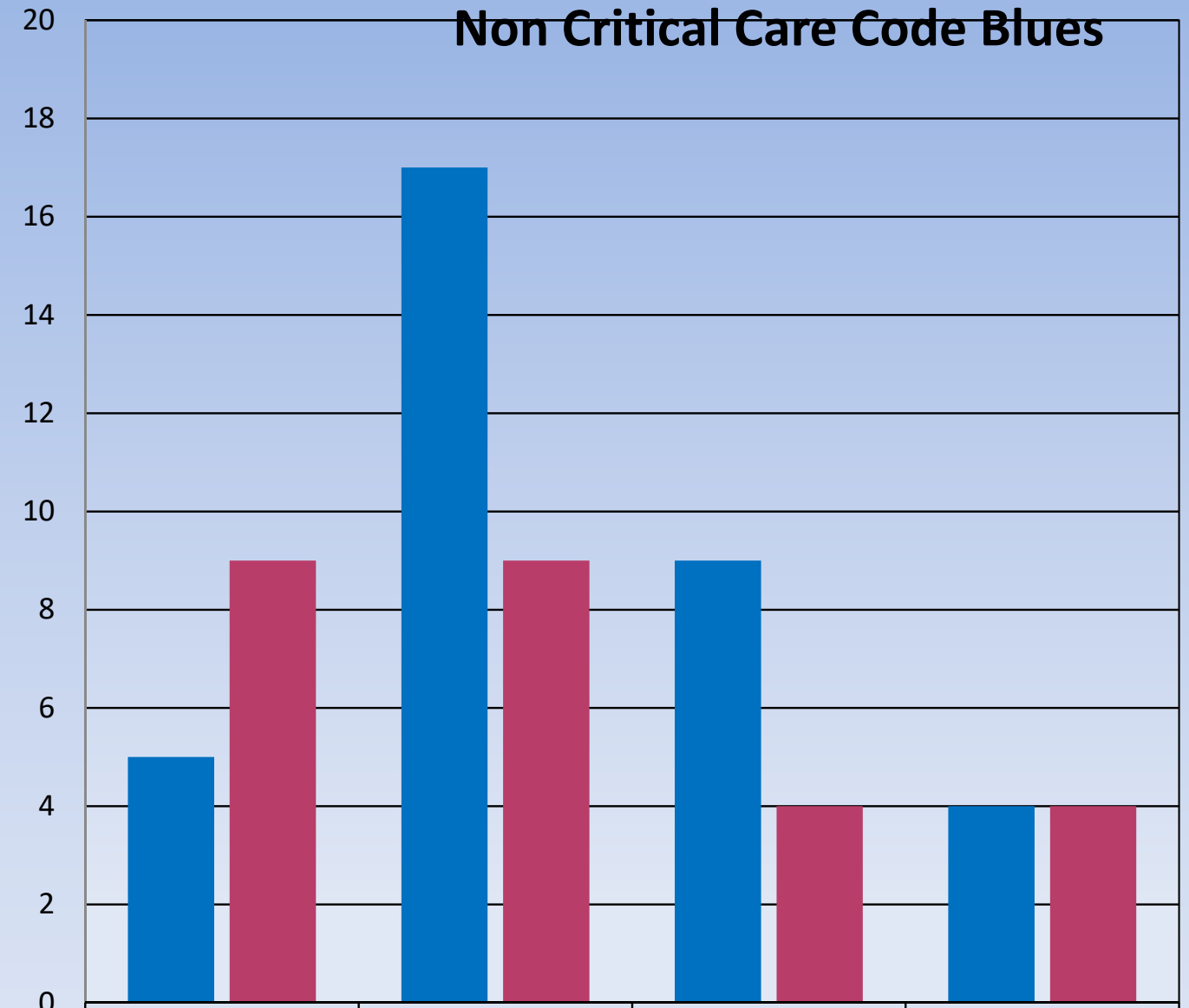
Code Blue Data

Resuscitations (Code Blues) & Rapid Response Team Alerts (RRT's)

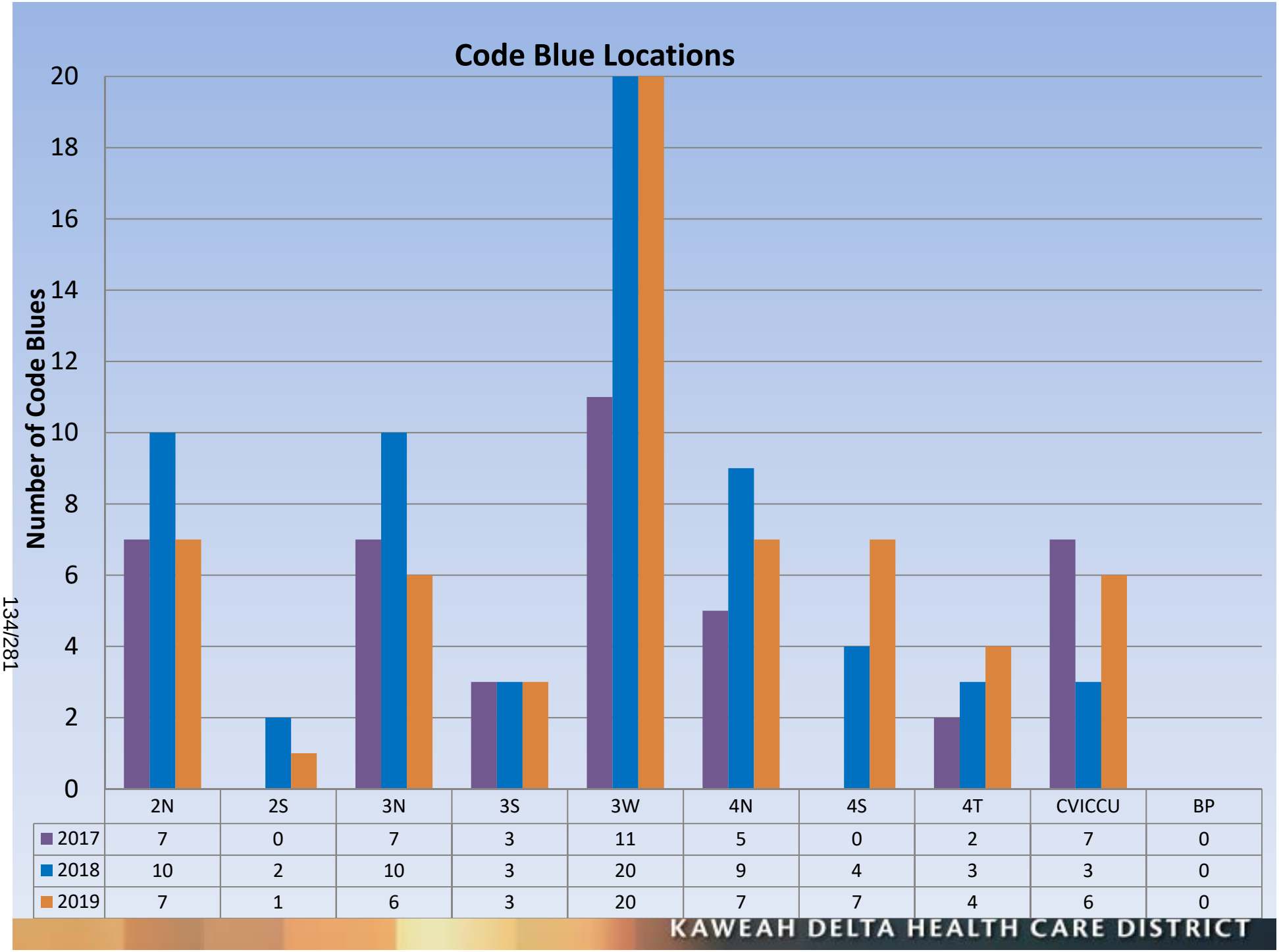


	2015	2016	2017	2018	2019
RRT Rate per 1000 discharges	101.9	83	80	88	78
Code Blue Rate per 1000 discharges	2.8	3.3	2.5	3.6	3.4

Non Critical Care Code Blues

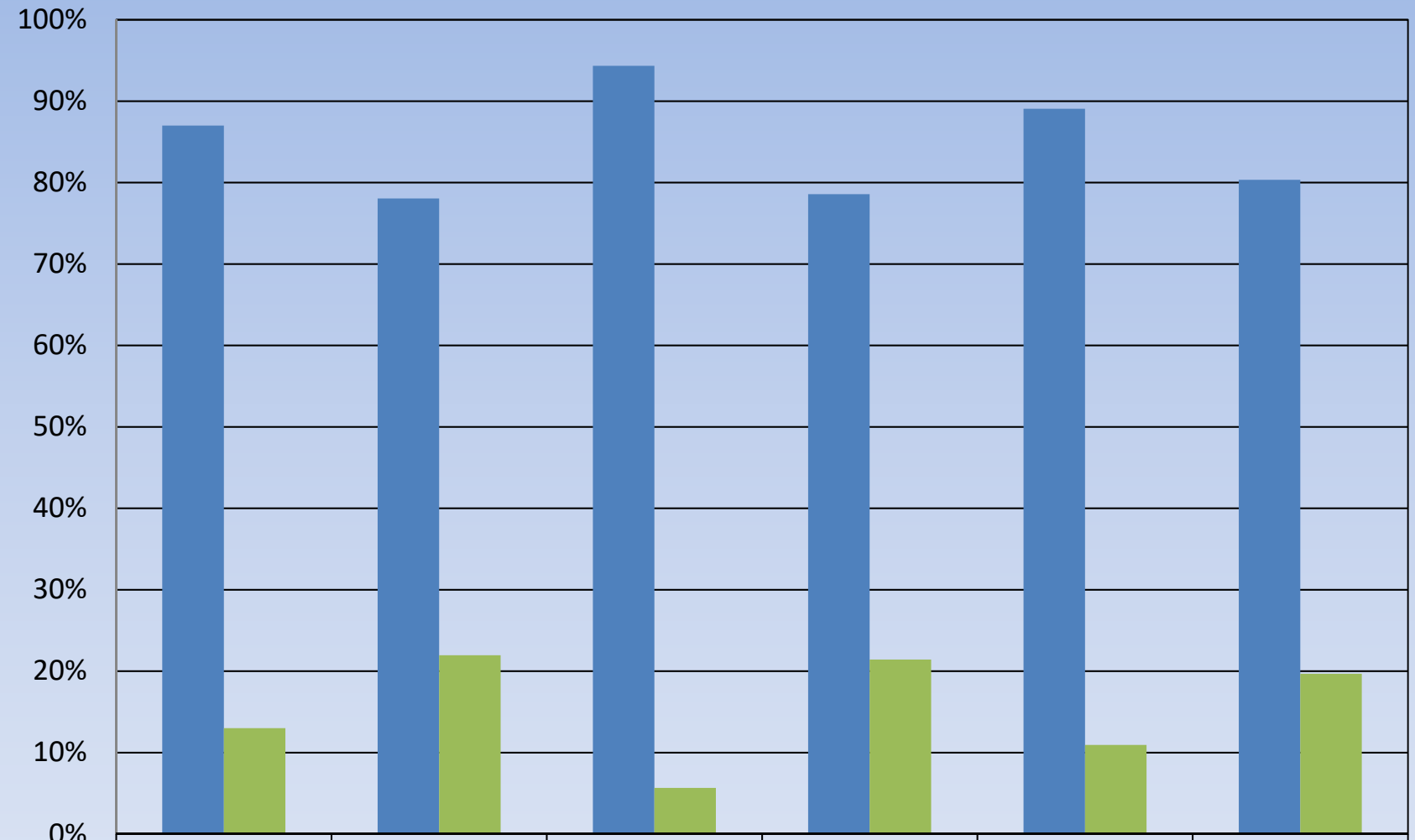


	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Med Surg Code Blue	5	17	9	4
Intermediate Care Code Blue	9	9	4	4



	2N	2S	3N	3S	3W	4N	4S	4T	CVICCU	BP
2017	7	0	7	3	11	5	0	2	7	0
2018	10	2	10	3	20	9	4	3	3	0
2019	7	1	6	3	20	7	7	4	6	0

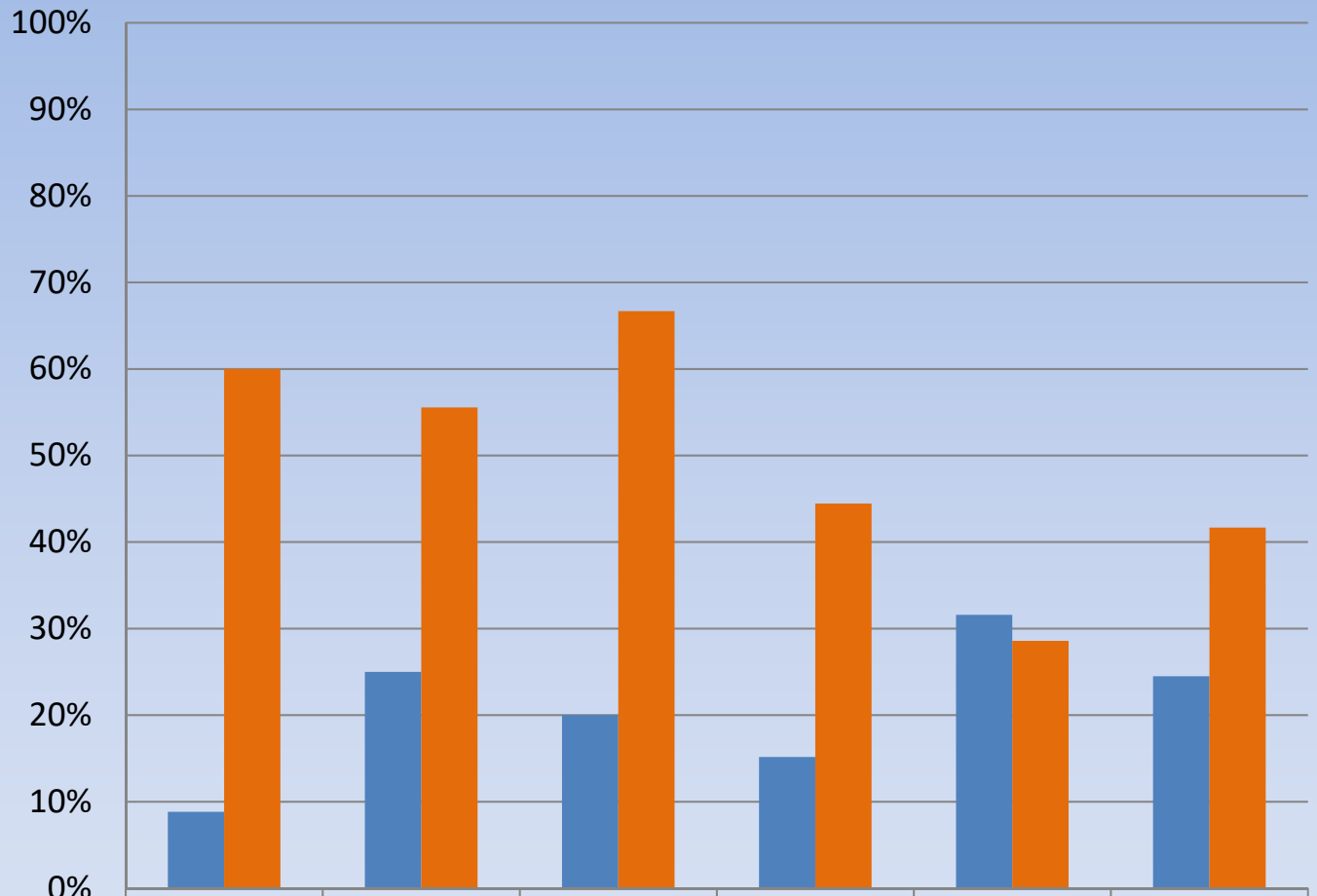
Med Surg- Code Type



	2014	2015	2016	2017	2018	2019
Asystole and PEA	87%	78%	94%	79%	89%	80%
V Fib and V Tac	13%	22%	6%	21%	11%	20%

Med Surg- Shockable vs Non Shockable Codes Survival to Hospital Discharge

AHA Survival Outcomes
Discharged Alive
PEA/A=11.4%
VF/VT= 36.5%

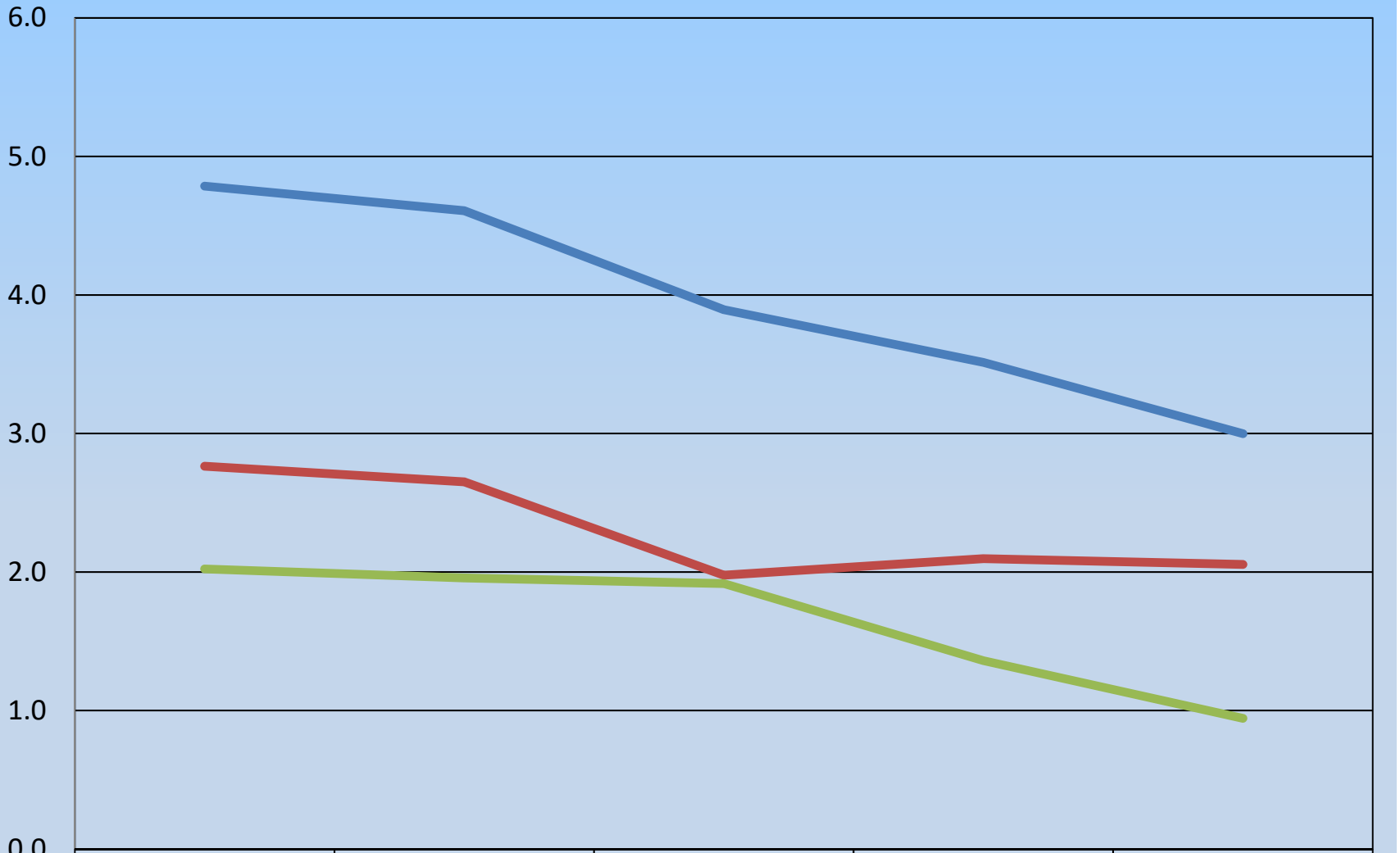


	2014	2015	2016	2017	2018	2019
Asystole and PEA: Survived to Hospital Discharge	9%	25%	20%	15%	32%	24%
Vfib and Vtac: Survived to Hospital Discharge	60%	56%	67%	44%	29%	42%

Critical Care Codes

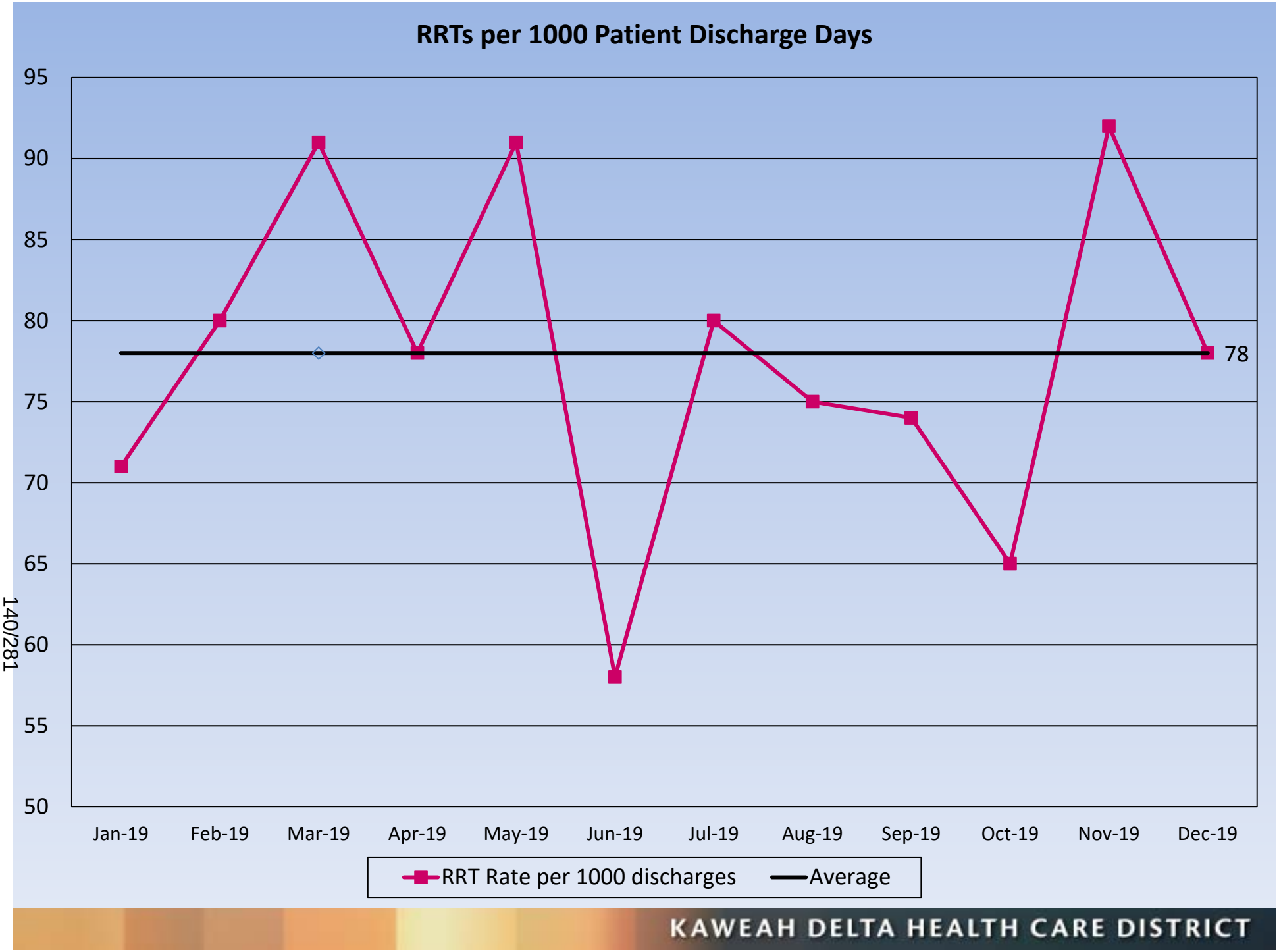
	CVICU & ICU	CVICU	ICU
2015	71	30	41
2016	73	31	42
2017	65	32	33
2018	62	24	37
2019	54	17	37

Code Blues per 1000 discharges for CVICU and ICU



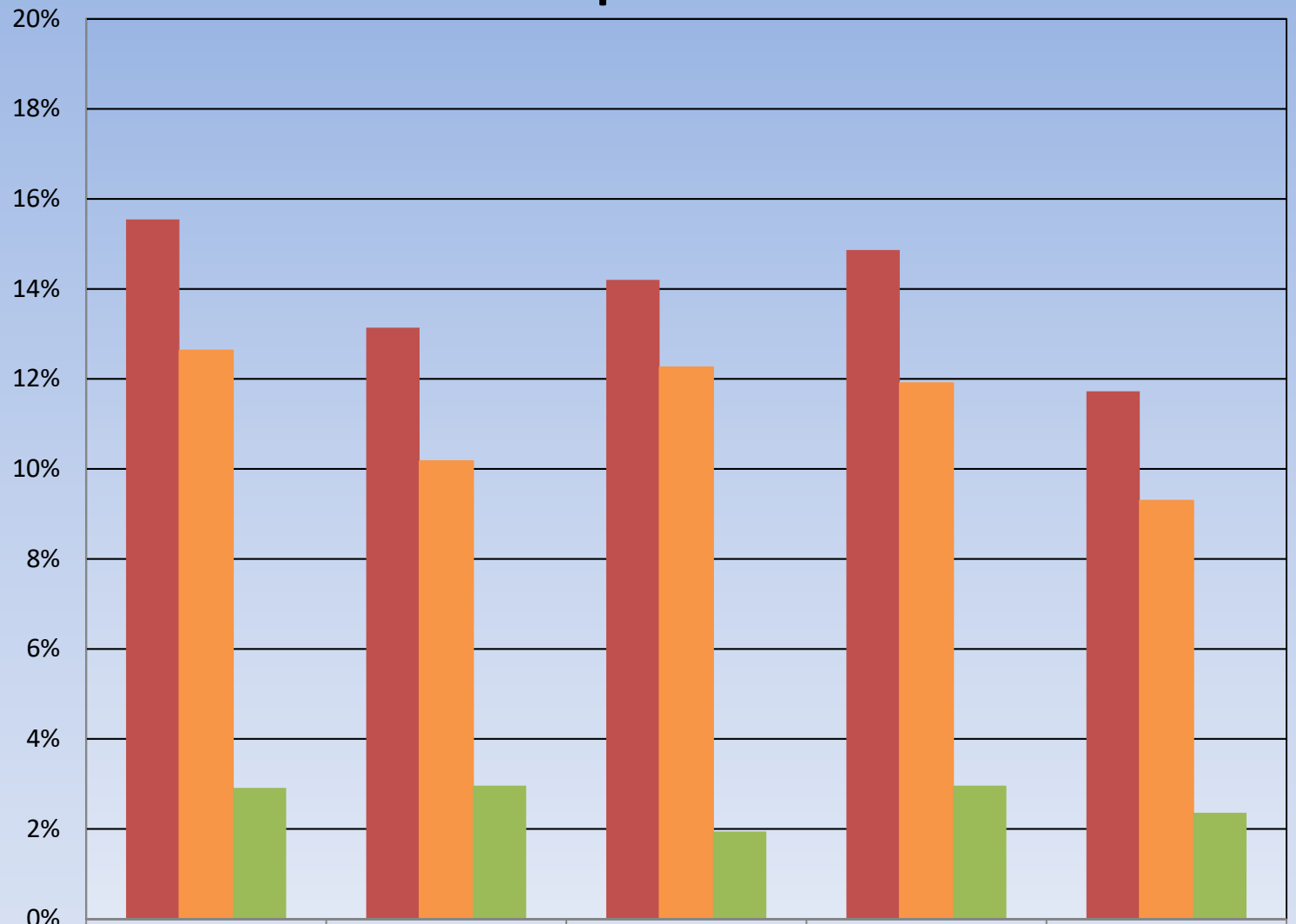
	2015	2016	2017	2018	2019
CVICU & ICU	4.8	4.6	3.9	3.5	3.0
ICU	2.8	2.7	2.0	2.1	2.1
CVICU	2.0	2.0	1.9	1.4	0.9

Rapid Response System Data

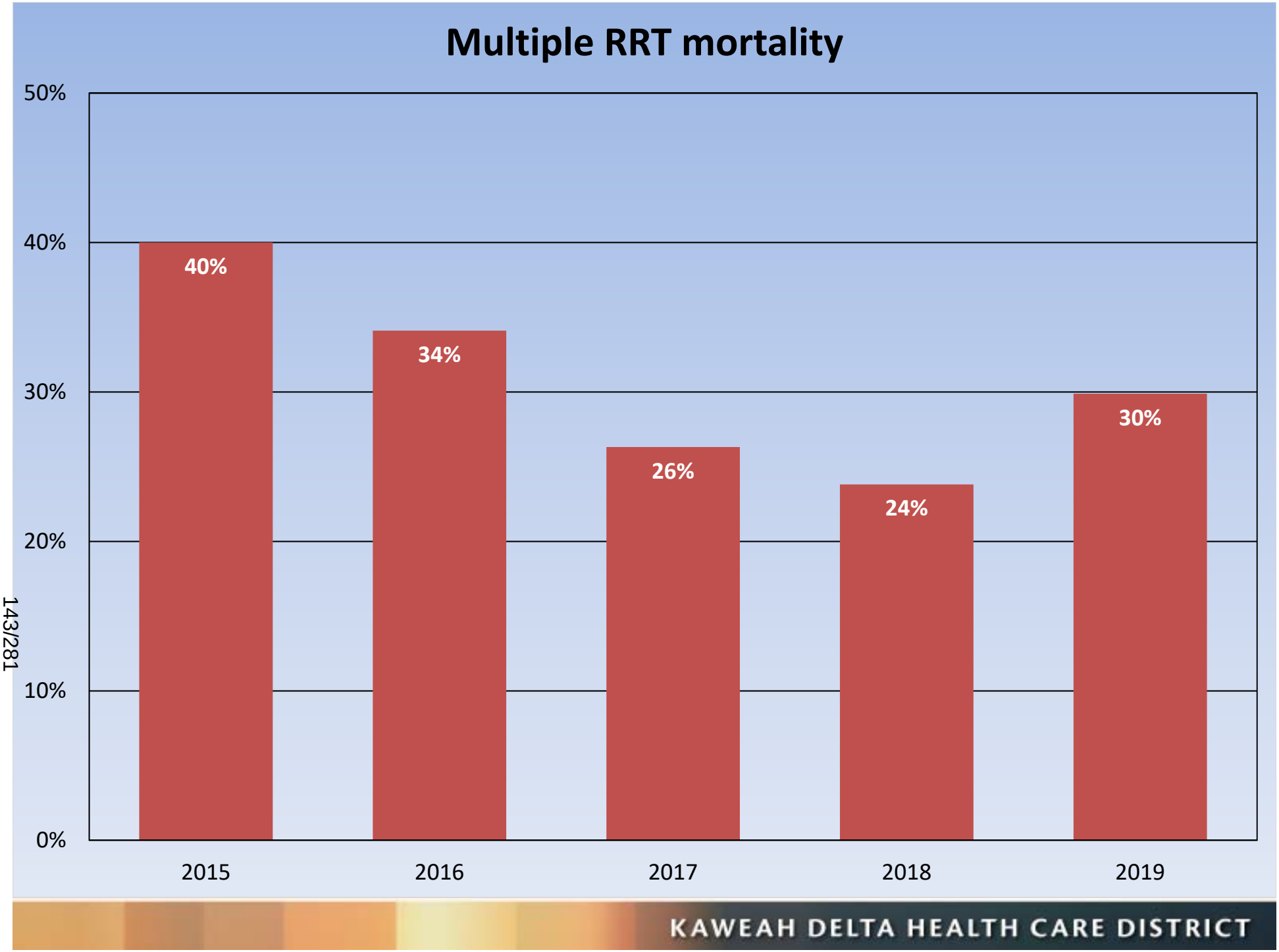

RRTs per 1000 Patient Discharge Days
95
90
85
80
75
70
65
60
55
50
78
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
RRT Rate per 1000 discharges
Average
KAWEAH DELTA HEALTH CARE DISTRICT

Alert Location	Q 1 2019	Q 2 2019	Q 3 2019	Q 4 2019	Totals
KDMC 3W	83	79	64	79	305
KDMC 4S	52	51	57	52	212
KDMC 3S	35	40	36	40	151
KDMC 2N	32	34	33	38	137
KDMC 3N	46	39	33	16	134
KDMC 4N	24	27	36	34	121
KDMC 14	28	30	28	20	106
KDMC 2S	21	17	13	22	73
KDMC CV	14	13	12	20	59
KDMC 1E	14	12	12	11	49
KDMC IC	10	9	9	9	37
KDMC BP	4	4	5	1	14
RRT Tracked Total	363	355	338	342	1398
Labor Triage/ Mother Baby	6	5	4	4	19
KDMC CVOR/Cath lab	7	6	0	5	18
KDMC 2E	3	5	2	5	15
Surgery (Pre/Post op)	3	3	7	2	15
Endoscopy	0	3	1	0	4
KDMC ED	1	2	0	0	3
KDMC CT/radiology	0	1	0	0	1
KDMC Pediatric	0	0	0	0	0
RRT Not Tracked Total	20	25	14	1	60

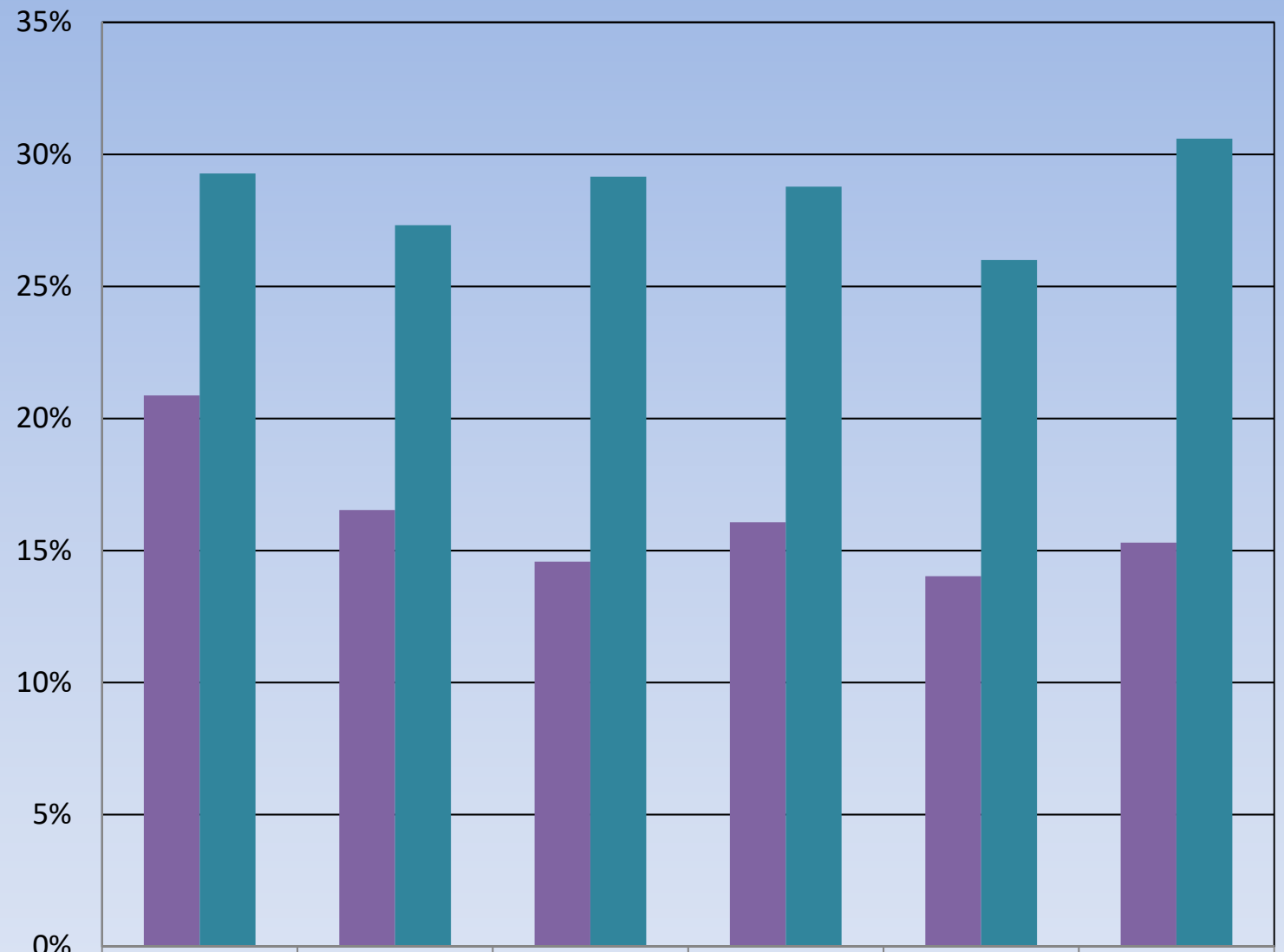
Patients with Multiple RRT's



	2015	2016	2017	2018	2019
Total Number of Multiple RRT's	16%	13%	14%	15%	12%
2 RRT's	13%	10%	12%	12%	9%
3 or more RRT's	3%	3%	2%	3%	2%


Multiple RRT mortality
50%
40%
30%
20%
10%
0%
40%
34%
26%
24%
30%
2015
2016
2017
2018
2019
KAWEAH DELTA HEALTH CARE DISTRICT

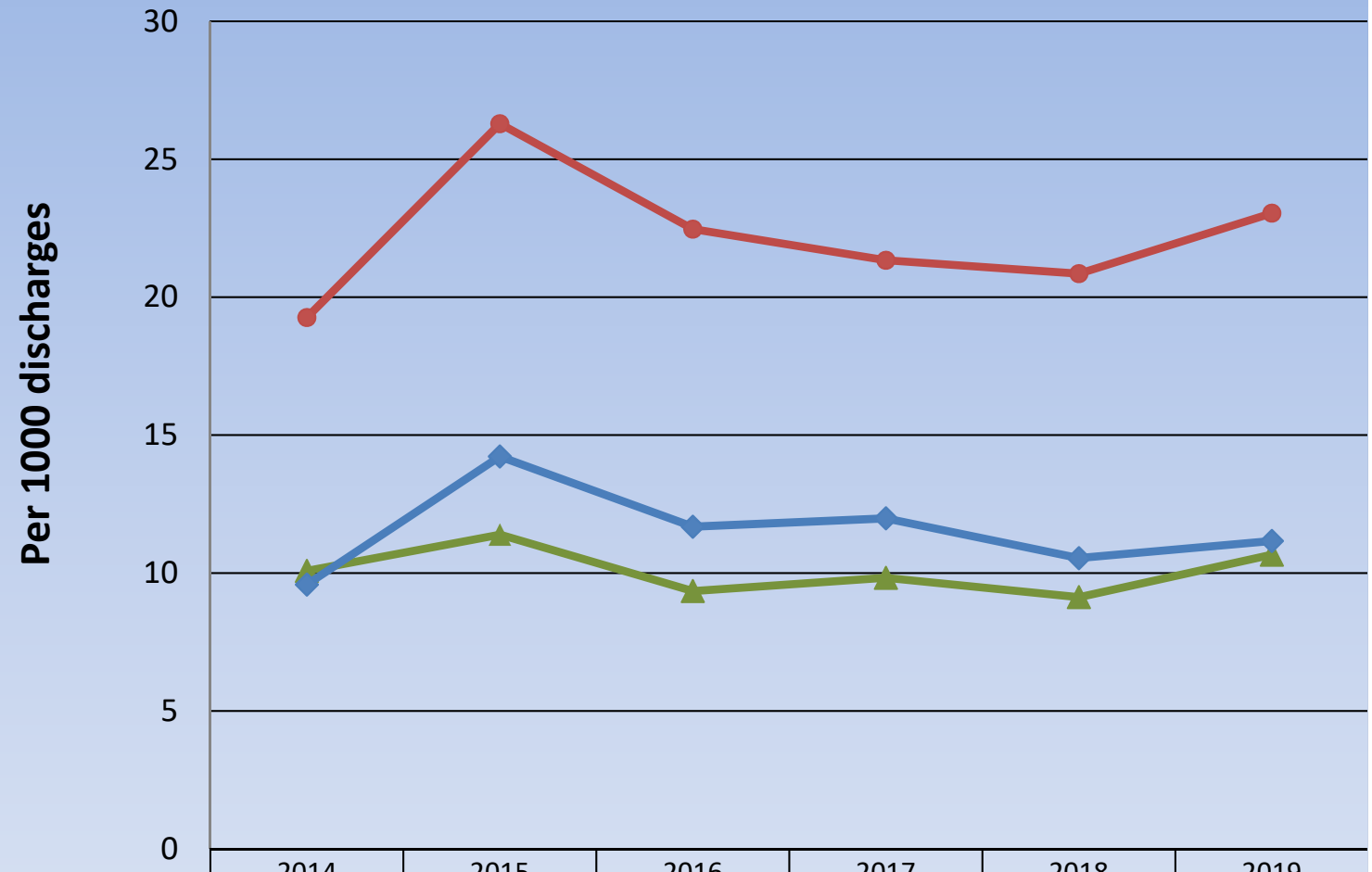
Disposition of RRT



	2014	2015	2016	2017	2018	2019
(%) Transferred to ICU/CVICU	21%	17%	15%	16%	14%	15%
(%) Transferred to ICCU	29%	27%	29%	29%	26%	31%

*1E added 2019

RRTs Admitted from ED within 24 hours

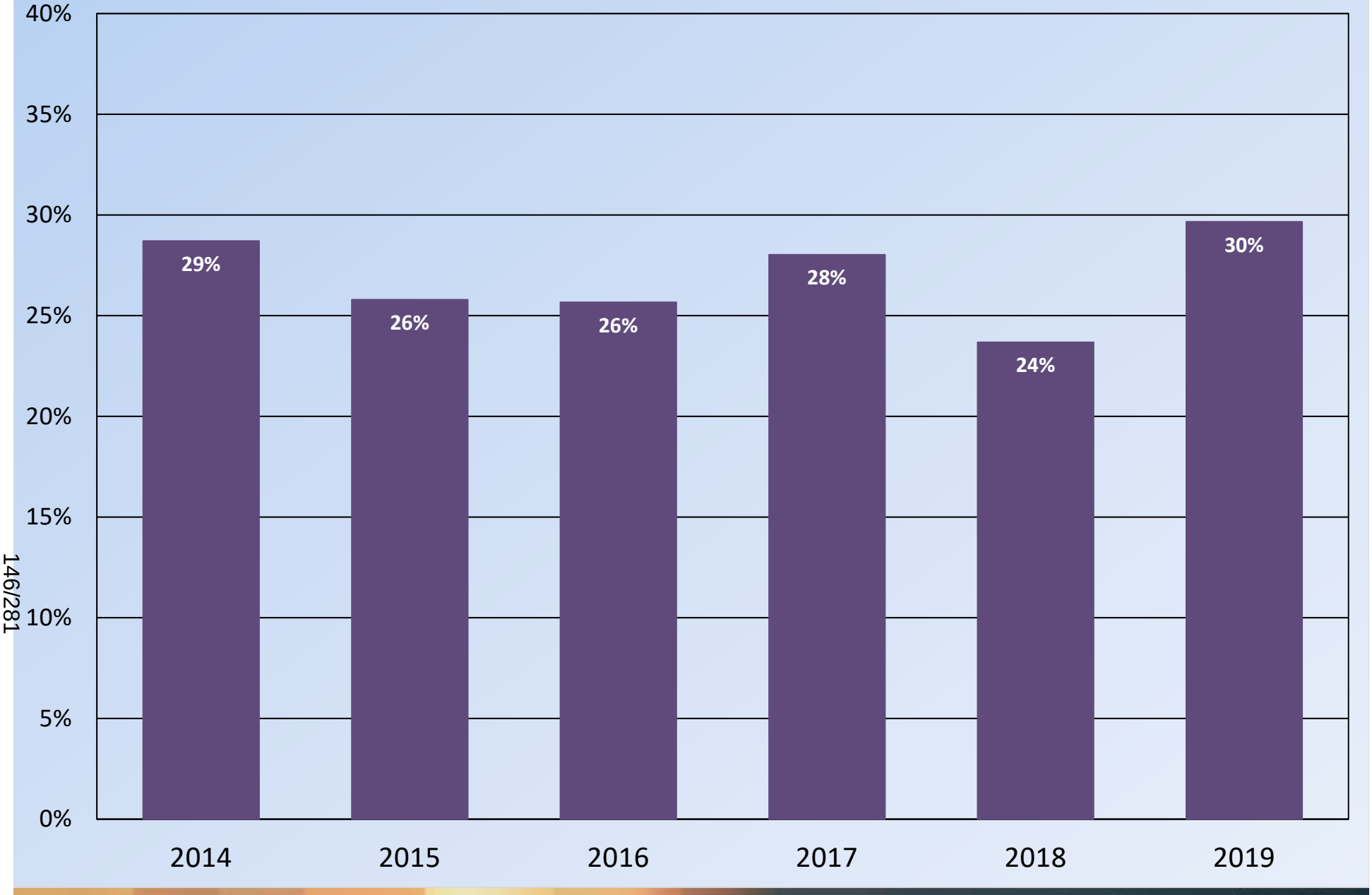


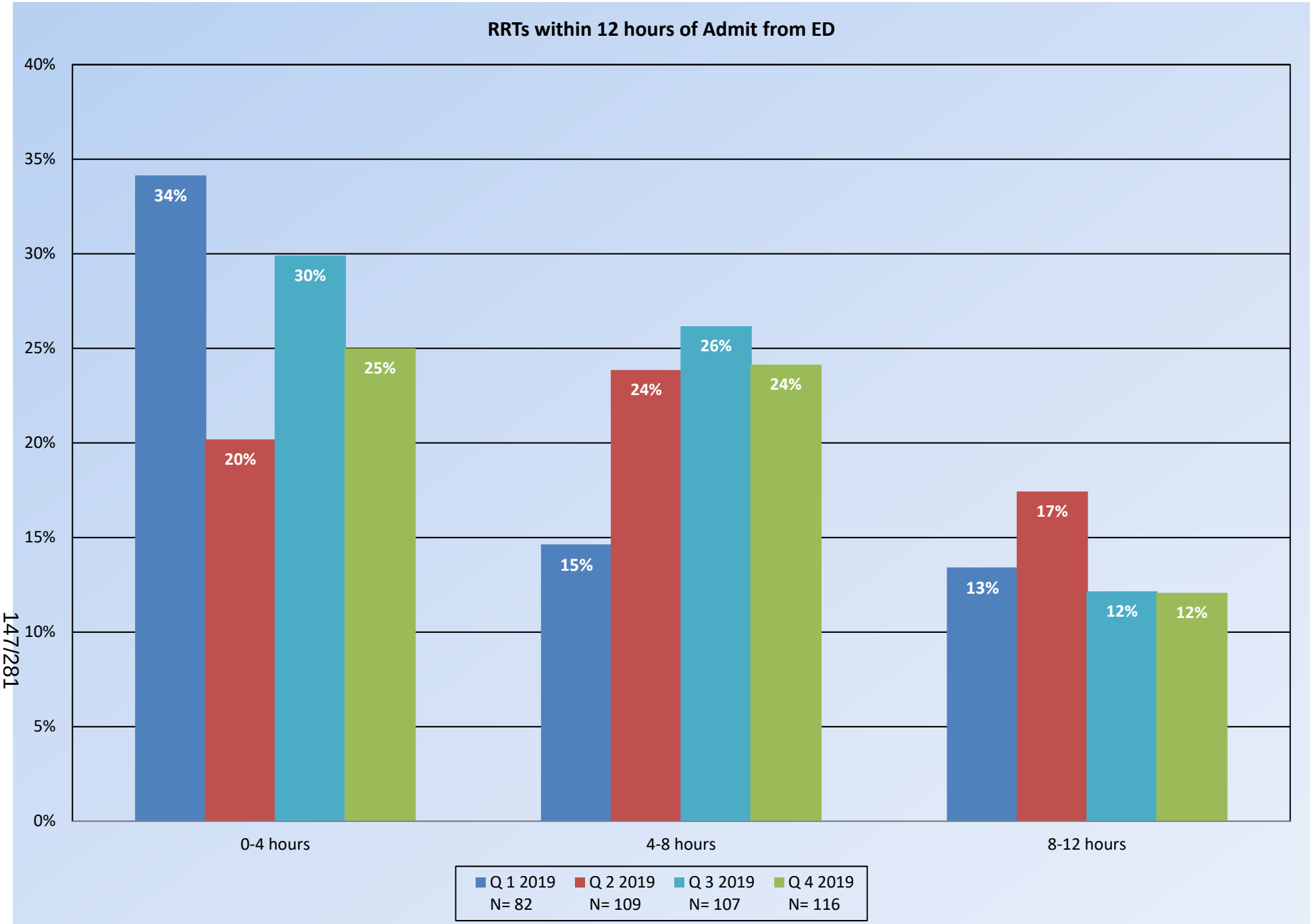
	2014	2015	2016	2017	2018	2019
RRT within 24 hr admit from ED	19	26	22	21	21	23
RRT within 24 hours of admit transferred to (ICU/ICCU)	10	11	9	10	9	11
RRT within 24 hours of admit from ED: Stayed in Room	10	14	12	12	11	11

