March 14, 2024

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in a Quality Council Committee meeting at 7:30AM on Thursday, March 21, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

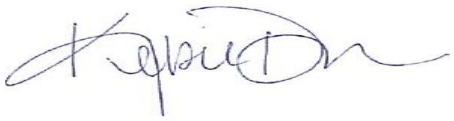
The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Quality Council Committee at 7:31AM on Thursday, March 21, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277, pursuant to Health and Safety Code 32155 & 1461.

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Quality Council Committee meeting at 8:00AM on Thursday, March 21, 2024, in the Kaweah Health Lifestyle Fitness Center Conference Room, 5105 W. Cypress Avenue, Visalia, CA 93277.

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 Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer



Kelsie Davis
Board Clerk, Executive Assistant to CEO

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

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
QUALITY COUNCIL

Thursday, March 21, 2024
5105 W. Cypress Avenue
Kaweah Health Lifestyle Fitness Center Conference Room

ATTENDING: Board Members; Michael Olmos – Committee Chair, Dean Levitan, MD; Gary Herbst, CEO; Keri Noeske, RN, BSW, DNP, Chief Nursing Officer; Tom Gray CMO/CQO; Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair; LaMar Mack, MD, Quality and Patient Safety Medical Director; Sandy Volchko DNP, RN CLSSBB, Director of Quality and Patient Safety; Ben Cripps, Chief Compliance and Risk Management Officer; Evelyn McEntire, Director of Risk Management; and Kyndra Licon, Recording.

OPEN MEETING – 7:30AM

1. **Call to order** – *Mike Olmos, Committee Chair*
2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.
3. **Approval of Quality Council Closed Meeting Agenda** – 7:31AM
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair.*
   - **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management and Ben Cripps, Chief of Compliance and Risk Officer.*
4. **Adjourn Open Meeting** – *Mike Olmos, Committee Chair*

CLOSED MEETING – 7:31AM

1. **Call to order** – *David Francis, Committee Chair & Board Member*

2. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Julianne Randolph, DO, Vice Chief of Staff and Quality Committee Chair*

3. **Quality Assurance** pursuant to Health and Safety Code 32155 and 1461 – *Evelyn McEntire, RN, BSN, Director of Risk Management, and Ben Cripps, Chief Compliance and Risk Officer.*

4. **Adjourn Closed Meeting** – *Mike Olmos, Committee Chair*

OPEN MEETING – 8:00AM

1. **Call to order** – *Mike Olmos, 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. Safety Culture Action Plan Update
    3.2. Fall prevention Committee Report
    3.3. Hospital Acquired Pressure Injury Committee Report
    3.4. Infection Prevention Quarterly Dashboard
    3.5. Maternal Child Health Quality Report
    3.6. Handoff Quality Focus Team – No update
    3.7. Best Practice Teams – No update

4. **Cardiology Services Quality Report –** A review of key quality measures and actions plans focused on the care of cardiac patient population. *Dr. Ashok Verma, MD, Medical Director – Cath Lab; Tracy Salsa, Director of Cardiovascular Service Line; Christine Aleman, Director of Cardiac/Surgical Services.*

5. **Clinical Quality Goals Update-** A review of current performance and actions focused on the clinical quality goals for Sepsis, and Healthcare Acquired Infections. *Sandy Volchko, RN, DNP, Director of Quality and Patient Safety.*

6. **Adjourn Open Meeting** – *Mike Olmos, 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.

Safety Culture Survey Results and Next Steps

Quality Council March 21, 2024

Sandy Volchko DNP, RN, CPHQ, CLSSBB
Director Quality & Patient Safety

Kaweah Health Safety Culture Survey Summary

- Survey administered Jan-Feb 2023
- Response Rate: 66% (2,445/3,711)
- Kaweah Health overall Safety Culture Index 3.92, +0.06 better than Press Ganey like comparison of US facilities >400 beds (overall measure of safety culture)
- Press Ganey Groups questions together into 3 Safety Culture subcategories:
  - Prevention & Reporting (8 items) – Kaweah Health score 4.15, +0.10 BETTER than like comparison of US facilities >400 beds
  - Resources & Teamwork (7 items) - Kaweah Health score 3.62, +0.04 BETTER than like comparison of US facilities >400 beds
  - Pride & Reputation (4 items) - Kaweah Health score 3.97, -0.03 BELOW like comparison of US facilities >400 beds
- Results analyzed and disseminated to leaders based on location and role
- Action plans submitted by all staff locations surveyed

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Timeline for Leaders

Unit/Department Level Reports and COMPLETED Action Plans

Report Dissemination and Leader Training

Apr- May 2023

- Units/department leaders receive reports
- Leaders attended 1 Press Ganey Session “How to read and interpret your report and action plan”.

Staff Survey Results Debriefing

May - June 2023

- Staff Debriefing completion by June 9, 2023
- Staff in roles and units/departments with lowest significant overall safety culture index score debriefed with a Quality & Patient Safety Facilitator.
- Unit level results disseminated in a standardized format and messaging through a Power point template provided to leaders

Action Planning

- Unit/department action plans submitted to Quality & Patient Safety Department by June 23, 2023
- Action plans submitted on Stop Light Report template which provides visual display to staff on status of action plans; provided to leaders

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Recommended Timeline

Organizational Level Reports and COMPLETED Action Plans

Report Dissemination	Analysis & Debriefing
• Overall initial results to Quality Improvement Committee (QIC), Leadership meeting and Quality Council completed April – May 2023	• Review “concern” questions and other low scoring items. Analysis conducted by work setting and role and presented to Patient Safety Committee completed July 2023 for action plan recommendations • Recommendations presented for discussion and to Quality Improvement Committee completed August 2023. Focus on job stress and the Midas event reporting system • Action plans ongoing (see next slides), plan for resurvey to determine effectiveness June 2024

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Kaweah Health Focus Areas

- Question #14 *"The amount of job stress I feel is reasonable"*
  - the 1 question that Press Ganey identified as "concern" for Kaweah Health when compared to like facilities (facilities >400 beds). A "concern" is a question that is scoring significantly lower than the comparison

  ACTION:
  - QIC analyzed the data by location and determined that each location has individualized concerns specific to that work setting (ie. staffing). The Chiefs will work with each low scoring location identified on this question to address the individualized concerns.
  - Plan to resurvey as part of Employee Engagement Survey approximately June 2024 to determine effectiveness

Kaweah Health Focus Areas

- Question #6 “When a mistake is reported, I feel like the focus on solving the problem, rather than writing up the person”, and question #26 “The Midas event reporting system is easy to use
  - Question #26 is a custom question, there is no national benchmark. When compared to last survey there has been no improvement; however, with turnover and new staff and leaders, many do not have familiarity with Midas and its intent for safety improvements. Therefore difficult for staff to gage ease of use with little historical context.
  - Question #6 is performing above the mean when compared to like facilities >400 beds, but is lower than the Press Ganey overall national comparison.

  ACTIONS:
  - The perception of some staff is that they do not receive follow up or see resolution for submitted events. One identified root cause is that follow up is not possible when event reports are submitted anonymously.
  - Evaluated the current default of “anonymous” in the “submitted by” name field which may be inadvertently contributing to more events submitted anonymously. Plan to change default to blank. Also, evaluating option to add text prompts near this field to instruct staff how to insert their name in the “submitted by” field. This will allow proper investigation and follow up to occur.
  - Risk Management has made many changes to the Midas event report forms to simplify for the end user by: reducing the number of required fields, eliminating extraneous forms and fields, removing the need for submitters to select an event type category. Risk Management has been attending staff meetings in-person over the last several months to educate on the Midas system and event reporting. In 2023, we have seen a reduction in event reports which reached the patient and submitted anonymously from 75% to 61% (lowest rate since Midas implementation in 2015).
  - Streamlined data reports for department leaders to increase access to and analysis of their own data for improvement work.

  NEXT STEPS:
  - Change ‘anonymous’ default to blank and evaluate ability to add text prompts on how to enter submitter’s name.
  - Solicit further input from front line staff and providers during the Patient Safety Fair (March 2024) on how to further improve the ease of the Midas system.
  - Educate and make available to department leaders event report prioritization charts to aid in identifying high-risk, problem prone areas for feedback to staff and improvement work.
  - Re-survey staff during Employee Engagement Survey approximately June 2024.

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Kaweah Health Focus Areas

- Safety Culture Scores by Role
- 2 roles were identified by Press Ganey as being “disengaged” (lowest scoring roles)
- Results reviewed with leaders and debrief sessions held with staff to gain insight into survey results and guide action planning
- “Stop Light” action plans developed for each role and included in the following slides/pages. The action plans are in process and the Stop Light report allows a mechanism to communicate status of action plans directly to staff

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Kaweah Health Focus Areas

Safety Culture Scores by Role

Stoplight Reports Updated Feb 2024

Kaweah care — Stoplight Report

Department: Acute Wound 6191 Date: June 21, 2023 to June 20, 2024

Completed:

(Enter text here)

The following are the Team's top priorities as indentified in the Safety Culture Survey:
Key strategies for hardwiring accountability were adopted by the team on June, 21st:
1. Call staff to make appointments to see patients at the nurse's convenience.
2. Provided ACTS team with education re: wound care and wound vacs. Met with residents and surgical attendings on March 17,2023.
3. Recognized certified wound nurses on Certified Nurses Day on March 19, 2023

In progress:

(Enter text here)

1. Involved in interdisciplinary rounding to view wounds together, discuss plan of care and provide input and ensure wound orders are completed in a timely manner and are sufficient for the patient.
2. Surgeons to contact wound nurses when they want a consult to view wound and if urgency to consult.
3. Request that NM/ANM in shift huddles monthly and add in CSI email to remind staff to be present when involved with wound nurse consultation.
4. Ensure providers do not automatically order wound consults. Providers unaware

Can't be completed at this time, and here's why:

(Enter text here)

1. Some leaders are defensive when wound nurses bring information to their attention. Hard to change perceptions of their staff members. In the future, maybe attend staff meetings to provide information about wound nurse workflow and answer questions.
2. Re-establish Kaweah Care. Going above and beyond does not exist anymore. Unable to re-establish as the wound team, but can bring forward to leadership to see if we can start again or investigate another initiative.

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Kaweah Health Focus Areas

Safety Culture Scores by Role

Stoplight Reports Updated Feb 2024

Kaweah care — Stoplight Report

Department: Patient Access ED Date: 6/22/23 to 7/1/24

Completed:

(Enter text here)

*Hiring process to include staff/staff leads - this is in place
*Staff feel they need a place to sit - 2 stationary workstations are now available.
*Education on how to enter Midas events - job aid from Risk Management was shared
*WOW's may not be safe, wires exposed - ticket opened SD-294937 to review speed, privacy and wires - Completed by ISS
*Registration is not notified of changes - Strong partnership in place between leaders and communication will be channeled through the start desk

In progress:

(Enter text here)

*Some people do not want to come to work
Action: Holding people accountable, Rounding, Addressing personnel issues as they arise
*Communication with Emergency department is difficult
Action: PA leaders working with clinical leaders, attended Kai Zen event
*Communication with certain individuals is difficult
Action: Teambuilding exercises - Staff meetings scheduled for 10/17 & 10/19

Can't be completed at this time, and here's why:

(Enter text here)

Is there an "other" option in language - Not available in system, there is only "patient declined"

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Questions?

Kaweah Health Safety Culture Survey Reference Materials

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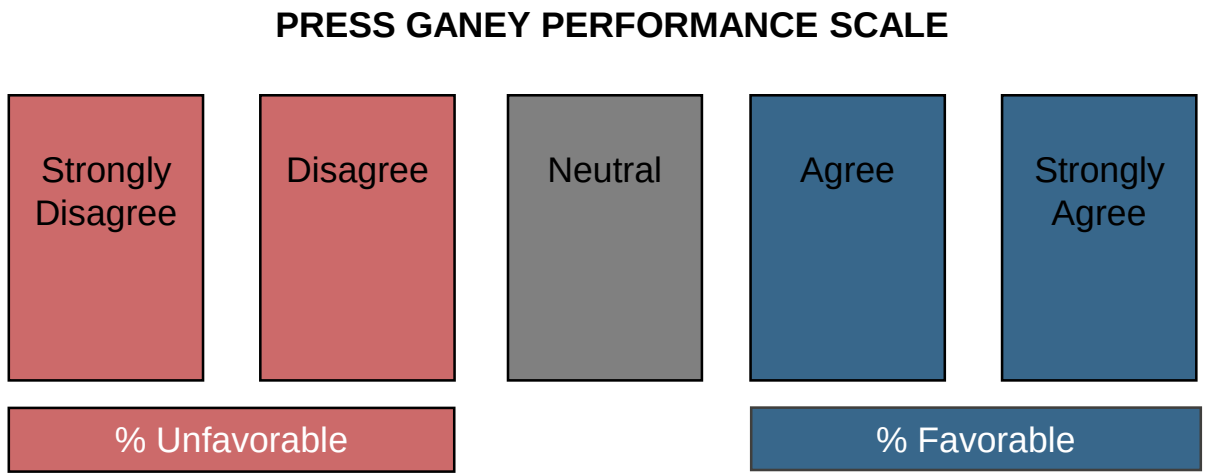
Measuring Culture of Safety

There are 19 survey questions that make up the **Safety Culture Module/Index**

- Subcategory 1: “Prevention & Reporting” = 8 items
- Subcategory 2: “Resources & Teamwork” = 7 items
- Subcategory 3: “Pride & Reputation” = 4 items



Safety Culture Subcategories

Prevention & Reporting (8 items)	Items that focus on prevention. If there is an error, employees feel comfortable speaking up, and that mistakes are used as learning experiences.
Resources & Teamwork (7 items)	Items that measure if employees feel they are well equipped, and that there is effective communication and teamwork within and between departments.
Pride & Reputation (4 items)	Employees feel the organization places an emphasis on safety and would feel comfortable recommending their organization for patient care.

Safety Culture Survey Results

How to Read the Results

- Questions were answered on a 5 point scale – strongly agree to strongly disagree
- Results are reported as the % of staff who had a positive response to the question, marked “agree” or “strongly agree”

Benchmark	Description
Bed Size – Organizations >400 beds	This is a Press Ganey customized benchmark. Unless otherwise noted, all PG client data is compared to this norm. • *56 clients, 78 facilities, and 177,113 respondents**

** Collected Jan 2021 – Dec 2022*

Kaweah Health vs. Benchmarks (all respondents)

Response Rate: 66% (2,445/3,711)

PressGaney

Kaweah Health: 2445 Respondents

2023 Kaweah Health Culture of Safety Survey

Organization	Manager	Employee
3.85	4.15	4.09
+0.05 vs. Nat'l Healthcare >400 Bed Avg 2023	Benchmark Not Applicable	+0.12 vs. Nat'l Healthcare >400 Bed Avg 2023

Safety Culture Index

+0.06 vs. Nat'l Healthcare >400 Bed Avg 2023

	Score	vs. Nat'l Healthcare >400 Bed Avg 2023
Safety Culture	3.92	+0.06
Prevention & Reporting	4.15	+0.10
Resources & Teamwork	3.62	+0.04
Pride & Reputation	3.97	-0.03

Kaweah Health Results - STRENGTHS

	Item	Domain	Distribution (Unfavorable / Neutral / Favorable)	Score	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
Strengths						
1	I can report patient safety mistakes without fear of punishment.	Organization	4% / 8% / 87%	4.29	+0.18	2,419
4	We are actively doing things to improve patient safety.	Organization	3% / 10% / 87%	4.28	+0.16	2,422
2	In my work unit, we discuss ways to prevent errors from happening again.	Employee	3% / 7% / 89%	4.32	+0.13	2,423
9	My work unit works well together.	Employee	4% / 10% / 85%	4.25	+0.09	2,432
7	Where I work, employees and management work together to ensure the safest possible working conditions.	Employee	7% / 13% / 80%	4.08	+0.13	2,431
8	I feel free to raise workplace safety concerns.	Employee	5% / 10% / 85%	4.18	+0.08	2,438
3	Employees will freely speak up if they see something that may negatively affect patient care.	Employee	5% / 10% / 84%	4.19	+0.09	2,420
20	Nurses/staff support a culture of patient safety in this work unit.	Organization	3% / 12% / 86%	4.15	-	2,387
22	I enter reports about events in which I was involved.	Employee	3% / 12% / 86%	4.15	-	2,137
23	I make Kaweah Health a safer place for patients by entering event reports.	Employee	2% / 11% / 86%	4.20	-	2,178

Kaweah Health Results - CONCERNS

PressGaney

Kaweah Health: 2445 Respondents

Concerns Report

	Item	Domain	Distribution			Score	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
			Unfavorable	Neutral	Favorable			
Concerns								
14	The amount of job stress I feel is reasonable.	Employee	23%	24%	53%	3.36	+0.06	2,423

Kaweah Health All Question Results

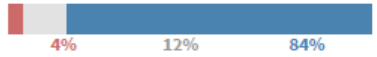
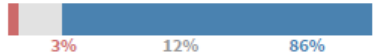
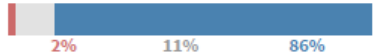
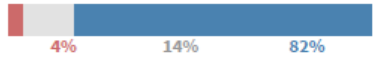
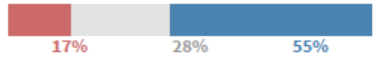
	Item	Domain	Distribution (Unfavorable / Neutral / Favorable)	Score	vs. Overall Organization	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
Current View: All Items							
1	I can report patient safety mistakes without fear of punishment.	Organization	4% / 8% / 87%	4.29	0.00	+0.18	2,419
2	In my work unit, we discuss ways to prevent errors from happening again.	Employee	3% / 7% / 89%	4.32	0.00	+0.13	2,423
3	Employees will freely speak up if they see something that may negatively affect patient care.	Employee	5% / 10% / 84%	4.19	0.00	+0.09	2,420
4	We are actively doing things to improve patient safety.	Organization	3% / 10% / 87%	4.28	0.00	+0.16	2,422
5	Mistakes have led to positive changes here.	Organization	5% / 18% / 77%	4.01	0.00	+0.06	2,389
6	When a mistake is reported, it feels like the focus is on solving the problem, not writing up the person.	Organization	11% / 20% / 69%	3.82	0.00	-0.04	2,398
7	Where I work, employees and management work together to ensure the safest possible working conditions.	Employee	7% / 13% / 80%	4.08	0.00	+0.13	2,431
8	I feel free to raise workplace safety concerns.	Employee	5% / 10% / 85%	4.18	0.00	+0.08	2,438
9	My work unit works well together.	Employee	4% / 10% / 85%	4.25	0.00	+0.09	2,432
10	Different work units work well together in this organization.	Organization	9% / 26% / 64%	3.74	0.00	+0.04	2,370
11	There is effective teamwork between physicians and nurses at this hospital.	Organization	9% / 25% / 66%	3.73	0.00	-0.06	2,236
12	My work unit is adequately staffed.	Organization	33% / 22% / 45%	3.13	0.00	+0.17	2,425

Kaweah Health All Question Results

	Item	Domain	Distribution (Unfavorable / Neutral / Favorable)	Score	vs. Overall Organization	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
13	Communication between work units is effective in this organization.	Organization	15% / 26% / 59%	3.57	0.00	+0.06	2,412
14	The amount of job stress I feel is reasonable.	Employee	23% / 24% / 53%	3.36	0.00	+0.06	2,423
15	Communication between physicians, nurses, and other medical personnel is good in this organization.	Organization	13% / 29% / 58%	3.56	0.00	-0.05	2,357
16	This organization provides high-quality care and service.	Organization	5% / 17% / 78%	4.02	0.00	-0.06	2,435
17	I would recommend this organization to family and friends who need care.	Engagement Indicator	7% / 19% / 74%	3.93	0.00	-0.11	2,438
18	This organization makes every effort to deliver safe, error-free care to patients.	Organization	6% / 14% / 80%	4.03	0.00	0.00	2,434
19	Senior management provides a work climate that promotes patient safety.	Organization	8% / 19% / 74%	3.89	0.00	+0.04	2,417
20	Nurses/staff support a culture of patient safety in this work unit.	Organization	3% / 12% / 86%	4.15	0.00	-	2,387

PressGaney

Kaweah Health All Question Results

	Item	Domain	Distribution Unfavorable Neutral Favorable	Score	vs. Overall Organization	vs. Nat'l Healthcare >400 Bed Avg 2023	Responses
21	The manager supports and leads a culture of safety in my work unit.	Manager	 4% 12% 84%	4.17	0.00	-	2,417
22	I enter reports about events in which I was involved.	Employee	 3% 12% 86%	4.15	0.00	-	2,137
23	I make Kaweah Health a safer place for patients by entering event reports.	Employee	 2% 11% 86%	4.20	0.00	-	2,178
24	The unit/department Director supports and leads a culture of safety in my work unit.	Manager	 4% 14% 82%	4.12	0.00	-	2,401
25	Physicians support a culture of patient safety in my work unit.	Organization	 5% 20% 74%	3.93	0.00	-	2,296
26	The Midas event reporting system is easy to use.	Organization	 17% 28% 55%	3.49	0.00	-	2,171

PressGaney

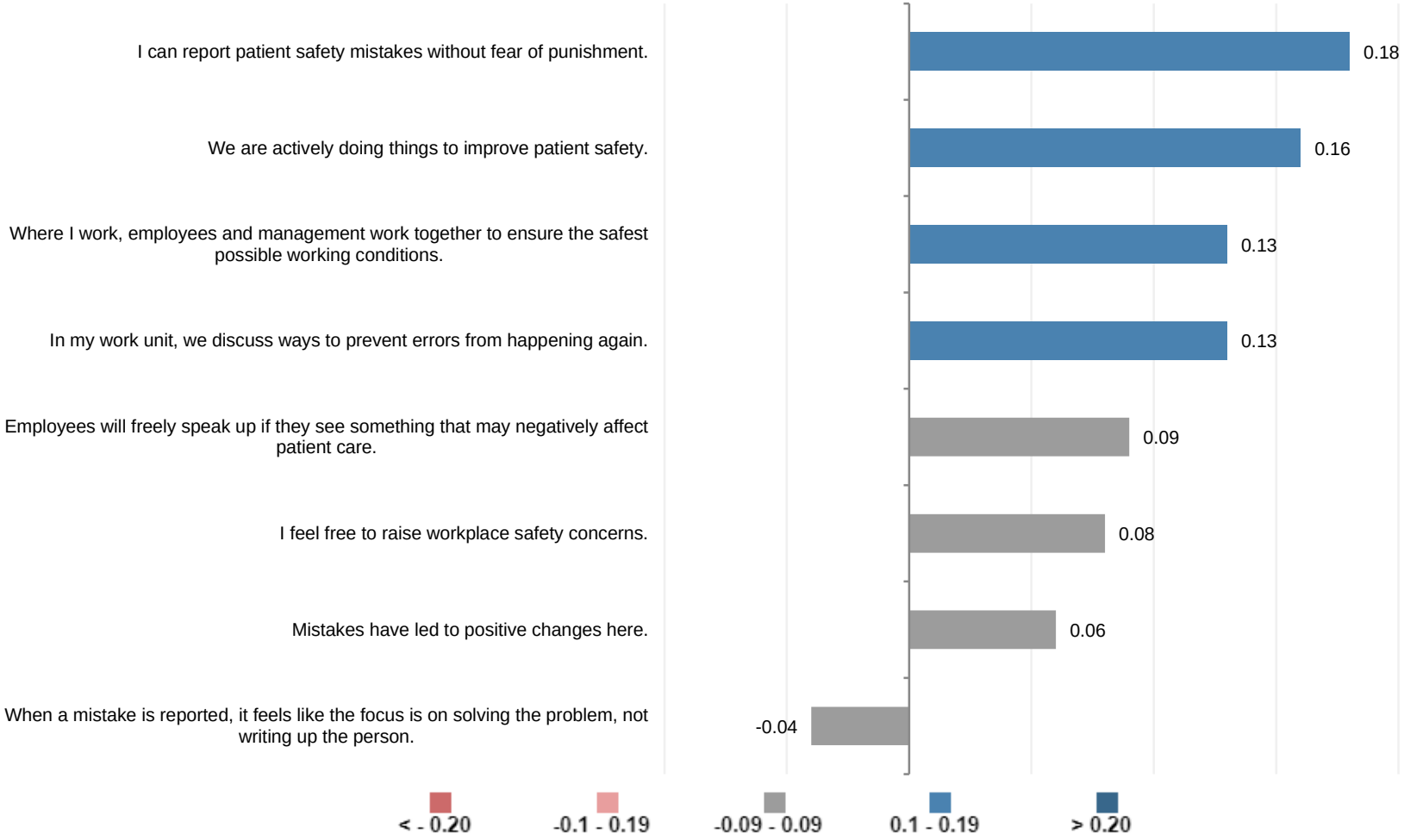
Safety Culture

+0.06 vs. Nat'l Healthcare >400 Bed Avg 2023

Prevention & Reporting 4.15

Items that focus on prevention. If there is an error, employees feel comfortable speaking up, and that mistakes are used as learning experiences.

vs. Nat'l Healthcare >400 Bed Avg 2023



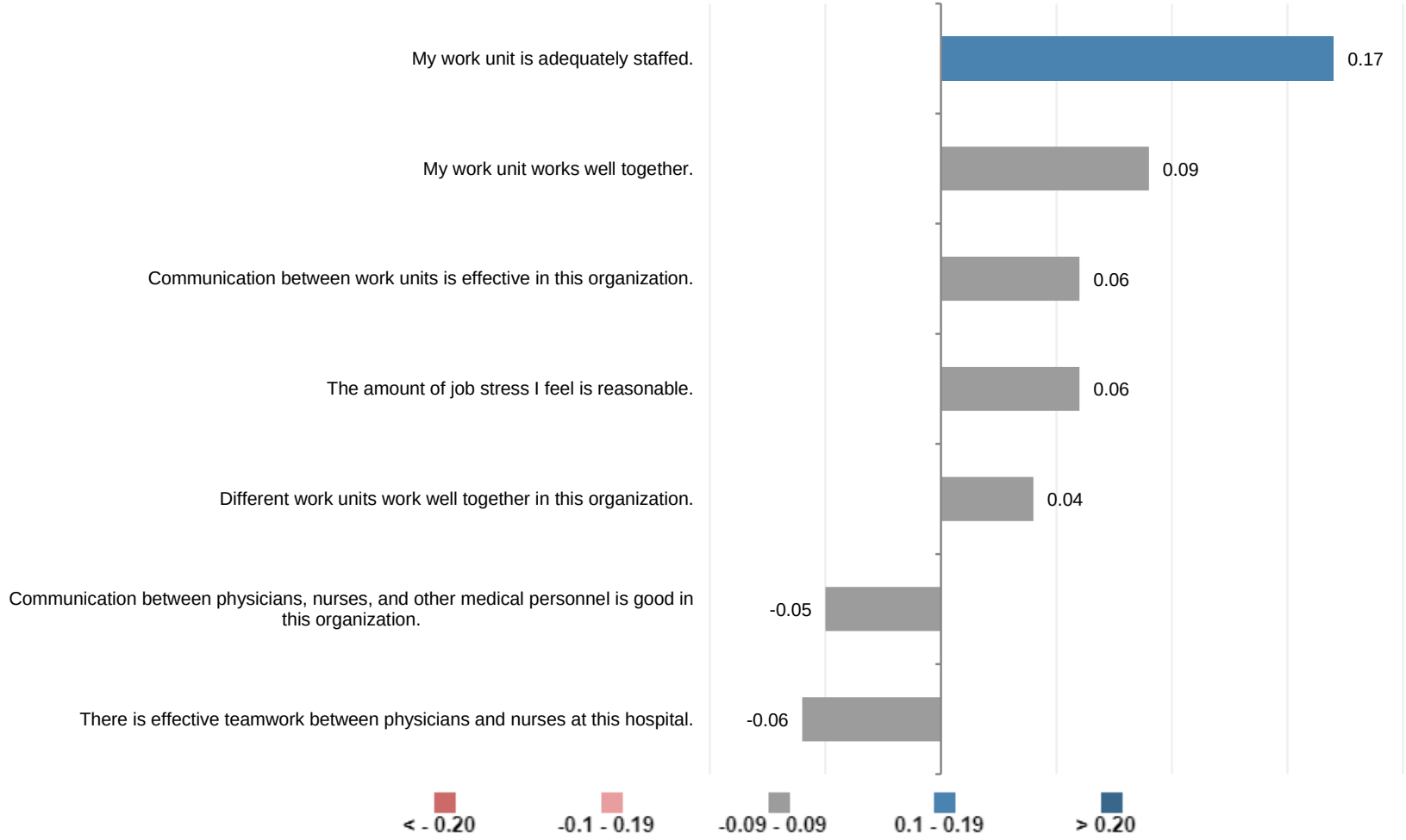
Safety Culture

+0.06 vs. Nat'l Healthcare >400 Bed Avg 2023

Resources & Teamwork 3.62

Items that measure if employees feel they are well equipped, and that there is effective communication and teamwork within and between departments.