*1E added 2018

RRTs within 24 hours of Admit from ED

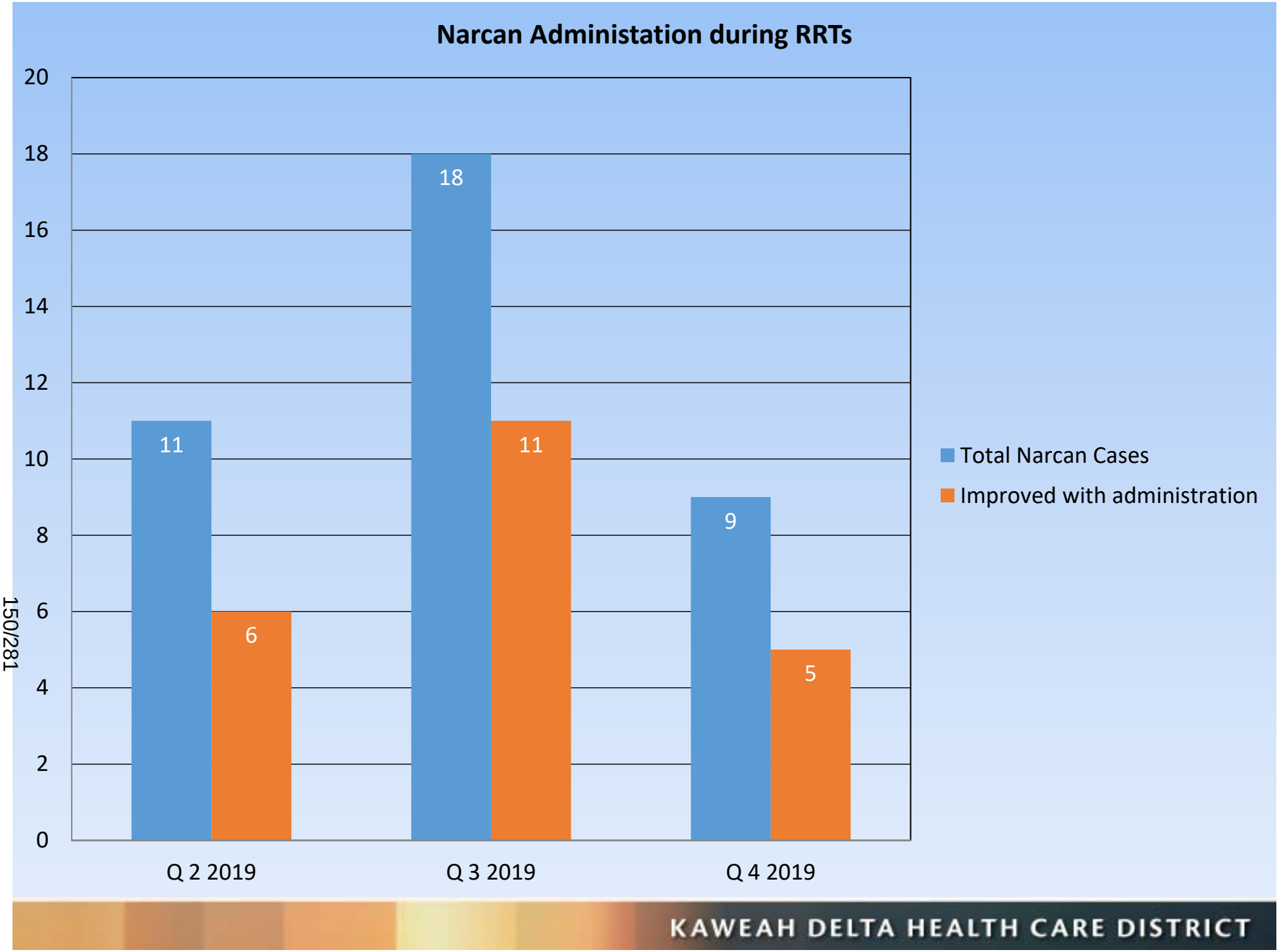
*1E added 2018




RRTs within 12 hours of Admit from ED
40%
35%
30%
25%
20%
15%
10%
5%
0%
34%
20%
30%
25%
15%
24%
26%
24%
13%
17%
12%
12%
0-4 hours
4-8 hours
8-12 hours
Q 1 2019 N= 82
Q 2 2019 N= 109
Q 3 2019 N= 107
Q 4 2019 N= 116

RRTs on 3w	Q 1 2019	Q 2 2019	Q 3 2019	Q 4 2019	Total
Total Number of RRTs on 3w	83	79	63	78	**303**
RRTs on 3w Transferred to Critical care	19	20	15	18	**72**
Multiple RRTs on 3w (Last RRT on 3w)	8	6	3	11	**28**
Multiple RRTs Transferred to critical care	2	4	1	3	**10**
Multiple RRTs Stayed in Room	5	1	2	7	**15**
Multiple RRTs Change in Resuscitation Status	1	1	0	1	**3**

RRTs on 3w within 12 hours after admission from ED	Q 1 2019	Q 2 2019	Q 3 2019	Q 4 2019	Total
Total Count	13	25	25	21	**84**
Transferred to Critical Care	3	8	7	7	**25**
Stayed in Room	10	17	17	14	**58**
Multiple RRT	2	0	2	2	**6**


Narcan Administation during RRTs
20
18
16
14
12
10
8
6
4
2
0
11
6
18
11
9
5
Q 2 2019
Q 3 2019
Q 4 2019
Total Narcan Cases
Improved with administration

Data Going Forward

Measurable Goals	Current Finding (2019)
Reduction in number of cardiac arrest (in-hospital)	135
Reduction in deaths from cardiac arrest	46
Reduction in number of days in ICU post arrest	Currently building report
Reduction in number of days in hospital after arrest	657
Inpatient deaths (in-hospital)	2.197 per 1000 patients

Comparison to Benchmark Studies

- 50% reduction in non-ICU arrests

  Buist MD, Moore GE, Bernard SA, Waxman BP, Anderson JN, Nguyen TV. Effects of a medical emergency team on reduction of incidence of and mortality from unexpected cardiac arrests in hospital: preliminary study. *BMJ*. 2002;324:387-390.

- Reduced post-operative emergency ICU transfers (58%) and deaths (37%)

  Bellomo R, Goldsmith D, Uchino S, et al. Prospective controlled trial of effect of medical emergency team on postoperative morbidity and mortality rates. *Crit Care Med*. 2004;32:916-921.

- Reduction in arrest prior to ICU transfer (4% vs. 30%)

  Goldhill DR, Worthington L, Mulcahy A, Tarling M, Sumner A. The patient-at-risk team: identifying and managing seriously ill ward patients. *Anesthesia*. 1999;54(9):853-860.

- 17% decrease in the incidence of cardiopulmonary arrests (6.5 vs. 5.4 per 1000 admissions)

  DeVita MA, Braithwaite RS, Mahidhara R, Stuart S, Foraida M, Simmons RL. Use of medical emergency team responses to reduce hospital cardiopulmonary arrests. *Qual Saf Health Care*. 2004;13(4):251-254.

10 SOV Data

Identify Time Zero for all in-hospital patients:

- RRT Percent by Category
  - % Did not meet criteria at time of RRT
  - % Indeterminate
  - % Met Criteria up to 48 hours prior to RRT (Time Zero)
- Total % of time the 10 SOV was used promptly to activate an RRT
- RRT Activation Delay to Time Zero in Hours

RAPID RESPONSE NURSE INVOLVEMENT: *SEPSIS ALERTS*

BACKGROUND

- Organization's goal 2019 for severe sepsis: **70% compliance**
- Currently falling below that mark: ~60-65%
- Sepsis coordinator covers 40 hours of 168-hour work week
- Many cases falling on nightshift and weekends

STRATEGIES

- Second sepsis coordinator position created
- Executive team wanting to explore options for “around the clock monitoring”
- Jon Knudsen/rapid response nurses’ gracious assistance (thank you!)
- Realistic expectations

IDEAS For assistance

- Utilization of sepsis order sets
- ***MED Adult Severe Sepsis/Septic Shock*** order set
- Handoff to the primary nurse?
- Checklist similar to an SBAR?

QUESTIONS FOR DISCUSSION?

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: Rapid Response **ProStaff/QIC Report Date: May 11, 2020**

Measures Analyzed:

1. Code Blue Rates/1000 discharges (Slide 3 & 9)
2. RRT Rates/1000 discharges (Slide 3 & 11)
3. Code Blue Classifications of Med Surg and ICCU (Slide 4)
4. Code Blue and RRT by unit location (Slide 5 & 12)
5. Code Blue Classification of Vfib/Vtac to PEA/Asystole; survival to discharge (Slide 6 & 7)
6. Critical Care Code Blue Rates (Slide 8 & 9)
7. Patients with Multiple RRTs (Slide 13)
8. RRT Mortality (Slide 14)
9. RRT Disposition (Slide 15)
10. RRT within 24 hours of admission from the ED (Slide 16 & 17)
11. RRT within 4 hours, 8 hours, and 12 hours of admission from the ED (Slide 18)
12. RRTs on 3w (Slide 19 & 20)
13. Narcan Administration during RRTs (Slide 21)

Date range of data evaluated:

January 2019 to December 2019

Analysis of all measures/data: (See Attachment)

- Med Surg/ ICCU: 2019 code blues have resulted in a decreased incidence of 3.4/1000 discharges; this is a decrease from 2018 of 3.6/1000 discharges.
- Med Surg: code blues have decreased for 2019.
- ICU/CVICU: 2019 code blues are decreased at 3.0/1000 discharges when compared to 2018 with 3.5/1000 discharges.
- Total RRT cases for 2019 resulted in 78/1000 discharges. This is a decrease in RRT cases from year 2018 with 88/1000 discharges.
- 2019 mortality for multiple RRTs cases is 30%. This is an increase compared to 24% in 2018.
- Total RRT cases for 2019 resulted in 30% being called within the first 24 hours of admission from the ED with the majority occurring in the first 4 hours. This is the highest recorded percentage since 2014.
- The committee was interested in monitoring RRT cases on 3w for 2019. Trends were not identified at this time.
- The committee was interested in monitoring RRT cases with narcan adminstration for 2019. Trends were not identified at this time.

Next Steps/Recommendations/Outcomes:

1. The medical director role has been filled by Dr. Tang in January 2020. Under his leadership the following quality improvement projects have been started.
    a. RRT nurses are attending quality improvement committees to increase RRT presence and participation in quality initiatives.
    b. Formalization of processes and role definition of each member of the RRT team. We are developing checklists to ensure consistency with practice.
    c. Formalization of RRT handoff after a rapid response and utilizing a physician communication handoff tool.
    d. ICU step-down and downgrade rounding protocols. This process includes checking for SIRS criteria, lab work, rounding on previous RRT patients, and following up with the nursing staff caring for the patient to ensure patients are continuing to improve clinically.
    e. Improve early identification. Educational opportunities for our bedside nurses and ensuring the information taught during the orientation process for newly hired nurses and care providers are accurate and that it relays the urgency of our cause.
    f. Formalization of family activated of RRT process.
2. The committee continues to evaluate the cause for a decrease in the number of code blues and RRTs.
3. The committee continues to evaluate the cause of RRT cases within the first 24 hours after admit from ED.
4. The committee plans to compare our 2020 data to the following benchmark studies after implementation of our quality improvement projects.
    a. Reduction in number of cardiac arrest (in-hospital)
    b. Reduction in deaths from cardiac arrest
    c. Reduction in number of days in ICU post arrest
    d. Reduction in number of days in hospital after arrest
    e. Inpatient deaths

Submitted by Name:
Dr. Tang
Linde Swanson
Jeanette Callison
Jon Knudsen
Eileen Paul

Date Submitted:
5/11/2020

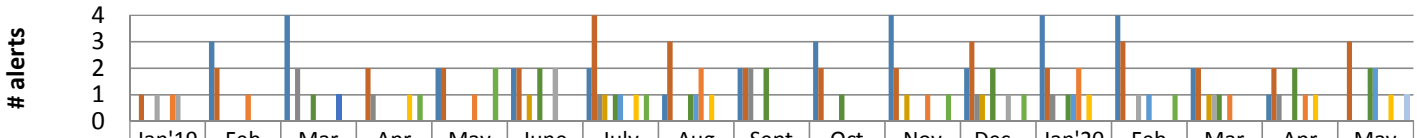
Stroke Program Dashboard 2019/20

	GWTG Bench-marks	2019 Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	2020 Jan	Feb	March	April
Grouping of Stroke Patients																	
Ischemic		30	42	39	43	36	41	31	33	32	50	40	43	39	42	38	23
Hemorrhagic		4	10	10	9	7	8	2	13	8	10	11	6	8	6	5	7
TIA (in-patient and observation)		20	28	35	25	24	22	36	36	19	29	42	28	33	44	29	24
Transfers to Higher Level of Care (Ischemic)		2	2	3	3	2	1	2	4	4	3	0	1	1	2	3	3
Transfers to Higher Level of Care (Hemorrhagic)		1	1	2	1	1	1	1	2	1	4	1	1	1	1	1	1
% of Alteplase - Inpatient & Transfers		16%	14%	14%	13%	18%	21%	6%	14%	6%	11%	15%	11%	20%	14%	10%	8%
Total # of Pts who rec'd Alteplase (Admitted Patients)		4	4	4	4	5	8	2	2	1	3	6	4	7	5	3	1
Total # of Pts who rec'd Alteplase (& Transferred Out)		1	2	2	2	2	1	0	3	1	3	0	1	1	1	1	1
TOTAL NUMBER OF PATIENTS		57	83	89	81	70	73	72	88	64	96	94	79	82	95	72	58
Rate of hemorrhagic complications for Alteplase pts	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% Appropriate vital sign monitoring post Alteplase	90%	50%	50%	57%	66%	71%	67%	75%	100%	50%	80%	83%	67%	75%	75%	100%	50%
Core Measure: OP-23 Head CT/MRI Results	72%	NA	50%	100%	100%	33%	66%	0%	0%	75%	75%	100%	50%	100%	NA	0%	100%
% tPA Arrive by 2 Hrs; Treat by 3 Hrs. (GWTG)	85%	100%	100%	83%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	80%	NA	50%
STK-5 Early Antithrombotics by end of day 2 (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	96%	92%	93%	97%	100%
STK-1 VTE (GWTG, TJC)	85%	100%	100%	100%	100%	100%	100%	100%	100%	97%	93%	95%	98%	100%	100%	95%	100%
STK-2 Discharged on Antithrombotic (GWTG, TJC)	85%	100%	97%	100%	98%	98%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-3 Anticoag for afib/aflutter ordered at Dc (GWTG, TJC)	85%	80%	89%	100%	100%	100%	100%	100%	100%	100%	100%	90%	89%	100%	89%	100%	100%
% Smoking Cessation (GWTG)	85%	100%	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	100%
STK-6 Discharged on Statin (GWTG, TJC)	85%	100%	100%	100%	100%	98%	96%	92%	94%	94%	98%	100%	100%	100%	98%	100%	100%
% Dysphagia Screen prior to po intake (GWTG)	75%	100%	93%	94%	88%	88%	98%	94%	92%	92%	96%	96%	96%	85%	85%	91%	90%
STK-8 Stroke Education (GWTG, TJC)	75%	88%	91%	84%	89%	93%	92%	100%	92%	96%	100%	100%	100%	93%	97%	94%	100%
STK-10 Assessed for Rehab (GWTG, TJC)	75%	97%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
STK-4 Alteplase Given within 60 min (GWTG, TJC)	75%	100%	25%	25%	100%	100%	100%	NA	50%	100%	100%	100%	NA	100%	100%	100%	NA
% LDL Documented (GWTG)	75%	92%	88%	100%	96%	94%	96%	98%	88%	97%	93%	98%	92%	91%	84%	96%	100%
Intensive Statin Therapy (GWTG)	75%	91%	82%	90%	89%	91%	80%	90%	88%	91%	96%	93%	94%	94%	91%	88%	88%
% tPA Arrive by 3.5 Hrs; Treat by 4.5 Hrs (GWTG)	75%	100%	80%	86%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	59%
% NIHSS Reported (GWTG)	75%	97%	98%	97%	100%	97%	100%	100%	95%	97%	96%	97%	98%	100%	93%	92%	100%
% Appropriate stroke order set used (In-Patient)	90%	90%	97%	97%	94%	93%	90%	95%	96%	99%	95%	87%	84%	95%	97%	99%	97%
% Appropriate stroke order set used (ED)	90%	85%	92%	90%	92%	94%	93%	93%	94%	88%	88%	84%	87%	94%	92%	88%	89%
LOS Hemorrhagic (Mean)		13.5	10.8	6.86	13.88	4	4.38	3	7.5	5	16.5	10.36	5.53	4.8	4	9	5.5
LOS Ischemic (Mean)		5.61	6.42	4.94	5.21	6.72	4.95	4.5	5.25	4.32	5.08	4.25	3.14	5	5.08	5.27	3.41

2019-2020

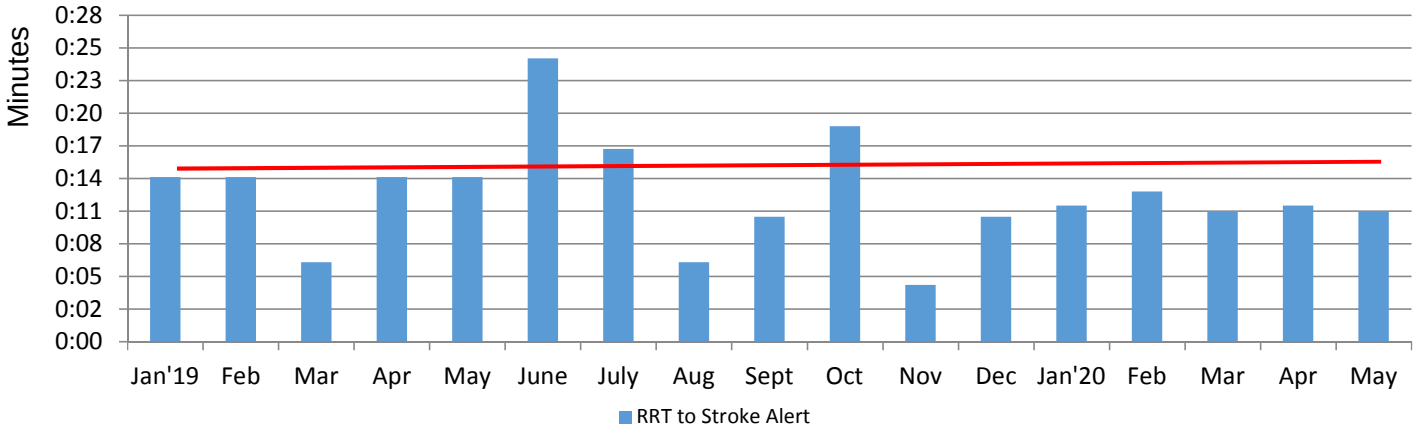
In-House Stroke Alert Dashboard

Stroke Alert Location



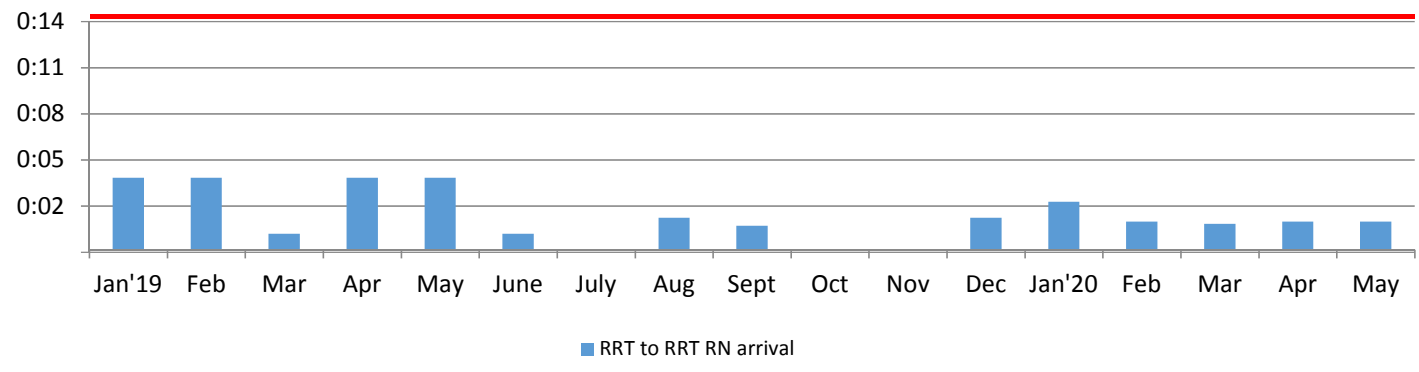
	Jan'19	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan'20	Feb	Mar	Apr	May
3W		3	4		2	2	2	1	2	3	6	2	4	4	2	1	
4S	1	2		2	2	2	4	3	2	2	2	3	2	3	2	2	3
2S			2	1			1		2			1	1			1	
3S						1	1				1	1			1		
Cath Lab	1								0					1	1		
CVICU			1			2	1	1	2	1		2	1		1	2	2
ICU							1	1	0				1	1			2
4N	1	1			1			2			1		2		1	1	
3N	1					2			0			1					
4T				1			1	1	0				1			1	1
PACU			1														
2N				1	2		1				1	1		1			
5T																	1

RRT to Stroke Alert



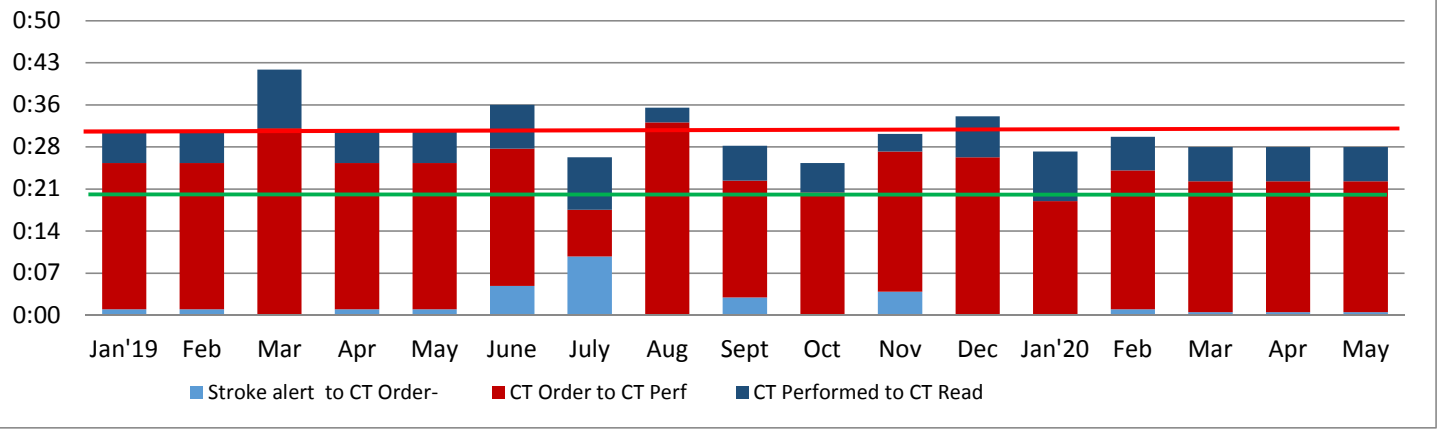
If patients exhibit any new or worsening neuro deficits while in the hospital; RNs are to call an RRT. The RRT RN will evaluate and determine if a stroke alert should be called. The goal from calling RRT to stroke alerts should be <15 minutes.

RRT to RRT RN arrival

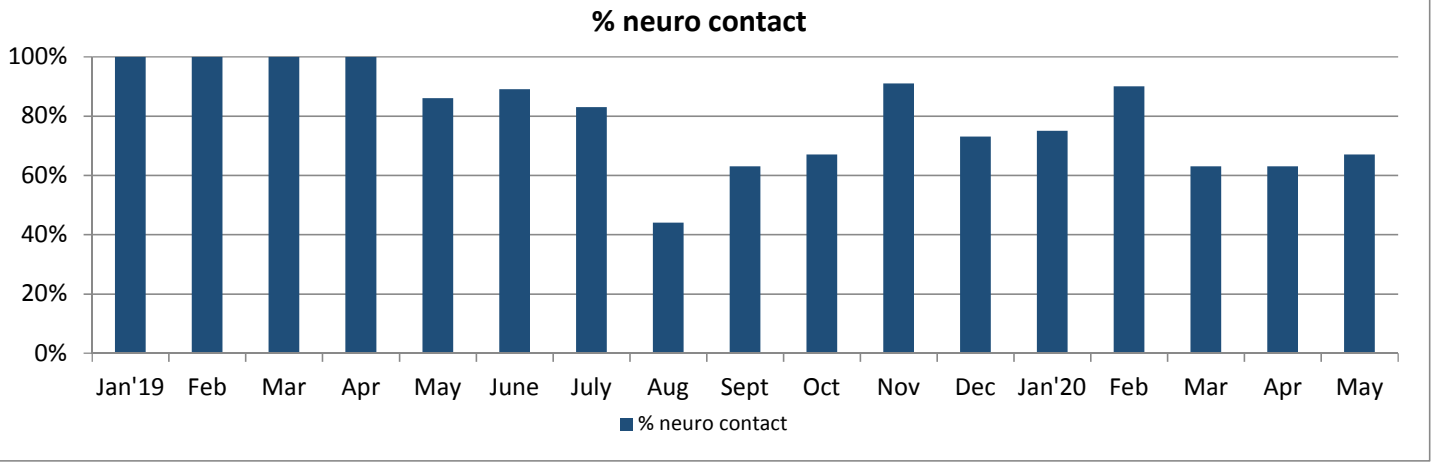


TJC expectation is that a designated provider is at the bedside within 15 minutes of stroke alert. KDH has designated the RRT RN as the provider for in-house stroke alerts.

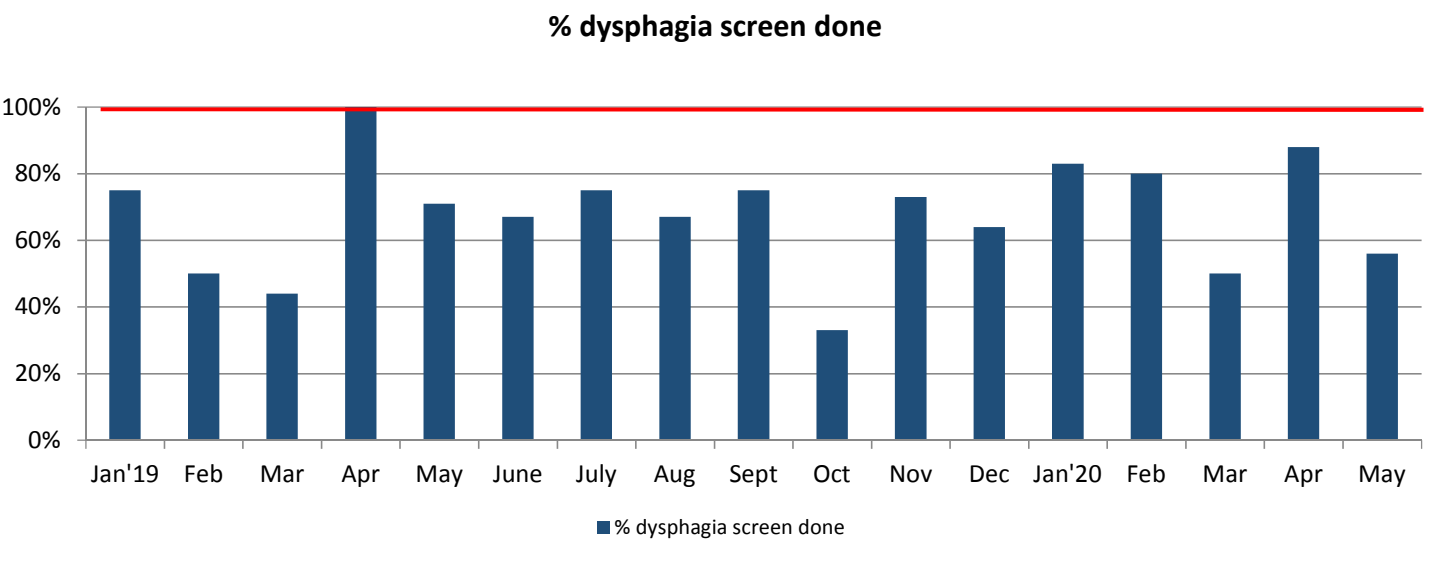
2019-2020
In-House Stroke Alert Dashboard



TJC expectation is that the CT will be read within 45 minutes of arrival. KDH's goal is 30 minutes **(red line).** TJC added a new metric in 2018; the expectation is that the CT will be performed within 20 minutes of alert **(green line).**



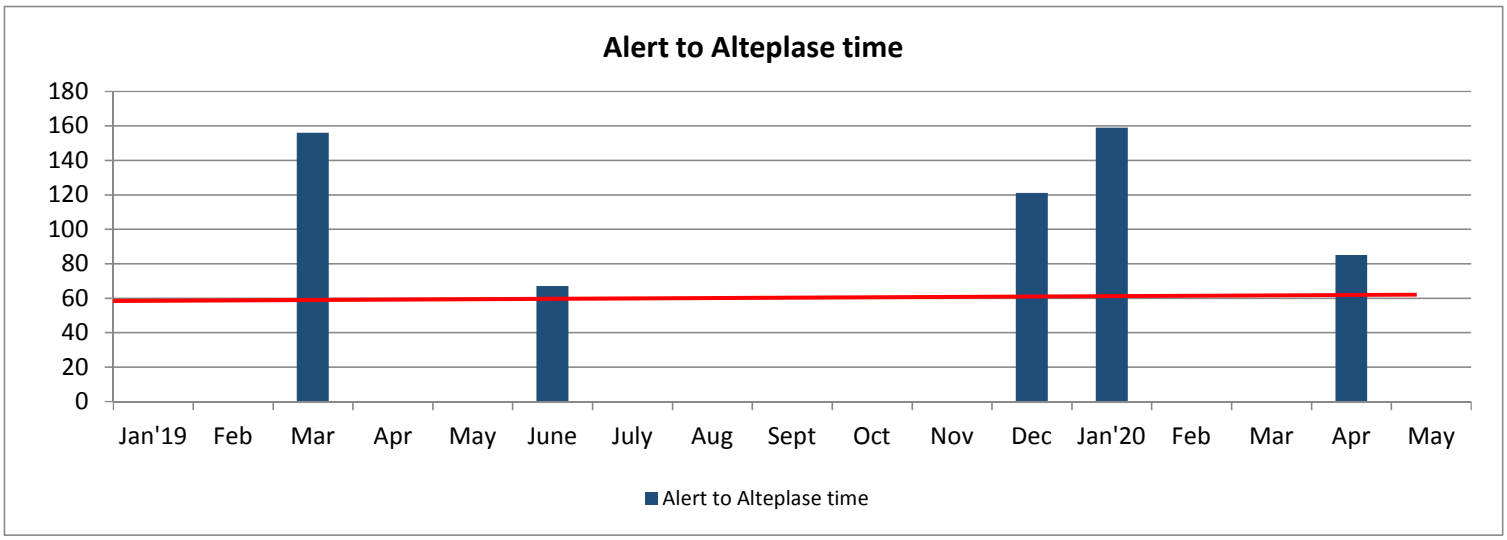
Neurology consultation should occur on all in-house stroke alerts.



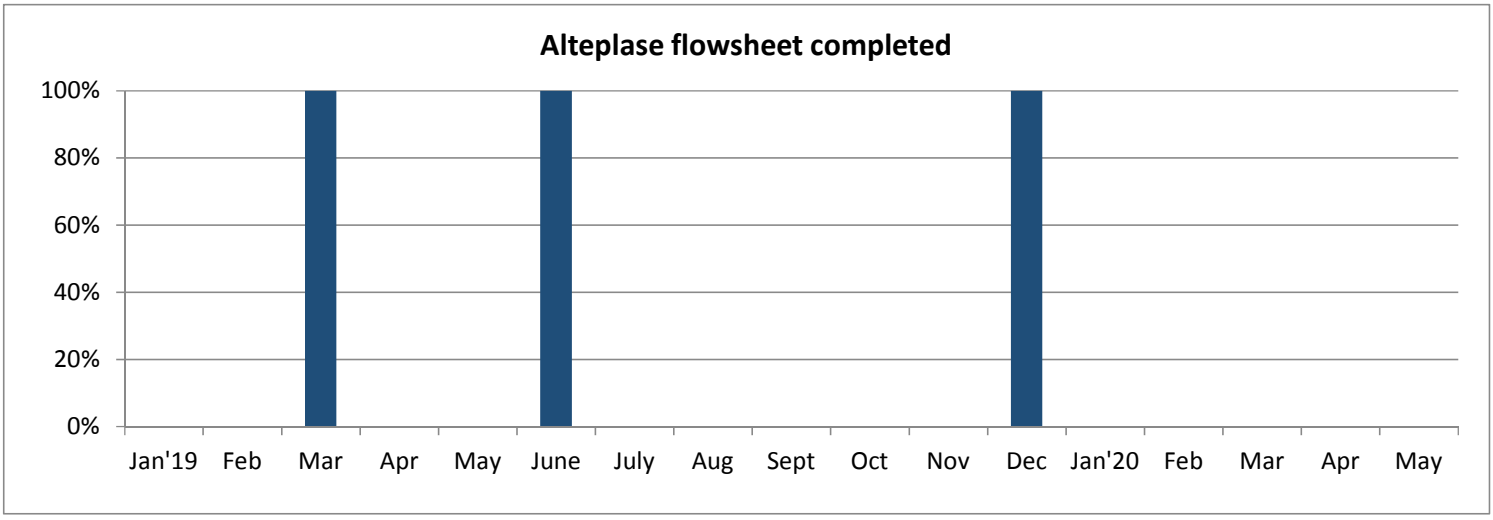
Whenever there are new or worsening neurological deficits ≥3 points, the RN should perform a dysphagia screen to evaluate the patient's ability to swallow.

2019-2020

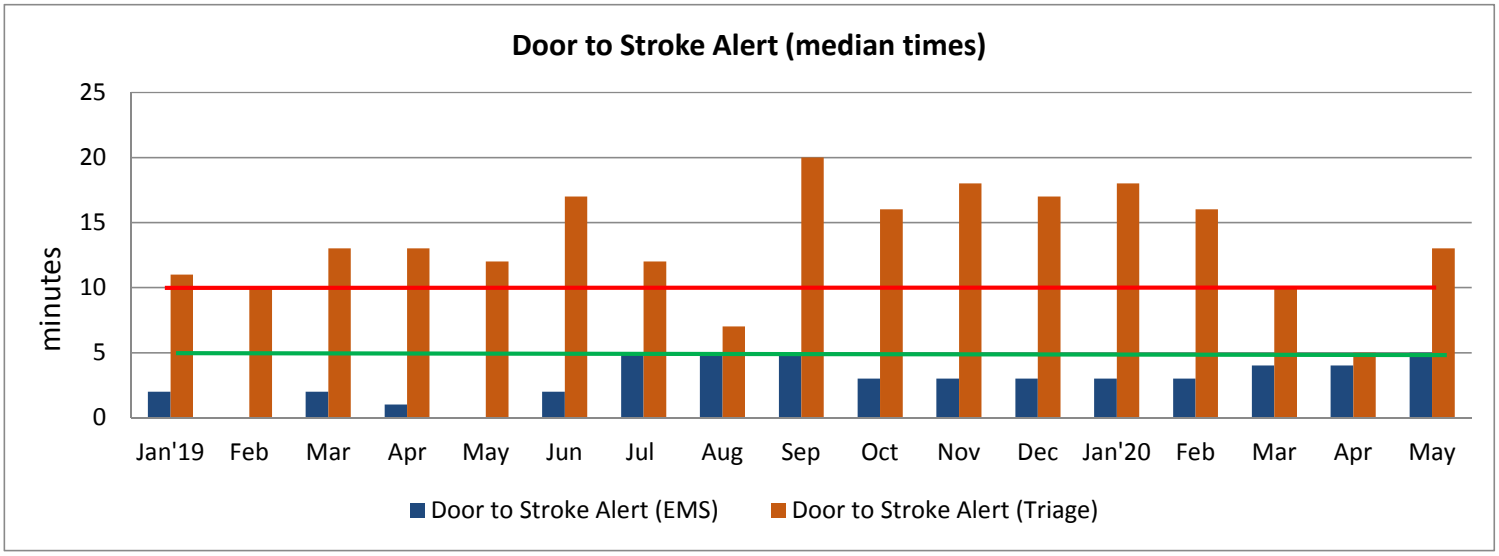
In-House Stroke Alert Dashboard



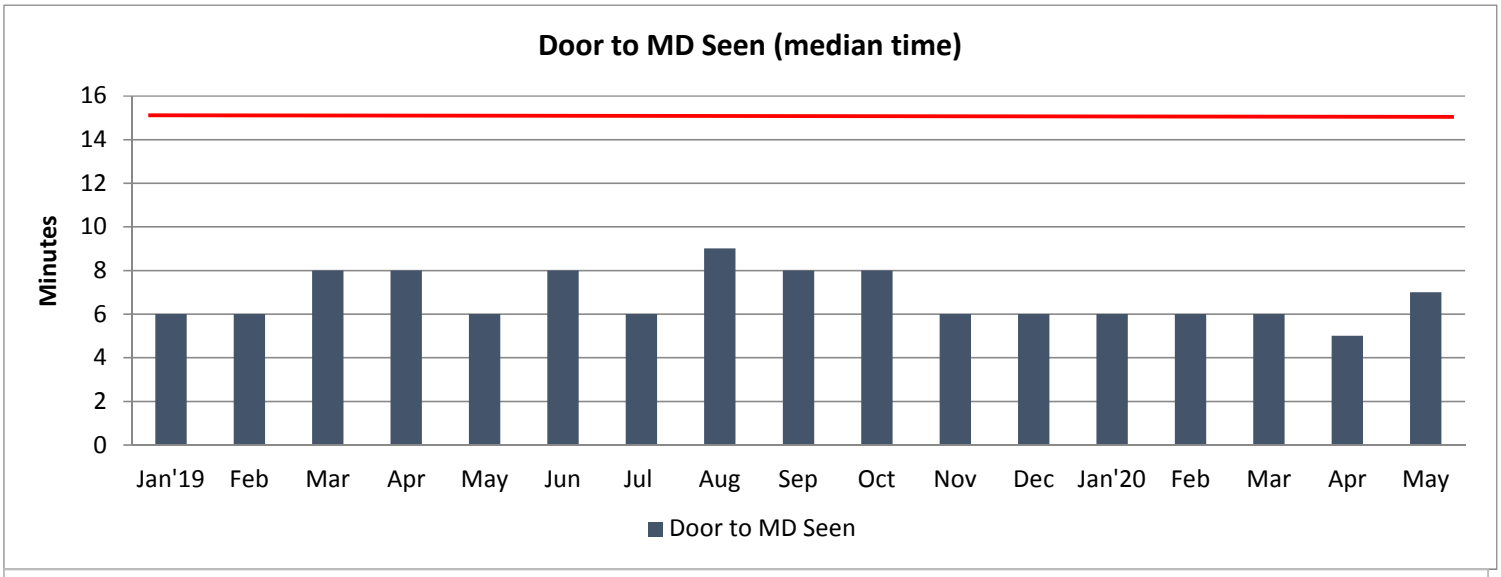
ED Patients: TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. In-House Stroke alerts: KDH expectation is that IV thrombolytics are given within 60 minutes to eligible patients who have been identified with new or worsening stroke symptoms



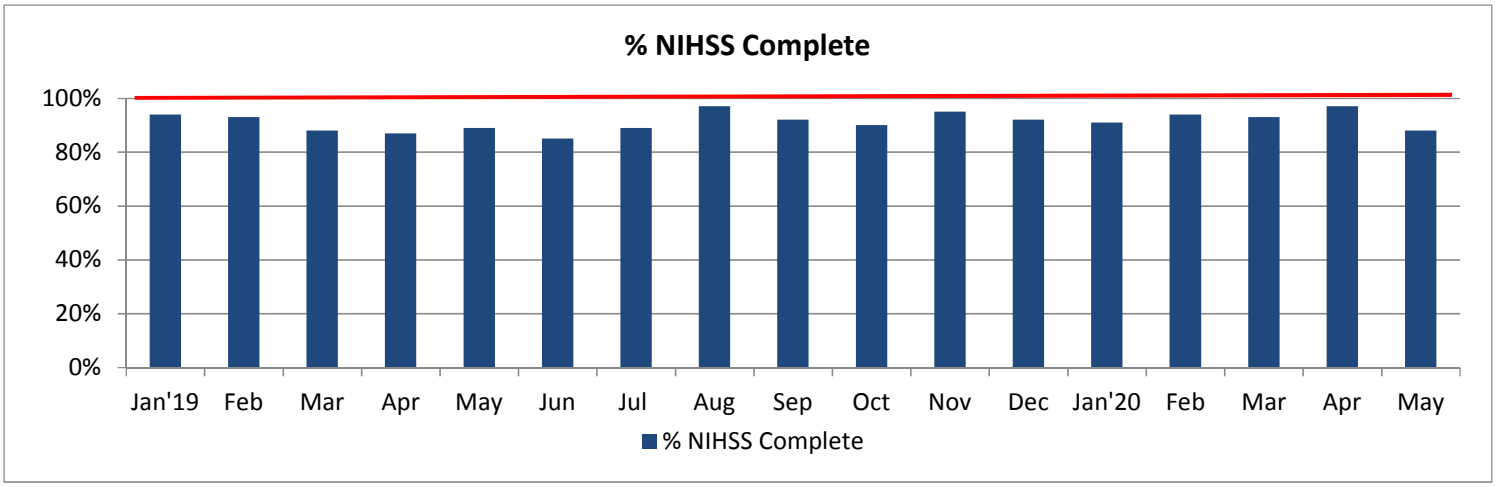
2019-2020 Stroke Alert Dashboard



Per KDH ED Stroke Alert process; stroke alerts to be called within 5 min for EMS and 10 min for Triage. ED Stroke Alert Triage task force convened to look for opportunities for improvement March 2020.



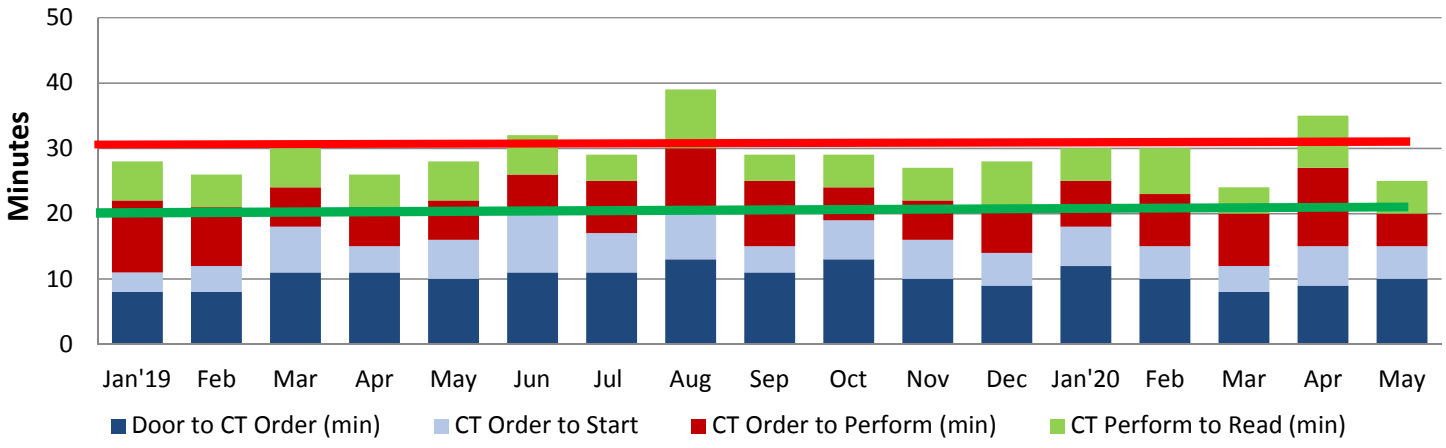
The expectation is that the physician will see the stroke alert patient within 15 minutes of arrival. Improvements made throughout the past year include: early notification from EMS, MD meets the pt at the door upon arrival, scribe documents first seen time in the record.



The expectation is that all stroke alert patients will have a NIHSS completed by a certified ED staff member and/or the attending physician; the primary responsible person is the attending/resident physician.

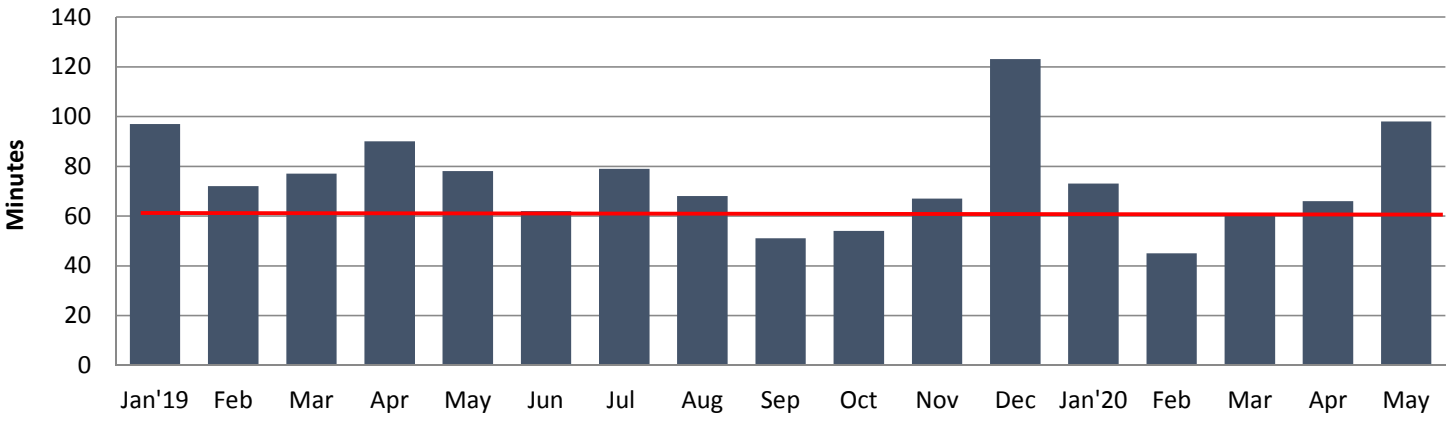
2019-2020 Stroke Alert Dashboard

Door to CT Times (median times)



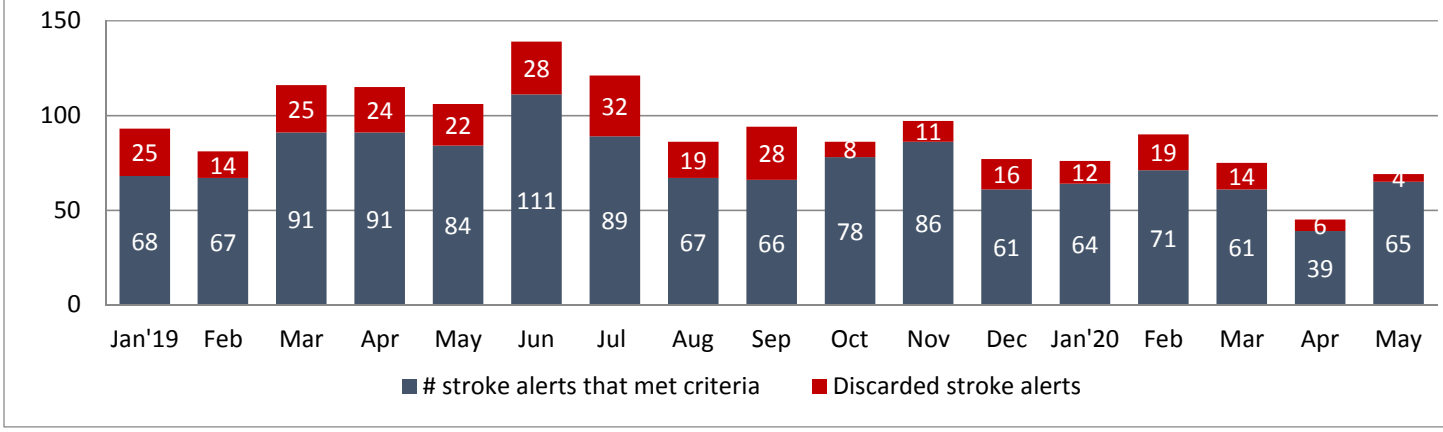
CMS and TJC expectation is that the CT will be performed by 20 minutes and read by 45 minutes of arrival. KDH's CT read time goal is 30 minutes. Starting 2019; tracking of CT start times will be included in this measurement. start time is define by the first CT images in Synapse.

Door to Alteplase (median time)



The data in this graph includes all Alteplase patients, no exclusion criteria. TJC expectation is that IV thrombolytics are given within 60 minutes to eligible patients who present for stroke care at least 50% of the time. 2019 AHA/ASA has set new IV thrombolytic goal time to 45 minutes at least 75% of the time. To meet this goal, changes to the stroke alert process <4 hours have been made.

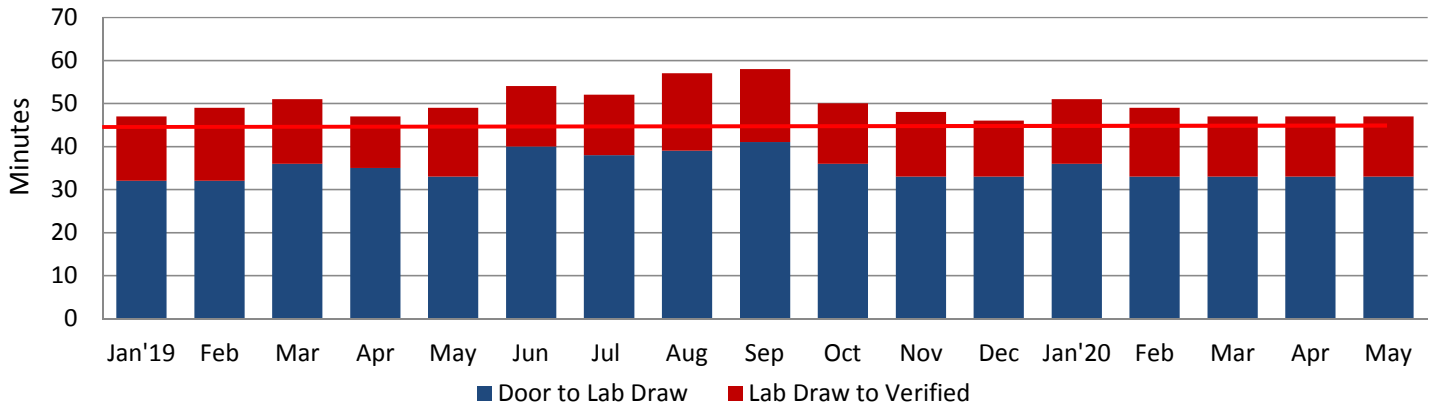
ED Stroke Alert Volume



Stroke alert criteria includes: pt presenting with stroke like symptoms +FAST screen, stroke alerts called prior to arrival and up to 1 hour after arrival. Excluded cases: >1 after arrival or if stroke alert was cancelled.

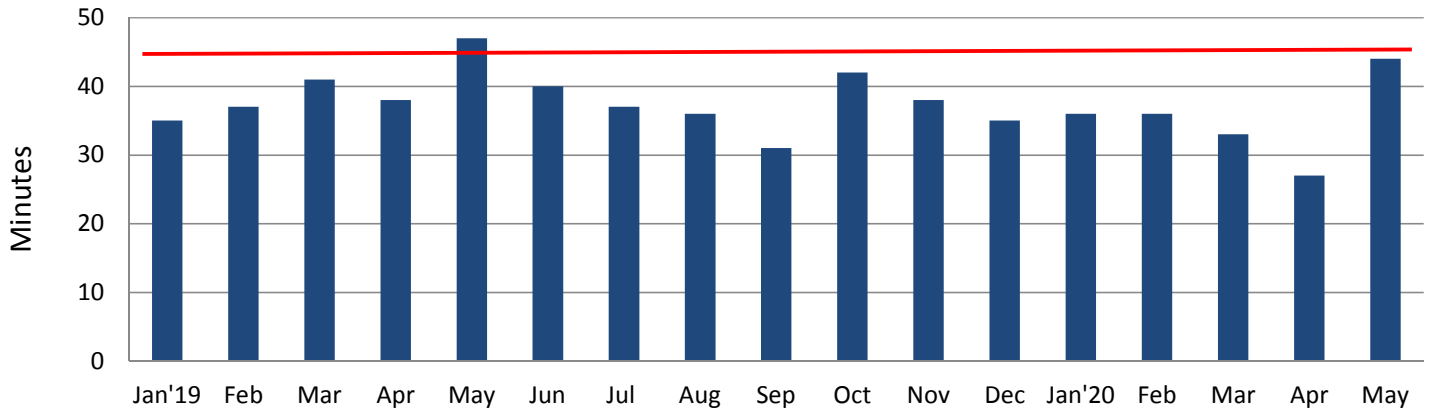
2019-2020 Stroke Alert Dashboard

Door to Lab Time (median times)



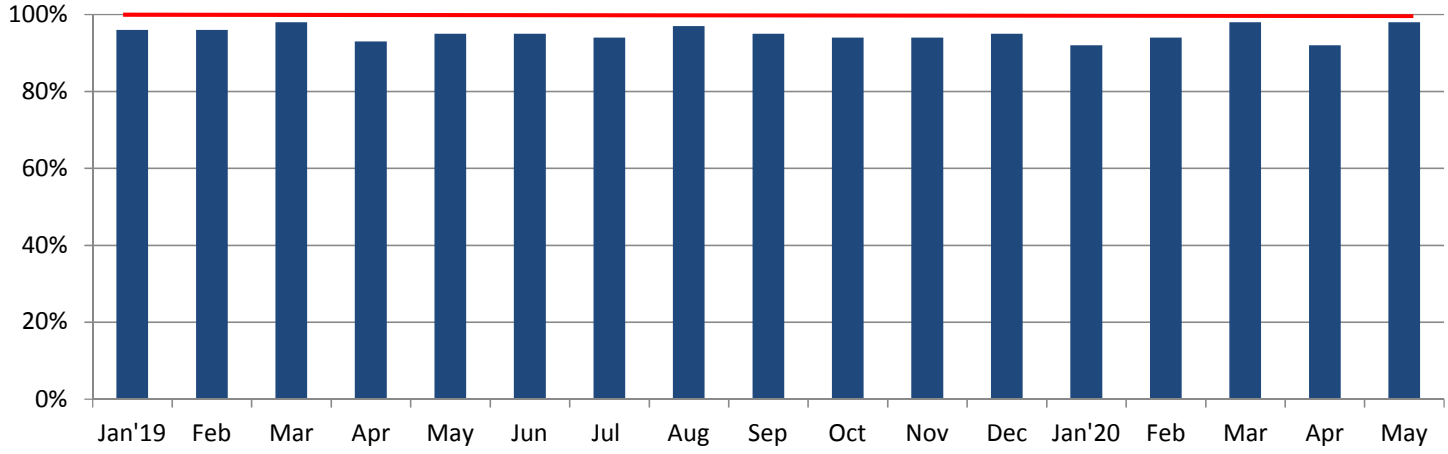
TJC expectation is that laboratory tests are completed within 45 minutes of arrival. Changes in stroke alert process has been made early 2019 to improve lab verified times. Action items taken: IV start kits in CT rooms with lab tubes, lab lable makers in both CT rooms and specimens taken immediately down to lab.

Door to EKG Time (median time)



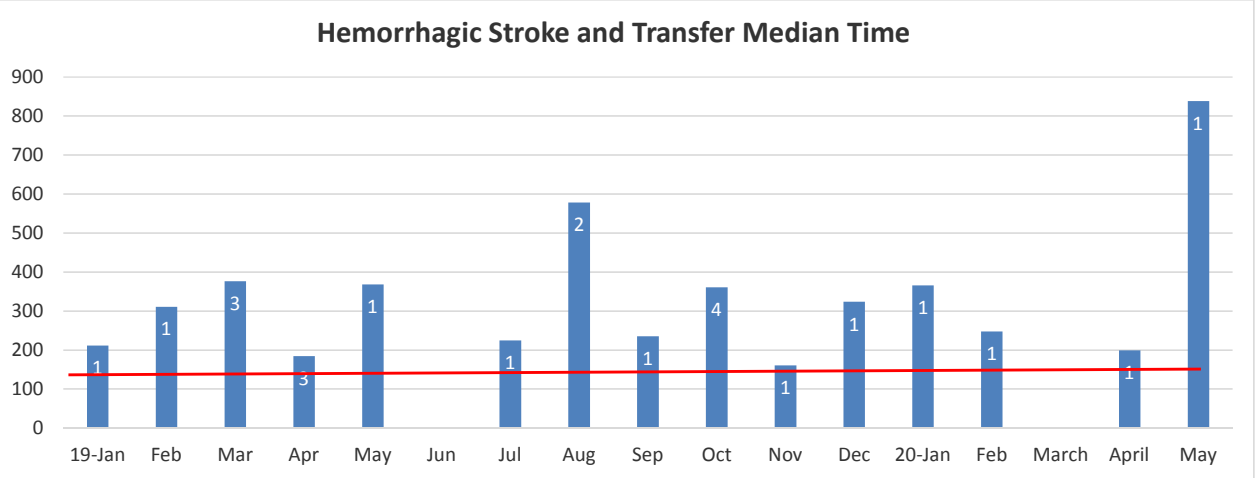
TJC expectation is that EKGs are completed within 45 minutes of arrival.

% Dysphagia screen completed when ordered

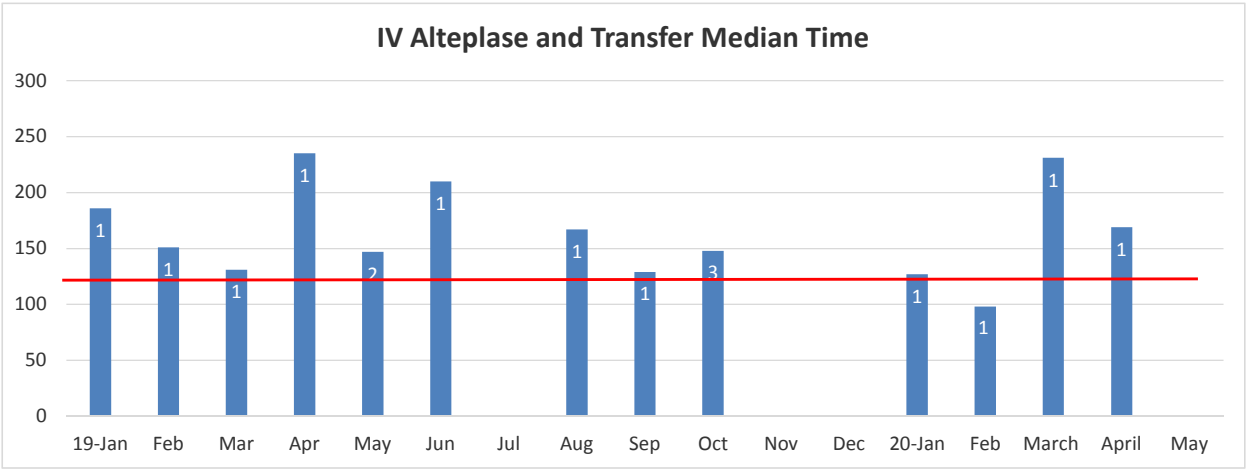


Dysphagia screening should be completed by the RN on all stroke alert patients prior to any po intake, including meds. Dysphagia screening is part of the ED stroke alert order sets. Goal is 100% compliance.

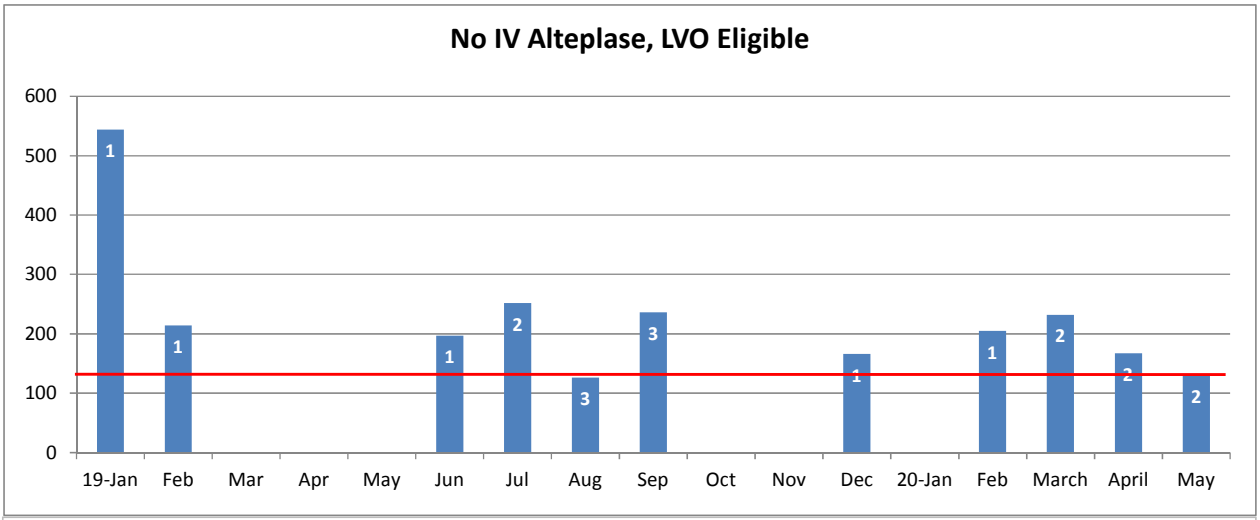
2019/20 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes



New TJC metric as of January 2019. TJC expectation is that if patients require transfer to a tertiary center that the door to transfer should be <120 minutes. Only a few hemorrhagic patients are transferred out for other procedures not done at KDH, specifically coiling/clipping of aneurysms or bleeds. A Transfer Task Force has been set up to help streamline the process, all action items are captured in PDSA document.



New TJC metric as of January 2019. TJC expectation is that if patients require transfer to a tertiary center that the door to transfer should be <120 minutes. These are considered our "drip and ship" cases. Transfers for ischemic strokes occur primarily if a large vessel occlusion is noted on CTA that would be eligible for endovascular treatment. As a result of the effects made by the ED Stroke Alert Committee and the Transfer Process Task Force door to transfer times have improved over the last several months.



New TJC metric as of January 2019. TJC expectation is that patients requiring transfer to a tertiary care center that the door to transfer should be less than 120 minutes. This cohort of patients have a large vessel occlusion that would be eligible for endovascular treatment and do not meet criteria for Alteplase administration. A Transfer Task Force has been set up to help streamline the process.

PI Goal: ED Door to Transfer Process 2020

Plan – Goals	Solutions (root cause)
• **Door to transfer of the hemorrhagic stroke patient: <120 minutes (STK-OP-1b)** • **Door to transfer: drip 'n ship <120 minutes (STK-OP-1c)** • **Door to transfer: acute ischemic stroke: + large vessel occlusion/+MER eligible: <120 minutes (STK-OP-1d)** • **Door to transfer: acute ischemic stroke: + large vessel occlusion/-MER not eligible: <120 minutes (STK-OP-1e)** • **Door to transfer: ischemic stroke: no alteplase, -+ large vessel occlusion: <120 minutes (STK-OP-1f)**	• Streamline transfer process by working closely with EMS, Skylife and receiving hospitals. •

DO – Implementation (include dates)

November 2018: ED Transfer Process Task Force developed. Interdisciplinary team including our local EMS agencies, Skylife, and ED staff/providers, Nursing, and Case Management.

Spring 2019: Stroke Team Lead (STL) training. ED RNs who are selected as Stroke Team Leads take a computer based learning course, attend STL didactic session and shadow an experienced STL.

Spring 2019: Education to staff and physicians/residents regarding the goal times for transfer.

Summer 2019: Discussions with EMS agencies have taken place to ensure we have a contact name and phone number for decision making.

August 2019: Collaborated with receiving hospitals on improving transfer process and timeliness. Ensure we have established transfer agreements with the receiving hospitals.

September 2019: Fastest transfer time information is posted in staff and physician lounges and in the EMS documentation room.

September 2019. Ischemic/Hemorrhagic transfer guide posted in key areas to reinforce goal of <120 -minute transfer.

October/November 2019: Collaborated with receiving hospitals who have Synapse to utilize PowerShare which allows hospitals to share imaging.

December 2019: Because of the ongoing ED construction, inability to utilize helipad, and/or need for fixed wing air transport; Skylife has secured a car rental to ensure timely transportation of the crew to the hospital.

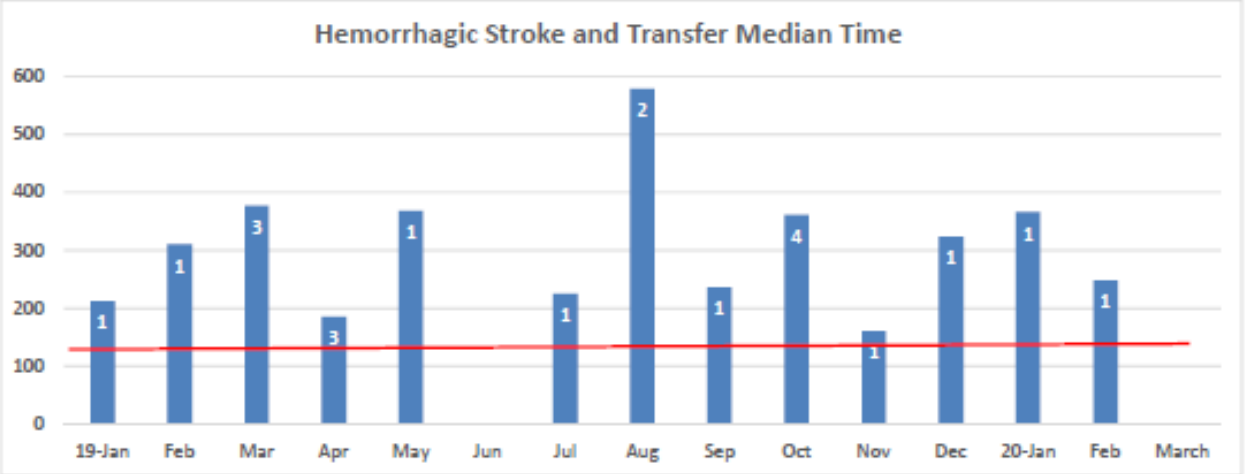
January/February 2020: Skylife to provide Flight Vector app for our ED staff and case managers to help track helicopter arrivals to our facility and receiving facility.

Ongoing 2019: Investigating ways to acquire RAPID software to help identify viable penumbra prior to transfer of patients with last known well >4 hours.

Ongoing: Annual Provider education includes transfer goal of <120 minutes for the ischemic and hemorrhagic stroke patients, and potential patient identification issues.

STUDY – RESULTS (CURRENT AND YTD DATA)

2019/20 TRANSFERS FROM ED TO ANOTHER ACUTE CARE FACILITY
Median Time by Minutes - Goal 120 Minutes



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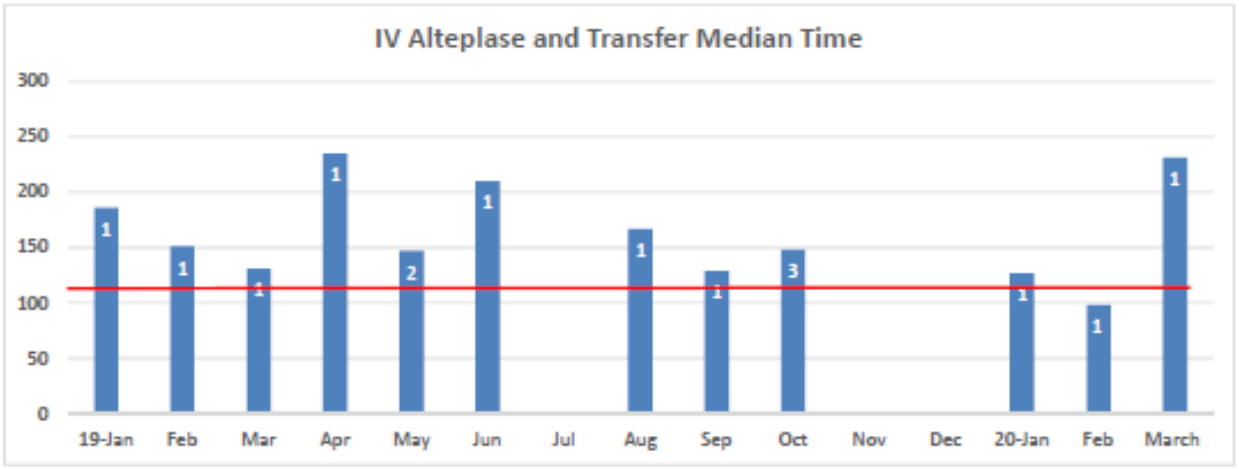

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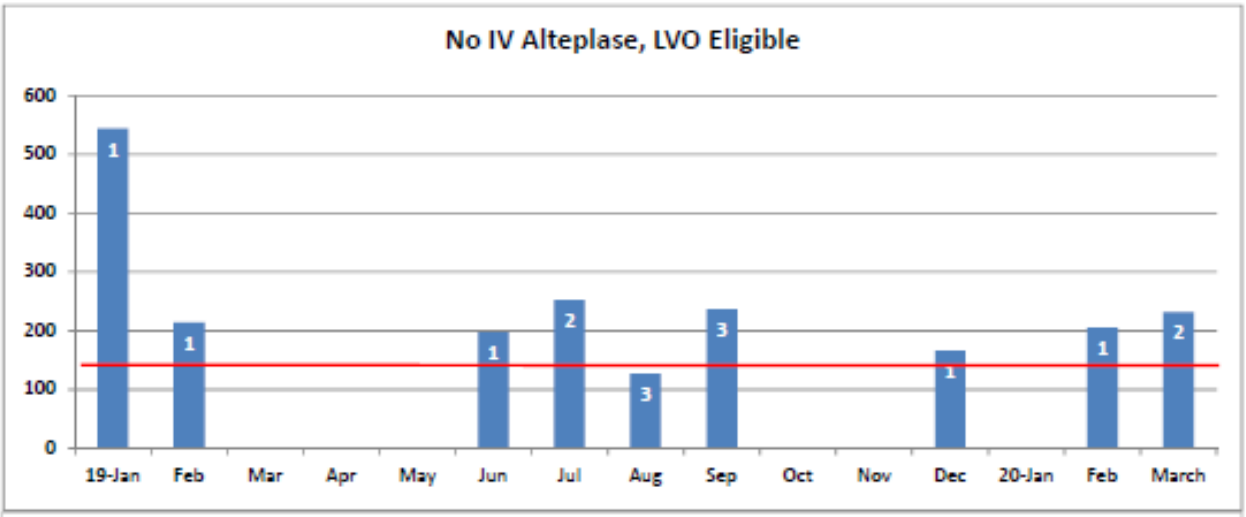

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ACT – OUTCOMES & CONCLUSIONS To Date	CONTACT
Outcomes / Conclusions • Ongoing review of process improvement opportunities. • We are close to the goal time if the patient is an ischemic stroke with a large vessel occlusion, however, our hemorrhagic stroke patient transfer times are significantly higher. • Need early identification of ischemic/hemorrhagic stroke patients even when the last known well is >16 hours.	❑ Cheryl Smit, RN, Stroke Manager Tel: 624-2133

PI Goal: Post Alteplase Monitoring & Assessment 2020

Plan – Goals

- Patients who receive Alteplase for acute ischemic stroke are in need of consistent performance and documentation of post-Alteplase monitoring, including blood pressure, pulse, respirations, and NIH Stroke Scale
- KDH Stroke Program monitors compliance of vital sign and neuro checks on all patients that have received Alteplase. Compliance is defined as all checks are completed; if any are missed then we deem the case to be noncompliant.
- November 2017: Goal of 90% compliance of post Alteplase monitoring by March 2018

Solutions (root cause)

- Early 2017: ED Stroke Alert Task Force created and implemented Alteplase flowsheet that is used by both ED and ICU.
- Good compliance since the initiation of the flowsheet; however, a few checks have been missed in recent months.
  - Occurring during change of shift
  - Nursing travelers caring for the post Alteplase patient prior to completion of orientation/education

DO – Implementation (include dates)

March 2017: Developed Alteplase flowsheet, education to ED and ICU post Alteplase monitoring

- June 2017: Included Alteplase flowsheet in stroke alert packets
- August 2017: Modification to Traveler Competency checklist
- November 2017: Re-emphasis on compliance with flowsheet; primarily during change of shift
- January 2018: ED and ICU RNs to perform vital sign/neuro check upon transfer to ensure no lapse in
- Ongoing summaries of Alteplase cases shared with staff and physicians at the ED Stroke Alert Subcommittee monitoring.
- Spring 2019: ICU leadership to focus education on compliance with post alteplase monitoring
- October 2019: Working on converting the paper flowsheet to electronic version in Cerner
- March 2020:
  - The paper post alteplase flowsheet will continue…we will **not** be converting to the electronic version**.**
  - Current annual CBL competencies for ICU, CVICU and ED will be updated to include post alteplase monitoring, flowsheet review and the importance of compliance
  - Provide education to ICU, CVICU and ED staff on face-to-face hand-off and review of the post alteplase form

STUDY – RESULTS (CURRENT AND YTD DATA)

Figure 1. Post-Alteplase Compliance

Data: Apr'19-Mar'20	Goal	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% compliance	90%	66%	71%	67%	75%	100%	50%	80%	83%	67%	89%	75%	100%

ACT – OUTCOMES & CONCLUSIONS To Date

Outcomes / Conclusions

- Close coordination and provision of feedback on a concurrent basis helps departments identify nurses who need reinforcement of their role in post-Alteplase monitoring
- Significant improvements have been made since the implementation of the post Alteplase flowsheet, refining the stroke alert process, and having designated Stroke Team Leads in the ED.
- Continued focus on staff compliance with post alteplase monitoring.

CONTACT

❑ Cheryl Smit, RN, Stroke Manager
Tel: 624-2133

Unit/Department: Rehabilitation Services **Pro Staff Report Date:** May 2020

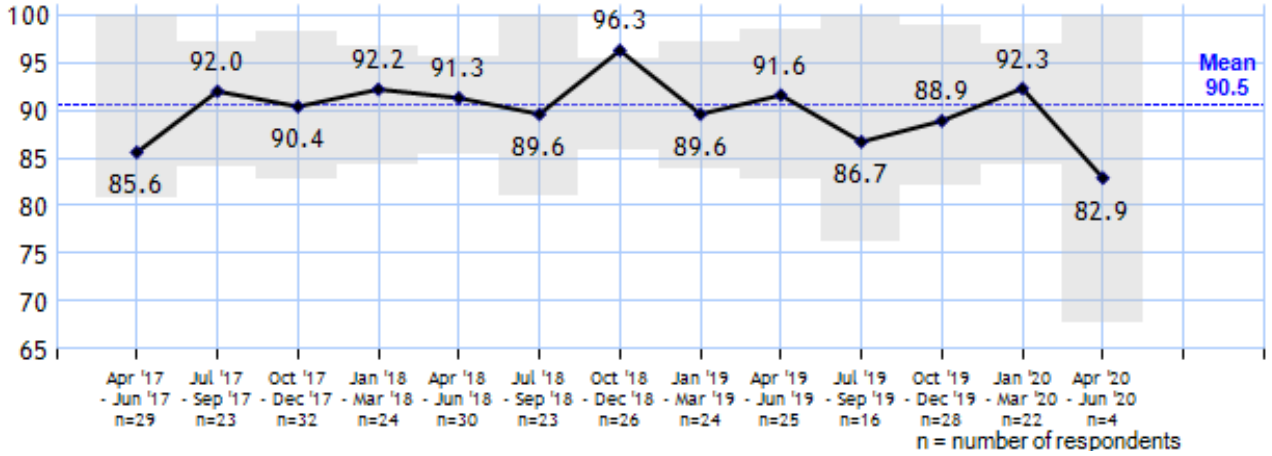
Measure Objective/Goal:

Acute rehabilitation program evaluation, including patient satisfaction, clinical quality including functional outcomes and referral review

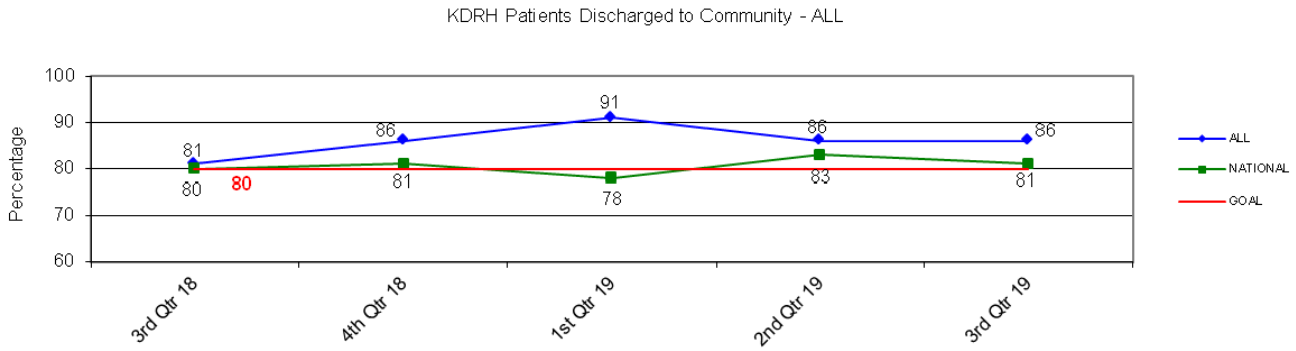
Date range of data evaluated: Rehab quarterly report, October 2019- December 2019 internal data, July 2019-September 2019 external data

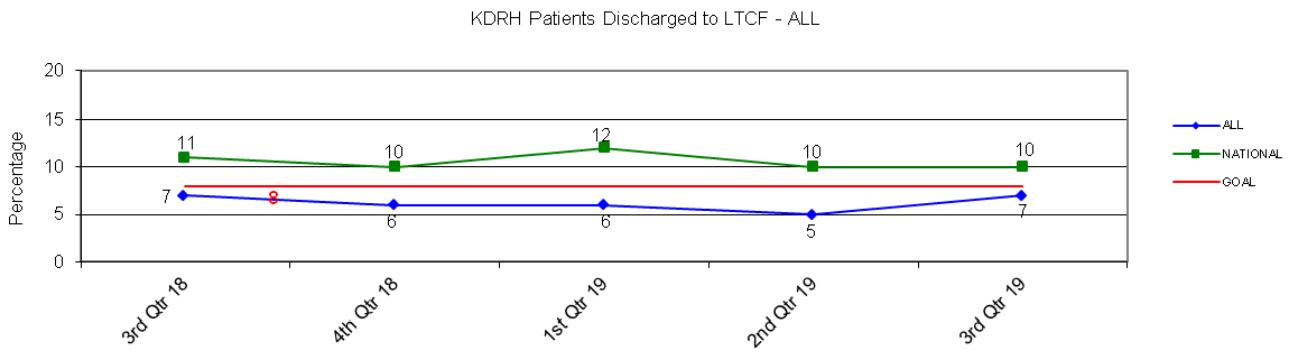
Analysis of all measures/data: (Include key findings, improvements, opportunities)

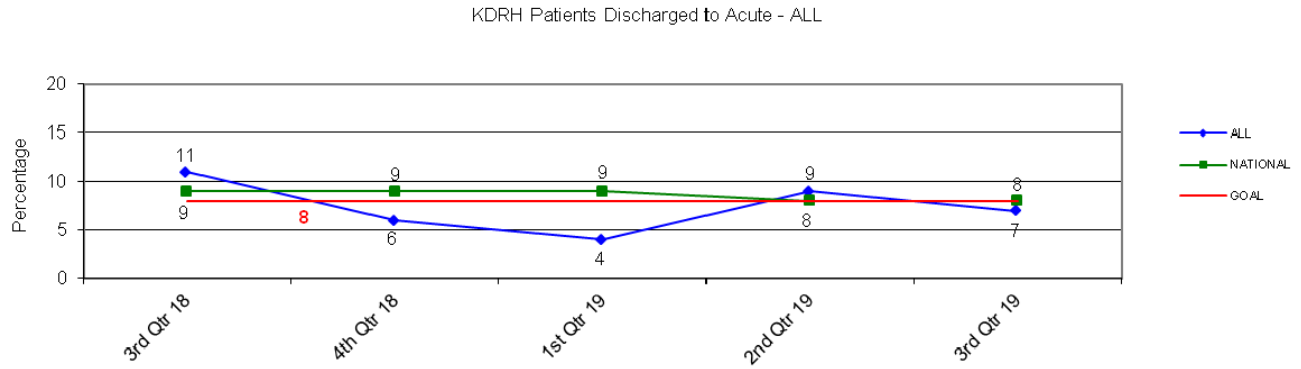
Patient satisfaction: Mean score for the most recent quarter was 92.3 placing the program in the 79th percentile for the quarter.



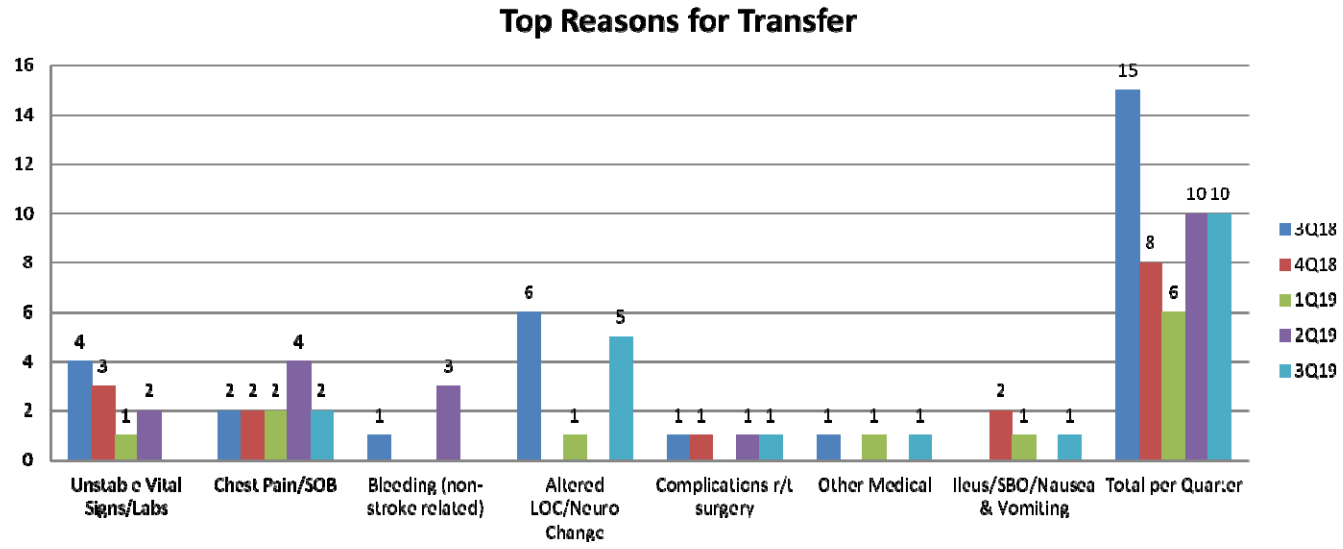
Outcomes: 86% of patients returned to community, above national average of 81. Skilled Nursing Facility discharges were 7% compared to national average of 10%. Acute care discharges were 7%, well below the national average of 8%.







Transfer of Care Analysis



- Total transfers to acute were 10 for the quarter. 50% were due to altered level of consciousness or neuro changes, 4 of those were new or evolving strokes. Action plan underway to get staff NIH Stroke Scale certified to facilitate early identification of new stroke symptoms in patients admitted to rehab for stroke.

If improvement opportunities identified, provide action plan and expected resolution date:

Patient satisfaction remains high overall. Areas of focus for improvement include daily room cleaning, with new checklist in place for CNA responsibilities to include room cleaning, use of staff portable phones to decrease noise associated with call lights, scripting with therapy staff to improve patient engagement in goals, and initial tour with activity coordinator to help reinforce what to expect during the rehab stay.Clinical outcomes continue to be strong.

Measure Objective/Goal:

Nursing indicators relative to NDNQI

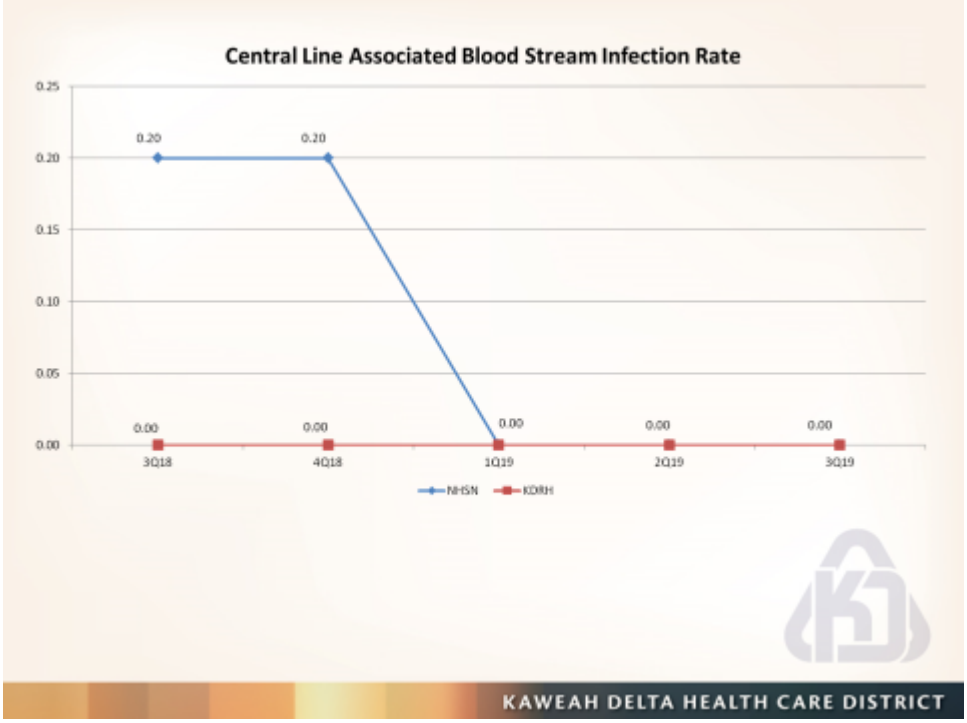
Date range of data evaluated: 3rd quarter 2019

Analysis of all measures/data: (Include key findings, improvements, opportunities)

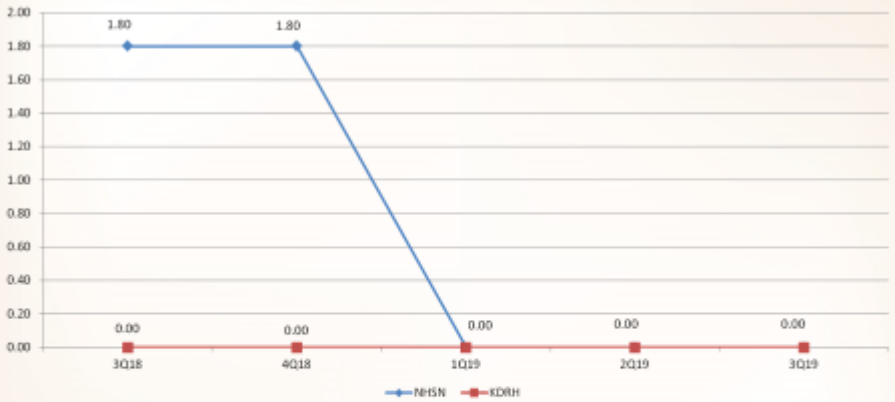
Kaweah Delta Rehab had zero incidence of catheter associated urinary tract infection, central line blood stream infections or hospital acquired pressure ulcer stage II or above. Fall rate per 1000 patient days was below NDNQI benchmarks, but there was an overall increase in falls. There was one injury, a scrape to the elbow

If improvement opportunities identified, provide action plan and expected resolution date:

Continue existing initiatives for CAUTI, pressure ulcer. Areas of focus for staff re-education due to the increase in falls included attended toileting, SPLAT, ensure wheelchair alarms are on.



Catheter Associated Urinary Tract Infection Rate (per 1000 patient days)



Continue to use bundle strategies to prevent infections from occurring.
Participating in quarterly prevalence study for indwelling urinary catheters.
Checking patients with catheters for compliance with bundle strategies.
Infection Control weekly audits on unit to monitor.

Removing catheters soon after admission if present on admission.

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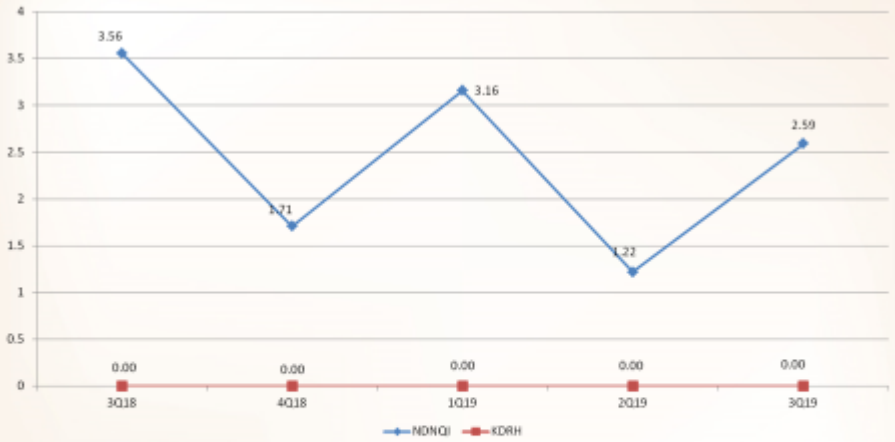
Hospital Acquired Pressure Ulcer (Stage 2 and above)



No findings with unit Prevalence study for last 2 quarters.

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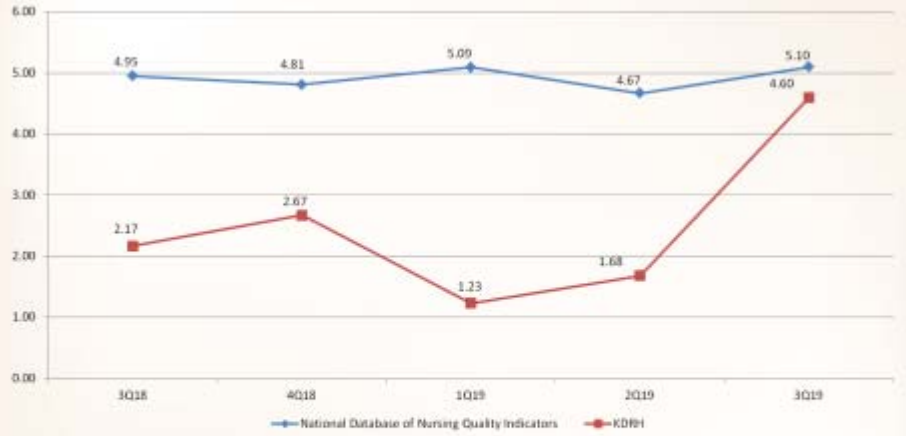
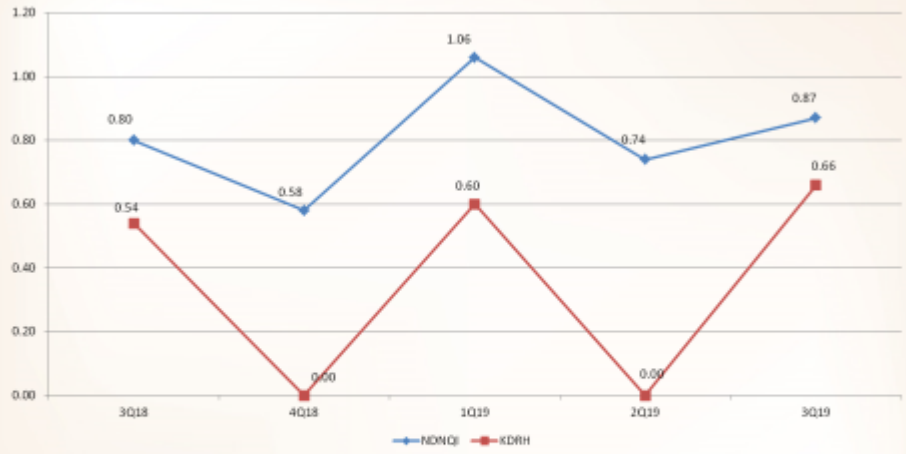
Fall Rate/1000 Patient Days



Total of 7 Rehab falls. Three falls out of wheelchair with wheelchair alarms sounding but staff not able to stop fall from happening. One fall patient rolled out of bed. He was a 1:1 day prior but was removed since he didn't have unsafe activity noted. Bed alarm sounded and patient fell onto floor mat. 1:1 reinstated after fall. Three falls during toileting. 2 with staff present to assist patient during transfer but was a failed transfer. One fall with patient requesting staff to step out and then lost balance leaning forward. No injuries with all falls.