vs. Nat'l Healthcare >400 Bed Avg 2023



PressGaney

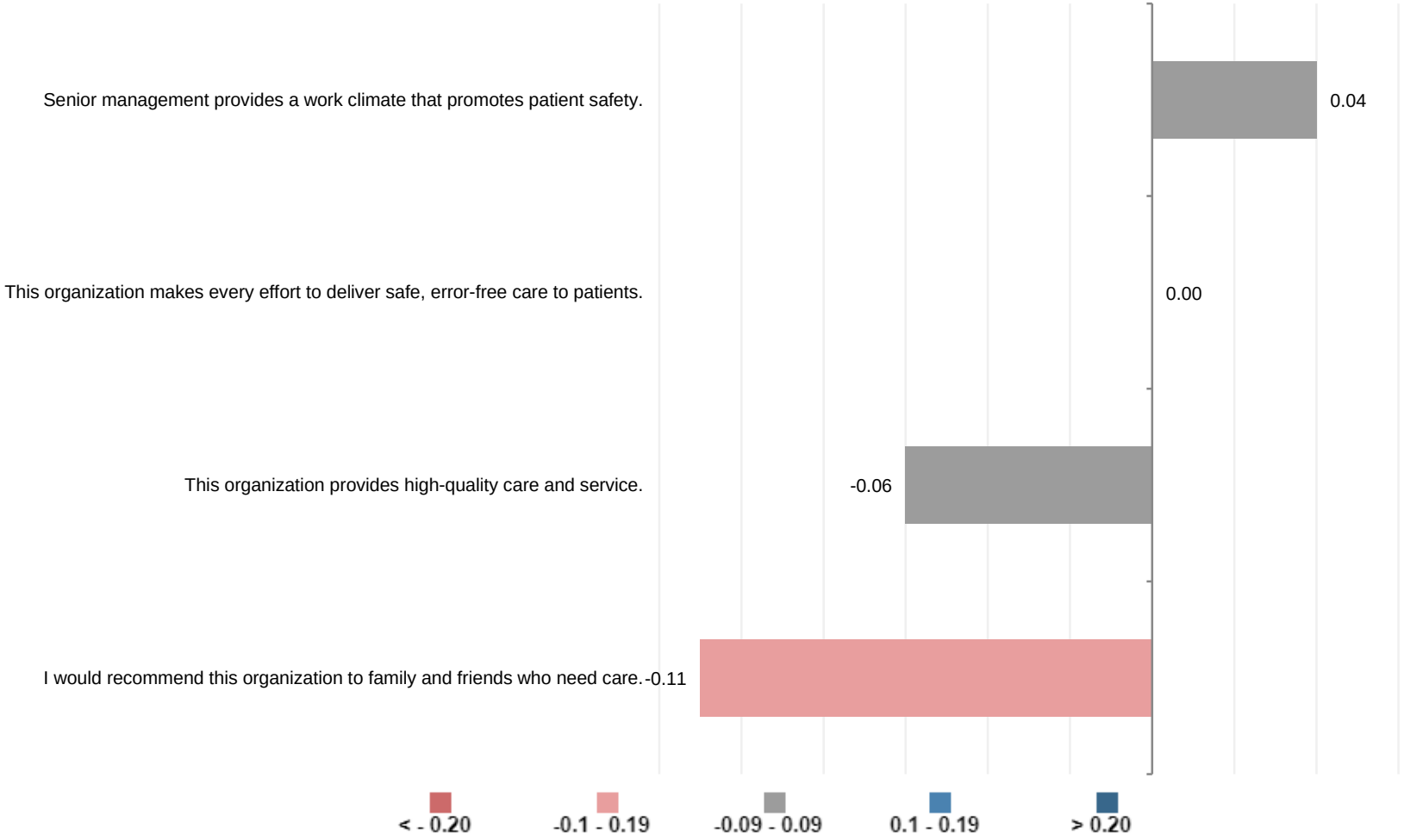
Safety Culture

+0.06 vs. Nat'l Healthcare >400 Bed Avg 2023

Pride & Reputation 3.97

Employees feel the organization places an emphasis on safety and would feel comfortable recommending their organization for patient care.

vs. Nat'l Healthcare >400 Bed Avg 2023



Kaweah Health Positions & Safety Culture Engagement

To determine the level of engagement specific to the culture of safety at Kaweah Health, each position needs to meet a Reporting Threshold = 3 or more respondents.

Highly Engaged	Mean score between 5.00 - 4.50
Engaged	Mean score between 4.49 - 4.00
Neutral Engaged	Mean score between 3.99 - 3.75
Neutral	Mean score between 3.74 - 3.50
Neutral Disengaged	Mean score between 3.49 – 3.00
Disengaged	Mean score between 2.99 and under

PressGaney

Kaweah Health Positions: Safety Culture Overall

Highly Engaged	Engaged	
Chaplain	Assistant Nurse Manager	OP Registration/Cust Svc Rep
CT Technologist	Biomedical Technician II	Patient Care Pharmacy Tech
Nurse Practitioner-Clinics	Cardiac Sonographer-Registered	Personal Care Aide-OAH
Occupational Therapist III (d)	Certified Hemodialysis Tech	Pharmacist-Clinical
Pharmacist-Retail	Certified Nursing Assist-EKG	Pharmacy Tech I
Therapy Manager	Driver/Cust Sv Rep/Gurney Tran	Pharmacy Tech II
Transcriber-Secretary	ED Tech II	Pharmacy Tech/Biller
	EVS Floor Tech	Physical Therapist
	EVS/Pt Transport Dispatcher	Physical Therapist II
	HHA-Hospice	Physical Therapy Assistant
	Imaging Office Specialist	Physical Therapy Assistant II
	Imaging Specialist	Physical Therapy Assistant III
	Imaging Tech-In Patient	Practice Manager
	Interpreter	Radiation Therapist
	Interpreter II	Registered Dietitian
	Lab Services Coordinator	Rehab Aide
	LVN-Clinics Lead	RN-Admissions/Transfer Center
	Medical Assistant	RN-Clinical Documentation Spec
	Medical Business Office Assist	RN-Nurse Liaison
	Nurse Manager	RN-PPS/MDS Coordinator
	Nursing Assistant	Security Officer (driving)
	Occupational Therapist II	Social Work Assistant
	Occupational Therapist III	Student Nurse Intern

PressGaney

Kaweah Health Positions: Safety Culture Overall

Neutral Engaged		Neutral	Neutral Disengaged
Aide	Newborn Tech	Advanced Practice Provider	Laboratory Technician
ASW/AMFT	Occupational Therapist	Anesthesia Tech	LCSW/LMFT
ASW-Clinics	Overall Organization	Cardiac Sonographer-Unreg	Licensed Psych Tech
Business Services Coordinator	Patient Access Specialist	Charge Nurse	MRI Technologist
Care Coordination Specialist	Patient Transport Aide	Clinic Business Office Lead	RN-First Assistant
Cath Lab Tech II	Pharmacy Coordinator	Clinical UR Specialist	RN-Rapid Response Nurse
Certified Nursing Assistant	Phlebotomist I	EVS-Operating Room	Security Officer Lead
Clinical Lab Scientist-CLS	Phlebotomist II	Financial Counselor	SP Tech Certified
ED Tech I	Physical Therapist III	Health Unit Coordinator	Telemetry Monitor Technician
Environmental Services Aide	Physician	Nutrition Host	Ultrasound Tech-Registered
Environmental Services Lead	Polysomno Technologist-Reg	Physician Assistant	
GME Resident	Registered Nurse	RN-Nurse Practitioner	
Imaging Services Aide	Respiratory Therapist	RN-Oncology Office	
Imaging Technologist	Respiratory Therapist-Reg	Security Officer III	
Lab Aide I	RN-Case Manager	Staff Facilitator	
Lab Aide II	RN-Clinical Educator	Surgical Team Assistant	
Laboratory Section Chief	RN-Clinical Educator with ACLS	Surgical Tech	
Licensed Vocational Nurse	Security Officer II	Tele Sitter	
LVN-Skilled Nursing	Security Services Supervisor	Unit Secretary	
Mammography SpecialistMental	SP Tech I Non-Certified		
Health Worker	Student Nurse Aide		

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Kaweah Health Positions: Safety Culture Overall

Disengaged
Medical Social Worker
RN-Acute Wound Care Nurse III

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Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

UNIT/DEPARTMENT: **Fall Prevention Committee** REPORT DATE: **March 2024**

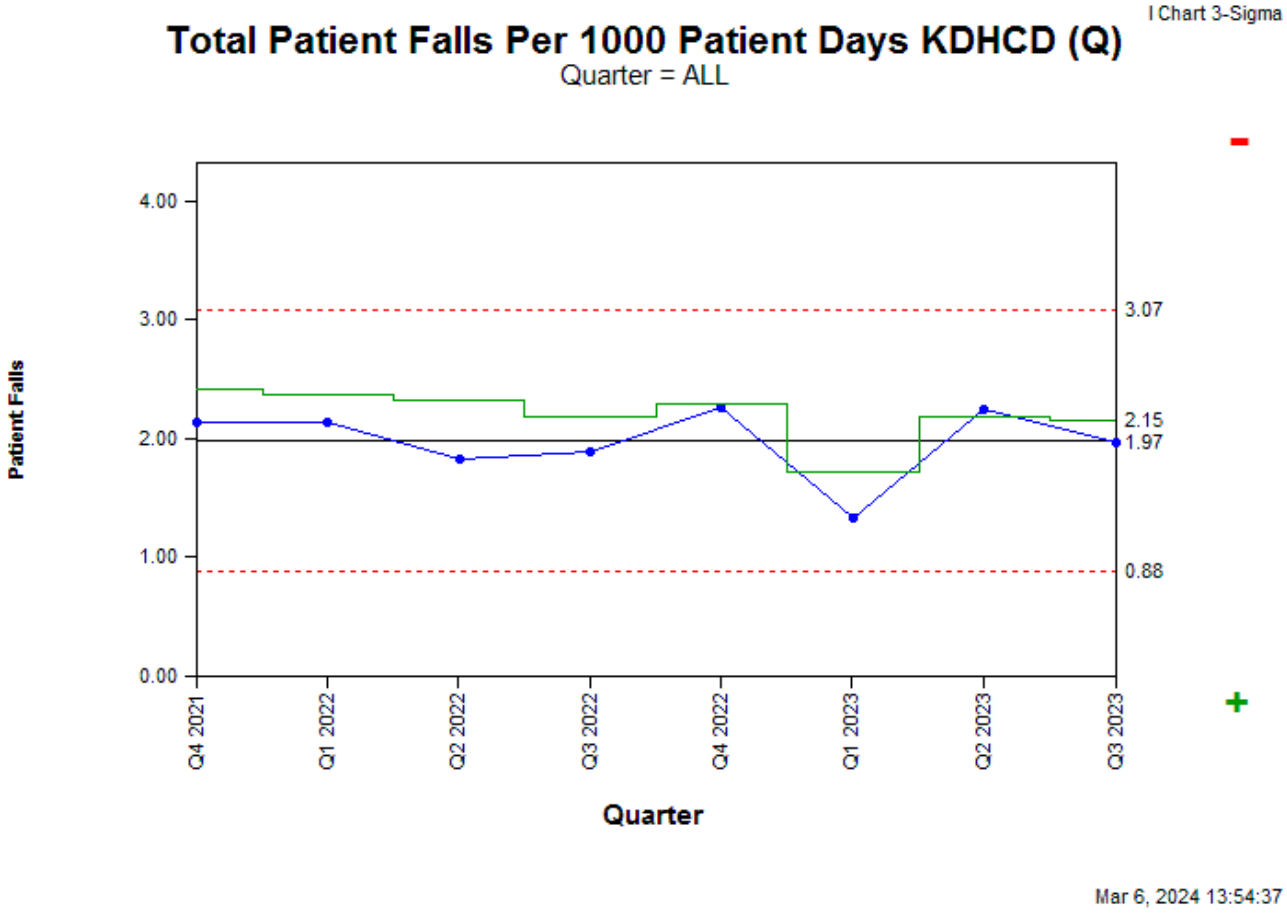
Kaweah Health Nursing Unit Falls Data, Benchmarked Nationally:

The National Database of Nursing Quality Indicators® (NDNQI®) provides a national database of more than 2,000 U.S. hospitals that features nursing-sensitive outcome measures used to monitor relationships between quality indicators and outcomes. Participating Kaweah Health nursing units include 2North, 2South, 3North, 3South, 3West, 4North, 4South, 4Tower, Broderick Pavilion, ICU, CV-ICU, CV-ICCU (5Tower), Mental Health, Pediatrics, and Acute Rehab.

INDICATOR #1 **Total Patient Falls per 1000 Patient Days**

GOAL **Outperform national target metric and/or reduce fall rate by 10%**

DATE RANGE **Q3 2023**



	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Patient Falls	2.14	2.14	1.82	1.89	2.26	1.32	2.25	1.97
Target	2.42	2.37	2.32	2.18	2.29	1.72	2.18	2.15

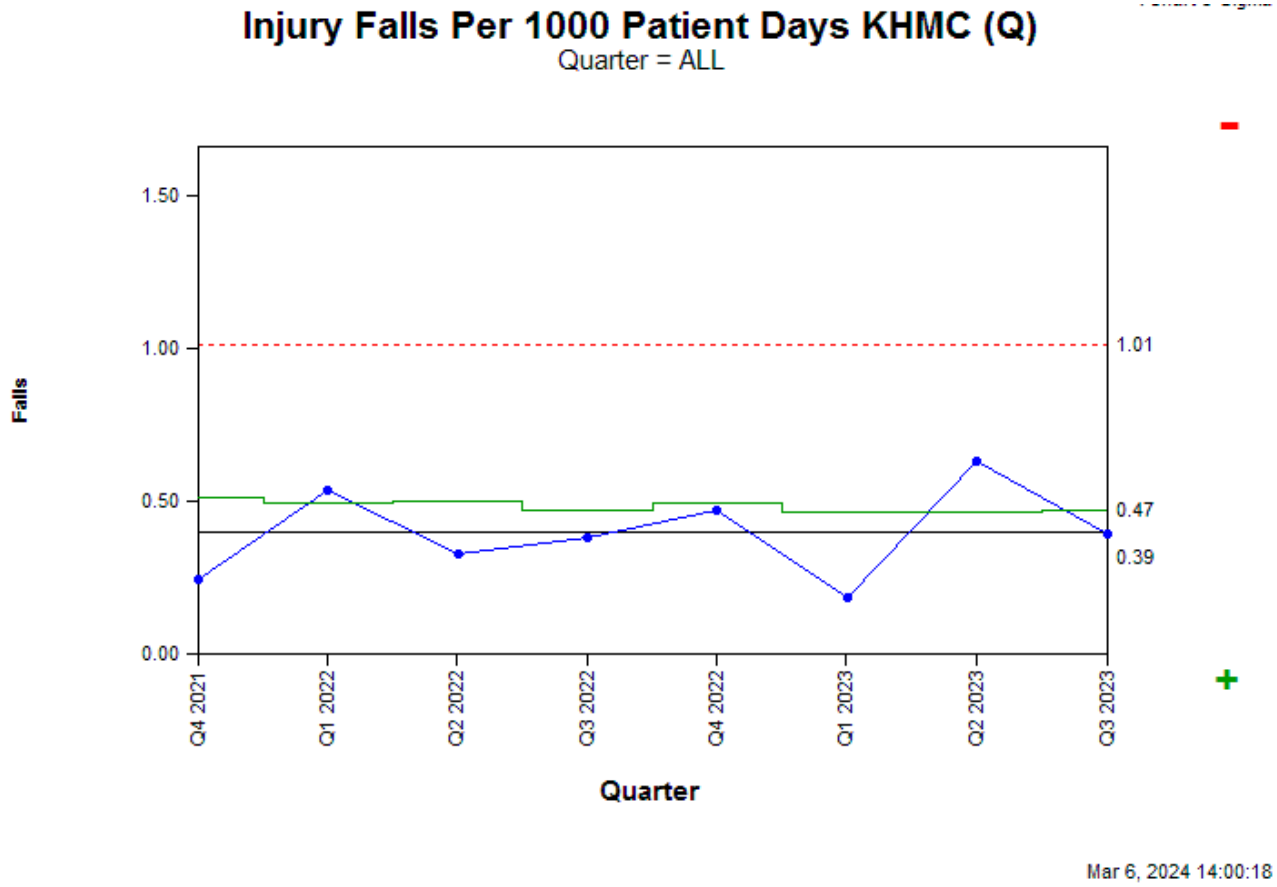
ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

✓ **Goal met: Q3 2023 outperformed the national target metric. Improvement from previous quarter to below the target of 2.15**

INDICATOR #2 **Injury Falls per 1000 Patient Days**

GOAL **Outperform national target metric and/or reduce injury fall rate by 10%**

DATE RANGE **Q3 2023**



	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Falls	0.24	0.53	0.33	0.38	0.47	0.18	0.63	0.39
Target	0.51	0.49	0.50	0.47	0.49	0.46	0.46	0.47

ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

✓ **Goal met: Q3 2023, outperformed the national target metric. Improvement from previous quarter to below the target of 0.47**

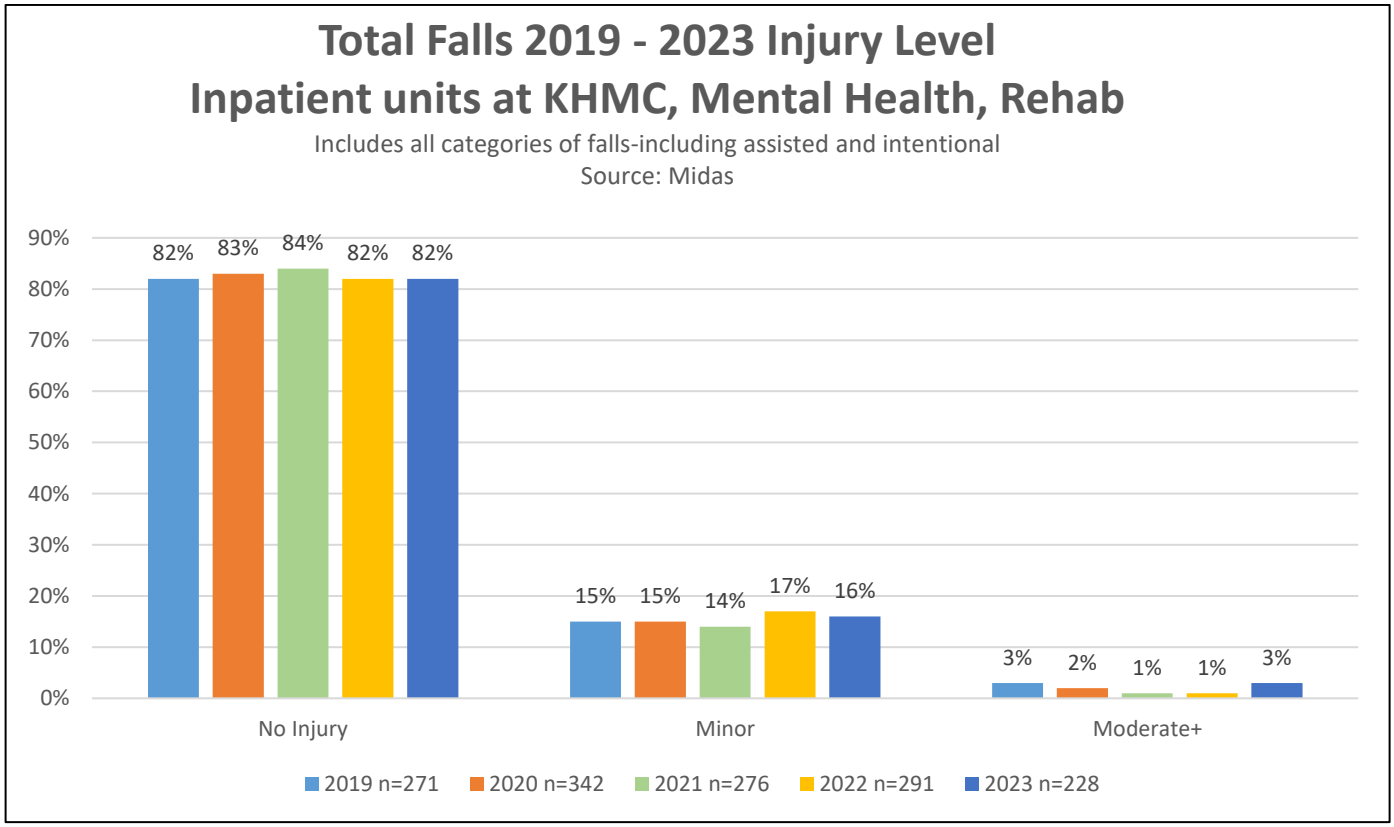
Unit/Department Specific Data Collection Summarization

QIC/ProStaff Committee Report

INDICATOR #3	**Total Falls – Injury Level**
GOAL	**100% injury falls classified either no injury or minor injury**
DATE RANGE	**CY 2019-2023**

NDNQI Defined Injury Levels

- *None* — *Resulted in no signs or symptoms of injury as determined by post-fall evaluation (which may include x-ray or CT scan)*
- *Minor* — *Resulted in application of ice or dressing, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion*
- *Moderate* — *Resulted in suturing, application of steri-strips or skin glue, splinting, or muscle/joint strain*
- *Major* — *Resulted in surgery, casting, traction, required consultation for neurological (e.g., basilar skull fracture, small subdural hematoma) or internal injury (e.g., rib fracture, small liver laceration), or patients with any type of fracture regardless of treatment, or patients who have coagulopathy who receive blood products as a result of a fall*
- *Death* — *The patient died as a result of injuries sustained form the fall (not from physiologic events causing the fall)*



ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

⦸ **Goal not met:**

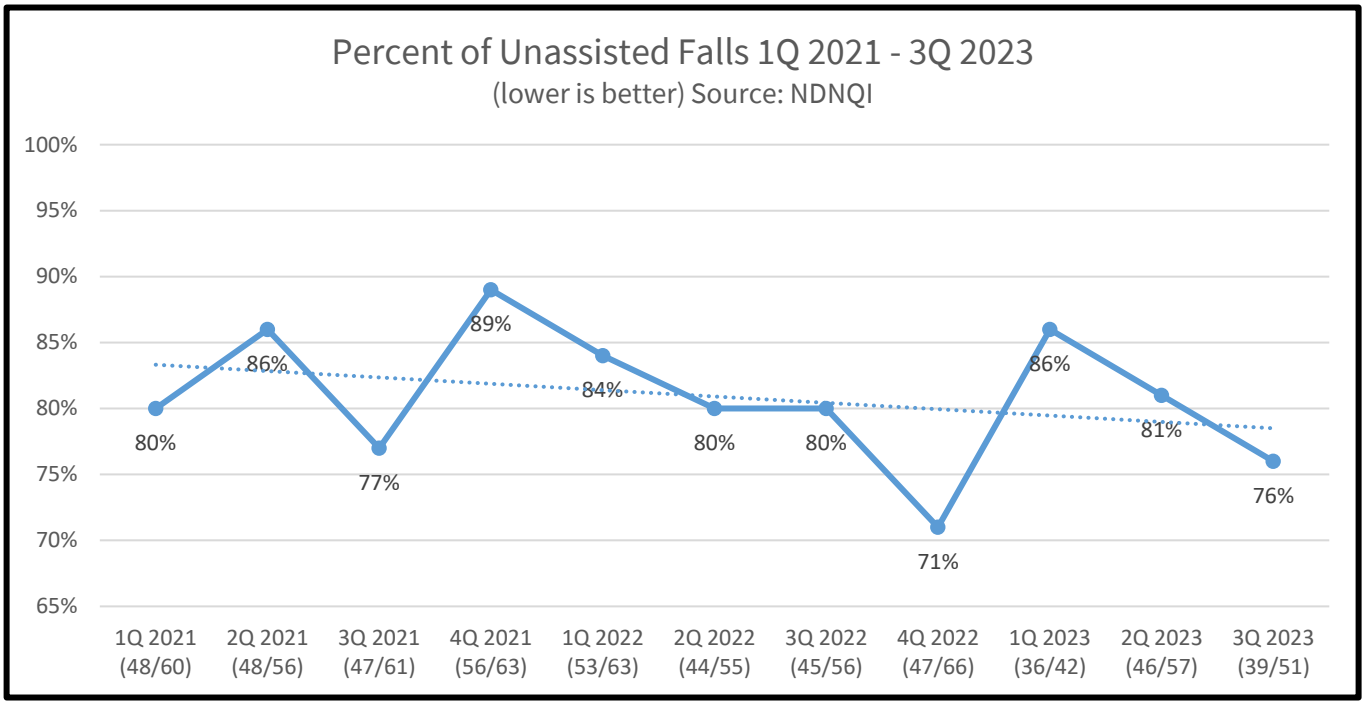
- **The total percentage of falls with no injuries in 2023 was unchanged from 2022 (82%) with minor injury level falls decreasing from 17% to 16%, the moderate + injury level increased to 3% in 2023 from 1% in 2021 and 2022.**

- **Opportunities for improvement: Continue to monitor patient falls, review falls at Falls University and send out take-aways for information. Provide ongoing education to staff related to fall prevention. Returning to pre-COVID fall awareness using yellow socks. Yellow socks have become the standard sock for all patients.**

INDICATOR #4 **Unassisted Falls**

GOAL **Reduce unassisted falls by 10%**

DATE RANGE **Q4 2022-Q3 2023**



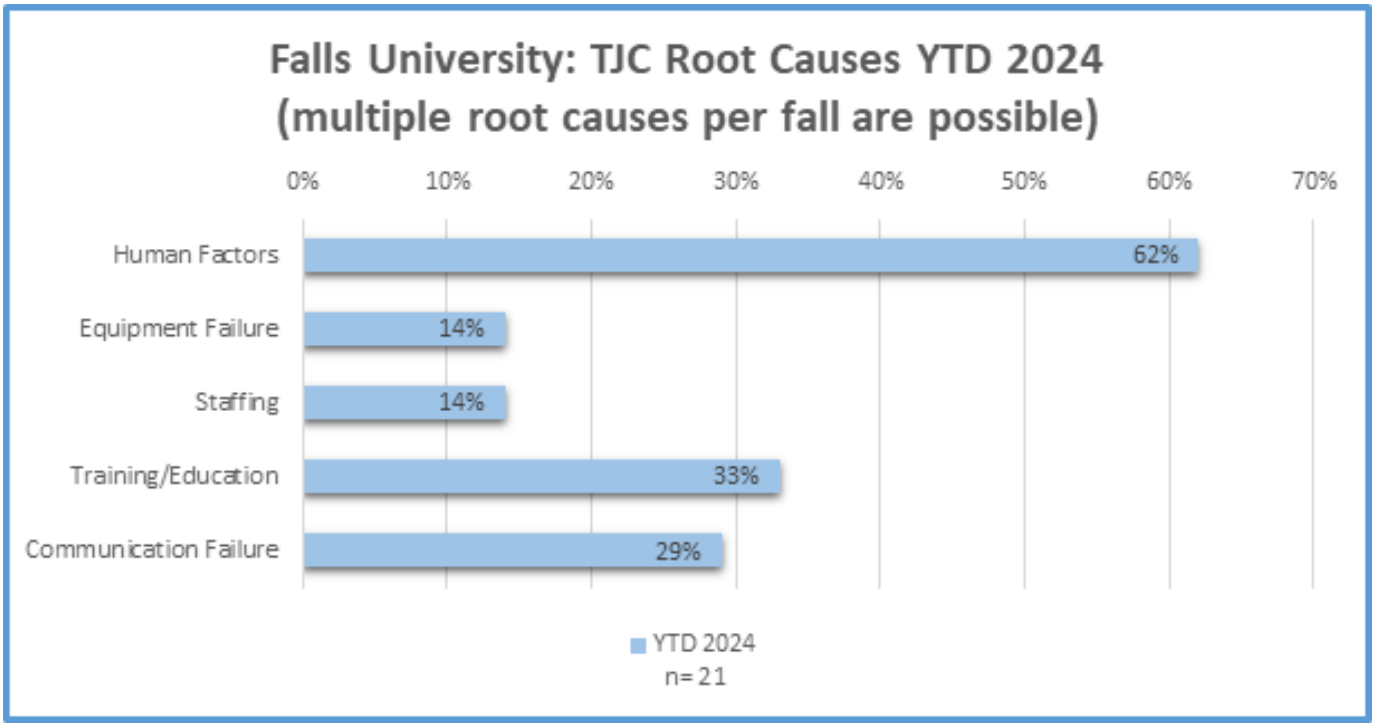
ANALYSIS OF MEASURE/DATA (Include key findings, improvements, opportunities)

✓ **Goal met: Unassisted falls increased from 4Q 2022 to 1Q 2023 (>21%) but decreased in the subsequent quarters to 76% in 3Q 2023, greater than 11% decrease.**
<u>NOTE</u>: Percent of unassisted falls at KH includes inpatient units, Mental Health and Rehab. Overall unassisted falls in 2023 appear to be moving in the desired direction from first quarter of 2023. Work continues through the Falls Prevention committee and Falls University to support staff in their efforts to decrease falls and improve patient outcomes.

IMPROVEMENT OPPORTUNITIES / ACTION PLANS / NEXT STEPS, RECOMMENDATIONS, OUTCOMES:

- **Falls Prevention Committee meeting monthly**
- ***Falls University continues* to meet biweekly with units who report falls in the occurrence reporting system. Real-time discussion of events and opportunities for utilization of prevention strategies is shared with staff.**

- **Utilize The Joint Commission's framework for Root Cause Analysis to explore impact of performance, resources, knowledge/skill-set, and communication on patient outcome (see attribution information below)**



- **Email communication to nurses at all levels includes key "Take-Aways" from Falls University event review**
- **Managers to include takeaways in their weekly updates disseminated to staff**
- **Report recommendations/actions to QComm meetings using the SBAR tool.**
- **Human factors (62%) continues to be the number one root cause. We continue to encourage staff to pause prior to leaving the patients room to ensure all safety precautions are in place (SPLAT the room).**

- **<u>Work in Progress</u> (WIP) – summary of collaborative efforts led by Emma Camarena, Director of Nursing Practice, Kari Moreno, Nurse Manger and Cindy Vander Schuur in partnership with quality, clinical informatics and nursing leaders:**
  - **Post-Fall electronic charting**
    - **Stakeholders made final edits based on input from various departments/divisions to ensure global applicability and post-fall electronic charting is in use.**
    - **Optimize post-fall iPOC to include alerts/task prompts to drive interventions**
    - **Developing a workflow for LVNs and LPTs to assist in the post falls interventions and documentation**
  - **Prevention and Intervention Strategies**

- **Partner with unit staff and leaders, clinical educators, quality and patient safety partners to educate staff on the importance of ensuring room safety using the SPLAT acronym addressing frequently cited human factors (e.g., alarms, slip/trip hazards) as root causes for falls.**
- **Falls committee Participation in Patient Safety Awareness Week campaign to provide falls prevention information to staff.**

- **Documentation**
  - **Working with MCH to complete iView documentation into PowerForm to improve workflow and standardize information capture. MCH staff utilize a different falls tool to document falls in mothers and Peds.**
  - **Documentation optimization of IPOCS with Chartis to begin in April**
- **Policy**
  - **Policy was revised to reflect updated prevention, intervention, workflow, and documentation per WIP listed above**
- **Education and Training**
  - **Continue to review staff education and update as needed.**
  - **All hospital staff need foundational falls prevention education. Escalated education for nursing. Revision of falls education in progress for all patient care staff**
  - **Yearly MAT testing for Falls in progress.**

SUBMITTED BY: DATE SUBMITTED: **March 12, 2024**

Emma Camarena, DNP, RN, ACCNS-AG
Director of Nursing Practice

Cindy Vander Schuur, BSN, RN
Quality and Patient Safety

Kari Moreno, MSN, CMSRN, DSD
Acute Rehabilitation Nurse Manager
DON-Skilled Nursing

Unit/Department Specific Data Collection Summarization

Quality Improvement Committee

Unit/Department: HAPI & Inpatient Wound Prevention **Report Date:** February 2, 2024

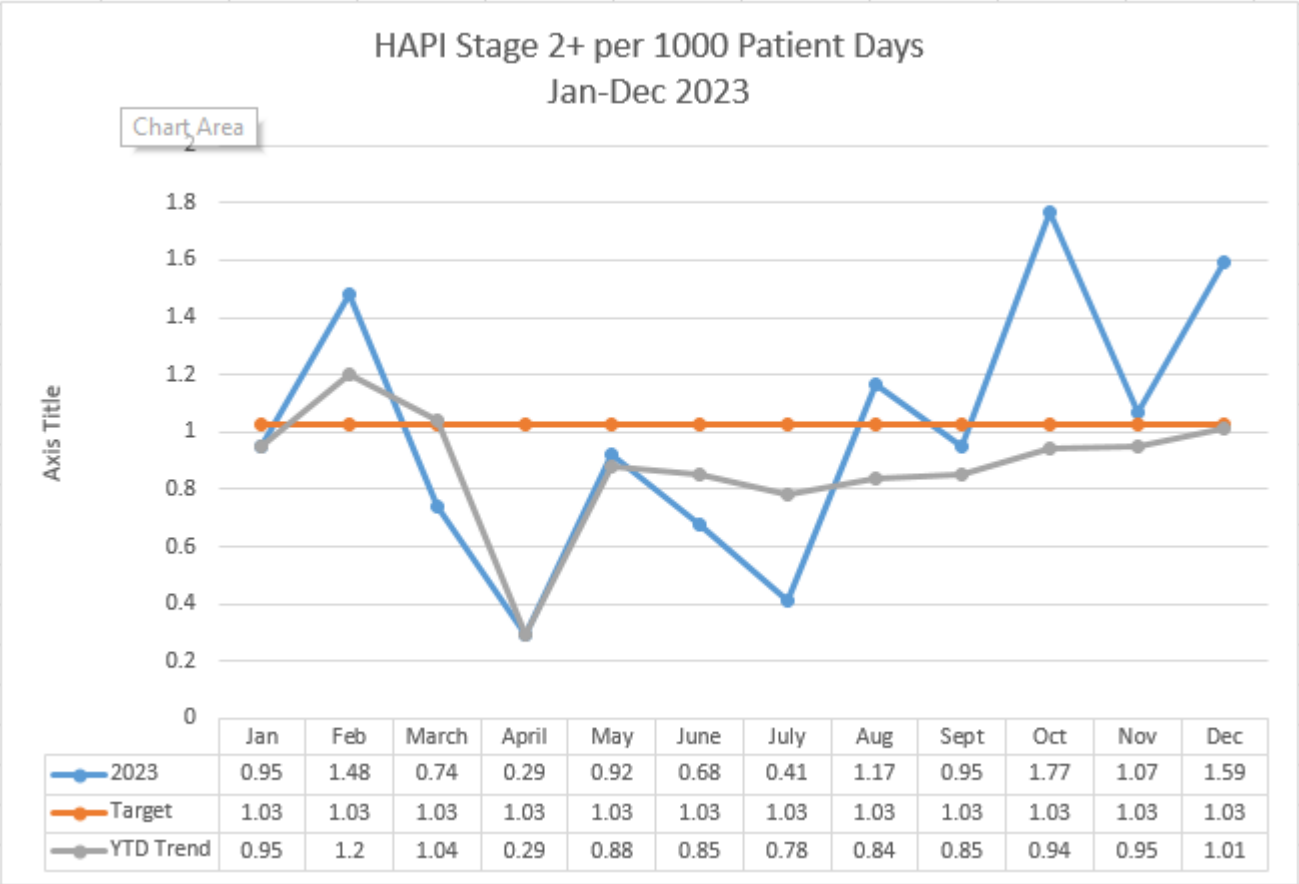
Measure Objective / Goal:

Hospital Acquired Pressure Injuries (HAPI), Total and Device-Related
Incidence data compiled from staff/unit-level self-report, with and without prompting from wound nurse consultant. Includes Stage 2-4, unstageable, suspected deep tissue pressure injury (DTPI).

Indicator #1 HAPI Stage 2+ per 1000 Patient Days

Goal 1.03 (-10% from 2022)

Date Range Jan 2023-Dec 2023



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2023	0.95	1.48	0.74	0.29	0.92	0.68	0.41	1.17	0.95	1.77	1.07	1.59
Target	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03	1.03
YTD Trend	0.95	1.2	1.04	0.29	0.88	0.85	0.78	0.84	0.85	0.94	0.95	1.01

Analysis of Measures / Data: (include key findings, improvements, opportunities)

∅ **Goal #1** Met: Improved to below target of 1.03 in September to 0.95 but had an increase from Oct-Dec 2023. Multiple patient care units above the goal.

✓ Met: Cumulative YTD below target from April to December 2023.

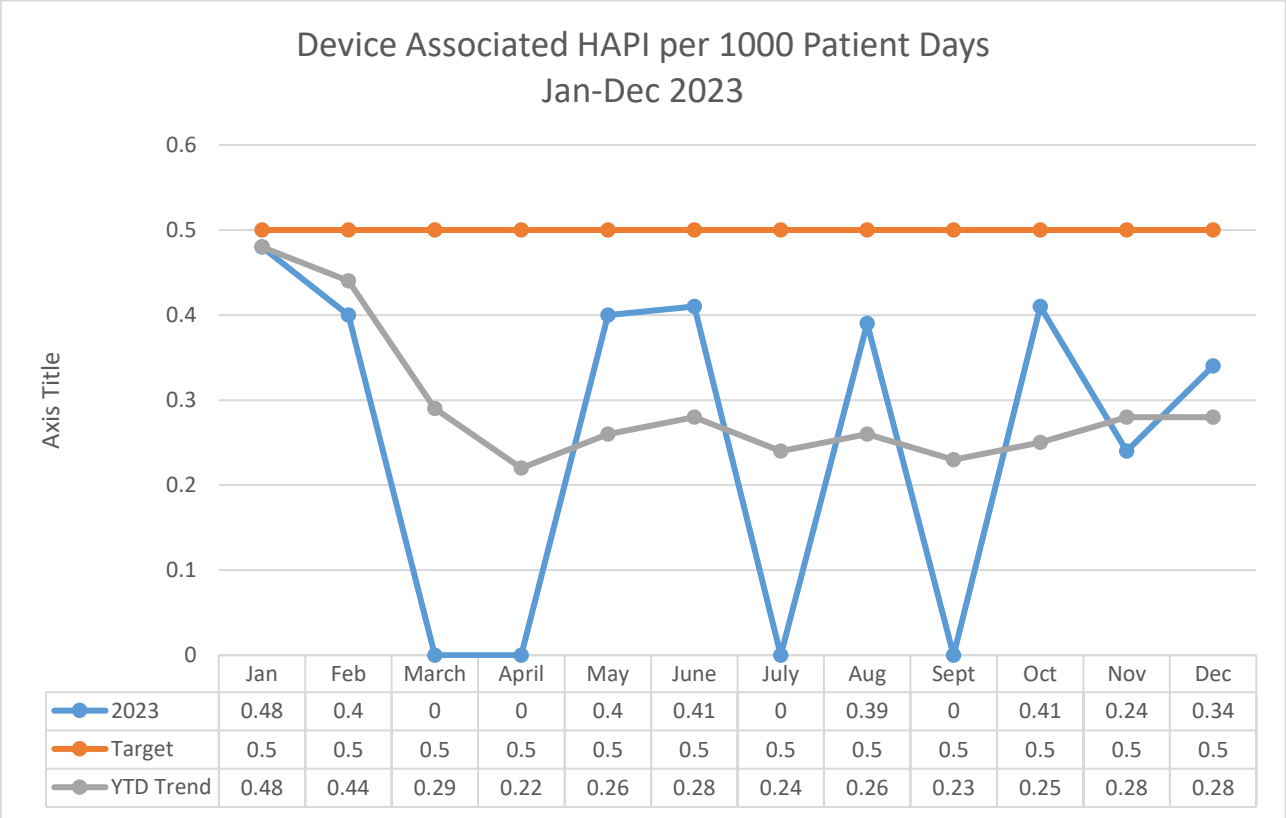
Update: HAPIs are reviewed in CSI every other week. Staff and leadership review and prepare CSI reports for review by the Wound Care team. Take-aways learned from staff and nurse manager

investigations are shared with all patient care units. The wound team completed their series of scheduled staff meetings in all patient care units and are attending staff meetings by request to review preventative measures and answer questions related to HAPIs and their role as wound care RNs. Please see 2023 Dashboard for detailed information.

Indicator #2 Device Associated HAPI per 1000 Patient Days

Goal 0.50 (-10% from 2022)

Date Range Jan 2023-September 2023



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2023	0.48	0.4	0	0	0.4	0.41	0	0.39	0	0.41	0.24	0.34
Target	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
YTD Trend	0.48	0.44	0.29	0.22	0.26	0.28	0.24	0.26	0.23	0.25	0.28	0.28

Analysis of Measures / Data: (include key findings, improvements, opportunities)

- ✓ **Goal #1** Met: Met for all months in 2023.
- ✓ Met: Cumulative YTD below target (0.26)

Our device related HAPIs remain below the target of 0.5. The HAPI committee meets on a monthly basis to review data and discuss ongoing individual unit issues.
Please reference 2023 Dashboard for detailed information.

2023 Dashboard:

2023 Stage 2+ HAPI Dashboard

Measure Description Outcome Measures	2023 Benchmark/ Target	2020 Baseline	2021 Baseline	2022 Baseline	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD 2023
HAPI Stage 2+ per 1,000 pt days (all HAPIs)	1.03 (-10% from 2022 target)	1.61	1.26	0.69	0.95	1.48	0.74	0.29	0.92	0.68	0.41	1.17	0.95	1.77	1.07	1.59	1.01
Device Associated HAPI per 1,000 pt days	0.50 (-10% from 2022 target)	0.72	0.61	0.23	0.48	0.40	0.00	0.00	0.40	0.41	0.00	0.39	0.00	0.41	0.54	0.34	0.28
PSI 3 - Claims-based HAPI Stage 3, 4, and Unstageable per 1,000 discharges	**0.59** - Hospital Compare (Q3 2020-Q2 2022) **0.35** - Midas 50th Percentile (2013)	0.95	1.42	0.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.24	pending	0.00	0.31
Process Measures	(-10% from 2022 target)	2020	2021	2022	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD 2023
Respiratory Device associated HAPI per 1,000 pt days	0.32	0.44	0.40	0.05	0.00	0.13	0.00	0.00	0.00	0.00	0.00	0.13	0.00	0.14	0.27	0.11	0.07
% of Respiratory Device associated HAPI's (out of all of the device associated HAPI's)	48%	61%	65%	22%	0%	33%	0%	0%	0%	0%	0%	33%	0%	33%	50%	33%	23%
Unit Level	(-10% from 2022 target)	2020	2021	2022	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD 2023
4N - HAPI 2+ per 1,000 pt days	1.00	2.02	1.22	0.31	0.00	6.54	0.00	0.00	0.00	1.30	2.51	0.00	1.23	2.59	2.63	0.00	1.37
3W - HAPI 2+ per 1,000 pt days	2.06	3.2	2.55	0.79	0.00	0.00	8.10	0.00	4.44	0.00	0.00	0.00	0.00	2.24	0.00	1.99	1.47
ICU - HAPI 2+ per 1,000 pt days	3.35	7.44	4.14	2.38	0.00	8.17	5.10	0.00	5.32	0.00	0.00	0.00	5.71	19.87	10.26	10.13	5.29
CVICU - HAPI 2+ per 1,000 pt days	3.48	6.23	4.31	1.51	0.00	0.00	0.00	4.85	0.00	12.15	0.00	4.81	4.48	0.00	0.00	9.71	3.05
2N - HAPI 2+ per 1,000 pt days	0.57	0.22	0.71	0.30	1.07	0.00	0.00	0.00	0.00	0.00	1.21	1.18	0.00	1.28	0.00	0.00	0.40
2S - HAPI 2+ per 1,000 pt days	0.73	1.51	0.90	0.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3N - HAPI 2+ per 1,000 pt days	0.89	0.72	1.11	0.87	2.70	0.00	0.00	1.12	0.00	1.09	0.00	1.97	0.00	2.16	0.00	0.00	0.78
3S - HAPI 2+ per 1,000 pt days	0.07	0.5	0.09	0.09	0.00	1.17	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.09
4S - HAPI 2+ per 1,000 pt days	0.93	0.66	1.15	0.91	3.19	0.00	0.00	0.00	0.00	0.00	0.00	5.17	1.03	0.00	1.12	2.05	1.09
4T - HAPI 2+ per 1,000 pt days	0.22	0.45	0.28	0.55	1.53	1.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.61	3.10	0.69
BP - HAPI 2+ per 1,000 pt days	0	0.62	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rehab - HAPI 2+ per 1,000 pt days	0.13	0.00	0.16	0.48	0.00	0.00	0.00	0.00	4.90	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.42
5T - HAPI 2+ per 1,000 pt days	1.18	0.4	1.46	1.11	0.00	1.65	0.00	0.00	0.00	0.00	0.00	0.00	3.55	1.57	0.00	2.81	0.77
Other Units	2023 Benchmark/ Target	2020	2021	2022	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD 2023
Sub-Acute	decrease from baseline	6	5	2	1	0	0	0	0	0	0	2	1	3	0	0	7
Labor & Delivery								1	0	0	0	0	0	0	0	0	1
Endoscopy														1	0	0	1
Emergency															1	0	1

Meeting or Better than Target

Within 10% of goal

Does not meet Target

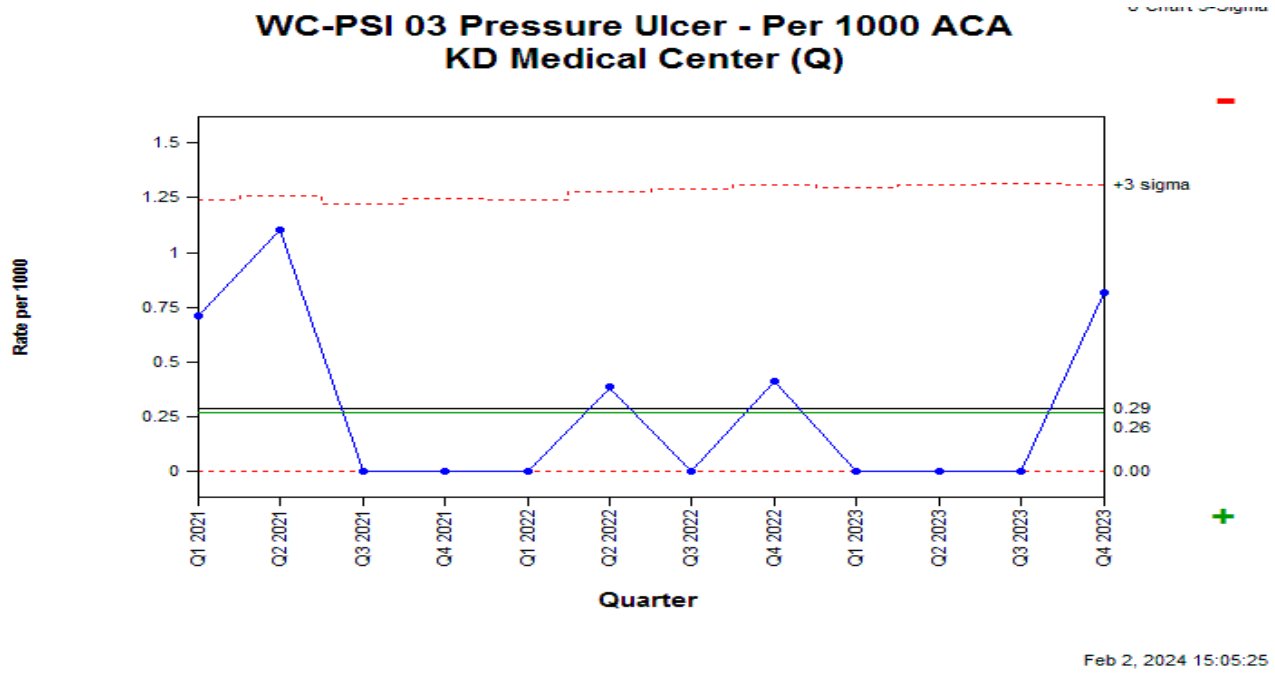
PSI 03: Pressure Ulcer Rate

Pressure ulcers have been associated with an extended length of hospitalization, sepsis, and mortality. The Agency for Healthcare Research and Quality (AHRQ) developed measures that health providers use to identify potential in-hospital patient safety problems for targeted institution-level quality improvement efforts. Patient Safety Indicator (PSI) 03 includes stage 3 or 4 pressure ulcers or unstageable (secondary diagnosis) per 1000 discharges among surgical or medical patients ages 18 years and older. *Exclusions: stays less than 3 days; cases with principal stage 3 or 4 (or unstageable) pressure ulcer diagnosis; cases with a secondary diagnosis of stage 3 or 4 pressure ulcer (or unstageable) that is present on admission; obstetric cases; severe burns; exfoliative skin disorders.*

Indicator #3 PSI-03 Claim-based HAPI Stage 3, 4, Unstageable per 1000 discharges

Goal 0.26 (Hospital Compare)

Date Range Q4 2023



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Numerator	2	3	0	0	0	1	0	1	0	0	0	2
Denominator	2833.00	2724.00	2940.00	2794.00	2807.00	2626.00	2536.00	2456.00	2518.00	2459.00	2412.00	2463.00
Rate per 1000	0.71	1.10	0.00	0.00	0.00	0.38	0.00	0.41	0.00	0.00	0.00	0.81

Analysis of Measures / Data: (include key findings, improvements, opportunities)

- ∅ **Goal #3** Not Met for Q4 2023. We had 2-PSI 03 pressure ulcers for Q4 of 2023. There was an uptick of HAPIs in ICU. The ICU began a campaign to educate and monitor all patients for HAPIs. This began in October and has already seen an improvement of HAPIs.

Improvement Opportunities Identified, Action Plan and Expected Resolution Date / Next Steps, Recommendations, Outcomes:

HAPI committee continues to meet as a committee to track and trend our data and quality measures surrounding HAPIs. Ongoing education and support from the wound care team and clinical education are happening on all floors and at NPC. Competency now required yearly for all bedside nurses. Reporting avenue and review is occurring regularly on all floors. We continue to monitor and report findings as needed.
Wound care classes were added to accommodate our new licensed nursing staff.
New members have been invited to attend HAPI committee meetings and share concerns and solutions.

Ongoing

- ✓ Due to a huge decrease in participation, we stopped holding regular CSI meetings with leadership and staff. The format of CSI changed to a discussion of the HAPI review sheets by the wound care team. The wound care team sends out review sheets to managers every other week to help guide the investigation of HAPIs found on their units. After discussion, CSI takeaways are sent out to units to share with staff root causes and key takeways to help prevent future HAPIs.

- ✓ Quarterly education at NPC for bedside staff. Rotating topics shared with latest supplies and wound techniques to share with their units.

- ✓ Monthly in services scheduled with vendors for wound vacs, waffle boots and mattresses, etc. Multiple dates/times scheduled to accommodate both day and night shift staff.

- ✓ Education and maintenance of wound certification for the wound RNs to strengthen knowledge base and provide best practice to patients and nursing staff, improving patient outcomes.

- ✓ The Wound Care team held the first annual Pressure Prevention fair with participation from ICU, RT and our current vendors to review HAPI prevention and products. The fair was well received. We hope this will become an annual occurrence.

- ✓ Review of policies to improve compliance with reporting and documentation of HAPIs.

Submitted By: **Date Submitted:** February 2, 2024
Emma Camarena, Director of Nursing Practice

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
I. Environmental Surveillance							
A. **Sterilization and High Level Disinfection Quality Control**							
Goal <2% of Immediate Use Sterilization		1.60%	1.28%	1.52%			**1st QTR:** There were a total of 44 IUS events out of 2,724 cases performed. **2nd QTR:** There were 44 IUS events out of 3,427 cases performed. **3rd QTR:** There were 40 IUSS events out of 2,633 cases performed. Primarily ENT by Bien Air is device most reprocessed by IUSS. **4th QTR:**
B. Dialysis Water/Dialysate Quality Control (AAMI RD52:2004) (% of machines that did not exceed limits)							
Acute Dialysis (Inpatient) RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		100%	100%	100%			**1st QTR:** 51 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **2nd QTR:** 51 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **3rd QTR:** 56 Reverse Osmosis and 5 Dialysate samples tested all below maximum allowable limits - no action required. **4th QTR:**
Outpatient Dialysis RO Water [Target: <200cfu] [Action: > or = 50cfu] Endotoxin [Target: <2EU] [Action: > or = 1EU]		100%	100%	100%			**1st QTR** 8 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **2nd QTR:** 8 Reverse Osmosis and 6 Dialysate samples tested all below maximum allowable limits - no action required. **3rd QTR:** 6 Reverese Osmosis and 9 Dialysate samples tested all below maximum allowable limits - no action required. **4th QTR:**
C. Environmental Cleaning (ATP testing surfaces)							