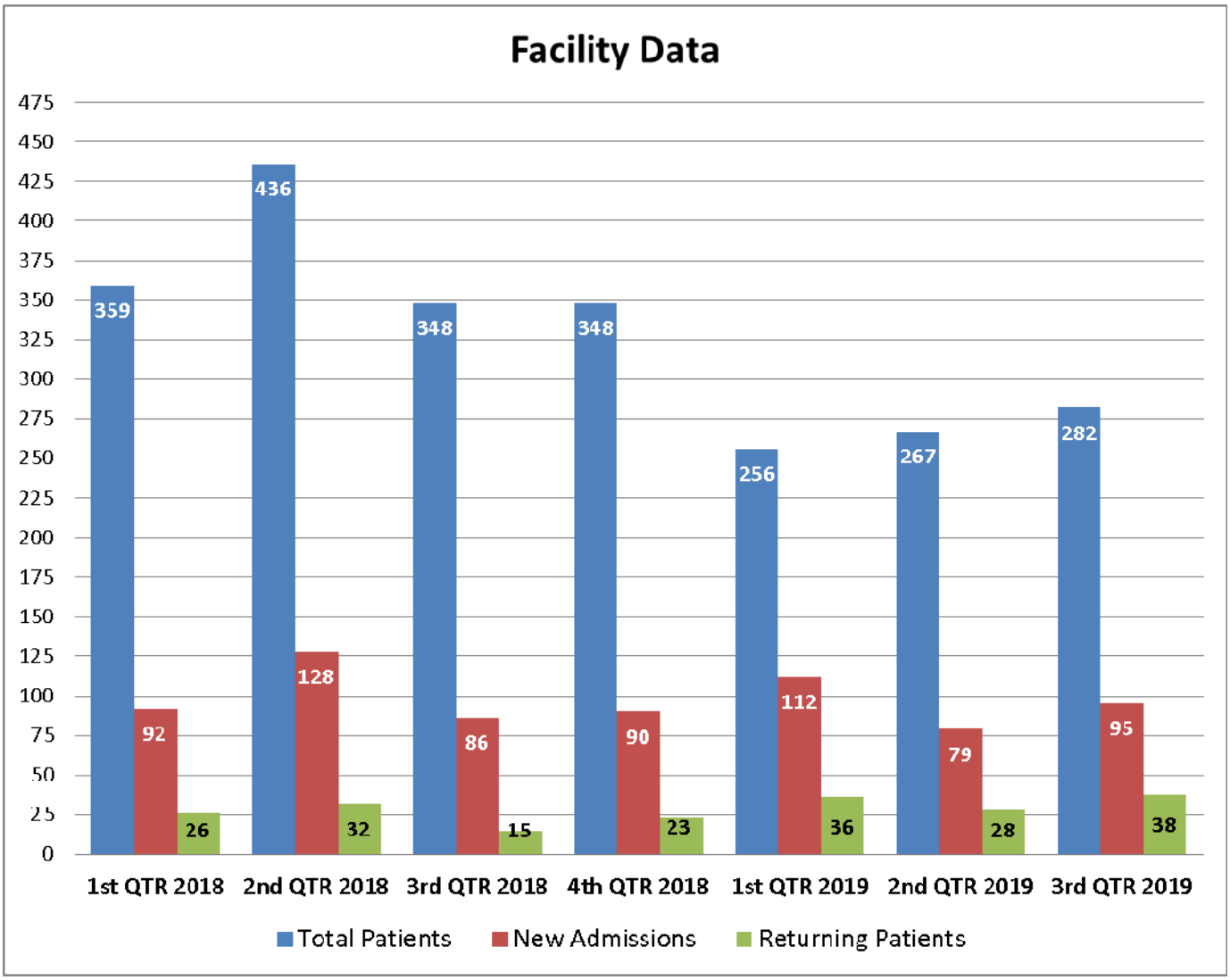
Continued education for attended toileting with staff.

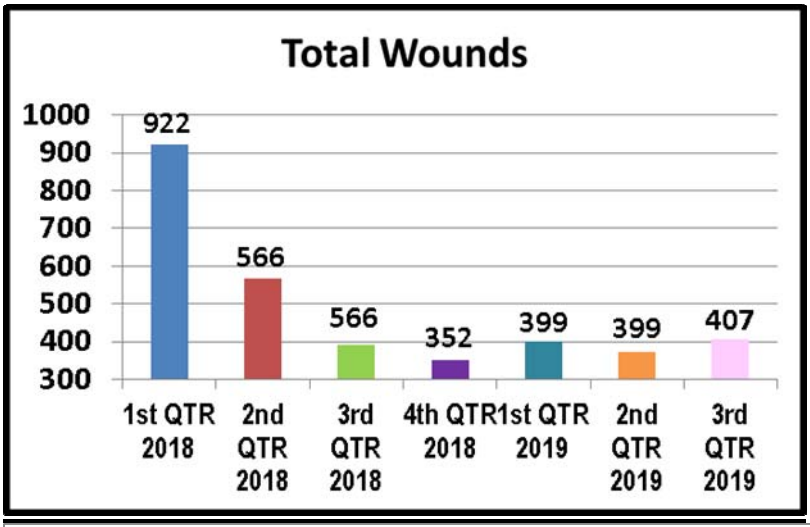
Fall Rate with Injury/ 1000 Patient Days

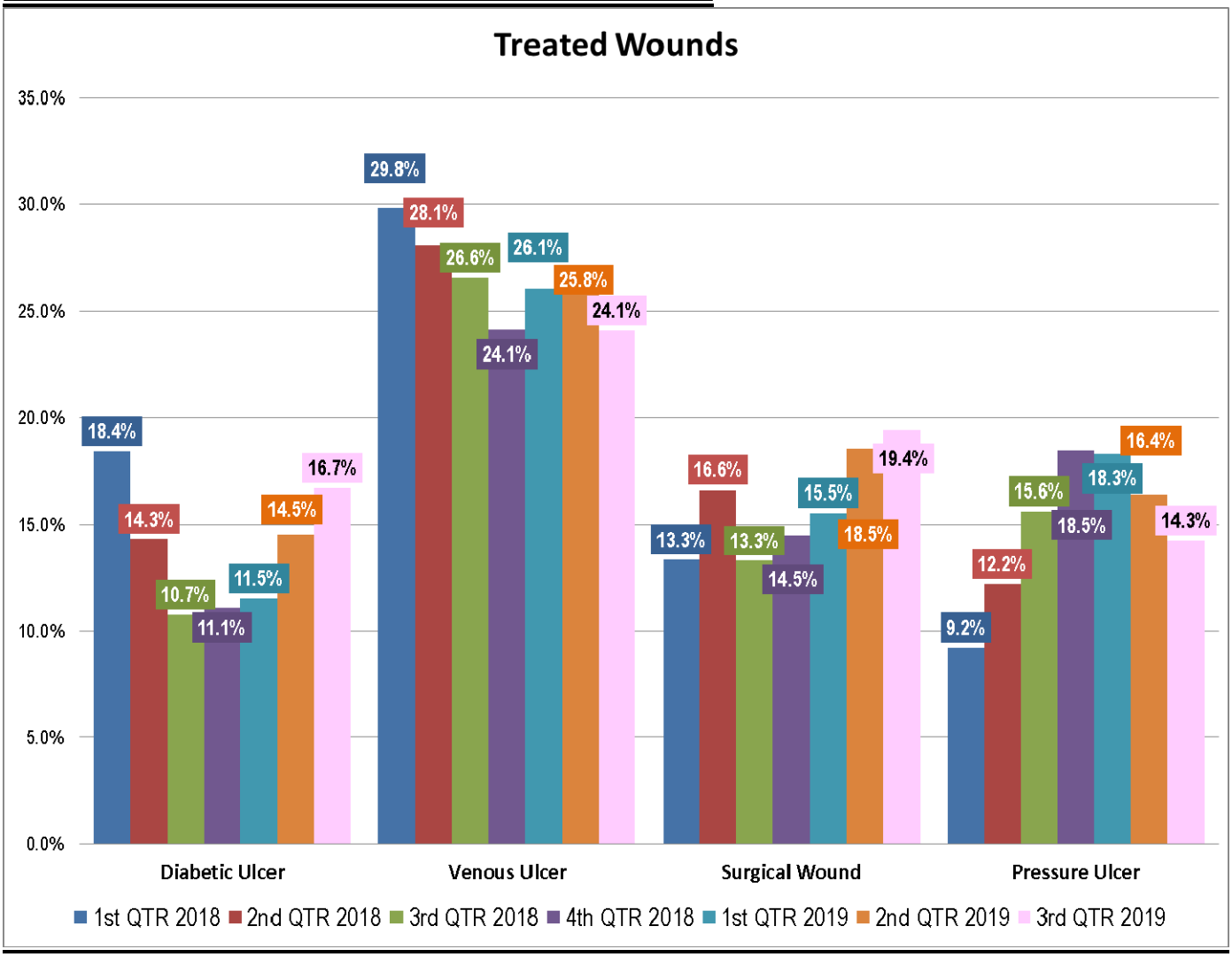


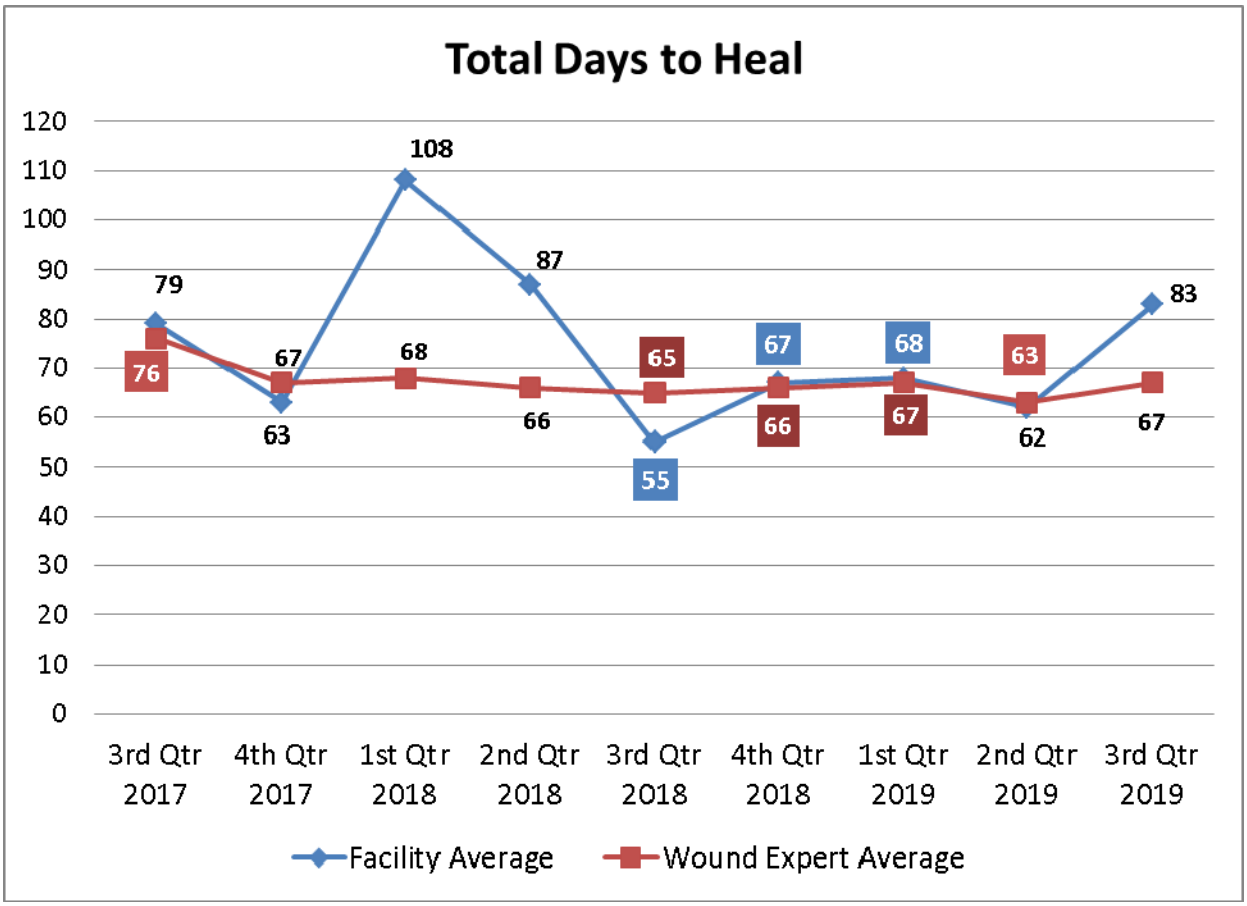
KAWEAH DELTA HEALTH CARE DISTRICT

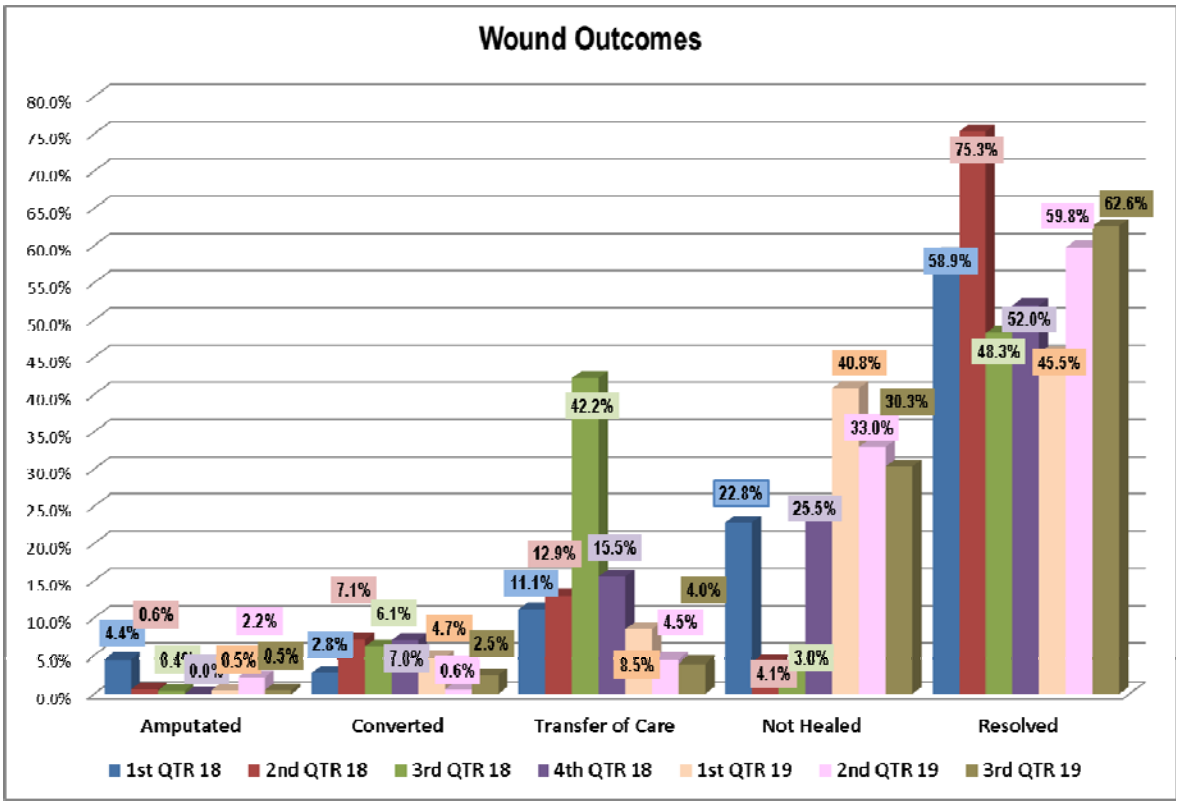
Measure Objective/Goal: Wound Center outcomes
Date range of data evaluated: 3rdd quarter 2019
Analysis of all measures/data: (Include key findings, improvements, opportunities)
Increase in overall visits, HBO decreased – primarily due to increased screening of candidates. 407 wounds – increased diabetic and surgical wounds. 198 wounds with an outcome- very small number amputations and conversions, decreased transfer of care and not healed – increase in resolved. 45.4% completed treatment. Total days to heal – above benchmark – due to venous stasis ulcers. Diabetic ulcers slightly above benchmark. Surgical wounds continue to improve in days to heal – PICO wound vac appears to be a significant factor in this. Venous stasis increased – one patient with multiple long term wounds that resolved this quarter

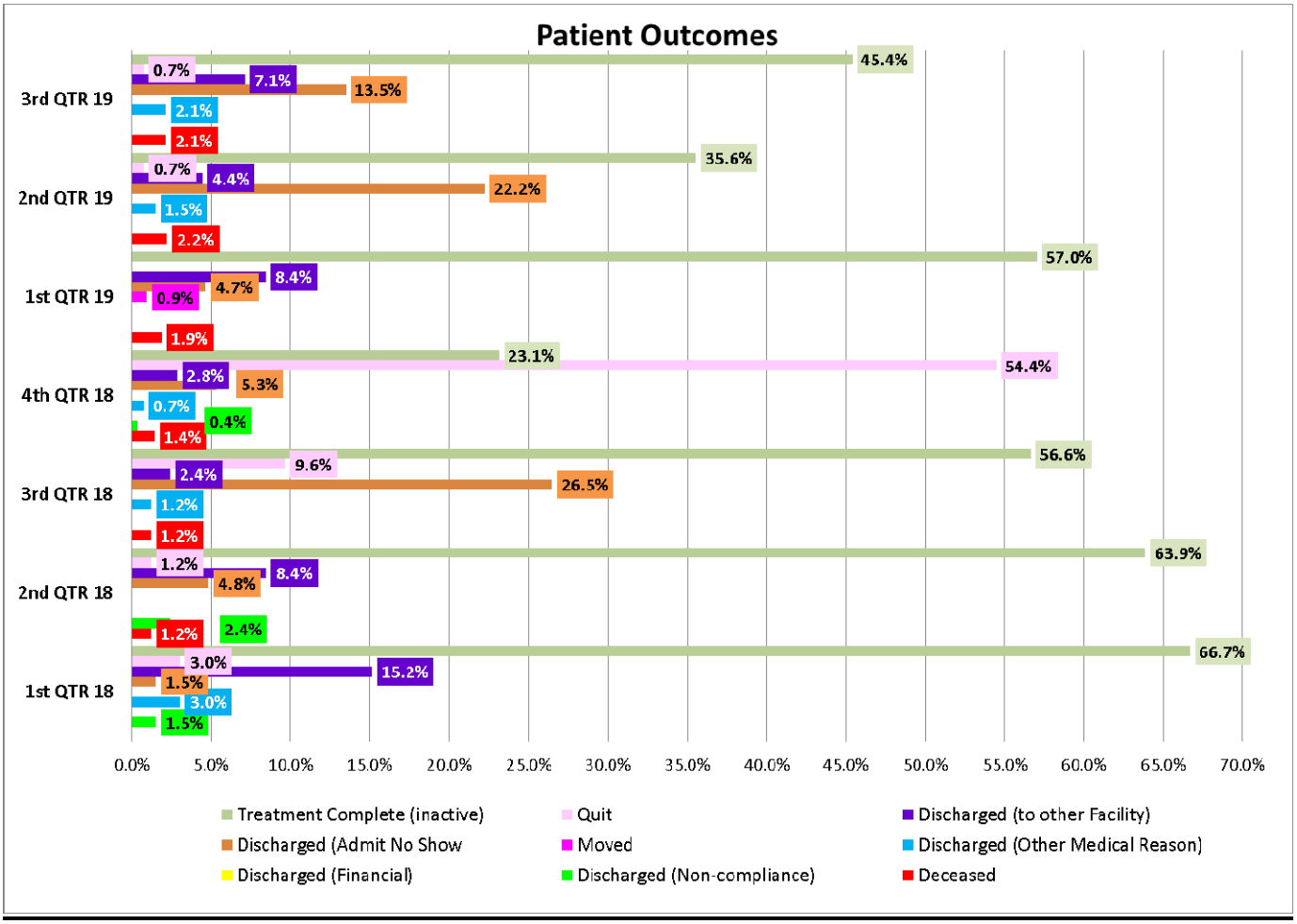



Total Wounds
1000
900
800
700
600
500
400
300
922
566
566
352
399
399
407
1st QTR 2018
2nd QTR 2018
3rd QTR 2018
4th QTR 2018
1st QTR 2019
2nd QTR 2019
3rd QTR 2019


Treated Wounds
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
18.4%
14.3%
10.7%
11.1%
11.5%
14.5%
16.7%
29.8%
28.1%
26.6%
24.1%
26.1%
25.8%
24.1%
13.3%
16.6%
13.3%
14.5%
15.5%
18.5%
19.4%
9.2%
12.2%
15.6%
18.5%
18.3%
16.4%
14.3%
Diabetic Ulcer
Venous Ulcer
Surgical Wound
Pressure Ulcer
1st QTR 2018
2nd QTR 2018
3rd QTR 2018
4th QTR 2018
1st QTR 2019
2nd QTR 2019
3rd QTR 2019


Total Days to Heal
120
110
100
90
80
70
60
50
40
30
20
10
0
79
63
108
87
55
67
83
76
67
68
66
65
66
67
68
63
62
67
3rd Qtr 2017
4th Qtr 2017
1st Qtr 2018
2nd Qtr 2018
3rd Qtr 2018
4th Qtr 2018
1st Qtr 2019
2nd Qtr 2019
3rd Qtr 2019
Facility Average
Wound Expert Average


Wound Outcomes
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
4.4%
0.6%
0.4%
0.0%
0.5%
0.5%
2.2%
2.8%
7.1%
6.1%
7.0%
4.7%
0.6%
2.5%
11.1%
12.9%
42.2%
15.5%
8.5%
4.5%
4.0%
22.8%
4.1%
25.5%
3.0%
40.8%
33.0%
30.3%
58.9%
75.3%
48.3%
52.0%
45.5%
59.8%
62.6%
Amputated
Converted
Transfer of Care
Not Healed
Resolved
1st QTR 18
2nd QTR 18
3rd QTR 18
4th QTR 18
1st QTR 19
2nd QTR 19
3rd QTR 19



Submitted by Name: Lisa Harrold **Date Submitted:** May 8, 2020

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: **Orthopedic Service Line Surgical Site infection** **ProStaff Report Date:** **06/14/2020**

Measure Objective/Goal: Measuring the percentage of total arthroplasty surgical patients who experienced a **surgical site infection** within 90 days after surgery. An incidence rate calculation is determined using the total number of THR/TKR surgeries (performed during a 12-month period) versus the total number of infections using CDC/NHSH criteria. The goal of this data collection is to identify opportunities to prevent infections with total arthroplasty procedures.

Date range of data evaluated: January 1, 2019 to December 2019 (12 months)

Analysis of all measures/data: (Include key findings, improvements, opportunities)

Overall, the joint procedures performed on hips and knees from January 1, 2019, through December 2019 at Kaweah Delta resulted in zero infections and an overall standardized infection ratio of 0% of 2.6% predicted number of infections based on procedures performed and risk-adjusted elements for the patients receiving hip and knee replacement procedures during this time period.

Type of SSI	Total # of Procedures 12 Months	Actual # of Infections	Predicted # of Infections	Standardized Infection Ratio
KPRO	446	0	2.931	0
HPRO	265	0	2.222	0
Total	**711**	**0**	**2.577**	**0**

If improvement opportunities identified, provide action plan and expected resolution date:

1. No specific improvement opportunities identified at this time.
2. An updated pre-op joint booklet with ERAS information for families and patients (same info as general surgery). New booklets implemented Sept 2019.
3. Discussing standard practice among orthopedic surgeons and OR team with prepping/draping prior to surgery.

Next Steps/Recommendations/Outcomes:

Orthopedic NP continues to attend monthly surgical site infection (SSI) subcommittee meeting to stay current with SSI topics related to prevention and best practices. Information will be shared with orthopedic surgeons on a regular basis. Continue to hardwire ERAS program with nursing staff, therapies, and surgeons in the coming year.

Submitted by Name: Jag Batth, DPT **Date Submitted:** 6/14/2020

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee

Unit/Department: **Orthopedic Service Line Complication Rate** **ProStaff Report Date:** **06/14/2020**

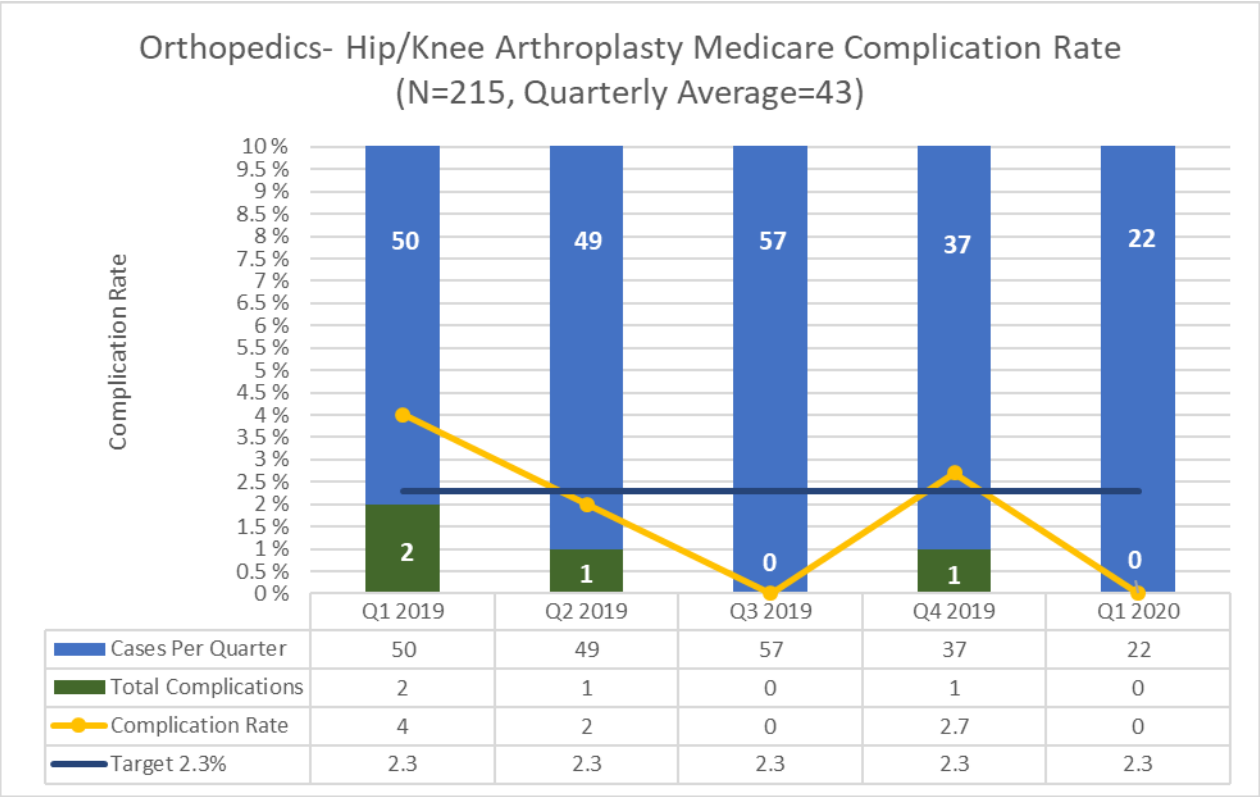
Measure Objective/Goal: Monitor and measure the **complication rate** for total arthroplasty patients who underwent either a total hip or knee joint replacement. The benchmark sources are both CMS and hospitals within the Midas database. The CMS target is **2.3%** for Medicare patients and **1.4%** target for all payers within the Midas database.

The inclusion criteria for complication include the following:

1. Mechanical complication within 90 days
2. Wound Infection or periprosthetic joint infection within 90 days
3. Surgical site bleeding within 30 days
4. Pulmonary embolism within 30 days
5. Death within 30 days
6. Acute myocardial infarction with 7 days
7. Pneumonia within 7 days
8. Sepsis, septicemia, or shock within 7

Date range of data evaluated: Quarter 1, 2019 to Quarter 1, 2020 (15 months)

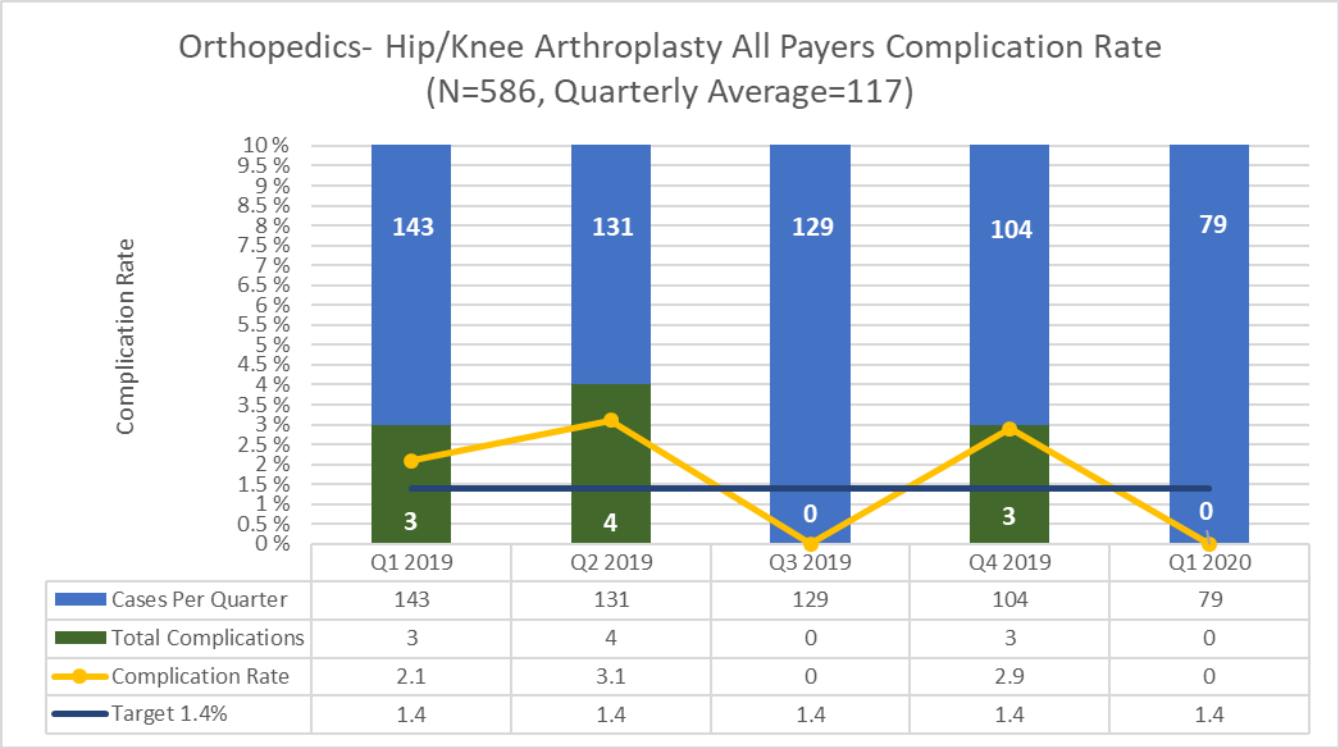
Analysis of all measures/data: (Include key findings, improvements, and opportunities) (If this is not a new measure, please include data from your previous reports through your current report):



	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Cases Per Quarter	50	49	57	37	22
Total Complications	2	1	0	1	0
Complication Rate	4	2	0	2.7	0
Target 2.3%	2.3	2.3	2.3	2.3	2.3

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Cases Per Quarter	143	131	129	104	79
Total Complications	3	4	0	3	0
Complication Rate	2.1	3.1	0	2.9	0
Target 1.4%	1.4	1.4	1.4	1.4	1.4

If improvement opportunities identified, provide action plan and expected resolution date:

Overall, performing well with Medicare patients. Four complications (1.9% complication rate) in the last 5 quarters, which resulted in being slightly lower than the CMS benchmark of 2.3%. The all payer complication rate at 1.7%, which was slightly above the Western region Midas benchmark of 1.4%. Ten complications noted over the last 15 month. Three of the ten complications were related to falls at home after surgery. No additional specific diagnostic patterns were noted with the remainder of the complications.

Next Steps/Recommendations/Outcomes:

1. Working with the surgeons to coordinate home health physical therapy prior to discharge. The focus with HHPT will include home safety assessment, strength/ROM exercises, and gait/balance training.
2. Increased focused at the pre-op joint class related to home safety and modifications prior to surgery as well as caregiver training.
3. Consider short staff skilled nursing stay vs directly discharging to the home setting if patient remains at risk for falls.

Submitted by Name: Jag Batth, DPT **Date Submitted:** 6/14/2020

Unit/Department Specific Data Collection Summarization

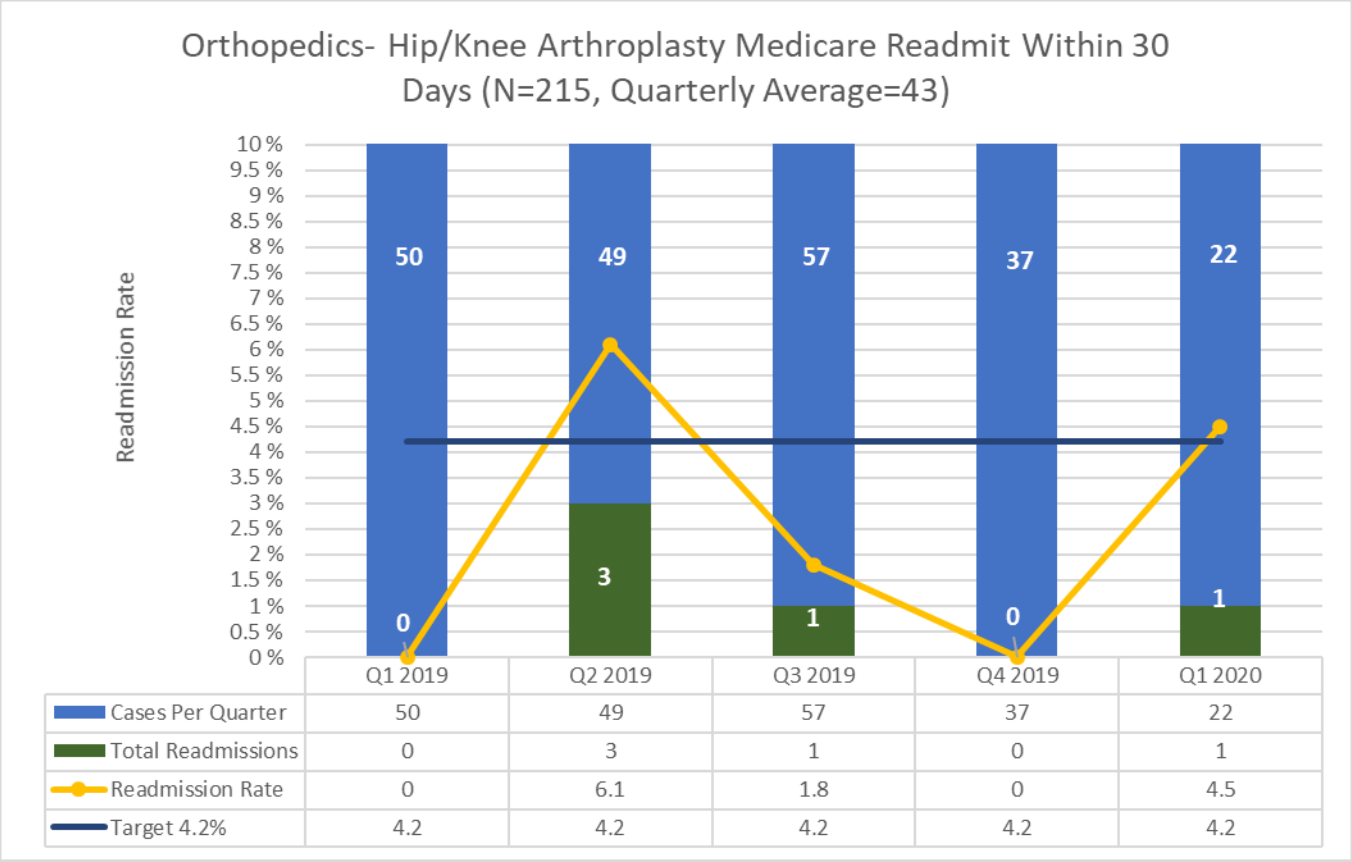
Professional Staff Quality Committee

Unit/Department: **Orthopedic Service Line Readmission Rate** **ProStaff Report Date:** **06/14/2020**

Measure Objective/Goal: Monitor and measure any cause 30-day **readmission rate** for total arthroplasty patients who underwent a joint replacement. The benchmark sources are both CMS and hospitals within the Midas database. The CMS target is **4.2%** for Medicare patients and **2.4%** target for all payers.

Date range of data evaluated: Quarter 1, 2019 to Quarter 1, 2020 (15 months)

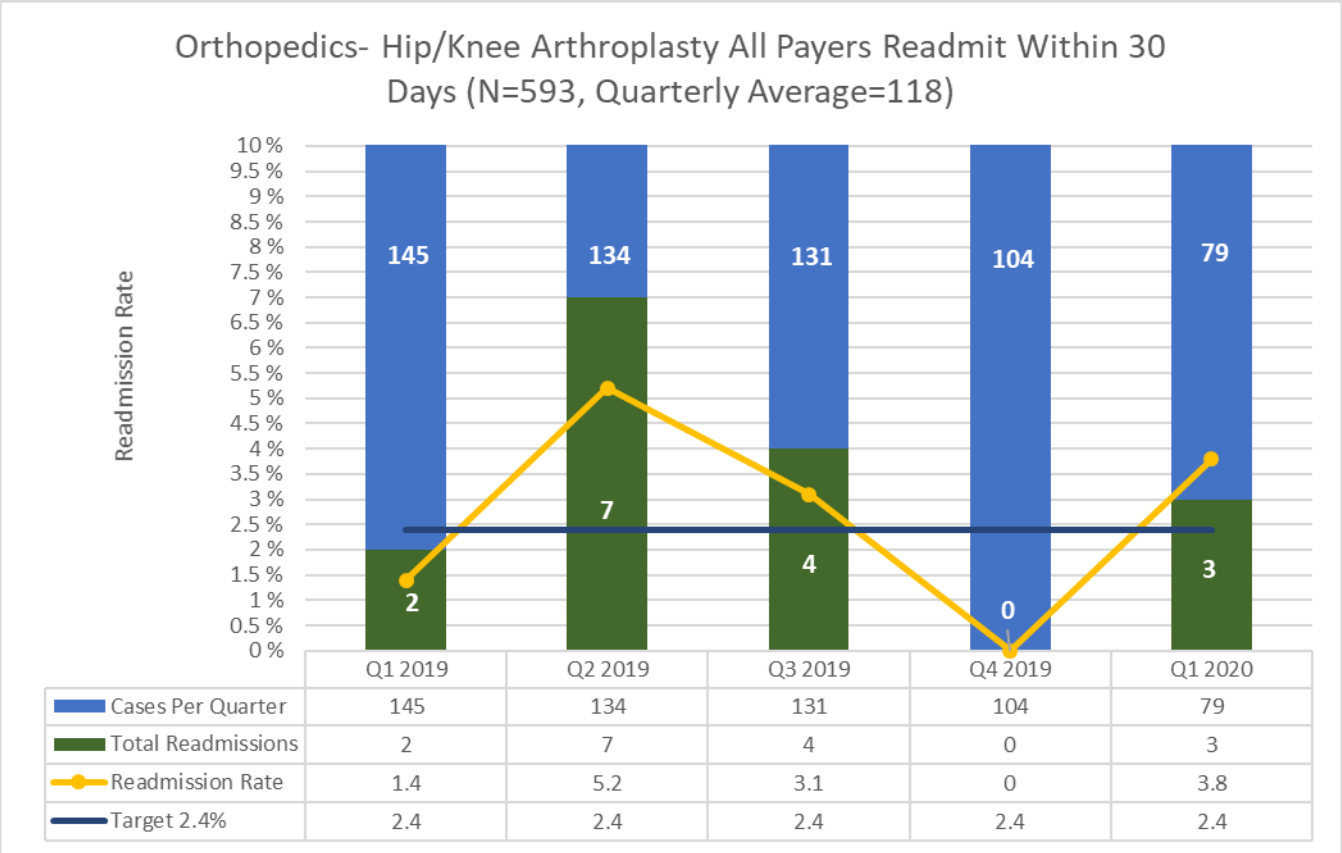
Analysis of all measures/data: (Include key findings, improvements, opportunities)
(If this is not a new measure, please include data from your previous reports through your current report):



	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Cases Per Quarter	50	49	57	37	22
Total Readmissions	0	3	1	0	1
Readmission Rate	0	6.1	1.8	0	4.5
Target 4.2%	4.2	4.2	4.2	4.2	4.2

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee



	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020
Cases Per Quarter	145	134	131	104	79
Total Readmissions	2	7	4	0	3
Readmission Rate	1.4	5.2	3.1	0	3.8
Target 2.4%	2.4	2.4	2.4	2.4	2.4

If improvement opportunities identified, provide action plan and expected resolution date:

Overall, performing well with the Medicare patients in regards to re-admissions. Total of five re-admissions out of 215 Medicare cases in the last 15 months. Averaging 2.3% re-admission rate compared to 4.2% benchmark. Unfortunately, the all payer readmission rate was higher than the national benchmark. 16 re-admissions out of 593 in the last 15 months. Averaging a 2.7% re-admission rate compared to 2.4% target. Five of the 16 re-admissions were related to superficial surgical site infections that required a washout procedure with the orthopedic surgeon. Three of re-admissions again were related to falls.

Next Steps/Recommendations/Outcomes:

1. Recently changed draping/prepping procedures in the OR to prevent infections.
2. Standardized education and increased emphasis with prevention of surgical site infections during the pre-op education class. Focused on how to clean the surgical incisions and dressing/badge changes.
3. Readmissions related to falls, same action plans as complications.

Submitted by Name: Jag Batth, DPT **Date Submitted:** 6/14/2020

Sepsis Core Measure
(Sep-1 Early Management Bundle)

KAWEAH DELTA HEALTH CARE DISTRICT

Sep-1 Early Management Bundle

Three Hours

- **Blood Cultures prior to ABX**
- Lactic Acid & **REPEAT in 6 hours if elevated (>2)**
- Broad Spectrum Antibiotics
- 30ml/kg Crystalloid Fluids for Initial Hypotension/Lactic Acidosis (SBP<90 or LA≥4) **(MUST DOCUMENT WEIGHT THAT YOU USED TO CALCULATE FLUIDS – IT CAN BE AN ESTIMATED WEIGHT OR IBW)**

Six Hours Septic Shock

If hypotension persists after fluid administration-

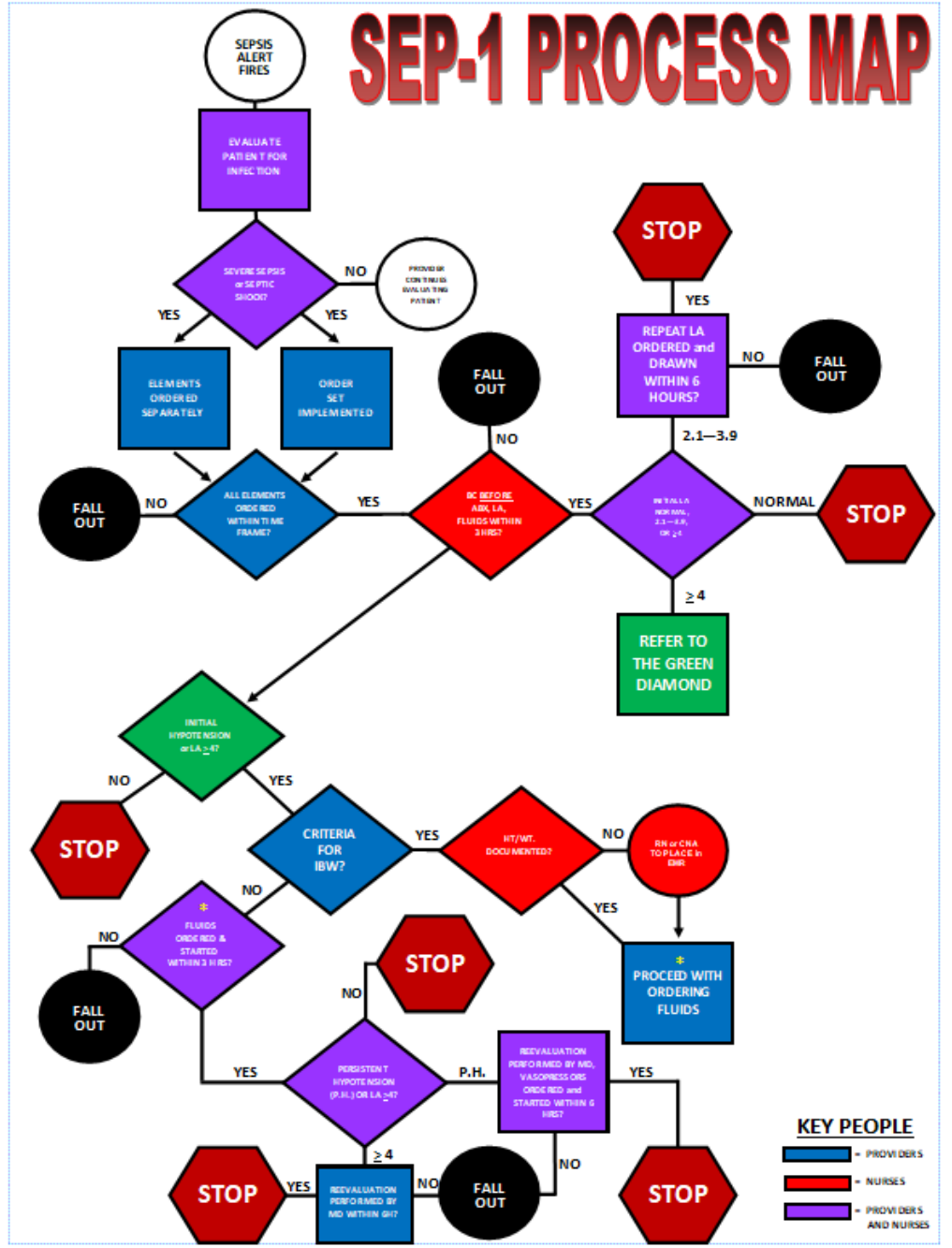
- Vasopressors
- Reassessment (if hypotension persists or initial LA ≥ 4). Any of the following:
  - CVP
  - SvO2
  - Bedside Cardiovascular US
  - Passive Leg Raise

OR

  - Focus Exam – by provider (Five of the following):
    - VS, SpO2, Cardiopulmonary, Cap refill, skin, & peripheral pulses, UO

CMS Sepsis Bundle

- The CMS Sepsis bundle requires a multidisciplinary team approach; the care requirements are timed, with several decision points throughout the process , and the required documentation is precise
- To make it easier, the early management bundle has been put into order sets



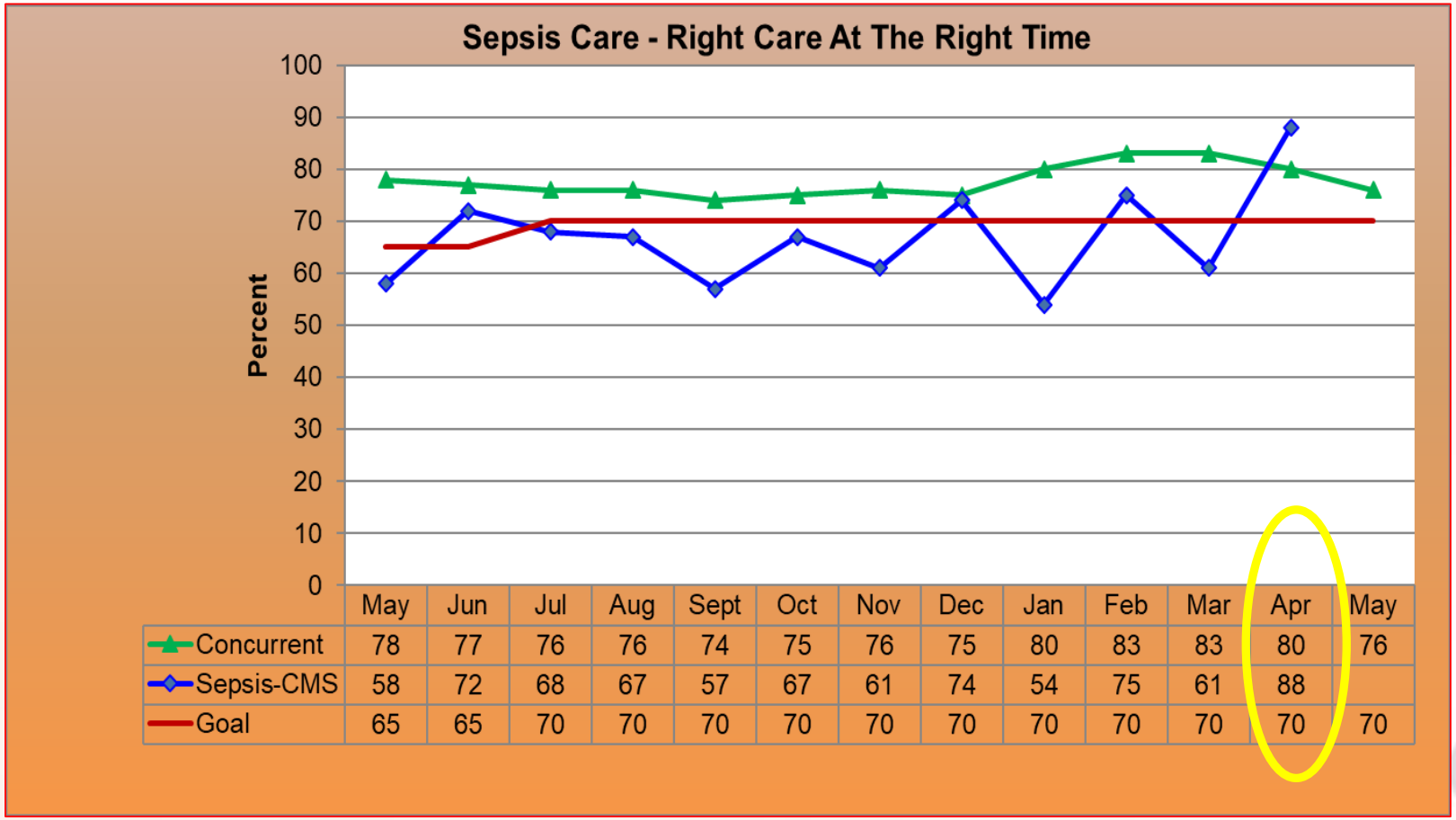
SEP-1 Early Management Bundle Compliance

CA State Compliance 63%

National Compliance 59%

Top Performing Hospitals 81%

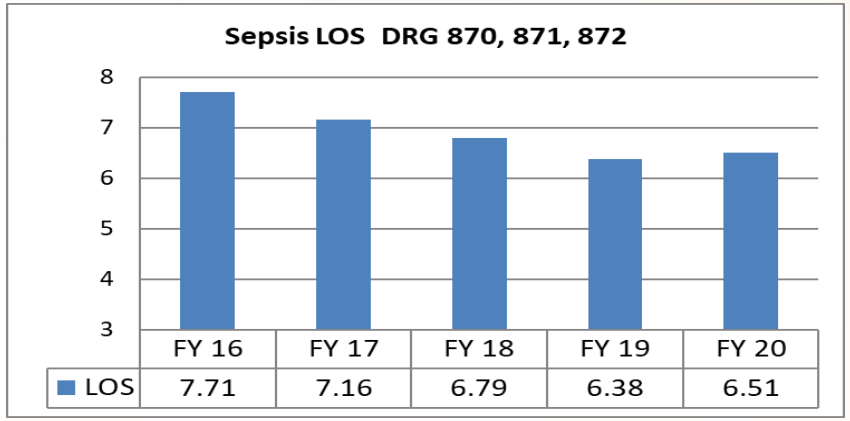
KDHCD NEW FY 2021 GOAL = 70%

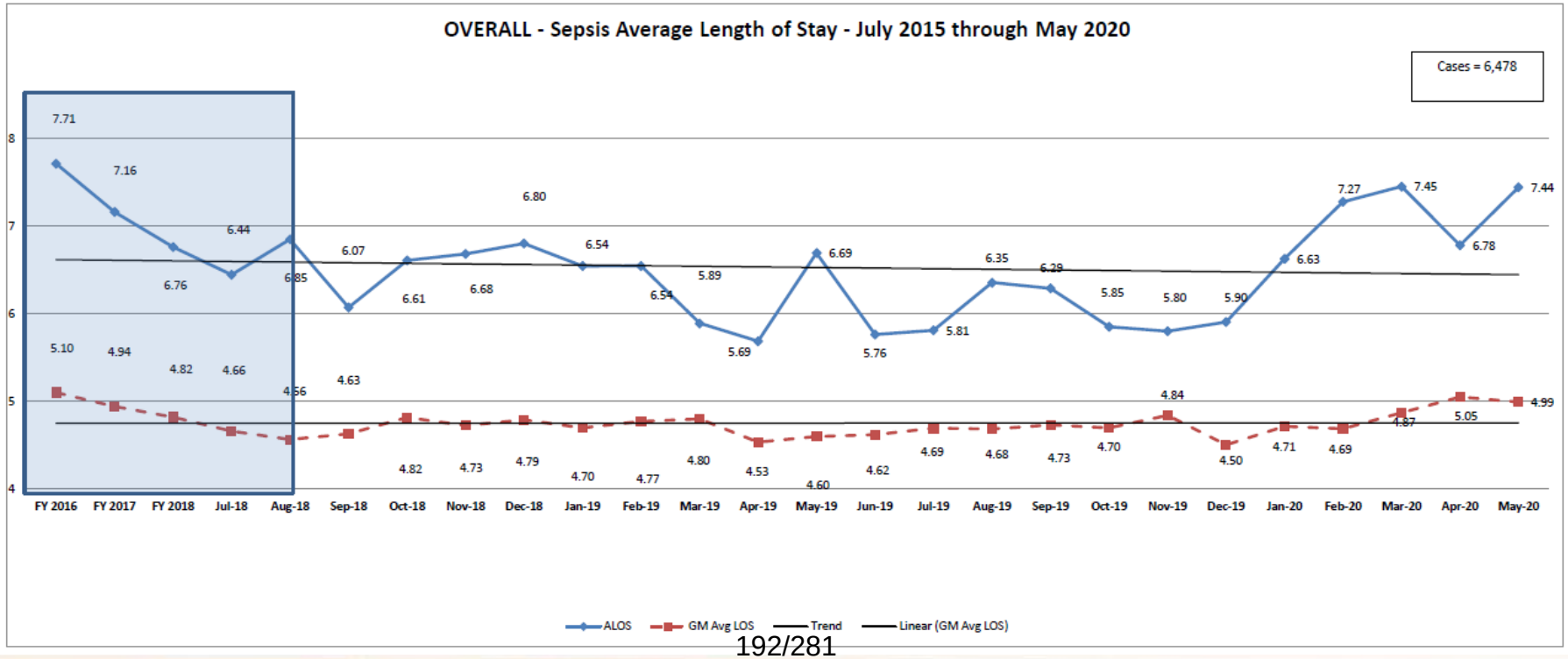


	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Concurrent	78	77	76	76	74	75	76	75	80	83	83	80	76
Sepsis-CMS	58	72	68	67	57	67	61	74	54	75	61	88	
Goal	65	65	70	70	70	70	70	70	70	70	70	70	70

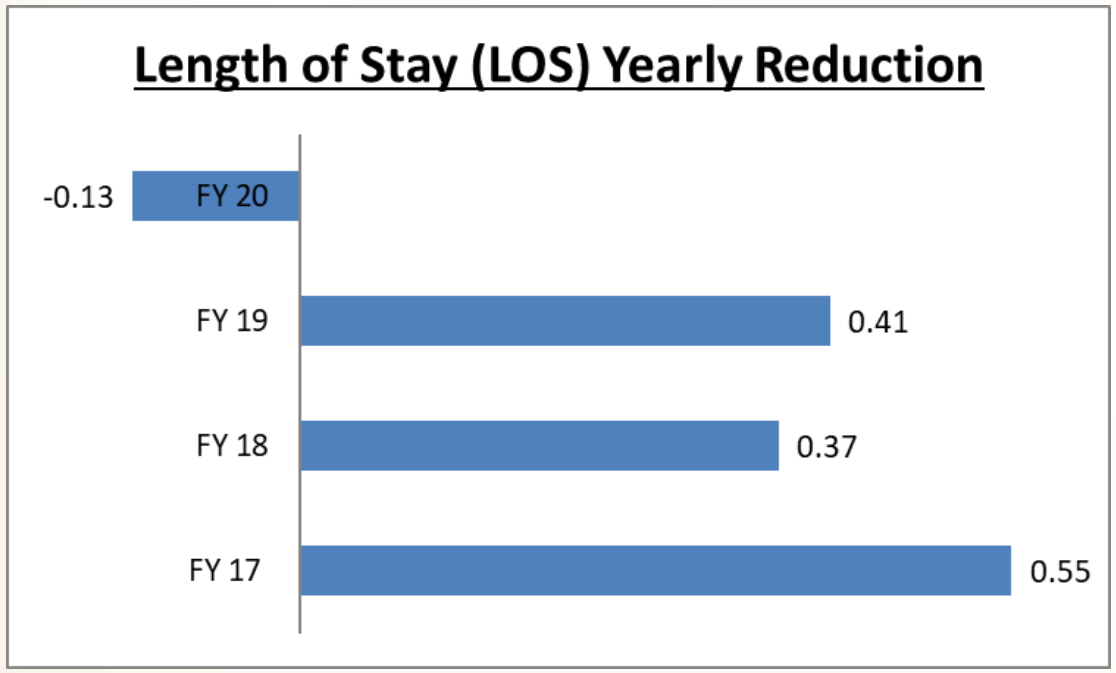
In April 2020, KDMC is in the top decile for sepsis bundle compliance in the nation!

Sepsis Length of Stay (LOS)

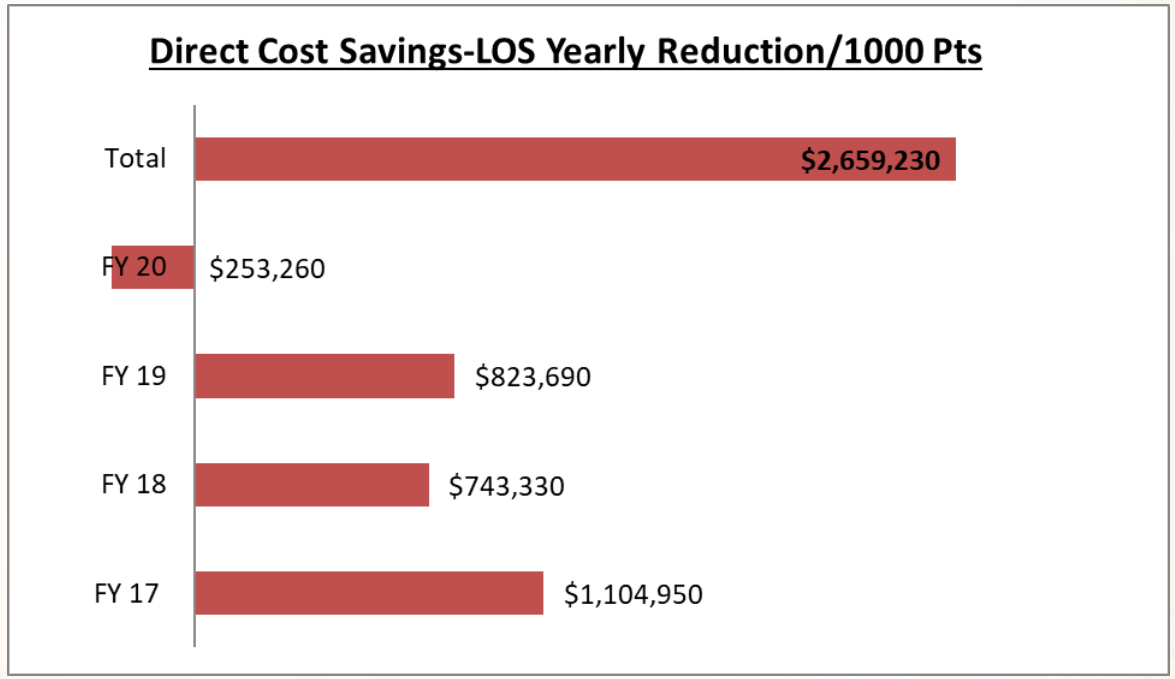




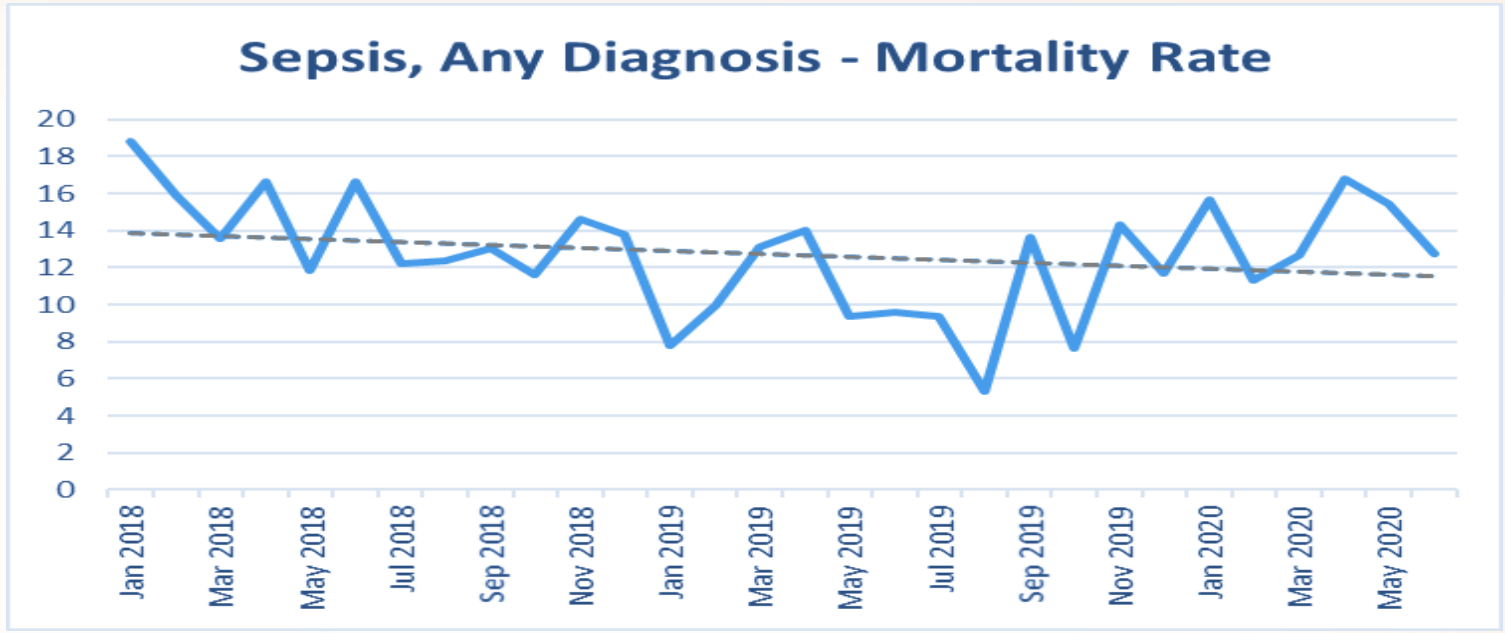
Sepsis Length of Stay Reduction & Savings

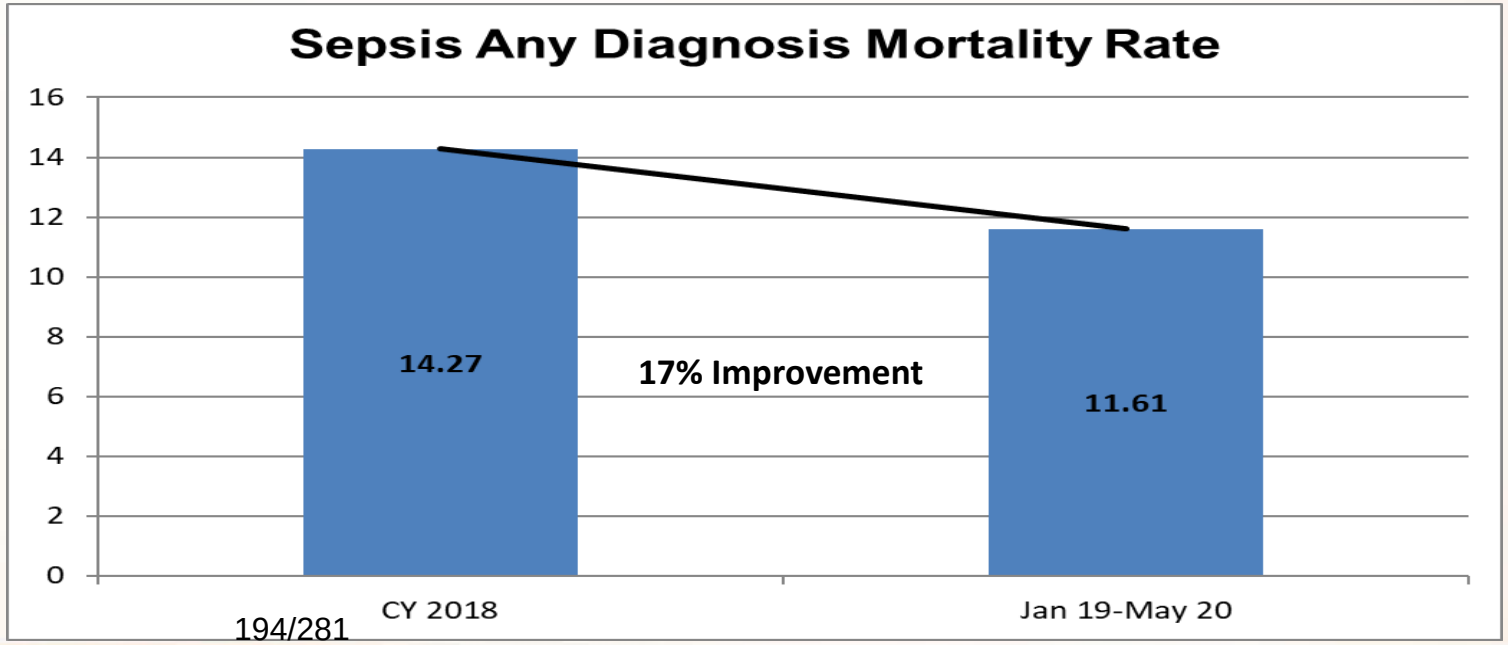


FY20 LOS continued to show a reduction through March; however, we have seen an increase in LOS for septic patients as related to COVID-19 infections in April & May.



Reducing Mortality & Saving Lives



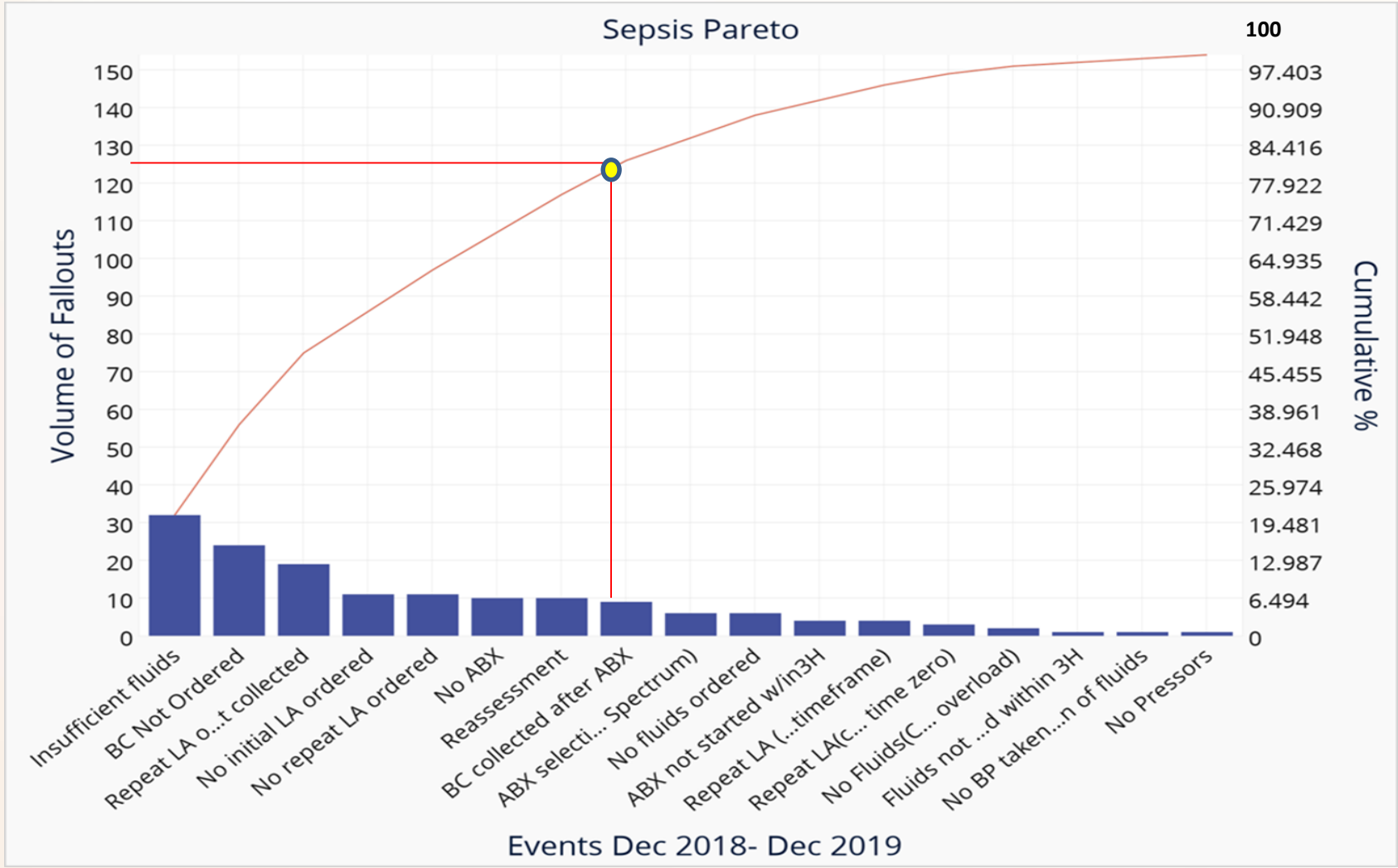


New Initiatives to Increase Sepsis Bundle Compliance

- Sepsis Kaizen Project - All CMS Sepsis fallouts from Dec 2018-Dec 2019 were analyzed by the Sepsis Team and root causes were identified

- Pareto chart developed to focus team's efforts on the root causes that would yield the biggest outcomes for our patients

80/20 Rule: Sepsis Bundle Fallouts



Fall Out	Total	Cumulative Total	%	Cumulative %
Insufficient Fluids	32	32	20.78	20.78
BC Not Ordered	24	56	15.58	36.36
Repeat LA Not Collected	19	75	12.34	48.70
No Initial LA Ordered	11	86	7.14	55.84
No Repeat LA Ordered	11	97	7.14	62.99
No Abx	10	107	6.49	75.47
Reassessment	10	117	6.49	75.47
BC Collected after Abx	9	126	5.84	81.82

Quality Improvement Strategies

- In March 2020, a Kaizen event involving resource experts targeted the 80% of fallouts
  - Refining order sets
  - Make it easy to document we have done the right thing
- In May 2020, a second Sepsis Coordinator joined team (7 days/week coverage)
- Increasing awareness:
  - GME
  - Nursing
  - Medical Staff

Sepsis Kaizen Update & QI Initiatives

Project Prioritization Matrix: Sepsis QFT, June 2020

Group Strategy Affects	Improvement Strategy		DIFFICULTY or Cost/ Time to Implement Rate 5 to 1 High = 1 Low = 5		FEASIBILITY (likelihood of Success/ability to achieve the outcome Rate 5 to 1 High = 5 Low = 1		SCOPE Strategy affects multiple or a high volume root cause Rate 5 to 1 High = 5 Low = 1		LEVERAGE (Positive Impact on Other Processes) Rate 5 to 1 High = 5 Low = 1		Total Project Priority
ED Pro	2. ED - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered (not "grayed out") COMPLETE		4.0	x	5.0	x	5.0	x	5.0		500.0
CC/INPT RN	6. Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion IN PROCESS		2.0	x	4.0	x	4.0	x	5.0		160.0
ED Pro & CC/HOS	11. Build dot phrase - If it's not Sepsis, document it COMPLETE	x	4	x	2	x	4	x	5		160.0
ED Pro/ ED GME	9. Schedule ED and GME regular education/awareness of bundle, and order set usage IN PROCESS	x	2	x	4	x	4	x	4		128.0
ED Pro	1. Improve ED provider notification by Sepsis Coordinator when attempting to avoid fallouts concurrently IN PROCESS	x	4.0	x	2.0	x	4.0	x	3.5		112.0
ED/CC RN	20. Hand off sheet/pathway checklist (concerns about paper lost); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, belonging forms "ad hoc" forms. Ideally it populate, and reminder to complete IN PROCESS	x	3	x	2	x	4	x	4		96.0
CC/INPT RN	7. Mandatory for RN to fill out "provider notification form" after sepsis alert fires – alerts suppressed for 48hrs, so RNs do not receive multiple alerts. THIS IS DEPENDENT ON #6 Investigate what happens If you bypass the alert one time it appears very difficult to get it back – further education/awareness of where to find alert IN PROCESS	x	4.5	x	3.0	x	2.0	x	3.0		81.0
CC/INPT RN	10. (Q&P/S) obtain safety summit compliance rates to validate if new staff are getting instructions upon hire of requirements COMPLETE	x	4	x	3	x	2	x	3		72.0
ED Pro	16. Reflex alert, when Abx ordered (specific list of Abx) provider gets alert "do you want BC" IN PROCESS	x	4	x	4	x	4	x	1		64.0
ED/CC/ HOS pro	15. > 126ml/hr option added to ED AND INPATIENT ADULT SEPSIS order sets COMPLETE	x	4	x	3	x	2	x	2		48.0
ED/CC/ HOS Pro	19. Add to ED AND INPATIENT order set Reflex LA order when previous LA >2 COMPLETE	x	2	x	4	x	4	x	1		32.0
ED/CC/ HOS Pro	17. Dot phrase for when Abx are urgent, so provider documentation is in EMR COMPLETE	x	4	x	3	x	1	x	1		12.0
CC/INPT RN	8. Evaluate what clin Ed provides to new RNs about sepsis alerts and how to respond? Ideally hands on training upon hire, look at alerted patient and walk through documentation IN PROCESS	x	1	x	4	x	2	x	1		8.0
CC/HOS Pro	22. Standardized documentation of attending reassessment (Dr. Malli's phrase) IN PROCESS	x	3	x	2	x	1	x	1		6.0
ED RN	13. ED Techs input height and weight in EMR; RN input for BIBA patients SHOLD dependent on #14 IN PROCESS	x	2	x	1	x	1	x	1		2.0
ED RN	14. IBW automated in fluid order when height and weight are documented COMPLETE	x	2	x	1	x	1	x	1		2.0

- Kaizen work began March 2020
- Key Stakeholders: Physicians, GME Residents, Nursing, ISS, Clinical Education in ED, ICUs, ICCUs
- Over 20 identified QI strategies identified
- Seven (7) strategies have been completed and implemented
- Eleven (11) strategies are in development and nearing completion
- Four (4) strategies in parking lot
- Concurrent and CMS bundle compliance are trending above national average and Org goal in April, pending May results
- Data reveals an increase in compliance of the 3-hour and 6-hour bundles (Former top fallouts: repeat LA, fluid administration, and reassessment)

Sepsis Summary & Actions

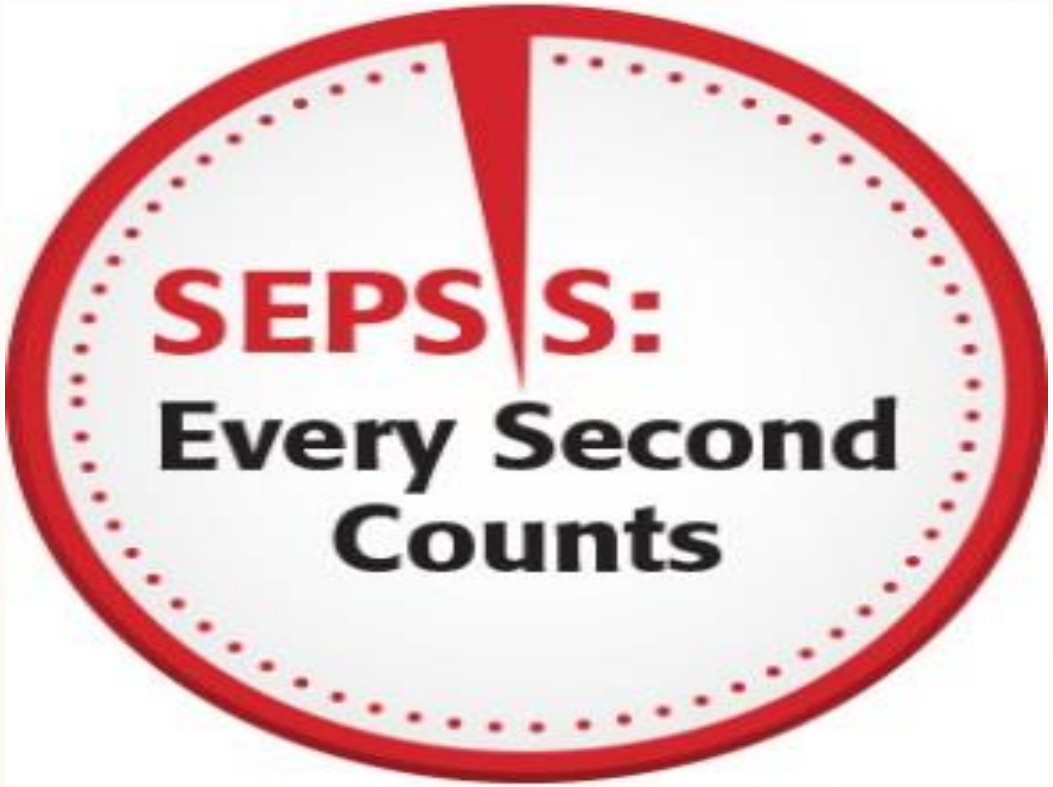
Summary

- Sepsis Bundle Compliance Jul 2019 - May 2020 = 67% *(CMS bundle)*
  - Not currently meeting FY org goal of ≥70% (must achieve ≥84% in May & June to meet org goal)
  - Sepsis Bundle Compliance Jul 2019-Jan 2020 = 74% *(Cases followed by Sepsis Coordinator)*
- Successes as a result of Kaizen work:
    - 100% compliance of provider reassessment for 3 consecutive months (formerly the most frequent fallout)
    - ≥92% compliance for blood cultures within 3 hours of sepsis identification for 3 consecutive months (formerly the 3rd most frequent fallout)
    - Improved provider documentation and sepsis order sets
    - Improved sepsis 3-hour bundle compliance (lactate management, blood culture orders, antibiotic administration)
    - Improved sepsis 6-hour bundle compliance (repeat lactic acid lab, fluid resuscitation, and reassessment by provider)

Actions

- Continued work by Kaizen group:
    - Administer IV fluid resuscitation within expected timeframe
    - Order and draw repeat lactic acid labs within expected timeframe
    - Nursing documentation
    - Ongoing sepsis education to nursing, providers, and GME residents

Questions?



Sepsis QI Strategies 2020

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status
Unable to Identify Sepsis				
Unable to ID sepsis because there is a delayed presentation and provider does not receive notification either by: • Sepsis alert (20% specificity), or • RN via sepsis alert (not addressed in some way 36% of time -in-patient only, no ED/OHS)	ED MD	1. Improve ED provider notification	Ryan & Dr. Gray	Ryan and Dr. Gray to follow up with Dr. Seng to determine a consistent process of provider notifications
	ED MD	2. **ED** - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered (not "grayed out") **THIS ACTION ITEM IS DEPENDENT ON ACTION #13**	Curtis/Blake Stacey	4/1/20 - Build in process; pending email response from ISS on go live date 04/6/20- Built, with exception of 126ml/hr fluid additions, Ryan to email Kurtis with kg ranges/infusion hrs and wording above orders. Go live date_____
	CC/HOS	3. Admit to CC/3W Orders (ED orders that follow to inpatient): Short list of orders… if this not done… for each piece of bundle, this is like a continuation of initial sepsis orders or active "hold" orders to keep the ball rolling. ISS, system will allow according to Dr. Haley; written order with attribution to admitting physician, ONLY FOR PTS WITH KNOWN DX OF SEPSIS. Evaluate if ED have privileges to enter those orders?	Dr Gray	4/8/20 Dr Gray will contact Dr. Haley to investigate status of this functionality, what are the barriers to making this happened? Based on that, contact needs to be made with med staff office regarding privileges for ED doctors to enter these orders.
		4. Evaluate Workflow in Cerner r/t sepsis alerts & notification (long term) (Sepsis Q&P/S team). Potentially alerts can fire to cell phones.	Stacey	4/8/20 - Can sepsis alerts fire to cisco phones? Inquire with Daniel Baker. Right now RN has to be in EMR to see alert. Maybe Burbee? Paging system, to send alert to cisco phones. Emma Mozier is the director who trialed Burbee

201/281

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status
				04/09/20 Emailed Daniel Baker, initiative on hold for COVID. Ticket open (Participants include Evelyn McEntire, Sandy Volchko, Daniel Baker, Christopher Born, and Jeremy Cannon.
		5. Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion. Evaluate checklist for RNs to complete after sepsis alert fires. A checklist would "pare down the specificity of the alerts	Ryan	4/8/20 – Ryan will look at literature and what other hospitals. Ryan will contact ISS to determine if changes to power form can be made.
		6. Mandatory for RN to fill out "provider notification form" after sepsis alert fires – alerts suppressed for 48hrs, so RNs do not receive multiple alerts.	Ryan	This is dependent on completion of #5. Ask Katie and Sarah brown if we can make mandatory.
		7. Evaluate what clin Ed provides to new RNs about sepsis alerts and how to respond? Ideally hands on training upon hire, look at alerted patient and walk through documentation	Evelyn	Clin Ed Rep for sepsis, Erin Miller & Erin Marquez. Ask Erin to provide a list of what education/training is provided to new staff. Ask Clin Ed to add to their training - If you bypass the alert one time it appears very difficult to get it back – further education/awareness of where to find alert. 4/8/20 – Erin provides 1.5 – 2 hrs of sepsis educ in NH Orientation, but does not include the provider

202/281

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status
				notification form. She will send me the PP. This is populated on the nurse's task list and CC nurses do not use the task list much (MS more common). Erin confirmed that the ICU iView does include the Provider Notification Form in it, but there is no hard stop so the nurse ignores it and it shows as "overdue."
Potentially unaware of CMS sepsis criteria	ED/ ED GME	8. Schedule ED and GME regular education/awareness of bundle, and order set usage	Ryan	Ryan to discuss with Dr. Seng/Tu to get on provider meeting regular schedule; and discuss with Amy Shaver/Linda Herman for ED GME conference schedule.
	CC/INPT RN	9. (Q&P/S) obtain safety summit compliance rates to validate if new staff are getting instructions upon hire of requirements Also addressed with action item #7	Sandy	4/8/20 – Sandy will contact Kathy Allred for report.
Sepsis in differential – Not documented when not Sepsis because: • Not standard documentation practice (backward) • Unaware of CMS sepsis documentation requirements	ED & CC/HOS	10. Build dot phrase - If it's not Sepsis, document it (Dr. Shafer)	Seth (ISS) Stacey	4/1/20 – Build in process, Stacey will follow up with Seth to get status update and inform of ED leadership requests. 4/2/20- Dr. Malli agrees to dot phrases, ensure that cc/hos have access to these 04/08/20 Stacey will send list of dot phrases to Dr. Gray; Dr. Gray will send our draft dot phrases to our ED providers for approval. Once approved give ISS green light to go live. Notify Dr. Malli/Dr. Said that these dot phrases exist for use. Stacey will ask Seth "how to providers go about using these dot

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status
				phrases" so that our provider education can be specific.
Root Causes of Patient not receiving fluids @ 30mL/kg (per actual or ideal body weight)				
Missing documentation ideal body weight and its use in fluid calculation because: • Ideal body weight not readily available • Less than ideal communication between RN Sepsis Coordinator and ED providers when suggesting documentation revisions • Potentially unaware of CMS sepsis criteria	ED	11. ED Techs input height and weight in EMR; RN input for BIBA patients **HOLD**	Billy &Tom	4/1/20 – Education completed for ED techs. 10 pts reviewed of non-BIBA pts with 0% compliance with entering height. Plan to pull sample again on 4/15/20 and 4/30/20 and follow up with Sandy and Evelyn. **There's no point in staff doing this if #12 isn't possible; don't advocate further until #12 has been fully evaluated**
	ED	12. Working with ISS to have IBW automated in fluid order when height and weight are documented	Rick Brown Evelyn	4/1/20 – Need to verify if this is working with Rick Brown; Rick mentioned that this workflow may impact other workflow (ie. Nutrition); Evelyn to follow Up 04/6/20- Kurtis will follow up with dietary and other involved stakeholders and provide updates. Katie Morley in office 04/07/20 to follow up in person with Monica Lopez and Rick Brown 4/17/20 – Rick Brown and Monica Lopez have built and tested the functionality of the height/length field in the ED Result Review and iView. Conversion and the correct DTA are showing in the iView and have been validated. Rick has sent the ticket back to Blake and Kurtis for cert testing and functionality of the Sepsis PowerPlan.

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status
Potentially contraindicated (HF,RF) • Reluctance to give fluid • Provider ordering individual bolus to see Pt response, 2nd L outside window	ED/CC/ HOS	13. > 126ml/hr option added to <u>ED AND INPATIENT ADULT SEPSIS</u> order sets * Must be started w/in 3 hr window * Must meet 30 ml/kg volume requirement	Curtis/Blake Stacey	4/1/20 pending build; verify it's added to SEP-1 (verified it is one SEP-1A, catch up), verify verbiage is correct. 4/2/20 – Dr. Malli agreed to add this to adult inpatient order set 04/06/20- Build format discussed, pending kg/hr ranges with wording above order; to be sent to Kurtis by Ryan. Go live date_____
Root Causes of Blood Cultures not Ordered (before Abx administered)				
Found infection source do not feel they need BC (medical habit)		Addressed with Action item #5		
Found infection source, but Sepsis in differential –Not documented when not Sepsis • Not standard documentation practice (backward) • Unaware of CMS sepsis documentation requirements		Addressed with Action item #5		
Delayed recognition of sepsis and provider does not receive notification either by: • Sepsis alert (20% specificity), or • RN via sepsis alert (not addressed in some way 36% of time - in-patient only, no ED/OHS)		Addressed by action item #2		
• Orders left in planned state (Cerner complexities)		Out of scope of sepsis; this issue is global and need ISS to address in a comprehensive manner		n/a

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status
Root Causes of Blood Cultures Ordered, but not in Correct Sequence (Before Abx Administration)				
Correct sequence in order set not used because: • Unaware of order set, not used • Unclear if patient is septic (order set not used)		Addressed by action item #4 (ED/GME education/awareness ongoing to include order set usage)		
	ED	• Addressed by action item #2 (catch up order set); and action item #5 14. Reflex alert, when Abx ordered (specific list of Abx) provider gets alert “do you want BC”	Kurtis/Blake Stacey	4/1/20 – Abx list sent to ISS, providers asked for list, waiting for response from ISS. Confirmed with ISS that these alerts are only for ED providers; if not we need to confirm with CC/Hosp if they want these alerts.4/2/20 – Dr. Malli advises that these alerts will NOT work for inpatient, do not include them 04/06/20 New ABX list to be sent to Kurtis from Ryan. Will only alert when ABX on provided list have indication of sepsis. Possibility of having alerts fire to RN when scan ABX and populate ad hoc form? Kurtis will keep team updated. ISS will need to test BC order attached in alert (Bridge must print out two labels). 4/8/20 Ryan sent list to Kurtis, waiting for Kurtis/Blake to reply.
Unaware of CMS bundle requirements	ED/ED GME	Addressed by action item #4 (ED/GME education/awareness ongoing to include order set usage). Also addressed by Action item #2		

206/281

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status
Waiting for other dx results before ordering (i.e., urine) looking for infection source (mindful of BC over-utilization)		Addressed by action item #2		
Urgency for Abx administration	ED/CC/ HOS	15. Requested dot phrase for when Abx are urgent, so provider documentation is in EMR	Seth Stacey	4/1/20 – Build in process, Stacey will follow up with Seth to get status update and inform of ED leadership requests; 4/2/20 – Dr. Malli agreed, include cc/hosp for these dot phrases. 04/08/20 Stacey will send list of dot phrases to Dr. Gray; Dr. Gray will send our draft dot phrases to our ED providers for approval. Once approved give ISS green light to go live. Notify Dr. Malli/Dr. Said that these dot phrases exist for use. Stacey will ask Seth "how to providers go about using these dot phrases" so that our provider education can be specific.
BC collected after Abx (ED): Failed sequence 1.BC drawn 2.Abx scanned 3.BC labels printed • Doc requirements is unnatural workflow • Not aware of CMS doc requirements	ED RN	16. Evaluate BC labeling process; set up meeting with ED and Lab and ISS/Bridge to determine if there is a process where the actual time the labs were drawn (via generic label) can be used when "real" label is printed after provider order is obtained		4/1/20 – need to set up meeting with ED/Lab and ISS. Sandy emailed Lacey and Carol/Randy to confirm ISS & Lab attendees. 4/8/20 Hold for now r/t COVID-19 as lab is inundated.
Root Causes of Lactic Acid, Orders for Initial and Repeat (If initial >2, within 6 hrs of initial)				
No order for initial LA	ED MD	Addressed by Action Items #2, #4		

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status

• Sepsis not identified
  • Unclear/delayed sepsis presentation
  • No alert/notification of alert
• Not using order set
  • Not aware of order set
  • Unclear/delayed sepsis presentation
• Not aware of CMS bundle requirements				

No order for repeat LA (if previous LA >2)
• Not using order set, ordering a-la-cart
  • Unclear/delayed sepsis presentation
  • No alert/notification of alert
  • Unaware of order set
• Not aware of CMS bundle requirements
	ED/ED GME/CC/ HOSP	17. **Add to ED AND INPATIENT order set** Reflex LA order when previous LA >2
		
		Also addressed with action item #2, #4
			Katie & Sarah, and Kurt Remmert	4/1/20 – follow up with ISS to determine status; 4/2/20 – Dr. Malli agrees with adding reflex order to inpatient adult order set
				04/06/20 Kurtis and/or Katie Morley to follow up with Kurt R. regarding build (verify IE/inpatient workflow), added language to orders to discontinue future LA orders when LA <2.0.

RN not drawing LA within 6 hrs of time zero or not drawing at all • RN not aware of time zero? • Not aware of CMS bundle requirements • Pt leaves ED to 1E or floor without handoff communication of need & time for repeat LA (r/t lab vs RN draw, need to cancel order and reorder so lab draws, lab draws all inpatient	ED/CC RN	18. Hand off sheet/pathway checklist (concerns about paper lost); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, belonging forms “ad hoc” forms. Ideally it populate, and	Stacey	4/1/20 – Need to identify a person in ISS to work on this with us. 4/2/20 – cc RNs agreed to this strategy 04/06/20 Kurtis to send KDHUB request form to Stacey. 04/07/20 KDHUB form sent to Kurtis (pending finalization of paper handoff tool). 04/08/20 draft complete, Stacey will send to ED and CC RN/Leadership for final review and comment – if those

Root Causes	Group Strategies Applies	Potential QI Strategy	Person Assigned & Date of completion	Status
		reminder to complete.		groups are good Stacey will send to ISS to build. 04/09/20 emailed ED/CC Sepsis participants for feedback on form due by 04/14/20 1700.
	ED RN	Can RN get alert that order is there (for repeat LA)?		Handoff tool will address this #18
	ED RN	Consider ED Drawing repeat LA before pt leaves ED to 1E (similar to how troponins are managed and drawn by ED RN if timing indicates), connect with lab.		PARKING LOT
Root Causes of missing reassessment (within 6 hrs if hypotension present after fluids)				
Reassessment is omitted because: • Provider unaware of CMS requirements • No standardized workflow Reassessment is documented, but does not have all required elements because: • Provider unaware of CMS requirements • No standardized workflow	CC/HOS	19. Standardized documentation of attending reassessment (Dr. Malli's phrase) Attestation		Dr. Gray to contact Dr. Malli to get his wording. Contact Leah D. to see how we get Dr. Malli's phrase into other MDs.