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Pass/Fail based on a threshold of ATP score of <200. Multiple high-touch surfaces tested each month.	Goal 100%	81%	81.9%	78.0%			**1st QTR:** A total of 223 first pass cleanings out of 275 opportunties. The devices with the highest first pass rate: Room sink; handrail, flush handle, counter. The devices with the lowest first pass rate: call button, rest room sink, telephone, bedrail. All fallouts result in room being re-cleaned. **2nd QTR:** A total of 240 first pass cleaning out of 293 opportunities. The devices with the highest first pass rate: Room sink, OR Bed Control, Flush Handle. The devices with the lowest first pass rate: Room Light Switch, Bedrail, Call Button, Telephone. All fallout results in room being re-cleaned. Areas with highest first pass rates: OB OR, Cath Lab. Areas with lowest first pass rates: ICU, CVICU. **3rd QTR:** A total of 338 first pass cleaning out of 433 opportunitiies. The devices with the highest first pass rate: Restroom sink, Restroom Doorknob, Flush handle. The devices with the lowest first pass rate: Bedside table, Room sink, Room Doorknob. All fallout results in room were re-cleaned. Locations that underwent ATP testing include all surgical operating room suites, CVICU, ICCU, and ICU. During this quarter a larger volume of ATP testing was performed (32% increase in test samples compared to 2nd QTR 2023). **4th QTR**
II. Antimicrobial Stewardship Measures							
# of antibiotic IV to PO conversion		112	148	137			**1st QTR:** The majority of IV-to-PO conversions over the past 3 months occurred in the ICU and CVICU, 19 and 21, respectively. **2nd QTR:** IV-to-PO conversions increased by 32% from previous quarter. The majority of IV-to-PO conversions occured in CVICU followed by ICU and 3W. **3rd QTR:** The greatest number of IV-to-PO interventions over the past 3 months occurred in the CVICU (33 events), followed by Broderick Pavilion (31 events), then 3 South with (21 events). There was a broader array of units with IV-to-PO impacts. IV-to-PO conversions helps with reducing the need for intravenous lines that could potentially predispose a patient to risk of sepsis if contamination occurs. **4th QTR:**
Average Days of Therapy per 1,000 patient days - Fluoroquinolones		NA					**1st QTR:** This information is unavailable at this time. **2nd QTR:** This informaiton is difficult to provide quarterly. This metric will no longer be reported on. The information is ultimately shared in the Antimicrobial Stewardship Committee. **3rd QTR: ----** **4th QTR: ----**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Average Days of Therapy per 1,000 patient days - Carbapenems		NA					**1st QTR:** This information is unavailable at this time. **2nd QTR:** This informaiton is difficult to provide quarterly. This metric will no longer be reported on. The information is ultimately shared in the Antimicrobial Stewardship Committee. **3rd QTR:** ---- **4th QTR: -----**
III. Employee Health							
A. Needlestick Injuries							
Number of sharps/needle stick reports		**22**	**17**	NA	NA		**1st QTR:** Majority (10) of needlestick injuries occur when engaging the needle safety mechanism. The majority of the sharps exposures involve RN's (9) followed by Residents (7). **2nd QTR:** Majorioty of needlestick injuries involve RN's (6), followed by, LVN's (4), Techs (4) GME Residents (2), and EVS (1). Most events associated with discarding needles (8), recapping (1), activating safety mechanism (1), lack of attention (3), surgery (2), needle disposed in trash and EVS worker poked (1). **3rd QTR:** No longer reported at IPC with IPC approval. Report available with EOC Committee. **4th QTR**: No longer reported at IPC with IPC approval. Report avaiable with EOC Committee.
IV. Healthcare Associated Infection Measures							
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		448	1258	1276			**Cumulative Ct:** 2,982
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]*		**2**	**14**	**9**			**1st QTR:** 2 **Predicted:** 7.991 **2nd QTR:** 14 **Predicted:** 16.348 **3rd QTR:** 9 **Predicted:** 17.123 **4th QTR:** **Predicted:**
D. SIR Confidence Interval (CI-KDHCD predicted range, based on risks)		0.042, 0.827	0.487, 1.403	0256, 0.965			**1st QTR:** Better than state average. **2nd QTR:** Better than state average. **3rd QTR:** Better than state average. **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. Standardized Infection Ratio (SIR) for all surgical procedures.	<1.0	0.25	0.856	0.526			**1st QTR:** There was 1 appendectomy and 1 colorectal surgical site infection. **2nd QTR:** There was 1 appendectomy, 1 small bowel, 1 gallbladder surgery, 1 heart bypass, 1 craniotomy, 1 spinal fusion, 1 total abdominal hysterectomy, 1 exploratory surgery, 3 colorectal surgeries, 3 cesarean section surgeries **3rd QTR:** There was 1 cholecystecomy, 2 craniotomy, 2 cesarean section, 2 spinal fusion, 1 abdominal hysterectomy, 1 small bowel surgery. **4th QTR:**
V. Specific Surgical Review	**SIR**						
A. Colon Surgery (COLO) CMS/VBP							
1. #Total Procedure Count		41	40	48			**Cumulative Ct:** 129
2. Total Infection Count		1 [1]	3 [3]	0 [0]			1st QTR: 1 Predicted: 2.945/CMS 1 Predicted: 1.358 2nd QTR: 3 Predicted: 2.274/CMS 3 Predicted: 1.107 3rd QTR: 0 Predicted: 2.888/CMS 0 Predicted: 1.35 4th QTR: Predicted: /CMS Predicted:
3. SIR CI (KDHCD predicted range, based on risks)		0.017, 1.675	0.336, 3.591	, 1.037			**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.717	0.34	1.319	0			**1st QTR:** One event in which clean closure was not performed. The surgical quality improvement committee is working on ensuring clean closure practice is performed for procedures it is indicated. **2nd QTR:** There were 3 colorectal SSI events reported. Opportunities to improve documentation to support PATOS criteria. All events occurred at the organ-space. **3rd QTR:** There were no COLO SSI events reported this quarter. **4th QTR:**
B. Gallbladder Surgery (CHOL)							
1. #Total Procedure Count		0	100	126			**Cumulative Ct:** 226
2. Total Infection Count		0	1	1			**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 1 **Predicted:** 0.157 **3rd QTR:** 1 **Predicted:** 0.855 **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.00	0.00			**1st QTR:** No procedures performed. **2nd QTR:** Worse than national average. **3rd QTR:** Worse than national average. **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	6.37	1.17			**1st QTR:** No procedures performed. **2nd QTR:** 1 event in which patient developed a post-op seroma that eventually was identified to be an abscess with a possible bile leak from the surgical site. E. coli was identified by specimen culture. This was an organ-space SSI event. **3rd QTR:** 1 event, 6 days post-op, intra-abdominal abscess with CT guided drainage. Patient seen by outside primary care provider who suspected an SSI. **4th QTR:**
C. Spinal Fusion (FUSN)							
1. #Total Procedure Count		26	94	58			**Cumulative Ct:** 178
2. Total Infection Count		0	1	2			**1st QTR:** 0 **Predicted:** 0.468 **2nd QTR:** 1 **Predicted:** 1.391 **3rd QTR:** 2 **Predicted:** 1.068 **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.036, 3.545	0.314, 6.188			**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** Worse than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	0.72	1.873			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** 2 superficial incisional primary surgical site infection event. Different surgeons. **4th QTR:**
D. Knee Replacement (KPRO)							
1. #Total Procedure Count		24	84	77			**Cumulative Ct:** 185
2. Total Infection Count		0	0	0			**1st QTR:** 0 **Predicted:** 0.198 **2nd QTR:** 1 **Predicted:** 0.556 **3rd QTR:** 0 **Predicted:** 0.561 **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0	0			**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	0.00	0.00	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
E. Small Bowel (SB)							
1. #Total Procedure Count		12	27	27			**Cumulative Ct:** 66
2. Total Infection Count		0.00	1	1			**1st QTR:** 0 **Predicted:** 0.484 **2nd QTR:** 1 **Predicted:** 1.218 **3rd QTR:** 1 **Predicted:** 1.204 **4th QTR: Predicted:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
3. SIR CI (KDHCD predicted range, based on risks)		0	0.041, 4.049	0.042, 4.097			**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** No different than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total	Goal SIR <1.00	**0.00**	**0.821**	**0.831**			**1st QTR:** No events. **2nd QTR:** 1 superficial incisional primary surgical site infection of the small bowel SSI event 9 days post-op. **3rd QTR:** 1 superficial incisional primary surgical site infection of the small bowel SSI event . **4th QTR:**
F. Hysterectomy (HYST) CMS/VBP							
1. #Total Procedure Count		6	30	28			**Cumulative Ct:** 64
2. Total Infection Count		**0** **[0]**	**1** **[1]**	**1** **[1]**			**1st QTR:** 6 **Predicted:** 0.096/**CMS** 0 **Predicted:** 0.042 **2nd QTR:** 1 **Predicted:** 0.536/**CMS** 1 **Predicted:** 0.253 **3rd QTR:** 1 **Predicted:** 0.559/**CMS** 1 **Predicted:** 0.244 **4th QTR: Predicted: /CMS Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0	0			**1st QTR:** Better than national average. **2nd QTR:** Worse than national average. **3rd QTR:** Worse than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.738	**0.00**	**1.87**	**1.79**			**1st QTR:** No events. **2nd QTR:** 1 organ-space total abdominal hysterectomy surgical site infection event. **3rd QTR:** 1 total abdominal hysterectomy resulting in an intra-abdominal abscess that was drained in C.T. **4th QTR:**
G. Coronary Bypass Graft (CBGB)							
1. #Total Procedure Count		12	66	56			**Cumulative Ct:** 78
2. Total Infection Count		**0**	**1**	**0**			**1st QTR:** 0 **Predicted:** 0.260 **2nd QTR:** 1 **Predicted:** 1.294 **3rd QTR:** 0 **Predicted:** 1.051 **4th QTR: Predicted:**
3. SIR CI (KDHCD predicted range, based on risks)		0	0.039, 3.813	, 2.851			**1st QTR:** Better than national average. **2nd QTR:** No different than national average. **3rd QTR:** No different than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	Goal SIR <1.00	**0.00**	**0.77**	**0.00**			**1st QTR:** No events. **2nd QTR:** 1 deep incisional primary surgical site infection event. **3rd QTR:** No events. **4th QTR:**
H. Fractures (FX)							
1. #Total Procedure Count		20	50	48			**Cumulative Ct:** 118
2. Total Infection Count		**0**	**0**	**0**			**1st QTR:** 0 **Predicted:** 0.194 **2nd QTR:** 0 **Predicted:** 0.550 **3rd QTR:** 0 **Predicted:** 0.481 **4th QTR: Predicted:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
3. SIR CI (KDHCD predicted range, based on risks)		0	0	0			**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**
4. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	Goal SIR <1.00	0.00	0.00	0.00			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
VI. Ventilator Associated Events (VAE)	**SIR**						
A. Ventilator Device Use SUR (standardized utilization ratio)		1.76	1.99	NA	NA		**1st QTR:** 811 **Predicted:** 459.943 **2nd QTR:** 810 **Predicted:** 407.023 **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
B. Total VAEs ICU (NHSN Reportable)	Includes IVAC Plus						
1. SIR Total VAE CI (KDHCD predicted range, based on risks)		1.645, 1.888	, 1.261	NA	NA		**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
2. Total VAEs SIR	<1.0	0.16	0	NA	NA		**1st QTR:** 1 VAE event, 6.409 predicted. **2nd QTR:** No events. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
C. Total IVAC Plus -ICU		1	0	NA	NA		**1st QTR:** 1 IVAC event very likely due to aspiration pneumonia secondary to large cerebellar infarction. Patient nares colonized with MRSA and he developed MRSA pneumonia. Mupirocin ordered 3 days after admission after IVAC identified. **2nd QTR:** No events. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.

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		Q1	**Q2**	**Q3**	**Q4**	**AVG. or TOTAL YTD**	**SUMMARY / ACTION**
1. Total IVAC Plus CI (KDHCD predicted range, based on risks)		0.021, 2.074	, 1.261	NA	NA		**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
2. Total IVAC *Plus* ICU SIR		**0.42**	**0**	NA	NA		**1st QTR:** 1. IVAC event, 2.378 predicted **2nd QTR:** No events. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
1. Process Measures							
% of patients with head of bed >30 dregrees per visual inspection.	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
% Sedation Vacation	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
% Oral Care Provided (per visual inspection)	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% CHG Bath within last 24 hours	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
% Vent Tubing Position Appropriately (drain away from patient - visual inspection)	**Goal = 100%**	NA	NA	NA	NA		**1st QTR:** Rounding not performed due to limited resources. **2nd QTR:** Rounding not performed due to limited resources. **3rd QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC. **4th QTR:** With approval of IPC this metric is reported to Critical Care Committee and no longer required at IPC.
VII. Central Line Associated Blood Stream Infections (CLABSI) CMS/VBP	**NHSN SIR**						
A. Total number of Central Line Days (CLD)		3,650	3,747	4,030			**Cumulative Ct:** 11,427
B. Central Line Device Use SUR (standardized utilization ratio)		**0.672**	**0.769**	**0.79**			**1st QTR:** 3,650 CLD **Predicted:** 5,429.792 **2nd QTR:** 3,747 CLD **Predicted:** 4,870.352 **3rd QTR:** 4,030 CLD **Predicted:** 5,103.727 **4th QTR:** CLD **Predicted:**
C. Total Infection Count Valule Based Purchasing (VBP) # events = [ ]		**3** **[3]**	**5** **[3]**	**6** **[4]**			**1st QTR:** 3 **Predicted:** 3.548 **/CMS:** 3 **Predicted:** 2.174 **2nd QTR:** 5 **Predicted:** 3.671/**CMS:** 3 **Predicted:** 2.204 **3rd QTR:** 6 **Predicted:** 3.929/**CMS:** 4 **Predicted:** 2.290 **4th QTR: Predicted: /CMS: Predicted:**
D. SIR Confidence Interval		0.215, 2.301	0.499, 3.019	0.619, 3.176			**1st QTR:** No different than national average. **2nd QTR:** Worse than national average. **3rd QTR:** No different than national average. **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.589 excluding COVID population**	**0.845**	**1.362**	**1.527**			**1st QTR:** 1 CLABSI event with Candidemia, on TPN, Diabetic; 1 CLABSI event with Candidemia in patient with multiple femoral CVCs, on Steroids, and receiving TPN/Fat Emulsion, Diabetic. CLABSI QFT is working with CMO/CQO, Medical Director for Quality, Medical Director for Infection Prevention on pursuing a comprehensive approach to reducing CLABSI events. **2nd QTR:** 5 CLABSI events. Improvement opportunities: Hand hygiene compliance, culturing practices, extended femoral access, multiple peripheral IVs (just-in-case-culture), documentation and actions related to most likely primary source of bloodstream infection (e.g. endocarditis, osteomyelitis). **3rd QTR:** 6 CLABSI events. Units involved: 4S (1), 4T (1), 3W (1), 3S (1), ICU (2). Primary bacteria identified - E. coli. Primary fallout(s) identified: expired peripheral IV x 3 events, lack of daily bath x 3 events, blood cultures collected prior to comfort care x 2 - both patients expired within 3 days of specimen collection. **4th QTR:**
F. Process Measures							
% of patients with a bath within 24 hours	**Goal 100%**	**92.1%**	**87.2%**	**92.8%**			**1st QTR:** 2,655 responses out of 2,884 responses (total of 3,511 rounds) **2nd QTR:** 2,467 responses out of 2,829 responses (total of 3,190 rounds) **3rd QTR:** 2,326 responses out of 2,506 responses (otal of 3,478 rounds) **4th QTR:**
% of central lines inserted with a valid rationale	**Goal 100%**	**91.7%**	**97.3%**	**96.0%**			**1st QTR:** 1,568 responses out of 1,710 responses (total of 3,511 rounds). **2nd QTR:** 1,533 responses out of 1,575 responses (total of 3,190 rounds). **3rd QTR:** 1,712 responses out of 1,783 responses (total of 3.478 rounds) **4th QTR:**
% of central line dressings clean, dry and intact	**Goal 100%**	**98.1%**	**98.6%**	**98.5%**			**1st QTR:** 1,693 responses out of 1,725 responses (total of 3,511 rounds). **2nd QTR:** 1,558 responses out of 1,580 responses (total of 3,190 rounds). **3rd QTR:** 1,756 responses out of 1,782 responses (total of 3,478 rounds) **4th QTR:**
% of central line dressing changes no > than 7 days	**Goal 100%**	**98.3%**	**99.0%**	**98.2%**			**1st QTR:** 1,693 responses out of 1,723 responses (total of 3,511 rounds). **2nd QTR:** 1,570 responses out of 1,586 responses (total of 3,190 rounds). **3rd QTR:** 1,757 responses out of 1,789 responses (total of 3,190 rounds). **4th QTR:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
% of patients with properly placed CHG patch	Goal 100%	97.2%	97.9%	98.6%			**1st QTR:** 963 responses out of 991 responses (total of 3,511 rounds). **2nd QTR:** 870 responses out of 889 responses (total of 3,190 rounds). **3rd QTR:** 1,163 responses out of 1,180 responses (total of 3,190 rounds) **4th QTR:**
% of patients with appropriate & complete documentation	Goal 100%	96.2%	96.0%	95.6%			**1st QTR:** 1,660 responses out of 1,726 responses (total of 3,511 rounds). **2nd QTR:** 1,521 responses out of 1,585 responses (total of 3,190 rounds). **3rd QTR:** 1,701 responses out of 1,779 responses (total of 3,190 rounds). **4th QTR:**
# of central line days rounded on		1,661	1,586	1,787			**1st QTR:** Total of 1,661 central lines were rounded on in multiple patient care units. **2nd QTR**: Total of 1,586 central lines were rounded on in multiple patient care units. **3rd QTR**: Total of 1,787 central lines were rounded on in multiple patient care units. **4th QTR:**.
Skilled Nursing/Acute Rehab % of central dressing clean/dry/intact	Goal 100%	100.0%	100.0%	100.0%			**1st QTR:** Total of 93 responses out of 93 responses (total of 257 rounds). **2nd QTR:** Total of 128 resposes out of 128 responses (total of 325 rounds). **3rd QTR:** Total of 80 responses out of 80 responses (total of 286 rounds). **4th QTR:**
Skilled Nursing/Acute Rehab % of central line dressings changed no > 7 days	Goal 100%	100.0%	100.0%	100.0%			**1st QTR:** Total of 93 responses out of 93 responses (total of 257 rounds). **2nd QTR:** Total 129 responses out of 129 responses (total of 325 rounds). **3rd QTR:** Total of 81 responses out of 81 responses (Total of 286 rounds). **4th QTR:**
VIII. Catheter Associated Urinary Tract Infections (CAUTI) CMS/VBP	**NHSN SIR**						
A. Total number of Catheter Device Days (CDD)		4,247	4,013	3,991			**Cumulative Ct:** 12,251
B. Catheter Device Days SUR (Standardized Utilization Ratio)		0.933	0.973	0.945			**1st QTR:** 4,247 CDD **Predicted:** 4,550.281 CDD **2nd QTR**: 4,013 CDD **Predicted:** 4,122.823 CDD **3rd QTR:** 3,991 CDD **Predicted**: 4,233.154 CDD **4th QTR:** CDD **Predicted:** CDD
C. Total Infection Count Value Based Purchasing (VBP) # of events = [ ]		0	3	2			**1st QTR:** 0 **Predicted:** 5.505 /**CMS:** 0 **Predicted:** 3.091 **2nd QTR:** 3 **Predicted:** 5.234/**CMS:** 2 **Predicted:** 2.674 **3rd QTR:** 2 **Predicted:** 5.171/**CMS:** 1 **Predicted:** 2.860 **4th QTR: Predicted: /CMS: Predicted:**

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		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
D. SIR Confidence Interval		0	0.146, 1.560	0.065, 1.278			**1st QTR:** Better than national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR**:
E. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.650 excluding COVID population**	**0**	**0.573**	**0.387**			**1st QTR:** No events. **2nd QTR:** 3 CAUTI events. Opportunities for improvement: Pursue an alternative to an indwelling urinary catheter, ordering cultures for patients on comfort care, stool management, hand hygiene compliance. **3rd QTR:** 2 CAUTI events. Opportunities exist with reducing indwelling urinary catheter use, seeking alternatives to indwelling urinary catheters. **4th QTR:**
F. Process Measures							
% of patients with appropriate cleanliness (a minimum of peri-care in the last 12 hours)	**Goal 99%**	**95.9%**	**96.8%**	**97.5%**			**1st QTR:** 1,862 responses out of 1,862 responses (total of 3,511 rounds). **2nd QTR:** 1,749 responses out of 1,806 responses (total 3,190 rounds). **3rd QTR:** 1,987 responses out of 2,038 responses (total of 3,478 rounds). **4th QTR:**
% of IUCs with order and valid rationale	**Goal 100%**	**93.3%**	**93.0%**	**93.9%**			**1st QTR:** 1,803 responses out of 1,932 responses (total of 3,511 rounds). **2nd QTR:** 1,676 responses out of 1,807 responses (total of 3,190 rounds). **3rd QTR:** 2,229 responses out of 2,375 responses (total of 4,019 rounds). **4th QTR:**
% of IUCs where removal was attempted		**1.9%**	**11.4%**	**8.5%**			**1st QTR:** 36 responses out of 1,945 responses (total of 3,511 rounds). **2nd QTR:** 130 responses out of 1,139 responses (total of 3,190 rounds). **3rd QTR:** 126 responses out of 1,479 responses (total of 4, 019 rounds) **4th QTR:**
% of patients where alternatives have been attempted		**4.0%**	**8.0%**	**6.8%**			**1st QTR:** 78 responses out of 1,192 responses (total of 3,511 rounds). **2nd QTR:** 103 responses out of 1,216 responses (total of 3,190 rounds). **3rd QTR:** 114 responses out of 1,670 responses (total of 3,190 rounds). **4th QTR:**
% of IUCs removed because of unit "GEMBA" rounds		**2.2%**	**2.9%**	**1.5%**			**1st QTR:** 42 responses out of 1,929 responses (total of 3,511 rounds). **2nd QTR:** 53 responses out of 1,799 responses (total of 3,190 rounds). **3rd QTR:** 36 responses out of 2,355 responses (total of 4,019 rounds). **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
# of IUCs removed because of unit "GEMBA" rounds		42	53	36			**1st QTR:** No additional comments. **2nd QTR:** No additional comments. **3rd QTR:** **4th QTR:**
# of Indwelling Urinary Catheter days rounded on		1,819	1,803	2,352			**1st QTR:** No additional comments. **2nd QTR:** Total of 1,803 responses (total of 3,190 rounds). **3rd QTR:** Total of 2,352 responses (total of 4,019 rounds). **4th QTR:**
Skilled Nursing/Acute Rehab % of completed baths performed within 48 hours for patients with central lines	**Goal 100%**	**100.0%**	**100.0%**	**99.6%**			**1st QTR:** 256 responses out of 256 responses (total of 257 rounds) **2nd QTR:** 323 responses out of 323 responses (total of 325 rounds). **3rd QTR:** 284 responses out of 285 responses (total of 286 rounds). **4th QTR:**
Skilled Nursing/Acute Rehab % of peri care performed within in a 12 hour shift	**Goal 100%**	**100.0%**	**100.0%**	**100.0%**			**1st QTR:** 176 responses out of 176 responses (total of 257 rounds). **2nd QTR:** 195 responses out of 195 responses (total of 325 rounds). **3rd QTR**: 204 responses out of 204 responses (total of 286 rounds). **4th QTR:**
IX. Catheter Associated Urinary Tract Infections Long Term Care/Rehabilitation	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		**0**	**1**	**1**			**1st QTR:** No cases, 151 catheter days (Cath utilization rate = 0.055) **2nd QTR:** 1 event, 31 catheter days (Cath utilization rate = 0.023) **3rd QTR:** 1 CA-SUTI case, 271 catheter days (Cath utilization rate = 0.099). **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		**0**	**0**	**0**			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
Acute Rehabilitiation (# of Infections/ Incidence Rate)		**0**	**0**	**0**			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
X. LTC Symptomatic Urinary Tract Infections	**Goal = 0**						
Short Stay (# of Infections/ Incidence Rate)		**0**	**1**	**0**			**1st QTR:** No cases. There were 2,770 resident days, and 2,619 non-catheter days. There were 5 urine cultures ordered (urine culture rate = 1.805) and there were 5 antibiotic starts. **2nd QTR:** 1 event, SUTI rate = 0.775. There were 1,381 resident days, and 1,290 non-catheter days. **3rd QTR:** No events. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
Subacute (# of Infections/ Incidence Rate)		0	1	1			**1st QTR:** No events. **2nd QTR:** 1 event, SUTI rate = 0.750. There were 1,364 resident days, and 1,333 non-catheter days. **3rd QTR:** 1 ABUTI event, SUTI rate = 0.407. There were 2,726 resident days, and 2,455 non-catheter days. **4th QTR:**
XI. Clostridium *difficile* Infection (CDI) CMS/VBP	**SIR**						
A. Total Infection Count	All units	11	8	6			**1st QTR:** 11 **Predicted:** 16.868 **2nd QTR:** 8 **Predicted:** 16.230 **3rd QTR:** 6 **Predicted:** 16.436 **4th QTR:** **Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.342, 1.133	0.229, 0.936	0.148, 0.759			**1st QTR:** No difference from national average. **2nd QTR:** Better than national average. **3rd QTR:** Better than national average. **4th QTR:**
C. SIR (Standardized Infection Ratio) total Value Based Purchasing (VBP) SIR = [ ]	VBP Goal <0.520	0.652	0.493	0.365			**1st QTR:** There is ongoing work to develop a pop-up in the EMR for providers reminding them not to order C. diff. testing for patients on a bowel program. Additionally, an automatic discontinuation of C. diff. orders that are not completed within 24 hours is being developed. **2nd QTR:** At the end of the second quarter the medical record pop-up reminder and auto-cancellation at 24 hours for C. difficile orders in which a specimen wasn't collected all went live. Continued education and just-in-time interventions to reduce inappropriate C. difficile testing performed throughout this quarter. **3rd QTR:** Number of HO C. difficile are trending downward. **4th QTR:**
XII. Hand Hygiene	**95%**						
A. Total Hand Hygiene Observations (combination of manual and electronic hand hygiene surveillance)		96.5%	96.09%	95.92%			**1st QTR:** 2,766,588 compliant out of 2,866,337 opportunities. **2nd QTR:** 2,663,467 compliant out of 2,771,846 oppportunities. **3rd QTR:** 2,568,546 compliant out of 2,677,800 opportunities. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
B. All units Percentage of Hand Hygiene compliance based on observations/opportunities (>200 observations/ month/unit) *(note these are partially patient observations)*		82.9%	87.9%	93.4%			1st QTR: Mental Health 756 compliant out of 756 opportunities or 100% compliance rate. All Clinics (including KHMG) NRC patient observations of HCP HH activities = 4,376 out of 5,438 opportunities or 80.5% compliance rate. 2nd QTR: Mental Health 663 compliant out of 663 opportunities or 100% compliance rate. All Clinics NRC patient observations of HCP HH activities = 1,754 compliant out of 2,087 opportunities or 84% compliance rate. 3rd QTR: Mental Health 704 compliant out of 704 opportunities or 100% compliant rate. All clinics NRC patient observations of HCP HH activities = 1,942 compliant out of 2,234 opportunities or 86.9% compliance rate. 4th QTR:
C. Percentage of Hand Hygiene compliance performed during "Day Shift"		96.5%	96.1%	95.95%			**1st QTR:** 1,629,768 compliant out of 1,688,354 opportunities. **2nd QTR:** 1,517,880 compliant out of 1,579,480 opportunities. **3rd QTR:** 1,469,455 compliant out of 1,531,148 opportunities. **4th QTR:**
D. Percentage of Hand Hygiene compliance performed during "Night Shift"		96.7%	96.3%	95.92%			**1st QTR:** 899,013 compliant out of 929,981 opportunities. **2nd QTR:** 871,728 compliant out of 905,221 opportunities. **3rd QTR:** 1,765,730 compliant out of 1,840,836 opportunities. **4th QTR:**
XIII. VRE (HAI) Blood-Hospital Onset (HO)							
A. Total Infection Count		0	1	0			**1st QTR:** 0 **Predicted:** 0 **2nd QTR:** 1 **Predicted:** 5.345 **3rd QTR:** 0 **Predicted:** 0 **4th QTR: Predicted:**
B. Prevalence Rate (x100)		0	0.019	0			**1st QTR:** There were no cases of VRE BSI. **2nd QTR:** There was 1 case of hospital onset VRE BSI. **3rd QTR:** There were no cases of VRE BSI. **4th QTR:**
C. Number Admissions		6,074	5,345				**Cumulative Ct:** 11,419
XIV. MRSA (HAI) Blood CMS/VBP	**SIR**						
A. Total Infection Count (IP Facility-wide)		1	2	1			**1st QTR:** 1 **Predicted:** 2.201 **2nd QTR:** 2 **Predicted**: 1.937 **3rd QTR:** 1 **Predicted:** 2.043 **4th QTR: Predicted:**
B. SIR CI (KDHCD predicted range, based on risks)		0.023, 2.240	0.173, 3.411	0.024, 2.414			**1st QTR:** Better than national average. **2nd QTR:** Worse than national average. **3rd QTR:** No different than national average. **4th QTR:**

Infection Prevention and Control Committee - IP Quality Improvement Dashboard CY 2023							
		Q1	Q2	Q3	Q4	AVG. or TOTAL YTD	SUMMARY / ACTION
C. SIR (Standardized Infection Ration) total Value Based Purchasing (VBP) SIR = [ ]	**≤ 0.726 excluding COVID population**	0.454	1.032	0.489			**1st QTR:** 1 event likely related to aspiration pnuemonia with secondary MRSA bloodstream infection. **2nd QTR:** 2 events. 1 event involving paitent with complex pyscho/neuro disorder (history of IVDU/homelessness), developed aspiration pneumonia and tested positive for MRSA BSI. 1 event involving a patient who fell at home sustaining multiple fractures, deteriorated during 2nd day of admission requiring an RRT due to hypoxia. Developed aspiration pneumonia and bloodstream infection due to MRSA on day 3 of admission. (both patients expired) **3rd QTR:** 1 case of HO MRSA BSI. **4th QTR:**
XV. MDRO LABID - Long Term Care							
Short Stay (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
Transitional Care (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
Subacute (# of Infections/ Incidence Rate)		0	0	0			**1st QTR:** No events. **2nd QTR:** No events. **3rd QTR:** No events. **4th QTR:**
XVI. Influenza Rates (Year 2022-2023)	**NHSN**						
A. All Healthcare Workers	**>90%**		84%				**2nd QTR:** A total of 4,096 employees received flu vaccination either with Kaweah Health or elsewhere out of a total number of 4,888 employees who worked at least 1 day at Kaweah Health during the influenza season. Employee = 84% vaccinated (3,451/4,113) LIP = 88% vaccinated (456/517) Students = 73% vaccinated (189/258)
Approved IPC: 4/27/23 Approved IPC: 7/27/23 Approved IPC: 10/26/23 Approved IPC: Prepared by: Shawn Elkin, Infection Prevention Manager							

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Maternal Child Health FY2024 Quality Improvement Dashboard

LABOR AND DELIVERY	Goal	2023	July 2023	Aug 2023	Sep 2023	July - Sep 2023	Oct 2023	Nov 2023	Dec 2023	Oct - Dec 2023	FYTD
Early Elective Deliveries: PC-01	0%	3.8%	1.7%	4.3%	2.0%	2.7%	9.0%	Unavailable	Unavailable	N/A	4.3%
Nullip Term Singleton Vertex : PC-02	30%	25.9%	26.5%	21.4%	30.0%	26.0%	21.8%	24.8%	Unavailable	N/A	24.9%
RASS Compliance	100%	88%	89.98%	91%	93%	91.3%	91%	91%	91.62%	91%	92.32%
Dermatome Compliance	100%	89%	95.25%	89.66%	93%	92.6%	91%	91%	91.62%	91%	92.93%
Severe Unexpected Complications in Term Newborns: PC-06.1	5%	9.80%	8.88%	5.60%	8.90%	7.8%	9.30%	9.30%	3.10%	7%	7.51%
Pitocin Use for Labor Induction/Augmentation	90%	96%	100%	100.0%	100%	100.0%	100%	100.0%	100%	100.0%	100%
Pitocin Increase Compliance	90%	80.6%	100%	97.0%	92%	96.3%	96%	96.0%	97%	96.3%	94%
Hand Hygiene Compliance	95%	97.2%	97.7%	96.4%	97%	97.1%	96%	96.0%	96.8%	96.4%	97.0%
MOTHER-BABY											
Exclusive Breastmilk: PC-05	52.4%	64.1%	54.2%	66.7%	61.0%	60.6%	62.6%	60.3%	55.0%	59.3%	59.8%
Latch Assessment Compliance	100%	74%	60%	60%	70%	63.3%	72%	52%	66%	63%	63%
RASS Compliance	100%	N/A	20%	30%	70%	40.0%	90%	50%	96%	79%	64%
Early Catheter Removal	100%	N/A	80%	80%	80%	80.0%	93%	80%	80%	84%	82%
Hand Hygiene Compliance	95%	97.5%	97.6%	97.9%	98.2%	97.9%	97.4%	97.0%	97.5%	97.3%	97.5%
NEONATAL-NICU											
CLABSI per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0
VAP per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0
Any Breastmilk for NICU Babies	100%	N/A	85.9%	93.5%	95.1%	91.5%	97.6%	98%	83%	93%	93%
Hand Hygiene Compliance	95%	99.5%	99.5%	99.3%	99.1%	99.3%	99.0%	99.1%	99.2%	99.1%	99.2%
PEDIATRICS											
PEWS Compliance	90%	98%	100%	100.0%	98%	99.3%	100%	100.0%	100%	100.0%	99.4%
Patient Falls per 1000 Patient Days	0	0	0	0	0	0	0	1	0	0.333333333	0.1667
Ambulation	90%	N/A	55%	20%	25%	33%	15%	20%	5%	13%	24.0%
Child Life Activities	90%	N/A	30%	8%	8%	15%	10%	15%	11%	12%	18.0%
CLABSI per 1000 Patient Days	0	0	0	0	0	0	0	0	0	0	0
Hand Hygiene Compliance	95%	97.5%	97.5%	98.1%	98%	97.9%	97.5%	98.2%	97.6%	97.8%	97.9%

>10% above goal/benchmark	Within 10% of goal/benchmark	Outperforming/meeting goal/benchmark

Neonatal Intensive Care Unit- Breast Milk for NICU Babies

Goal: 100% of qualifying Neonatal Intensive Care Unit patients receive any/some breast milk during their hospital admission to the Neonatal Intensive Care Unit.	**Med Staff Champion: Dr. Dosado**	**Subject Experts: Felicia Vaughn, Daniel Castaneda, Mary Dieterle**	**Time Period: July 2023- Dec 2023**
Team Leader: Felicia Vaughn	**Team members: All Staff**		**Revision (date): 01/16/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at the total number of qualifying patients who receive breastmilk during any point of their Neonatal Intensive Care Unit admission.