Catheter Associated Urinary Tract Infection (CAUTI) Quality Focus Team Report

July 9, 2020

Kari Knudsen, Director of Post-Surgical Care (Chair)
Alisha Sandidge, Advanced Practice Nurse (Co-Chair)
Shawn Elkin, Infection Prevention Manager (IP liaison)

KAWEAH DELTA HEALTH CARE DISTRICT

KAIZEN Root Cause Analysis

Analysis:

Identified Root Causes

(in order from most significant to least):

1. **Communication**
2. **Leadership Standard Work**
3. **Peri-care/Bathing**
4. **Prompt Catheter Removal**
5. **Culture Ordering**
6. **Retention Management**
7. **Staff Consistency with prevention bundle**
8. **Alternatives to Catheter Insertion**

Kaizen improvement strategies focused on addressing the top 4 root causes

Action Plan

Action Plan:

Improvement Strategy	Who?	When?
Standardize the Unit Shift Safety Huddles to include components of prevention bundle	Maria Trujillo	3/10/20
IUC Gemba (CAUTI rounds) – Every catheter rounded on daily by NM, IP, Clin Ed/APN for best practice compliance	Kari Knudsen	3/10/20
Standard Work developed for handoff on CAUTI prevention components on transfer pts	Kristie Alvarado	3/10/20
Leadership Standard Work developed to standardize NM daily, weekly and monthly tasks to address compliance with best practices	Mary Laufer	3/10/20
ED Staff education on Catheter alternatives	Tom S.	2/14/20
Incorporate catheter necessity in critical care MD/RN rounds	Ryan T., Maria & Shawn	1/31/20
RN Education: scope of practice with IUC insertion	Kaizen	3/10/20
CNA Education: peri-care/bath documentation in real time (During IUC Gemba)	Kaizen	3/10/20

Post Kaizen-Gemba Data

CAUTI Committee Dashboard			
Measure Description	Benchmark/ Target	Mar-20	Apr-20
OUTCOME MEASURES			
Number of CAUTI	0	0	1
Days Between Events (from last CAUTI to end of reporting month OR next CAUTI) BASELINE (4/1208 to 10/2019) = 12.78	>30	49	2 (4/28/20)
Quarterly SIR (all payor)	≤ 0.838	0.52	
FYTD SIR (all payor) BASELINE (FY19) =1.557	≤ 0.838	0.96	0.93
PROCESS MEASURES			
IUC Shift Huddles			
% Huddles Accurately Completed	100%	74%	89%
% insertion missed	0%	19%	40%
% cleanliness missed	0%	81%	60%
IUC Gemba Rounds			
% of Gemba Rounds Completed	100%	n/a	n/a
% of pts with appropriate cleanliness	100%	98%	99%
% of IUCs with order & valid rationale	100%	90%	93%
% of IUCs where removal was attempted	n/a	8%	5%
% of pts where alternatives have been attempted	n/a	15%	12%
# of Pt Catheter days rounded on	n/a	616	720
% of IUCs removed because of Gemba Round	n/a	7%	6%
# of IUCs removed because of Gemba Round	n/a	46	42

Total catheter days rounded on = 1336

99% of patients with daily bath and peri-care per shift

93% have order and valid rationale

88 catheters removed as a result of the Gemba

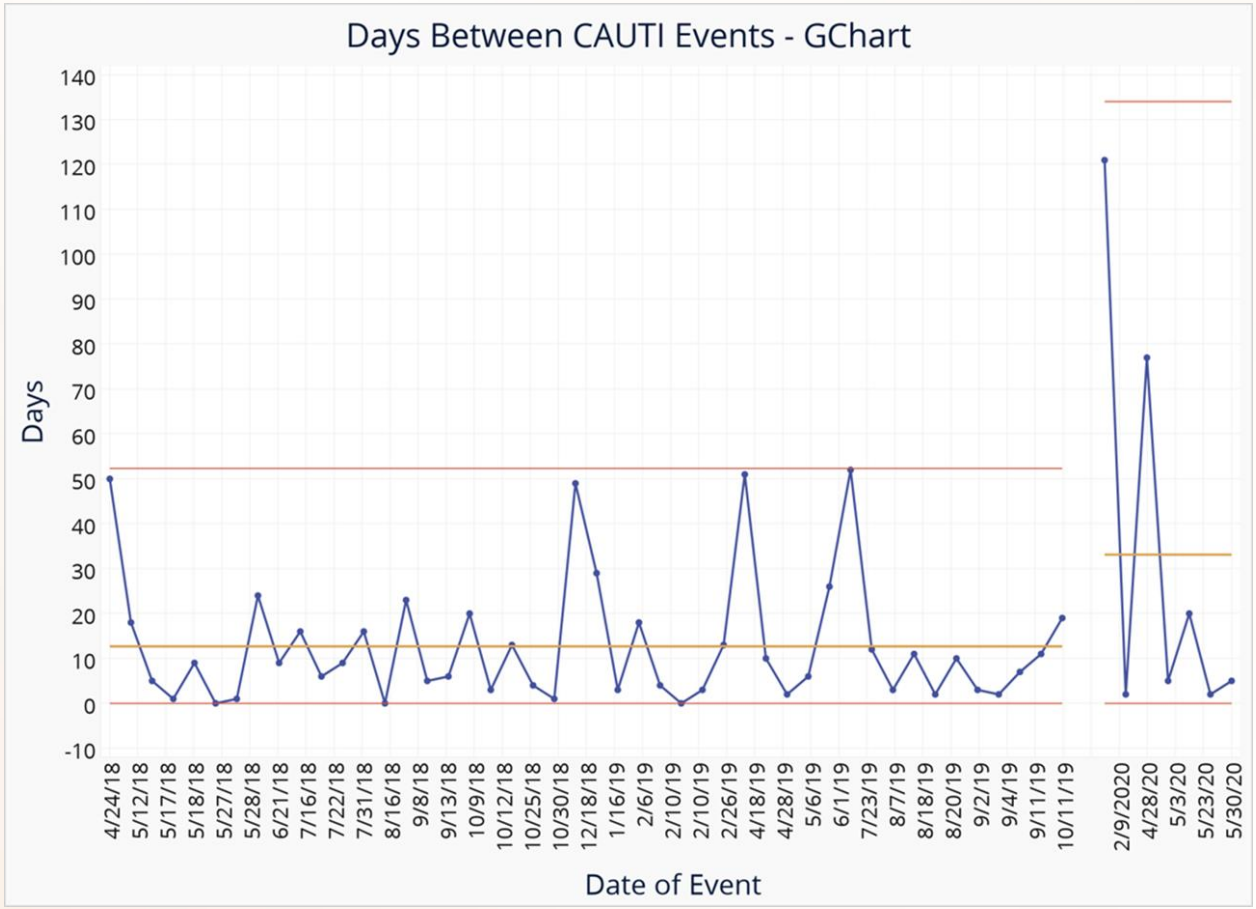
Shift huddle data collection continues to be fine tuned.

IUC Gemba Next Steps

- IUC/Central Line Gemba form revised for ease of use
- Data collection process simplified
- Safety huddle form and process revised for ease of use

Days Between CAUTI

April 24, 2018 through May 30, 2020



Results Report May 2020

FYTD SIR (7/2019-4/2020) = 0.93 Goal = <0.828

Mean days b/w CAUTI 4/2018 to 1/2020= 12.72 Goal >30

Post Kaizen: Mean days b/w CAUTI 10/2019 to April 2020= 33.14

***2 astronomical points noted at 121 and 77 days**

CAUTI QFT – Plans for Improvement

- IUC insertion powerplan- build complete, going to ORC in July for approval
  - Add initial straight catheterization option prior to inserting IUC
  - Add change of IUC prior to specimen collect if in greater than 72 hours
- IUC discontinue orderable- build complete, going to ORC in July for approval
  - Asks provider to consider ordering the urinary retention management order
    - Retention Management- standardized retention management orders for post removal of indwelling urinary catheter (IUC) that exist upon discontinuation of the IUC build complete, go live mid July
- Culture of Culturing- change orders for urine culture to reduce number of cultures collected
  - Auto discontinue urine culture order if specimen not collected within 12 hours, build pending
  - Add hard stop criteria to the urinalysis with reflex culture if indicated order. Criteria would represent signs of urinary tract infection. Go live mid July.
  - Add 'Restricted' to label of culture only order with criteria of when this order should be used. Go live mid July.

CAUTI QFT – Plans for Improvement

- CAUTI Case review process and form updated
- Culture of Culturing follow up meeting on 6/26/20
  Recommendations pending

Future State Predictions

Organizational Clinical Quality Goals FY20

	Current									Future State Scenario				SIR	VBP
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total	GOAL	2021
CAUTI (SIR)	0.65	2.76	2.34	0.68	0.00	0.00	**0.00**	**1.33**	**0.00**	**0.67**	**0.00**	**0.00**	**0.77**	**<0.828**	**50**
numerator (actual)	1	5	4	1	0	0	0	2	0	1	0	0	14	**or**	**perc**
denominator (predicted)	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.5	1.5	1.5	1.5	1.5	18.21	**14**	**0.774**

QUESTIONS?

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Unit/Department: CAUTI QFT **ProStaff/QIC Report Date:** 7/14/2020

Measure Objective/Goal:

- Goal of ≤ 0.828 (CMS 50th percentile); Current SIR = 0.93, this is an improvement of 67% from our pre Kaizen baseline SIR of 1.557
- Expected actual number of CAUTI for our population is 6 per year. Actual number of CAUTI = 14
- Desired days between CAUTI to achieve the goal is greater than 30.
  Current days between = 2

CAUTIs result in poor outcomes for patients, a negative public perception of care through publically reported safety scores and financially impact the organization through HAC and VBP programs as well as increased treatment costs and LOS.

Date range of data evaluated: FYTD SIR (7/2019 – 4/2020)

Analysis of all measures/data: (Include key findings, improvements, opportunities)

(If this is not a new measure please include data from your previous reports through your current report):

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Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

Unit/Department Specific Data Collection Summarization

Professional Staff Quality Committee/Quality Improvement Committee

Performance calculator: with no CAUTI for the remainder of the FY, achieving our goal is possible

Future State Scenario				SIR	VBP
April 2020	May 2020	June 2020	Total	GOAL	2021
0.67	0.00	0.00	0.77	<0.828	50
1	0	0	14	or	perc
1.5	1.5	1.5	18.21	14	0.774

If improvement opportunities identified, provide action plan and expected resolution date:

Action Plan:

Improvement Strategy	Who?	When?
Standardize the Unit Shift Safety Huddles to include components of prevention bundle	Maria Trujillo	3/10/20
IUC Gemba (CAUTI rounds) – Every catheter rounded on daily by NM, IP, Clin Ed/APN for best practice compliance	Kari Knudsen	3/10/20
Standard Work developed for handoff on CAUTI prevention components on transfer pts	Kristie Alvarado	3/10/20
Leadership Standard Work developed to standardize NM daily, weekly and monthly tasks to address compliance with best practices	Mary Laufer	3/10/20
ED Staff education on Catheter alternatives	Tom S.	2/14/20
Incorporate catheter necessity in critical care MD/RN rounds	Ryan T., Maria & Shawn	1/31/20
RN Education: scope of practice with IUC insertion	Kaizen	3/10/20
CNA Education: peri-care/bath documentation in real time (During IUC Gemba)	Kaizen	3/10/20

Next Steps/Recommendations/Outcomes:

A. Continue to maintain Kaizen initiatives: Daily IUC Gemba rounds, IUC shift huddles
B. Continue to monitor CAUTI events and perform case reviews with staff education following any CAUTI
C. Culture of Culturing follow up meeting 6/26/2020, recommendations pending.
D. Order changes in progress
    1. Urinalysis orders
        a. Culture only order. add 'restricted use' in the name of the orderable. Add to the body of the orderable: 'Restricted use unless previous positive UA resulted in the last 48 hours, nephrology patient, pediatric patient, out-patient. Go live expected mid July.

Please submit your data along with the summary to your PI liaison 2 weeks prior to the scheduled report date.

b. UA with culture reflex order- add hard stop criteria for ordering (multi-select) with the following options: Dysuria, suspected sepsis, fever plus one other, new onset altered LOC, CVA tenderness, pelvic discomfort, flank pain, suprapubic pain. Go live expected mid –July.
c. For all 3 UA orders [UA, UA with culture reflex, Culture only] auto-discontinue the order if no specimen collected within 12 hours. Build pending.

2. Insert Indwelling Urinary Catheter (IUC) orders- Powerplan for IUC insertion and maintenance. Going to Order Review Committee July 2020
    a. Add straight catheter options prior to inserting IUC as appropriate
    b. For IUC maintain- add if IUC in greater than 72 hours change IUC prior to specimen collection DO NOT change IUC if inserted by urology, inserted surgically, or MD indicates that IUC should not be removed. For any questions, consult the MD. Change IUC after 30 days, DO NOT change IUC if inserted by urology, inserted surgically, or MD indicates that IUC should not be removed. For any questions, consult the MD.
    c. For Discontinue IUC- urinary retention management orders built, alert will ask provider to place post discontinuation. Go Live mid July.
3. Discontinue IUC orderable
    a. Alert prompts provider to place Urinary Retention Management order allowing management of acute retention following discontinuation of IUC.
    b. Reference text reminds the RN to discontinue the Insert IUC Powerplan and maintain IUC orderable.

Submitted by Name: Kari Knudsen **Date Submitted:** 6/26/2020

Nursing Workforce 2020: Safe Practice & Risk Assessment

Mary Laufer, DNP, RN, NE-BC
Director of Nursing Practice

KAWEAH DELTA HEALTH CARE DISTRICT

June 2020 PCL/PCM

Foundation for the Role of Nurses

How can I provide for this right thing to be always done?

(Nightingale, 1918)

Nurse Work Environment

- Facilitate or constrain nursing practice
- Linked to patient outcomes
- Characterized by
  - Safe staffing
  - Communication & team work
  - Competent managers
  - Supportive senior leadership

(Carthon et al., 2019)

Adequate Nurse Staffing

- Contributes to improved patient outcomes
  - Surveillance
  - Time with patients
  - Early detection

(Carthon et al., 2019; Costa & Yakusheva, 2016)

High Patient Workloads

- Nurses consistently report patient safety concerns
  - Information falling through the cracks
  - Delayed or missed care
  - Risk of adverse event

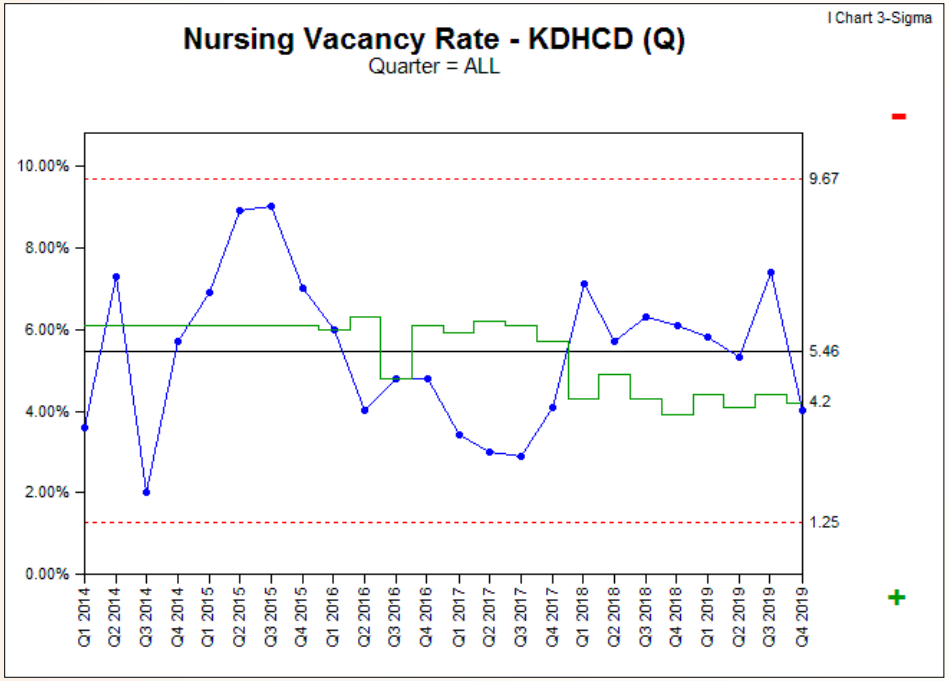
(Carthon et al., 2019)

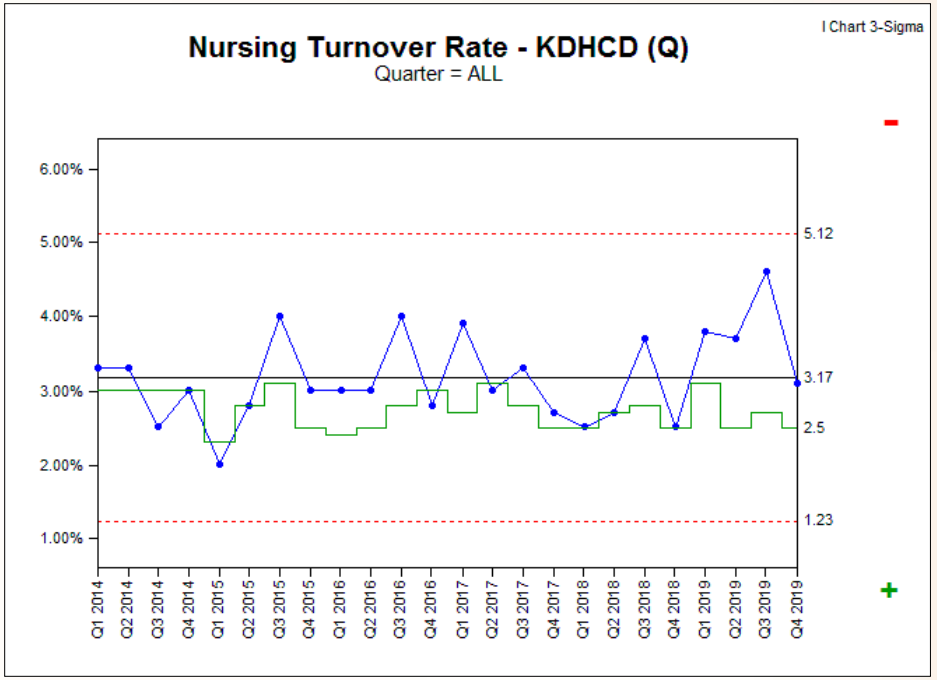
High Patient Workloads

- Increased likelihood of adverse nurse outcomes
  - Burnout
  - Job dissatisfaction
  - Intent to leave

(Shin, Park, & Bae, 2018)

Vacancy & Turnover Rate





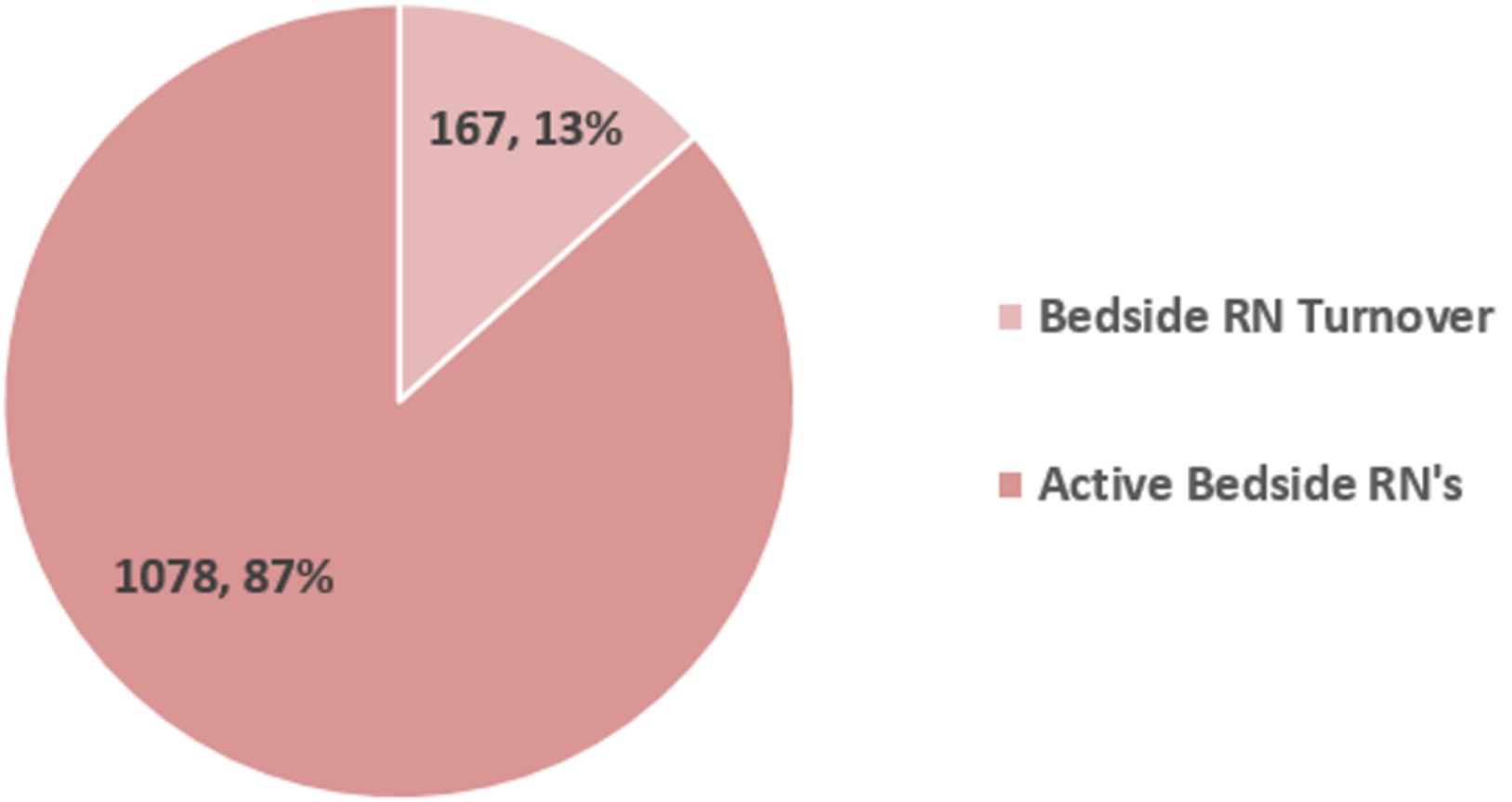
Cost of Clinical Nurse Burnout

- 74% of nurses are concerned about stress
- 45% of nurses are tired of their jobs
- 34% of nurses suffer from “Burnout Syndrome”
- $65,000 average cost to replace one nurse
- RN turnover costs: ↑ 1% = $337,000 per year
- Brain drain
- 2% decrease in patient satisfaction for every 10% of dissatisfied nurses
- Increase in HACs

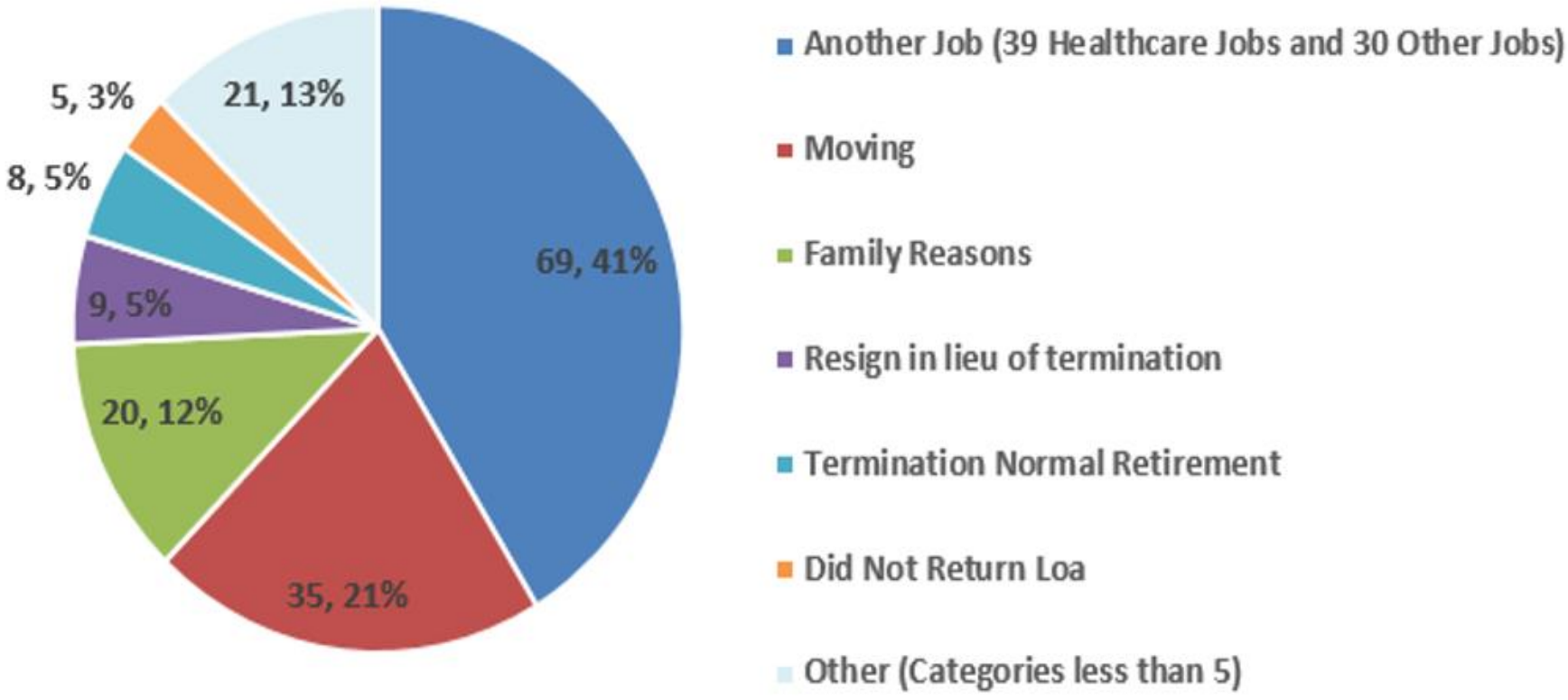
Ruggiero, J. & Vanek, F. (2019). *Engaging Leaders by Prioritizing Their Wellbeing and Resillency.* Presentation at the annual AONE Conference, San Diego, California
Holm, C. (2019). *Attributes in Leaders Most Desired by Clinical Nurses.* . Presentation at the annual AONE Conference, San Diego, California

Direct Care RN Turnover (FT/PT)

(May 2019 – April 2020)



Reasons Direct Care RNs Left
167 FT/PT RNs (May 2019 – April 2020)

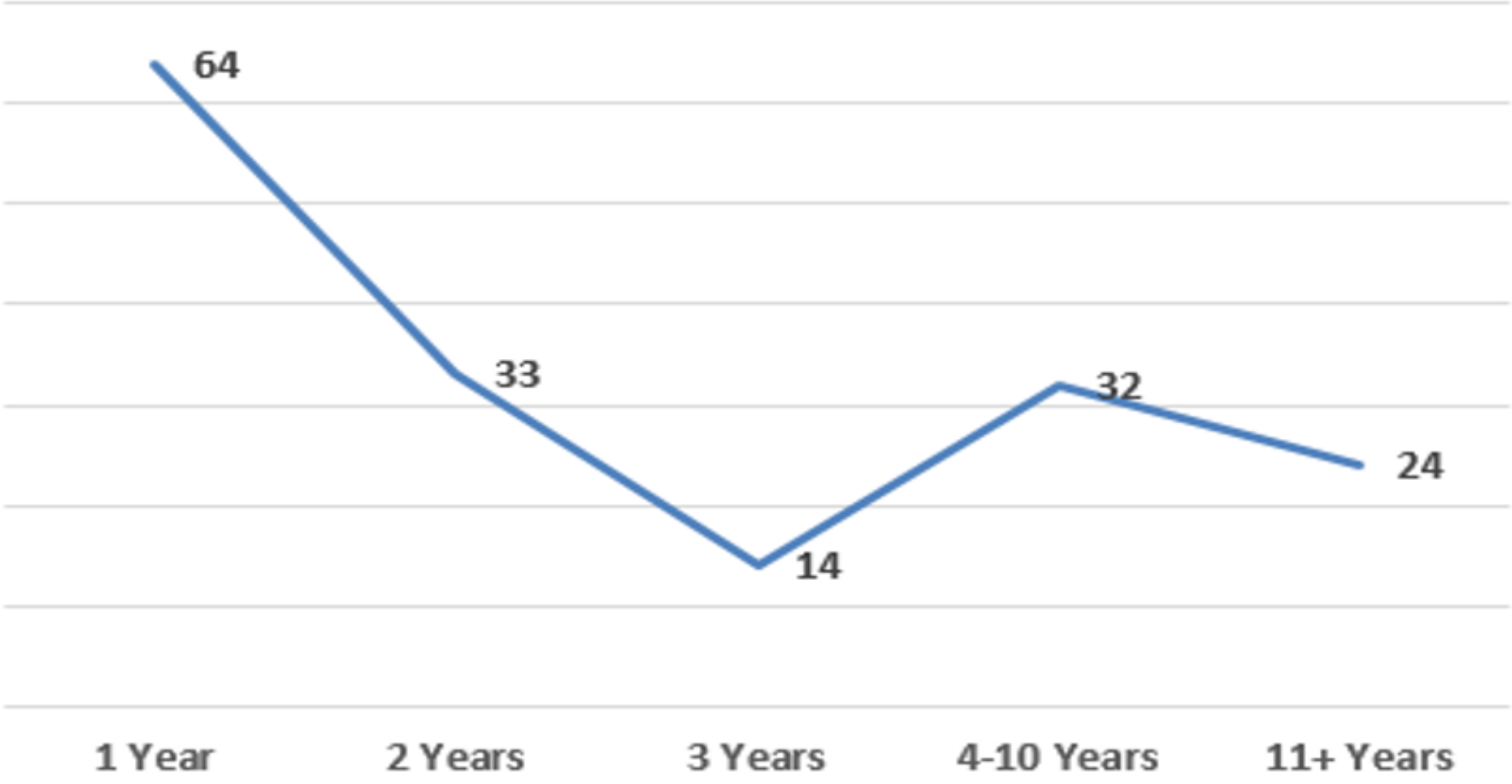


Direct Care RN Terms by Generation
(May 2019 – April 2020)

CATEGORIES	# of TERMS	TOTAL # of FT/PT RNs in CATEGORY	% of CATEGORY TURNOVER
Silent Generation (1927-1945)	0	1	N/A
Baby Boomers (1946-1964)	17	119	14%
Gen X Baby Busters (1965-1980)	41	349	12%
Gen Y Millennials (1981-2000)	109	609	18%
Gen Z Digitals (2001+)	0	0	N/A
TOTAL	167	1078	

Direct Care RN Terms by Tenure

(May 2019 – April 2020)



Working RNs per 100,000 Population (2017)

State with the lowest ratios	RNs per 100,000	States with the highest ratios	RNs per 100,000
Utah	741	South Dakota	1,509
Nevada	752	Massachusetts	1,375
Idaho	797	Kansas	1,349
California	826	Ohio	1,346
Oklahoma	832	Minnesota	1,338
Arizona	866	Iowa	1,312
Georgia	903	Alaska	1,304
Colorado	918	North Dakota	1,289
Wyoming	924	Wisconsin	1,284
South Carolina	938	Rhode Island	1,280

Source: U.S. Bureau of the Census. 2018. American Community Survey, Summary File, 2017. Washington DC: U.S. Bureau of the Census. Note: States with small sample sizes have greater margin of error in the estimated RN-to-population ratio.

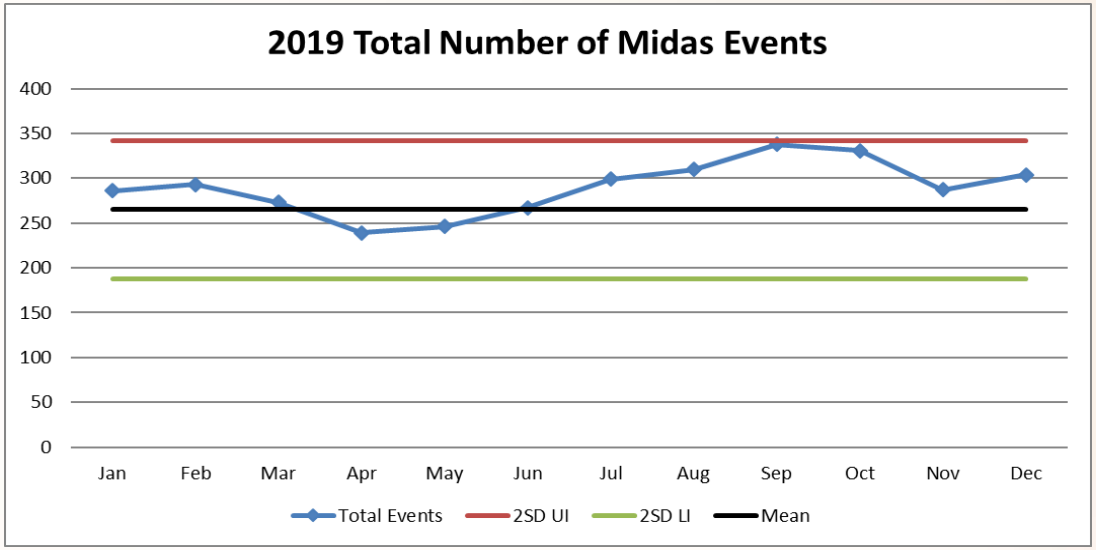
Adverse Events and Staffing

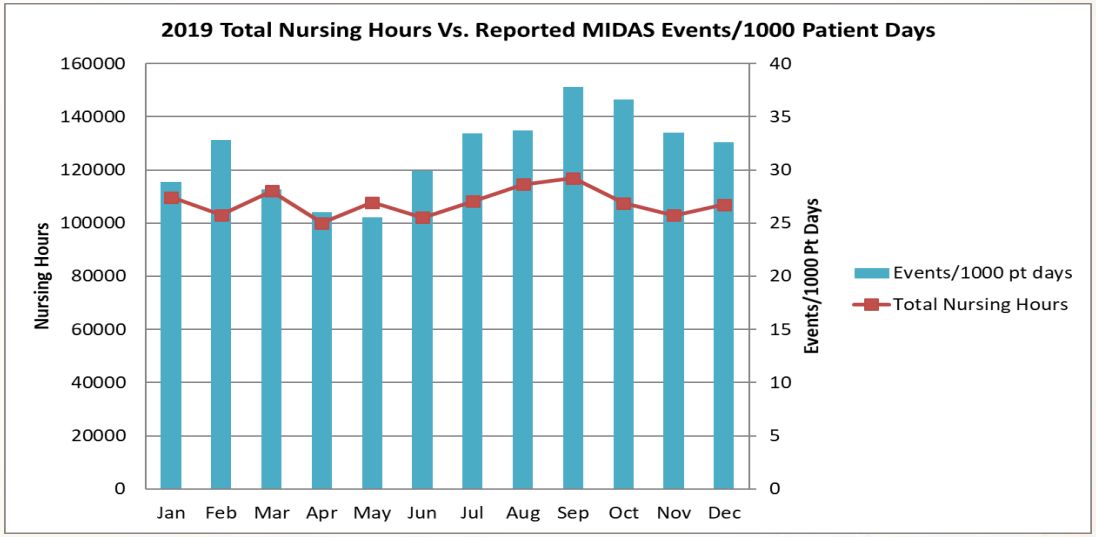
- In 2019 total of 17 Focus Reviews/Root Cause Analyses completed
- **41% of Cases Were Related to Staffing or Lack There Of**
  - Novice staff – Enhanced orientation and education
  - Minimally staffed – Active recruitment to fill open positions; Job fairs; Contract labor
- **65% of Cases Related To Communication**
  - Team Communication Tool - CUS Training (New Hire and Annually)
  - 2018 Continued Handoff Communication Quality Focus Team (Quantified Joint Commission Quality Tool)
  - Enhancement of Just Culture throughout the organization to increase likelihood of staff/leaders in communicating safety concerns
  - Re-design of electronic documentation
  - Revised policies and procedures including second timeout process in Cath Lab
- **11% Related To Sedation Pre and Post Procedures**
  - Collaboration with Anesthesia group to increase coverages and back up on-call availability
  - Revised pain management ordersets for renal patients

Adverse Events and Staffing

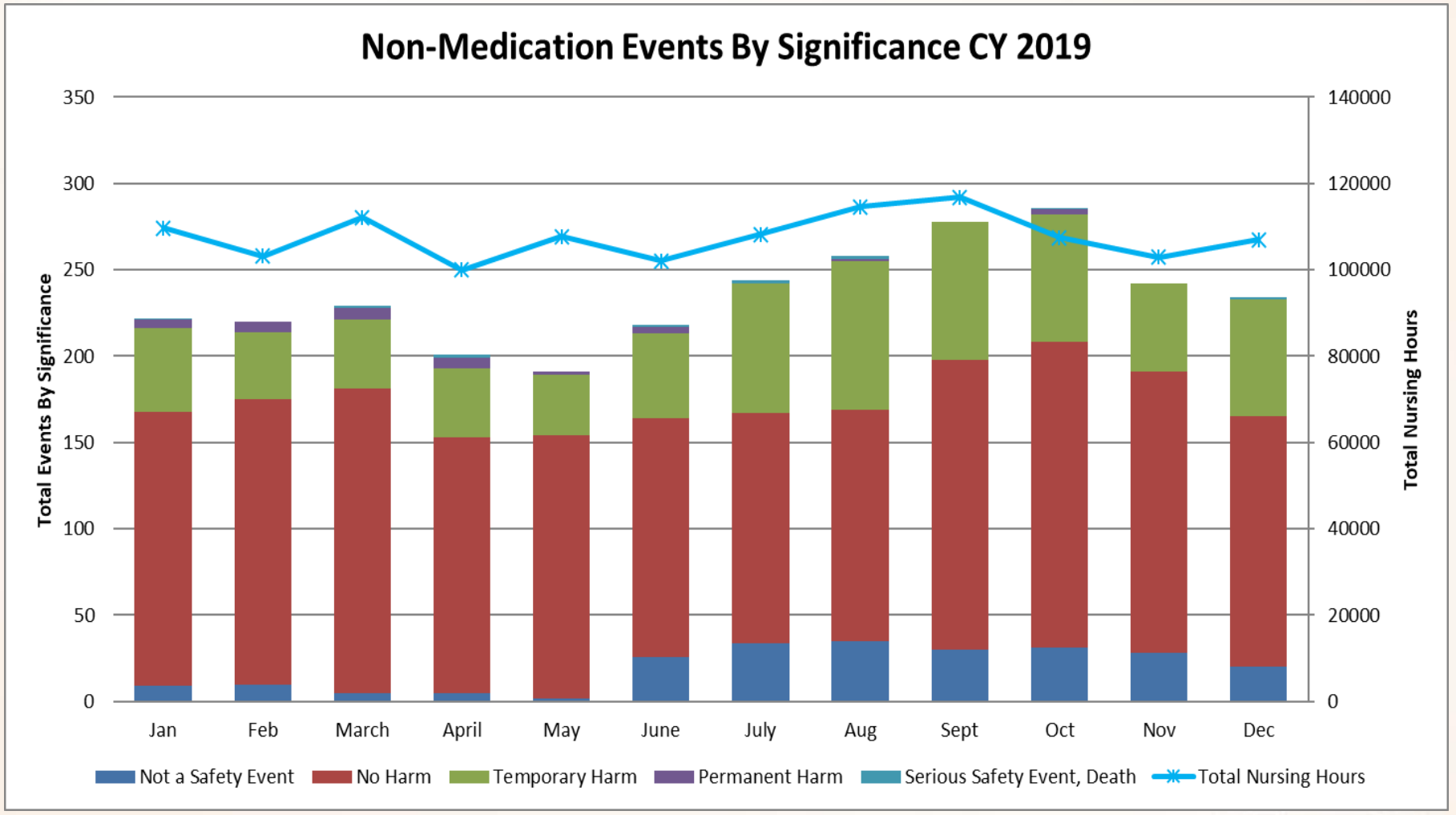
Analysis

- No special cause outlier identified.
- No correlation observed between nursing hours, events, and significate type.

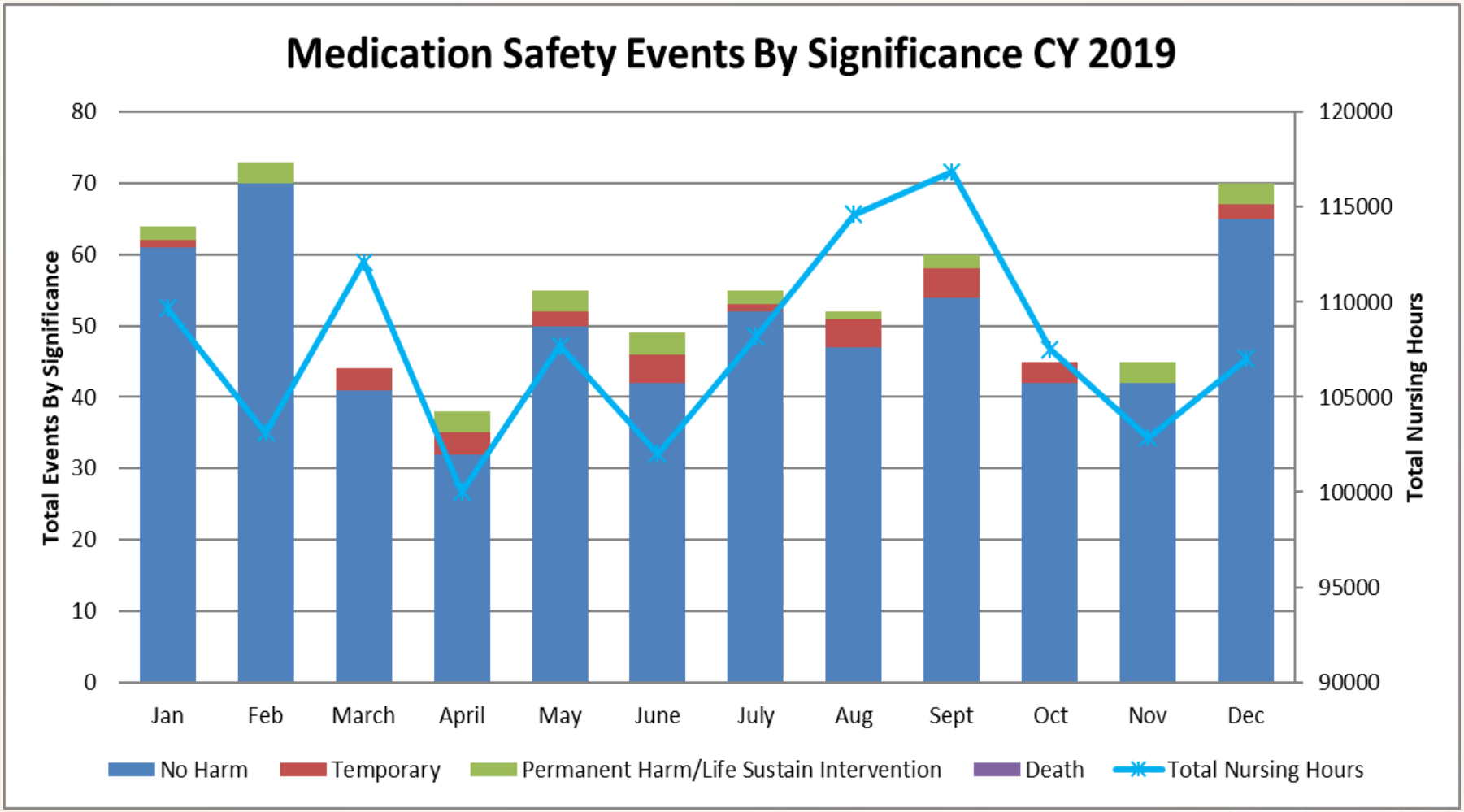




Adverse Events and Staffing



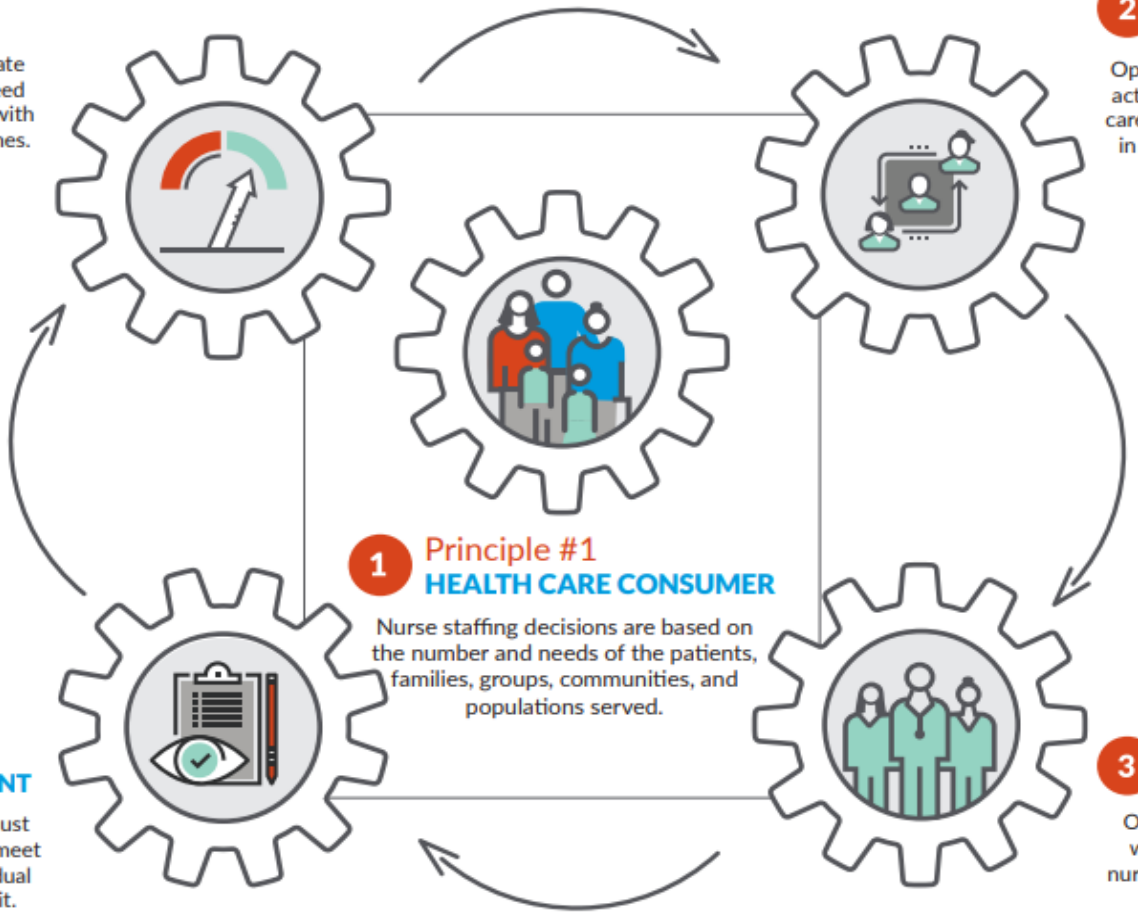
Adverse Events and Staffing



ANA
AMERICAN NURSES ASSOCIATION

Principles for Nurse Staffing

Nurse staffing is an asset to ever-evolving health care systems. Appropriate nurse staffing, with sufficient numbers of nurses, improves the health of the populations. Nurses at all levels within a health care system must have a substantive and active role in staffing decisions.