Exclusion Criteria:
Exclusive formula preference from mother, observation admissions with less than 4 hours in the NICU, transfers out of the NICU before the first feeding and expiration of life prior to first feeding.

Current Condition: YTD 92.2%
July- Sept 2023 = 91.5%
Oct- Dec 2023= 92.9%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
When the baby is in the neonatal intensive care unit, it can be overwhelming for the mother. This can create issues with mothers milk supply and often mothers are worried about their baby so they may choose to give formula instead.

DO

Countermeasure / Action Plan / Solutions:

- Early lactation support for mothers with breastfeeding preference on admission.
- Acknowledge and recognize mothers who provide express breast milk with breastfeeding awards.

CHECK

Results / Metrics:
Goal not met.

ACT / ADJUST

Follow-Up / Sustainability:
Continue to support families that wish to provide breast milk for their infants.

Kaweah Health

Labor and Delivery Early Elective Delivery

Goal: The goal is to have zero early elective deliveries.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Laura Robertson, Christine Chavez**	**Time Period: July 2023-December 2023**
Team Leader: Laura Robertson	**Team members: All OB Providers**		**Revision (date): 1/31/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
Patients with an induction or cesarean procedure prior to labor including patients with 37/38 week deliveries, excluding those with a condition justifying an elective delivery (per The Joint Commission) or a history of prior stillbirth IF induction or cesarean performed in current delivery.

Current Condition: YTD 3.4%
Jan – Mar 2023 = 3.7%
Apr – Jun 2023 = 3.2%
Jul – Sept 2023 = 2.6%
Oct 2023 = 9.1%
Nov – Dec 2023 = (excluding Nov & Dec's data, California Maternal Quality Care Collaborative operates about 6 weeks behind)

Target / Goal: 0%

Problem Analysis / Root Cause, Gap:

1. There is no stop gap when a provider calls to schedule an early elective delivery.

DO

Countermeasure / Action Plan / Solutions:
Meeting with Dr. Betre/Banks 07/18/23 to discuss how the providers can assist us in meeting this metric and develop an action plan.
09/2023 – Development of task force in progress. 1st meeting planned for September.
09/1/23 – Email sent to OB providers requesting preference for meeting with no response.
09/18/2023 – 2nd request sent to provider group, Dr. Betre notified of no response
10/05/2023 – Invite sent to providers for 1st meeting on 10/16/23.
10/16/23 – 1st meeting. Discussed focus and goals of the task force. Reviewed data for January 2022-July 2023. Brainstormed possible solutions and next steps.
11/21/23 – 2nd meeting. Discussed having OB scheduler contact Dr. Banks with any fallouts in real time to determine if patient meets the criteria for early elective delivery.
12/2023 – no meeting due to schedule conflicts and holidays.
01/23/24 – 3rd meeting. Discussed scheduling a meeting with Maternal Fetal Medicine as they recommend early elective deliveries for obesity, hypertension, etc.

CHECK

Results / Metrics:
We will continue to monitor compliance.

Labor and Delivery Early Elective Delivery

		ACT / ADJUST	**Follow-Up / Sustainability:** We will continue to monitor for compliance.

Labor and Delivery RASS and Dermatome

Goal: The goal is to have 100% compliance	Med Staff Champion: Dr. Betre/Banks	Subject Experts: Laura Robertson, Christine Chavez	Time Period: July 2023-December 2023
Team Leader: Laura Robertson	Team members: All L&D RNs		Revision (date): 1/31/24
PI Liaison:			Revision #: 1

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
There was a Joint Commission finding that we were not compliant with Epidural order set in documenting RASS and Dermatome assessment with an epiduralized patient. This measure looks at how many opportunities to chart RASS and Dermatomes within the order parameters when a patient has an epidural and how many were compliant. All RNs with an epiduralized patient should be charting RASS and Dermatomes per the order set.

Current Condition:
YTD = RASS 90% Dermatome 91%
Apr – Jun 2023 = RASS 88% Dermatome 89%
Jul – Sept 2023 = RASS 91% Dermatome 93%
Oct – Dec 2023 = RASS 91% Dermatome 91%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:

1. There was lack of understanding of appropriate charting with an epiduralized patient.

DO

Countermeasure / Action Plan / Solutions:

- Analyzed order sets and policy to ensure we were following best practice.
- Reviewed charting and worked with ISS to make charting location more visible and adding forced cells to assist with compliance
- Created charting guide to make clear the expectations
- Begun auditing by RN in October to ensure auditing was being done with a full understanding of the clinical picture
- Discussions with RNs out of compliance, initiating correction as needed
- In November began celebrating RNs with 100% compliance
- In the planning stage of adding RASS and Dermatome to Annual Update to audit every RN and to ensure 100% compliance

CHECK

Results / Metrics:
We will continue to monitor compliance.

ACT / ADJUST

Follow-Up / Sustainability:

We will continue to monitor for compliance.

MOTHER BABY EARLY URINARY CATHETER REMOVAL

Goal: Early Urinary Catheter Removal Compliance goal is 100%	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti**	**Time Period: July 2023-December 2023**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date): 01/31/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement: Early urinary catheter removal: % of elective C-section cases who have foley catheter removed within 12 hrs after delivery.

Current Condition: YTD 75.84%
Jul-Sep 2023 78.06%
Oct-Dec 2023 73.63%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
Staff are not charting the Early Catheter Removal

DO

Countermeasure / Action Plan / Solutions:
Identification of compliance through reports and auditing.
Jul-Sep 2023: Unit Based Council completed 50 random audits, findings were provided via minutes to all staff. Staff directed to be increasingly diligent and reminder was added to staff huddle.
Oct-Dec 2023: Unit Based Council members completed 50 random audits, findings published via UBC meeting minutes.
Mother Baby leadership additionally audited 100% off all elective c-section cases to further identify gaps. Year to date findings will be shared during upcoming staff meeting. For consecutive misses from staff, Manager is implementing discipline conversations and use of case study for additional education and reinforcement.

CHECK

Results / Metrics:
Goal was not met for either 3rd or 4th quarter of calendar year 2023.

ACT / ADJUST

Follow-Up / Sustainability:
Mother Baby leadership now completing 100% of all elective c-section audits to evaluate all opportunities. Will track and trend for improved compliance.

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MOTHER BABY EARLY URINARY CATHETER REMOVAL

Goal: The goal is 100% of our patients who are exclusively breastfeeding will have a LATCH assessment documented at least once per shift.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti, Lactation Team, Staff Rn's**	**Time Period: July 2023-December 2023**
Team Leader: Stephanie Genetti	**Team members: All Staff, UBC**		**Revision (date): 01/31/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
The goal is 100% of our patients who are exclusively breastfeeding will have a LATCH assessment documented at least once per shift as required per our standards of care following California Department of Public Health Model Hospital Policy, excluding any patients that are formula feeding only.

Current Condition: YTD 69.5%
Jan –Mar 2023 75%
April-Jun 2023 64.86%
July- Sept 2023 63%
Oct-December 2023 63.3%

Target / Goal: 100%

DO

Countermeasure / Action Plan / Solutions:
Jan 2023: Intervention-Unit Based Council tasked for solution: education to staff via huddles and Unit Based Council meeting minutes to advise staff the latch is an assessment and must be completed each shift.
Apr 2023: Staff now directed to remind oncoming shift during bedside report to confirm latch score has been completed.
July 2023: Hold one another accountable and include lactation for tracking of trends.
Oct 2023: During the last hour of the shift, the LVN will audit charts and notify RN's if latch score still need to be charted.
Dec 2023: Manager implemented conversations with staff to address trends/gaps as a warning prior to implementing discipline.
Unit Based Council/Breast Is Best Committee/Charge Nurse staff have all been included in problem solving and compliance. Unit Based Council in collaboration with our lactation team is working on these audits at this time. Extensive education has been provided via huddle, peer accountability, LVN's now reviewing charts for the last hour of their shift and reminding staff to document their LATCH scores prior to shift change. Manager has sent out reminders. Unit Based Council has asked manager to send out notification of audit findings for non-compliance and 2 encounters will initiate progressive discipline. Will also have staff begin to present in form of case study for incomplete documentation.

CHECK

Results / Metrics:
Will continue to monitor compliance. Unit Based Council is reporting the findings on a monthly basis to staff who have started to also hold one another responsible during change of shift reports.

MOTHER BABY EARLY URINARY CATHETER REMOVAL

	Problem Analysis / Root Cause, Gap: Staff note the patients do not call for every feeding and in turn some opportunities to assess are lost. Staff referenced further it was not clear that this was an assessment.		
		ACT / ADJUST	**Follow-Up / Sustainability:** We will continue to monitor for compliance. LATCH is reported monthly to all staff and the UBC team for process improvement. Lactation team is also partnering for additional reinforcement.

Mother Baby RASS

Goal: Richmond Agitation Sedation Scale must be assessed within 60 minutes of giving an oral narcotic medication.	**Med Staff Champion: Dr. Betre/Banks**	**Subject Experts: Stephanie Genetti**	**Time Period: July 2023- December 2023**
Team Leader: Stephanie Genetti	**Team members: All Staff**		**Revision (date): 01/31/24**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at compliance of the Licensed Nurse documenting the Richmond Agitation Sedation Scale (RASS) of a patient within 60 minutes of administering an oral narcotic medication. The follow up from the Licensed Nurse must be documented using the RASS scoring 100% of the time.

Current Condition: YTD 59.33%
Jul-Sep 2023 40%
Oct-Dec 2023 78.67%

Target / Goal: 100%

Problem Analysis / Root Cause, Gap:
Staff are not charting the RASS

DO

Countermeasure / Action Plan / Solutions:
Identification of compliance through reports and auditing.
Jul-Sep2023: Unit Based Council audited 50 random charts q month.
Oct-Dec 2023: Licensed Vocational Nurse utilized to complete daily audits on all patients and notifies staff Registered Nurse if there are any RASS scores that have not been documented. Increase in compliance from 40 to 78.7% noted. Still not meeting the metric. Have included reminder to huddles and weekly updates. For consecutive misses from staff, Manager is implementing discipline conversations and use of case study for additional education.

CHECK

Results / Metrics:
Goal was not met for either 3rd or 4th quarter of calendar year 2023.

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance.

Child Life Activities

Goal: 90% compliance in documenting a Child Life Activity opportunity during each shift.	**Med Staff Champion: Dr. Dr. Valladares**	**Subject Experts: Danielle Grimaldi**	**Time Period: July 2023-Dec 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 1/31/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many pediatric patients had a Child Life Activity documented each shift.

Current Condition: YTD 13.7 %
July-Sept 2023 = 15.3%
Oct-Dec 2023= 12%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
This is a new goal for us in regards to documentation. Patients are frequently in the Play room or playing in their rooms but are potentially not being documented appropriately by staff. Patients are frequently sick during early admission, and documentation is missing in regard to patient not being able to participate in Child Life Activities early in their disease process.

DO

Countermeasure / Action Plan / Solutions:
Continue to audit weekly and remind staff to complete the documentation. Starting 2/1/24, implemented shift-to-shift handoff checking for documentation prior to the nurse leaving their shift.

CHECK

Results / Metrics:
Goal Not Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance. We will educate to documentation more frequently using our audits as tools. We will relook at documentation to see if change in documentation choices need to be updated.

Patient Ambulation

Goal: 90% compliance in documenting a Patient Ambulation opportunity.	**Med Staff Champion: Dr. Dr. Valladares**	**Subject Experts: Danielle Grimaldi**	**Time Period: July 2023-Dec 2023**
Team Leader: Danielle Grimaldi	**Team members: All Staff**		**Revision (date): 1/31/2024**
PI Liaison:			**Revision #: 1**

PLAN (DEFINE/MEASURE/ANALYZE)

Background/Problem Statement:
This measure looks at how many pediatric patients had the opportunity to ambulate each shift.

Current Condition: YTD 23.3 %
July-Sept 2023 = 33.3%
Oct-Dec 2023= 13.3%

Target / Goal: 90%

Problem Analysis / Root Cause, Gap:
This is a new goal for us in regards to documentation. Patients are ambulating in the room, but staff are not documenting it appropriately. Patients are frequently sick during early admission, and documentation is missing documenting patients inability to ambulate early in the disease process.

DO

Countermeasure / Action Plan / Solutions:
Continue to audit weekly and remind staff to complete the assessments. Starting 2/1/24, implemented shift-to-shift handoff checking documentation prior to the nurse ending her shift.

CHECK

Results / Metrics:
Goal Not Met

ACT / ADJUST

Follow-Up / Sustainability:
We will continue to monitor for compliance. We will educate to documentation more frequently using audits as a tool. We will relook at documentation to see if change in documentation choices needs to be updated.

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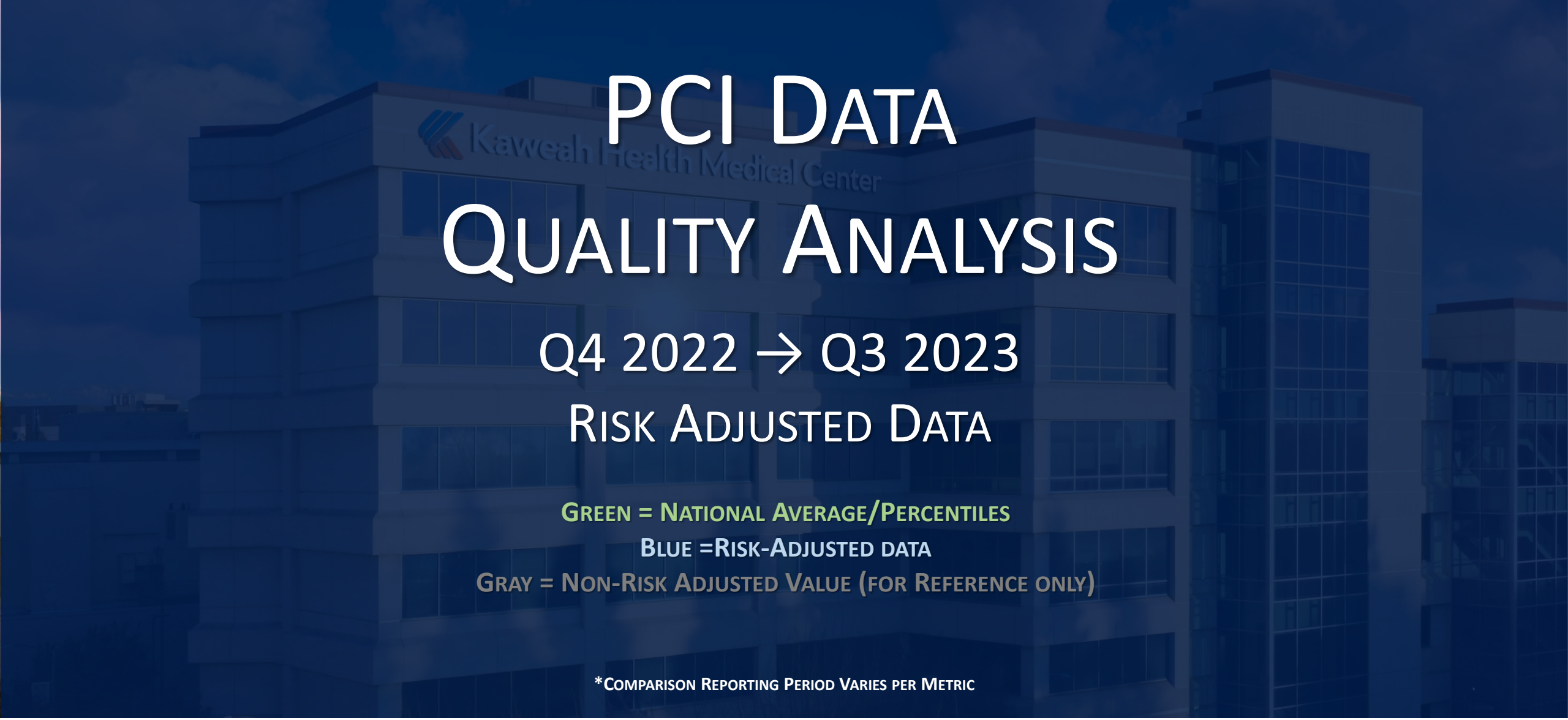


PCI Data Quality Analysis

Q4 2022 → Q3 2023

Risk Adjusted Data

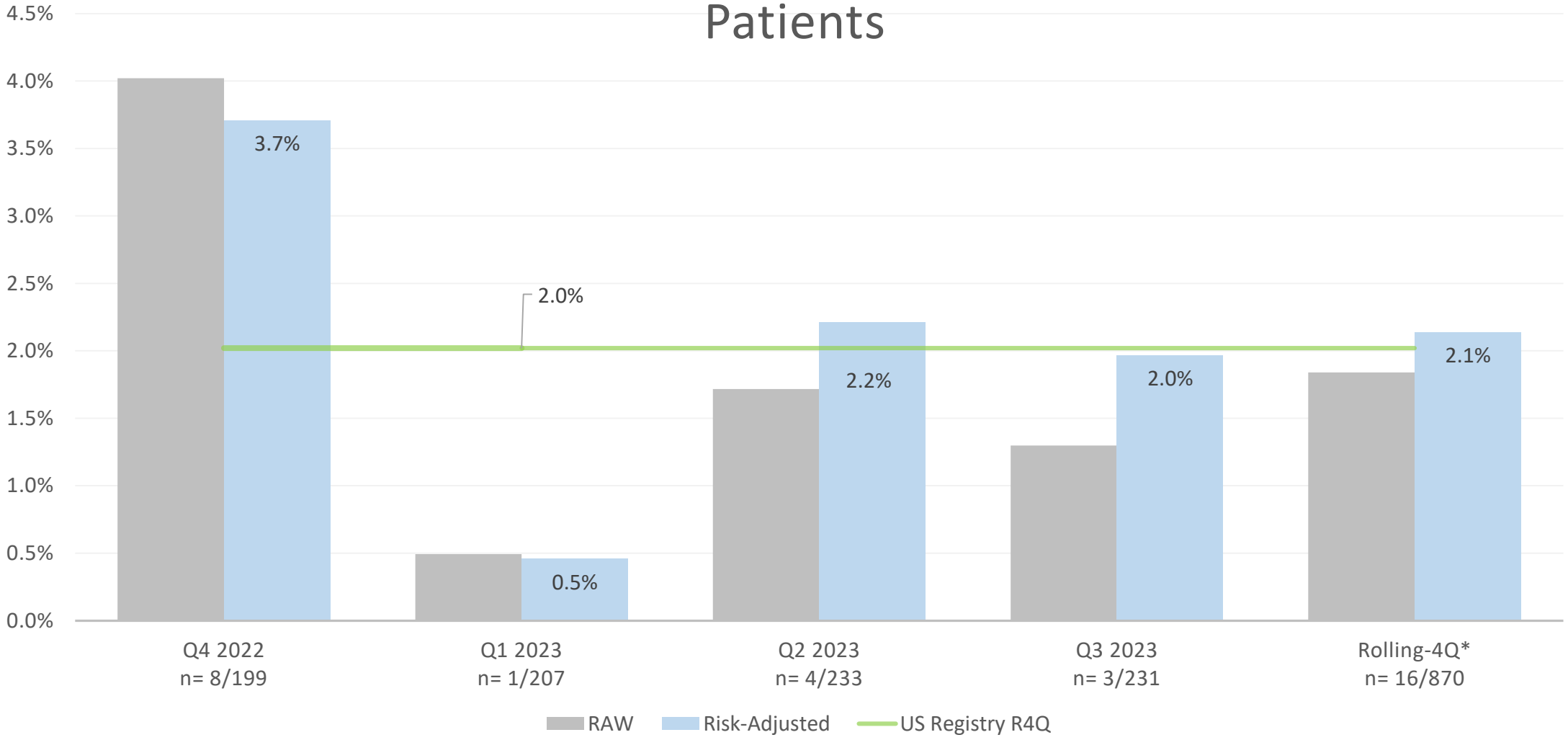
Green = National Average/Percentiles

Blue =Risk-Adjusted data

Gray = Non-Risk Adjusted Value (for Reference only)

*Comparison Reporting Period Varies per Metric

PCI In-Hospital Risk-Adjusted Mortality Rate – All Patients



R4Q Risk-Adjusted O/E = 1.06

Exclusions include patients with a discharge location of "other acute care hospital." (ref: MetricKey 13010, 13022)

***Comparison reporting period is 10/01/22 through 09/30/23. †Risk-standardized data only available for R4Q. Quarterly Data is Risk-Adjusted**

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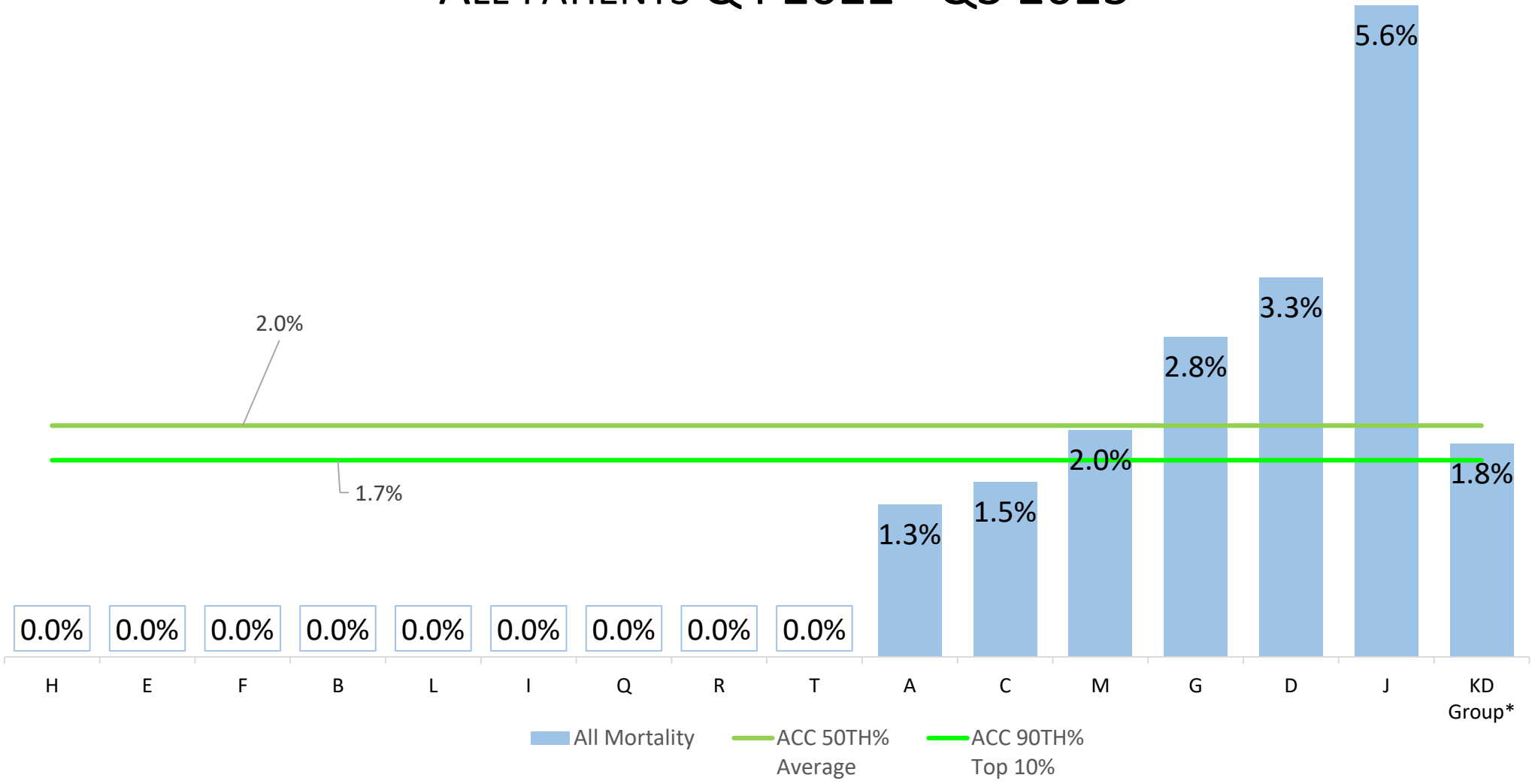
PCI Mortality[1] Rate by Physician
All patients Q4 2022 - Q3 2023



1 PCI in-hospital mortality rate for all patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

* **Comparison reporting period is 10/01/22 through 09/30/23**– Raw DATA all Quarters – NOT-RISK-ADJUSTED

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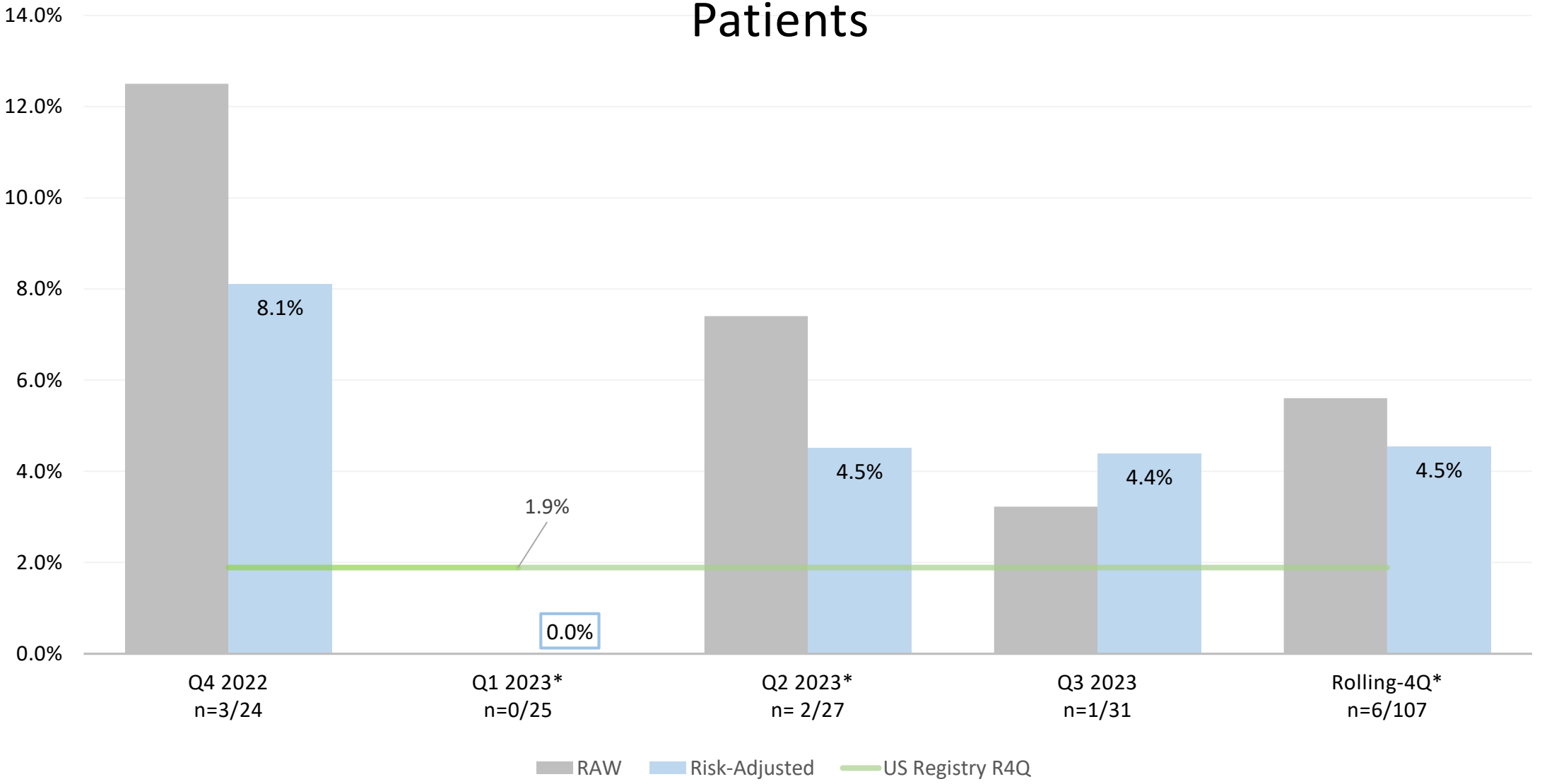
PCI In-Hospital Risk-Adjusted Mortality Rate – STEMI Patients



R4Q Risk-Adjusted O/E = 1.74

Exclusions include patients with a discharge location of "other acute care hospital", pre-op cardiogenic shock, and cardiac arrest (ref: Metric 13020, 13024, 13012)

***Comparison reporting period is 10/01/22 through 09/30/23. Quarterly data is Risk-Adjusted, %ile not available for Risk-adjusted metric only for risk-standardized**

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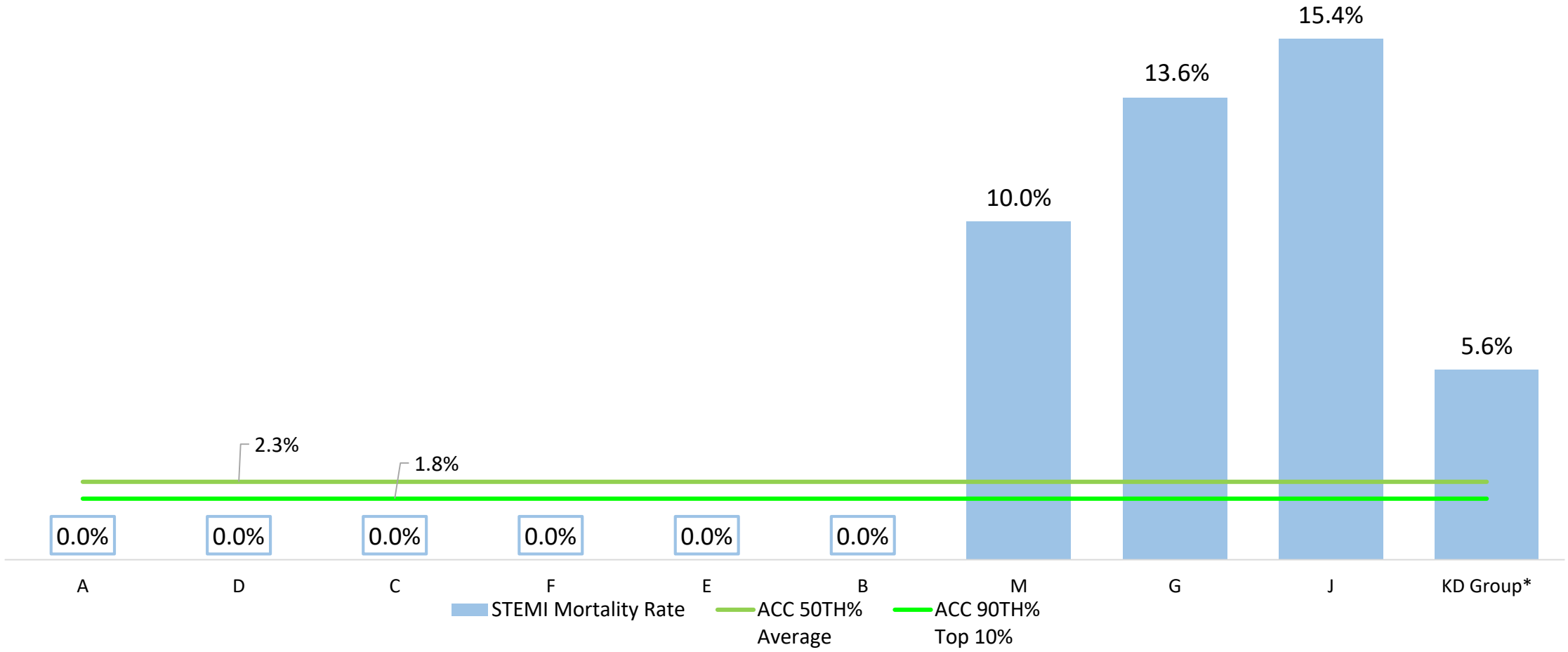
PCI Mortality[1] Rate by Physician
STEMI Patients - Rolling 4 Quarters (Q4 2022 – Q3 2023)



[1] PCI in-hospital mortality rate for STEMI patients for that MD. Exclusions include patients with cardiac arrest, cardiogenic shock, and a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*** Comparison reporting period is 10/01/22 through 09/30/23– Raw DATA all Quarters – NOT-RISK-ADJUSTED**

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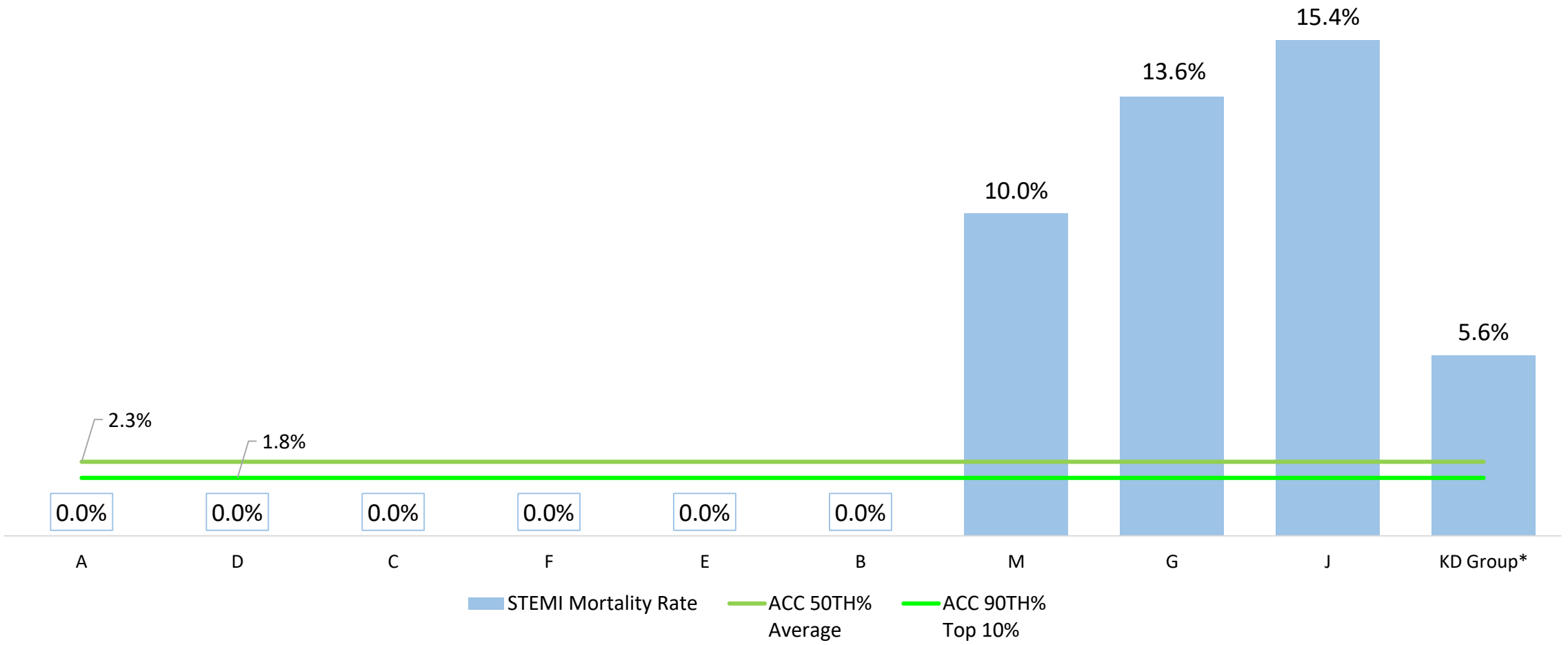
PCI Mortality[1] Rate by Physician
STEMI Patients - Rolling 4 Quarters (Q4 2022 – Q3 2023)



[1] PCI in-hospital mortality rate for STEMI patients for that MD. Exclusions include patients with cardiac arrest, cardiogenic shock, and a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*** Comparison reporting period is 10/01/22 through 09/30/23– Raw DATA all Quarters – NOT-RISK-ADJUSTED**

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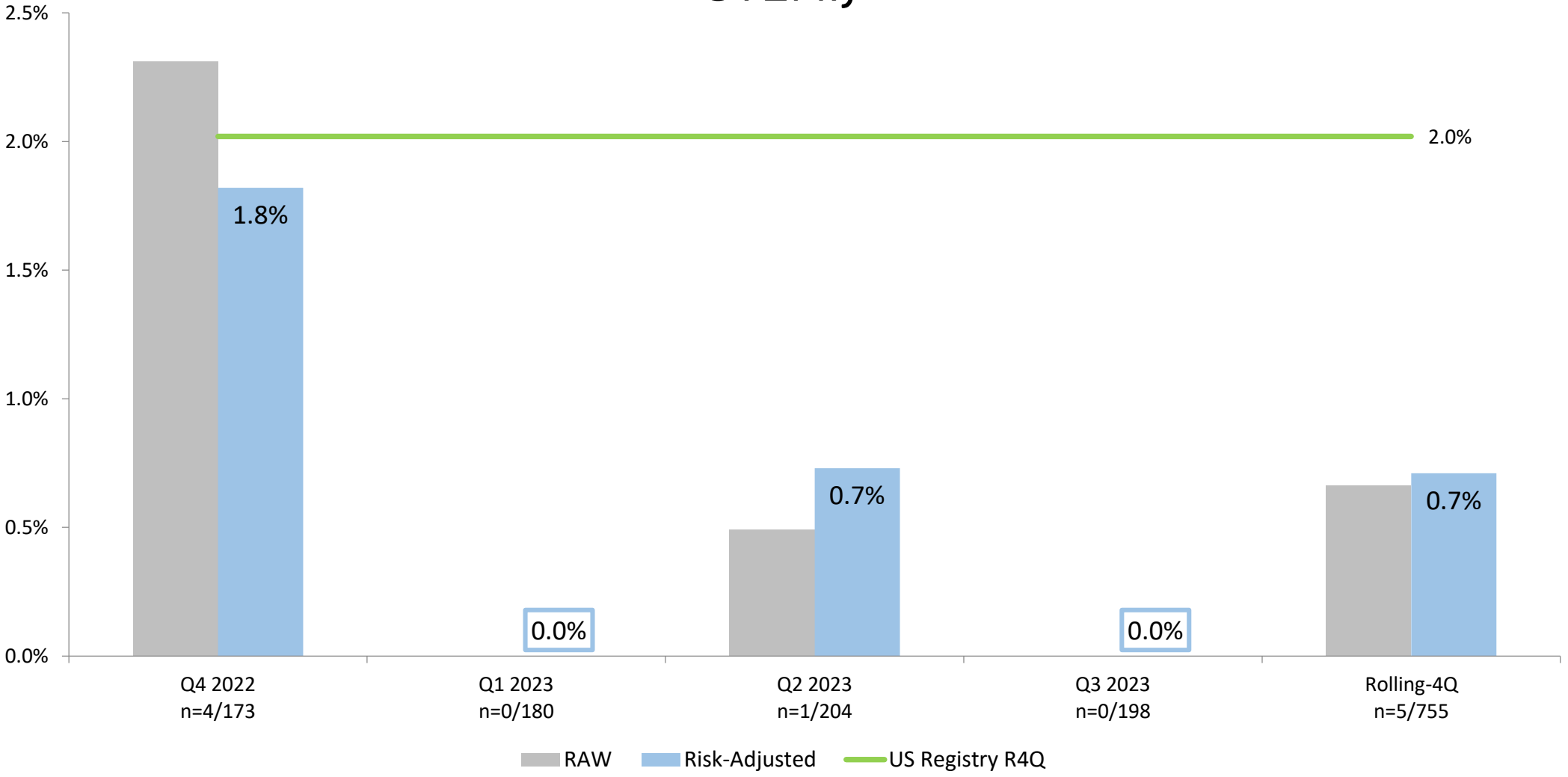
PCI In-Hospital Risk-Adjusted Mortality Rate[1] (pts w/out STEMI)



R4Q Risk-Adjusted O/E = 0.85

[1] PCI in-hospital mortality rate for all patients Excluding STEMI. Exclusions include patients with a discharge location of "other acute care hospital." (ref: , 13019)

*** Comparison reporting period is 10/01/22 through 09/30/23. Quarterly Data is Risk-Adjusted, no %ile data available, only available for risk-standardized metric**

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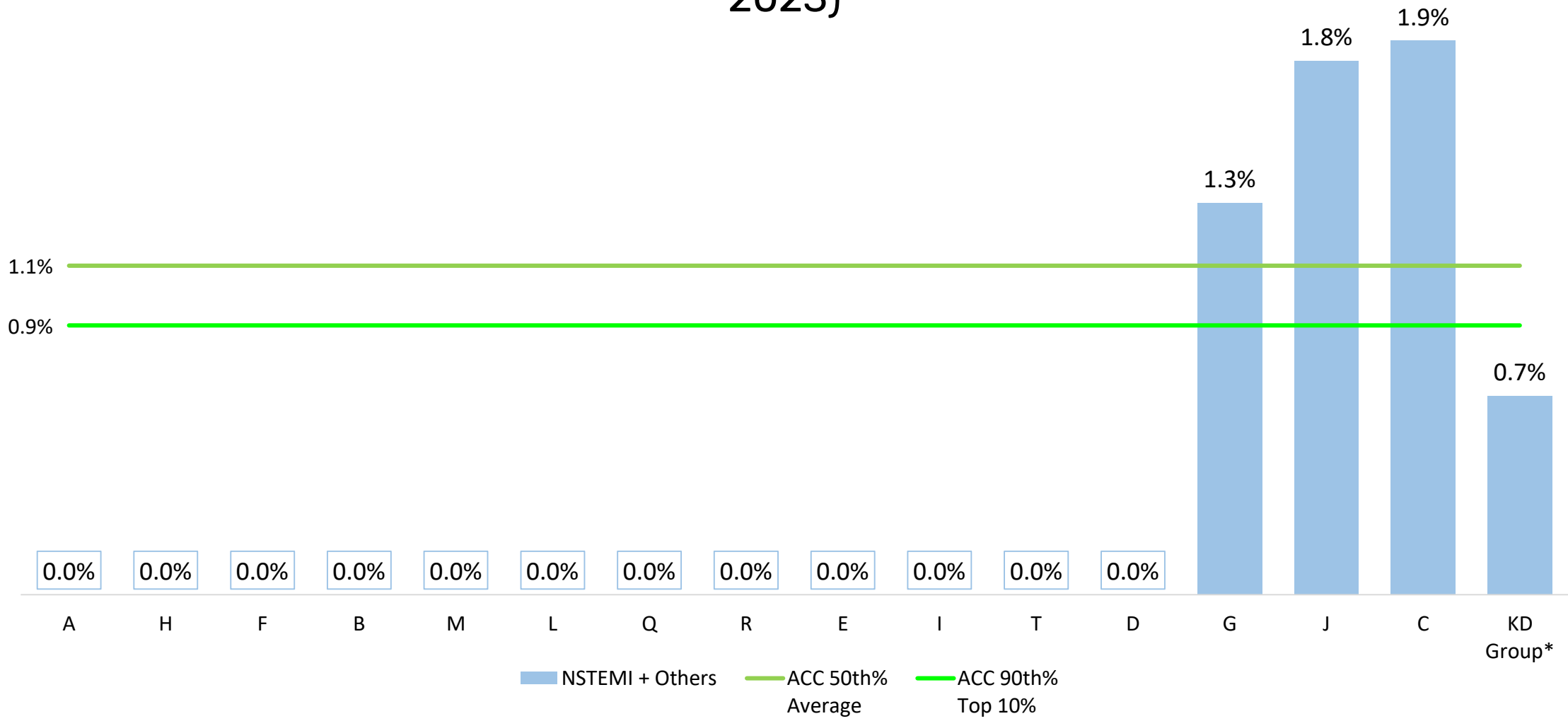
PCI Mortality[1] Rate by Physician
N-STEMI, USA, Elective Patients - Rolling 4 Quarters (Q4 2022 – Q3 2023)



[1] PCI in-hospital mortality rate for N-STEMI, USA, Elective patients for that MD. Exclusions include patients with a discharge location of "other acute care hospital." (ref: NCDR/ACC Physician Dashboard)

*** Comparison reporting period is 10/01/22 through 09/30/23– Raw DATA all Quarters – NOT-RISK-ADJUSTED**

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STEMI Triage Guidelines

Thoughtful Pause

➢ Should go to CVICU first, not the Cath Lab

- Cardiac Arrest with CPR ≥ 20 minutes and un/minimally responsive
- Cardiogenic Shock, age ≥ 80
- STEMI ≥ 24 hours without Chest Pain
- Excess risk of bleeding (e.g. active internal bleed, ICH<3 mos, Hct<22, PLT<30K)
- Altered Mental Status
- Apparent sepsis or other conditions (other than pure cardiogenic shock) that would markedly increase the risk of dying within 30 days
- Pre-existing DNR / No Code Status

❖ Consider lytic agents for symptoms < 3 hours, anticipated DTB time > 120 minutes and low risk of bleeding

❖ These are intended as guidelines, not to supersede clinical judgement

*Adopted from the Cleveland Clinic Heart Institute: Triage Guidelines for STEMI patients.

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Predicted Mortality Model

Elements included in the Mortality Risk Adjustments- v5

- Age, Gender
- Cerebral Vasc. Disease
- Peripheral Vasc. Disease
- Chronic Lung Disease
- Previous PCI
- In-stent Thrombosis w/in 30 days of prior PCI
- Diabetes Mellitus
- CHSA Clinical Frailty Scale
- NYHA Class I/II/III/IV
- Kidney Disease (pre-op creatinine)
- Renal Failure (Dialysis)
- Left Ventricular Ejection Fraction
- Systolic Blood Pressure
- Cardiac Arrest - timing
  - Responsiveness after arrest, prior to PCI
- Surgical Treatment recommendation
- Aortic Stenosis
- STEMI (any timing or stability)
- PCI of Left Main or Proximal LAD
- PCI Status
  - Salvage PCI
  - Refractory Cardiogenic Shock
  - Cardiogenic Shock
  - Acute Heart Failure
  - Emergent, urgent, elective
  - Cardiovascular Instability

*Risk Factors taken from the American College of Cardiology Metrics #48-51: PCI in-hospital Risk Standardized Mortality Risk Model for Predicted Mortality: version 5 (Release date 1/25/2022)

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Quality Initiative

Treatment Algorithm for Invasive Cardiac Procedures

- Targeted Temperature Management
  - Immediate hypothermia measures to be implemented on cardiac arrest patients
- 12-Lead ECG must be done within 10 minutes of arrival to hospital
- ACT initiated – (Do not delay cooling measures)
  - Assessment for unfavorable resuscitation features
  - Consultation between ED, Critical Care and Cardiology physicians
  - Transport to Cath Lab urgently when consensus reached

*Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." Journal of the American College of Cardiology 66.1 (2015): 62-73.

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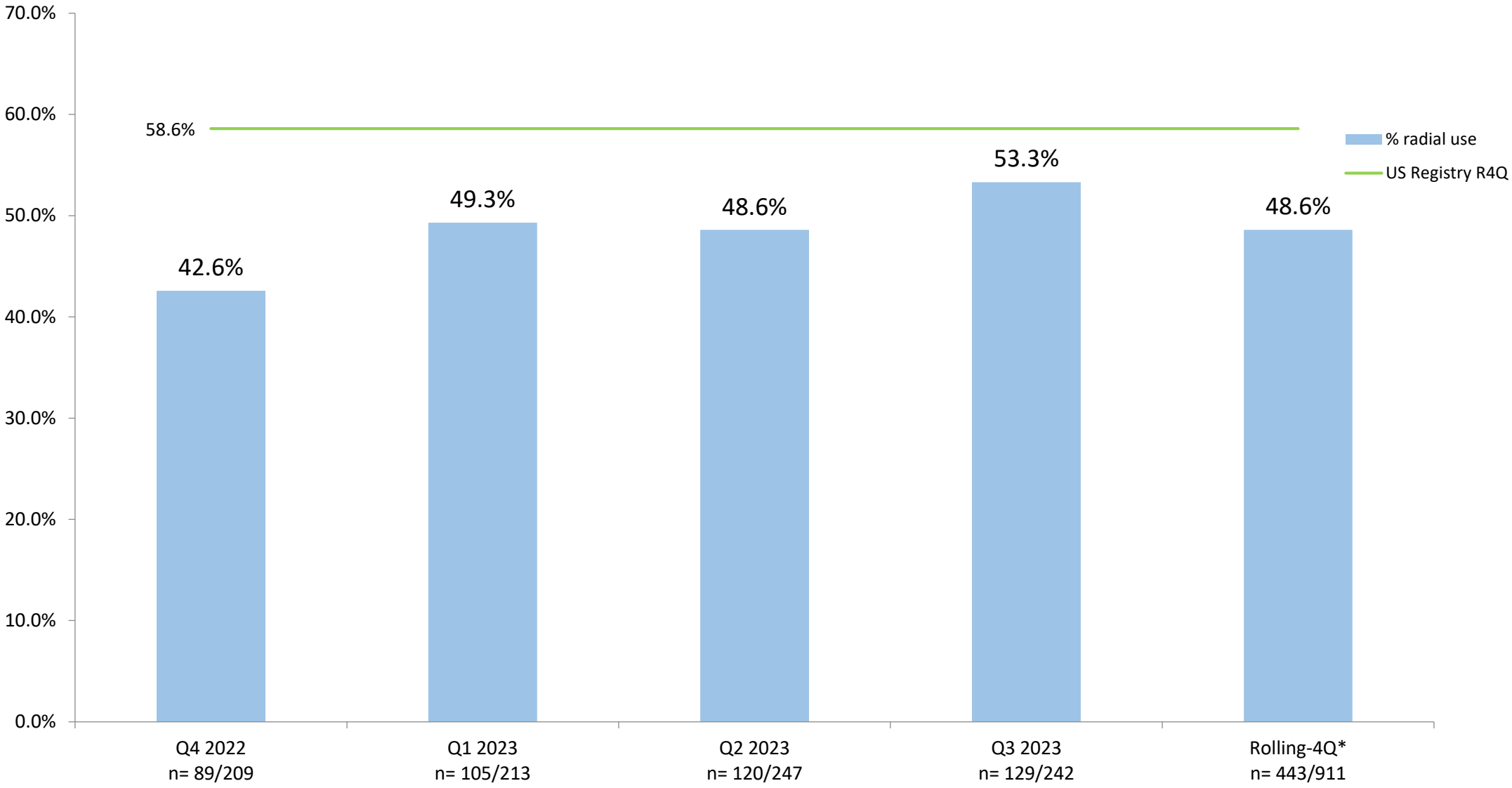
Quality Initiative

Vitally Important Ethical Steps

- Physician collaboration & coordination between departments is required
- Cardiologist must participate in all thoughtful pause discussions
- ED physician and Cardiologist will consult with an Intensivist as needed for difficult cases
- Intensivist will respond to the ED for thoughtful pauses as requested
- Thoughtful pause must be documented in patient's EMR by a Provider
- Honest communication between all parties is required to maintain transparency and trust. Families must be given aggressive treatment options with their corresponding prognosis or futility
- Ethical issues are unavoidable in the care of critically ill patients but we must maximize our ethical decision-making
  - Clinical judgments of the multidisciplinary physicians must be observed whenever possible
  - Diagnostic tools and data must be readily available for discussion in real time so that critical decisions can be made quickly
  - Additional research into emerging data on this topic and diagnostic tools to keep our patients receiving state of the art care
  - Transparent discussions at the practice and policy making levels about what characterizes appropriate or futile care
  - Assessing patient wishes, respecting DNR and advanced directives even in times of family crisis and proxy decision makers
- Lastly and importantly, frank and honest discussions with families as to what is futile care

*Rab, Tanveer, and Karl B. Kern. "Cardiac Arrest A Treatment Algorithm for Emergent Invasive Cardiac Procedures in the Resuscitated Comatose Patient." Journal of the American College of Cardiology 66.1 (2015): 62-73.