1 Principle #1
HEALTH CARE CONSUMER

Nurse staffing decisions are based on the number and needs of the patients, families, groups, communities, and populations served.

2 Principle #2
INTERPROFESSIONAL TEAMS

Optimal care is achieved through individual actions and collaboration with other health care team members. Nurses are full partners in the delivery of safe, quality health care.

3 Principle #3
WORKPLACE CULTURE

Organizational leaders must create a workplace environment that values nurses as critical members of the health care team.

4 Principle #4
PRACTICE ENVIRONMENT

All nursing care delivery systems must provide the necessary resources to meet each health care consumer's individual needs and the demands of the unit.

5 Principle #5
EVALUATION

Organizations must have appropriate nurse staffing plans. All settings need well-developed staffing guidelines with measurable nurse-sensitive outcomes.

https://www.nursingworld.org/~4a51bc/globalassets/practiceandpolicy/nurse-staffing/staffing-principles-infographic.pdf

KD Staff Assignment Guidelines

- ***Level of overall nursing experience*** (i.e., novice to expert)
  - Consider the experience level of the RNs at all times, all shifts
  - Consider reassigning/redistributing pts in an effort to balance workload
- ***Resources for mentoring, precepting, addressing skill development needs of nurses***
  - New hires assigned to Mentor RN as resource in addition to Charge RN
  - RN's who are orienting another RN should not be given a more difficult assignment because there are "2" of them
- ***Specific needs of population served***
  - MH.60.02 Person to Room Assignment Planning in a Dynamic Context
  - Reassess assignments throughout the day
  - Modify assignments as driven by unit activity & patient acuity.
  - Attempt to keep RN room assignments approximated
  - PC. 205 Staffing & Scheduling, PC.180 Patient Placement Guidelines, Critical Care/Telemetry Units admission guidelines

https://www.nursingworld.org/~4a51bc/globalassets/practiceandpolicy/nurse-staffing/staffing-principles-infographic.pdf

KD 2019-2020 Staffing Update

- 3North updated staffing matrix to reflect 1:4 ratio (change from 1:5)
- 3South increased CNAs on dayshift
- 4North updated staffing matrix to reflect free Charge Nurse (at census ≥ 23)
- 4South updated staffing matrix to reflect 1:4 ratio (change from 1:5)
- Cross-trained Broderick Pavilion RNs to co-manage COVID-19 patients
- Patient care units added LVNs to cover meal breaks
- Additional Travelers and contract extensions as needed
- Recruitment efforts successfully pivoted to virtual platforms in response to pandemic

KD Applies Principals for Nurse Staffing to Mitigate Adverse Events

1. Staffing decisions based on census *and* acuity
2. RNs lead/partner in collaborative health care teams
   - Gemba rounds, Quality Focus Teams
3. Protected time to participate in safety culture initiatives
   - Kaizen, Comprehensive Unit-Based Safety Program

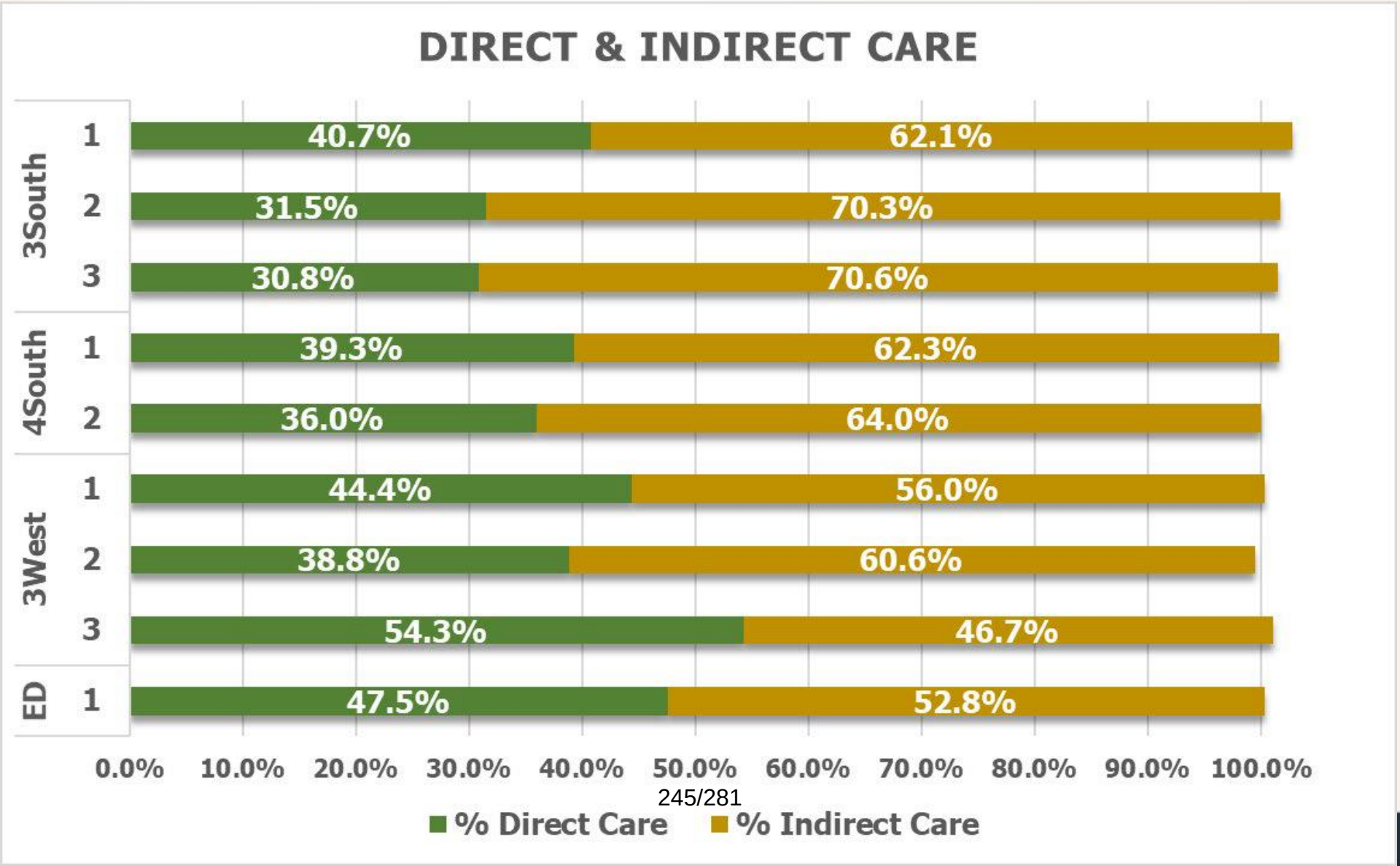
https://www.nursingworld.org/~4a51bc/globalassets/practiceandpolicy/nurse-staffing/staffing-principles-infographic.pdf

KD Applies Principals for Nurse Staffing to Mitigate Adverse Events

4. Flex resources at all levels to meet rapidly changing patient/community needs
   - Staff training & competency, technology, personal protective equipment, environment
5. Ongoing efforts to improve data reporting and technology to support unit-level review of nurse-sensitive outcome indicators
   - Bar Code Medication Administration (BCMA), Midas prompts include staff role in event

https://www.nursingworld.org/~4a51bc/globalassets/practiceandpolicy/nurse-staffing/staffing-principles-infographic.pdf

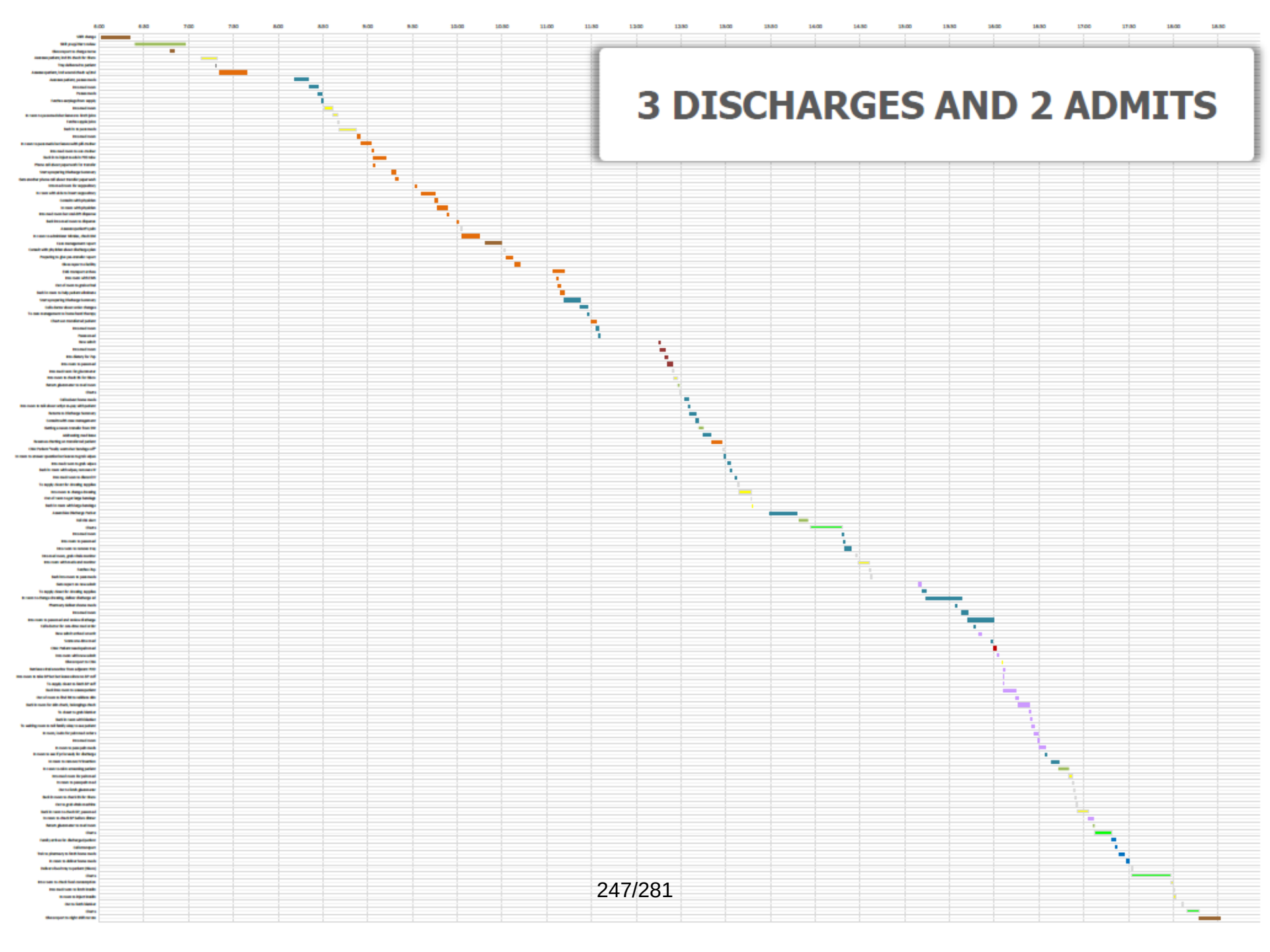
Front-Line Nursing Work Practice Study



3 DISCHARGES AND 2 ADMITS

- Exception
- Fetching
- Physician interdependency

Room	Activity	Start	End	Duration	
	Shift change	6:02:00	6:21:00	0:19:00	
	Shift prep/chart review	6:24:00	6:58:00	0:34:00	
	Gives report to charge nurse	6:48:00	6:50:00	0:02:00	
4	Assesses patient, but BG check for Gluco	7:08:00	7:19:00	0:11:00	Removes my arm bandage. Why is my BG being checked?
4	Tray delivered to patient	7:18:00	7:18:15	0:00:15	
5	Assesses patient, but wound check w/Dad	7:21:00	7:39:00	0:18:00	PRN tube popped out. Elevate need changing
8	Assesses patient, passes meds	8:11:00	8:20:00	0:09:00	Why did she DC oral antibiotic? I think I'm getting strep.
8	Iris med room	8:21:00	8:27:00	0:06:00	
8	Passes meds	8:27:00	8:29:00	0:02:00	
8	Fetches earplugs from supply	8:29:00	8:30:00	0:01:00	Can I get some earplugs and water?
4	Iris med room	8:31:00	8:37:00	0:06:00	
4	In room to pass meds but leaves to fetch juice	8:37:00	8:40:00	0:03:00	Why am I taking so many pills?
4	Fetches apple juice	8:40:00	8:41:00	0:01:00	
4	Back in to pass meds	8:41:00	8:52:00	0:11:00	
5	Iris med room	8:53:00	8:55:00	0:02:00	
5	In room to pass meds but leaves with pill crusher	8:56:00	9:02:00	0:06:00	PM crusher not working. Patient may need suppository.
5	Iris med room to use crusher	9:03:00	9:04:00	0:01:00	
5	Back in to inject meds in PRN tube	9:04:00	9:12:00	0:08:00	
5	Phone call about paperwork for transfer	9:04:00	9:05:00	0:01:00	New procedure for SBP transfer. Not familiar.
5	Starts preparing Discharge Summary	9:16:00	9:19:00	0:03:00	
5	Gets another phone call about transfer paperwork	9:19:00	9:20:00	0:01:00	Patient needs to poop before transfer to SBP. Doesn't want to give report until patient poops.
5	Iris med room for suppository	9:32:00	9:33:00	0:01:00	
5	In room with aide to insert suppository	9:36:00	9:45:00	0:09:00	Patient refused suppository.
5	Consults with physician	9:45:00	9:47:00	0:02:00	
5	In room with physician	9:47:00	9:53:00	0:06:00	Doctor and nurse in Nicolas for PRN tube administration.
5	Iris med room but couldn't dispense	9:53:00	9:54:00	0:01:00	Couldn't dispense Nitrolax. Wait for pharmacy to approve new order.
5	Back Into med room to dispense	10:00:00	10:01:00	0:01:00	
4	Assesses patient's pain	10:02:00	10:03:00	0:01:00	
5	In room to administer Nitrolax, check BM	10:03:00	10:15:00	0:12:00	Patient milled green.
	Case management report	10:19:00	10:30:00	0:11:00	
4	Consult with physician about discharge plan	10:31:00	10:32:00	0:01:00	
5	Preparing to give pre-transfer report	10:33:00	10:37:00	0:04:00	
5	Gives report to facility	10:39:00	10:42:00	0:03:00	
5	EMS transport arrives	11:04:00	11:12:00	0:08:00	
5	Into room with EMS	11:07:00	11:08:00	0:01:00	Patient needs to poo before EMS transport.
5	Out of room to grab urinal	11:08:00	11:09:00	0:01:00	
5	Back in room to help patient eliminate	11:09:00	11:12:00	0:03:00	
8	Starts preparing Discharge Summary	11:12:00	11:22:00	0:10:00	
8	Calls doctor about order changes	11:22:00	11:27:00	0:05:00	Hand surgeon recommended Augmentin.
8	To case management re home hand therapy	11:27:00	11:28:00	0:01:00	
5	Charts on transferred patient	11:30:00	11:33:00	0:03:00	
8	Iris med room	11:33:00	11:35:00	0:02:00	
8	Passes med	11:35:00	11:36:00	0:01:00	
6	New admit	12:15:00	12:16:00	0:01:00	
6	Iris med room	12:16:00	12:19:00	0:03:00	
6	Iris dietary for 7up	12:19:00	12:21:00	0:02:00	
6	Iris room to pass med	12:21:00	12:24:00	0:03:00	
4	Iris med room for glucometer	12:24:00	12:25:00	0:01:00	
4	Iris room to check BS for Gluco	12:25:00	12:28:00	0:03:00	Lunch tray already in patient's room. Agreeable to BS check but not insulin.
	Return glucometer to med room	12:28:00	12:29:00	0:01:00	
4	Charts	12:29:00	12:30:00	0:01:00	
8	Calls about home meds	12:33:00	12:35:00	0:02:00	
8	Iris room to talk about script copay with patient	12:35:00	12:36:00	0:01:00	
8	Returns to Discharge Summary	12:36:00	12:40:00	0:04:00	
8	Consults with case management	12:40:00	12:42:00	0:02:00	Hand surgeon wants patient to start hand therapy the day after discharge.
	Getting a neuro transfer from SW	12:42:00	12:45:00	0:03:00	
8	Addressing med issue	12:45:00	12:50:00	0:05:00	Doctor needs to DC med order but is in transit and can't access EHR.
5	Resumes charting on transferred patient	12:51:00	12:57:00	0:06:00	
4	CNA: Patient "really wants her bandage off"	12:58:00	12:59:00	0:01:00	Patient escalation concern about arm bandage to CNA.
8	In room to answer question but leaves to grab wipes	12:59:00	13:00:00	0:01:00	
8	Into med room to grab wipes	13:01:00	13:03:00	0:02:00	
8	Back in room with wipes, removes IV	13:03:00	13:04:00	0:01:00	
8	Into med room to discard IV	13:06:00	13:07:00	0:01:00	
4	To supply closet for dressing supplies	13:08:00	13:09:00	0:01:00	
4	Into room to change dressing	13:09:00	13:17:00	0:08:00	
4	Out of room to get large bandage	13:17:00	13:17:15	0:00:15	
4	Back in room with large bandage	13:17:15	13:18:00	0:00:45	Patient can't get next pain med until 3 pm (1 hour, 40 min later)
8	Assembles Discharge Packet	13:29:00	13:48:00	0:19:00	Ready to discharge but ride won't arrive until 15:30
	Fall risk alert	13:49:00	13:55:00	0:06:00	
4	Charts	13:57:00	14:18:00	0:21:00	
8	Into med room	14:18:00	14:19:00	0:01:00	
8	Into room to pass med	14:19:00	14:20:00	0:01:00	
8	Into room to remove tray	14:20:00	14:24:00	0:04:00	
4	Into med room, grab vitals monitor	14:27:00	14:28:00	0:01:00	
4	Into room with meds and monitor	14:29:00	14:36:00	0:07:00	
4	Fetches 7up	14:36:00	14:37:00	0:01:00	
4	Back into room to pass meds	14:37:00	14:38:00	0:01:00	
23	Gets report on new admit	15:09:00	15:11:00	0:02:00	
8	To supply closet for dressing supplies	15:12:00	15:14:00	0:02:00	
8	In room to change dressing, deliver discharge ml	15:14:00	15:38:00	0:24:00	
8	Pharmacy delivers home meds	15:34:00	15:35:00	0:01:00	
8	Into med room	15:38:00	15:42:00	0:04:00	
8	Into room to pass med and review discharge	15:42:00	16:00:00	0:18:00	
8	Calls doctor for one-time med order	15:46:00	15:47:00	0:01:00	Needs one-time order for Lisinopril.
23	New admit arrived on unit	15:50:00	15:51:00	0:01:00	
8	Scans one-time med	15:58:00	15:59:00	0:01:00	
6	CNA: Patient needs pain med	16:00:00	16:01:00	0:01:00	
23	Into room with new admit	16:02:00	16:03:00	0:01:00	Looks for vitals machine.
4	Gives report to CNA	16:05:00	16:06:00	0:01:00	
23	Retrieves vitals monitor from adjacent POD	16:06:00	16:07:00	0:01:00	
23	Into room to take BP but but leaves since no BP cuff	16:06:00	16:06:15	0:00:15	No BP cuff in room.
23	To supply closet to fetch BP cuff	16:06:15	16:06:30	0:00:15	
23	Back into room to assess patient	16:06:30	16:14:00	0:07:30	
23	Out of room to find IDs to validate skin	16:14:00	16:16:00	0:02:00	Out to find 2nd nurse to validate skin.
23	Back in room for skin check, belongings check	16:16:00	16:23:00	0:07:00	
23	To closet to grab blanket	16:23:00	16:24:00	0:01:00	
23	Back in room with blanket	16:24:00	16:25:00	0:01:00	
23	To waiting room to tell family okay to see patient	16:25:00	16:27:00	0:02:00	
23	In room, looks for pain med orders	16:27:00	16:29:00	0:02:00	
23	Into med room	16:29:00	16:30:00	0:01:00	
23	In room to pass pain meds	16:30:00	16:34:00	0:04:00	
8	In room to see if pt is ready for discharge	16:34:00	16:35:00	0:01:00	Patient wants to wait another 10 min before calling for wheelchair.
8	In room to remove IV insertion	16:38:00	16:43:00	0:05:00	
	In room to calm screaming patient	16:43:00	16:50:00	0:07:00	
4	Into med room for pain med	16:50:00	16:52:00	0:02:00	
4	In room to pass pain med	16:52:00	16:53:00	0:01:00	
4	Out to fetch glucometer	16:53:00	16:54:00	0:01:00	Out to fetch glucometer.
4	Back in room to check BS for Gluco	16:54:00	16:55:00	0:01:00	
4	Out to grab vitals machine	16:55:00	16:55:30	0:00:30	Out to fetch vitals machine.
4	Back in room to check BP, pass med	16:55:30	17:03:00	0:07:30	
23	In room to check BP before dinner	17:03:00	17:06:00	0:03:00	
	Return glucometer to med room	17:06:00	17:07:00	0:01:00	
	Charts	17:07:00	17:19:00	0:12:00	
8	Family arrives for discharged patient	17:19:00	17:21:00	0:02:00	
8	Calls transport	17:21:00	17:22:00	0:01:00	
8	Text to pharmacy to fetch home meds	17:24:00	17:27:00	0:03:00	To pharmacy to fetch home meds.
8	In room to deliver home meds	17:29:00	17:30:00	0:01:00	
4	Delivers food tray to patient (Gluco)	17:32:00	17:33:00	0:01:00	
	Charts	17:32:00	17:58:00	0:26:00	
4	Into room to check food consumption	17:58:00	18:00:00	0:02:00	
4	Into med room to fetch insulin	18:00:00	18:01:00	0:01:00	
4	In room to inject insulin	18:00:00	18:02:00	0:02:00	
4	Out to fetch blanket	18:06:00	18:07:00	0:01:00	
	Charts	18:09:00	18:17:00	0:08:00	
	Gives report to night shift nurses	18:17:00	18:31:00	0:14:00	


3 DISCHARGES AND 2 ADMITS

Questions…

Board of Directors

Infection Prevention Quality Report

July 2020

Acronyms and clinical definitions:

- Central Line Associated Bloodstream Infection (CLABSI): an event in which an intravenous line that terminates in a large blood vessel near or at the heart is implicated as the source of a patient's bloodstream infection while admitted to the hospital.
- Methicillin Resistant Staphylococcus aureus bloodstream infection (MRSA BSI): A Bloodstream infection caused by Methicillin Resistant Staphylococcus aureus bacteria after day 3 of a hospital admission.
- Catheter Associated Urinary Tract Infection (CAUTI): an event in which an indwelling urinary catheter is implicated as the source of a patient's urinary tract infection.
- Surgical Site Infection (SSI): an event in which a superficial (SIP), deep (DIP) or an organ space infection occurs within 30 to 90 days post-operatively and is attributed to the hospital in which the procedure was performed.
    - Colon surgery (COLO): an organ space SSI involving the large intestine.
    - Total Abdominal Hysterectomy (HYST): an organ space SSI involving removal of the uterus through the abdomen.
    - Cesarean Section (CSEC): a SSI (SIP/DIP) involving a C-section procedure for removal of the fetus from the uterus through the abdomen.
    - Spinal Fusion (FUSN): a SSI (SIP/DIP) involving a procedure in which the vertebrae of the spine are joined into a single structure.

CLABSI – KDHCD
All Units – 2019 to 2020 1st QTR

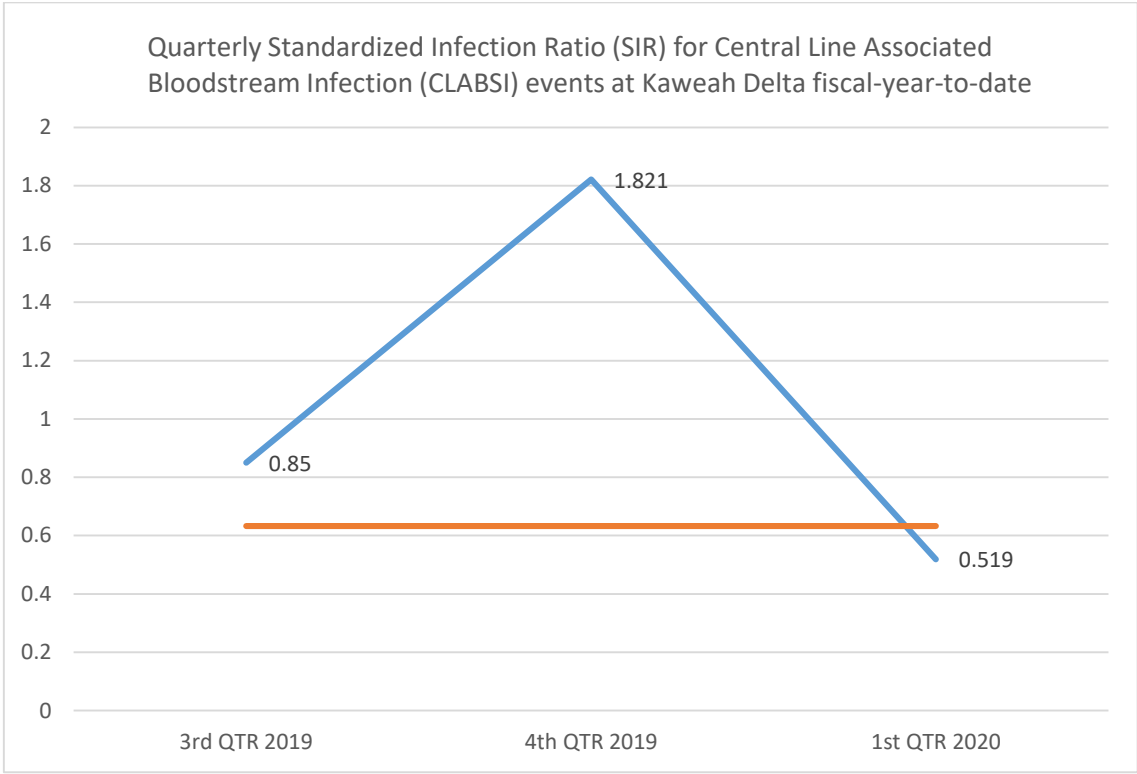
Define: Central line associated bloodstream infections (CLABSI) are infections that occur as a result of insertion or maintenance of a central line.

Measure: Standardized Infection Ratio of 0.633 or less. In other words less than 10 CLABSI events per year, with the goal of zero events for the year.

Analyze: It has been a dynamic 2019-2020 fiscal year. During February, the CLABSI Kaizen Project was initiated. Top four root causes identified by the subject matter experts include: 1) Line necessity, 2) Bundle Practice, 3)Education, and 4) the culture of culturing.

Improve: The pandemic has certainly impacted many of planned activities to reduce CLABSI events. However, several interventions that address the "culture-of-culturing", "just-in-case-culture", have been implemented as well as enhanced education. The IV Safety Team disbanded to help free up Float Pool personnel to work on the units. CLABSI "GEMBA" unit rounds replaced the activity of the IV Safety Team. Now all staff actively perform interventions to reduce CLABSI events. CLABSI "GEMBA" unit rounds have been very successful. As of 6/15/2020, the Fiscal Year To Date SIR for CLABSI = 0.81, the lowest it has been for years.

Control: CLABSI reduction interventions are still new. There is still a lot of work ahead of us to achieve zero CLABSI events for 12-months of greater.



MRSA BSI – KDHCD
All Units – 2019 to 2020 1st QTR

Define: Bloodstream infection caused by Methicillin Resistant Staphylococcus aureus bacteria after day 3 of a hospital admission.

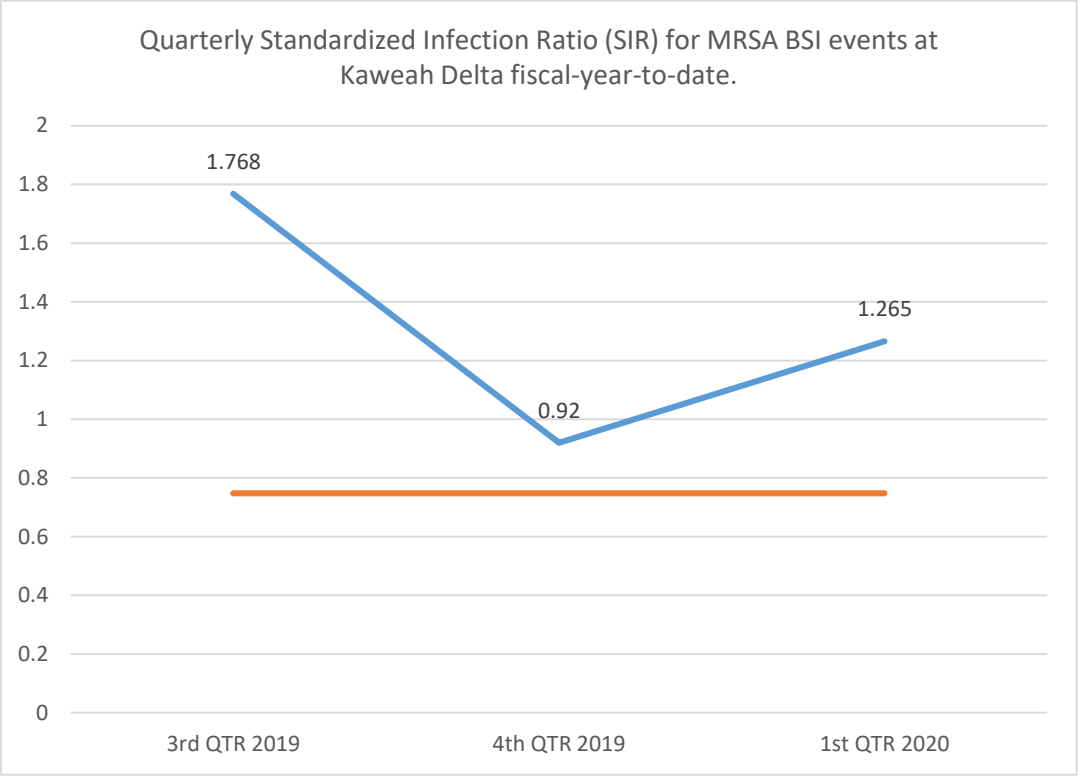
Measure: Standardized Infection Ratio of 0.748 or less. In other words less than 6 MRSA BSI events per year, with the goal of zero events for the year.

Analyze: An association between expired peripheral IV lines and MRSA bloodstream infections was an established theory at Kaweah Delta. Through the efforts of the IV Safety Team and more recently the CLABSI "GEMBA" unit rounds, it is apparent the "Culture-of-Culturing" is a problem that contributes to the identification of MRSA BSI events.

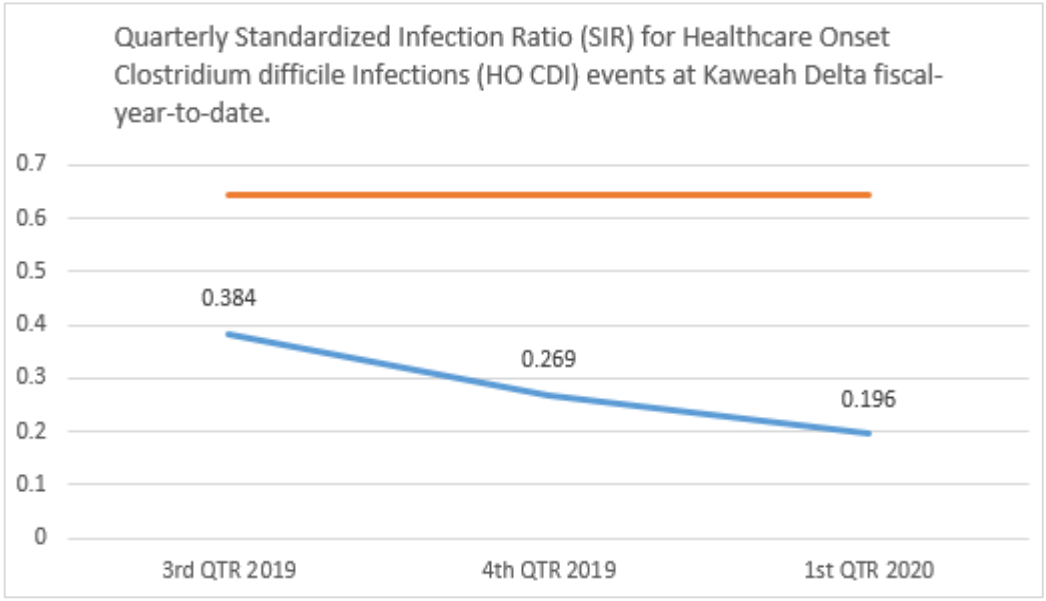
Improve: Interventions related to CLABSI reduction also contribute to reduction of MRSA BSI events, so mid-fiscal year 2019-2020, the MDRO Committee split. MRSA BSI reduction planning efforts were conjoined with CLABSI reduction. Additionally, Kaweah Delta was identified as one of a few hospitals in the State of California with the highest MRSA BSI rates. Kaweah Delta agreed to join a project led by the State to determine what makes hospitals like Kaweah Delta different when it comes to MRSA BSI events. While there was great work underway to identify contributing factors, the COVID-19 Pandemic ensued and efforts to further evaluate what may be causing increased MRSA BSI rates in a small group of large medical centers in California was put on hold indefinitely.

In response, Kaweah Delta is addressing the "Culture-of-Culturing" in part as an initiative of the CLABSI Kaizen Project and in part an initiative of its own. We are also implementing the use of the Biovigil electronic hand hygiene compliance system extensively throughout the hospital to decrease the risk of hand contamination resulting in MRSA BSI events.

Control: MRSA BSI reduction interventions are underway. There is still a lot of work ahead of us to achieve zero MRSA BSI events for 12-months of greater.



HO CDI – KDHCD All Units – 2019 to 2020 1st QTR
Define: A Clostridium difficile infection that is identified after day 3 of hospital admission.
Measure: Standardized Infection Ratio of 0.646 or less. In other words less than 10 healthcare-onset Clostridium difficile events per year, with the goal of zero events for the year.
Analyze: There have been 7 healthcare-onset Clostridium difficile infection events for the 2019-2020 fiscal year. For the same period, 44 of these events were predicted.
Improve: Current interventions such as the C-difficile algorithm for testing, along with proactive efforts to ensure appropriate C. difficile testing have been successful at reducing healthcare-onset Clostridium difficile infection.
Control: Metric is under control.



CAUTI – KDHCD
All Units – 2019 to 2020 1st QTR

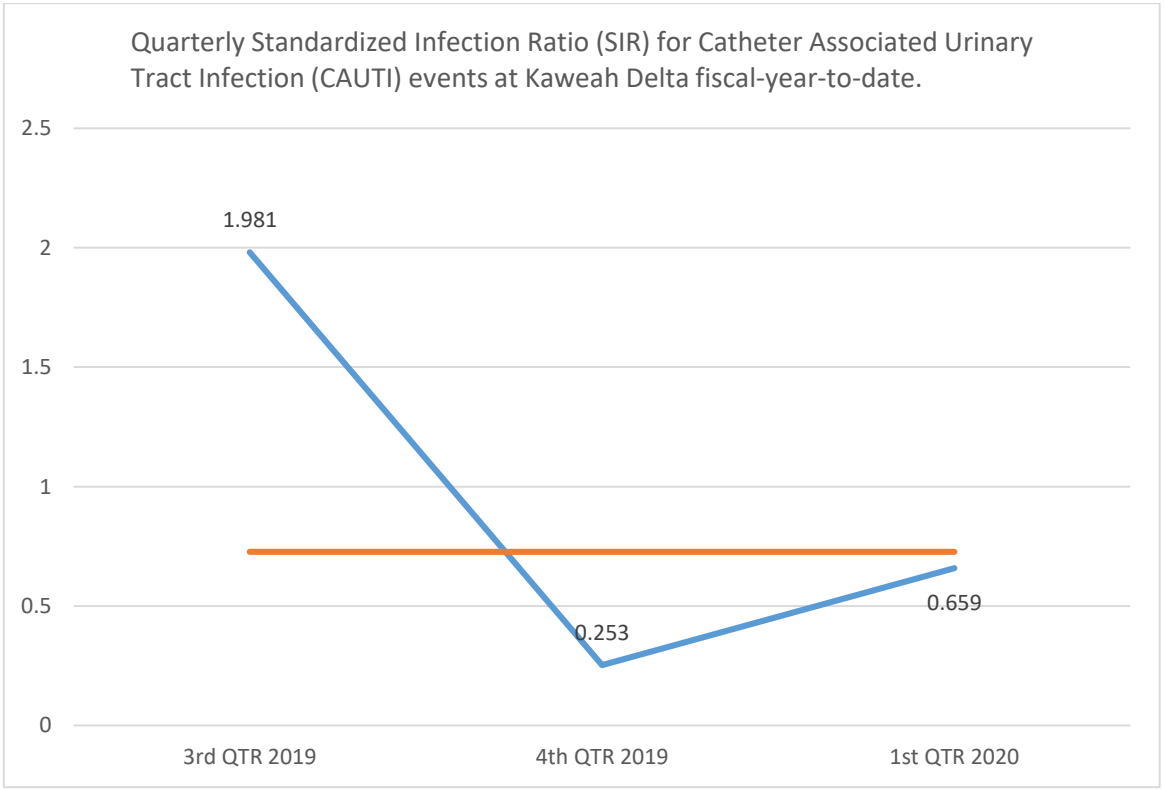
Define: Catheter Associated Urinary Tract Infection (CAUTI) is an infection that occurs because of insertion or maintenance of an indwelling urinary catheter.

Measure: Standardized Infection Ratio of 0.727 or less. In other words less than 12 events a year, with the goal of zero events for the year.

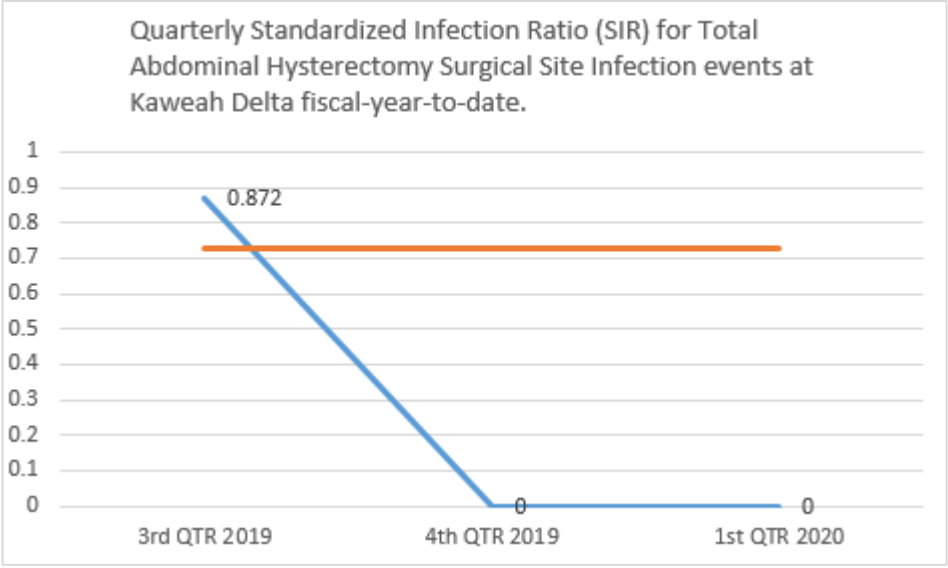
Analyze: CAUTI increased through the latter part of the fiscal year. Lacking peri-care, patient bathing and prolonged use of indwelling urinary catheters beyond their indication are some contributing factors for increased CAUTI events. Additionally, indiscriminate urine culture practices have resulted in identification of bacteria colonizers within the urinary tract.
During February, the CAUTI Kaizen Project was initiated. Interventions related to care and maintenance of indwelling urinary catheters (IUCs), early removal of IUCs, alternatives to IUCs and measures to reduce unnecessary urine specimen culture testing were implemented late March, early April. Along with these interventions, CAUTI "GEMBA" unit rounds are performed daily, bringing attention to reducing CAUTI events.

Improve: Through implementation of some interventions initiated as part of the CAUTI Kaizen Project, the CAUTI SIR for April is 0.93 the lowest seen in years. There is more work being done related to addressing variables that cause CAUTI events. Under development currently is a physician order for urine culture that will drive the provider toward ordering urine cultures when clinically indicated, based on specific evidence-based parameters.

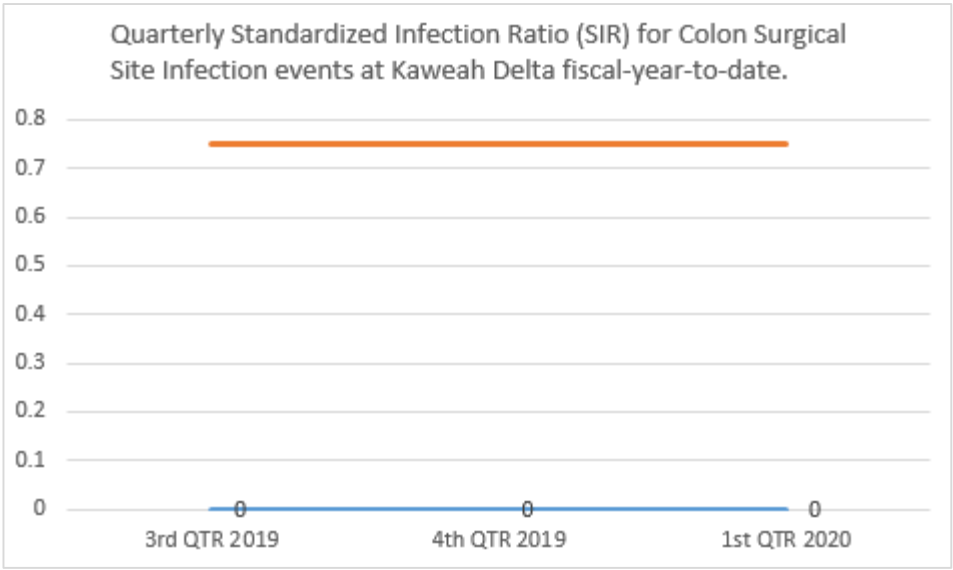
Control: CAUTI reduction interventions are underway. There is still a lot of work ahead of us to achieve zero CAUTI events for 12-months of greater.



SSI HYST – KDHCD All Units – 2019 to 2020 1st QTR
Define: Deep or organ space surgical site infection involving the Uterus 30 days post-abdominal hysterectomy operation.
Measure: Standardize Infection Ration of 0.727 or less, with the goal of zero SSI HYST events for 12-months.
Analyze: There were 4 SSI HYST events during 3rd Quarter of 2019. Patient anxiety issues were associated with most of these events. More anticipatory guidance was provided for patients exhibiting anxiety prior to discharge.
Improve: SSI HYST events drastically reduced to zero for both 4th QTR 2019 and 1st QTR 2020**.** No improvement interventions implemented at this time.
Control: Metric is under control.



SSI COLO – KDHCD All Units – 2019 to 2020 1st QTR
Define: Deep or organ space surgical site infection involving the large intestine 30 to 90 days post-operation.
Measure: Standardized Infection Ratio of 0.749 or less, with the goal of zero SSI COLO events for 12-months.
Analyze: There were no events of SSI COLO for the fiscal year to date.
Improve: Along with efforts to reduce the number of people present in the O.R. suite during surgery, there is also work being done to ensure appropriate pre-op antibiotic selection, administration timing, clean-closure, diabetic control, and post-op education is be provided consistently.
Control: Metric is under control.



SSI CSEC – KDHCD
All Units – 2019 to 2020 1st QTR

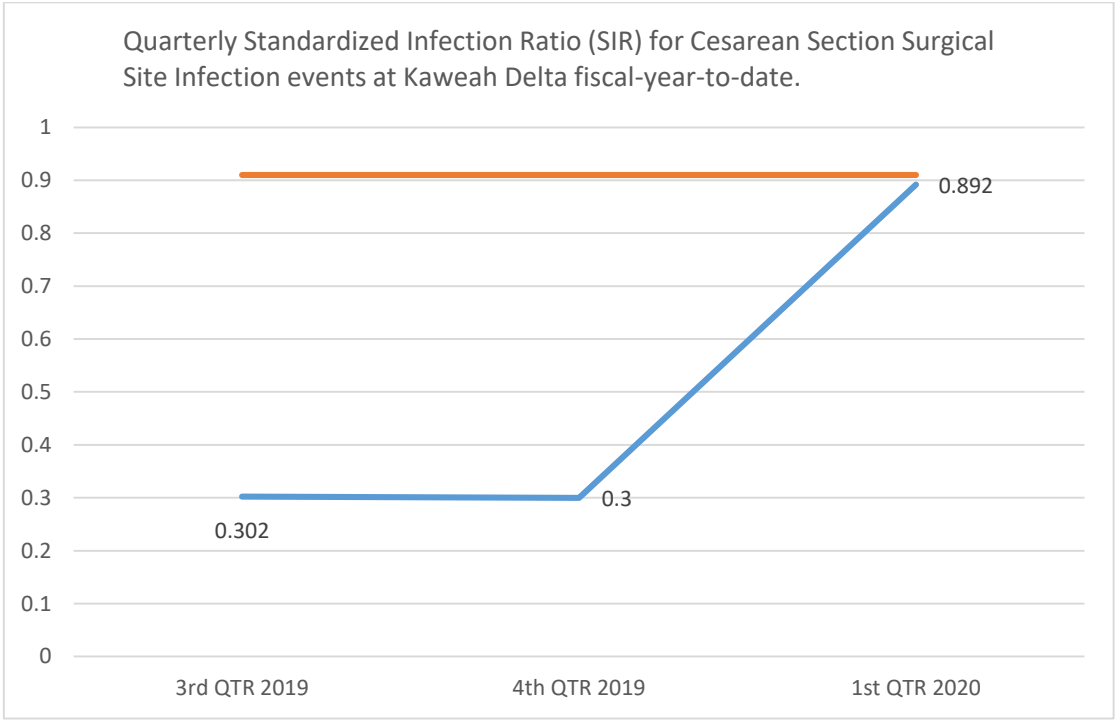
Define: Deep or organ space surgical site infection involving the intra-abdominal space 30 days post-cesarean operation.

Measure: CDPH 2018 Annual Benchmark of 0.91 or less.