PCI Radial Artery Access



R4Q O/E = 1.2
(ref: NCDR Detail Line 4163) When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.
*** Comparison reporting period is 10/01/22 through 09/30/23**

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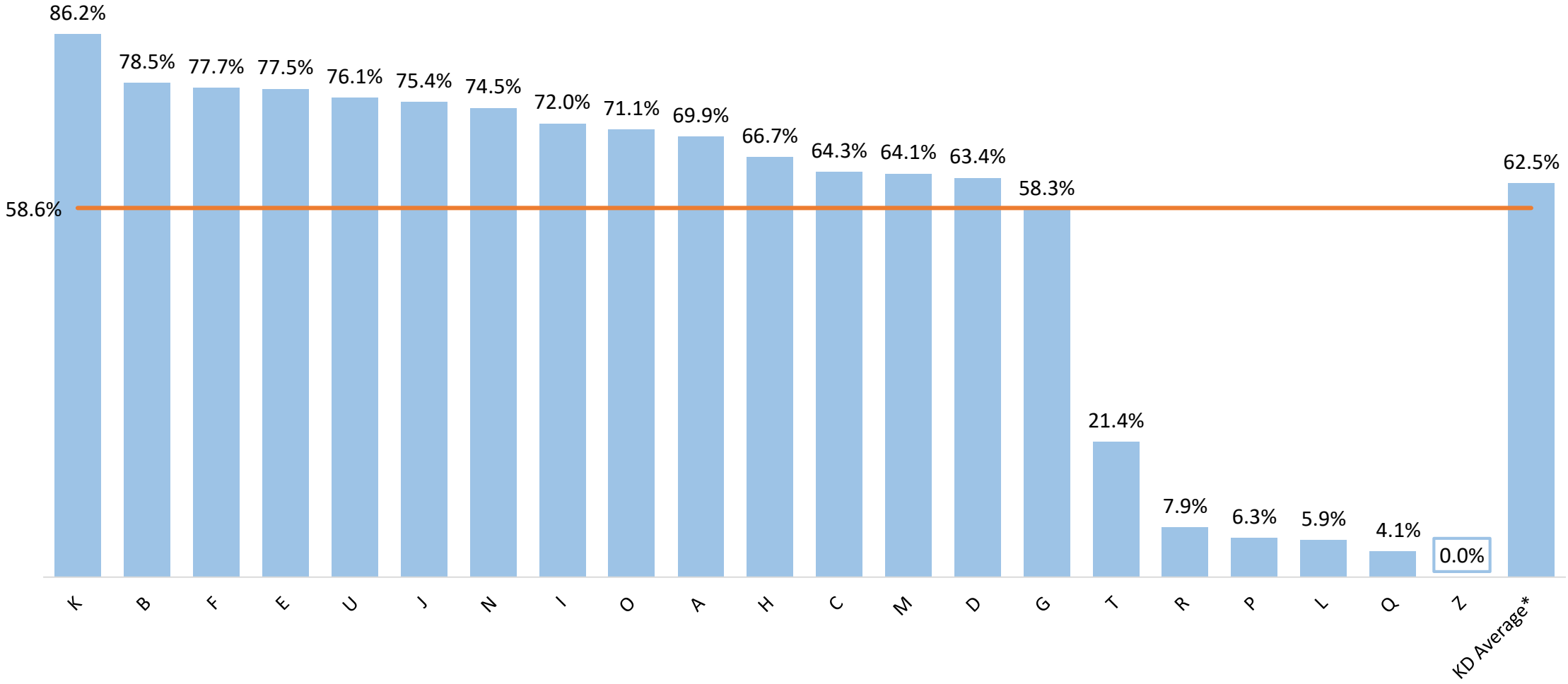
All Caths Radial Artery Use[1] by Physician
Rolling 4 Quarters (Q4 2022– Q3 2023*)



[1] PCI & Diagnostic Cardiac Catheterization Procedures - Arterial Access Site equaling "Radial" for all patients for that MD. No Exclusions; Pt.'s with an aborted Radial attempt included in denominator (ref: SENSIS Statistical Manager) When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

*** Comparison reporting period is 10/01/22 through 09/30/23 – *ALL RAW DATA**

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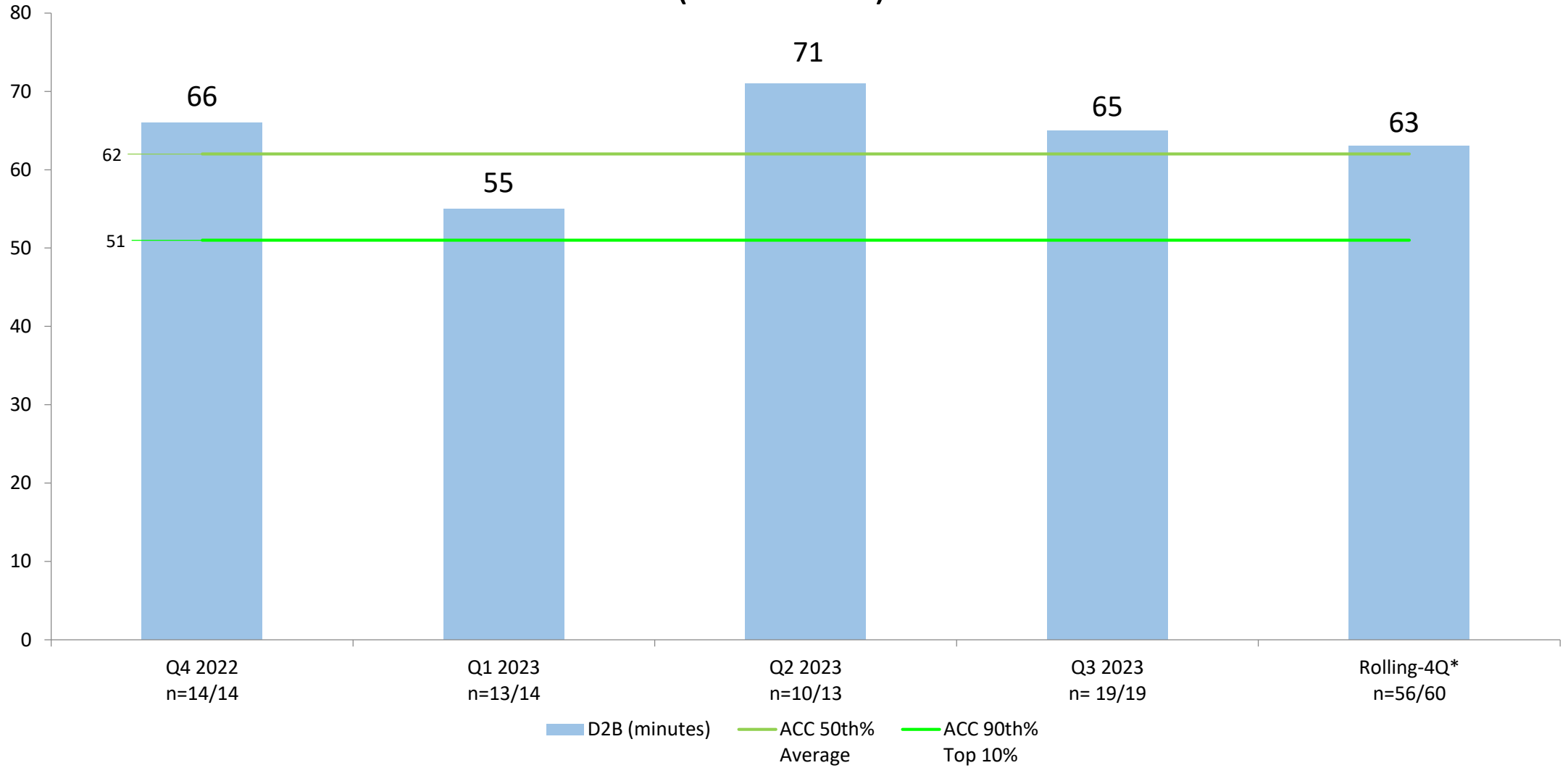
IMMEDIATE PCI FOR STEMI (IN MINUTES)[1]



R4Q O/E = 1

[1] Median time frame from hospital arrival to immediate PCI for STEMI pts in minutes. Exclusions: Patients transferred in from another acute care facility; Reasons for delay does not equal none. N= pt.'s receiving PCI within 90 minutes. (ref: Metric 3, 4448)

*** Comparison reporting period is 10/01/22 through 09/30/23**

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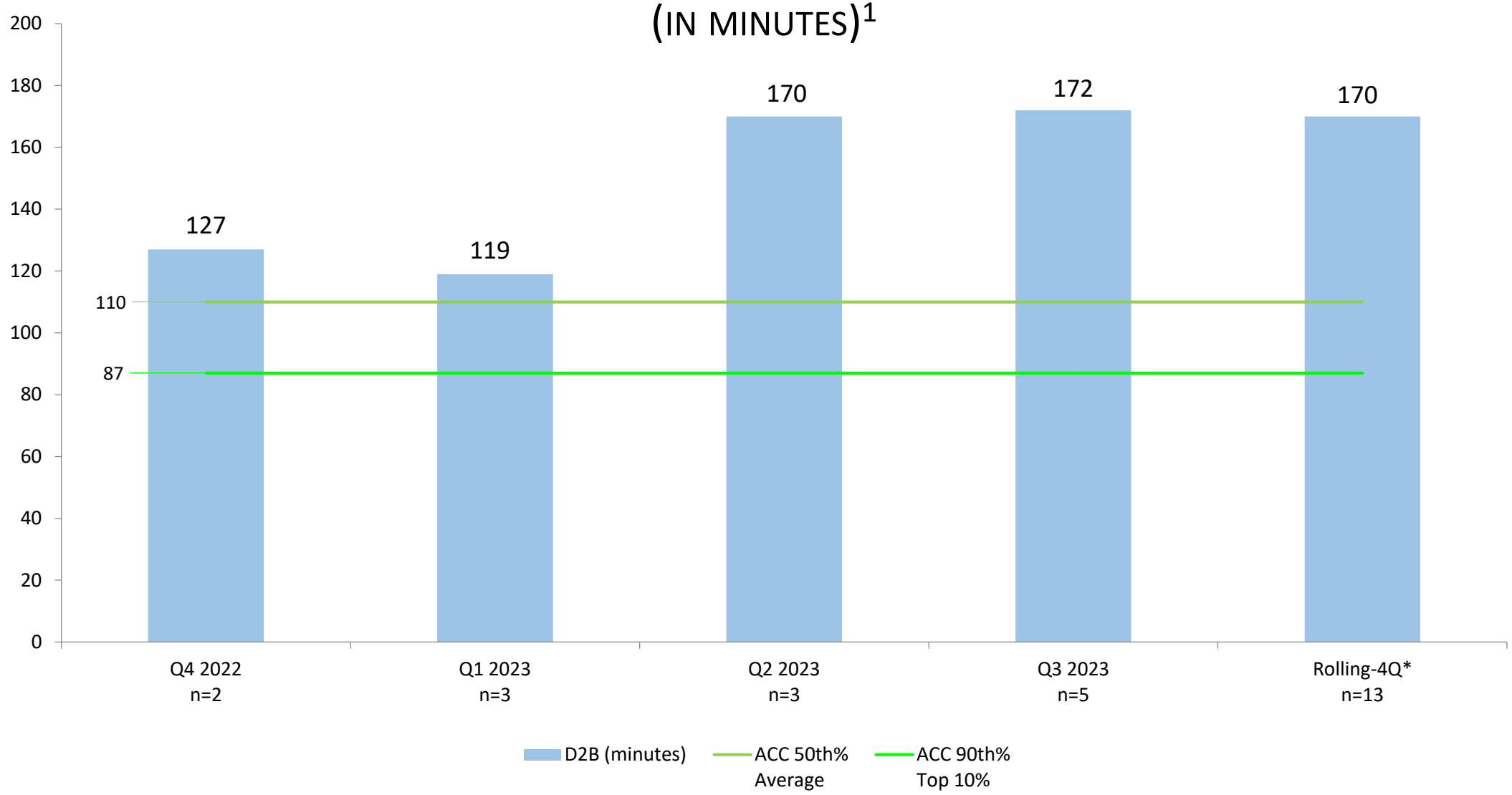
Immediate PCI for STEMI Transfers (in minutes)[1]



R4Q O/E = 1.5

[1] Median time from ED arrival at STEMI transferring facility to immediate PCI at STEMI receiving facility among transferred patients (excluding reason for delays); Reasons for delay does not equal none. (ref:4452, 10888)

* Comparison reporting period is 10/01/22 through 09/30/23

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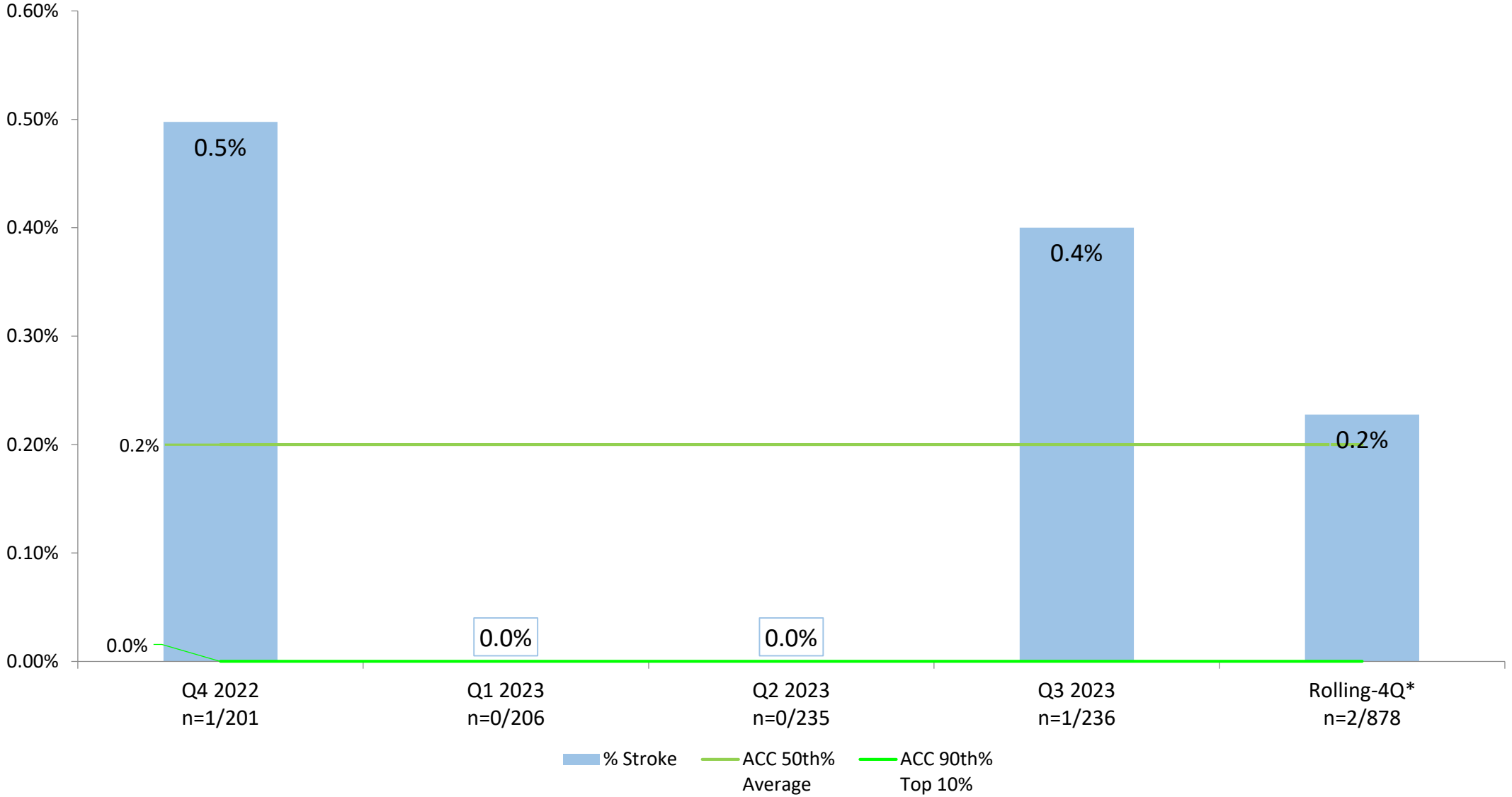
Quality Initiative

Best Practice in Door To Balloon

- 4 Staff on call at all times (initiated Fall 2020)
  - Crew response time of 20 minutes
- Recognition of staff: Monthly fastest Door to Balloon award to incentivize staff
- Cardiac Alerts to be called at the time of leaving transferring hospitals
- Initial ED EKG to be placed in EMR or Tracemaster immediately
- STEMI taskforce with ED, Quality and Cath Lab to review ED STEMI hand off practices
  - Including STEMIs called in the field and from other facilities
- Cardiac Alerts called within 10 minutes of ED arrival unless Thoughtful Pause is documented

STROKE POST PCI[1]



R4Q O/E = 1.1

[1] Exclusions: Patients with an Intervention this admission (Surgery, EP, Other); Pt's discharged to *Other Acute Care Facility* (ref: 4235)

*** Comparison reporting period is 10/01/2022 through 09/30/2023**

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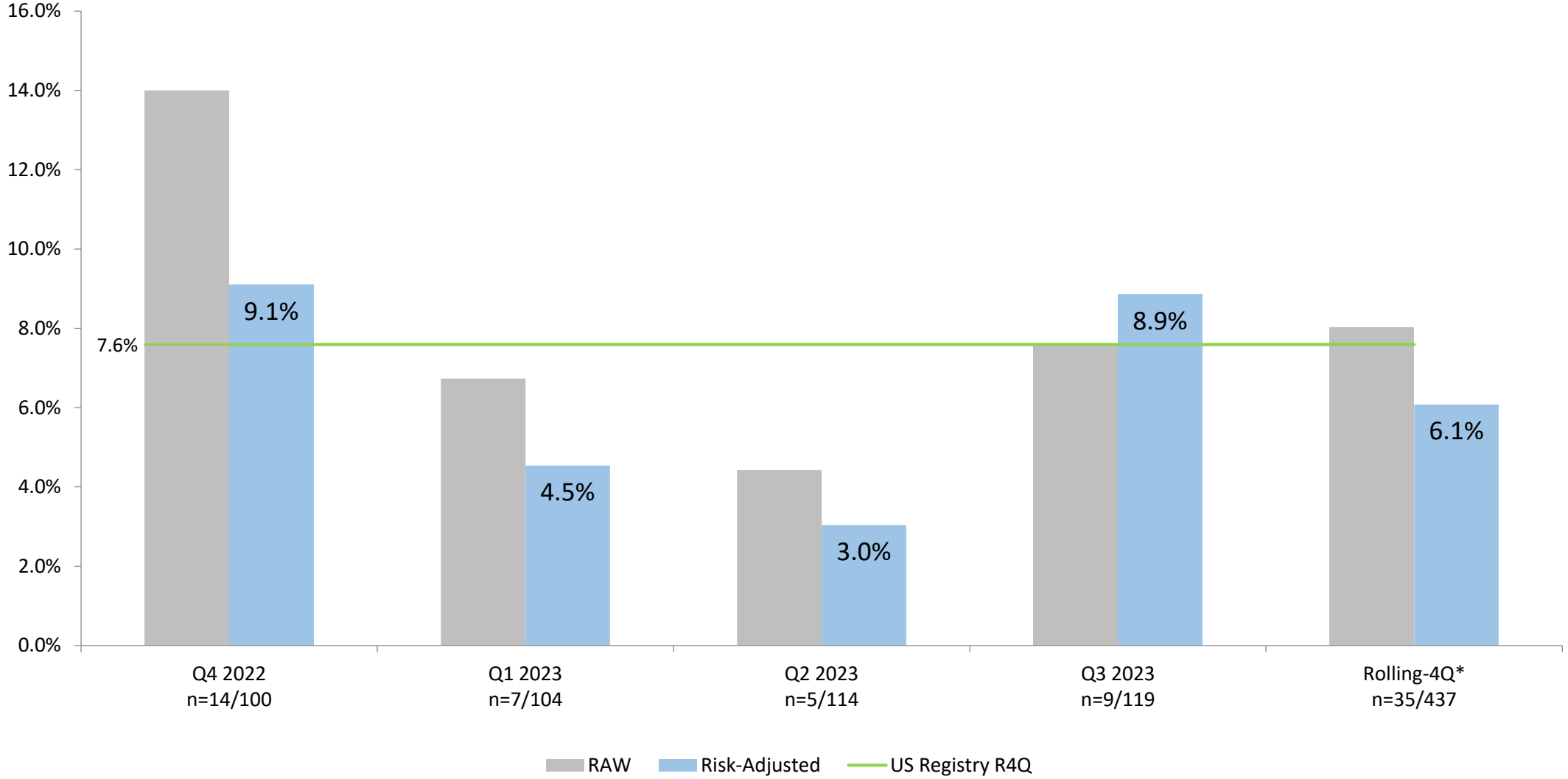
Quality Initiative

Stroke Recognition and Treatment

- Assess Stroke Risk factors in PCI for each patient
- Age, gender, history of CVA, End Stage Renal Disease, Diabetes, Hypertension, Peripheral Vascular Disease, Smoking, Congestive Heart Failure, Atrial Fibrillation, CABG surgery or emergent PCI
- Rapid recognition of stroke symptoms in Cath Lab
- Use of the clear protocol for recognition and interventions will facilitate efficient care in the unlikely event of a stroke in Cath Lab

Risk-Adjusted Acute Kidney Injury[1] Post PCI



R4Q Risk-Adjusted O/E = 0.8

[1] Proportion of pt.'s with a rise of serum creatinine of > 50% or ≥0.3 mg/dL over the pre-procedure baseline; all pt.'s w/ New Requirement for Dialysis. Exclusions: pt.'s on dialysis pre-procedure; pt.'s second PCI within this episode of care; same day discharges. (ref: 15663)

*** Comparison reporting period is 10/01/2022 through 09/30/23 %ile data only available for risk-standardized metric**

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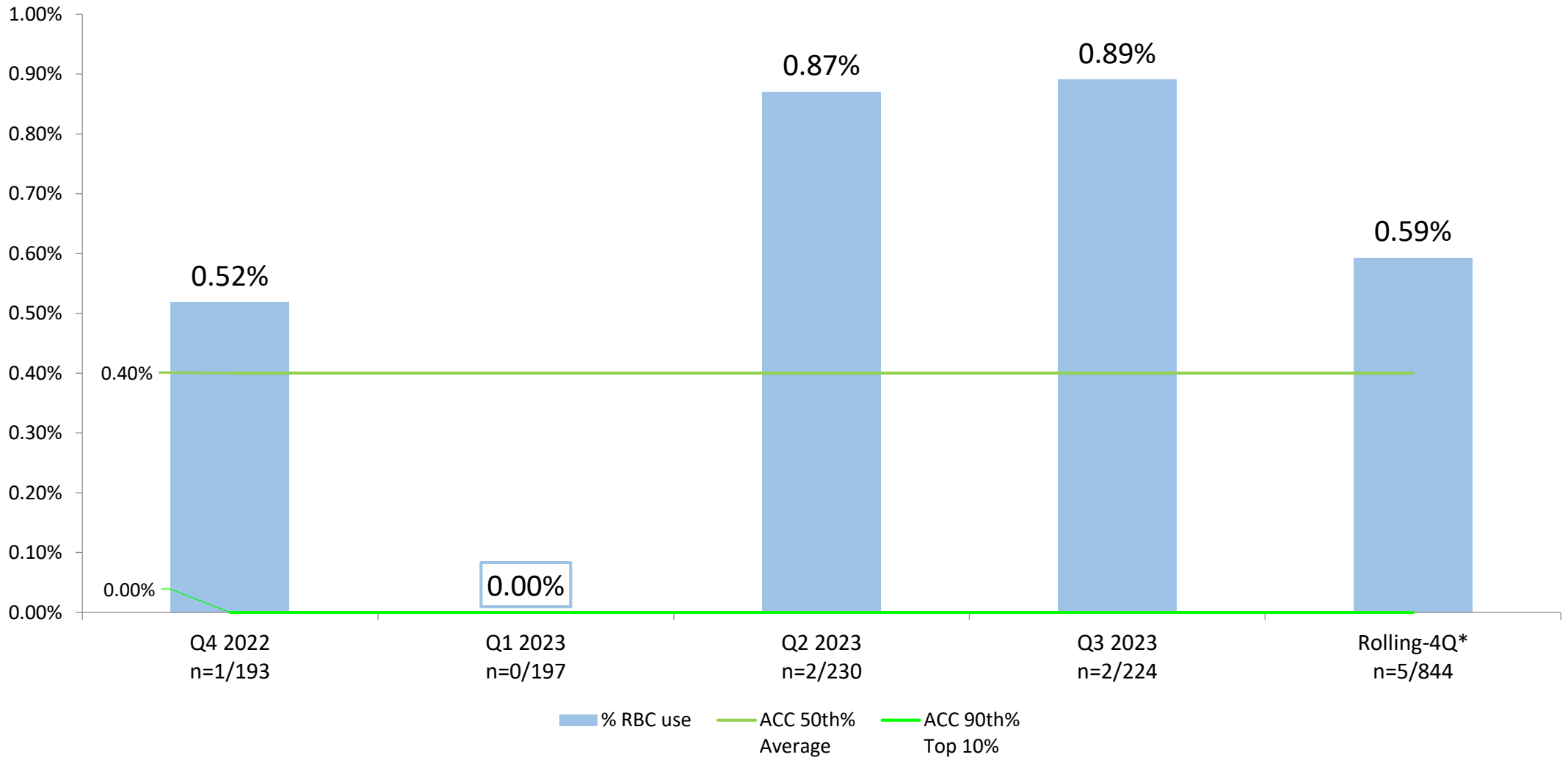
Quality Initiative

Acute Kidney Injury

- Renal impairment = estimated glomerular filtration rate ≤ 60mL/min
- Hydration Needs
  - Pre procedure: Normal Saline at 250 ml/hour to be started upon arrival
  - Intra procedure:
    - LVEDP <18 → NS 500 mL/hr for 4 hours
    - LVEDP >19 → NS 250 mL/hr for 4 hours
  - Post procedure: Normal Saline at 250 ml/hour for 6-24 hours
- Outpatients; increase in oral hydration encouraged the day before arrival. Patients are encouraged to drink clear liquid up to 2 hours prior to procedure
- Post procedure labs must be ordered; Metabolic panel one day post procedure
- Track and Report contrast utilization for Diagnostic and Interventional procedures

*Merschen, Richard. "An Overview of Chronic Kidney Disease and Useful Strategies for Clinical Management." Cath Lab Digest, Mar. 2012. http://www.cathlabdigest.com/articles/Overview-Chronic-Kidney-Disease-Useful-Strategies-Clinical-Management

TRANSFUSION POST-PCI OF RBCS[1]



R4Q O/E = 0.8

[1] Proportion of pt.'s who receive a transfusion of whole blood or RBCs during or after, but within 72 hours of PCI procedure.
Exclusions: Patients on dialysis; EP study or CABG or other major surgery during the same admission; Pt.'s with a pre-procedure hemoglobin <8g/dL or no value. (ref: Metric 25, 4288)

*** Comparison reporting period is 10/01/22 through 09/30/23**

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KAWEAH HEALTH POLICY (TR-036)

GUIDELINES FOR USAGE OF BLOOD PRODUCTS (RELEASE CRITERIA)

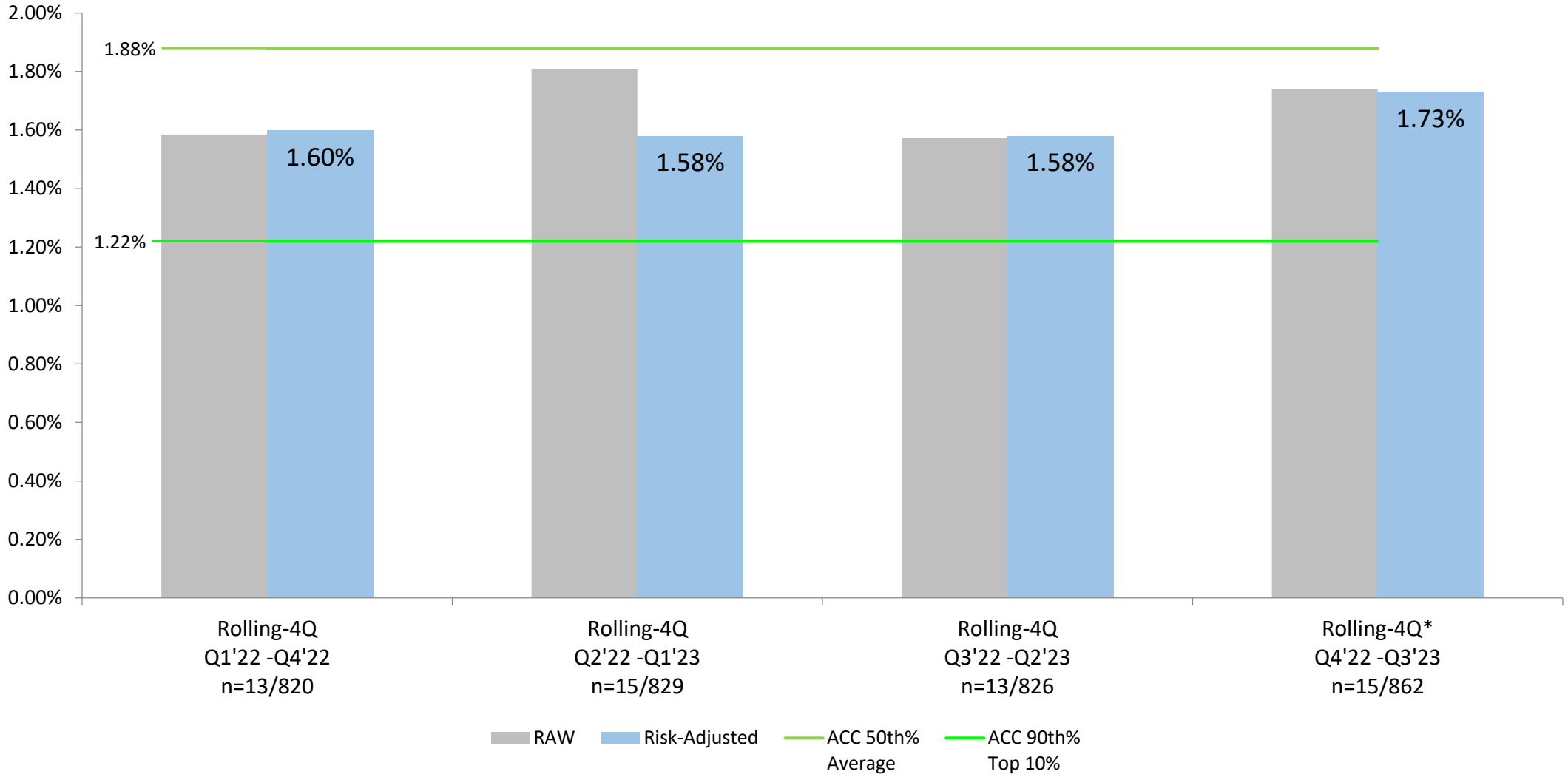
DATE APPROVED: 12/13/2022

A. Pre-transfusion hematocrit of less than 24% or hemoglobin less than 8 grams/dl.

B. Transfusion may be administered when hemoglobin levels are 8-10 grams/dl in the following circumstances:

1. Acute Blood Loss/Active Bleed
2. Presence of Symptomatic Anemia
3. HGB <9 w/ Chemotherapy
4. HGB <10 w/ Radiation Treatment

Risk Standardized Bleeding Rate[1]



R4Q Risk standardized bleeding ratio = 0.77 [1] Pt's with a Bleeding event defined as 1) occurring within 72 hours of procedure (Bleeding at access site, hematoma at access site, retroperitoneal bleed, GI, GU or any transfusion) 2) occurring during hospitalization (hemorrhagic stroke, tamponade, Hgb drop ≥4 g/dL requiring transfusion, or a procedural intervention/surgery to reverse/stop or correct the bleeding) Exclusions: subsequent PCI procedures, death w/in 24 hours, CABG this hospitalization, transfusion in presence of mechanical support. (ref: Metric 40, 4934)

* Comparison reporting period is 10/01/22 through 09/30/23

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Quality Initiative

Bleeding Reduction Protocol

- Establish a vascular site protocol in accordance with SCAI safe femoral access guidelines
  1. Radial as Primary Access Site
  2. Use of Ultrasound Guidance for accessing the artery
  3. Use of Fluoroscopy to mark the Femoral head
  4. Micro puncture needle used as standard device

- Hemostasis Management Best Practices standardized for Post Procedure Bleeding and Sheath Removal
  - Education Program on Hemostasis Management & Early Recognition of Post-op Bleeds
    - Includes recognition of signs and symptoms of bleeding & Standardized Communications between:
      1. The procedure team and physician emphasizing the quality of the groin stick and use of sealant devices
      2. The procedure team and post-op nurse emphasizing the vascular access site assessment

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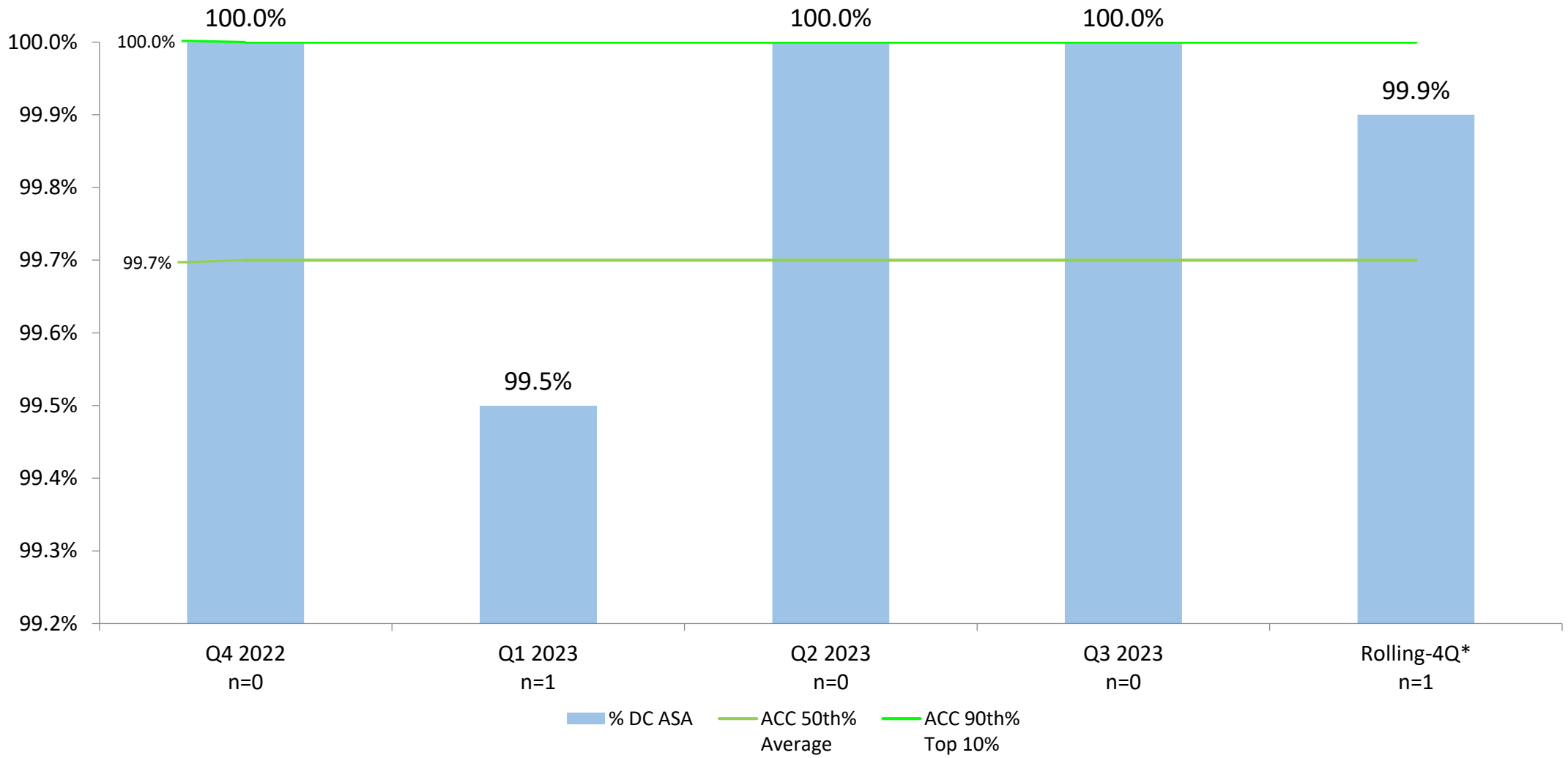
Quality Initiative

Bleeding Reduction Protocol (cont.)

- Manual sheath removal
  - Hold manual pressure minimum of 20 minutes
  - Frequent vital signs and distal pulse monitoring
  - Diligent vascular access site assessment
  - Assess Patient for pain
- Vascular sealant device
  - Hold manual pressure minimum of 5 minutes
  - Frequent vital signs and distal pulse monitoring
  - Diligent vascular access site assessment
  - Assess patient for pain
- RN Education: Mandatory self study presentation (Post Study test must be completed)
  - Added to Nursing Unit Annual Competency
  - Added to core curriculum nursing education (Cardiac and CVICU units)
    - 4 Tower, 2 North, 3 West, CVICU, ICU and CVICCU.
- Post-PCI Bleed Mock Simulation performed 2/year. In the skills lab and the nurses home unit

ASA Prescribed at DC[1]



R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed aspirin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: Metric 8, 4702)

*** Comparison reporting period is 10/01/22 through 09/30/23**

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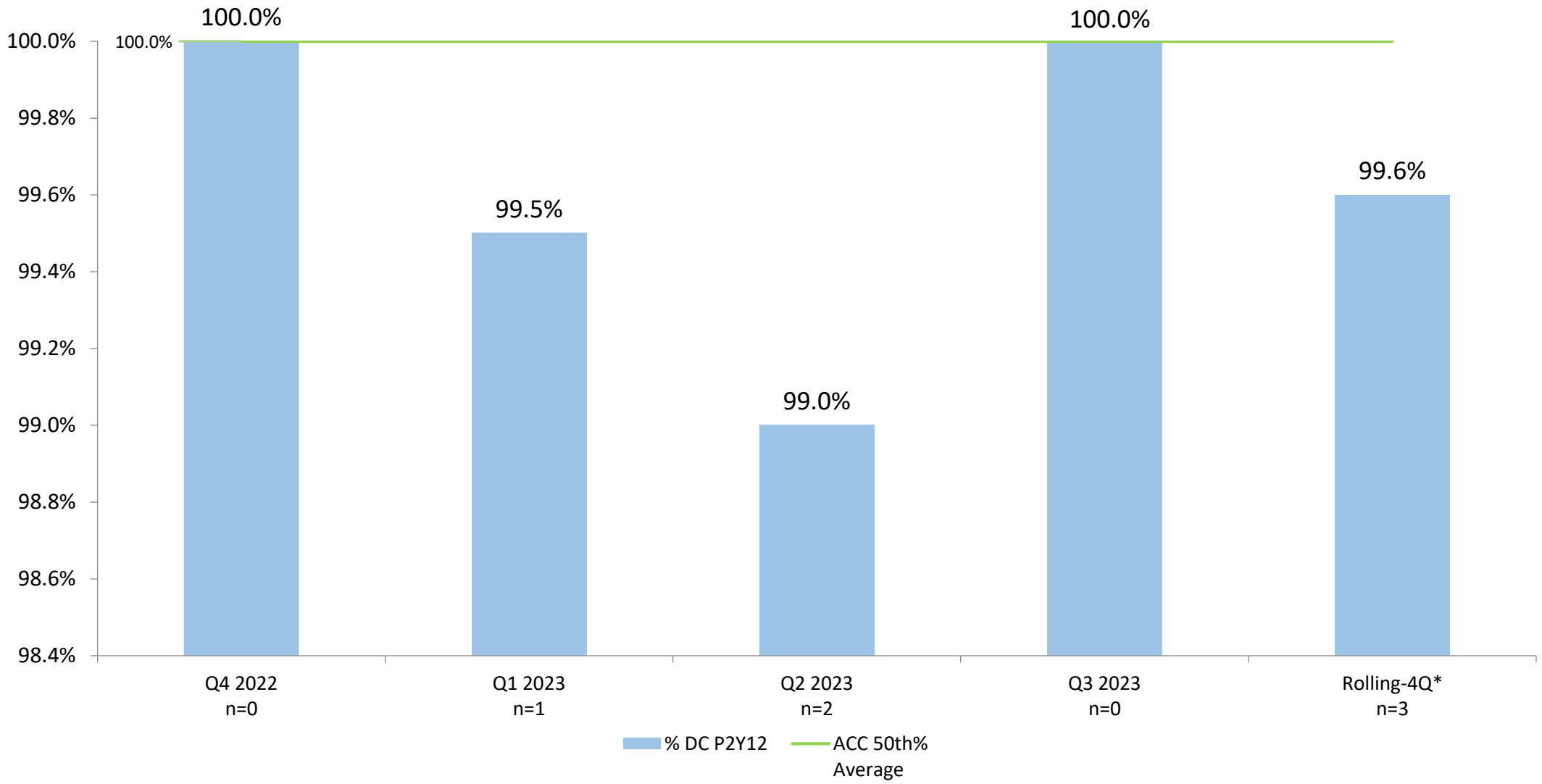
P2Y12 Inhibitor Prescribed at DC[1]



R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a cardiac stent placed that were prescribed a thienopyridine/P2Y12 inhibitor at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths (ref: Metric 9, 4711)

*** Comparison reporting period is 10/01/22 through 09/30/23**

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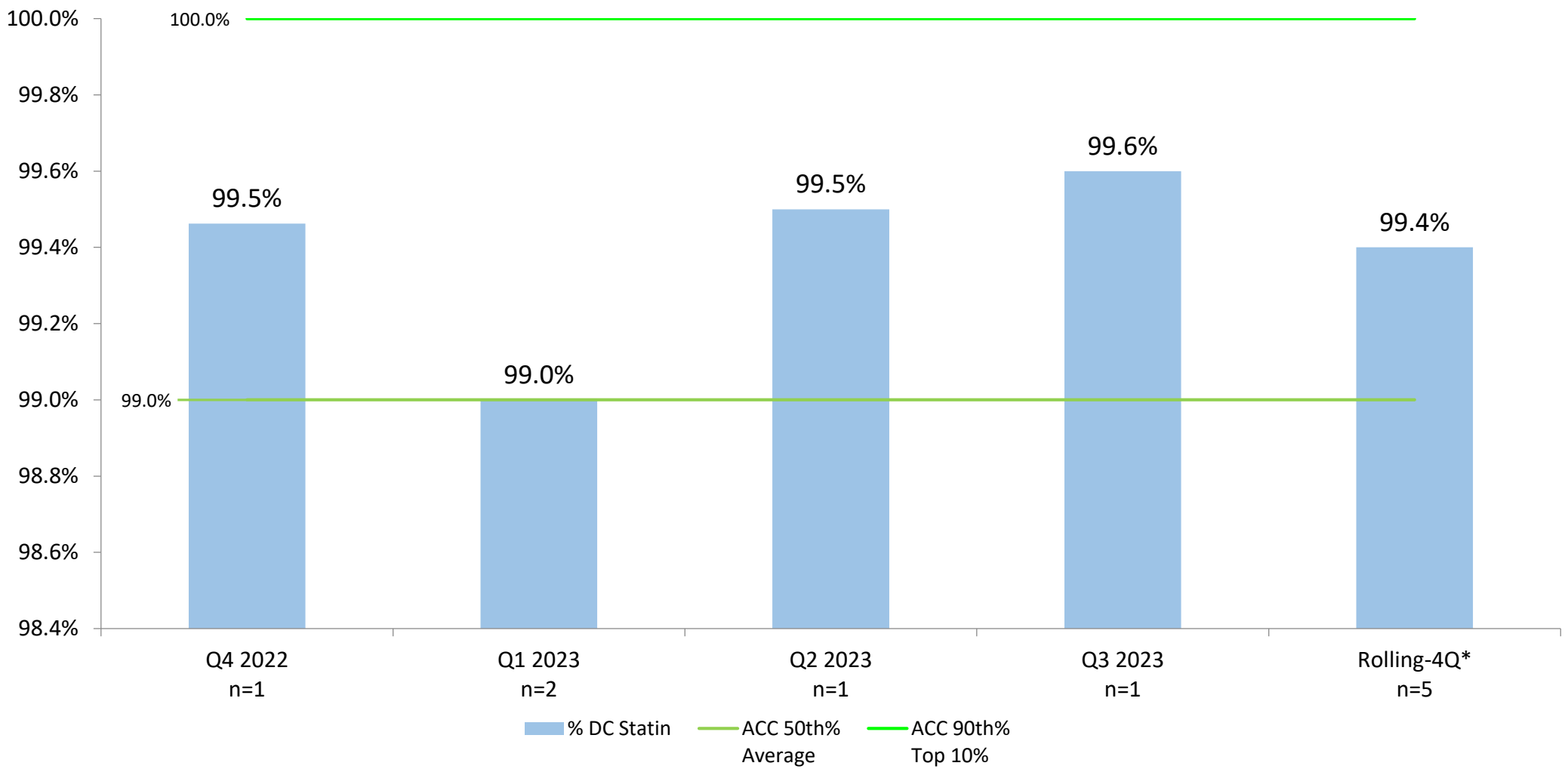
STATINS PRESCRIBED AT DC[1]



R4Q O/E = 1.0

[1] Proportion of pt.'s (without a documented contraindication) with a PCI attempted or performed that were prescribed a statin at discharge. Exclusions: pt.'s that were discharged on Comfort Measures only; discharged to "Other acute care hospital", "Hospice", "Left against medical advice (AMA)" or deaths. (ref: 4707)

*** Comparison reporting period is 10/01/22 through 09/30/23**

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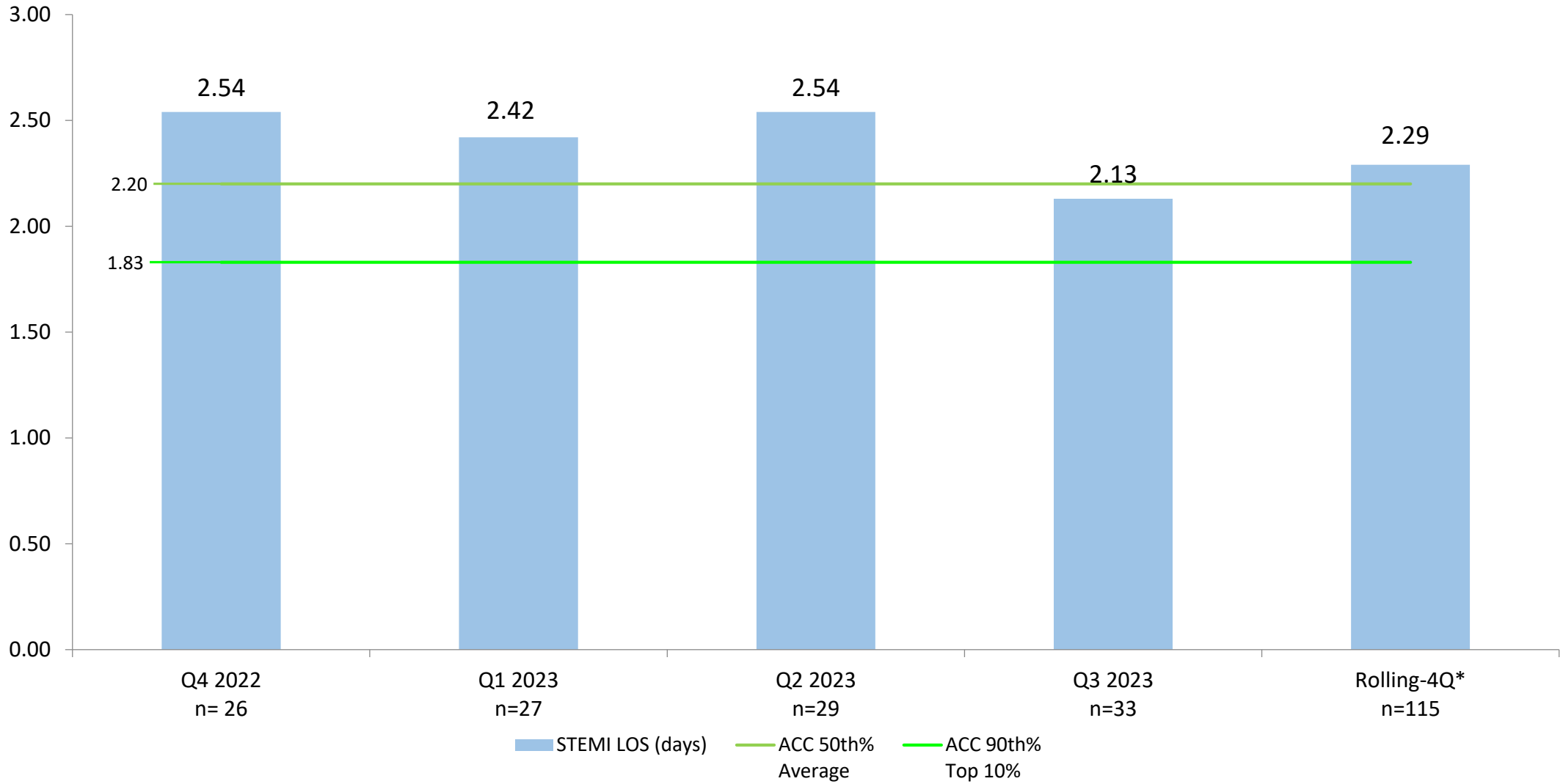
Quality Initiative

Discharge Medications

- Implement PCI specific Discharge Order Set
- Educate Hospitalists and Nurse Practitioners on importance of specific discharge medications in this patient population and utilization of new Order Set.
- Track utilization of Order Set & track fallouts
- Continue to contact Lead Hospitalist, Lead Nurse Practitioner with all fallout specifics
- Improve Clinical documentation in the Discharge Summary of any contraindications
- Improve Clinical documentation in the Discharge Summary clarifying any pending diagnosis (i.e. possible NSTEMI, possible MI)

POST-PCI LENGTH OF STAY[1] – STEMI



R4Q O/E = 1.1

[1] Median Post-procedure length of stay in STEMI patients. Exclusions: pt.'s discharged to Another Acute Care Facility; death during procedure (ref:4340, 10894)

*** Comparison reporting period is 10/01/22 through 09/30/23**

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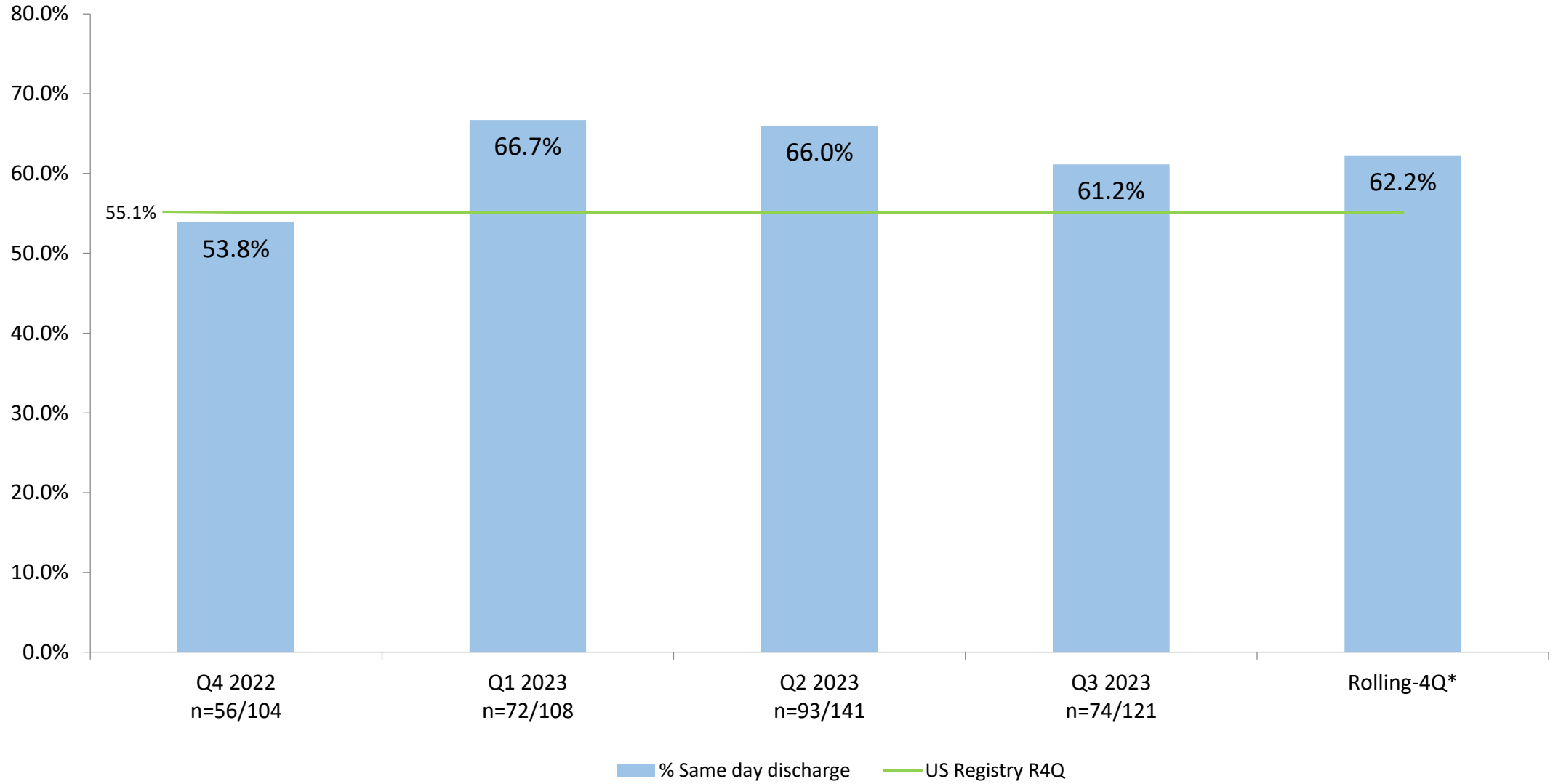
POST-PCI SAME DAY DISCHARGE - ELECTIVES



R4Q O/E = 1.1

[1] Elective scheduled patients discharged on the same day as procedure. Exclusions: mortalities and pt.'s discharged to Another Acute Care Facility or AMA (ref:4971, 15645)

When no Percentile rankings are available, US Like Volume Group R4Q Averages are used for comparison purposes.

*** Comparison reporting period is 10/01/22 through 09/30/23**

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Outstanding Health Outcomes Update

Sandy Volchko DNP, RN, CPHQ, CLSSBB
Director Quality & Patient Safety

February 2024

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Outstanding Health Outcomes (OHO) Dashboard

Sepsis (SEP)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
SEP-1 CMS % bundle compliance	85%	75%	73%	68%	77%	76%	76%	82%	67%							76%
Sepsis and Related Conditions o/e mortality	≤0.78		1.12	0.75	0.82	0.78	0.84	1.38	1.02							0.95

Central Line Associated Blood Stream Infection (CLABSI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CLABSI Events		18 Ex COVID	14 Ex COVID	1	2	3	0	3	0							9
CLABSI SIR	0.39	1.01 Ex COVID	0.93 Ex COVID	0.83	1.16	2.22	0.00	1.15	0.00							1.14
Central Line Utilization Rate (ICU)	0.68	1.02	0.88	0.749	0.791	0.828	0.774	0.685	0.876							0.78

Catheter Associated Blood Stream Infection (CAUTI)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
CAUTI Events		23 Ex COVID	12 Ex COVID	0	0	2	0	2	1							5
CAUTI SIR	0.40	1.09 Ex COVID	0.55 Ex COVID	0.00	0.00	1.06	0.00	0.97	0.46							0.41
Indwelling Uninary Catheter (IUC) Utilization Rate (ICU)	0.70	1.18	1.22	0.869	0.925	1.040	1.080	1.10	1.077							1.01

Methicillin-Resistant Staphylococcus Aureus (MRSA)	FY 2024 Target	FY 2022	FY 2023	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	FYTD 24
MRSA Events		10 Ex COVID	6 Ex COVID	0	0	1	0	1	3							1
MRSA SIR	0.55	1.11 Ex COVID	0.66 Ex COVID	0.00	0.00	1.47	0.00	1.32	3.00							0.96

KEY	Does not meet goal/benchmark	Within 10% of goal/benchmark	Outperforming/ meeting goal/benchmark

Action Plan Summary

Our Mission

Health is our passion. Excellence is our focus. Compassion is our promise.

Our Vision

To be your world-class healthcare choice, for life

Sepsis

- Focus on 1 hr bundle and expanding to inpatient areas, new order sets/power plans in process with physician stakeholders
- Six Sigma improvement work in process to re-identifying root causes of SEP-1 non-compliance to focus improvement work on the highest contributing factors

Healthcare Acquired Infections

- New super "HAI Brain Trust" Quality Focus Team established, approved by Quality Improvement Committee
- Combine and focus efforts on process metrics that affect the SIRs for CAUTI, CLABSI & MRSA and includes:
    - Line utilization (both central lines and indwelling urinary catheters
        - Multidisciplinary rounds started January 2024 in high risk areas, addresses line necessity (less lines=less infections), monitoring line utilization rates to evaluate effectiveness
    - Decolonization rates
        - Nasal – Significantly improved from 32% (Jan-June 2023) to 84% (July – Jan 2024). Includes patients who are screened and test positive for MRSA upon admission and not discharged within 24 hours of Mupirocin order (decolonization agent). Next Steps – determining and addressing root causes of patients missed screening, and review of workflow of Mupirocin order to administration processes
        - Skin – New discussions on process for skin decolonization through CHG bathing
    - Cleaning effectiveness in high risk areas
        - Quantifying the effectiveness of cleaning during EVS onboarding and annual review with ATP testing; continue to measure cleaning effectiveness through ATP testing in high risk areas (ie. OR's, ICUs)
    - Hand Hygiene (use of BioVigil system for monitoring)
        - Increased use of system, improvement from 31% of active users achieving target badge hours in FY 2023, to 47% (July 23' to Jan 24'). Next steps, additional tools provided to leaders and staff to support increase use, and evaluation of active users with the denominator
        - Starting February 2024 – RECOGNITION PROGRAMS for units/departments that have achieve highest % of staff meeting 80hrs active time (paired) per month!

Questions?

The pursuit of healthiness