Analyze: There were 3 SSI CSEC events over the 2019-2020 fiscal year. The large volume of procedures performed at Kaweah Delta significantly dilutes the impact of the 3 events that occurred. A combination of variables contribute to Cesarean Section procedures becoming infected in patients cared for at KDCHD. Some of these variables include emergent need for C-section very short time between pre-op antibiotic administration and cut-time. Pregnant patients presenting with multiple comorbidities (i.e. Diabetes, Obesity, Cardiac ailments). Lastly, because C-section infections can be reported up to 30 days post-op, patients themselves have contributed to their own infections in the home setting.

Improve: Infection Prevention observations in the L&D OR have begun to review intra-operative practices, and implement necessary evidence-based interventions.

Control: This metric is currently stable with no events during 1st QTR 2020, but we do need to continue monitor these events.



SSI FUSN – KDHCD
All Units – 2019 to 2020 1st QTR

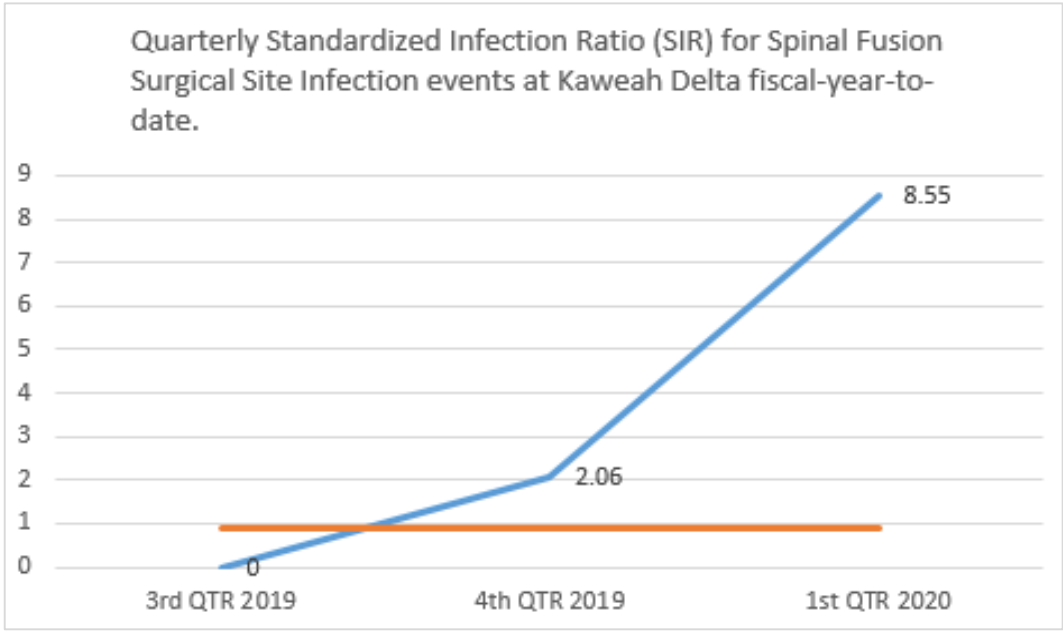
Define: Deep or organ space surgical site infection involving the spine 30 to 90 days post-spinal fusion operation.

Measure: CDPH 2019 Annual Benchmark of 0.91 or less.

Analyze: There have been 2 SSI FUSN events for fiscal year 2019-2020. Although only a couple of SSI FUSN events occurred, the small volume of this procedure unfortunately, results in a significantly high, standardized infection rate and incident rate. These two events involved infection with skin flora organisms. Decolonization practices were not performed on these patients and for one patient the incision site was shaved instead of clipped, likely resulting in micro-abrasions, a portal-of-entry for infectious pathogens.

Improve: Neurosurgery and Orthopedic service line representatives attend the SSI Prevention Committee and share findings with others for the appropriate service line. A midlevel practitioner from the orthopedic service line follows patients to long-term rehab to assess incision sites and consult. A gap analysis review is underway to determine if there are other evidence-based activities that could help reduce this particular type of SSI event.

Control: This metric is not in control. We are redirecting our efforts to address reduction of SSI FUSN event.



Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Overall Surgical Site Infections (SSI)	**IR/SIR**						**SSIs calculated internally though standard incidence rate and externally through Standardized Infection Ratio (SIR) from National Health and Safety Network (NHSN).**
A. #Total Procedure Count		1381					**Annual running total**: 1,381
B. Total Infection Count *[note: SSI events can be identified up to 90 days from the last day of the month in each quarter and only DIP and Organ Spc SSI are reported in NSHN]*		**6**					**1st QTR:** 6 **Predicted:** not available
C. Incidence Rate (IR) [# of total SSI infections/# total procedures x 100]	Internal 0.70 Goal	**0.43**					**1st QTR:** Total number of SSI events fell well below the threshold of 0.70 this is better than Statewide averages.
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		not available					**1st QTR:** not available
E. Standardized Infection Ratio (SIR)	NHSN	not available					**1st QTR:** not available
F. Action Plan for Improvement							**1st QTR:** Ongoing action plans to improve on administration timing of pre-op antibiotics; antibiotic selection; antibiotic dosing. Reduction of staff entering/exiting O.R. suite during surgery.
II. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		32					**Annual running total**: 32
2. Total Infection Count		**0**					**1st QTR:** 0 **Predicted:** not available
3. SIR CI (KDHCD predicted range, based on risks)		not available					**1st QTR:** not available
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		not available					**1st QTR:** No COLO SSI events reported. Clean Closure is routinely being performed.
B. Cesarean Section (CSEC)							
1. #Total Procedure Count		368					**Annual running total:** 368
2. Total Infection Count		**1**					**1st QTR:** 1 **Predicted:** not available
3. SIR CI (KDHCD predicted range, based on risks)		not available					**1st QTR:** Although an SIR is not available the CSEC incidence rate = 0.27 which is very low.
4. SIR (Standardized Infection Ration) total		not available					**1st QTR:** Working on addressing "splash & dash" skin prep technique for emergency CSEC procedures. Also, recommending limiting number of staff in entering/exiting the O.R. suite during surgery.
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		39					**Annual running total:** 39
2. Total Infection Count		**1**					**1st QTR:** 1 **Predicted:** not available
3. SIR CI (KDHCD predicted range, based on risks)		not available					**1st QTR:** Although an SIR is not available the FUSN incidence rate = 2.56 which is high for the volume of this type of procedure being performed.

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total		not available					**1st QTR:** Action plan includes recommendations to provide nares and skin decolonization for MRSA/MSSA. Recommendation to clip, not shave the surgery site. Recommend providing ample instructions on what to do post-operatively if evidence of infection is apparent.
D. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		48					**Annual running total:** 48
2. Total Infection Count		0					**1st QTR:** 0 **Predicted:** not avialable
3. SIR CI (KDHCD predicted range, based on risks)		not					**1st QTR:** not available
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		not available					**1st QTR:** No HYST events reported. Clean Closure is routinely being performed.
II. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		not available					**1st QTR:** 891 vd **Predicted:** not available
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus	2					**1st QTR:** 2 **Predicted:** not available
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		not available					This is an internal quality driven metric. A State or National benchmark has not been made available.
2. Total VAEs SIR		not available					**1st QTR:** not available
C. Total IVAC Plus -ICU		0					**1st QTR: Predicted:** not available
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		not available					This is an internal quality driven metric. A State or National benchmark has not been made available.
2. Total IVAC *Plus* ICU SIR		0					**1st QTR:** No IVAC or PVAPs reported.
D. CVICU/**KDHCD** Total VAEs (not NHSN/Internal)		0					**1st QTR:** CVICU had no VAEs.
E. Total VAEs-Both Units		2					**1st QTR:** There were 2 VAC events both in ICU.
III. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		3917					**Annual running total:** 3917
B. Central Line Device Use SUR (standardized utilization ratio)		0.74					**1st QTR:** 3917 **Predicted:** 5261.50
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		2					**1st QTR:** 2 **Predicted:** 3.86
D. SIR Confidence Interval		0.087, 1.713					**1st QTR:** No different than National benchmark.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		0.519					**1st QTR:** Implementation of action plans approved through the CLABSI Kaizen Project. Performing daily nursing unit "Gemba" rounds. Emphasizing methods to reduce the "culture-of-culturing" and "just-in-case" culture of peripheral and CVC line utilization.
IV. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		3549					**Annual running total:** 3549

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. Catheter Device Days SUR (Standardized Utilization Ratio)		0.767					**1st QTR:** 3549 **Predicted:** 4624.70
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		3					**1st QTR:** 3 **Predicted:** 4.553
D. SIR Confidence Interval		0.168, 1.793					**1st QTR:** No different than National benchmark.
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		0.66					**1st QTR:** Implementation of action plans approved through the CAUTI Kaizen Project. Performing daily nursing unit "Gemba" rounds. Emphasizing methods to reduce the "culture-of-culturing" and "just-in-case" culture of inserting indwelling urinary catheters when not indicated. Emphasizing alternatives to an indwelling urinary catheter and straight catheterization. Guiding providers away from ordering cultures based on urine color/sediment.
V. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	3					**1st QTR:** 3 **Predicted:** 15.297
B. SIR CI (KDHCD predicted range, based on risks)		0.050, 0.534					**1st QTR:** No different than national benchmark.
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]		0.196					**1st QTR:** Closely monitoring C. difficile rates. Occasionally reminding providers and nurses to look for alternative reasons for diarrhea (i.e. stool regimen) in advance of testing for C. difficile.
VI. Hand Hygiene	**95%**						
A. All units Percentage of correct Hand Hygiene observations/opportunities (30 observations/month/unit)		88%					**1st QTR:** ICU and 4N Renal Unit are trialing Biovigil electronic hand hygiene surveillance system. Hand hygiene compliance rates remain above 97% with thousands of observations occuring weekly. The remaining nursing units perform unit based hand hygiene observations and the IP Liaison and Infection Prevention perform hand hygiene audits in these locations. The 88% HH compliance rate is composite of these observations. The Do You Disinfect Everytime (D.U.D.E.) Campaign continues with videos posted on KDCentral.
VII. VRE (HAI) Blood-Hospital Onset (HO)	**BM**						
A. Total Infection Count		0					**1st QTR:** 0 **Predicted:**
B. Prevalence Rate (x100)		0					**1st QTR:** No VRE BSI events reported.
C. Number Admissions		6591					6,591

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2020

		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
VIII. MRSA (HAI) Blood **CMS/VBP**	**SIR**						
A. Total Infection Count (IP Facility-wide)		**2**					**1st QTR:** 2 **Predicted:** not available
B. SIR CI (KDHCD predicted range, based on risks)		0.212, 4.180					**1st QTR:** not available
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]		**1.265**					**1st QTR:** Both cases involved patients who had blood cultures later than 3 days into their admission. Both patients demonstrated elevation in WBCs which initated blood culture orders. However, findings for one patient demonstrated evidence of pneumonia, this patient never had respiratory secretion cultures performed. The second patient had a liver abscess that was drained, but blood cultures were performed a day in advance of the drainage procedure and MRSA was found.
IX. Influenza Rates (Year 2019-2020)	**NHSN**						
A. All Healthcare Workers		**97.8%**					**Season 2020-2021**: 3,947 out of 4,034 healthcare personne received influenza vaccination during the influenza season. This is down by 0.2% from the 2019-2020 Influenza Season vaccination rate. A total of 84 healthcare personnel declined influenza vaccine and 3 healthcare personnel had a medical contraindiction to receiving influenza vaccination. **Action:** Early preparation fora potentially challenging year with a combined influenza season and COVID-19 pandemic

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Prepared by Shawn Elkin, MPA, BSN, RN, PHN, CIC
Infection Prevention Manager

Safety Culture Update

May 2020

Safety Culture Update

1. Safety Culture reporting requirements
2. SAQ 2018 results review & current org strategies
3. Just Culture Steering Committee Update
4. TeamSTEPPS training Evaluation
   - Broad dissemination of “Say it again, Sam” (aka 2-Challenge Rule)
5. Event Reporting QI
6. Safety Attitudes Questionnaire Update

Safety Culture Measurement and QI

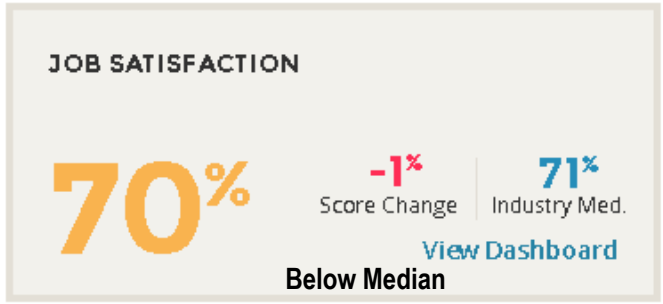
Entities/Initiatives with Requirements:

- Leapfrog National Quality Forum Safe Practice, included in Leapfrog Safety Score/Grade
  - Teamwork training is a NQF safe practice QI strategy
- The Joint Commission – Patient Safety Chapter requirements
- Kaweah Strategic Plan (under Kaweah Culture pillar)
  - Teamwork and Safety Climate

2018 KDHCD SAQ Domain Scores & Organizational Initiatives

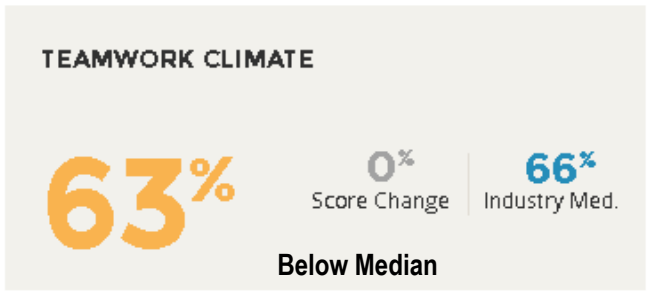
- 5 categories below the 50th percentile, 1 above and 1 equal
- 3 domains have improved from 2016, 2 have decreased and 2 are unchanged

Score change is % change from KDHCD's 2016 SAQ survey

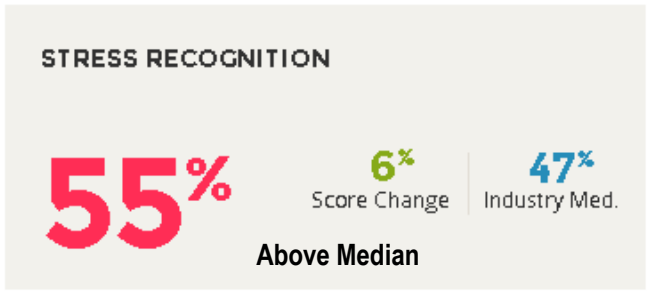


ORG INITIATIVE

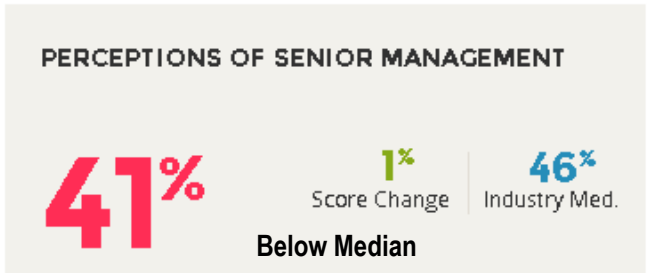
- Employee engagement initiatives
- Unit-Level SAQ action plans



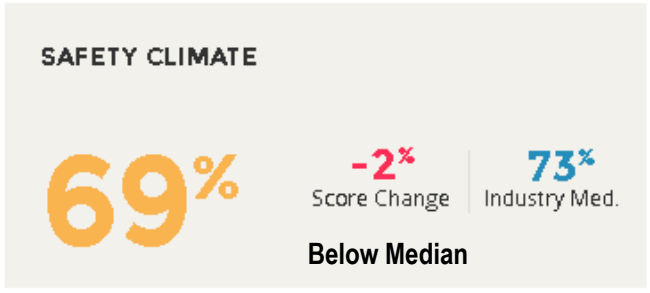
- TeamSTEPPS
- CUSP Program



- Stress Recognition modules for all new hires and ad hoc

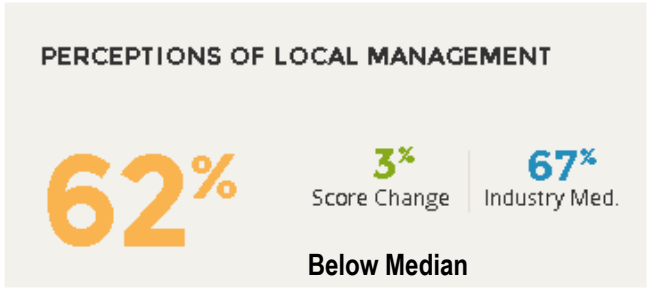


- CUSP ET Sponsors
- Leader rounding
- Just Culture

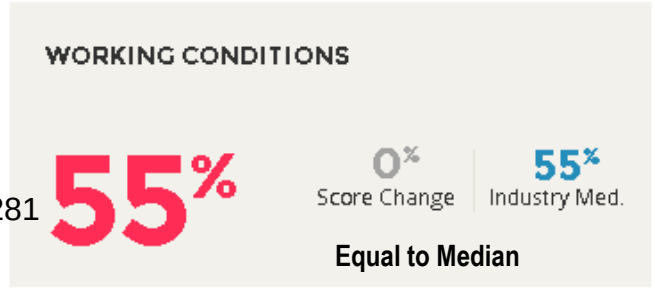


ORG INITIATIVE

- Just Culture
- Midas system revisions
- Good catch/Hero
- CUSP/IP Liaison
- CUS mandatory new hire module



- CUSP
- Leader rounding
- Just Culture



- Employee engagement initiatives
- Unit-Level SAQ action plans

Just Culture Steering Committee Update

- Plan for Just Culture staff awareness campaign tentatively fall 2020
- Evaluating additions of Just Culture questions to event follow up in Midas
- Including the Just Culture focused questions in the 2020 SAQ (compare to 2018 baseline)
- Ongoing manager training to Just Culture and the Marx Algorithm

TeamSTEPPS Training Evaluation
March 3&4, 2020

Mean response on 1-5 Likert Scale (1=poor, 5=excellent)	n=30
The objectives of this course were met	4.87
Course content is relevant to my work	4.93
My understanding of the topic prior to the course (n=15)	3.20
My understanding of the topic after the course	4.77
Change pre/post training	1.57
Percent improvement	49%
Would recommend this course to others	97%

- Summary: The training did what it was supposed to, participants felt it was useful to their role/work, and learning occurred: 49% improvement in the understanding of TeamSTEPPS

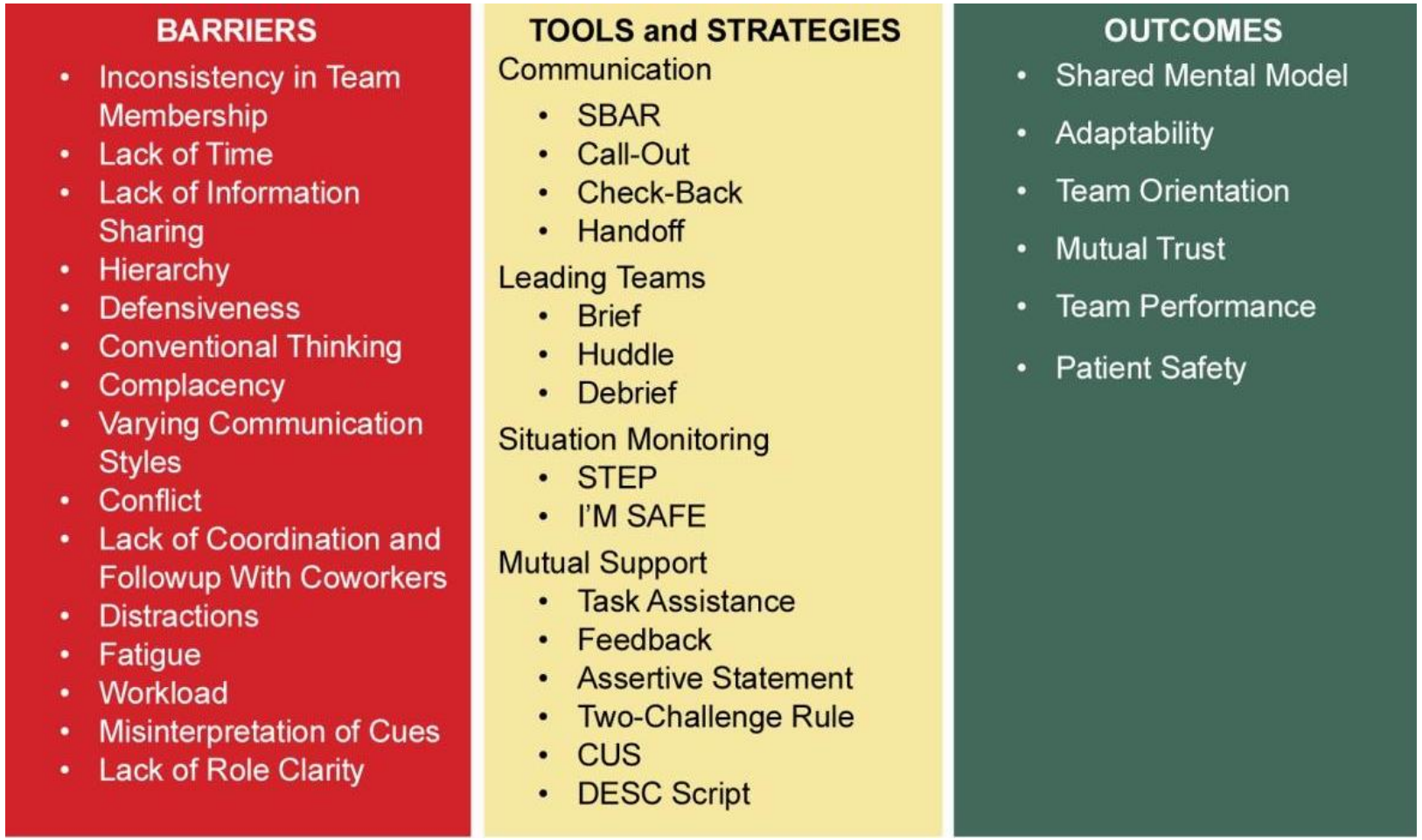
TeamSTEPPS Training Evaluation
March 3&4, 2020

- Wordle: The size of the word indicates how frequently the word was used in free text answers
- List 3 benefits you received from this program, top used words:
  - ***Understanding***
  - ***Team***
  - ***Safety***
  - ***Tools***
  - ***Communication***
  - ***Implement***
  - ***Improve***

TeamSTEPPS Training Evaluation

- 15 TeamSTEPPS Tools
- Implemented, or plan to be implemented in 11 different units/depts at Kaweah Delta
- TeamSTEPPS takes us:
  - **To a new environment**
  - **Using a new language**
  - **That builds teams**
  - **Brings more joy and meaning to the workplace**
  - ***and Saves Lives***

The TeamSTEPPS Tool Box



Say it again, Sam

Get your concern addressed! Say it twice for patient safety!

Say it again, Sam is used to speak up to a care team member if you have a patient safety concern or need clarification on an issue. **It's all about saying it twice!** Use this with or without your "CUS" words (I am Concerned, Uncomfortable, it's a Safety Situation).

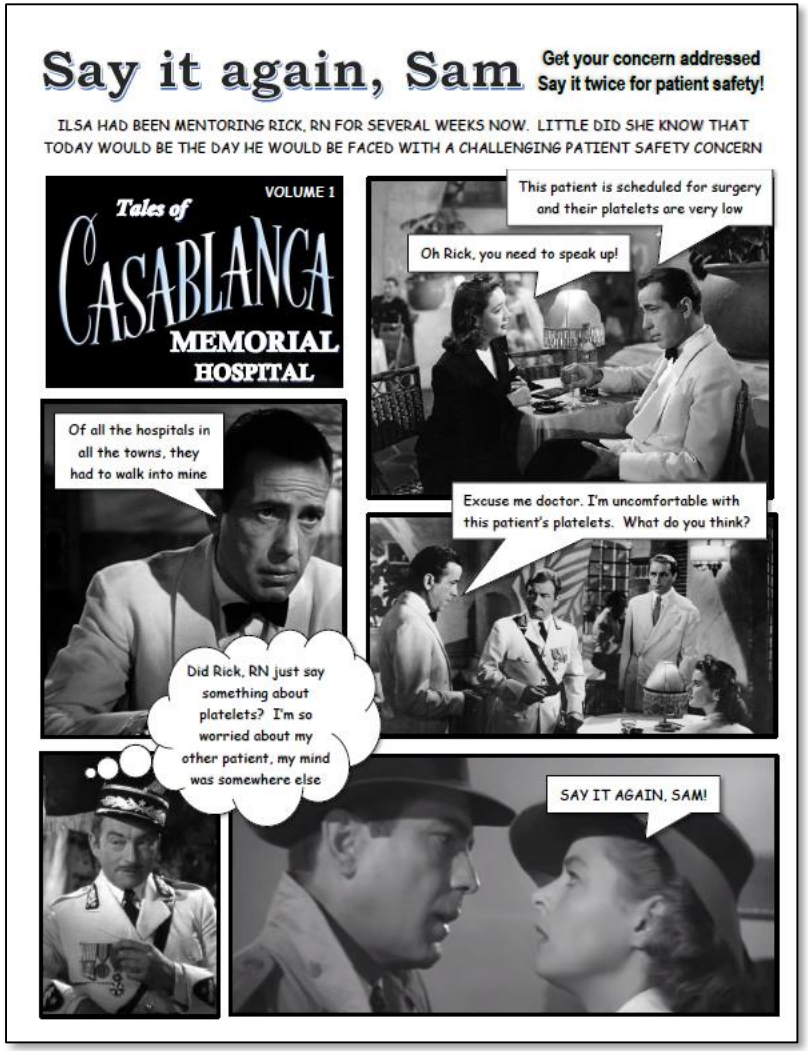
1. Speak up about your patient safety concern
2. If your concern is ignored or dismissed, Say it Again – **add more detail about your concern**.
3. If your concern is not addressed after 2 attempts, **use chain of command.**

Say it again, Sam is all about advocating for patients. It ensures that your concern has been:

- heard
- understood
- acknowledged

If a patient care concern is stated to you twice **stop, listen**, and respond**;** this is a very real concern that needs attention!

This communication is key to patient safety and helps us provide quality care to our patients.



Next Steps for TeamSTEPPS

- Leader coach tool implementation
- Evaluating a staff level voluntary TeamSTEPPS option (recommended by leader coaches)
- Broad awareness of “Say it again, Sam”
- Cohort #3 planned for next FY

Event Reporting QI

Based on careful evaluation and staff feedback the event reporting system was revised to be easier for staff and providers to enter event reports

The Journey to Improving Safety Culture: Reducing Entry Time for Patient Safety Events

Evelyn McEntire, BSN, RN, Sandy Volchko, DNP, RN, CLSSBB, Jennifer Halsey, BS, Eduardo Castro, BIS, Mary Rogers
Kaweah Delta Risk Management and Quality & Patient Safety Departments

Background

Encouraging patient safety reporting empowers an organization's most valuable assets – its people – to always be vigilant for hazards in the face of varying system conditions.

Reporting close calls is an important step toward developing the ability to respond to "weak signals" or poorly detected risks. Close calls are defined as unsafe acts or conditions — errors, procedure violations or hazards — that could have seriously harmed a patient but did not because they were identified, reported, and addressed or eliminated (The Joint Commission (TJC), 2018).

Reporting close calls is important for the following reasons:
- They provide valuable information on active and potential weaknesses in health care systems.
- They are more frequent than events causing harm and provide information about errors from the perspective of health care workers in different positions.
- Analysis of high-frequency or high-potential-severity near miss reports makes it possible to identify system weaknesses and learn from them in the context of daily workflow or systems use (TJC, 2018).

To enhance the value of event reporting systems, industry experts Cuong Pham, Girard, & Pronovost (2013) recommend making reporting easier. "Rather than making adverse event reporting systems more complex, we should move to making reporting exceedingly easy and less burdensome. Healthcare providers should have quick and ready access (electronic, web-based) to these systems. These systems should be so simple that staff can use them with minimal or without training. Given the infrequent nature by which most staff members report adverse events, any training will likely have been forgotten at the time of reporting."

These systems should ask for a minimal amount of information about the event. And instead of asking the healthcare provider to categorize the event, rate the event, and attribute causes, a free text description and some identifying information may be all that is required. The ease of event reporting is key in increasing the amount of events reported, the identification of close calls, and in an organization's journey of just culture.

Introduction

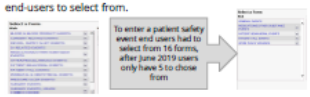
In 2018 a custom question was added to the organization's safety culture survey to assess the users perceptions of the ease of event reporting. Based on a Likert scale of 1-5, over 2,000 health care providers answered the question: "The event reporting system is easy to use." 59% of respondents answered favorably (agree [4] or strongly agree [5]). It was evident from these results that changes needed to occur to move forward in the safety culture journey.

Beginning in 2013, the organization has administered the Safety Attitudes Questionnaire (SAQ) every two years to assess safety culture and focus improvement efforts. In 2018 seven custom questions focused on elements of just culture were added to obtain a baseline measure of staff's perceptions of just culture in the organization; the ease of event reporting was one of those questions.

Methodology

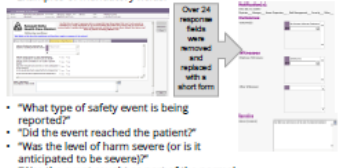
Between 2018 and early 2019 feedback on how to make the event reporting system and process easier was solicited from staff and providers using formal and informal methods. This input was used in evaluating components of event reporting forms and workflow by patient safety leadership, and resulted in several significant system modifications:

1. The 16 existing forms were reviewed and evaluated for necessity and 12 were consolidated into 1 form titled "general event." Reducing the number of forms to select from 16 to 5 made reporting easier by limiting the number of options for end-users to select from.



2. The need for end-users to categorize the event was removed. Previous to the system modifications, end-users were required to select categories such as "Unexpected Return to the OR" and , "Wrong Type of Test/Treatment/ Procedure" to submit an event. There were over 170 categories in total to choose from, often confusing and time consuming for the end-user. Workflow changes led to Risk Management Department taking on the responsibility of this function, which took the onus off the end-user and resulted patient safety experts categorizing events accurately upon initial review.

3. Several mandatory fields were eliminated. More importantly, five (5) tabs/pages of questions were eliminated including over two (2) dozen fields. As a result end-users complete one short form instead of multiple tabs and fields to click through. Examples of mandatory fields:



- "What type of safety event is being reported?"
- "Did the event reached the patient?"
- "Was the level of harm severe (or is it anticipated to be severe)?"
- "Was the event caught as part of the normal checks in the process?"

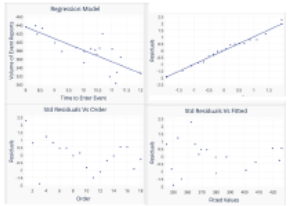
Results

The mean amount of time required to submit an event report decreased following the system modifications:
- Mean time to submit a general event 10.7 minutes from July 2018 – June 2019
- Mean time to submit a general event 9.09 minutes from July 2019 – December 2019
- There was a significant difference in the time before system modifications (M=10.70, SD=0.462) and after (M=9.09, SD=0.721); t(16)=5.796, p = 0.001
- Estimated time savings per event entry 1:37
- There are on average 171 general events submitted per month
- Estimated time savings in event entry: 4 hrs 34 min per month; >55 hrs per year

The mean volume of patient safety events submitted increased after system modifications were completed.
- Mean volume of event reports submitted monthly January 2017 to May 2019 (before system revisions) 357
- Mean volume of event reports submitted monthly June 2019 to January 2020 (after system revisions) 405
- There was a significant difference in the volume of events before system changes (M=1357, SD=41.15) and after (M=405.38, SD=34.71); t(35)=2.03, p = 0.0045

Simple linear regression was carried out to investigate the relationship between number of event reports and time to enter events (minutes). The scatterplot showed that there was a strong negative linear relationship between the two, which was confirmed with a Pearson's correlation coefficient of -0.725. Simple linear regression showed a significant relationship between time to enter an event and number of events ($p < 0.001$). The slope coefficient for volume of events was -27.29 so the volume of event reports increases by 27 (95% CI [-39.98, -14.59]) when the time to enter decreases by 1 minute. The R2 value was 0.526 so 52.6% of the variation in volume of event reports can be explained by the model containing only time to enter events.

Results Cont'd



Regression Model

Regression Statistics

Coefficient Table

ANOVA

Conclusion

The system modifications for event entry resulted in significant reduction in the time to enter events. Following the system modifications the volume of events increased significantly. Considering no other strategies targeted at increasing event reporting were implemented parallel to the system modifications it is reasonable to assume that "reporting complexity" was a significant root cause of under reporting. Simplification was the countermeasure and this resulted in less time to report and more reporting.

Next Steps

In April 2020 the organization will administer the Safety Attitudes Questionnaire (safety culture survey) to approximately 3,000 staff. The just culture focused questions from the administered 2018 SAQ survey will be included in the 2020 survey as a means to measure the change of the end-users' perceptions of the ease of event reporting. Further evaluation will continue to identify additional opportunities to reduce reporting burden.

References

Julius Cuong Pham, Thierry Girard, Peter J. Pronovost (2013). What to do with healthcare Incident Reporting Systems. Journal of Public Health Research, volume 2:e27.
The Joint Commission (2018). Sentinel Event Alert #60: Developing a reporting culture: Learning from close calls and hazardous conditions. Retrieved from : jointcommission.org

RESULTS

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- There was a significant difference in the time before system modifications (10 70 SD= 0 462 and after M= 9 09 SD= 0 721 t(16 5 796 p 0 001
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- There are on average 171 general events submitted per month
- Estimated time savings in event entry 4 hrs 34 min per month, 55 hrs per year

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- T here was a significant difference in the volume of events before system changes M= 1357 SD= 41 15 and after M= 405 38 SD= 34 71 t(35 2 03 p 0 0045

Safety Culture Measurement

- SAQ tentatively for Nov/Dec 2020
- Includes the 7 custom Just Culture Questions plus an additional new question for 2020

1. When I see others doing something unsafe for patients, I speak up.
2. My manager supports and leads a culture of patient safety in my work setting.
3. When staff make clinical errors, we focus on learning rather than blaming.
4. I enter reports about events in which I was involved.
5. I make the hospital a safer place for patients by entering event reports.
6. My Director supports and leads a culture of patient safety in my work setting.
7. The event reporting system is easy to use.
8. Physicians support a culture of patient safety in this work setting. NEW!

Questions? Comments?

Kaweah Clinical Quality Goals

June 2020

Sepsis **Kaweah Clinical Quality Goal Calculator - FY20**

	Current										Future State Scenario			FYTD			
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	**Total**	**Total**	**Baseline 67% 0%**	**Goal 70%**	Top 10% = 81% (Q3 2018 - Q2 2019)
SEP-1 Early Management Bundle	68%	67%	58%	67%	61%	74%	54%	75%	61%	88%	84%	80%	70%	**67%**			
numerator	13	16	14	20	17	17	14	18	14	22	21	20	206	165			
denominator	19	24	24	30	28	23	26	24	23	25	25	25	296	246			

Sepsis Six Sigma:

- Root causes identified, 20 QI strategies developed and prioritized to improve processes to ensuring patients get all components of the bundle every time
- 2nd Sepsis Coordinator started 5/17, help from light duty and other Quality & Patient Safety staff starting in April

Project Prioritization Matrix: Sepsis QFT, June 2020

Group Strategy Affects	Improvement Strategy		**DIFFICULTY** or Cost/ Time to Implement Rate 5 to 1 High = 1 Low = 5		**FEASIBILITY** (likelihood of Success/ability to achieve the outcome Rate 5 to 1 High = 5 Low = 1		**SCOPE** Strategy affects multiple or a high volume root cause Rate 5 to 1 High = 5 Low = 1		**LEVERAGE** (Positive Impact on Other Processes) Rate 5 to 1 High = 5 Low = 1		Total Project Priority
ED Pro	2. ED - Build and utilize SEP-1A "Catch Up" order set so all bundle components can be ordered (not "grayed out") **COMPLETE**	x	4.0	x	5.0	x	5.0	x	5.0		**500.0**
CC/INPT RN	6. Make form revisions to "provider notification"; provide prompts for critical thinking and order set initiation, and title it differently to eliminate confusion **IN PROCESS**	x	2.0	x	4.0	x	4.0	x	5.0		**160.0**
ED Pro & CC/HOS	11. Build dot phrase - If it's not Sepsis, document it **COMPLETE**	x	4	x	2	x	4	x	5		**160.0**
ED Pro/ ED GME	9. Schedule ED and GME regular education/awareness of bundle, and order set usage **IN PROCESS**	x	2	x	4	x	4	x	4		**128.0**
ED Pro	1. Improve ED provider notification by Sepsis Coordinator when attempting to avoid fallouts concurrently **IN PROCESS**	x	4.0	x	2.0	x	4.0	x	3.5		**112.0**
ED/CC RN	20. Hand off sheet/pathway checklist (concerns about paper lost); can checklist be triggered electronically for RN when order set is used? This way checklist is available electronically, and can be available to print anywhere in patients Sepsis hospitalization course regardless of location. Similar to existing workflow with MRI safety form, belonging forms "ad hoc" forms. Ideally it populate, and reminder to complete. **IN PROCESS**	x	3	x	2	x	4	x	4		**96.0**
CC/INPT RN	7. Mandatory for RN to fill out "provider notification form" after sepsis alert fires – alerts suppressed for 48hrs, so RNs do not receive multiple alerts. THIS IS DEPENDENT ON #6 Investigate what happens If you bypass the alert one time it appears very difficult to get it back – further education/awareness of where to find alert. **IN PROCESS**	x	4.5	x	3.0	x	2.0	x	3.0		**81.0**
CC/INPT RN	10. (Q&P/S) obtain safety summit compliance rates to validate if new staff are getting instructions upon hire of requirements **COMPLETE**	x	4	x	3	x	2	x	3		**72.0**
ED Pro	16. Reflex alert, when Abx ordered (specific list of Abx) provider gets alert "do you want BC" **IN PROCESS**	x	4	x	4	x	4	x	1		**64.0**
ED/CC/ HOS pro	15. > 126ml/hr option added to ED AND INPATIENT ADULT SEPSIS order sets **COMPLETE**	x	4	x	3	x	2	x	2		**48.0**
ED/CC/ HOS Pro	19. Add to ED AND INPATIENT order set Reflex LA order when previous LA >2 **COMPLETE**	x	2	x	4	x	4	x	1		**32.0**
ED/CC/ HOS Pro	17. Dot phrase for when Abx are urgent, so provider documentation is in EMR **COMPLETE**	x	4	x	3	x	1	x	1		**12.0**
CC/INPT RN	8. Evaluate what clin Ed provides to new RNs about sepsis alerts and how to respond? Ideally hands on training upon hire, look at alerted patient and walk through documentation. **IN PROCESS**	x	1	x	4	x	2	x	1		**8.0**
CC/HOS Pro	22. Standardized documentation of attending reassessment (Dr. Malli's phrase) **IN PROCESS**	x	3	x	2	x	1	x	1		**6.0**
ED RN	13. ED Techs input height and weight in EMR; RN input for BIBA patients HOLD dependent on #14 **IN PROCESS**	x	2	x	1	x	1	x	1		**2.0**
ED RN	14. IBW automated in fluid order when height and weight are documented **COMPLETE**	x	2	x	1	x	1	x	1		**2.0**

Sepsis Kaizen QI Strategy Update

- Six Sigma work began March 2020
- Key Stakeholders: Physicians, GME Residents, Nursing, ISS, Clinical Education in ED, ICUs, ICCUs
- Over 20 identified QI strategies identified
- Seven (7) strategies have been completed and implemented
- Eleven (11) strategies are in development and nearing completion
- Four (4) strategies in parking lot
- Data reveals an increase in compliance of the 3-hour and 6-hour bundles (Former top fallouts: repeat LA, fluid administration, and reassessment)

CAUTI, CLABSI & MRSA

Kaweah Clinical Quality Goal Calculator - FY20

CAUTI = Catheter Associated Urinary Tract Infection; CLABSI = Central Line Associated Blood Stream Infection; MRSA = Methicillin-resistant Staphylococcus aureus

	Current											Future State Scenario		FYTD	Baseline	SIR GOAL	VBP
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total*	Total			
CAUTI (SIR)	0.65	2.76	2.34	0.68	0.00	0.00	0.00	1.24	0.00	0.67	2.67	0.00	**0.98**	**1.09**	**Baseline 1.557 ↓30%**	**SIR GOAL ≤0.828 or 14**	**VBP 2022 50 perc ≤0.727**
numerator (actual)	1	5	4	1	0	0	0	2	0	1	4	0	18	18			
denominator (predicted)	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.61	1.24	1.5	1.5	1.5	18.06	16.56			
Denominator (Actual 9 months + Predicted Apr - Jun) Linear Regression	1.53	1.81	1.71	1.47	1.46	1.03	1.7	1.61	1.24	1.69	1.62	1.58	18.45				

	Current											Future State Scenario		FYTD	Baseline	SIR GOAL	VBP
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total*	Total			
CLABSI (SIR)	0.00	0.00	2.70	3.67	1.11	0.00	0.00	0.00	0.00	0.82	0.00	0.00	**0.68**	**0.74**	**Baseline 1.253 ↓41%**	**SIR GOAL <0.784 or 12**	**VBP 2022 50 perc ≤0.633**
numerator (actual)	0	0	3	4	2	0	0	0	0	1	0	0	10	10			
denominator (predicted)	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22	1.22	1.22	1.22	14.72	13.5			
Denominator (Actual 9 months + Predicted Apr - Jun) Linear Regression	1.19	1.23	1.11	1.09	1.8	1.13	1.02	1.27	1.22	1.22	1.23	1.23	14.74	0.68			

	Current											Future State Scenario		FYTD	Baseline	SIR GOAL	VBP
	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020	June 2020	Total	Total			
MRSA (SIR)	2.67	1.33	1.33	0.00	0.00	2.78	0.00	1.89	1.89	0.00	0.00	0.00	**1.00**	**1.09**	**Baseline 1.410 ↓22%**	**SIR GOAL <0.815 or 7**	**VBP 2022 50 perc ≤0.748**
numerator (actual)	2	1	1	0	0	2	0	1	1	0	0	0	8	8			
denominator (predicted)	0.75	0.75	0.75	0.72	0.72	0.72	0.53	0.53	0.53	0.67	0.67	0.67	8.01	7.34			

CAUTI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Apr-20	May-20	Jun-20
OUTCOME MEASURES					
Number of CAUTI	0	0	1	4	
Days Between Events (from last CAUTI to end of reporting month OR next CAUTI) BASELINE (4/1208 to 10/2019) = 12.78	>30	49	2 (4/28/20)		
Quarterly SIR (all payor)	≤ 0.838	0.52			
FYTD SIR (all payor) BASELINE (FY19) =1.557	≤ 0.838	0.96	0.93	1.09	
PROCESS MEASURES					
IUC Shift Huddles					
% Huddles Accurately Completed	100%	74%	89%		
% insertion missed	0%	19%	40%		
% cleanliness missed	0%	81%	60%		
IUC Gemba Rounds					
% of Gemba Rounds Completed	100%	n/a	n/a		
% of pts with appropriate cleanliness	100%	98%	99%		
% of IUCs with order & valid rationale	100%	90%	93%		
% of IUCs where removal was attempted	n/a	8%	5%		
% of pts where alternatives have been attempted	n/a	15%	12%		
# of Pt Catheter days rounded on	n/a	616	720		
% of IUCs removed because of Gemba Round	n/a	7%	6%		
# of IUCs removed because of Gemba Round	n/a	46	42		

Better than Target | Within 10% of Target | Does not meet Target

April Highlights:

- 720 Patient catheter days gemba-ed – WOW!
- 42 catheters removed because of gemba! WOW!
- 89% of time huddles include both cleanliness and insertion date; when something is missed it is more often cleanliness
- However, 99% of the time patients with catheters have had cleanliness addressed (either bath or peri-care) daily. This is significant since cleanliness was identified as a major root cause of CAUTI – AMAZING!
- REMINDER – Huddles required for evening shift only (gemba covers day shift)

Next Steps:

- Accurate temperature taking
- Minor UA order changes
- IUC insert and discontinue order fine tuning to make it easier to order and easier on nursing
- Keep doing those Gemba walks- we appreciate the investment these require from the team- they are making a difference!

CLABSI Committee Dashboard

Measure Description	Benchmark/ Target	Mar-20	Apr-20	May-20
OUTCOME MEASURES				
Number of CLABSI	0	0	1	0
Days Between Events (from Nov 2019) (from last CLABSI to end of reporting month OR next CLABSI) BASELINE(4/1208 to 10/2019) = 12.78	>30	143	26 (4/4/20)	
Quarterly SIR (all payor)	≤ 0.784	0.248		
FYTD SIR (all payor) BASELINE (FY19) =1.557	≤ 0.784	0.9	0.81	0.74
PROCESS MEASURES				
CL Gemba Rounds				
% of Gemba Rounds Completed	100%	n/a	n/a	
% of pts with bath within 24 hrs	100%	n/a	81%	
% of CL with valid rationale	100%	n/a	93%	
% of CL dressings clean, dry and intact	100%	n/a	92%	
% of CL that had drsg change no > than 7 days	100%	n/a	97%	
% of patients with proper placed gardiva patch	100%	n/a	83%	
% of CL pts with app & complete documentation	100%	n/a	81%	
# of Pt Central Line days rounded on	n/a	n/a	426	

Better than Target | Within 10% of Target | Does not meet Target

April Highlights:

- 426 Patient central line days gemba-ed – WOW!

Below 85%:

- Patients baths within 24 hours
- Patient with properly placed GuardIVa patch
- Patients with appropriate and complete documentation

Next Steps:

- Ensuring peripheral IV's are not expired; checking every shift and remove expired peripheral IV's!
- Obtaining GuardIVa patches (and par levels) that will fit these different types of catheters (larger lumen) to ensure contact of patch all the way around the catheter.
- Gemba rounds – keep addressing the bathing daily! They make a HUGE difference!

“Culture of Culturing” (aka Culturing Stewardship)

CLABSI & MRSA Kaizen Action Plan - Culture of Culturing Team

#	Task	Original Due Date	Status
1	Cerner alert pop-up for blood cultures ordered within 24 hours apart (SOFT STOP, drop down option to clarify need for order)	2/24/20	
2	Report build to track and trend over-rides (dependent on #1)	2/24/20	
3	One Page Wonder of Culturing Guidelines	2/24/20	
4	CL Tip Culture: “Not Available in Kaweah Delta Laboratory“ * Removal of all references to catheter tip culture	2/24/20	
5	New Insert CL order set, phased Power Plan, with alert for physicians for “line OK to use”	3/6/20	

BC ordered within 24 hrs
provider alert went live 5/21 !

Report Summary (5/21-6/16)

- Alert fired 213 times
- 76 BC were averted with the alert, the alert popped up indicating that a BC was ordered in the past 24 hrs and the provider chose not to order
- Reasons for ordering documented, Dr. Gray analyzing as there are legitimate reasons for ordering!

Annualized that is >900 blood cultures averted